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**EVALUATION REPORT:  
FPMD SUPERVISION ASSISTANCE TO THE  
FAMILY PLANNING PROGRAM OF  
THE BURKINA FASO DIRECTORATE OF  
FAMILY HEALTH**

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**FAMILY PLANNING MANAGEMENT DEVELOPMENT**

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## ACRONYMS

DFH/DSF	Directorate of Family Health/Direction de la Santé et de la Famille
FP	Family Planning
FPMD	Family Planning Management Development
FPMT	Family Planning Management Training
FRAC	Francophone Regional Advisory Committee
IEC	Information, Education and Communication
MCH	Maternal and Child Health
MOHSA	Ministry of Health and Social Action/Ministère de la Santé et de l'Action Sociale
MSH	Management Sciences for Health
NGO	Non-governmental Organization
TOT	Training of Trainers
USAID	United States Agency for International Development

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## **I. EXECUTIVE SUMMARY**

Management Sciences for Health's (MSH) Family Planning Management Development (FPMD) Project's technical assistance to the Directorate of Family Health (DSF, for *Direction de la Santé et de la Famille*) in Burkina Faso has focussed on improving the supervisory system at all levels of the country's family planning program. This, according to the author, was a well-identified project, as discussed in Section III. Also discussed in Section III are four other key aspects of the project:

- The project has introduced a new philosophy of supervision where the concept had previously been associated with control and inspection.
- The project has introduced new supervision tools, tools that supervisors praise as a tangible set of instruments that have given them responsibility for program improvement and resulted in better staff relations.
- Through a multiplier effect, the project has expanded beyond the family planning and Maternal and Child Health (MCH) sector into other health activities and geographic areas in Burkina Faso.
- People involved in the Burkina Faso supervision project are extremely happy with FPMD's technical assistance, although some criticisms were received regarding workshops.

Section IV presents favorable circumstances for the implementation of the project. The government of Burkina Faso is committed to a population policy and National Family Planning Program, indicated in part by its intention to increase the contraceptive prevalence rate to 60 percent by 2005 and then to reduce fertility by 10 percent every five years, beginning in 1995. There is also a strong demand for family planning services in Burkina Faso. Constraints surrounding the project are also discussed in Section IV. These are: organizational changes, personnel turnover, lack of resources, weak bureaucratic structures, and confusion about the role of the central level in the implementation of the project.

The author asks two important questions in Section IV, questions that, given current data, can only be answered in part: First, did the project have an impact on the quality of services provided? While data are not available to fully answer this question, interviews with supervisors show that they are giving more attention to the quality of the services provided to clients. Second, Were cultural differences a constraint to the project? The interviews conducted for this evaluation did not seem to indicate great cultural obstacles for the acceptance of new perspectives on supervision and the use of new supervisory tools.

Two important lessons were learned from this project, discussed in Section V. First, there was a clear need for a local coordinator for this project. Four criteria indicating this need can be cited:

- The organizational framework had several weaknesses and did not have all the requirements necessary for efficient communication with MSH and the smooth coordination with the project.

- Compared to other projects administered by the DSF, this one is very small, and no one at the central level could spare the attention the project required.
- The presence of a local coordinator from the onset of the project would have made the extension of the project in time and geographic area easier.
- The project extended over a wide area, making it more difficult to manage.

The second lesson that can be learned is that the issue of project extension should be better addressed during project design and during the implementation of the initial phase of the project. More formal attention during the initial phase could be paid to: criteria to justify the extension, how to use the strengths of the first phase for the next phase, what can be learned from weaknesses of the first phase, how to involve persons from the first phase in the second phase, and how the project needs to be changed for the second phase.

In conclusion, the supervision project in Burkina Faso can be declared a success, despite the constraints cited. The process, however, should be institutionalized and applied to other geographic areas and other levels of the supervisory system. It is imperative that MSH assist in the extension of the project and indicate its availability to provide technical assistance for such an extension.

## II. INTRODUCTION

MSH began its assistance to the Government of Burkina Faso during the Family Planning Management Training (FPMT) project, the predecessor of FPMD<sup>1</sup>. In 1986 an FPMT team visited the country to conduct a preliminary needs assessment. Based on this assessment, a scope of work emphasizing improvement of management with particular attention to supervision was developed. Assistance focussed on training key provincial and central level health personnel in management and supervision. During FPMT, the primary emphasis was on training through a variety of workshops dealing with management and supervision and through long- and short-term overseas training for Burkinabe family planning officials. The development of supervision tools and training materials, including a comprehensive supervisory curriculum for use in the training of central and provincial family planning managers, was initiated. A review of these activities took place at the end of FPMT and resulted in a series of recommendations for the continuation of technical assistance during the follow-on project (FPMD).

It was recommended that the supervisory protocols and guides would be further developed and adjusted to the needs of the family planning program, and that the supervision process would be further intensified and institutionalized at the provincial level. It was also stated explicitly that the basic goal of the development of an effective supervisory system at all levels of the

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<sup>1</sup> The information on the technical assistance of FPMT and FPMD can be found in Madden 1994.

family planning program was to enhance the quality of services and to expand the number of facilities where family planning services are provided.

FPMD assistance to the Government of Burkina Faso was structured in two phases. The first phase (Summer 1992 - Summer 1994) involved the following activities:

- completion of a general needs assessment and a review of the work conducted under FPMT
- design and implementation of a baseline survey of the family planning supervisory system<sup>2</sup>
- training of 17 central and provincial health providers in the supervision of family planning programs
- revision and finalization of a comprehensive supervision curriculum
- an informal training of trainers (TOT) for central level supervision training team
- development, pretesting, and finalization of an operations manual for provincial supervisors

The second phase began in Summer 1994 and will run through June 1995, and it includes the following activities:

- workshop to finalize MCH and family planning protocols and to develop supervision checklists
- reproduction and dissemination of operations guide for supervision and supervision checklists to 15 USAID-sponsored provinces
- three two-week supervision workshops with a total of 65 participants

This evaluation report of FPMD's technical assistance will focus on four issues. First, it will summarize the five most positive key aspects of the project. Second, attention will be given to favorable circumstances and the constraints affecting the implementation of the project. Third, it will deal with two important questions—questions that can be answered only partially in this evaluation report. Fourth, it will try to summarize some lessons to be learned from the project. The evaluation report finishes with a strong recommendation for safeguarding the long term effects of the project.

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<sup>2</sup> For the final report on this baseline survey see Madden et. al., 1992.

### III. FIVE POSITIVE KEY ASPECTS OF THE PROJECT

#### A. Example of good project identification

The project is one that definitely puts its finger on one of the most critical—if not *the* most critical—aspect of the family planning and general health programs in Burkina Faso. Supervision is always a problem in a situation with scarce resources and a shortage of trained personnel. The project is therefore an example of good project identification. As one official described the project: "The project has filled a real lacuna. It was a gift sent from heaven into a jungle of misunderstanding about the supervision process." It is therefore useful to look at the genesis of the project. Credit should be given to both Ministry of Health and Social Action (MOHSA) and USAID, which identified the lack of adequate supervision as a key constraint to the delivery of effective family planning services. Once identified, it was MSH that, through its assessment teams, further defined the problem and its potential solutions. The aforementioned baseline study, conducted at the outset of FPMD, shed additional light on the problem.

#### B. Introduction of a new concept of supervision

The most important result of the project is the introduction of a new philosophy of supervision. Several people involved in the project use the term "revelation" to describe their experiences in acquiring this new perspective on supervision. In Burkina Faso, as in many other areas of Africa, supervision tends to be associated with and defined in terms of control and inspection. Supervision visits are often viewed as a kind of spying exercise. The interviews are unanimous in pointing to the most conspicuous effect of the project: the project has changed the spirit of supervision. As one person puts it very well: "The project has convinced us of the creative aspects of supervision neglected in Burkina Faso which were in fact completely unknown to us." As another astute observer remarked: "In our environment it is just assumed that supervision falls from heaven with the appointment of a supervisor. For us supervision remains limited to administrative control."

In probing for these so-called creative aspects of supervision, the following benefits are especially cited:

- While supervision is both art and technique, the project has shown us that *there is a technical knowledge of supervision*, that one has to prepare supervision, that supervision needs to have objectives, and that the supervisory process can give us the means to attain the objectives.
- The new philosophy of supervision creates a much *more dynamic role for the supervisor*; it creates capacity for better management; it transforms the supervisor into an educator who educates her staff; and it has shown us the importance of monitoring and evaluation as supervisory tools.

- The new vision *makes supervisees aware that supervision exists to improve his/her work*, that s/he has an interest in being supervised because it directly impacts on his/her performance.
- By transforming the roles of the supervisor and supervisee, the project has made a *substantial contribution to human resource development*.
- The new approach to supervision *establishes closer links with our clients*; the inspection of the supervision checklists really makes us aware that the welfare of the client is at the core of good supervision.
- The new perspective on supervision makes it *much easier to plan our activities*, to identify problem areas and priorities. For example, it makes it easier to respond to the Bamako initiative<sup>3</sup> and identify elements of sustainability. The supervision checklist enables one to identify weaknesses in the field and to obtain information on the local level about which nothing was known at the central level.

### C. Introduction of new supervision tools

The previous paragraphs have already hinted of the introduction of new supervision tools. Supervisors in the program repeatedly expressed their satisfaction in having acquired a tangible set of instruments that, according to them, has transformed their supervisory responsibilities into an exciting process of program improvement and has resulted in much better relations with the supervised staff.

The following tools should be singled out:

- *Training in Supervision for MCH and Family Planning Programs*. The Manual for Trainers (*Formation en Supervision des Prestations de Santé Maternelle et Infantile/Planning Familial: Guide pour les Formateurs*) is a sturdy, well-organized training curriculum organized into five modules dealing with human relations in supervision, planning of supervision, implementation of the supervision process, monitoring of supervision, and institutionalization of supervision. The modules are supplemented with a rich assortment of reference material dealing with various aspects of supervision. Except for an important complaint that not enough copies of The Manual are available, all comments on this manual were very positive.
- *Supervision Guides (Guides de Supervision) and Supervision Checklists (Fiches de Supervision)*. The supervision guides give concrete instruction in how to conduct appropriate supervision. The checklists are fundamental supervision tools which permit the supervisor to collect the information to supervise the activities of the supervisees and to write his analytical supervision reports. Each checklist is dedicated to a particular type of MCH and family planning service. It consists of a series of indicators grouped by sequence of activities which have to be followed to provide the particular

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<sup>3</sup> The Bamako initiative refers to efforts originally emanating from WHO and UNICEF to promote the introduction of community cost-sharing mechanisms in support for primary health care.

service. There are checklists for pregnancy monitoring—including delivery and postpartum follow-up, evaluation of abortion risk, evaluation of postnatal follow-up, evaluation of preventive exams for children up to 5 year of age, evaluation of vaccination, family planning service, distribution of specific contraceptives and cessation of their use, follow-up of family planning use, management of contraceptive stocks, and equipment for MCH services. These supervision checklists are used by the provincial supervisors during their visits to the health stations<sup>4</sup>. The information obtained allows for rating the different health posts according to performance and quality of services. With this information the supervisors can make a very concrete supervision report. At the same time they have all the information needed to discuss and improve the performance of their supervisees. These supervision checklists are highly appreciated by the supervisors at the provincial directorates of health that were visited<sup>5</sup> because they enable them to collect crucial information on the quality of work of their respective supervisees in a short time and at the same time provide supervisors with the means to discuss with their supervisees weaknesses needing special attention.

It should be noted that all these supervisory tools have been the subject of in-depth testing and evaluation before there was agreement on their final shape.

#### D. Multiplier effect

The project has a strong multiplier effect at three levels. The new philosophy of supervision is being integrated into the curriculum of the School of Public Health, where the Manual has found a very hospitable reception. Second, some persons trained in the workshops of the project have set up supervision nuclei upon their return to the provinces to train persons active in other health areas. They have also contributed to the elaboration of supervisory material, especially in supervision related to IEC activities. Third, some of those who are transferred to other provinces (see further observations on personnel mobility as a source of constraints) applied the newly-acquired supervision methodology to their new environments. It thus can be said that the project to a certain degree has expanded beyond the family planning and MCH sector through its introduction of new thinking on supervision to other health activities and other geographic areas of Burkina Faso.

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<sup>4</sup> The term health station in this report refers to the Medical Centers (*Centres Medicaux*), the Centers for Health and Social Promotion (*Centres de Santé et de Promotion Sociale*) and Primary Health Care Centers (*Postes de Santé Primaire*).

<sup>5</sup> The plan was to test the supervision guides in two provinces, Oubritenga and Kossi. In Kossi they had very good results. Through Oubritenga received funding for the pre-test, they did not complete it due to lack of information and supervision from the central level.

## E. High quality technical assistance

People involved in the project are unambiguously happy with the technical assistance provided through FPMD. Many of the interviewed persons appreciated the intellectual content of, and the interpersonal skills reflected in, FPMD's assistance. Following are some quotes from the interviews:

- MSH proved to be extremely flexible and always answered our requests for consultants.
- The assistance was unobtrusive [*discret* in French], but especially through its focus and the production of the supervision tools it is going to have a long range effect.
- When changes were wanted in the project design, MSH always responded well. Furthermore, the technical assistance was superb.
- The project is well-sequenced. It reflects the experience and the pedagogic skills of MSH.
- Communication with MSH in Boston was smooth and efficient. Our requests always received prompt attention.

The workshops in general were also well received. Typical in this regard are comments such as the following:

- Starting with this course one really became aware of what supervision tools are. The concepts of supervision, monitoring and evaluation became much more precise.
- In the workshop one didn't talk just about supervision but about the management of health systems. It is my experience that for good supervision one needs to have a good knowledge of the health system. The workshop supported this insight.

Nevertheless, three critical observations on some aspects of the workshops were made. Some persons felt that the DSF team was insufficiently involved in the conception of the workshops<sup>6</sup>. Several persons criticized the practice sessions at the end of the workshop for the absence or incompleteness of documents and for the lack of appropriate supervision of the practical applications (as a consequence of the lack of supervision experience of those who had to supervise practice). Some persons also commented that more lecturers should have advanced linguistic skills.

This project profited from an important FPMD project for Francophone Africa: the Francophone Regional Advisory Committee (FRAC) project<sup>7</sup>. For example, the new project coordinator and his immediate supervisor had the opportunity to participate in the 1994 Conakry FRAC workshop and thus received an introduction to important management issues. There was also participation of persons from Burkina Faso in the FRAC workshops in Boston,

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<sup>6</sup> It should be noted, though, that MSH staff involved in this work felt a lack of interest in being closely involved. See Madden 1994.

<sup>7</sup> For an overview and evaluation of the FRAC project, see Mertens 1995.

Rwanda, and Tunisia. The success of the project was further assisted by enthusiastic professional attention from in-country USAID personnel.

#### **IV. FAVORABLE CIRCUMSTANCES AND CONSTRAINTS FOR THE IMPLEMENTATION OF THE PROJECT**

##### **A. Favorable circumstances**

1. The government of Burkina Faso is committed to a population policy and a National Family Planning Program.

The reduction of population growth and fertility is now recognized as an important aspect of the country's development strategy. Burkina Faso established a National Population Council in 1983. A national plan for a family planning program (*plan d'action nationale en matière de planification familiale*) was put together in 1986. At the same time, the 1920 law prohibiting the distribution of contraceptives was abrogated. The year 1988 saw the emergence of a national action plan in favor of women. In 1989 a new Family Code was introduced, as outlined in the 1991 population policy document. The government intends to increase the contraceptive prevalence rate to 60 percent by the year 2005 and to reduce fertility by 10 percent every five years starting from 2005. The formulation of these new policies and programs, together with changes in family and contraceptive legislation, has been translated into a strong willingness of the government of Burkina Faso to implement MCH/FP projects and to promote their integration into primary health care. The government indeed has now rather elaborate plans to increase the use of family planning, especially in rural areas, to increase the quality of service delivery, and to undertake a variety of IEC programs and to promote the role of women. This has made the government agencies much more aware of the importance of the need for high quality supervision<sup>8</sup>.

2. Within the current set-up of the family planning program, still rudimentary, there is a strong demand for family planning services in Burkina Faso.

During field visits, interviewees regularly observed that the health services in Burkina Faso are insufficiently utilized by the population and that one of the most important priorities for the health program was to make it more attractive to potential clients<sup>9</sup>. For family planning

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<sup>8</sup> Information in this paragraph is based on Ministère du Plan et de la Coopération.

<sup>9</sup> Apparently cultural factors (preference for traditional medicine until the most critical stage of a disease when traditional means showed their inability to solve the problem); sociopsychological factors (lack of participation of people in the conception and implementation of health programs which are viewed as initiatives purely emanating from the government. "We do not consider our clients as health actors, only as beneficiaries," as someone put it);

services, on the contrary, there is more demand than supply in the present circumstances. The supply problem is further compounded by logistic problems. In one provincial directorate of health I was told about strongly motivated women who came all the way to the provincial health directorate because the local health station had run out of contraceptives. The family planning program is therefore in a stage in which the demand for contraceptives within the present framework is not fully satisfied.<sup>10</sup> This has given more urgency to the problem of supervision and has created a strong substratum of interest in the improvement of supervision procedures.

## **B. Constraints**

### **1. Organizational changes**

There have been several reorganizations of the bureaucracy responsible for the implementation of the project. In 1994 the Ministry of Health, Social Action and Family was split into two ministries: the Ministry of Health and the Ministry of Social Action and Family. This in fact was a reversion to a previous situation. Although there are persons who did not think that this physical separation was a mental separation, it is not difficult to become aware of the problems of continuity, coordination, program efficiency, monitoring, and personnel mobility created by such organizational transformations.

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economic factors (costs of treatment); and logistic factors (insufficient supply of drugs in health stations) are responsible for this situation. To increase the demand for health services, emphasis is on two approaches: use of IEC and involvement of the population in decision making about health programs. It was recognized that they are still searching for the most appropriate messages. Audiovisual methods were much better than posters, which run the danger of being devoured by termites. Theater groups have proven to be popular, even if the multiplicity of languages occasionally creates problems. Sometimes the understanding of program logos is very different from the intended one. In some parts of the country the logo for the family planning program, represented by a couple and their two children, was perceived as a family affected by AIDS. It is also recognized that serious efforts have to be made to involve the population in health programs and that people should be given the opportunity to talk about their problems and what they want. Sometimes problems are not correctly identified. In one health station, the example was given of a village for which latrines had been built while the village thought that the supply of clean water was felt to be more urgent.

<sup>10</sup> This does not mean that the family planning program does not have to confront problems. Opposition of husbands (in one place I was told about women who, out of fear for their husbands, came secretly to the health station to get contraceptives), fear of parents that family planning IEC activities in schools will turn their daughters into prostitutes, and resistance of girls to discuss matters related to sex were some of the problems cited in the interviews.

## 2. Personnel turnover

The project has been plagued with serious problems of personnel mobility at two levels: at the central level and at the provincial levels among those trained in the workshops. At the central level, this resulted in serious management interruptions. Replacements need considerable time to become familiar with the project. During my first evaluation visit (December 1994) to the project I was an immediate witness of the consequences of personnel turnover at the central level. Because of the reorganization mentioned in the previous paragraph, the project coordinator and associated project personnel had to leave the Ministry of Health for the Ministry of Social Action and Family. The new project coordinator and his direct supervisor, although both very well-intentioned, were completely new to the project. They did not know much about the objectives and structure of the project. Requesting an opportunity to interview former participants (residing in the Ouagadougou area) in the training seminars on supervision, I was told that I had to talk to the former project coordinator and his associates to get some candidates. It took me until the last day of that first visit to set up a meeting with the former project coordinator, when it had become too late to interview former workshop participants. It was a somewhat of phantasmic search—looking for supervision at the central level in a project with the improvement of supervision as its basic goal.

Personnel turnover in the provinces is a very serious problem in the health sector. Several persons who were trained through the project did not stay with family planning and MCH. Although this does not mean that efforts in training these persons are completely lost (see paragraph on multiplier effect) it nevertheless affects the smooth progress of the project. The high personnel turnover is the consequence of a variety of factors: desire for promotion; arbitrary decisions by the government; and a substantial proportion of the family planning workers are women who will follow their husbands when they change jobs or are transferred.

It does not require much explanation to realize, as will be emphasized later, that these organizational transformations and the high degree of personnel turnover at both the central and provincial levels make the extension of the project to a wider geographic area more difficult.

## 3. Lack of resources

Lack of resources is an important inhibiting factor in the implementation and the further extension of the program. Lack of resources is primarily translated into severe limitations on the number of supervisory visits that can be made each year. The project assumes that at least two to three supervisory visits per year should be made. In practice, the number of annual supervisory visits barely surpasses one, and in some cases does not even reach that number. Transportation costs are one aspect of the problem, but not the most important one. The most important issue is the per diem (*prise en charge*, as it is called in French) covering meals and hotels. Employees have had to partially, or even completely, pay for their meals, and in some

cases even for the hotel, because the per diem was too low or because they never got paid. This situation, paired with low salaries, involves real sacrifices and, of course, sharply diminishes the desire for field visits.

In some cases donors are providing resources for supervisory visits. This was the case in two provinces that I visited. In one province, a Dutch NGO with support from the Dutch government was providing the funds for field supervisory visits over a period of about five years. In another province USAID was in the last phase of such support. However, such external support does not guarantee that the frequency of the supervisory visits will be maintained after the cessation of these donations. It may even hinder efforts to explore new approaches to deal with this resource scarcity, which almost has to be considered a given in the Burkina Faso situation.

In fact, there have been initiatives to remedy this problem through new approaches like the use of checklists periodically filled out by the supervisees and then subsequently submitted to the respective supervisor.

#### 4. Weak bureaucratic structures

The project had to be implemented within a bureaucratic framework with serious limitations at both the central and provincial levels. As a consequence of organizational transformations and personnel turnover, the project was not as strong as it could have been. Furthermore, administration at the central level tends to be heavy. Staff members at the central level frequently use the term "bureaucratic heaviness" (*lourdeurs administratives*), to characterize the administration<sup>11</sup>. At lower levels the administrative framework is very weak, especially on the financial side. All donors agree that there are enormous problems with proper accounting and financial reporting in the provinces. Provinces frequently delay sending supporting documents for their expenditures. Because of these delays further payments have to be postponed, often by a period of nine to ten months with disastrous consequences for smooth project implementation. UNFPA has therefore decided to provide unusual assistance and has supported the training of thirty accountants from the provinces.

#### 5. Confusion about the role of the central level in the implementation of the project

This project is primarily directed to middle level managers. This is a great asset of the project and certainly contributed to its success. However, the success of the project also depends on the central level. We have already seen how organizational transformations and job turnover at the central level, coupled with other bureaucratic weaknesses, has put constraints on the project. In addition, there sometimes seems to be a lack of proper attention to the project at the

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<sup>11</sup> A recent example was the delay of the government in adjusting an unrealistic per diem rate to changing economic conditions, resulting in the postponement of workshops.

central level. As one external observer puts it: "They (central level managers) do not look at the project as a project to manage, rather they look at it as a series of activities to deal with." There is a danger that the current laudable efforts to decentralize MCH/FP and other health programs reinforces this lack of attention. The development of supervisory capabilities at intermediate levels is rightfully seen as a sine qua non condition for decentralization. But decentralization does not mean that the central level should abdicate its responsibilities for full attention to the quality of supervision at intermediate levels by assuming that decentralization and development of supervision skills at intermediate levels does not require dynamic attention to supervision at the provincial level.

## **V. TWO IMPORTANT QUESTIONS THAT CAN ONLY BE ANSWERED IN PART**

### **A. Did the project have an impact on the quality of services provided?**

One of the most important objectives of the project was the improvement of the quality of service in the areas of family planning and MCH. Whether this has occurred could only be partially assessed by this evaluation exercise. To really investigate this issue, one would need to interview clients in areas where the project was implemented and areas not yet covered by the project (controlling, of course, for other factors possibly responsible for differences in the quality of services between the two areas). Indirectly, it would be possible to explore some of the same aspects if good statistics were available on aspects of the distribution of services (such as contraceptive mix, motivation of supervisors and supervisees, characteristics of clients in both regions etc.). However, little or no current data are available which allow for meaningful comparisons in this regard.

Two types of information suggest that the quality of services is possibly improving in the areas covered by the project. On one hand, the project includes efforts to transmit to the health workers the idea that improvement in the quality of services is a basic goal of both the training and the tools for supervision. On the other hand, the interviews with the supervisors show that through training and the use of the supervision checklists they are giving more attention to the quality of services provided to the clients.

### **B. Were cultural differences a constraint to the implementation of the project?**

It is common knowledge that there are important differences in management style between different cultures and nations. Popular books are regularly published on such differences. They also have been the subject of serious comparative research. Much less robust and systematic knowledge, however, is available on how differences in culture can affect the transmission of management philosophy and technologies. In doing this analysis one should guard against presenting cultural differences as inescapable obstacles which would make any such transfer impossible—or at least extremely difficult—in the short run. This evaluation exercise could obviously not study the role of culture in any depth. Nevertheless, some efforts

were made to explore the possible role of culture as an inhibiting or facilitating agent. Some of the above-described constraints might be partially culture-bound. However, the reaction on the part of the interviewees to the transfer of management technology as contained in this project did not seem to indicate great cultural obstacles for the acceptance of new perspectives on supervision and on the use of the supervisory tools. "Once one gets imbued by the new supervision philosophy, the use of the supervision checklists almost becomes natural," declared one of the provincial supervisors. A related question is whether the influence of French styles of supervision, inherited from the colonial period, added problems to the implementation of the project. This seems to be the case as reflected in some resistance to more democratic styles of supervision. The exact extent of such an influence, however, needs more in-depth research.

## **VI. LESSONS LEARNED FROM THE PROJECT EXPERIENCE**

### **A. Need for local coordinator**

The question of whether a particular project needs a local coordinator or a resident adviser is continuously debated in MSH. The more general question of whether it is possible to develop criteria to identify ahead of time the need for a local coordinator or a resident adviser is a complementary and even more burning question.

From very early in the project, FPMD thought that a local coordinator was indispensable. Experience has shown that FPMD correctly anticipated the need for such a person. As the project went on, it was first decided to have at least a local coordinator for the financial arrangements of the project, and a local accounting firm was hired. This accounting firm has provided useful services to the project. Its director, a very able person, has a good grasp of accounting problems in Burkina Faso, especially in the outlying provinces. He is also very much aware that the accounting problems in Burkina Faso do not stand by themselves and require close local project coordination. He therefore concurred with FPMD's desire and subsequent decision to appoint a local coordinator for the project. The experience to date has shown that this was a wise decision.

Are there any general lessons to be learned about criteria to anticipate the need for local coordinators or resident advisers? Although one project is not sufficient to come to robust conclusions in this regard, it may nevertheless be useful to try to formulate some generalizations<sup>12</sup>. At least four criteria can be cited as a probable indication of the need for such a person. First, the project had to be implemented within an organizational framework which, as already shown, had several weaknesses. It was too optimistic to assume that this organizational framework had all the requirements in place for efficient communication with

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<sup>12</sup> In other cases, indicators can be discerned showing the opposite—that neither a local resident adviser nor a coordinator is needed. See Mertens 1994.

MSH and the smooth coordination of the project. Second, it should be emphasized that DSF is responsible for the implementation of many projects. In financial terms this is a small project and therefore had to compete with many other projects for attention. It was difficult for DSF to give full attention to all the details of the project. The problem was further compounded by organizational transformations and personnel turnover. No one at DSF central level could spare all the attention required by the project. Third, the project—although not specifically intended to be extended—could eventually be extended in time and geographic area. The initial phase, therefore, was crucial in the eventuality of project extension. The presence of a local coordinator definitely would have made such an extension much easier. Fourth, the project did not cover just the capital, Ouagadougou, but extended over several provinces of the country. These points, known at the beginning of the project, should have been an unambiguous indication of the need for the presence of a local coordinator from the very beginning of the project.

## **B. Project extension**

This project was conceived and implemented for 15 provinces of the country. Although there was never a formal plan to extend it to the remainder of the country few persons would deny the desirability to extend the project to other provinces and within the existing provinces to lower levels of the health system. Several FPMD projects are of this nature in the sense that they could be viewed as the initial phase of a project which eventually has to be extended to other areas of the country or to other segments of the population. Too often, besides the fervent wish to extend the geographic/demographic coverage of the project at the successful completion of the initial phase, few or no solid arrangements are made for its eventual extension. The concrete planning of the subsequent phase(s) is completely left to the eventual existence of a follow-on project. A smooth transition would thus require that the eventual extension of a project would receive more attention during the initial phase. More formal attention during the initial phase, especially during the last year of the project, could go to issues such as the following: determination of criteria to justify the extension, how to use the strengths of the first phase for the next phase, how weaknesses encountered during the first phase can be taken care of for an improved second phase, how to involve persons associated with the first phase, and the degree to which the nature of project has to be changed for its successful implementation during the second phase.

In case USAID would be phasing out its programs in Burkina Faso, any extension of the coverage of the project will have to be funded from other sources. At USAID in Burkina Faso, I got the impression that this was no problem because the World Bank would be responsible for the extension. While investigating this at the World Bank office, I realized that the World Bank is only barely aware of this project and does not really have a formal protocol to extend the coverage of the project.

At DSF there were also some concerns with an eventual extension of the coverage. The legitimate concern was expressed that there have been many examples of projects which were

extended but with less good results than for the initial project. It was recognized that the extension in coverage would be useful but would require additional efforts to sustain the quality of the work in the past and that at least two more years were required for the full institutionalization of the project. A careful selection should be made of those areas where the context and manpower are favorable for the diffusion of the supervisory tools developed during the first phase. It was especially felt that it should be a gradual process and that the pace of the extension should be moderate because of monitoring constraints. It was also admitted that not all programs at the central level were well integrated.

These concerns, together with the lack of formal arrangements for the extension of the coverage of the project are convincing reasons that the "extension" issue should be more explicitly tackled in the design and during the implementation of the initial project.

## **VII. CONCLUSION AND KEY RECOMMENDATION**

In spite of the many constraints and the absence of a local coordinator during a substantial period of the project, this project can be declared a success. Persons involved in the project have acquired a new philosophy of supervision and new supervision tools which—admittedly slowly—are spreading through other health sectors and even more slowly through other areas of the country as a consequence of personnel transfer. The incorporation of training in supervision in the program of the School of Public Health is bound to have a long term effect that will eventually permeate all health sectors and geographic areas of the country. However, this process needs to be further institutionalized. It also is desirable that attention to supervision be extended to other provinces and to other levels of the supervisory system. It is imperative that MSH approach current donors including USAID or lenders such as the World Bank to see that this really happens. MSH, in fact, could provide the technical assistance to write the protocol for such an extension. It should also indicate its availability to provided any technical assistance for such an extension. The project's local coordinator could also be used for the extension. If these measures are not taken, the impact of the project will be less than the original intention. Furthermore, it would make it possible to consolidate what the project has already done and increase its institutionalization, still considered relatively weak by DSF.

**ANNEX 1**  
**METHODOLOGY**

The final evaluation of this project was conducted through two one-week visits to Burkina Faso, one in December 1994 and one in April 1995. In both visits, semi-structured interviews were used to obtain information from persons at the central level (DSF) and in the provinces. The interviews principally dealt with reactions to the workshops and supervision tools designed under the project and with the impact of the project on the conduct of supervision in the provinces and on the improvement of family planning and MCH services.

During both visits officials in DSF and from a small number of donor agencies were interviewed. Although it was also the intention during the first visit to interview former participants in the training courses who had supervisory responsibilities, this could not be done during the first visit for reasons explained in the report (see Page 9). The second visit, however, made this possible. This visit included field trips to the health stations of three provinces: Kadiogo, Oubritenga and Bazega. The sample of persons interviewed is definitely not a random sample. All of these health stations were within one day (going and return from Ouagadougou). Their radius of coverage varies from about 50 to 90 km. Efforts were made to cover a small range of diverse situations in regard to the status of supervision. Although the conclusions from this report cannot be based on a rigorous random sample, answers obtained through the interviews reflect reactions which are typical of a fair share of those who were directly involved in this project. This impression is corroborated through conversations with other knowledgeable persons from outside the project.

The evaluation was further completed with an inspection of several documents and trip reports related to the project. These are listed in Annex 2. It should also be noted that this evaluation report profited from the evaluation of the workshops which was conducted immediately after they took place and from the baseline study which was conducted at the beginning of the project.

## ANNEX 2

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**ANNEX 3**

**LIST OF PERSONS INTERVIEWED**

<u>NAME</u>	<u>ORGANIZATION</u>
Mrs. Elise BAKIMA	
Dr. BEMBA	DSF
Ms. P. CASSALON	DSF
Perle COMBARY	USAID
Felix COMPAORE	
Dr. Zeinab DERME	Ministry of Health
Mrs. Louise DONDASSE	DSF
Dr. Mohammadin GORMAONO	
Joanny KABORE	INTRAH
Seydou K. KABRE	PPLS
Dr. Celestine Toe KI	Médecin Chef due Centre Medical de Kongoussi
Ms. Claude MILOGOS	USAID
Jeanne NYAMEOGE	Ministry of Social Action and Family
Mr. Youssef OUEDRAOGO	Population Council
Arsene OUEDRAOGO	Ministry of Health, Retired
Dr. Toussaint OUEDRAOGO	Ministry of Health
Dr. Saidou Ouili	
Seydrou RABRE	World Bank
Dr. Francois RAMDE	
Mrs. Pascaline SEBGO	Projet Femmes et Santé
Dr. Sidiosso Germain TRAORE	DSF
Jean-Jacques ZEBA	
Mrs. Thérèse ZEBA	UNFPA
Celestin ZINCONE	Bacoma
Mme. ZOUNGRANA	