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POPULATION NEEDS ASSESSMENT  
UPPER VOLTA

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## TABLE OF CONTENTS

	Page
GLOSSARY OF ABBREVIATIONS AND ACRONYMS.....	vii
1.0 INTRODUCTION.....	1
1.1 Purpose.....	1
1.2 Methodology.....	1
1.3 Organization of This Report.....	2
2.0 COMPONENT 1: DEMOGRAPHIC DATA, OTHER RESEARCH, AND POPULATION POLICY/ATTITUDES.....	5
2.1 Assessment of the Current Situation.....	5
2.1.1 Demographic Data.....	5
2.1.2 Other Research.....	10
2.1.3 Population Policy/Attitudes.....	12
2.2 Related Training Activities.....	19
2.3 Related Donor Activities.....	20
2.3.1 AID.....	20
2.3.2 Other Donors.....	20
3.0 COMPONENT 2: INFORMATION, EDUCATION, AND COMMUNICATION (IE&C).....	21
3.1 Assessment of the Current Situation.....	21
3.1.1 Existing Infrastructure.....	21
3.1.2 Capabilities and Conditions Favoring IE&C...	22
3.1.3 Limitations and Obstacles.....	24
3.2 Related Training Activities.....	26
3.3 Related Donor Activities.....	26
3.3.1 AID.....	26
3.3.2 Other Donors.....	26
4.0 COMPONENT 3: MATERNAL AND CHILD HEALTH (MCH) INTERVENTIONS.....	29
4.1 Assessment of the Current Situation.....	29
4.1.1 Government Programs.....	29
4.1.2 Private Programs.....	30
4.2 Related Training Activities.....	31
4.3 Related Donor Activities.....	32
4.3.1 AID.....	32
4.3.2 Other Donors.....	32

5.0 COMPONENT 4: FAMILY PLANNING INTRERVENTIONS.....	35
5.1 Assessment of the Current Situation.....	35
5.1.1 Existing Infrastructure.....	35
5.1.2 Contraceptive Availability, Use, and Distribution.....	37
5.1.3 Natural Family Planning (NFP).....	41
5.1.4 Service Statistics and Evaluation.....	42
5.1.5 Cost Factors.....	44
5.2 Related Training Activities.....	45
5.3 Related Dcnor Activities.....	46
5.3.1 AID.....	46
5.3.2 Other Donors.....	46
6.0 CONSTRAINTS ON THE DEVELOPMENT OF A FAMILY PLANNING PROGRAM.	49
6.1 Constraints Related to Demographic Data, Other Research, and Population Policy/Attitudes.....	49
6.2 Constraints Related to IE&C.....	50
6.3 Constraints Related to MCH Interventions.....	50
6.4 Constraints Related to Family Planning Interventions...	51
6.5 Constraints Related to Training.....	51
6.6 Constraints Related to Donor Activities.....	51
7.0 CONCLUSIONS AND RECOMMENDATIONS.....	55
7.1 General Conclusions and Recommendations.....	55
7.1.1 Conclusions.....	55
7.1.2 Recommendations.....	55
7.2 Component-Related Conclusions and Recommendations.....	57
7.2.1 Demographic Data, Other Research, and Population Policy/Attitudes.....	57
7.2.1.1 Conclusions.....	57
7.2.1.2 Recommendations.....	58
7.2.2 IE&C.....	62
7.2.2.1 Conclusions.....	62
7.2.2.2 Recommendations.....	63
7.2.3 MCH Interventions.....	65
7.2.3.1 Conclusions.....	65
7.2.3.2 Recommendations.....	66

7.2.4	Family Planning Interventions.....	67
7.2.4.1	Conclusions.....	67
7.2.4.2	Recommendations.....	68
7.3	Training-Related Conclusions and Recommendations.....	74
7.3.1	Conclusions.....	74
7.3.2	Recommendations.....	75
TABLE 1	Recommendations According to Time Frame	82
ANNEX 1:	List of Team Members	
ANNEX 2:	List of Principal Contacts	
ANNEX 3:	Maps of Upper Volta	
ANNEX 4:	Organograms: Ministries of Health and Rural Development	
ANNEX 5:	Decree Establishing National Population Council	
ANNEX 6:	Job Descriptions for Health Personnel	
ANNEX 7:	Job Description for AID Population Officer (Draft)	
ANNEX 8:	Bibliography	
ANNEX 9:	Analyse des Principaux Problemes Sanitaires de la Haute-Volta	

## GLOSSARY OF ABBREVIATIONS AND ACRONYMS

ASV	Agent de Sante de Village
AT	Accoucheuse Traditionnelle
AVBEF	Voltaic Association of Family Well-Being
CEDPA	Center for Education in Population Activities
CENATRIM	Centre National de Traitement d'Informatique
Cents 4	Census and Tabulation System
CESAO	Centre d'Etudes Economiques et Sociales de l'Afrique de l'Ouest
CFJA	Centre de Formation de Jeunes Agriculteurs
CFSC	Community and Family Study Center
CILSS	Comite Permanent Inter Etats de Lutte contre la Secheresse dans le Sahel
CM	Medical Centers
CNRST	Centre National de Recherche Scientifique et Technique
CONCOR	Consistency and Correction
CPS	Contraceptive Prevalence Survey
CPS/WFS	Contraceptive Prevalence Survey/World Fertility Survey
CSPS	Centres de Sante et de Promotion Sociale
DAAF	Division of Administrative Affairs and Finances
DDD	Demographic Data for Development
DRD	Division de la Recherche Demographique
DSP	Direction des Services Pharmaceutiques
EPC	Enquete Post-Censitaire
FAC	Fonds d'Aide et de Cooperation
FAO	Food and Agriculture Organization
FIDEF	Federation International d'Entr'aide Familial
FIFO	First In - First Out
FPIA	Family Planning International Assistance
FRG	Federal Republic of Germany
GOUV	Government of Upper Volta
GV	Groupement Villageois
IBRD	World Bank
IE&C	Information, Education, and Communication
IFORD	Institut Formation Recherche et Demographique
IMR	Infant Mortality Rate
INAFA	Institut National d'Alphabetisation et de Formation des Adultes
INSD	Institut National de la Statistique et de la Demographie
IPDP	Integrated Population/Development Planning Project
IPPF	International Planned Parenthood Federation
IRFP	International Research Fertility Program
IUD	Intrauterine Device
JHPIEGO	Johns Hopkins University Program for International Education in Gynecology and Obstetrics

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MCH	Maternal and Child Health
MOH	Ministry of Health
MOPH	Ministry of Public Health
MORD	Ministry of Rural Development
MOSA	Ministry of Social Affairs
NFP	Natural Family Planning
NGO	Non-Governmental Organization
NPC	National Population Council
OC	Oral Contraceptive
OCCGE	Organisation de Coordination et de Cooperation pour la Lutte contre les Grandes Endemies
ONAP	Office National d'Approvisionnement Pharmaceutique
ONU/DTCD	United Nations Department of Technical Cooperation for Development
ORD	Regional Development Organizations
PAM	World Food Program
PHCP (PSP)	Primary Health Care Post
RAPID	Resources for the Awareness of Population Impact on Development
SAED	Societe Africaine pour l'Etude du Developement
SPONG	Secretariat Permanent des Organisations Non-Gouvernementales
TBA	Traditional Birth Attendent
TFR	Total Fertility Rate
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
USAID/UV	USAID/Upper Volta
WHO	World Health Organization

## INTRODUCTION

### 1.1 Purpose

The purpose of this report is to provide an assessment of recent and current population/family planning activities in Upper Volta. This assessment will be used by the U.S. Agency for International Development (AID) in designing a strategy for the development of a family planning project in that country.

### 1.2 Methodology

A team of eight people--two public health physicians, a public health nurse, an anthropologist/sociologist, a demographer, a communications consultant, a logistics consultant, and a population planner--spent approximately three weeks assessing the prospects for a population/family planning project in Upper Volta (see Annex 1 for a list of team members). After briefings with AID/W (Bureau for Africa) and USAID/Ouagadougou, the team met with about 30 representatives of relevant ministries, at the Ministry of Plan; these meetings were organized in four groups related to various aspects of population/family planning to develop a collaborative work plan.

Four days were devoted to a field trip by the team and four representatives of the Ministries of Health and Rural Development. This trip included visits to Dedougou, Koudougou, Nouna, Bobo-Dioulasso, and Banfora. Contacts and interviews included prefecture and sous-prefecture officials, medical staff, rural development and social welfare staff, training and research staff, religious leaders, and other interested individuals (see Annex 2 for a list of principal contacts). Institutions visited included hospitals; medical centers; dispensaries; maternal and child health (MCH) centers; nutrition centers; social welfare centers that included health and nutrition services; and training institutions for nurses, and for health and rural development staff.

The following week was devoted to visits by individual team members, often accompanied by Ministry representatives, to relevant institutions in Ouagadougou. In addition, the entire team met with key officials, such as the Ministers of Plan and of Health.

The third week was devoted to the writing of individual draft reports, discussions with AID staff, and completion of individual and institutional visits.

Although one cannot expect to completely understand a national culture and development effort in three weeks, the team believes enough information was obtained during its visit to make a reasonable assessment of prospects for a population/family planning project in Upper Volta.

### 1.3 Organization of This Report

The body of this report is organized according to the four major components of population/family planning activities:

- o Component 1: Demographic Data, Other Research, and Population Policy/Attitudes--the precursors of a family planning program (Section 2.0)
- o Component 2: Information, Education, and Communication (IE&C) (Section 3.0)
- o Component 3: Maternal and Child Health (MCH) Interventions (Section 4.0)
- o Component 4: Family Planning Interventions (Section 5.0)

Within each of these components, an assessment of recent and current activities is presented. This is followed by a section on training activities related to that component; throughout the report, training is treated separately because of its particular importance within all areas of activity. Finally, for each component, related activities of AID and other donors are described.

The discussion of current activities by component is followed by a section (6.0) summarizing constraints to the development of a family planning program within each component.

Finally, Section 7.0 presents Conclusions and Recommendations. These are organized by component, again with training treated as a separate topic. Each conclusion is linked to the body of the report by a number in parentheses indicating the section in which the supporting analysis for that conclusion is presented. Also, the recommendations, organized by area of activity in the text, are shown in Table 1 according to the time frame suggested for their implementation--short-, medium-, or long-term.

The report also includes the following Annexes:

- o Annex 1: List of Team Members
- o Annex 2: List of Principal Contacts
- o Annex 3: Maps of Upper Volta
- o Annex 4: Organograms: Ministries of Health and Rural Development

- o Annex 5: Decree Establishing National Population Council
- o Annex 6: Job Descriptions for Health Personnel
- o Annex 7: Job Descriptions for AID Population Officer (Draft)
- o Annex 8: Bibliography
- o Annex 9: Analyse des Principaux Problemes Sanitaires de la Haute-Volta



## 2.0 COMPONENT 1: DEMOGRAPHIC DATA, OTHER RESEARCH, AND POPULATION POLICY/ATTITUDES

This section addresses what may be regarded as the essential precursors of any family planning program. These include, first, the collection and analysis of basic demographic data, to be used for baseline program development; second, other types of research, including social/anthropological, operations, and third, the country's population policy, and the attitudes toward family planning of its leaders and others. This section first presents an assessment of the current situation in Upper Volta within these three areas; it then addresses related training activities; and finally, it describes related recent and current activities of AID and other donors.

### 2.1 Assessment of the Current Situation

#### 2.1.1 Demographic Data

Because any family planning project should be based on sound demographic data and analyses, we turn first to a look at the demographic data available for Upper Volta. The discussion below presents a summary of what is currently known of the demographics of Upper Volta; it then describes the major sources of these data.

##### 2.1.1.1 The Demographics of Upper Volta

The recognition of demographic growth as a dominant factor in the development equation is a fairly recent phenomenon in Upper Volta. There is now a growing awareness that efforts to attain social and economic development objectives may be overwhelmed by the sheer weight of numbers.

Fertility. The current demographic situation in Upper Volta, with a population of approximately 6.5 million, places a severe constraint on all development efforts. The rate of natural increase is estimated to be 2.7 percent per year (World Bank, 1983). The Total Fertility Rate (TFR), or mean number of children born to each woman during her childbearing years, is now 6.5, with a mean birth interval of about 25 months.

This high level of fertility may well rise even further as regional problems of infecundity and subfecundity are ameliorated, and as traditional birth spacing practices are abandoned. At present, the rate of natural increase is partially offset by an annual emigration rate of approximately 0.6 percent, resulting in an annual net rate of population growth of 2.1 percent.

Mortality/Morbidity. In developing countries, health status depends on many variables--some of them directly related to the process of development. In Upper Volta, the variables having an effect on health could be divided into four groups:

- o Water supply and sanitary conditions
- o Food supply and malnutrition
- o Prevalence of communicable diseases
- o Inadequate health facilities and personnel

The level of socioeconomic development in Upper Volta, together with concomitant high birth rates, has resulted in levels of infant and child mortality that are among the highest in the world. Although there are no comprehensive data in the Ministry of Health regarding the infant mortality rate (IMR), in the early 1970s (the most recent data available) the rate was approximately 160 per thousand. Taken from a 1976 post-census survey, the IMR seems to be around 150 (161 to 140) per 1000 births<sup>1</sup>, and life expectancy at birth is 35 to 40 years--one of the lowest in the world.

A perinatal mortality rate between 46 and 86 per 1000 births has been found in government health facilities (World Bank, 1982). A recent survey in the rural zone of the Bwa Region has determined that the neonatal mortality rate is around 68 per 1000 newborns. These high rates are mainly caused by the insufficiency and poor quality of maternity services, as well as maternal malnutrition and the high incidence of morbidity.

The 1976 census survey indicated that at least 27% of all children die before their fifth birthday, mainly from malaria (30 deaths per 1000 new born < 1 year); measles (50% of deaths in the 1-4 age group); and diarrhea, leading to rapid dehydration (about 30 deaths per 1000 children in the 1-4 age group). Meningitis (5 deaths per 1000 children 1-4) often occurs in epidemics.

Morbidity patterns in the under 5 population parallel fairly closely the infant mortality pattern. In order of importance, children's diseases include malaria, diarrhea/parasites, respiratory diseases (whooping cough, influenza, and pneumonia), and other communicable diseases

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<sup>1</sup>Current IMRs in more industrialized countries are between 13 to 17 per 1000.

(measles and meningitis). Moreover, these diseases are often complicated by malnutrition. One study found marasmus more common than kwashiorkor among malnourished children.<sup>2</sup> In any case, it is estimated that 30% to 40% of preschool children are malnourished, and therefore extremely vulnerable to diseases.<sup>3</sup> Malnutrition is both the cause and effect of common childhood diseases. The high fertility rate and short birth intervals are consistent with shorter breastfeeding periods, which are in turn severely detrimental to an infant's chance of survival.

As regards maternal health, traditionally, most poor women in developing countries are either pregnant or breastfeeding during most of their reproductive years. Their bodies do not have time to replenish stores of vital nutrients. This is still true for a great number of women in Upper Volta. The total fertility rate of 6.5 children per woman and the birth rate of 48 per 1000 are high and comparable to other African countries. A maternal mortality rate of 3.3 per 1000 deliveries found in one study<sup>4</sup> is high, although a survey of 1961 indicated a higher figure of 9.6 per 1000 deliveries, which seems more realistic.

The lack of adequate maternities in rural areas (many pregnant women do not come to the prenatal and postnatal clinics because of the distance they have to walk), as well as the lack of trained personnel, poor nutrition, and non-potable water, probably plays some role in maternal health. Studies by the Food and Agriculture Organization (FAO) on the consumption of food in 1981 indicate a differing amount of caloric intake depending on the region and on socioeconomic status. For instance, in the Kaya department it was estimated in 1978 that the mean consumption in calories was 1516, with 49 grams of protein (FAO has estimated a need of 2370 calories for a normal adult in Upper Volta).

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<sup>2</sup>Among 1404 cases of treated malnutrition in Yako from 1972 to 1977, 81% of cases were due to marasmus, 6% to kwashiorkor, and 13% to both (World Bank), 1982).

<sup>3</sup>The rate of malnutrition was 42% among children in the pre-school feeding program in 1980 (Stephens, 1981).

<sup>4</sup>Ministry of Health, 1978 (data from a public maternity in the Kaya Region).

Migration. Upper Volta has the highest rate (and volume) of emigration in West Africa, with the Ivory Coast being the major receiving country. It is estimated that during the period 1970-75, 30 percent of the natural increase was lost by emigration, and that in 1975 Upper Voltaics abroad represented about 19 percent of the Voltaic population (World Bank Paper No. 415).

As is generally found, migration is selective of the young and educated. In 1975, 73 percent of all migrants were between the ages of 10 and 40; 22 percent of returned migrants were literate, compared to only 11 percent of the nonmigrant population. The largest migratory streams are between rural areas and foreign countries. In the period 1970-75, about 70,000 left the country annually, and 37,000 returned, resulting in a net migration loss of 33,000 annually. There is a small but increasing trend in family-type migration. The duration of stay of six years and over increased from 8 percent in 1960 to 43 percent in 1973. Approximately 97 percent of migrants were from the rural areas, with males predominating.

Urbanization. Urbanization is focused on the two major cities. Ouagadougou is estimated to be growing at a rate of 8.9 percent annually, and Bobo-Dioulasso at 4.9 percent, largely because of rural-to-urban migration. Growth of the other cities is largely attributable to natural increase only.

Age Distribution. The dynamics described above have resulted in a fairly youthful population in which approximately 45 percent of the population is less than 15 years old.

#### 2.1.1.2 Sources of Demographic Data for Upper Volta

Resources Available for Data Collection. There are two institutions in Upper Volta with primary responsibility for demographic data collection: the Institut National de la Statistique et de la Demographie (INSD) and the Centre National de la Recherche Scientifique et Technologique (CNRST).

Institut National de la Statistique et de la Demographie (INSD), within the Ministry of Plan, has a technically strong unit of 10 demographers, 5 statisticians, and several data processors, which make up the Direction de la Recherche Demographique (DRD). The computer facilities include 2 IBM/PC's, each with 256K bytes, which were provided by the United Nations Fund for Population Activities (UNFPA) in March, 1983. INSD also has an Apple II with the complete range of auxilliary equipment provided under the Resources for the Awareness of Population Impact on Development (RAPID) and associated projects, beginning in October, 1982. In addition, INSD had access to the Honeywell Bull 64 DPS at the Centre National de Traitement d'Informatique (CENATRIN).

The Directeur of the DRD will head the unit responsible for providing technical support for the National Population Council (See Section 2.1.3.1 below). Funding for the support of this demographic research unit will be provided by UNFPA (see Section 2.3 below). This unit will be placed within the DRD, and will function as the Permanent Secretariat for the National Population Council. The agreement with UNFPA provides support for two training courses (one of one month, for regional representatives, and two of six months, for representatives from different ministries), two seminars, a national director, two outside consultants, six Voltaic demographers, and a data base expert.

Centre National de la Recherche Scientifique et Technologique (CNRST), under the Ministère de l'Enseignement Supérieur et de la Recherche Scientifique et Technique, does research for all branches of the Government. The number and qualifications of its staff, and the research that it has done and is undertaking, indicate that CNRST is well qualified to do specific studies which may be required.

Existing Data Sources. There are two major sources of demographic data for Upper Volta: 1) the single-round retrospective survey of 1960-61, which was a stratified random sample of 75,000 persons; and 2) the country's only census, which was taken December 1-7, 1975. The census questionnaire asked only 1) name, 2) relationship, 3) age, 4) year of birth, 5) marital status, 6) residence status (usual or visitor, etc.), 7) birthplace, 8) literacy, 9) emigration in past year, and 10) economic activity. In April 1976, the Post-Enumeration Survey (Enquete Post-Censitaire, or EPC) of 200,000 persons measured the quality of the census results, and, in addition, obtained complementary data on 1) migration; 2) fertility by ethnicity and religion, last live birth, number, sex, and survivorship of all children ever born; 3) births in the past 12 months; 4) deaths in the past 12 months; and 5) living conditions. The EPC has been used extensively in subsequent fertility analyses. Information on migration has been supplemented by that from a nationwide sample survey carried out in 1974-75.

In addition to the 1960-61 survey and the 1975 census, there is the on-going Sahelian Infant Mortality Study (Enquete Mortalite Infantile au Sahel) funded through the U.S. Bureau of the Census. This study was begun in 1978, with the cooperation of the Institut de Formation et de Recherche Demographique (IFORD) in Yaounde, the Institut du Sahel, and INSD. It is scheduled to be completed December 1984. The analysis of data from Ouagadougou, including 19,000 case studies which were followed from 1978-80, has been delayed because of lack of funds to rent time on the mainframe computer at CENATRIM. The remainder of the data, collected at 4-month intervals over a 2-year period in Banfora, Dedougou, and Ouahigouya, will be

programmed for microcomputers. Data from Bobo-Dioulasso are being analyzed at the Institut de Sahel.

A final source of demographic data for Upper Volta is civil registration, estimated to be 60 to 80 percent complete in major urban centers, and perhaps 5 percent complete in rural areas. Because birth certificates are required for school entrance, birth registrations are more complete than are those for deaths, marriages, etc. INSD would like to establish a Commission National de l'Etat-Civil to develop ways to encourage more complete and timely registration, and to create an interministerial system that would allow all data to be compiled into a demographic data base. This was first proposed to UNFPA in 1979, but nothing has yet been done about this or related proposals.

Future Plans. The Minister of Plan has identified the 1985 census as his first priority. The initial results of this census should be available in time to be incorporated into the Fifth National Development Plan of 1988-93, and should be invaluable in all development planning.

Census preparation is scheduled to begin in January, 1984, with the pilot census to be held in April, 1985. The census itself is scheduled for the first week of December, 1985. UNFPA is expected to provide partial support for this effort (see Section 2.3 below).

## 2.1.2 Other Research

In addition to the collection and analysis of demographic data, three other types of research may be considered: social/anthropological, operations, and biomedical.

### 2.1.2.1 Social/Anthropological Research

The primary capability for conducting social/anthropological research within Upper Volta lies with the private Societe Africaine Pour l'Etude du Developement (SAED) and the governmental CNRST. The former has a permanent staff of five researchers ("charges d'etudes") who direct research in various areas. In addition, SAED maintains a roster of Voltaic specialists whom they can engage as the need arises for specific studies. The fact that SAED has no computer equipment greatly limits its research capability, however.

Although SAED's staff includes several sociologists and health experts, their research over the past years has not been heavily focused on social/anthropological areas. This is because SAED conducts its projects upon request from clients (which since 1972 have included Voltaic ministries, AID, CILSS, OXFAM, the World Bank, UNICEF, FAO, and some commercial

clients). Some of this research has been social/anthropological in nature, including several studies of the integration of women in rural development projects, and a study of the social aspects of a resettlement project. However, most research has been in areas such as agricultural development, urban development, prefeasibility studies (for commercial clients), and industrial development. SAED has been asked by the World Health Organization (WHO) to conduct an evaluation of a regional primary health care project, but there have been some difficulties in launching this study.

CNRST has existed (under several different names) for years in Ouagadougou, and has a total staff of nearly 100 persons. Social/anthropological research is conducted within the Institut de Recherches en Sciences Sociales et Humaines of CNRST, which includes 3 sociologists, 1 demographer, 1 historian, 1 anthropologist, and 2 linguists. Like SAED, CNRST conducts research upon request from its clients, which are primarily international and regional organizations and Government ministries. For example, l'Institut du Sahel has requested a study of rural health and development, although problems for nearly three years have prevented this project from getting underway. In addition, CNRST develops its own research program according to the interests of its staff. However, there is a problem of staff members taking extended vacation or leaving the country for training. This, combined with transportation difficulties for field data collection and lack of a computer, limit CNRST's research capability to some extent. The Directeur de Recherches en Sciences Sociales et Humaines, a sociologist, is particularly interested in studies on the role of women in development. Although some research in this area has been conducted, neither CNRST nor SAED has conducted studies that touch upon the attitudes of Voltaics toward fertility or contraception. A review of population research conducted in Upper Volta between 1975 and 1983, provided by Johns Hopkins University's computerized Population Information Program Resources Center, indicated that very little attention has been given to the social aspects of population, apart from migration. The latter has been, and continues to be, of major concern to Voltaic planners, and has thus attracted the interest of numerous researchers. Similarly, the process of urbanization has been the subject of much social research. However, researchers studying both of these processes (migration and urbanization) have rarely explored the attitudes of migrants or urban dwellers regarding population and fertility. Most studies have been designed to provide statistics on objectively measurable characteristics of respondents, such as sex, age, marital status, ethnicity, and the like, as well as childbearing patterns (although not attitudes toward childbearing). Some studies have been done on women's roles in development in Upper Volta, but, again, attitudes toward fertility and contraception were not addressed.

### 2.1.2.2 Operations Research

The team is unaware of research conducted in Upper Volta to date for purposes of examining alternate approaches to the delivery of family planning and maternal and child health services.

### 2.1.2.3 Biomedical Research

There is presently no biomedical research in Upper Volta on family planning or contraception. There have been some studies on infertility. The team found some interest in doing such research among the staff of the Yalgado Ouedraogo maternity in Ouagadougou.

### 2.1.3 Population Policy and Attitudes

#### 2.1.3.1 Population Policy

Officially, Upper Volta has no defined population policy. Some officials claim that it is not necessary to limit the population increase since the surplus of population is being taken care of by external migration. Also, an old French law of the 1920s still officially bans family planning activities, including sterilization, contraception, and information pertaining thereto, although it is not enforced. As a result, family planning services are given only on an individual basis. Thus the Government's attitude toward family planning can be described as laissez-faire. This attitude is not a serious obstacle to a family planning program. As a matter of fact, the team found a real interest in family planning among those interviewed in the rural areas, as well as in the cities. At the highest levels, the Ministry of Plan is concerned about the relationship between socioeconomic development and population increase. The new Minister of Health stated that while family planning is not a priority in his Ministry, it is an important component to be integrated with maternal and child health (MCH).

Within the Ministry of Plan, INSD continues its efforts to create an awareness of the relationship between population growth and development. The Institute collaborated with the USAID centrally funded RAPID project to develop the "RAPID: Haute-Volta" presentation. This was shown nine times in October 1982, to more than 100 government officials, including the Director of the Cabinet, the Minister of Plan, and the General Directors of Equipment, Commerce, Plan, Economy, and Finance. In April 1983, INSD presented a five-day workshop on "Accroissement de la Population et Developpement" to more than 50 participants, focusing on population redistribution, urbanization, employment, and education. The microcomputer equipment given to INSD under the RAPID project continues to be used for both presentation and data analyses.

On February 18, 1983, in a move reflecting the Government's increasing concern over population growth, the National Population Council (NPC), under the Minister of Plan, was created by decree. The Council is chaired by the Minister of Plan; the first Vice-President is the Minister of Health, and all relevant ministries are represented. The NPC includes representation from the Presidency, the Prime Minister's office, 14 ministries, the Prefectures of all the Departments, and the two major cities. Its purpose is to define the need for population research and education, plan appropriate data collection, and promote family welfare. Thus there is an official agency for donors to assist in the development of a population/family planning program. Although the NPC has not been very active yet, the Minister of Plan has requested his staff to develop ways of facilitating donor planning. As noted in Section 2.1.1.2 above, a Permanent Secretariat will be established within the Direction de la Recherche Demographique of INSD to provide technical support to the NPC.

The decree establishing the NPC also established three commissions:

- o The Commission of Demographic Research will define areas of research necessary for planning, including the identification of procedures which will improve the civil registration system so that the data can be used for demographic research.
- o The Commission on Population and Development is responsible for developing a policy to link basic demographic data and socioeconomic data with a central information system in order to integrate the population variable into development planning.
- o The Commission for the Well-Being of the Family is responsible for research on the ways to improve family well-being, particularly that of women and children.

#### 2.1.3.2 Attitudes

Government. As noted earlier, despite a myriad of difficulties, several droughts, and frequent changes in the Government, the Government of Upper Volta seems to be determined to accelerate the nation's development on many fronts at the same time. The government is aware that, to meet its development goals, it must address the problem of population growth. Water supply and hydraulic projects, of paramount importance for the nation's health, are given some priority, and the Ministry of Health has endorsed a clear plan focusing on rural primary health care programs.

Thus it is clear that the Government, as represented by officials interviewed, is concerned about its population problem and is not hostile to family planning. This was indicated by the warm welcome extended to the team. The first meeting was attended by about 30 counterparts from several ministries and chaired by the Director General of the Department of Demography of the Ministry of Plan. All team members immediately met with national counterparts, four of whom accompanied the team on the four-day field trip. The Ministers of Plan and Health both took a personal interest in the work of the team. The former declared population/family planning a priority, while the latter welcomed family planning activity as a part of MCH services.

Discussions with various officials, from ministers to department prefects to health administrators, revealed no hostility to a discussion of population/family planning. This can be sharply contrasted with the situation in many African countries, where the mere mention of the word family planning can cause a distinct negative reaction. Many recognized the word RAPID and seemed to have benefited by its presentation. Demographers and statisticians are eager for assistance to improve their data base and their analytic capability. Health personnel, whether doctors, nurses, midwives, or paramedical staff, were willing to discuss family planning. They generally have some grasp of the deleterious effect on the health of mothers and children of too many, too closely spaced births. They regret their inability to respond to requests for help in spacing children, and some even requested services for themselves. Very few have been trained in family planning, and they do not have the equipment or contraceptives required. A family planning program would respond to a felt need among many health personnel. Some indicated a clear Government policy regarding family planning would be appreciated, especially in the current climate of job insecurity.

The new revolutionary Government seems dedicated to action in development. Conversations with officials, statements of the President, TV and radio broadcasts, and slogans on street banners all indicate the Government's intention of bringing development to rural areas, of involving women, of educating the masses, and of emphasizing food and nutrition. All of these bode well for support for a national population/family planning program that would reach rural areas with information and services designed to liberate women, improve maternal and child health, and lessen the food deficit.

<sup>p</sup> Religious Groups. Religion should not be a serious inhibiting factor to the introduction of a family planning program. The vast majority of Voltaics are animists with no particular doctrine interdicting birth control. In fact, traditional methods of birth spacing such as breastfeeding, abstinence abetted by polygamy, and traditional medicines seem to be the custom.

For minority Muslims (20%), there is no doctrinal interdiction against family planning in the Koran. Tracts asserting this, written by distinguished Muslim scholars (ulamas), have been used for information purposes in other country programs and could be used similarly in Upper Volta. This may be necessary since the team found evidence that some Muslims would use only natural methods, while some unenlightened and poorly educated mullahs tend to be opposed to any development, including artificial means of child spacing. Information appealing to the desire for protecting the health of mothers and children and explaining Islamic doctrine (through Muslim ulamas) should defuse any religious inhibitions.

Christians are a minority, perhaps 20 percent, mostly Catholic. However, many Government officials and other influential leaders are Christian. Thus care should be taken not to offend their religious convictions unnecessarily in mass IE&C campaigns.

Catholic doctrine emphasizes responsible parenthood; some Catholic priests in Upper Volta belong to the local affiliate of the International Planned Parenthood Federation (IPPF) and are fostering natural family planning (NFP). They are conscious of the need for child spacing, both for development and for health. They may have an exaggerated view of the efficacy of NFP, but they do induce people to think about spacing children. The natural family planners interviewed said that they discuss all methods of contraception, although they offer only natural methods. Thus they would be eligible for AID assistance.

The team found a variety of attitudes toward family planning among Catholic missionaries. Some want nothing to do with birth control. On the other hand, nuns were contacted who believe that natural methods are "unrealistic" and recommend artificial means. The majority appear to follow strictly official Catholic doctrine, and therefore will offer only NFP services, but they will discuss other methods. What can be expected from the Catholic community is promotion of natural methods, with neutrality toward artificial means or referrals to clinics offering effective scientific methods.

Private Groups. The Association Voltaïque pour le Bien-Etre Familial, or Voltaic Association for Family Well-Being (AVBEF), the IPPF affiliate, is favorable to all family planning methods except abortion. Although they currently provide only information and referral to private practitioners, they plan to start clinical services in the near future. They have secured room for clinical work, and already have storage space for contraceptive devices such as IUDs.

AVBEF considers the GOUV attitude toward family planning to be favorable. The GOUV has recognized AVBEF as an official Non-Governmental Organization (NGO), knowing that it promotes family planning, and in spite of the old French law prohibiting family planning activities. AVBEF, in its role as a member of the National Population Council, intends to work with the Council to change that pronatalist legislation. AVBEF is confident that most officials and the majority of the population favor birth spacing.

Private doctors, nurses, and midwives are now providing unofficial family planning services and could be expected to participate freely in any authorized program. Associations of midwives and nurses have requested assistance to provide family planning information and service.

No other groups are actively engaged in family planning. However, most groups engaged in providing MCH or nutrition services (such as OXFAM, WFP, Foster Parents, or the Seventh Day Adventists) recognize the negative health effects of too frequent pregnancies and would welcome a family planning component in their ongoing programs if assistance were available.

Public. In this agro-pastoral society, a great value is attached to early and abundant offspring. Infertility, by contrast, is an unacceptable status for the Voltaic couple. However, it is reported that in large cities, such as Ouagadougou and Bobo-Dioulasso, a growing interest in spacing children has begun among a small segment of women, most of whom are educated. Also, internal migration to the urban centers, as well as to foreign countries, has begun to change the mind of some rural parents regarding family size. However, in a society in which 90 percent of the population remains rural, the incipient change is very slow.

Very few empirical data exist on the attitudes of the people of Upper Volta toward population, fertility, and family planning. No study like the World Fertility Survey has been conducted in Upper Volta, and, as noted earlier, social scientists conducting research in the country have focused on enumerating the population and on such areas as migration and urbanization. While studies have been conducted on fertility, and on infant/child mortality, the attitudes of respondents toward these issues have not been addressed.

For the above reasons, an assessment of the attitudes of the Voltaic people regarding population and family planning must be based on two sources: the limited empirical data available from neighboring countries (with caution in imputing identical attitudes to the people of Upper Volta); and anecdotal information obtained from discussions with Voltaics working in the areas of health and family planning, as well as with several

groups of villagers. Bearing in mind their limitations, these two sources can provide a useful assessment of the attitudes of Voltaics toward population and family planning.

It should be noted at the outset that for the vast majority of Voltaics, of whom no more than 10 percent are literate, population as a factor in societal development is not a relevant issue. Awareness of the importance of demographic factors has developed only recently among governmental leaders. However, at the individual and family level, there are likely to be strongly held views, as well as traditional practices, which directly affect the country's demographic situation. Although limited, some empirical data on these beliefs and practices are available from other West African countries.

For example, although sociocultural values establish children as the raison d'etre of marriage, it is known that traditional methods of contraception have been widely practiced throughout Africa for centuries, primarily for purposes of child spacing. The two methods most frequently employed are prolonged breastfeeding and postpartum abstinence.

Although there has been no large-scale study of breastfeeding in the region, some small-scale studies have been done. A review made several years ago of research conducted between 1975 and 1977 revealed that for the West African countries taken as a whole, the weaning age is 18-36 months, with substantial variation among countries.<sup>5</sup> The duration of breastfeeding is becoming shorter; thus it is possible that birth intervals will also decrease, leading to higher rates of population growth. (It should be noted that the contraceptive effects of breastfeeding have not been precisely documented, and are known to vary with the duration and frequency of suckling.)

The second common method of avoiding pregnancy has been postpartum abstinence--abstinence from sexual relations for a fixed period (varying widely among ethnic groups) following the birth of a child. In the rural milieu, this often involves the wife's returning to live with her parents during this period. One study found that Upper Voltaic women are frequently forbidden to have sexual intercourse until the child has begun

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<sup>5</sup>J.M. Mondot-Bernard; Relationships between Fertility, Child Mortality and Nutrition in Africa, Paris: Development Centre of the Organization for Economic Cooperation and Development, 1977, pp. 32-55.

to walk.<sup>6</sup> Another study conducted in Western Upper Volta indicated that resumption of intercourse was forbidden until the child's weaning. According to these findings, periods of postpartum sexual abstinence varied between 6 and 31 months (mean 17-1/2 months).<sup>7</sup> It is widely believed that urbanization is leading to a decline in this practice, as well as that of breastfeeding. This is due largely to crowded urban living conditions and greater participation of women in the salaried labor force (the latter preventing them from returning to their villages for prolonged periods of time).

Another characteristic of Voltaic attitudes toward population is a low level of knowledge concerning modern contraceptive methods. Qualitative information from interviews with Voltaic nurses and midwives from each of the country's regions indicates that some substances, generally prepared from mixtures of roots and herbs, are used and believed to be effective in preventing pregnancy. These health personnel report that very few women have heard of any modern contraceptive method. Those who are aware of their existence usually know of the pill, and their number appears to be increasing.

The situation in Upper Volta is likely to be similar to that in Senegal, another francophone country within the region. There, the World Fertility Survey revealed that only 1 percent of women had ever employed a modern method of contraception.<sup>8</sup> Voltaic health and social workers who have been interviewed report the following observations:

- o In urban areas, there is definitely an increasing awareness of the advantage of limiting fertility. In spite of the high value attached

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<sup>6</sup> Ls. Bloch (ed.), *The Physician and Population Change: A Strategy for Africa, the Middle East and Europe*, Bethesda, Maryland: World Federation for Medical Education, March, 1979, pp. 220-24.

<sup>7</sup> A. Spira and P. Gouannet (eds.), *Les facteurs de la fertilité humaine (avec référence particulière au sexe masculin)*, Colloque, Cargese, 21-23 September, Paris, INSERM, 1982, pp. 469-73.

<sup>8</sup> Senegal World Fertility Survey Report, International Statistics Institute, WFS, 1978.

to children, there is a growing desire to educate them, and the cost is high. Thus, additional children become a financial burden rather than an asset.

- o There is increased understanding of the negative health and nutritional effects of having many, closely spaced children, particularly among more educated couples.
- o Women tend to be more accepting of the notion of family planning than men, many of whom continue to view children as a symbol of male virility. As a consequence, even women who are interested in spacing births may be reluctant to seek advice.
- o Attitudes toward family planning are more progressive in the urban than in rural areas. In the latter, there is still a tendency to believe "many hands are needed to work the fields." However, in visits with two village groups of men, the team found a great interest in the possibility of spacing children (a possibility about which they had not previously heard). They were concerned with the problems of food availability and the costs of education. The men indicated they would use contraception provided it did not interfere with marital relationships.

## 2.2 Related Training Activities

As noted above, there is a strong corps of 10 well-trained demographers and 5 statisticians at INSD. Since 1977, Voltaics have attended IFORD. Graduates include the Director of the DRD, the Secretary General of the Ministry of Plan, a data processor, and two demographers with DRD.

In addition, the Secretary General of the Ministry of Plan was trained in the use of INSD's new Apple II computer in the United States in 1983 under the AID centrally funded Integrated Population Development Planning (IPDP) Project. Cartographic training, necessary for both censuses and surveys, has been ongoing. Also, two persons were trained in Dakar and two in Tunis in 1980, two in Libreville in 1981, and three at the Catholic University of Louvain in 1982. Others have been trained in information retrieval at the U.S. Bureau of the Census.

Also as noted above, part of the UNFPA support for the DRD will be dedicated to training activities.

## 2.3 Related Donor Activities

### 2.3.1 AID

In the near future, there will be two centrally funded activities related to demographic data collection and analysis. First, the U.S. Bureau of the Census will be sending an expert to Upper Volta in April or May, following a conference in Senegal. Second, RAPID is sponsoring a one-week program in March or April designed to train INSD personnel in the use of microcomputers for data analysis.

### 2.3.2 Other Donors

According to the Upper Volta UNDP Representative, UNFPA will partially support the upcoming 1985 census. The total cost of the census is estimated to be \$1.5 million. The Government will itself contribute approximately \$48,000. The UNFPA Program Officer for Upper Volta has said that UNFPA census support should begin in 1984 and will total \$1 million. Unless the shortfall between the estimated cost of the census and the available funds is made up, the quality of the census may be seriously jeopardized. In this case, the census would not provide the sound data base needed as a benchmark for population projects and development planning over the coming decade.

UNFPA (Department of Technical Cooperation for Development) will also support the DRD within INSD. This support began in January 1984 at a level of \$431,000 for two years, and will provide for both personnel training costs and several small studies related to population policy development.

Partial support for the DRD is also given by the U.N. Department de la Cooperation Technique pour la Developpement (ONU/DTCD), which has a support agreement with INSD for \$775,800 for 3 years, beginning in January 1982.

As regards social/anthropological research, Upper Volta received assistance from the United Nations in 1981-82 to examine traditional beliefs on demography, with the goal of integrating these into the official population policy. In addition, a number of studies have been sponsored by non-Voltaic organizations, including the World Bank, the Canadian Center for Research on International Development, and ORSTROM, as well as by universities and individual social scientists.

### 3.0 COMPONENT 2: INFORMATION, EDUCATION, AND COMMUNICATION (IE&C)

An information, education, and communication (IE&C) program is an essential component of any health campaign; it should not be considered as an afterthought or an appendix to the overall health program. Similarly, it is not worth funding, preparing, and implementing a full-fledged campaign if services are inadequate, or if contraceptives are not available at an affordable price to the general population. The efforts are interrelated and should be coordinated.

In Upper Volta, at the moment, there is virtually no family planning material being created in-country. However, many ministries, international organizations, and private concerns (such as GRAAP) can produce and/or distribute IE&C material. A good number of these groups were visited or contacted, although this section of the report is by no means based on an exhaustive survey of all of them. Nevertheless, from this investigation of these "producers/distributors," and from numerous interviews with end-users of their information, it is reasonably safe to make the observations below.

#### 3.1. Assessment of the Current Situation

##### 3.1.1 Existing Infrastructure

In Upper Volta, two entities are involved in IE&C activities--one in the Ministry of Education and one in the Ministry of Health.

The Institute National d'Alphabetisation et de Formation des Adultes, or INAFA (Ministry of Education), has a diversified sex-education program. Sex education in Upper Volta is taught to secondary school pupils and the general public under the health umbrella, along with nutrition and sanitation. Over the past few years, INAFA has held yearly seminars to train sex educators (see Section 3.2 below). They have also started to reach young people through conferences in classes in some "Maison des Jeunes."

INAFA also has a mass-media component. In the past, French-language radio programs have been presented sporadically. Now there is a much more ambitious project: a weekly prime-time fifteen-minute radio program--again in French. These programs will be prepared in collaboration with health specialists, and are expected to start broadcasting in January 1984. Topics to be discussed on the air include abortion, dating, raising children, puberty, etc. The outline of several programs has already been established. The program will probably be hosted by two persons, and will include studio

and on-location interviews. Although the biggest hope is to produce the programs in local languages, it is believed that this may take some time. The principal barrier is the translation of sexual terms into local languages. Apparently, it is very difficult to come up with words that will not be shocking and yet will be understandable to all.

The Centre National d'Education Pour la Sante (Ministry of Health) produces IE&C material, notably health posters that are technically well done, but are weak from a conceptual point of view: the messages are difficult to understand without any explanation, and they rely too much on French-language written text. Pre-testing is not carried out because of lack of funds and personnel, and there is no budget for the distribution of the posters. The Centre is not operating at full capacity.

The Centre is also producing a series of six AID-funded health films to be executed by the Centre National du Cinema. When the time is right, films dealing with family planning/sex education could be produced under a similar protocol. In addition, the Centre was recently given equipment for their transportation and conferences--a Cherokee vehicle, film and slide projectors, etc., most of which are out of commission because parts and service are not readily available.

The Centre is also always lacking essentials: cartons, paper, printer's ink, slide film, a camera, etc.

### 3.1.2 Capabilities and Conditions Favoring IE&C

A number of capabilities and conditions favoring IE&C activities exist in Upper Volta. Many of these can be described in terms of their potential for enhancement.

Technical Capability. In the event of a health/family planning program, there exists in Upper Volta the infrastructure and the human resources to produce, within the country, IE&C material of an acceptable technical quality comparable to that of almost anything produced in West Africa. This applies to radio, television, print, and film. (Note: for film processing, final mix and prints must be done in France.)

Education through Entertainment. There is often a good grasp of the education/entertainment concept in the delivery of social development messages. It is a well-known fact that adults, as well as young people, are not very receptive to cut-and-dried educational materials. In the case of radio programming, people will save their batteries for more interesting programming.

Among examples of "entertainment" approaches is Radio Rurale, the network of Le Ministere du Developpement Rural,

which has a program called "Varietes Voltaiques" (in local languages), incorporating agricultural advice, quizzes, musical entertainment, and audience participation in the villages where programs are recorded before being broadcast nationally. As another example, when the "Cine-mobiles" of the Ministry of Information used to present educational films in the villages, the encadreur or animateur would also show Charlie Chaplin short features to attract crowds and to give relief from the educational materials.

Three Languages--80% of the Population. Much has been said of the "communicator's nightmare" that Upper Volta might represent because of the many languages spoken in the country. However, it is possible to reach 80 percent of the population with three languages (More, 50 percent; Dioula, 20 percent; Peulh, 10 percent). This means that a very large proportion of the population can be addressed through the mass media in a cost-effective way.

Relatively Low Production Costs. It is relatively inexpensive to produce communications material in Upper Volta. The human resources are part of the civil services: adequate equipment already exists and does not cost anything to rent, and, in most instances, is said to be operational and well maintained. The additional costs are mostly supplies (films, video-cassettes, radio-cassettes, paper, cartons, printer's ink), as well as provisions for transportation, distribution, and circulation.

Integrated Health Campaigns Capability. Local resources appear capable of setting up and conducting integrated IE&C campaigns for health programs, using a mix of interpersonal, mass-media, and traditional channels. Some campaigns have been well organized, were addressed to specific audiences in targeted areas, and had budgets and timetables; an example is the Ministry of Health's "programme elargi de vaccination." On the other hand, there have been other instances of disorganized efforts where various departments would mistakenly give conflicting information.

The People Can Be Reached. There is the necessary ministerial infrastructure to reach almost every target audience for health and family planning purposes. The groupements villageois (Ministry of Rural Development), the Maisons des Jeunes (Youth and Sports), the schools, and the health units represent literally thousands of potential outlets for communications purposes.

Good Sponsor/Producer Protocols. In Upper Volta, a good official working protocol exists between sponsoring ministries (which supply the content of the IE&C material) and the production/distribution departments (which produce the

material). For instance, the Ministry of Health may identify a need for hygiene education films. It will then prepare a proposal--often after having been assured of financial backing by a funding organization--outlining the problem, giving objectives and target audiences, and supplying the content and medical background. The producing unit will respond with a detailed budget and sometimes a timetable. After approval, a normal film production schedule gets under way.

However, for all the professionalism and seriousness brought into the initiation of a project, things still take a very long time to be completed. From the identification of the need, to the proposal, to the allocation of budgets, to the production, to the IE&C campaign start-up, several years can go by before the end-user gets the information.

The Voltaic and the Cinema. It has been often been suggested that the use of video, film, and even illustrative training aids might not be appropriate to reach people who lack visual literacy. Some people believe that the technology can be overwhelming or completely disconcerting in certain cases, with misunderstanding of the use of close-ups, anatomical reproductions, etc. Apparently, such is not the case, at least in Upper Volta. Because of the long-running mobile movie units program, some people estimate that every Voltaic has seen films at least a few times in his/her life. As long as the commentary justifies or explains the images, the films or illustrative aids are well understood and accepted.

### 3.1.3 Limitations and Obstacles

The team also found a number of limitations and obstacles to the enhancement of IE&C activities in Upper Volta.

Getting Feedback on the Effectiveness of the Material. In some sectors, there is good awareness of the need for an evaluation of the effectiveness of IE&C material; some efforts have been made to obtain such feedback from target audiences and end-users. Radio rurale asks its animateurs of the Clubs d'Ecoute to fill in forms with information on the quality of broadcasts, number of participants, relevance of message, complaints, suggestions, etc. The mobile movie units also keep track of their audiences. Unfortunately, in both of these cases, budgets and human resources are not sufficient to analyze the data and put them to full use.

Not Enough Pre-Testing. The team did not discover any significant pretesting of the material that is produced. The procedure does seem to be known because there is some pretesting using the staff of institutions. Producers say that this is better than nothing, but agree that it does not constitute a

significant sample of the target audience. Except for posters, it is believed that pretesting is generally not carried out before the final product is issued.

Finding the Right Level of Language. Although the communication material is often technically adequate, the tone or level of language used in the messages is not quite suited to the intended target audiences. Health specialists sometimes try to reach the average citizen with a level of language that is meant more for other university graduates. Even in African publications such as "Poco" and "Bella," which are intended for literate audiences, the frequent articles on health, family planning, and venereal disease are written in a very technical and, in fact, uninteresting way.

Poor Distribution and Circulation. One of the main IE&C problems right now is the distribution of material--getting the message to the intended target audience. The following are examples:

- o Some say that the Clubs d'Ecoute (radio listening groups) of Radio Rurale are in serious trouble because the receivers used in villages are old or broken, or batteries are not available. Another problem facing Radio Rurale is the proliferation of individually owned radios. While listeners may still tune in to educational programs, and later discuss these programs between themselves, it is more difficult for the animateurs to make sure that the content is fully understood.
- o The seven cine-vans that were used to bring educational films to villages all over the country--and which by some estimates reached over 500,000 persons each year--are now all out of commission. To get a film presentation, a village (or a government service or unit) must contact the Direction Generale du Cinema, and send for the films and projection equipment.
- o Television could yet prove to be a useful tool to reach citizens of the two main urban centers (nobody knows how many TV sets there are in Upper Volta since most of them have been smuggled in, and there is a yearly ownership tax on the sets). However, television has also had its problems. The Ouagadougou transmitter cannot operate at full capacity. With a current broadcast range of only 10 km, it cannot cover Ouagadougou entirely.

- o The Centre National d'Education pour la Sante does not have the funds to distribute its material either by mail or by messenger. It must wait for health workers from outer regions to drop into the Centre when they are in the capital, and pick up their posters.

### 3.2 Related Training Activities

It is important that those involved in IE&C activities, including both educators and health personnel, have good communications skills. They will then be able to use language and media appropriate to target populations.

As noted earlier, the AID mission has supported yearly seminars designed to train sex educators. To date, this training has reached 85 persons--half of them high school teachers, and half various health specialists. AID has also worked closely with both INAFA and the Centre National d'Education pour la Sante, funding specialized training for their personnel. Some support has also been provided by AID and the United Nations Fund for Population Activities (UNFPA) for the training of personnel within the Association Voltaïque pour le Bien-Etre Familial (AVBEF), established in 1979 and accepted as the Upper Volta affiliate of the International Planned Parenthood Federation (IPPF): AID and UNFPA have each sponsored two trainers at the Center for Education in Population Activities (CEDPA) for five weeks. IPPF has also supported the training of several dozen members of the Ministries of Plan and Health in IE&C through lectures and seminars offered by AVBEF.

Finally, a recent hiree of the AID mission, Mrs. Martine Ilboudo, a citizen of Upper Volta, is a graduate of a four-year course in communications from the University of Ottawa. She has studied mass media, person-to-person communications, writing, and pretesting. While in Canada, she was a consultant to the Canadian International Development Agency. She represents a valuable IE&C resource.

### 3.3 Related Donor Activities

#### 3.3.1 AID

As noted above, AID has provided support for the training of sex educators, and for the training of two AVBEF personnel at CEDPA. Both training and project support have been extended to INAFA and the Centre National d'Education pour la Sante in Ouagadougou (for which AID supplied printing equipment and has funded health films).

#### 3.3.2 Other Donors

To date, AVBEF has been involved exclusively in IE&C

activities. Primary support for AVBEF comes from IPPF--\$49,000 in 1982 and \$58,000 requested in 1983. (Members pay \$1 - \$1.50 dues annually, and some money will be raised locally in the future by sales of T-shirts and a fair.) The Association has four full-time paid employees, 15 volunteer workers, and a total of fewer than 100 members. Members are mostly professionals, largely civil servants, and often health staff. As noted above, several dozen members of the Ministries of Plan and Health have been trained in IE&C through lectures or seminars offered through AVBEF. IPPF has supplied such equipment as projectors and films for these efforts.

In addition to the training support for AVBEF personnel noted above, UNFPA is expected to support continued sex education in secondary schools as part of its \$750,000 three-year budget for Upper Volta. UNESCO has already used UNFPA funds to train 15 trainers of sex educators at a school in Bobo-Dioulasso.

Finally, the Upper Volta affiliate of the Association of Professional Nurses is involved in some IE&C work. They have raised some money among themselves for this purpose, but need paper and a reproducing machine to expand these efforts.

4.0 COMPONENT 3: MATERNAL AND CHILD HEALTH (MCH)  
INTERVENTIONS

#### 4.0 Component 3: MATERNAL AND CHILD HEALTH (MCH) INTERVENTIONS

Thanks largely to the national health plan adopted in 1978, Upper Volta has a relatively strong governmental infrastructure for MCH activities, supplemented by a number of private programs and supported by various donor agencies. This infrastructure is critical to the development of any family planning project in Upper Volta. Indeed, it is the primary conclusion of this report that the existing MCH infrastructure should be used as the vehicle for enhanced family planning activities (see Section 7.0).

#### 4.1 Assessment of the Current Situation

##### 4.1.1 Government Programs

Before 1978, MCH services were sporadically offered in rural dispensaries, in the maternities at the rural hospitals (at the Sous-Prefecture and Prefecture levels), and at the two national hospitals (Bobo-Dioulasso and Ouagadougou). In addition, mobile public health teams--which were active in the 70s--were responsible for immunizations, as well as for special programs such as onchocercosis, trypanosomiasis, and leprosy. This system became obsolete because of the lack of supervision and properly trained personnel, the emphasis on curative medicine, the increasing recurrent costs, and the inadequacy of coverage.

Since 1978 the Government has adopted a new national health plan (1980-1990), based on primary health care services as defined at the Alma-Ata World Health Organization (WHO) Conference in 1978. This plan is described at length in the "Document de Programmation Sanitaire National" edited by the Ministry of Health (MOH).

At the level of the village, about 7,000 primary health care posts (PHCPs) will be created. Each will be staffed by an Agent de Sante de Village (ASV) and a traditional birth attendant (Accoucheuse Traditionnelle, or AT), chosen by the community, who will deliver some basic health care, including health education and sanitation. MCH services are limited to normal pregnancy and delivery and referrals for high-risk pregnancy. Other basic health tasks may be performed, such as treatment of diarrhea and simple curative treatments. A local pharmacy will also be maintained at this level.

Next in the pyramid are the approximately 500 Centres de Sante et de Promotion Sociale, or CSPSS (Health and Social Promotion Centers). These units will be staffed by trained paramedical personnel (midwives and nurses). These personnel will be responsible for supervising the PHCPs, and will be

involved in the Extended Program of Immunization; they should receive special attention in a family planning program. The CSPSs will be supervised by the staff of approximately 65 Centres Medicaux (medical centers) at the level of the Sous-Prefectures. Staffed by one or two physicians depending on their importance, they will provide non-specialized medical care.

At the departmental level, a regional hospital (with some specialised services such as surgery and Ob/Gyn) and a mobile team for the public health program (immunization, leprosy, etc.) will be found. Data will be collected at that level. The two national hospitals at Ouagadougou and Bobo-Dioulasso will be upgraded and maintained as teaching hospitals.

Although the MOH has not yet achieved the goals set out in the plan, the infrastructure is gradually being extended.

### Current and Projected Health Infrastructure, 1983

(Estimates from WHO-MOH data)

	<u>Hosp.</u>	<u>Med. Center</u>	<u>CSPS/DISP</u>	<u>PHCPs</u>
Projected Facilities	11	69	500**	7,000**
Actual Facilities	5	39	458*	964

#### 4.1.2 Private Programs

There are numerous non-governmental organizations (NGOs) in Upper Volta that are active in MCH-related programs, mainly geared to primary health care and nutritional activities.<sup>9</sup> Among the most important of these organizations are CATHWEL, PPIK, Terre des Hommes, Sahel Solidarite, Euro-Action Accord, and the Seventh Day Adventists. At present, none delivers family planning services. However, the Seventh Day Adventists intend to include family planning in their project, but have not yet done so because of logistical and staffing reasons. (see Section 4.3 below).

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\*Approximately 48 are fully functioning CSPSs according to the MOH definition.

\*\*Approximate figures.

<sup>9</sup>The SPONG (Secretariat Permanent des Organisations Non Gouvernementales) has edited a report citing all health/sanitation activities by region.

The only private clinic which offers MCH services is the Clinique Sainte-Camille. The pill is available upon prescription by a physician, but there are no other family planning activities. The personnel would require training if the range of the clinic's family planning activities were to be extended.

#### 4.2 Related Training Activities

There are some recently trained MCH personnel at the MOH and within the health system throughout the country at all different levels. However, there are not many of these people, and they do not benefit from continuing education or sufficient supervision. Health education, an essential component of MCH programs, is offered in some centers and neglected in others. Again this depends on the individual in charge. In some instances, such training is offered through parallel programs such as social affairs and even rural development. Nutrition education is offered in Nutrition Rehabilitation Centers existing at the Prefecture or Sous-Prefecture level.

There are also a number of donor activities related to training (described more fully in Section 4.3 below). These include support for the training of traditional midwives (UNFPA and UNICEF); the training of nurses (WHO); and the training of physicians (Fonds d'Aide et de Cooperation, France). The Association of Professional Nurses of Upper Volta would like to have some nurses trained abroad (one has been trained at Tunis), so that matrons and village midwives can in turn be trained locally.

#### 4.3 Related Donor Activities

##### 4.3.1 AID

As noted above, AID is supporting the creation of a planning unit within the MOH. Steps toward strengthening this unit have already been taken.

AID is involved in other activities related to MCH, and potentially to the enhancement of family planning efforts. The largest of these is the PL480 food program, administered by Catholic Relief Services, which addresses malnutrition. The AID-funded water project not only provides safe water, but also has a health education component to ensure proper use and maintenance. Some 350 sanitary agents have been trained by sanitarians (who had received training at Abidjan). These sanitary agents deliver aspirin, chloroquin, etc., and could conceivably deliver condoms, suppositories, and resupplies of oral contraceptives.

##### 4.3.2 Other Donors

UNFPA's three-year budget of \$750,000 for Upper Volta will fund several MCH-related activities. As noted above, these will include the training of traditional midwives, as well as technical assistance and medicines to be provided to the division of MCH/family health within the MOH. In addition, a major UNFPA activity is the assistance expected by the Association Voltaïque pour le Bien-Etre Familial (AVBEF) in establishing a clinical service unit.

The World Bank is planning support for a comprehensive health project. An IBRD pre-appraisal team is due in Upper Volta in November 1983. To date, \$490,000 has been made available for pre-project studies, and \$26 million is proposed to cover 95% of the cost of a six-year program. The proposed project will support the development of health services countrywide, including the primary health care (PHC) system planned by the MOH, consistent with WHO doctrine. Fifty health centers will be built and 150 renovated. All will be equipped and furnished, and staff will be trained and given operations manuals. Prophylaxis for malaria and immunizations (EPI Program) will be emphasized. Studies will be done on drugs required, nutrition, cost recovery, and village health systems. The Planning Unit of the MOH will be strengthened and will serve as the Project Management Unit. Family planning has not been incorporated into the project despite strong IBRD pronouncements regarding population. However, since it is consistent with IBRD policy, family planning might conceivably be included later.

UNICEF has a \$1.6 million program that includes support to the EPI program, water, the training of traditional midwives,

and the supplying of drugs. Oral rehydration packets and traditional midwifery kits are provided. There is no direct assistance to family planning, although its relevancy to health is understood and those involved believe that a program in Upper Volta would be useful.

WHO assistance is largely technical. It has primarily involved helping the MOH to plan, including intensive efforts in support of the development of the PHC program. UNFPA and WHO have a joint project with the division of MCH/family health of the MOH to support nutrition, MCH, and family planning; a consultant has been recruited but has not yet arrived. Part of the \$159,000 obligated for three years has been spent to train 25 nurses, and training is planned for 30 more this year; overseas training has been postponed for this year. The nurses can give information about family planning, but there are no supplies or equipment for service.

PAM or the World Food Program is largely confined to providing food, with the support of the Food and Agriculture Organization (FAO), the U.S., and other countries. They did have a nutritionist, but do not have an educational program or outreach workers. The Director, an American priest, recognizes the need for a family planning program and thinks the new Government's emphasis on bringing women into development makes such a program timely. He finds urban women interested in spacing children, but not rural women.

A number of other multilateral programs have an effect on health services:

- o CILSS, or Comite Permanent Inter Etats de Lutte contre la Secheresse dans le Sahel - Club du Sahel
- o Programme de Lutte contre l'Onchocercose
- o OCCGE: Organisation de Coordination et de Cooperation pour la Lutte contre les Grandes Endemies
- o CESAO: Centre d'Etudes Economiques et Sociales de l'Afrique de l'Ouest

In addition to AID support, Upper Volta receives bilateral MCH assistance from both France and Germany.

France is still the main source of technical assistance in Upper Volta. The Fonds d'Aide et de Cooperation (FAC) is primarily aiding the MOH in the curative medicine sector; 50 French physicians, mainly trained in the Military School of Medicine in Bordeaux, are located in the hospitals of Ouagadougou, Bobo-Dioulasso, and Ouahigouya. There is no

special emphasis on Ob/Gyn-trained medical personnel, and there are no paramedical personnel. The FAC remains the main contractor for foreign drug supplies and vaccines. In the management area, a GSO Officer has been seconded to the MOH, and is responsible for drug supplies and equipment procurement and distribution. The renovation and equipping of the Ouahigouya hospital and the Ophthalmology Department of the Bobo-Dioulasso hospital are also sponsored by the FAC. The officer in charge of social development at the French Embassy would like to focus on more preventive medicine projects in the near future.

The Federal Republic of Germany (FRG) has 41 volunteers in Upper Volta, of whom 18 work in the health field. All volunteers have at least two years of professional experience. There are eight doctors, five nurses, and a midwife. They work at medical centers at the Sous-Prefecture level (such as Nouna) and at the PHCPs. Buildings are constructed or renovated, supplied with medical equipment and furniture, and provided with drugs. Nurses and assistant nurses are trained to work at the village level, supported by the village health council, which decides cost recovery issues. Aspirin, chloroquin, aureomycin, eye ointment, charcoal, and ear drops are provided, but no antibiotics, injections, or transportation. The program, which tries to follow the MOH-WHO plan for PHC, will be coordinated with the IBRD-funded project. There is no official family planning component, but some of the FRG doctors have inserted a few IUDs and written a few OC prescriptions on demand. When and if the GOUV decides to add family planning to MCH services, FRG personnel would be happy to participate and expect that there would be some acceptors.

Finally, among private international groups, the Seventh Day Adventists have organized services for a rural population of about five thousand people 80 kilometers from Ouagadougou. A site visit revealed a school for 35 boarding students, which is to be expanded to 75. Two hours of classroom work is followed by actual farming in a large irrigated area to permit application of the student skills. A health center provides basic health services to about 100 clients per day. Clients have shown an interest in child spacing. Unfortunately, the excellent clinic building was recently robbed of equipment and drugs, and the health worker died in an accident. However, a nurse who could operate the clinic and desires family planning training is available should funding become available for one year's salary.

## 5.0 COMPONENT 4: FAMILY PLANNING INTERVENTIONS

As noted earlier, a primary conclusion of this report is that the existing MCH infrastructure should be used as the vehicle for family planning activities in Upper Volta. The GOUV favors family planning as an MCH service, and is interested in social and health implications rather than just population control; in particular, there is an interest in child spacing.

In addition to the MCH infrastructure discussed in Section 4.0, the Ministries of Rural Development and Social Affairs might be used peripherally to reinforce a family planning program that was integrated with MCH services. This is discussed below, followed by an examination of various aspects of current family planning activities in Upper Volta: contraceptives (availability, use, and distribution); natural family planning (NFP); service statistics and evaluation; and cost factors. Related training activities are addressed separately, as they are throughout this report. Finally, family planning-related support from donors is described.

### 5.1 Assessment of the Current Situation

#### 5.1.1 Existing Infrastructure

##### 5.1.1.1 Ministry of Rural Development (MORD)

Much of the responsibility for developmental activities in the rural areas falls under the Regional Development Organizations (ORDs), which are financially autonomous units directly responsible to the Secretary General of the Ministry of Rural Development (MORD) (see the MORD organogram in Annex 4). Presently, there are 11 ORDs, corresponding to the former regional administrative units of the GOUV. It is anticipated that the ORDs will be redefined to conform with the newly created provinces (of which there are 25). The ORDs coordinate rural development activities within their respective catchment areas. They are responsible for the in-service training of extension agents, and most do some training every year, especially if the program is sponsored by an outside agency. The ORDs have the authority to enter into direct agreements with foreign agencies, including private voluntary agencies.

The most prevalent rural extension agents are the encadreurs, of whom there are presently more than 1200. Because of budgetary problems in the last few years, most ORDs have been unable to replace encadreurs who have left, and therefore the number has been gradually diminishing. Until 1983, the encadreurs were paid by the ORDs. However, over the next three or four years, they will gradually be taken on by the MORD.

The encadreurs must have a primary school qualification. They are trained for one year, at the Matourkou center, in agricultural techniques, communications, and village development. They live and work at the village level and have responsibility for a zone that generally includes a number of villages. They are not provided with transportation although some, theoretically, receive a small supplement to buy extra gas for their own motorbikes.

Some of the ORDs have another cadre of extension agents--the aminateurs/animatrices, who are usually from the village in which they work. Most are literate. In general, they are found only in places where they were recruited and trained to work as motivators or facilitators in a special project. Most of those who worked for the ORDs are gradually being absorbed by the Ministry of Social Affairs. Some are still funded by special projects.

One other cadre that plays a significant role in the rural sector is the corps of teachers in the Young Farmer Training Centers (CFJA, or Centres de Formation des Jeunes Agriculteurs). The training school for these teachers falls under the MORD.

The most important formally recognized structure involved in development at the village level is the village group (groupement villageois, or GV), of which there are, at present, approximately 2,000 registered. The concept was developed during the mid-1970s when the MORD recognized that the cooperative movement, largely centrally directed, was not as successful as had been anticipated. The village groups are autonomous units that are formed and managed by members of the village for the purpose of supporting village development activities (of which approximately 80 percent are agricultural). The encadreurs act as facilitators and advisors to the village groups. Once a village group is formally registered by the ORD, it is eligible for credit.

#### 5.1.1.2 Ministry of Social Affairs (MOSA)

The Ministry of Social Affairs is another infrastructure that could be utilized in setting up a family planning project. The MOSA operates 35 social affairs centers and plans to open 5 more in 1983. Traditionally, the social affairs centers were located in urban areas, but they are gradually extending into the rural sector. The centers are responsible for welfare cases. In addition, their activities include home economics, health education, rehabilitation programs for malnourished children, and well-baby care. Some centers also have other MCH services, including prenatal and postnatal care. All MCH activities are supervised by the regional medical officer, and all clinical personnel working in MOSA centers actually belong

to the MOH. (The MOSA does not operate MCH services in places where there is already an MOH MCH center.) In response to local demand, more and more of the women's groups that are attached to social affairs centers are involved in productive activities, such as home and market gardens, small stock raising, dyeing and dressmaking, pottery, etc. A number of these groups have been commercially successful and have been able to finance the expansion of their activities. Some of the more successful groups have had outside assistance from the International Labor Organization (ILO), UNICEF, or individual private voluntary organizations.

At present, there are 135 social aides (aides sociales)--28 men and 107 women--who work in the centers. The social aides must have a pre-baccalaureate certification (BPC), and are trained for 3 years. In the past, the first year was offered in common with the nurses' training, but it is now separate. Approximately 25 social aides are graduated per year.

The MOSA is gradually taking on a cadre of village extension agents trained under special projects--monitrices (who have a primary school-level diploma) and animatrices (who do not have any diploma). At present, there are about 130 of these extension agents in the MOSA. Their activities vary, but they usually continue working in the same women's groups, nutrition education programs, or other village activities in which they were previously involved.

The MOSA does not have a regular program of in-service training. However, occasionally UNICEF, FAO, or other donors support in-service training activities in which MOSA personnel participate. The Ministry is especially interested in establishing training programs for the animatrices and monitrices.

#### 5.1.2. Contraceptive Availability, Use, and Distribution

##### 5.1.2.1 Contraceptive Availability and Use

Oral contraceptives are not being distributed routinely through the MOH network (ONAPHA), although pills and IUD's can be bought in private pharmacies with a doctor's or midwife's prescription. These limited services are just starting and are quite minimal in Upper Volta. They are mainly available in large cities, such as Ouagadougou and Bobo-Dioulasso. At the National Maternity Center of Yalgado Ouedraogo, the three Ob/Gyns posted there (out of a total of five in the whole country) have not yet launched any kind of organized family planning clinic. L'Association Voltaïque pour le Bien-Entre Familial (AVBEF) has not yet begun service delivery, although it has received a few contraceptives.

The oral contraceptives available in pharmacies appear to be limited to 21-day-cycles of French manufacture, costing approximately \$1 to \$3 per cycle. The 21-day-cycle is a handicap, especially for uneducated or undisciplined women. IUDs can be found in Bobo-Dioulasso and Ouagadougou. Their costs vary from \$20 to \$30, not including insertion. Moreover, there is a lack of trained personnel aside from the few already overloaded Ob/Gyn specialists. Contraceptive foams are found in some main pharmacies but are not popular.

Condom acceptability is limited and is often associated with extramarital sex, sexually transmitted diseases, and/or prostitution. Condoms (made in France) are to be found in pharmacies at high prices (\$2.00 for 6). Some tubal ligations are done for medical reasons (after 2-3 cesarean sections) or if requested by a couple. The minilaparotomy method is used at the national hospital. There is some service in rural areas (e.g., in Nouna, 5 to 6 tubal ligations are performed annually).

At the main maternities of Ouagadougou or Bobo-Dioulasso, where several dozen deliveries occur daily, services for child spacing are almost non-existent. Women who have had obstetrical problems during previous deliveries are told "to go and manage" (se debrouiller) in the maternity of Ouagadougou, and many come back pregnant. Many beds have two patients, and there is only one operating room (for septic cases as well as for the more sophisticated interventions). Thus even in the capital city of the country, maternity care is very poor. One can almost predict that this situation is not going to improve substantially for some years unless an additional O/R, more trained personnel (Ob/Gyn and paramedics), and a good postpartum/family planning program are set up with a strong management component.

One laparocator was sent to the Ouagadougou maternity hospital, but apparently it was not used by the consultants. Following the Johns Hopkins University Program for International Education in Gynecology and Obstetrics (JHPIEGO) training of two national Ob/Gyn physicians in Tunisia, two laparocators are due. They will be distributed to the maternities of Ouagadougou and Bobo-Dioulasso. Full laparoscopic equipment for infertility diagnosis as well as sterilization is needed.

#### 5.1.2.2 Pharmaceutical Distribution Infrastructure

While there is currently no functioning program for the distribution of contraceptives in the government or private sector, the existing distribution system for pharmaceuticals and pharmaceutical products will provide clues as to how a contraceptive distribution network might function. The system of management and distribution of pharmaceuticals is a mixed one involving two government offices and the private sector, as described below.

The Direction des Services Pharmaceutiques (DSP), within the MOH, is one of seven directorates reporting to the Secretary General of Health. Its responsibilities include the following:

- o Distribution of pharmaceutical products to government health facilities (hospitals, dispensaries, and medical clinics)
- o Licensing of private pharmacies
- o Establishment of a list of essential pharmaceuticals for Upper Volta

The MOH's Division of Administrative Affairs and Finances (DAAF) purchases government pharmaceuticals based on a list prepared by DSP (annual purchase = 100 million FCFA\*). Products purchased by DAAF are often more expensive or less appropriate than if they were purchased by pharmacists in the DSP. The DSP is also responsible for the warehousing and distribution of pharmaceuticals donated by WHO, UNICEF, and the Fonds d'Aide et de Cooperation (FAC) for use in government programs (approximate value = 300 million FCFA).

The DSP central warehouse is 15 x 25 meters--a block and steel roof building built by the French in the 1950s. It is located in Ouagadougou. The facility is adequate for the storage of drug and medical supplies, although dust collects quickly on all materials and personnel complain that there is not enough room to stock all the supplies. (When visited in October, 1983, only 20 percent of the warehouse was occupied by pharmaceuticals.) Products are grouped by type and also by distribution to the (present) 8 health regions in the country. All materials were neatly stacked, although some stacks were placed directly on the floor.

The DSP uses a stock card for each product at each dosage. The location of the product, by shelf number, is marked on the card. Spot checks of several cards revealed that the actual inventory on the shelf and that marked on the card were the same. When an order for medicines is received ("bon de commande"), the quantities supplied are marked on a shipping form ("bon de sortie") and the quantity of the product removed from the shelves is marked on the stock card. A notation is made on the stock card showing how much was shipped, when, and to what health facility. A first-in-first out (FIFO) system of stock rotation is used. An overall inventory is conducted quarterly.

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\*Although the rate of exchange varies considerably, it was recently 400 FCFAs for 1 U.S. dollar.

The DSP does not have a distribution system, although 4 UNICEF vehicles will be made available in the near future to help transport the pharmaceuticals to the 8 health regions. Presently, each health region comes to the warehouse for supplies.

The principal problem in the DSP is its lack of control over the ordering and arrival of pharmaceuticals. MOH budget appropriations are not sufficient, and the quantity of materials is not adequate for the public sector. Stock ruptures are frequent.

The Office National d'Approvisionnement Pharmaceutique (ONAP) is an office of the MOH charged with the exclusive authority to import pharmaceutical products into Upper Volta. ONAP does not receive a budgetary appropriation, but "self-finances" its operations through the resale of pharmaceuticals to public and private pharmacies and to MOH health facilities, and directly to the general public. Approximately 30 percent of all pharmaceutical importations are made by ONAP (700 million FCFA/year).

ONAP has a central warehouse in Bobo-Dioulasso, similar in construction and size to the DSP warehouse. In addition, 9 regional depots and 6 public pharmacies ("pharmacies nationales") serve as distribution points to private pharmacies, health facilities, and rural pharmacies. ONAP does not transport pharmaceuticals; products are available to be picked up at the depots or can be shipped on a "freight collect" basis.

The inventory system used at the central warehouse is adequate. A stock card is used for each product, showing a running tally of quantities shipped and remaining. Spot checks revealed that these quantities were accurate. An FIFO system is used.

ONAP does not have sufficient funds to import all of the pharmaceuticals needed for use in Upper Volta. Budgetary inadequacies are partly the result of the Government's failure to transfer credit to ONAP for purchases made by Governmental health units. ONAP has a cost flow problem and frequently is behind on payments to external suppliers. The 6 public pharmacies are as expensive as private ones and are frequently poorly stocked. There is no rational system for reordering pharmaceuticals based on minimum quantity or demand.

Finally, both private and village pharmacies are existing mechanisms that could prove useful to a family planning project.

Over 60 percent of all of the pharmaceuticals used in Upper Volta are imported by 10 private pharmacies. Compared to

the public pharmacies, these pharmacies, located primarily in Ouagadougou and Bobo-Dioulasso, are clean, well-stocked, and modern. The private pharmacies are responsive to public demand and need. For example, during an outbreak of yellow fever in Upper Volta, one private pharmacy purchased yellow fever vaccine for use by private physicians. The vaccine arrived in the country one week after the epidemic was announced by the Government. Private pharmacies also supply some of the rural pharmacies with pharmaceuticals. The rural pharmacies receive a 5-15 percent discount for their quantity purchases.

The village pharmacies, or "pharmacies villageoises," respond to the country's need for an effective distribution system of commonly used drugs to the rural population. Each is either a local cooperative or privately operated depot managed by a villager with minimal pharmaceutical training. Training is provided by the DSP or by the regional Government pharmacist. Pharmaceuticals available in these village pharmacies include aspirin, chloroquine, activated charcoal, cough medicine, and bandages. Prices are theoretically but not practically fixed, but are minimal (3 chloroquine = 10 FCFA). The most efficient pharmacies villageoises are those in which the manager receives a small compensation based on the sale of the pharmaceuticals in his or her pharmacy.

Approximately 600 village pharmacies are believed to be needed by the MOH. However, fewer than 100 have been opened in the 6 months since changes were made in the national pharmacy laws permitting the establishment of the village pharmacies.

In conclusion, the most efficient means of pharmaceutical distribution in Upper Volta rests with the private sector. Recent moves by the Government to regulate prices and limit the involvement of private pharmacies in the importation of pharmaceuticals will place increasing pressure on ONAP and the DSP to respond to health needs. At present, both of these offices lack the managerial and budgetary capacity to be responsive.

### 5.1.3 Natural Family Planning (NFP)

There is a small but promising network of NFP teachers, organized under Dr. Guy, the representative in Paris of Dr. Claude Langtot's Federation Internationale d'Entr'aide Familial (FIDEF). The team met with leaders of NFP groups in Bobo-Dioulasso, Banfora, and Ouagadougou who are teaching NFP in their respective parishes. They discussed their plans for further developing their teaching programs. The team reviewed the types of assistance that AID/W may be able to provide, and encouraged the Bobo-Dioulasso and Banfora groups to submit proposals to AID/W through USAID/UV. USAID has already been approached for financial support to develop the NFP program in Ouagadougou.

#### 5.1.4 Service Statistics and Evaluation

The infrastructure for the collection and analysis of service statistics exists at all levels of the Ministry of Health (MOH), from the central services to the peripheral stationary units, e.g., the dispensaries (CSPSS) (though not, apparently, including the primary health care posts). The CSPSSs, medical centers (CMS), and hospitals maintain registers in which consultations are recorded. There are monthly reporting forms on which each health unit records the total number of consultations, by category (including the distribution of diagnosed diseases). The monthly reports are sent to the Chief Medical Officer in the region, where they are supposed to be collated and forwarded to the MOH. At the central Ministry level, the regional reports are delivered to the statistics officer in the Division of Public Health and forwarded to the Statistics Unit within the Division of Research and Planning.

Statistics on the resources of the delivery system--the status of service units, personnel, equipment, and supplies --are supposed to be collected at the regional level and collated by the statistics officer within the relevant division of the Ministry. Theoretically, the Statistics Unit in the Division of Research and Planning assembles these data for annual Ministry reports.

The MOH has established patient monitoring cards for under 5 care, prenatal services, and the nutritional rehabilitation centers. When the published cards are not available, clients sometimes use blank notebooks in which consultations are recorded. In general, the child care cards are kept by the mothers, the notebooks are kept by the patients, and the prenatal and nutritional rehabilitation records are filed in the clinic.

The team's impression was that, in general, the health units routinely record consultations and regularly tabulate monthly reports. However, the collation and processing of these reports at both regional and central levels is deficient. The Ministry is five years behind in the analysis and publication of annual data. Individual patient monitoring appears to be relatively rare outside of a few well-established MCH centers and maternities in which there are regular well-baby and prenatal services.

The Ministry does not have reliable information on the status of resources. Frequently, the information is available at the regional level, but it is not systematically recorded and forwarded and thus is not available at the central level. In some instances, changes in the status of resources may not be reported because of the risk of budgetary reductions in the upcoming annual allocations; for example, if a dispensary became

inactive, the allocation of drugs for the region might be proportionately reduced, or if a health worker resigned, his post might be eliminated.

The format for registering and reporting service statistics is cumbersome. It demands a lot of time on the part of service providers to record, and especially to collate the data. They must laboriously maintain several daily registers and then periodically count up the services by category. Moreover, more information is demanded than is absolutely necessary for program supervision and evaluation. The forms on which routine reports from the individual units are submitted are too long, and the format does not lend itself to efficient analysis. (One very positive aspect is that nosological codes have been reduced to those diseases which are prevalent in the country and are generally recognizable, and each region has further reduced the list according to local epidemiological patterns.)

The major gap in the flow of information between the point of service delivery and the Ministry appears to be at the regional level, where the regional medical officer does not have the time to process regional statistics. Moreover, there is a certain amount of overlap at the central level, where each division of the MOH has its own statistical office, and information is not always turned over to the Statistics Unit.

In sum, at present, there is very little information that can be used for managing, planning, or evaluating the health services. The Ministry has not published summary statistics for a number of years, and those data that are available are unreliable. For example, there are discrepancies between the statistics available in different divisions of the Ministry on the total reported cases of specific diseases. In addition, the use of individual records for patient management is rare.

There is a WHO statistics advisor presently working with the government statistician in the Statistics Unit of the Division of Research and Planning. Together, they are attempting to develop a plan to improve the health information system of the Ministry. The WHO has agreed to support a program of training statisticians to work at the regional level. (The plan is to recruit individuals for this training who are already in government service and not to create a new cadre.) The Statistics Unit is also attempting to establish a system of coordinating information within the Ministry. For example, the Personnel Unit will report all new appointments, reappointments, deaths, and other changes to the Statistics Unit to ensure that the inventory of personnel will, to the extent possible, be current.

Improvements in data collection and analysis are needed as part of any effort designed to enhance family planning activities in Upper Volta. Such improvements are one object of an agreement between the GOUV and AID designed to strengthen the country's health planning capability (see Section 5.3 below).

#### 5.1.5 Cost Factors

In 1981, the total expenditure on health in Upper Volta was estimated at \$7.75 per capita. A significant proportion of health expenditures are financed by foreign aid (approximately 41 percent) and by the private sector (approximately 24 percent). More than two-thirds of all drugs and supplies are imported by the private sector; less than ten percent are distributed in the public sector, and the rest by donors.<sup>10</sup>

In 1982, the operating budget of the MOH was approximately 8.2 percent of the national budget. Between 1960-76, there was virtually no change in real terms in this operating budget. Since 1976 there have been significant annual increases in the absolute amount allocated, and in the proportion of the national budget. However, personnel expenditures have absorbed virtually all of this increase. At present, close to 90 percent of the MOH recurrent budget is spent on personnel, leaving little for other operating costs.

The same trend is seen in health expenditures in local budgets (responsible for non-skilled and semi-skilled health workers, and for transport of regional medical officers, for example).<sup>11</sup>

In the public sector, there is almost no cost recovery. There is an established schedule of hospital fees for inpatients, pro-rated according to the type of ward (private, semi-private, public), and including a schedule of discounts for various classes of people, such as civil servants, religious authorities, etc. Hospital revenues are supposed to be returned to the national treasury, but it is estimated that only a small proportion of these fees is actually collected and remitted. Another revenue source in the public sector is the sale to patients of individual health cards or notebooks for 25 CFA each. The funds remain in the service unit. Some units have used this money as a rolling fund for extraordinary expenses. For example, they may advance money to buy gas in order to transport emergency cases pending reimbursement by the patient.

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<sup>10</sup>World Bank, Upper Volta: Investment in Human Resources: Country Economic Memorandum, Washington, D.C., September 1983.

<sup>11</sup>Ministry of Health, GOUV, Ouagadougou, *Depenses de Sante en Haute-Volta selon l'Origine du Financement* (PPF 02-83), April 1983.

Consultations are free of charge, and drugs that are distributed through public health services units are gratis. However, the stock of free drugs is very small, and therefore most drugs are in fact purchased from state or private pharmacies. Even inpatients often must buy their own drugs. For example, in a very active rural maternity visited by the team, women were advised in advance what supplies they needed to bring for a delivery.

As for the potential effect of a family planning project on recurrent costs, if such a project were integrated with existing services, there should be no increase in personnel. Training is a development cost which, most likely, would be financed by the program. Training could result, however, in promotions, which would have a slight effect on personnel costs.

Supervision is an important operating cost which is not adequately financed at present. Considering the compensatory action that should be taken, plus the additional supervisory role that could be anticipated with the introduction of a family planning component, the recurrent cost implications would be significant.

The major recurrent cost of a family planning component would be the distribution of contraceptives.

## 5.2 Related Training Activities

Since most of the senior staff has been trained in France, the curricula of the School of Public Health follow very much the French pattern. In recent years, the curricula for midwives and nurses have been revised, but these revisions were not based on job descriptions and detailed task analyses appropriate to Upper Volta. The curriculum for practical nurses (infirmiers brevets) is currently under revision. The curriculum for midwives (accoucheurs) has been designed to serve the rural population and contributes much to activities related to water supply and sanitation. Neither curriculum includes family planning activities, although ten hours of theory in family planning has been integrated into the curriculum for midwives under the title "advice on family spacing." MCH is a component of the curriculum for paramedical personnel.

In the schools and services visited, it seems that family planning is discussed as a hidden appendix to a lesson. There are no books, references, or audio-visual materials available. It seems that the absence of Government policy on the issue, along with the lack of appropriate preparation of teachers, is the key factor in preventing the development of this component in the curriculum.

Recently, AID has funded family planning training for Voltaics in Santa Cruz, California; Tunisia; and Washington. It is hoped that these personnel will become resources for future action in family planning activities.

For the past three years AVBEF has organized a three-week seminar related to family health in which family planning activities are addressed. Unfortunately, the course is theoretical and only describes contraceptive methods. It does not include any communication skills, management supervision, practical demography, or statistics related to family planning; there are no practical exercises or clinical observations. The above course has potential but needs to be assessed and redesigned with a view to the delivery of services adapted to the population.

### 5.3 Related Donor Activities

#### 5.3.1 AID

As noted above, AID has signed an agreement with the GOUV to finance a project to strengthen the health planning capability. This project includes technical assistance and participant training to improve the collection, processing, interpretation, and use of data that are needed for health planning and management.

#### 5.3.2 Other Donors

While there is currently very little support for family planning activities in Upper Volta, a number of existing organizations have expressed an interest in extending their MCH services to include some family planning supplies and services.

To date, AVBEF, supported primarily by IPPF, has been involved only in IE&C activities, with no organized clinical services. However, an estimated 100 acceptors have responded to IE&C by asking for services. A small supply of orals, and Neosampon suppositories, and 4,000 condoms, provided by IPPF, has been exhausted. To receive even a referral from AVBEF one must be married and have a husband's consent form signed.

The Association of Professional Nurses of Upper Volta has also expressed an interest in family planning supplies and services. They would be happy to have contraceptives and a few basic drugs, such as aspirin and oral rehydration salts, in order to follow information with service. They will work on planning a request for assistance to FPIA or other AID centrally funded intermediaries.

Although the clinic run by the Seventh Day Adventists has suffered the recent setbacks described in Section 4.3 above,

the pastor is eager to start the clinic again and to offer basic health services, including family planning, He has a nurse available if he can guarantee a job. He was urged to prepare a draft proposal to present to FPIA; the FPIA regional staff member will assist him with this proposal during an imminent visit. With a minimum of training and equipment, a few basic medicines, and contraceptives supplied by IPPF (or FPIA), a pilot rural family planning service could be initiated.

Other private groups, such as OXFAM and Foster Parents, were interviewed. There seems to be a consensus that the GOUV is in a dynamic phase that favors change and emphasizes development, reaching the rural poor and involving women. Child spacing gets no organized support but is acceptable. If the means were available, some of the private groups would add child spacing services as requested by recipients of health services.

6.0    CONSTRAINTS ON THE DEVELOPMENT OF A FAMILY  
         PLANNING PROGRAM

## 6.0 CONSTRAINTS ON THE DEVELOPMENT OF A FAMILY PLANNING PROJECT

There are a number of constraints on the development of a family planning project in Upper Volta. These involve all of the components discussed in Sections 2.0-5.0, and should be addressed in the project planning stages.

### 6.1 Constraints Related to Demographic Data, Other Research and Population Policy/Attitudes

As regards the demographics of Upper Volta, urbanization is increasing, but most of the population still lives in rural areas. Education is improving at all levels, but is insufficient; the social conditions of women are still very poor, and illiteracy still remains at about 90 percent. These demographic factors could affect the design and effectiveness of a family planning project.

As noted in Section 2.1.2, although the infrastructure for demographic data collection and analysis exists, activities to date have been limited. If realized, the scheduled 1985 census would improve the demographic data base needed as a benchmark for population and development planning over the next decade. However, as noted earlier, UNFPA support for this is not sufficient to make up the difference between the Government's contribution and the cost of the census, and thus the effort could be significantly compromised.

As for social/anthropological research, activities in this area have been quite limited. The two primary entities with the capability to conduct such research--the private Societe Africaine d'Etudes pour le Developpement (SAED) and the governmental Centre National de Recherches Scientifiques et Technologiques (CNRST)--lack computer equipment and other facilities that would facilitate these efforts. As noted earlier, there has been neither operations nor biomedical research conducted in Upper Volta.

As noted in Section 2.1.3, Upper Volta has no defined population policy. Moreover, despite the creation of the National Population Council and other indications of Government interest in population issues, the Ministries of Health and Social Affairs are still low-priority ministries, and their management capabilities are not adapted to addressing real population problems.

One of the major issues is whether, in a rural society with continuing high morbidity and mortality, family planning will be accepted. Modern education, particularly in health and sexual matters, in conjunction with a substantial decrease in infant mortality, is likely to have an influence on cultural

concepts associated with family size. However, this development will occur more as a progressive phenomenon than a radical change.

Voltaic women in general desire many children. The barren woman is a social outcast. The present family size of 6.5 is "normal." Changes in rural attitudes, observed by the consultants, are needed to initiate a change in fertility behavior. This attitudinal change is perceived to be rather slow, however. A specific felt need to add family planning as a component to the basic health delivery system for this rural society is likely to occur only when the rural masses start to change their family-size norms. This will in turn happen when rural groups have been properly and adequately informed; when school children have received sex education; and when medical and paramedical personnel, convinced of the relationship between development, health, and family size, become promoters of family planning. A family planning program depends on visible, devoted, and adequately trained individuals, including determined officials. The initiation of effective service programs provided in a culturally acceptable fashion is an important aspect of creating this climate of interest and demand.

## 6.2 Constraints Related to IE&C

While there is an existing infrastructure for IE&C activities, such efforts are hampered by a number of factors. These include a general insufficiency of funds, trained staff, and equipment. This in turn seriously limits such efforts as pretesting, distribution of materials, and the gathering of feedback. A special problem is developing materials in local languages, at the right level for IE&C messages, particularly sexual terms that will not offend the target audience.

## 6.3 Constraints Related to MCH Interventions

If the existing MCH infrastructure is to serve as the springboard to a family planning project, it must be strong and efficient. Although the national health plan has been in effect since 1978, it is unrealistic to think that such a system will be implemented within a 10-year period under present conditions. Considerable effort will be required from the Ministry of Health, which does not have the required capability, including adequately trained personnel, at this time. Moreover, many obstacles remain to be overcome: the selection and training of the personnel at all levels (especially at the village level); the drug distribution system, and, above all, an adequate and efficient supervisory system at all levels. A department of Primary Health Care at the Ministry of Health, staffed by dynamic and competent personnel, seems a sine qua non if the project is to function well and to be properly evaluated as it proceeds.

Although the new health plan seems ambitious and unrealistic, the consultants remain convinced that it is one of the best approaches to addressing health/social problems at the village level. During field trip visits, the consultants witnessed local programs working very well. Some of these were at the level of the CSPPS, Centre d'Animation Sociale, or Centre de Reeducation Nutritionnelle; others involved the Centres Medicaux, Groupements Villageois or Clubs d'Ecoute. In each program, facility, or group which seemed successful, there was always a competent, trained, and motivated person on the staff. The consultants noticed in many instances that facilities offering health services (and other development services) have a structure in which supervision could be included; however, there is a general lack of preparation in management and supervision.

#### 6.4 Constraints Related to Family Planning Interventions

The most serious constraints do not lie at the legal level. Some of the main constraints to a program in family planning are a) the lack of supervision, trained personnel, and continuing education; b) the lack of proper equipment in MCH and other health facilities; c) inadequate job descriptions, which need to be redesigned and adapted to a family planning program; d) the high price of contraceptives; e) the lack of proper audio-visual materials; and f) continuing increases in recurrent costs.

While AVBEF is an entity with great potential for enhanced family planning activities, discussions with IPPF regional representatives and certain AVBEF members revealed problems: membership is too limited; fiscal responsibility is inadequate; clinical services are too delayed, perhaps because of Catholic members' influence; and there is dissension among the members. Thus there is a potential which may not be realized until AVBEF reforms itself, perhaps with IPPF pressure.

#### 6.5 Constraints Related to Training

As noted throughout this report, training is a major concern in the development of a family planning project in Upper Volta. A particular concern is the training of MCH personnel, who would be critical to the implementation of such a project. The number of medical and paramedical personnel is increasing, but their training is not appropriate for the country, and they have a very westernized approach to health problems.

#### 6.6 Constraints Related to Donor Activities

In designing a family planning program, one should consider not only the constraints existing in Upper Volta, but also those existing within the donor agency, AID.

The introduction of a family planning program too quickly, without adequate marketing efforts, might hamper the success of the program. In particular, it is important to take into account the opinions, beliefs, and practices of professional groups such as physicians, pharmacists, midwives, and nurses if the health and extended teams are to achieve their fullest potential.

Another serious constraint will exist if AID's funding for this project does not provide scholarships to prepare the core of leaders in public health and family planning activities before the onset of the project.

Although it would not necessarily be a constraint, the awarding of the contract to several subcontractors might be a serious handicap to implementation; it seems preferable for one contractor to be responsible to AID for all aspects of the project, including training, development of services, and supervision. Also important to the development and implementation of the program is recognition of the need for an AID coordinator who is familiar with the health situation and politics in Upper Volta, as well as with the intricate administrative details of the Agency.

## 7.0 CONCLUSIONS AND RECOMMENDATIONS

## 7.0 CONCLUSIONS AND RECOMMENDATIONS

The conclusions and recommendations presented in this section are divided into three categories: general; component-related (demographic data/research/policy and attitudes, IE&C, MCH, and family planning); and training-related. Each conclusion is linked to the body of the report by a number in parentheses indicating the section in which the supporting analysis for that point is presented. In Table 1, the recommendations are organized by time frame.

### 7.1 General Conclusions and Recommendations

#### 7.1.1 Conclusions

##### C.1 Upper Volta needs a population/family planning program and is receptive toward one. (2.1.3)

The team concluded that Upper Volta needs such a project to enhance economic and social development and to improve the health of mothers and children. All indicators of and requirements for social and economic development show a need for population limitations (see RAPID).

Top planning and development officials understand the need for slowing population growth rates. The team found receptivity at all levels of Government, and in the private sectors in urban and rural areas. Relevant ministries such as Plan, Health, Education, Rural Development, Youth and Sports, and Social Affairs expressed interest. Health officials and staff understand the benefits of child spacing and would welcome support in this area as in all MCH services. The people sometimes request help in spacing births, but these requests cannot be met because of a lack of trained personnel, equipment, and contraceptives.

##### C.2 Family planning activities in Upper Volta should be integrated into existing MCH facilities and services, with particular emphasis on child spacing. (4.0)

##### C.3 There is an existing infrastructure that could serve as a basis for enhanced family planning activities; however, personnel, expertise, and funds are limited, and therefore, any such activities should be introduced slowly and with careful attention to training, equipment, and funding needs. (5.1.1)

#### 7.1.2 Recommendations

##### R.1 AID should take advantage of the favorable climate in Upper Volta by immediately using centrally funded projects to support preliminary planning and demonstration efforts, while developing the documentation necessary to support a national program.

R.2 The Upper Volta National Population Council and relevant Ministries should be encouraged and assisted in developing a plan for a population/family planning program that AID could support.

Study tours, technical assistance, training, and some equipment in the near term from centrally funded projects would facilitate the development of a national population/family planning program. Technical decisions must be made by the relevant ministries so that an AID-supported program will be consistent with Upper Volta planning; moreover, only a collaboratively developed program will be accepted by Upper Volta. Repeated stimulation by top U.S. representation, such as the Ambassador and Mission Director, will no doubt be required.

R.3 AID should process the required documentation as rapidly as possible to try for a bilateral program funded in FY 84.

The present interest in and receptivity to a population/family planning program could be eroded by a lack of rapid follow-up. The use of centrally funded projects to meet immediate modest needs for program planning and development, as well as limited demonstration or pilot projects with training, information, and service components, should be vigorously pursued.

R.4 There should be a phased program so as not to overburden the existing infrastructure.

a) In the near term, central projects can assist the development of a planning capability and support demonstration projects. b) In the mid-term, a bilateral project could support a developing national program within the existing infrastructure. c) In the long term (5-10 years), when the primary health care program is in place nationwide, information and services can reach to the village level throughout the country.

R.5 The population/family planning program should work through existing institutions rather than through a new single-purpose organization.

The National Population Council should be supported as necessary so that it can perform its designated coordination function. Population/family planning training, information and appropriate services can be integrated into existing relevant programs in the Ministries of Health, Education, Rural Development, Information, Social Affairs, and Youth and Sports.

R.6 AID/Ouagadougou must have a qualified full-time population officer to give technical assistance, take

managerial responsibility, provide continuity, and coordinate with the GOUV the activities required to develop the projected program.

The present health and population officer has done an outstanding job of initiating the groundwork for a program. However, an effective country program cannot be developed on a part-time basis or by ad hoc consultants. A competent local-hire Voltaic is also required to provide long-term continuity and a deeper knowledge of the local scene and customs.

R.7 AID must closely monitor other donor activities to ensure all necessary support is given to the population/family planning program without duplication.

UNFPA is scheduled to be the primary donor for the 1985 census, but AID may have a role in training and technical assistance. IBRD is scheduled to support the national primary health care (PHC) program, along with UNICEF and WHO. IPPF and religious groups will be active in population/family planning activities. Ultimately, child spacing must be incorporated into the MCH services to be provided at the planned 7,000 service points in order to effect a demographic change and to protect the health of mothers and children. Several U.N. agencies and bilateral donors will be assisting in PHC and MCH activities.

7.2 Component-Related Conclusions and Recommendations

7.2.1 Demographic Data, Other Research, and Population Policy/Attitudes

7.2.1.1 Conclusions

Demographic Data

C.4 There is an acute need for timely, relevant, and reliable demographic and socioeconomic data on Upper Volta. As development resources grow increasingly scarce, careful planning is even more essential. (2.1.1.2)

Other Research

C.5 There is a need for social/anthropological research in Upper Volta (2.1.2.1)

C.6 Population/family planning is in such an embryonic state in Upper Volta that considerable information must be gathered to ensure rational decisions regarding policy, management, and technical matters. In particular, operations research to determine alternative approaches to family planning can and should be done in Upper Volta. (2.1.2.2)

- C.7 The momentum begun by RAPID and by the signing of the decree establishing the National Population Council must be continued. The development of a population policy, articulated in terms of the well-being of the family, needs to be encouraged. (2.1.3.1)
- C.8 The sensitization of high-level officials and professional organizations is of primary importance for a family health/population project. This should be the role of the National Population Council. The RAPID presentation could be updated and used widely, and the population at large should be informed by means adapted to the sociocultural environment of Upper Volta. (2.1.3.2)

7.2.1.2 Recommendations

Demographic Data

- R.8 AID should continue to foster its excellent collaborative relationship with INSD.

INSD should be encouraged to identify areas in which technical assistance may be useful as they become apparent over the next 5 years, thereby avoiding the risk of drowning INSD with too much assistance too soon. There are three centrally funded AID projects which are designed to be responsive to future INSD requests:

- a) The new Columbia University Development Law and Policy project (monitored by Adrienne Allison, S&T/POP) can give legal advice and provide model legislation for the development and implementation of a national family planning policy.
  - b) More generalized assistance in population policy development is also available through the RAPID project. This could well be given in conjunction with the development of the proposed new RAPID model on the determinants of fertility based on francophone African data.
  - c) The Demographic Data for Development (DDD) project (monitored by John Crowley, S&T/POP) can provide technical collaboration for data analysis, evaluation, and dissemination. When appropriate, it can transfer additional hardware and software, with the necessary training.
- R.9 Funding from other donors for data processing and analysis (as well as for training--see Section 7.3 below) should be sought immediately.

AID/W will send an expert from the Bureau of the Census to Upper Volta in May to review the plans for the census and to identify areas for possible AID technical assistance. The Ministry of Plan at present still expects to use microcomputers for census analysis. According to the Bureau of the Census, the software required for processing the amount of data obtained in a census of approximately 7 million people has not yet been developed. Programs that have been developed to facilitate analysis of census data, such as CONCOR (Consistency and Correction), used for editing census data, and Cents 4 (Census Tabulation System), which is used for analysis, can be used only with mainframe computers.

R.10 The centrally funded Family Planning and Demographic Survey Project, which is to be awarded in FY 84, should be implemented in Upper Volta as soon as possible.

If present scheduling plans are met, this could be as early as September, 1984. This survey would provide the baseline data essential for all population programs, particularly for program evaluation. It could be designed to provide data on the characteristics of potential family planning acceptors, on cultural perceptions and attitudes related to the practice of family planning, and on attitudes about the value of children. It could also be used to assess levels of mortality and patterns of morbidity, in addition to collecting basic information on nutritional practices. The contractors should be strongly encouraged to fully utilize the valuable human and technical resources which are now available in Upper Volta. In addition, a survey, 4 to 5 years later, should be built into this project to provide a reliable tool for evaluating program efficacy.

R.11 Ideally, the civil registration system should be simplified and streamlined, both vertically and horizontally, in order to encourage compliance, completeness, and dissemination.

However, any effort or offers of assistance by AID in this area at this time would be inappropriate because of the magnitude of the task and the relatively poor results that could be anticipated over the near and mid-term.

#### Other Research

R.12 Collaboration between donors and indigenous institutions should be considered in the conduct of social/anthropological research.

The Societe Africaine pour l' Etude du Developement (SAED) and the Centre National de la Recherche Scientifique et

Technique (CNRST) both appear to have qualified social scientists on staff and could conduct social/anthropological research if assisted in overcoming the problems that limit their present capability. For example, AID should consider providing microcomputers, related hardware and software, and other needed support. If SAED or CNRST were used to collect data in-country, an arrangement could perhaps be made to process the data, at least partially, in the U.S.

R.13 The project paper should plan funds for studies and operational research.

Basic research should be left primarily to more developed countries, but operational research to effect decision making should be done in Upper Volta. There are national public- and private-sector organizations able and willing to undertake operational research. It is important that such research be carried out before extending the program on a large scale. Applied research has already played an important role in other African countries in which new family planning programs have been introduced (e.g., Tulane, Columbia University, IDRC).

#### Population Policy/Attitudes

R.14 Because of the clearly stated concern for the well-being of mothers and children, the RAPID project should be asked to develop a follow-up presentation, based on WFS data from Senegal, Cameroon, and Ivory Coast.

These data would be used to illustrate the relationships between high infant mortality, birth spacing, and breastfeeding, and would also show the risks to mothers of prolonged childbearing. The second major component of the presentation should address alternative methods of family planning, including natural family planning, and show the relative effects on population growth rates that each may be expected to have. The presentation should also include a component on the prevalence of infertility and subfecundity and the effects of their gradual amelioration. This presentation should be shown to highest-level policy makers and national leaders, including the ministries to be involved in this family planning project (Health, Social Affairs, Rural Development, etc.), midwives, nurses, and AVBEF.

R.15 Ministers, prefets, and sous-prefets should receive family planning information. In particular, AID/Ouagadougou should consider requesting a second round of presentations of an updated RAPID: Haute-Volta to national leaders.

These persons have authority at all levels of the

population, command respect, and have a great deal of influence in the development of programs, their implementation, and their continuity: they are policy and decision makers. It is essential to plan an information session of a full day, covering the presentation of RAPID; the objectives of the program/project; the strategies planned; the contraceptive methods selected in upper Volta, including their advantages, disadvantages, and implications for the distribution system; the staff involved and their respective job descriptions; and the supervision system recommended. In addition to RAPID, a diorama could be presented as a complement to the written material prepared for this orientation/information session. An applied research project would be indicated before cassettes were purchased and prepared for each facility in the country.

R.16 Observational tours may be arranged under the new centrally funded Development Planning and Population Policy project (Project monitor is Adrienne Allison).

If a select group of senior officials from key ministries is taken to places such as Tunisia, the U.S., or Quebec, Canada, where family planning programs are well established, they will see first hand that 1) these programs are compatible with national development objectives, and 2) successful family planning can be safe and effective, as well as culturally and politically acceptable.

R.17 Population seminars, bringing together the research community and national leaders to discuss research findings and their policy implications, should be organized.

Topics could include ongoing studies of infant and childhood mortality and migration research. The organization and implementation of the seminars could be supported by either of three centrally funded projects--RAPID, DDD, or IPDP--or by the proposed family planning project.

R.18 It is recommended that a small-scale contraceptive prevalence/health survey be considered.

It is unfortunate that a World Fertility Survey was not conducted in Upper Volta and that this possibility no longer exists. The idea of conducting a contraceptive prevalence survey has been considered at various times. However, given other priority areas in which assistance is badly needed, it is not recommended that a full-scale CPS be conducted. This would serve only to use scarce resources to document empirically what is already known to be the case: that knowledge and practice of modern contraceptive methods in Upper Volta are extremely low. However, should there be a follow-on to the Westinghouse Health Systems project (as is likely to be the case), a modified small-

scale contraceptive prevalence/health survey could be of value. Limited samples could be drawn in the two major urban and selected rural areas, rather than conducting a nationwide survey. Thus, costs would be minimal and logistics greatly simplified. The resources of either SAED or CNRST could be drawn upon to execute such a survey.

If sampling techniques were correctly designed to permit extrapolation to the entire country, this would provide excellent baseline data for the evaluation of a family planning project. The study should measure more than simply contraceptive knowledge and use, but should provide data that would permit an evaluation of the project's ultimate impact on the health status of women and children. Questionnaire items should thus be included on pregnancy wastage, infant/child mortality, conditions of delivery, and births to "high risk" (under 20 or over 35, or high-parity) women, as well as on modern and traditional contraception.

R.19 In addition to the contraception/health survey recommended above, it will be important to conduct a survey of women's and men's attitudes toward contraception, and related factors such as ideal family size and sex preference. This could be in the form of a small marketing survey pertaining to family planning (use, attitudes, barriers, motivating factors, target audiences, etc.). This should only be a small-scale study, perhaps investigating respondents from three areas: a rural sector, a semi-urban zone, and an urban area. Such a survey would be relatively easy to design, carry out, and analyze by local specialists, with possible assistance from outside consultants. Whether this can be combined with the contraception/health survey (as would be desirable) may be determined by the nature of an AID-funded project being developed as a follow-on to the Westinghouse project. Another possible source of such assistance would be Family Health International, which conducted a contraception and breastfeeding survey in Lagos. In any case, it is essential that such information be obtained in order to identify barriers to successful project implementation, and to design and target IE&C programs.

7.2.2 IE&C

7.2.2.1 Conclusions

C.9 An eventual IE&C campaign based on a Government-approved population policy would require the cooperation of all authorities, down to the local level. (3.1)

- C.10 There is a general need for technical assistance, materials, and equipment among groups involved in IE&C in Upper Volta. (3.1)
- C.11 There is a particular need for IE&C materials in the French language. (3.1)
- C.12 Getting an acceptable local language vocabulary for sex education will literally set the tone for all future IE&C campaigns. The sooner this objective is achieved, the sooner population and family planning can become part of the national consciousness. (3.1)

#### 7.2.2.2 Recommendations

- R.20 AID should focus its IE&C collaboration efforts on the Institut National d'Alphabetisation et de Formation des Adultes (INAFA) and the Centre National d'Education pour la Sante, both in Ouagadougou. AID has already been working closely with these two organizations and has funded some of their projects, as well as specialized training for their personnel. On the other hand, AID should not eliminate any other organization from future consideration: it should always be on the lookout for any future prospects, public and private.

INAFA would not be opposed to having some outside technical assistance in the preparation of their radio programs, perhaps a media-trained person who could help develop program models, serve as an objective sounding board, perhaps even help carry out some pre-testing and evaluation of the programs. Also, assistance that would accelerate the adaptation of these programs into local languages should be considered. This could include funding additional linguists, pretesting the acceptability of sexual terms in local idioms, etc. Finally, INAFA could also use some basic material for their everyday work: a tape recorder and tape for on-location recording, a camera and film with slide projectors to prepare visual aids for their conferences, pamphlets, flip charts, basic reference material (in French).

- R.21 It is recommended that, if possible, both INAFA and the Centre National d'Education pour la Sante be provided with small operating budgets that would allow them to purchase basic supplies with a minimum of bureaucratic tangle. Those involved would be motivated by knowing that there need not always be an impossibly long delay between an idea and its implementation.
- R.22 Priority should be given to locating and/or developing books, references, and audio materials in the French language. These materials should be used in the

schools of health professionals, other technical schools (social affairs, etc.), continuing education programs, and services.

There is a repository of information in Dakar that could be used for IE&C in family planning and population policy. These materials have been gathered by UNESCO and are generally applicable for all francophone Africa. (The regional Population Education advisory is Mrs. Fama Ba.)

Two other potentially valuable educational resources exist. "La Contraception," published by the Community and Family Study Center (CFSC) of the University of Chicago, is a good basic French language book on family planning and contraception. Apparently, 200 copies would also be immediately available from the REDSO office in Abidjan. The CFSC can also produce a sturdy flip chart with French-language captions which explains the male and female reproduction system, conception, and birth control methods. AID in Upper Volta would have no trouble finding users for these two educational tools.

R.23 It is recommended that the communications skills of the health and extended team members be developed so that the language they use is appropriate to the target population in the project areas (see Section 7.3 below).

R.24 When the time comes to embark on a national information campaign for family planning, it is suggested that the services of a major advertising agency, preferably with African continent experience, be retained to handle directly (or to advise on) part of the campaign. The input of private enterprise would be beneficial and stimulating to all concerned. Advertising agencies, perhaps more than other business professionals, are judged on results. They are specialists in selling products and services, and in changing attitudes.

R.25 In the event of a national family health program, the hiring of a knowledgeable outside IE&C specialist would be useful for the expertise and fresh point of view he/she would bring. That person would at once be a sounding board for a quick objective evaluation of ideas and a catalyst for getting things started or keeping them on track.

For the time being, the AID mission should investigate the potential of a recent hiree, Mrs. Martine Ilboudo, a citizen of Upper Volta. She is a graduate of a four-year course in communications from the University of Ottawa. She has studied mass media, person-to-person communications, writing, and pre-testing. During her stay in Canada, she was a consultant to the Canadian International Development Agency. It is believed

that she is the only Voltaic who is a graduate of such a program. She is currently working in C&R. Her transfer to a post more in line with her qualifications should be immediately considered.

R.26 Among the targeted groups of any family planning campaign, it will be important to reach the young people of urban areas. It appears that there are two effective vehicles for reaching these people:

- o The Photo-Novel: International African magazines such as "Poco" and "Bella" carry illustrated love stories. By general consensus, they appear to be the favorite section of these magazines, read mostly by women. It would be relatively inexpensive to produce a photo-novel with a story that, while not overtly mentioning contraception, would at least stress sexual responsibility among young people. A well-thought-out photo-novel, using local technical, writing, and acting talent, could probably be produced at any time without upsetting anybody.
- o Commercials in Cinemas: The young people of Upper Volta are voracious film-goers. As in Europe, commercials are shown in film theatres. The production of one or two "spots" for theatre showing--using the same kind of discreet message as in the photo-novel--should be considered.

Small-scale initiatives such as these would give health professionals and IE&C specialists a good chance to get acquainted with the design, pre-testing, and production of family planning materials. They would also result in visible and tangible end-products.

### 7.2.3 MCH Interventions

#### 7.2.3.1 Conclusions

C.13 Although there is an existing infrastructure for the delivery of MCH services, the impact of most of these activities is small and dependent on a motivated and adequately trained individual. The facilities need equipment, drugs, management, and better supervision.  
(4.1)

C.14 It seems clear that one of Upper Volta's most urgent needs--a need which should begin to be met immediately --is in MCH within the context of social and economic development. This could influence population change in Upper Volta, and have implications for change in demographic behavior. (4.1)

C.15 Regarding the development of the health infrastructure, the number and distribution of facilities is critical. Even with the new health program, it would seem sine qua non to introduce a family health program within the context of primary health care and socio-rural development. (4.1)

7.2.3.2 Recommendations

R.27 AID should coordinate with other donors in support of the planning unit in the Ministry of Health. AID has already taken steps to strengthen this unit, and it appears that the World Bank may also take an interest. Here is the opportunity to plan at the highest level: among the government of Upper Volta, UNDP/UNFPA, the World Bank, WHO, and the numerous bilateral and NGO organizations.

R.28 Since family planning is part of primary health care, AID should consider a role in strengthening the activities of the SMI/Maternity at the CSPS level, as well as those of rural medical centers (centres medicaux), by adding equipment to increase the efficaciousness and acceptability of supervised deliveries in rural areas. It is difficult to imagine that family planning programs could precede or even parallel the program of increasing coverage of deliveries. Nevertheless, the coverage of assisted deliveries could become an important index for deciding on the introduction of the spacing component into MCH/postpartum activities. This provision of equipment and other appropriate material could also focus on the village level (TBA and primary health care agents). AID should orchestrate its actions with those of other donor agencies, such as UNICEF, the World Bank, and UNDP/UNFPA.

R.29 The problem of infertility is a serious concern of both health officials and the general population, and should therefore be addressed in any family planning program. Although the magnitude of the problem is questionable (WHO believes it is a minor problem except for a few areas), it should not be ignored because of its perceived importance. Currently, the only treatment is traditional and herbal. Requests for training and equipment should be considered in any family planning program; the problem of infertility could be integrated into training programs, as well as into services in major cities.

#### 7.2.4 Family Planning Interventions

##### 7.2.4.1 Conclusions

###### Existing Infrastructure

- C.16 As noted earlier, the team found an existing infrastructure, with some particularly successful health and social facilities at the rural level. No doubt, they could be very active in a family planning program. (5.1.1)
- C.17 A large-scale project would be difficult to implement in Upper Volta. The Government is not in an enviable position. The needed development is urgent, and the transportation difficulties, the still rudimentary infrastructure, the lack of materials and supplies, and the lack of technical management and supervisory manpower are a few of the liabilities of formidable dimension. Large projects are difficult to design, implement, monitor, and evaluate. Moreover, the Ministry of Health and other ministries do not have the capacity to incorporate a large-scale project. (2.1.2, 5.1)

###### Contraceptives

- C.18 Contraceptives, mainly available in the cities, are to be found at an excessive price. This remains an impediment to the acceptability of contraception in Upper Volta. (5.1.2)
- C.19 Upper Volta is too poor a country to permit recovery of all contraceptive costs without raising a barrier to their use. (5.1.2)

###### Natural Family Planning (NFP)

- C.20 Natural family planning groups in such locations as Bobo-Dioulasso and Banfora promote the Billings and other natural methods. Although the efficacy of this system as a method of family planning is less than optimal, NFP provides a unique opportunity to reach a stratum of the community heretofore considered inapproachable. The teaching of NFP may help to remove the cultural taboos surrounding human reproduction, and will promote the knowledge that fertility can be regulated. (5.1.3)

## Service Statistics and Evaluation

- C.21 If a family planning component were to be added to the MCH services of the Ministry of Health, it would be necessary to make a number of minor modifications and introduce new elements into the health information system to generate data for administration and evaluation. (5.1.4)

### Cost Factors

- C.22 If a family planning program were integrated into existing services, there should be no increase in personnel, and training is likely to be a development cost absorbed by the program. Supervision, on the other hand, is a need that could have significant recurrent cost implications. (5.1.6)
- C.23 The major recurrent cost of a family planning program would be the distribution of contraceptives (see under Contraceptives). (5.1.6)

### 7.2.4.2 Recommendations

#### Existing Infrastructure

- R.30 Given that the Government's emphasis regarding population policy is nondemographic and that family planning is a component of family health, family planning services should be developed in a low key manner in order to increase their acceptability (e.g., emphasizing child spacing for health reasons).
- R.31 It is recommended that applied small pilot projects be introduced as soon as possible into a few existing successful facilities. AID will have an opportunity to test various approaches and determine how the program might realistically develop in the future. To that end, it is recommended that family planning services be developed in the two maternity centers of Bobo-Dioulasso and Ouagadougou, where the main core of the country's Ob/Gyns are posted. These clinics should become referral and teaching centers and offer a full range of services (including most contraceptive methods and infertility services). At the peripheral/rural area level, it is recommended that smoothly functioning MCH (CSPS) centers with motivated personnel be identified, and that small-scale applied family planning research projects be integrated into those centers. These projects might also include the mobile

units and other members of the "extended team" (rural development, agriculture, social affairs, water projects, the information network, and school teachers).

Centrally funded population programs have been used for training and for demonstrating demographic trends, such as with RAPID. The use of central projects for these purposes needs to be expanded, and such AID intermediaries as FPIA or Pathfinder should be used to support a demonstration of how child spacing services can be incorporated within MCH services.

R.32 AID should watch the progress of the IBRD program carefully for the following reasons: (1) it will assist the Directorate of Plan of the MCH, with which AID already has a large project; (2) the IBRD should be stimulated to include family planning in PHC services; and (3) demographic change will depend upon having a large distribution network for family planning information and services such as PHC could provide.

R.33 It is recommended that the MORD structure be considered as a vehicle for family planning activities. It is suggested that the following options be explored:

- o The development of in-service training programs in family planning education for rural extension agents, especially the encadreurs
- o The introduction of a family health/family planning module into the pre-service training programs for rural extension agents and CFJA teachers
- o The incorporation of encadreurs and village groups into the network for distributing non-medical contraceptives

R.34 It is recommended that the MOSA structure be considered as a vehicle for family planning activities. It is suggested that the following options be explored:

- o Small demonstration family planning education and service projects to be tested in two or three of the well-organized women's groups (such as those in Zabre, Banfora, Tenkodogo, Katanga, and Tanghin Barrage)
- o The development of in-service training programs in family planning education for MOSA personnel, especially social aides and animatrices
- o The introduction of a family health/family planning module into the pre-service training program for social aides

R.35 Oral Rehydration Therapy could also be an excellent vehicle for promoting FP activities, and some attention should be given in that area.

R.36 Since other IPPF affiliates have overcome similar problems in their formative years, AID should monitor AVBEF as a potential vehicle for family planning.

#### Contraceptives\*

R.37 Contraceptives should be supplied to ONAP by AID for delivery through two principal channels: through the ministries, primarily the MOH, to be distributed via its pharmaceutical network to users at no cost or a nominal fee; and through the public and private pharmacies at a fixed price sufficient to cover transportation and distribution costs, and a small profit for incentive.

- o ONAP should be the exclusive recipient of donor-supplied contraceptives and contraceptive supplies in Upper Volta.
- o Short-term training and technical assistance should be supplied to ONAP personnel in the following areas (see also Section 7.3 below):
  - Ordering and reordering systems and procedures
  - Warehousing and inventory control at the regional level
  - National distribution to government and private health facilities, public and private pharmacies, and rural pharmacies
- o ONAP will distribute contraceptives and contraceptive supplies on an "at cost" basis, plus a surcharge to cover actual expenses involved in warehousing. Half of this surcharge should be reserved in a fund to assist ONAP in improving its distribution and warehousing services.
- o Public and private pharmacies may sell contraceptives for ONAP at cost plus a surcharge

\*The following recommendations are made based on the assumption that the public sector will play a larger role in the importation and distribution of pharmaceuticals and pharmaceutical products.

to cover transportation and a profit margin. (A profit margin of 25 FCFA per unit has been suggested.)

- o Public (governmental) health facilities should receive contraceptives from ONAP at no cost, to be distributed to family planning clients at no cost.
- o National pharmaceutical law should be amended to allow rural pharmacies (pharmacies villageoises) to distribute medical contraceptives upon receipt of a prescription. Retail cost should be based on the cost from ONAP plus a surcharge for transport and profit.

R.38 AID should focus on the logistic support for contraceptive distribution.

R.39 Recommendations to develop two family planning service referral centers should be taken into consideration.

In providing family planning, AID should consider the contraceptive means that are easy for the Voltaic couple to use and/or adapt to the rural milieu. One should take into consideration the problem of distance; transportation difficulties; follow up, if necessary; the price of contraceptives; and the availability of trained personnel. For instance, oral contraceptives, injectables, IUDs, and condoms could be included in the family planning services. The strategy should be ad hoc and include the training of some Ob/Gyn and other paramedical personnel. Sterilization, which is becoming more popular for health reasons, could be provided in main health facilities if more physicians were trained in minilaparotomy and/or laparoscopy. Two laparoscopic centers could be developed: one in Bobo-Dioulasso and one in Ouagadougou. The appropriate O/Rs should be renovated and equipped for laparoscopy, not only for the Yoon ring methods, but also for diagnostic treatment in infertility. The provision of an insuflator and hydrotubators should also be considered. IPAVS could be an intermediary in carrying out these activities. Following on the above, it might be possible to develop in Ouagadougou regional training/continuing education seminars in laparoscopy in the future. Equidistant from Abidjan and Dakar, these seminars could train French-speaking Ob/Gyn Africans who have already been trained at JHPIEGO. AID should explore such possibilities with interested Ob/Gyn personnel at the maternity of the Yalgado Ouedraogo hospital in Ouagadougou.

- R.40 Private organizations should be encouraged and invited to follow the government's lead. The IPPF-sponsored AVBEF should now be active in family planning services. Their annual seminar should include more pragmatic approaches to family planning activities, including the study of the environment and practical sessions in the clinic or in the field. AID may consider providing support for AVBEF at various levels.

#### Natural Family Planning

- R.41 Natural family planning groups, such as the ones in Bobo-Dioulasso and Banfora, should be encouraged by AID. These organizations seem not to be opposed to other methods and claim that the choice is a personal individual one. AID may consider helping them in service areas (medical equipment), as well as in training, the organization of seminars, and the development of audio-visual materials.

#### Service Statistics and Evaluation

- R.42 It is recommended that family planning service statistics be incorporated into the routine data collection system, and that these statistics be limited to the reporting of new acceptors and repeat visits, by method. It would be desirable to collect routinely other family planning information; however, the team believes that, given the frailty of the health information system and the relative disadvantages of diverting any more personnel time away from direct service, there is an overall advantage to the program in collecting only minimal data. Regular information on the volume of new and repeat services, by method, is adequate for basic program management and planning (e.g., estimating the quantities of commodities required, the patient load on providers, patterns of continuing use, etc.).
- R.43 It is recommended that other service-related information on family planning that is needed for program management and planning be obtained by periodic special studies that could be carried out by a research team or alternatively, by a sample of providers who would collect and report supplementary information for specified periods of time.

Special studies might be used to gather information about clients--age, fertility, experience of infant mortality, side effects, knowledge of and attitudes toward family planning,

etc.--or about providers--age, sex, training, attitudes toward family planning, etc. These studies would provide the information needed to achieve program developments and modifications, such as the preparing of curricula for in-service training programs or the planning of IE&C campaigns, or to identify patient characteristics that indicate risks for specific family planning methods, etc.

- R.44 To ensure the regularity, reliability, and appropriate utilization of family planning service statistics, as well as other routinely collected service data, it is recommended that the following be done:
- o The entire routine data collection system be streamlined (the team has provided the Statistics Unit with a simplified model)
  - o The flow of data from the service delivery point to the central statistics unit be systematized
  - o Summary statistics be produced at least twice a year, and preferably four times a year, at the regional and national level
- R.45 It is recommended that a card for monitoring individual clients be developed--either a separate family planning card or a maternal card that incorporates family planning. It is important for the sound management of family planning clients that the provider have a very simple medical history and an on-going record of the individual's family planning practice.
- R.46 It is recommended that clients retain their own records. This will save the time of clinic personnel and permit clients to obtain services at different places if they wish, or if they move; the card could even be used as a prescription. Some studies have shown that more patient records are lost by the clinic than by the patients.
- R.47 At the service unit level, it is recommended that evaluation be integrated into the supervisory role. The supervisors should help providers evaluate their own service--by interpreting the statistics they are reporting--and advise them on how to improve the service.
- R.48 At the program level, it is recommended that evaluation depend on process, not outcome indicators. The primary measures of program achievement should be acceptance rates and continuation rates. Secondary measures include the number of family planning workers trained, the number of active service outlets, and IE&C activities.

Measuring outcome, i.e., the effect of a family planning program on fertility, is a major undertaking and should be outside the purview of a family planning project in Upper Volta. (Also, it will take years for discernable effects to appear). A CPS/WFS with follow-up rounds, or a UNFPA-sponsored multi-round household would be more appropriate.

- R.49 It is recommended that periodic in-depth evaluation of program components be carried out in order to determine which factors contribute to program success and should be reinforced, and which need to be modified.

This type of evaluation should study, for example, activity rates, by category of provider and by type of training, the correlation between specific IE&C activities and changes in attitudes and practice, the capacity of the logistics system to provision the service units, etc.

#### COST FACTORS

- R.50 It is recommended that the MOPH charge new acceptors for a family planning card to add to the small discretionary funds generated by the service units.

- R.51 It is recommended that the GOUV be asked to consider allowing maternities to charge a fee for deliveries, which they would keep to help fund supervisory costs.

(Several other options, such as the caisse maladie, are presently under study by the GOUV).

### 7.3 Training-Related Conclusions and Recommendations

#### 7.3.1 Conclusions

- C.24 There is a need for training at all levels if a family planning program is to be developed in Upper Volta. (2.2, 3.2, 4.2, 5.2)

This training is required in the areas of demographic data collection and analysis, in IE&C, in the enhancement of MCH activities to include some family planning, and, of course, in family planning activities. The latter training is needed for government leaders, for health care personnel, and for members of the extended health team (e.g., social workers, teachers, and the like). (2.2, 3.2, 4.2, 5.2)

- C.25 For a population of approximately 6 million inhabitants, the lack of personnel, with respect

to both quality and quantity, remains the principal impediment to the development of health services in Upper Volta and to government efforts to improve health conditions. Since many tasks have been de facto delegated to paramedics and other members of the extended team, it is recommended that job descriptions for these personnel be revised.

### 7.3.2 Recommendations

#### Demographic Data

R.52 A family planning program should include the cost of sending two Voltaics each year for a two-year period to the training program at IFORD, which is basically oriented toward teaching the techniques of demographic research.

The IFORD program should soon include work on population policy development as well. The participants, who are selected from applicants from more than 10 francophone African countries, are enrolled in a two-year program which can be extended to a third, thereby allowing students to develop their own country specific research projects and to prepare for the Diplome d'Etat Approfondi.

R.53 Participants for the POPSTAN workshop for francophone Africa, which is scheduled for early 1984, should be identified.

Central funding for these participants is available. This workshop, which involves case studies for conducting censuses is particularly appropriate for Upper Volta at this time.

R.54 INSD should be asked to nominate one person each year for the next four to five years to attend the one year training program offered by the Bureau of the Census' International Statistical Training Program.

Training should focus on sampling and statistical methods, computer data systems and survey systems. This training would be applicable in both census analysis and in preparing and analyzing the Post Enumeration Survey. (The number of eligible candidates may be limited by the requirement of a minimum score of 70/70 (ALIGU) in language ability for all participants).

#### I E & C

R.55 In the area of "training for trainers," it is suggested that a few case histories (using actors in real-life situations) be developed and transposed to video or

film, for presentation to health and other professionals who will be providing family services. These case histories would be designed not only to upgrade technical knowledge, but also to improve the counselling skills of these professionals.

#### MCH

- R.56 Taking into account that a family health program takes time to plan, develop and implement, USAID should consider meanwhile developing and training a core of leaders and resource persons in family health, and particularly in family planning activities.

#### FAMILY PLANNING

- R.57 The training activities of family planning should be integrated into the activities related to family health.

The teaching of these activities should include theory and practice and be based on the job description of each discipline concerned. It should include the following:

- o A presentation of RAPID
- o Position of the Government concerning family planning
- o Program for the country and role of the health and extended team in FP activities
- o Technical knowledge and skills related to job description
- o Managerial aspects involved
- o Supervision and evaluation of staff and services
- o Reports to be done and feedback
- o Acquisition of communication skills
- o Initiation to applied research.

The above could be learned with the help of case studies developed on video cassette or cassettes, flip chart, slides, documents, reference material.

- R.58 At the onset of the program a core of leaders and resource persons--2 physicians (1 obs/Gyn.1 1 generalist); 2 midwives; 2 nurses; 2 managers--should be selected and sent for further training in Community and Family Health, Master of Public Health (MPH) and specialized in family planning activities.

These personnel will function in the Ministry of Health in la Division de la Sante Publique et la Division de la Formation Professionnelle et des Stages. They will contribute to the development and implementation of training and services and will act as advisors in family health and family planning activities.

R.59 Training programs at all levels should be considered.

The training in community health could take place in the following:

- o Lome--Centre Regional de developement sanitaire (one year)
- o Chapel Hill School of Public Health or Johns Hopkins or Ann Arbor, Michigan (MPH 1 year) or somewhere else in USA
- o Liverpool at the School of Tropical Medicine in the Department of International Community Health (1 year M.Comm)
- o Montreal, Universite de Montreal, Faculty of Nursing (1 or 2 years) for Masters degree

Training in family planning activities could take place in the following:

- o The Mauritius Island Program
- o Tunisia
- o Johns Hopkins Program for International Education in Gynecology and Obstetrics

Training in management could take place in the following:

- o Center for Education in Population Activities (CEDPA)
- o Coverdale Management courses
- o Chapel Hill School of Public Health summer course (6 weeks) in management, well designed course and adapted to developing countries
- c Santa Cruz, University of California

Training in adult education and audio-visual aids, communications could take place in the following:

- o University of Montreal, Montreal, Faculty of Education, Dept. of Adult Education, courses offered in Adult Education and Audio-visual Aids.

Training in applied research could take place in the following:

SHDS, Boston University (could be organized in Upper Volta) 3 weeks course in Health Services Research.

For the above personnel, it would be advisable to organize field visits to functioning family planning services covering all activities of a family planning program (including contraception and sterility). These observations could be made in the US, Canada, and in developing countries like Morocco or other countries. At least 1-1/2 year of training should be considered.

R.60 Taking into consideration the various job descriptions, the tasks to be performed, and levels of operation involved, the outline suggested for the curricula of members of the health team should be used in training health staff already functioning in health services (mobile and fixed), including traditional midwives.

If possible, it would be advisable to select one or two Departments of the country in which the MCH functions well, and the training of staff and the development and implementation of family planning activities could be coordinated. It would be an asset if the training were to include not only theory, but also observation and practice of family planning tasks. If the first phase cannot include one or two Departments, it would be advisable to select a few well-organized services receptive to family planning activities and start to prepare staff; these services could be used as training centers. From the beginning, applied research projects should be integrated to assess training, follow-up of trainees, supervision, response of the community, and needs for continuing education.

R.61 Training in family planning should be provided to the several groups of professionals and technicians involved in community development, who regularly interact with the population of all ages, these extended team members include social workers, teachers, rural development instructors, and agricultural officers.

These personnel could be great assets in giving appropriate information about family planning program activities and referring the interested population to the nearest service available. It would be appropriate to include in the curriculum the following aspects, based on the job descriptions of the various personnel:

- o RAPID

- o Government policy concerning FP in relation to development
- o Issues related to the life of teenagers and adults with the socio-cultural aspects specific to Upper Volta
- o Contraceptive methods available, and an in depth discussion of the methods that are appropriate and available in Upper Volta
- o Not to omit: abortion problems and male and female sterilization, pursuant to AID's policy of nonadvocacy of abortion
- o Sterility and its importance and implications for the Voltanic couple
- o Communication skills, particularly to adapt language used for target population
- o Services available in the country and in the nearby community
- o How to refer an interested person to a service
- o Supervision of staff offering the information and referral

R.62 It is recommended that supervision is given top priority in any program that is developed to ensure that the persons involved continue to perform their tasks and that the main objectives of the program are attained.

The upgrading of the MCH/Maternity services will be successful only with a strong system of supervision and continuing education. As a priority for starting program activities, AID should consider the training in family planning of all cadres involved in teaching, supervision, management and applied research. This involves mainly medical and paramedical personnel; intermediaries will play a role here. The training of senior staff responsible for training or supervising the members of the extended team is recommended. They then will train members of the health services and extended team already functioning in the field, possibly including the traditional midwives.

The curricula of medical and paramedical personnel have to be revised and adapted to future family planning activities. These curricula should be revised to integrate family planning techniques, services, and management, and should focus more on practical workshops and field sessions. Since the training of

physicians has just begun on site in Ouagadougou (the first graduation in 1986), this provides an opportunity to include family planning activities in the medical curriculum. For the first year, courses in Medical Demography (such as that developed and taught in the Department of Community Health in the Family of Medicine of Burundi) are also advised.

The integration of family planning activities should be included in the curricula of the extended team members involved in community development (social workers, teachers, rural development animateurs, etc.). Since many tasks have been de facto delegated to paramedics and other members of the extended team, it is recommended that job descriptions for these personnel be revised.

In family planning activities continuing education plays a special part. Updated information, new policies, techniques of contraceptive methods and drugs, and evaluation methodologies are very important. Continuing education should be carried out at low cost and in a practical manner.

R.63 A series of basic books, references and audio visual materials in French should be made available in the library of schools where training in FP is offered for the health and extended team members: A bibliography has been prepared in INTRAH (i.e., GRAAP, Chicago, material produced in Zaïre by Courtejoie, audio-visual material available through other USAID-funded intermediaries, etc.). In addition it would be advisable to develop audio-visual materials adapted to local conditions and languages.

If because of cost, all personnel could not receive a simple reference document for practice of family planning activities, at least the services should be provided with reference materials that will be helpful to the staff. An applied research project could be developed in order to assess which documents are most useful and the results made available throughout the country.

R.64 Considering the several types of services (health, agriculture, rural development, education, social services, etc.) offered to the population by different types of personnel, it appears imperative to develop the job description particular for each member of the health team, i.e., physicians, nurses, midwives, etc. as well as for members of the extended team i.e., agriculture, rural development, social affairs staff, as well as teachers in secondary schools.

This effort would help develop an integrated and well-orchestrated family planning program. The job descriptions

should be followed by a detailed list of the tasks, responsibilities, and limits of operation for each category of personnel, whether it involves informing the population, providing services, distributing contraceptives, providing referrals, preparing reports, supervising, managing, taking or providing continuing education, performing evaluations/assessments, conducting applied research, or coordinating activities. All parties should be clear about what has to be done, why, how, when, and where. Based on the willingness of each ministry concerned with the family planning program if trained appropriately and supervised regularly.

A rough outline of job descriptions for certain members of the health team is included in the "Document de Programmation Sanitaire Nationale (1980-1990) avant-projet, avril 1978 (Annex 6). As regards to family planning activities, advice on family spacing is only mentioned, as the responsibility of the accoucheuse-auxiliaire and midwife.

Two final points may be noted. First, if certain tasks assigned to midwives, nurses, and other personnel are beyond their usual scope of work and professional legislation, it would be important to clarify this from the onset of the program. Second, it would be advisable to carry on applied research projects before finalizing the job descriptions, using as a basis MCH services already functioning fairly well.

The job descriptions and detailed lists of tasks to be performed will be the basis for the training and supervision related to all activities within the family planning program.

TABLE 1. RECOMMENDATIONS ACCORDING TO TIME FRAME\*

AREA OF ACTIVITY	TIME FRAME		
	SHORT-TERM (IMMEDIATE ACTIVITIES)	MEDIUM-TERM (PROJECT DESIGN STAGE)	LONG-TERM (BILATERAL PROJECT STAGE)
<b>COMPONENT 1: DEMOGRAPHIC DATA, OTHER RESEARCH, POPULATION POLICY/ATTITUDE</b>			
<u>Demographic Data</u>	<ul style="list-style-type: none"> <li>● R.9: Seek funding from other donors for data processing and analysis (as well as for training), especially for 1985 census.</li> <li>● R.10: Implement centrally funded Family Planning and Demographic Survey Project in Upper Volta as soon as possible.</li> <li>● Consider a RAPID analysis on status of infant and child health, especially as related to birth spacing and parity.</li> <li>● Seek assistance from Data for Demographic Development for analysis of existing demographic data (2 implementing organizations - BUCEN and Westinghouse).</li> </ul>	<ul style="list-style-type: none"> <li>● R.8: AID to continue to foster its excellent collaborative relationship with INSD.</li> <li>● Contract with BUCEN to develop detailed scope of work for feasible census assistance (using PM&amp;R funds).</li> <li>● R.11: Consider long-term simplification and streamlining of civil registration system.</li> </ul>	<ul style="list-style-type: none"> <li>● Continue RAPID II and Demographic Data for Development central activities for policy development.</li> <li>● Consider limited assistance in census activities, requiring a project-funded contract with an organization like BUCEN.</li> </ul>
<u>Other Research</u>	<ul style="list-style-type: none"> <li>● R.13: Plan funds for studies and operational research in the project paper.</li> </ul>	<ul style="list-style-type: none"> <li>● R.12: Consider collaboration between donors and indigenous institutions in the conduct of social/anthropological research.</li> <li>● During design of service-delivery component, make plans for operations research (could use PM&amp;R funds to hire a consultant, seek assistance from ST/POP/R).</li> </ul>	<ul style="list-style-type: none"> <li>● In planning support for a gradually increasing service delivery component, give substantial attention to operations research of an experimental, monitoring, evaluation nature, and related to review of clinic-based, community-based, and commercial delivery approaches (central projects could provide technical assistance in design and implementation, and for commercial elements).</li> </ul>

33

\*The recommendations shown in this table are those described in detail in Section 7.0 of this report, with supplemental comments drawn from an AID/W review of the draft document.

TABLE 1. RECOMMENDATIONS ACCORDING TO TIME FRAME (continued)

AREA OF ACTIVITY	TIME FRAME		
	SHORT-TERM (IMMEDIATE ACTIVITIES)	MEDIUM-TERM (PROJECT DESIGN STAGE)	LONG-TERM (BILATERAL PROJECT STAGE)
<u>Population Policy/Attitudes</u>	<ul style="list-style-type: none"> <li>● R.1: AID take advantage of favorable climate in Upper Volta by immediately using centrally funded projects to support preliminary planning and demonstration efforts, while developing documentation necessary to support a national program.</li> <li>● R.2: Encourage National Population Council and relevant ministries to develop a FP program plan that AID could support.</li> <li>● Maintain momentum and prepare Upper Voltan leadership for participation in project design and implementation (potential sources of funds: central; PM&amp;R; Sahel Manpower Development--SMDF--funds).</li> <li>● R.3: AID process required documentation as soon as possible to try for bilateral program funded in FY84.</li> <li>● R.14: Ask RAPID project to develop a follow-up presentation based on WFS data from Senegal, Cameroon, and Ivory Coast.</li> <li>● R.15: Provide FP information to ministers, prefets, and sous-prefets. Seek another round of RAPID presentation to national leaders and policy makers (could be done by the Ambassador, with Mission/Embassy support as appropriate).</li> </ul>		<ul style="list-style-type: none"> <li>● In coordination with UNFPA, consider including support for strengthening the National Population Council.</li> </ul>

TABLE 1. RECOMMENDATIONS ACCORDING TO TIME FRAME (continued)

AREA OF ACTIVITY	TIME FRAME		
	SHORT-TERM (IMMEDIATE ACTIVITIES)	MEDIUM-TERM (PROJECT DESIGN STAGE)	LONG-TERM (BILATERAL PROJECT STAGE)
<u>Population Policy/Attitudes</u> (continued)	<ul style="list-style-type: none"> <li>● R.16: Arrange observation tours for Upper Voltan leaders to other francophone countries which have developing or established population policies and/or family planning programs (can be arranged under new centrally funded Development Planning and Population project).</li> <li>● R.17: Organize population seminars, bringing together the research community and national leaders to discuss research findings and their policy implications.</li> <li>● R.18: Consider a small-scale contraceptive prevalence/health survey including information on women at high risk of pregnancy, attitudes toward and access to contraception, infertility, etc. (technical assistance could be provided by Family Planning and Demographic Survey Project, with local cost funded by bilateral projects).</li> <li>● R.19: Conduct a survey of women's and men's attitudes toward contraception and related factors such as ideal family size and sex preference.</li> </ul>		
<u>COMPONENT 2: INFORMATION, EDUCATION, AND COMMUNICATIONS (IE&amp;C)</u>	<ul style="list-style-type: none"> <li>● Prepare leadership and develop materials placing child spacing and family planning in the context of maternal and child health, with possible assistance of Johns Hopkins University Population Communication Services—PCS—project.</li> </ul>	<ul style="list-style-type: none"> <li>● R.21: If possible, provide INAFA and the Centre National d'Education pour la Sante with small operating budgets that would allow them to purchase basic supplies with a minimum of bureaucratic tangle.</li> </ul>	<ul style="list-style-type: none"> <li>● R.24: When time comes for national information campaign for family planning, use services of a major advertising agency, preferably with African continent experience.</li> <li>● R.25: Consider hiring a knowledgeable outside IE&amp;C specialist.</li> </ul>

TABLE 1. RECOMMENDATIONS ACCORDING TO TIME FRAME (continued)

AREA OF ACTIVITY	TIME FRAME		
	SHORT-TERM (IMMEDIATE ACTIVITIES)	MEDIUM-TERM (PROJECT DESIGN STAGE)	LONG-TERM (BILATERAL PROJECT STAGE)
<u>COMPONENT 2: INFORMATION, EDUCATION, AND COMMUNICATIONS (IE&amp;C) (continued)</u>	<ul style="list-style-type: none"> <li>● R.20: AID focus its IE&amp;C collaboration efforts on the Institut National d'Alphabetisation et de Formation des Adultes (INAF) and the Centre National d'Education pour la Sante.</li> <li>--Provide technical assistance to INAF to get its radio program started.</li> <li>--Facilitate development of a family planning vocabulary for use in local language program.</li> <li>--Provide some basic IE&amp;C materials, such as tape recorder and camera.</li> <li>● R.22: Locate and/or develop books, references, and audio materials in the French language.</li> <li>● R.23: Develop communication skills of health and extended team members so that language they use is appropriate to target population in project areas.</li> </ul>		<ul style="list-style-type: none"> <li>● R.26: Among targeted groups of a family planning campaign, need to reach young people of urban area.</li> </ul>
<u>COMPONENT 3: MATERNAL AND CHILD HEALTH (MCH)</u>	<ul style="list-style-type: none"> <li>● R.27: AID coordinate with other donors in support of planning unit in Ministry of Health.</li> </ul>	<ul style="list-style-type: none"> <li>● R.28: Since family planning is part of primary health care, AID consider role in strengthening activities of SMI/Maternity at the CSPS level, as well as in rural medical centers, by adding equipment to increase the effectiveness and acceptability of supervised deliveries in rural areas.</li> </ul>	<ul style="list-style-type: none"> <li>● R.29: Address the problem of infertility.</li> </ul>

TABLE 1. RECOMMENDATIONS ACCORDING TO TIME FRAME (continued)

AREA OF ACTIVITY	TIME FRAME		
	SHORT-TERM (IMMEDIATE ACTIVITIES)	MEDIUM-TERM (PROJECT DESIGN STAGE)	LONG-TERM (BILATERAL PROJECT STAGE)
<b>COMPONENT 4: FAMILY PLANNING INTERVENTIONS</b>			
<u>Existing Infrastructure</u>	<ul style="list-style-type: none"> <li>● R.4a: As part of phased family planning program, central projects assist development of a planning capability and support demonstration projects.</li> <li>● R.6: Provide AID/Ouagadougou with qualified full-time population officer to give technical assistance, take managerial responsibility, provide continuity, and coordinate with the GOV activities required to develop a program.</li> <li>● R.7: AID monitor other donor activities to ensure that all necessary support is given to the program without duplication.</li> <li>● R.30: Develop family planning services in low-key manner to increase acceptability, e.g., emphasizing child spacing as health concern within existing health infrastructure.</li> <li>● R.31: Introduce small pilot projects into a few existing successful facilities.</li> </ul>	<ul style="list-style-type: none"> <li>● R.4b: Support a developing national program within existing infrastructure.</li> <li>● R.32: AID watch progress of IBRD program (which should be stimulated to include family planning in PHC services, and could provide large distribution network needed for family planning information and services.</li> <li>● R.33: Consider MORD structure as vehicle for family planning activities.</li> <li>● R.34: Consider MOSA structure as vehicle for family planning activities.</li> <li>● R.35: Consider Oral Rehydration Therapy as vehicle for promoting family planning activities.</li> <li>● R.36: Since other IPPF affiliates have overcome similar problems in their formative years, monitor AVBEF as potential vehicle for family planning.</li> </ul>	<ul style="list-style-type: none"> <li>● R.4c: Within 5-10 years, when FHC program is in place nationwide, extend information and services to village level throughout the country.</li> </ul>
<u>Contraceptives</u>	<ul style="list-style-type: none"> <li>● Seek centrally funded support for contraceptive services and supplies (IPPF, UNFPA, FPIA, others); consider AVBEF, Seventh Day Adventists, Nurse Midwives Associations, and selected MOH centers for service delivery.</li> </ul>	<ul style="list-style-type: none"> <li>● Contract with consultant for design of service delivery component, using PM&amp;R funds.</li> </ul>	<ul style="list-style-type: none"> <li>● Plan for a gradually increasing service delivery component in the public sector, the private organizational sector, and the private commercial sector.</li> </ul>

TABLE 1. RECOMMENDATIONS ACCORDING TO TIME FRAME (continued)

AREA OF ACTIVITY	TIME FRAME		
	SHORT-TERM (IMMEDIATE ACTIVITIES)	MEDIUM-TERM (PROJECT DESIGN STAGE)	LONG-TERM (BILATERAL PROJECT STAGE)
<u>Contraceptives</u> (continued)	<ul style="list-style-type: none"> <li>● R.37: Supply contraceptives to ONAP through two principal channels: MOH (distributed through its centralized network), and public and private pharmacies (at fixed price sufficient to cover transportation and distribution costs, and small profit for incentive).</li> <li>● R.38: AID focus on logistic support for contraceptive distribution.</li> <li>● R.39: Consider developing two FP service and referral centers. In providing family planning, AID consider contraceptive means that are easy for Voltaic couple to use and/or adapt to rural milieu; consider distance, transportation, follow-up price, and availability of trained personnel.</li> <li>● R.40: Encourage private organizations to follow the government's lead; involve AVBEF in particular in family planning services.</li> </ul>		
<u>Natural Family Planning (NFP)</u>	<ul style="list-style-type: none"> <li>● R.41: Encourage NFP groups, such as those in Bobo-Dioulasso and Banfora.</li> </ul>	<ul style="list-style-type: none"> <li>● Seek centrally funded assistance for specific NFP projects.</li> </ul>	
<u>Service Statistics and Evaluation</u>	<ul style="list-style-type: none"> <li>● R.42: Incorporate service statistics into routine data collection system; limit family planning statistics to reporting of new acceptors and repeat visits, by method.</li> </ul>	<ul style="list-style-type: none"> <li>● R.43: Obtain other service-related information needed for program management and planning through periodic special studies carried out by a research team, or by a sample of providers.</li> <li>● R.44: To ensure reliability and proper use of service data, do the following:  --Simplify routine data collection system.</li> </ul>	<ul style="list-style-type: none"> <li>● R.49: Carry out periodic in-depth evaluation of program components to determine which factors contribute to program success and should be reinforced, and which need to be modified.</li> </ul>

TABLE 1. RECOMMENDATIONS ACCORDING TO TIME FRAME (continued)

AREA OF ACTIVITY	TIME FRAME		
	SHORT-TERM (IMMEDIATE ACTIVITIES)	MEDIUM-TERM (PROJECT DESIGN STAGE)	LONG-TERM (BILATERAL PROJECT STAGE)
<u>Service Statistics and Evaluation (continued)</u>		<p>--Systematize flow of data from service delivery point to central statistics unit.</p> <p>--Produce summary statistics at least twice (preferably four times) a year, at regional and national levels.</p> <ul style="list-style-type: none"> <li>● R.45: Develop card for monitoring individual clients (separate card or maternal one that incorporates family planning).</li> <li>● R.46: Have clients retain their own records.</li> <li>● R.47: At service unit level, integrate evaluation into supervisory role.</li> <li>● R.48: At program level, make evaluation dependent on process, not outcome indicators.</li> </ul>	
<u>Cost Factors</u>		<ul style="list-style-type: none"> <li>● R.50: Have Ministry of Health charge new acceptors for a family planning card to add to small discretionary funds generated by service units.</li> <li>● R.51: Ask GOUV to consider allowing maternities to charge fee for deliveries, which they would keep to help fund supervisory costs.</li> </ul>	

TABLE 1. RECOMMENDATIONS ACCORDING TO TIME FRAME (continued)

AREA OF ACTIVITY	TIME FRAME		
	SHORT-TERM (IMMEDIATE ACTIVITIES)	MEDIUM-TERM (PROJECT DESIGN STAGE)	LONG-TERM (BILATERAL PROJECT STAGE)
<b>TRAINING</b>			
<u>Demographic Data</u>	<ul style="list-style-type: none"> <li>● R.52: Send two Voltaics each year for a two-year period to the training program at IFORD, which is basically oriented toward demographic research.</li> <li>● R.53: Identify participants for POPSTAN workshop for francophone Africa, scheduled for early 1984.</li> <li>● Following two-week workshop in French for census planners (scheduled for 30 April - 11 May 1984 in Dakar), have BUCEN instructor from workshop provide technical assistance to Upper Volta for 1985 census planning.</li> </ul>	<ul style="list-style-type: none"> <li>● Consider further training in uses of microcomputers for data analysis. (Note that Westinghouse component of DDD will hold microcomputer workshop on demographic techniques in conjunction with Sahel Institute, planned for late March in Bamako; two participants from Upper Volta would be welcome.)</li> <li>● R.54: Ask INSD to nominate one person each year for next 4-5 years to attend one-year training program offered by Bureau of the Census' International Statistical Training Program.</li> </ul>	<ul style="list-style-type: none"> <li>● Provide long- and short-term training for broad spectrum of policy-level personnel in economic planning, health, agriculture, and education who could give leadership in assessing the impact of demographic variables on development.</li> </ul>
<u>IE&amp;C</u>		<ul style="list-style-type: none"> <li>● R.55: In "training the trainers," develop case histories for video or film for presentation to health and other professionals who will be providing family planning services.</li> </ul>	
<u>MCH</u>	<ul style="list-style-type: none"> <li>● R.56: While family planning program is being developed, train a core of leaders and resource persons in family health, especially in family planning activities.</li> </ul> <p>--Short courses (in French) at Institute for Health Policy Studies, University of California, Santa Cruz, entitled "Workshop in Family Planning Program Management" (26 March - 18 May 1984, and 17 September - 9 November 1984). Three positions available for Upper Volta through Worldwide Training Funds; Mission encouraged to consider use of Sahel Manpower Development Funds for additional participants.</p>		

TABLE 1. RECOMMENDATIONS ACCORDING TO TIME FRAME (continued)

AREA OF ACTIVITY	TIME FRAME		
	SHORT-TERM (IMMEDIATE ACTIVITIES)	MEDIUM-TERM (PROJECT DESIGN STAGE)	LONG-TERM (BILATERAL PROJECT STAGE)
<u>MCH</u> (continued)	<p>—Short course (in French) at Johns Hopkins University Program for International Education in Gynecology and Obstetrics (JHPIEGO) in Baltimore, entitled "Reproductive Health for Administrators of Family Health and Family Planning Programs" (11 June - 29 June 1984). JHPIEGO funds travel, per diem, and tuition for those admitted to the course.</p> <p>—JHPIEGO also funds series of courses (many in French) for surgeons, nurses, anesthesiologists, etc. in advanced techniques of reproductive health.</p>		
<u>Family Planning</u>	<ul style="list-style-type: none"> <li>● R.57: Integrate training activities of family planning into those related to family health (see text for details).</li> <li>● R.58: Plan to select and send for training a core of leaders and resource persons—2 physicians (1 obs./gyn., 1 generalist), 2 midwives, 2 nurses, 2 managers (see text for details).</li> <li>● R.59: Consider training programs at all levels (community health, management, IE&amp;C, applied research).</li> <li>● R.63: Make available basic books, references, and audiovisual materials in French in libraries of schools where family planning training is offered for health and extended team members.</li> </ul>	<ul style="list-style-type: none"> <li>● Consider hiring consultant to develop training plan (funded through central projects or with PM&amp;R funds).</li> </ul>	<ul style="list-style-type: none"> <li>● R.60: Taking into account the job descriptions, tasks to be performed, and levels of operation of the various personnel, use outline suggested for curricula of health team (under R.63) in training health staff already functioning in health services, including traditional midwives.</li> <li>● R.61: Provide training to extended team members (social workers, teachers, rural development instructors, agricultural officers), who are involved in community development and regularly interact with the population of all ages.</li> </ul>

TABLE 1. RECOMMENDATIONS ACCORDING TO TIME FRAME (concluded)

AREA OF ACTIVITY	TIME FRAME		
	SHORT-TERM (IMMEDIATE ACTIVITIES)	MEDIUM-TERM (PROJECT DESIGN STAGE)	LONG-TERM (BILATERAL PROJECT STAGE)
<u>Family Planning</u> (continued)		<ul style="list-style-type: none"> <li>● R.62: Give top priority to supervision, to ensure that those involved continue to perform their tasks, and that the main objectives of the program are attained.</li> <li>● R.64: Develop job description particular to each member of health team--physicians, nurses, midwives, etc.--and to each member of the extended team--agriculture, rural development, and social workers, and teachers.</li> </ul>	

ANNEXES

92

ANNEX 1

LIST OF TEAM MEMBERS

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Social Development Consultant, Information and  
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Adrienne Allison  
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Yolande Mouseau-Gershman, Ph.D.  
Consultant, Health Services Training

Philip L. Graitcer, D.M.D., M.P.H.  
Centers for Disease Control, Logistics and  
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ANNEX 2

LIST OF PRINCIPAL CONTACTS

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Mission Director - Emerson J. Melaven  
Deputy Director - Lawrence C. Heilman  
Program Officer - Michael A. Rugh  
Project Development Officer - Patricia J. Lerner  
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Harper  
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Assistant Program Economist - Richard Traore

USAID Rural Health and Water Project, Bobo Dioulasso

Director - Brad Wallech  
Health Educator - Deborah Dishman

AID/W Population Office, Africa Bureau

William Bair  
Griffith Davis

AID-Regional

Regional Public Health Advisor - Dr. Peter Knebel

Ministere du Plan

Camarade Talata Eugene Dondasse - Ministre  
Mr. Jacques Sawadogo - Directeur de Cabinet  
Mr. Barthelemy Diabo - Secretaire General par Interim  
Mr. Mamadou Longue - Secretaire General  
Mr. Mathias Dakuyo - Directeur de la Recherche  
Demographique

94

Mr. Iohé Desiré Konaté - Chef de Service des Statistiques  
 Sociales (INSD)  
 Mlle Anne Marie Bakyono - INSD

Ministère de la Santé

Camarade Abdoul Salam Ouedraogo - Ministre de la Santé  
 Publique  
 Dr. Amadé Ouedraogo - Direction de la Formation  
 Professionnelle et des Stages  
 Madame Guindo Binta Barry - Cellule SMI/Nutrition  
 Dr. Michel Sombie, Chef, Direction Etudes & Planification  
 M. Donsag Vincent Some, Chef, Services de la Statistique,  
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 F. Ouedraogo - Directeur, Direction des Services  
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 Dr. Luc Sawadogo

Ministère des Affaires Sociales

M. Lalogo Mathias - Secrétaire General  
 M. Tapsoba Jean-Yves - Chief, Division of Personnel  
 Mr. Cheick Kabore, Chef, Direction des Etudes et  
 Programmes  
 Mr. Frédéric Zida

Ecole Nationale d'Administration

M. Celestin Dabire - Local Revenue Administration  
 Project

Ministry of Rural Development

M. Dialo Seidu - Economist, Direction Etudes et Projets,  
 MORD  
 M. Kontongonde Daouda - Chef, Direction Etudes et  
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 M. Kafando, Director, ORD du Centre

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Mr. Niangoran Essan - Fonctionnaire de Programme  
 Haute-Volta, UNFPA, New York  
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Mr. Kya Kaysire Gitera - Représentant-Resident Adjoint  
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 Mr. Michael Van Hutton, UNDP Representative

95

UNESCO

Almamy Conde - Regional Representative

World Food Program

Father Sean Walsh - Representative

UNICEF

Andrew Progeron - Representative

WHO

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M. Emmanuel Mabwire, WHO advisor, Services de la  
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IBRD

Michael Anderson, Resident Representative

Dean Jamison, PHN Department

Denise Vaillencourt, PHN Department

IPPF

Mwomba - Regional Representative

Sara Harouna - Secretary General, AVBEF

Jacqueline Caprola - Executive Secretary, AVBEF

B. PROGRAMMES REGIONAUX ET INTERNATIONAUXProgramme de Lutte contre L'Onchocercose

Dr. Masumbuko (Burundi) - Soins de Sante Primaire -  
Ouagadougou

Organisation de Coordination et de Cooperation pour la Lutte  
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Dr. Andre Stanghellini - Section Trypanosomiase

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Dr. John Madjiri - Chef de Recherche et de Publication

C. COOPERATION BILATERALE (HAUTE-VOLTA)

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social

Federal Republic of Germany

Dr. Cornelius Oepen

D. ORGANISATION NON GOUVERNEMENTALES (ONG)Secretariat Permanent des Organismes Non Gouvernementaux (SPONG)

Mr. Francois Nana - Secretaire General

Association Voltaique pour le Bien-Etre Familial (AVBEF)

Madame Jacqueline Tapsoba - Administrateur  
Mr. Oscar Damiba - Juriste, Coordinateur des Programmes

Association des Sage-Femmes

Mlle Zongo Celistine - Secretaire d l'organisation  
Mme Traari Filicite - Secretaire adjointe a l'ethique  
professionnelle  
Mme Sawadogo Mariam - Secretaire generale l. adjointe

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Mr. Issa Diako - Secretaire Administratif Principal -  
Prefecture de Koudougou  
Dr. Hema - Medecin Chef

Dispensaire Palogo (8 kms de Kougougou)

Mr. Jean Paul Bationo - Infirmier Brevete  
Adelaide Kanki - Accoucheuse-Matrone

Maternite-OMI Kossodo

Madame Seraphine Nebie - Sage-Femme  
Dr. Meurice Francois - de la cooperation belge  
Mme Bougouma Fati - Infirmiere D.E.  
Mme Traari Awa - Sage-Femme  
Mlle Traari Appoline - Accoucheuse-auxiliare  
Mme Ouedrago Ruth - Accoucheuse-auxiliare

NOUNA (Departement de la volta Noire)

Mr. Mathurin Filtite Kambou - Assistant de Sante  
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Bagala (Departement de la Volta Noire)

Mr. Joseph Coulibaly - Chef du Groupement Villageois

KAYA (Departement de Centre Nord)

Dr. Louis Hamade Ouedraogo - Directeur Departemental  
de la Sante Publique  
Dr. Roger Hien  
Dr. Ouedraogo Hamadi - Centre Medical de Koupela,  
Interessi a la Sante communautaire et au planning  
familial

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M. Baro Souliman, Directeur Adjoint  
M. Coulibaly, Agronome

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Technologiques (CNRST)

M. Yago Zakaria, Directeur de l'Institut de Recherche  
en Sciences Sociales et Humaines

Association Voltaique pour le Bien-Etre Familial (AVBEF)

M. Bacie Lambert, Commissaire National

Ecole des Infirmiers - Bobo-Dioulasso

Mr. Sayouba Guiro (CESSI, Dakar) B.P.

Entre Aide FamilialSection Bobo-Dioulasso - Paroisse Notre Dame - B.P. 312 -  
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Theodore Palenfo - Infirmier, Secretaire General  
Cyprien Lawson - Secretaire pour les Affaires  
Exterieures  
Simone Traore - Infirmiere au Bloc Operatoire,  
Hopital Regional de bobo-Dioulasso

CATHWEL, Bobo-Dioulasso

Soeur Helene Barome, Nutrition Education Training

Section Banfora

Soeur Kabore - Developpement Rural - Banfora

Hopital National

Mr. Abdoulaye Keita - Directeur

98

Maternite Yalgado Ouedraogo - B.P. 2048 - tel. 33-46-41

Dr. Joseph Kabore - Chef de Service  
Dr. Luc Sawadogo - OB/GYN  
Dr. Viviane Kone

Service Pediatrie

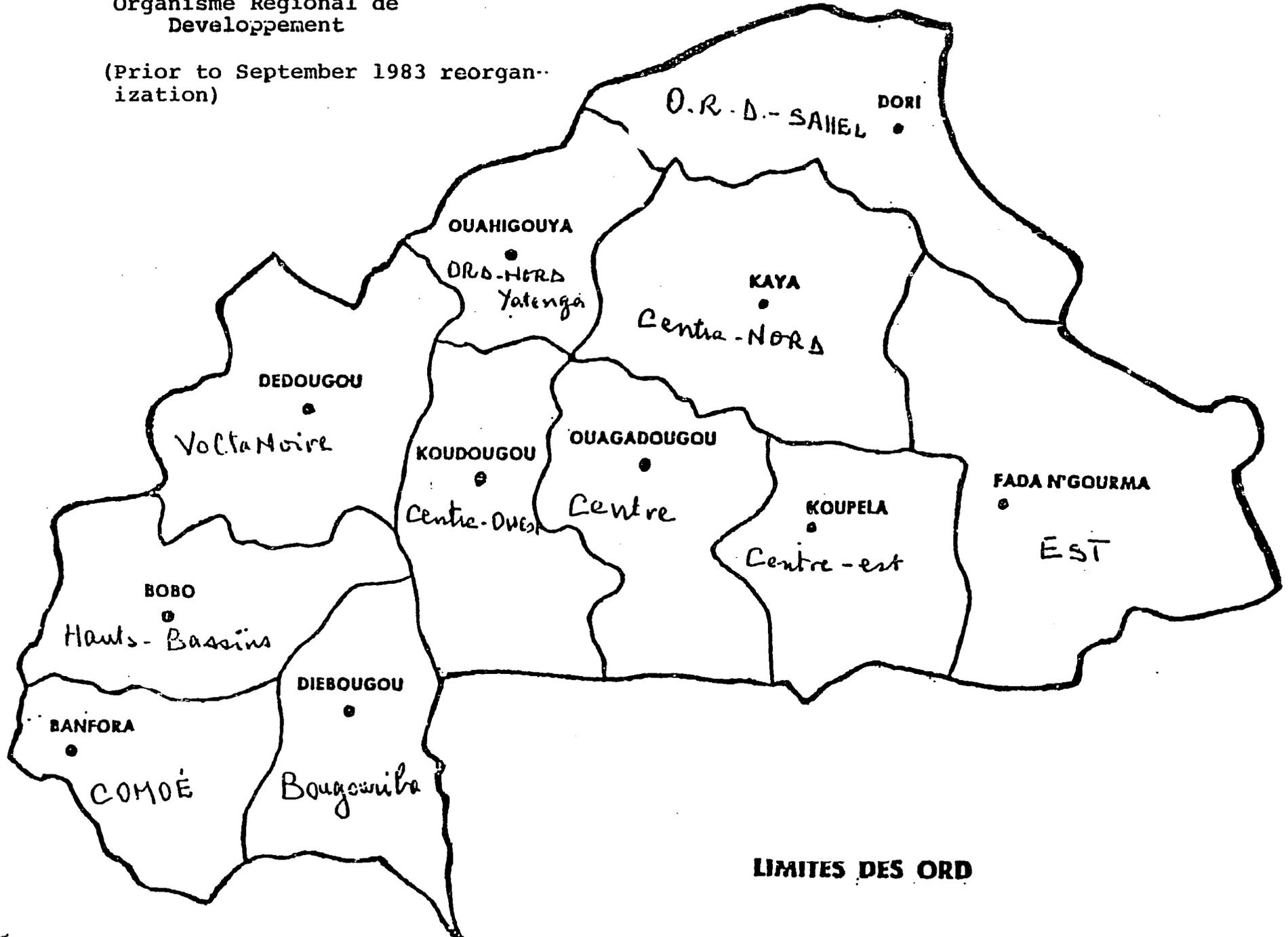
Dr. Alphonse Sawadogo - Directeur, Service Pediatrie

ANNEX 3

MAPS OF UPPER VOLTA

Organisme Regional de  
Developpement

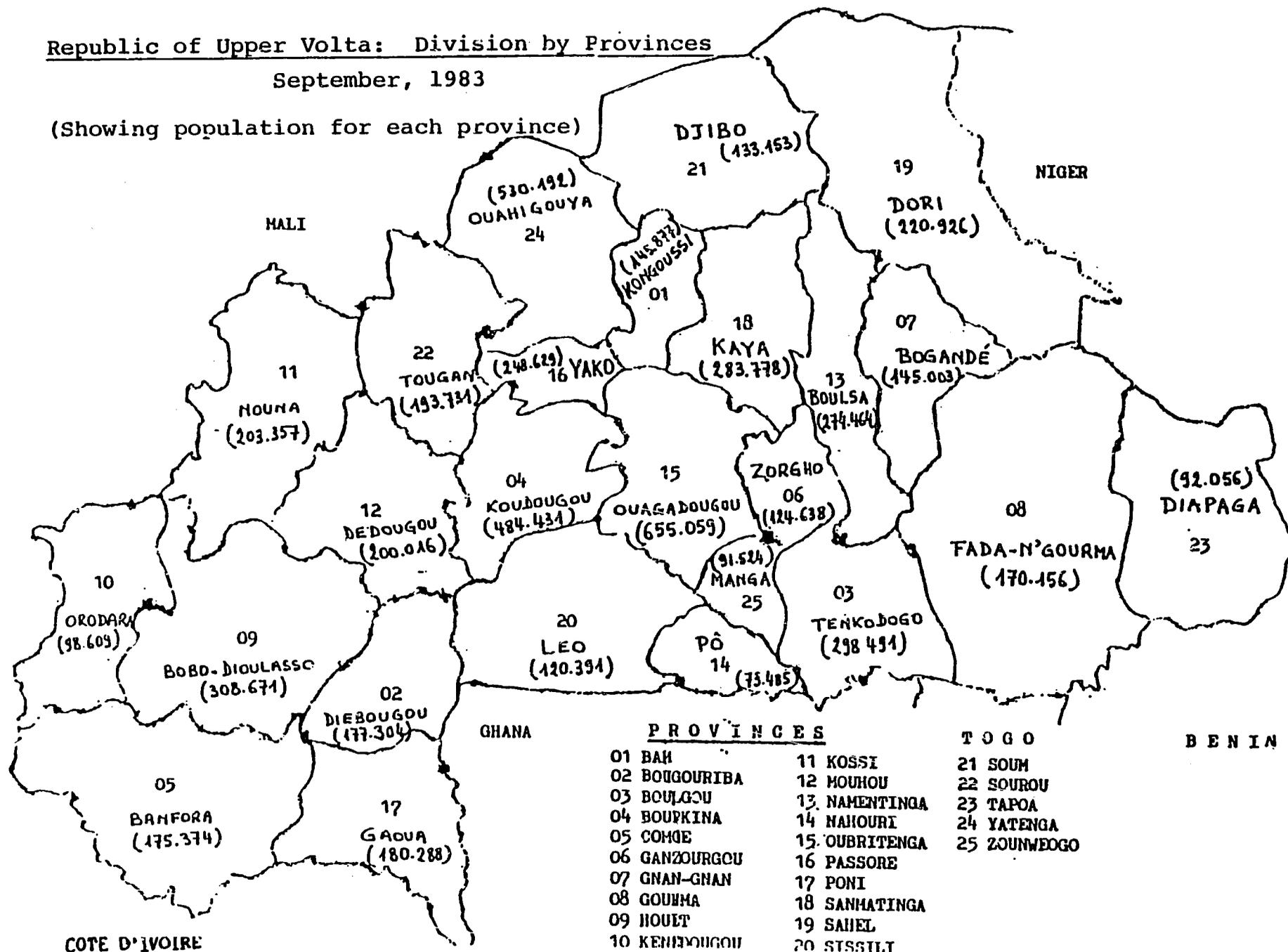
(Prior to September 1983 reorgan-  
ization)



Republic of Upper Volta: Division by Provinces

September, 1983

(Showing population for each province)



PROVINCES		T O G O	B E N I N
01 BAH	11 KOSSI	21 SOUM	
02 BOUGOURIBA	12 MOUHO	22 SOUROU	
03 BOULGOU	13 NAMENTINGA	23 TAPOA	
04 BOURKINA	14 NAHOURI	24 YATENGA	
05 COME	15 OUBRITENGA	25 ZOUNWEOGO	
06 GANZOURGOU	16 PASSORE		
07 GNAN-GNAN	17 PONI		
08 GOUNMA	18 SANHATINGA		
09 HOUE	19 SAHEL		
10 KENIENGOU	20 STSSTLT		

162

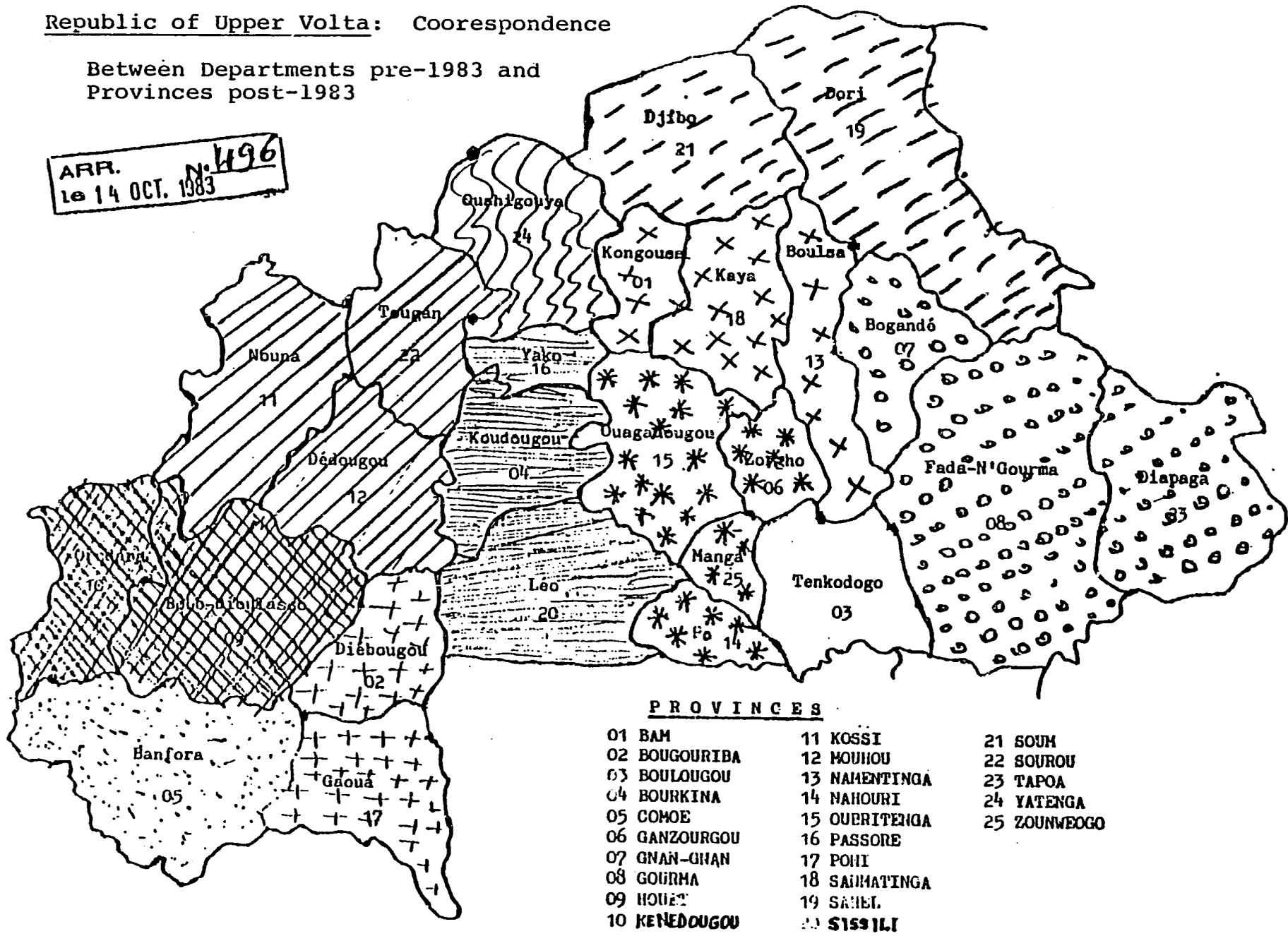
Key to following map showing the relationship between the  
Departments (pre Sept. 1983) and the Provinces (post Sept. 1983)

1°) Département du Centre:	15, 06, 25, 14
2°) Département du Centre-Est:	03
3°) Département du Centre-Ouest:	04, 16, 20
4°) Département du Centre-Nord:	01, 13, 18
5°) Département du Nord:	24
6°) Département de l'Est:	97, 08, 23
7°) Département de la Volta Noire:	11, 12, 22
8°) Département des Hauts-Bassins:	09, 10
9°) Département de la Bougouriba:	02, 17
10°) Département du Sahel:	19, 21
11°) Département de la Comoé:	05

Republic of Upper Volta: Coorespondence

Between Departments pre-1983 and  
Provinces post-1983

ARR. N. 496  
le 14 OCT. 1983

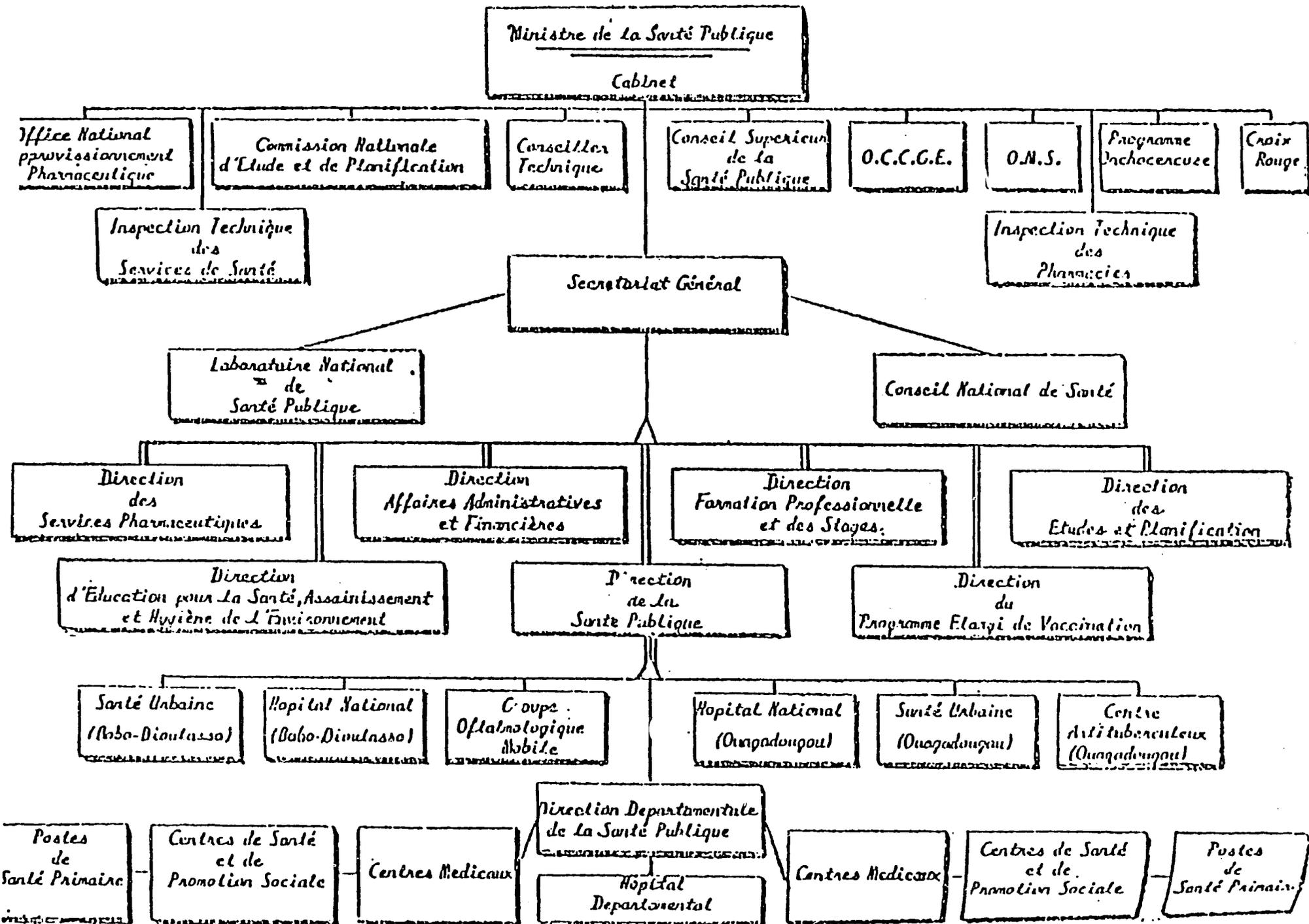


PROVINCES

- |               |                |              |
|---------------|----------------|--------------|
| 01 BAM        | 11 KOSSI       | 21 SOUM      |
| 02 BOUGOURIBA | 12 MOUHOU      | 22 SOUROU    |
| 03 BOULOUGOU  | 13 NAHENTINGA  | 23 TAPOA     |
| 04 BOURKINA   | 14 NAHOURI     | 24 YATENGA   |
| 05 COMOE      | 15 OUBERITENGA | 25 ZOUNWEOGO |
| 06 GANZOURGOU | 16 PASSORE     |              |
| 07 GNAN-GHAN  | 17 POHI        |              |
| 08 GOURMA     | 18 SAMMATINGA  |              |
| 09 HOUEI      | 19 SANEI       |              |
| 10 KENEDOUGOU | 20 SISSILI     |              |

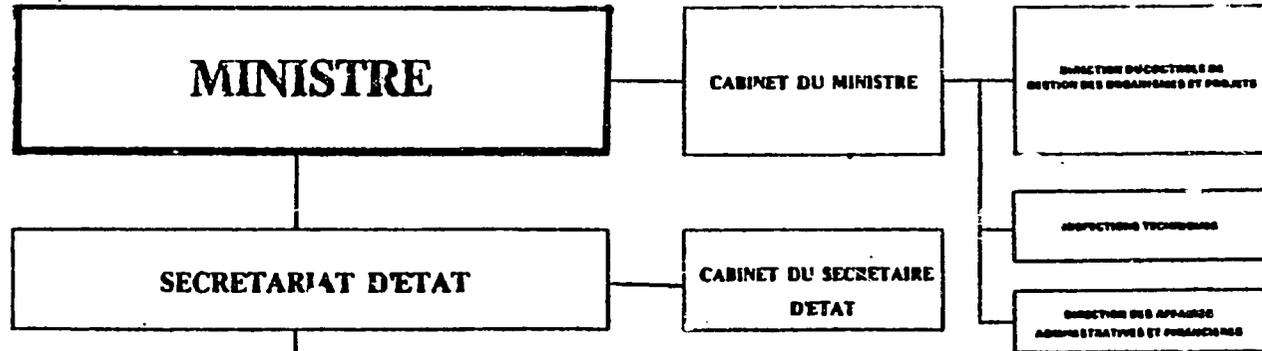
**ANNEX 4**

**ORGANOGRAMS: MINISTRIES OF HEALTH  
AND RURAL DEVELOPMENT**

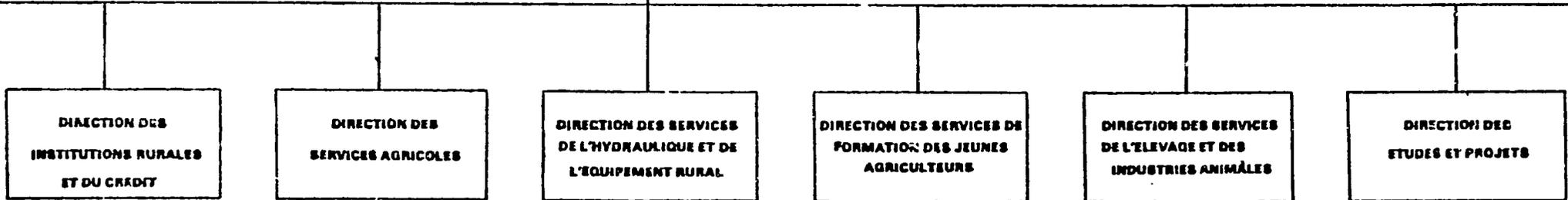


18

# MINISTRE DU DEVELOPPEMENT RURAL



- ORGANISMES REGIONAUX DE DEVELOPPEMENT (O.R.D.)
- AUTORITES DES AMENAGEMENTS DES VALLEES DES VOLTAS (A.V.V.)
- OFFICE NATIONAL DES CEREALES (O.F.N.A.C.E.R.)
- FONDS DU DEVELOPPEMENT RURAL (F.D.R.)
- FONDS D'ASSISTANCE ARCOMA/COREMA
- FONDS DE DEVELOPPEMENT



- CAISSE NATIONALE DE  
CREDIT AGRICOLE (C.N.C.A.)

- UNION VOLTAIQUE DES  
COOPERATIVES AGRICOLES  
ET MARAICHIERES (U.V.O.C.A.M.)

- SOCIETE VOLTAIQUE DES  
FIBRES TEXTILES (S.O.FI.TEX)

- CENTRE AGRICOLE POLYVALENT  
DE MATOURKOU

- OFFICE NATIONAL DES  
BARRAGES ET DE L'IRRIGATION  
(O.N.B.I.)

- OFFICE NATIONAL DES EAUX (O.N.E.)

- CENTRE DE FORMATION  
DES FORMATEURS ET FORMATRICES  
DES JEUNES AGRICULTEURS (C.F.F.J.A.)

- CENTRES DE PROMOTION RURALE  
(C.P.R.)

- OFFICE NATIONAL D'EXPLOITATION  
DES RESSOURCES ANIMALES (O.N.E.R.A.)

- CENTRE DE TANNAGE  
- CENTRE AVICOLE  
- SOCIETE VOLTAIQUE DES CUIRS ET PEaux  
- ECOLE NATIONALE D'ELEVAGE ET SANTE ANIMALE

107

ANNEX 5  
DECREE ESTABLISHING NATIONAL POPULATION  
COUNCIL

REPUBLIQUE DE HAUTE-VOLTA  
Unité - Travail - Justice

-----  
CONSEIL DE SALUT DU PEUPLE

-----  
PRESIDENCE DE LA REPUBLIQUE

-----  
DECRET N° 83- 0104 /CSP/PRES/PL  
portant création d'un Conseil National de  
la Population.

Via CF 10508  
16/02/83  
*[Signature]*

LE PRESIDENT DU CONSEIL  
DE SALUT DU PEUPLE,  
CHEF DE L'ETAT,

- Vu la Proclamation du 7 Novembre 1982 ;
  - Vu l'Ordonnance N° 82-0001/CSP/PRES du 26 Novembre 1982, portant création du Conseil de Salut du Peuple ;
  - Vu l'Ordonnance Organique N° 83-002/CSP/PRES du 19 Janvier 1983, définissant les principes et déterminant les modalités d'exercice du pouvoir gouvernement d'Etat ;
  - Vu le Décret N° 83-0040 bis /CSP/PRES du 19 Janvier 1983, portant nomination du Premier Ministre ;
  - Vu le Décret N° 82-0001/CSP/PRES du 26 Novembre 1982, portant composition du Gouvernement de la République de Haute-Volta, ensemble ses modificatifs ;
  - Vu le Décret N° 83-0019/CSP/PRES du 7 Janvier 1983, concernant l'Organisation-Type des Départements Ministériels, ensemble ses modificatifs ;
  - Vu le Décret N° 83-0020/CSP/PRES du 7 Janvier 1983, portant définition des Secteurs Ministériels, ensemble ses modificatifs ;
- SUR proposition du Ministre du Plan  
Le Conseil des Ministres entendu en sa séance du 20 Janvier 1983

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       D E C R E T E  
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ARTICLE 1er - Il est créé un Conseil National de la Population placé sous la tutelle du Ministre chargé du Plan.

ARTICLE 2 - Le Conseil National de la Population a essentiellement pour tâches d'asseoir à terme, une politique cohérente en matière de population, en harmonie avec les exigences du contexte socio-économique et culturel de la Haute-Volta .

- A ce titre il doit :
- définir les grandes lignes de la recherche et de l'éducation en matière de population
  - orienter les programmes de collecte des données en matière de population dans le sens des besoins nationaux en matière de planification
  - promouvoir le bien être de la famille et de ses membres.

- Les Préfets des départements ou leurs représentants
- Les Préfets des villes de Ouagadougou et Bobo-Dioulasso ou leurs représentants.

Article 5. - Les attributions des commissions prévues à l'article 2 ci-dessus seront définies par arrêté du Ministre du Plan.

Article 6. - Les activités du Conseil National de la Population sont animées, coordonnées et harmonisées par un secrétariat permanent. La Direction de la Recherche Démographique de l'Institut National de la Statistique et de la Démographie du Ministère du Plan, assure le Secrétariat Permanent.

Article 7. - Les membres composant le Conseil National de la Population sont désignés par arrêté du Ministre chargé du Plan sur proposition de la Présidence de la République, du Premier Ministre et des Ministères intéressés.

Article 8. - Des membres suppléants en nombre égal à celui des titulaires énumérés à l'article 4, sont désignés dans les mêmes conditions qu'à l'article 7. Les membres suppléants remplacent de plein droit les membres titulaires lorsque ceux-ci se trouvent empêchés.

Article 9. - Le Président du Conseil National de la Population peut admettre en commission ou en séance plénière du Conseil à titre consultatif, toute personne qualifiée pour ses compétences particulières.

Article 10. - Le Conseil National de la Population se réunit sur convocation de son Président, deux (2) fois l'an.

Article 11. - Le Ministre du Plan est chargé de l'exécution du présent décret qui sera publié au Journal Officiel de la République. *Jc*

Ouagadougou, le 18 Février 1965

PAR LE CHEF DE L'ETAT

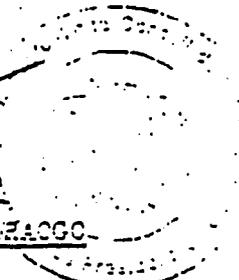
Le Premier Ministre

*[Signature]*

Capitaine Thomas SANKARA

Le Ministre du Plan

*[Signature]*  
  
Palais Eugène DOMBASSE, ministre

*[Signature]*  
  
MEDECIN-COMMANDANT  
JEAN-BAPTISTE OUEDEAGBO

ANNEX 6

JOB DESCRIPTIONS FOR HEALTH PERSONNEL

111

### 3. Description des tâches du personnel de Santé.

Avant de former du personnel, il faut définir correctement les tâches qui lui seront confiées.

Ce point nous a paru d'une extrême importance pour la répartition des tâches pour un meilleur rendement, mais toujours dans une équipe intégrée de santé globale.

#### 3.1. Agent de Santé de Village.

- Prévention des maladies transmissibles les plus courantes :
  - Paludisme
  - Gastro-entérites
  - Rougeole
  - Méningite
  - Conjonctivités
- Hygiène du milieu
  - Promouvoir et aider à la construction de latrines
  - Surveillance de l'approvisionnement en eau saine
  - Petite action de lutte contre les vecteurs
- Activités éducatives
  - Dépister et apprendre à dépister la malnutrition
  - Conseil alimentaire
  - Motiver, informer, la population sur les vaccinations
  - Convoquer la population pour la vaccination et participer à l'enregistrement des données.
  - Education sanitaire générale
- Activités curatives
  - Traitement des cas bénins
    - Diarrhées banales
    - Paludisme simple
    - Conjonctivite
    - Plaies et blessures
    - Immobilisation des fractures de membres
    - Action de premier secours.

#### 3.2. Accoucheuse de village.

- Accoucherent eutocique à domicile
- Petits soins aux nouveaux-nés et à la mère.

### 3.3. Fille de Salle.

- Entretien des lieux de séjour des malades
- Conduire les malades aux différents lieux d'examen
- Chargées de rassembler les résultats des examens
- Nursing.

### 3.4. Accoucheuse auxiliaire.

- Surveiller la grossesse normale : analyse des urines et T.A.
- Faire un accouchement normal
- Evacuer tous les cas compliqués
- Soins au nourrisson et à la mère
- Conseil sur les espacements de naissance.

### 3.5. Agent de Santé Itinérant:

- . Exécuter tous travaux simple d'assainissement
  - Campagne de latrines
  - Contrôle et entretien des installations sanitaires existantes (latrines et fosses septiques individuelles et collectives).
- . Exécuter les campagnes de lutte contre les vecteurs Assistance et contrôle des activités des Agents de Santé de village
- . Assiste le personnel Infirmier Breveté dans l'exécution des soins et traitements, dans l'application des mesures d'hygiène et de prophylaxie et dans la réalisation des différents programmes d'action sanitaire.
- . Peut remplacer l'infirmier breveté pour les activités primaires de soin, d'hygiène générale, de prophylaxie vaccinale et d'éducation sanitaire dans les formations fixes et dans les équipes mobiles de la Santé Publique.

### 3.6. Infirmiers (es) Brevetés

- . Assurent déjà les activités dévolues à l'agent de Santé de village auxquelles s'ajoutent :
  - Diagnostic des affections courantes
  - Soins infirmiers courants : injections, pansements, nursing
  - Actes courants : Prise de sang  
Tubage.
  - Traitement des affections courantes
  - Education sanitaire et nutritionnelle
  - Collecte des données statistiques
  - Rapports
  - Vaccination

Supervise l'agent de Santé de village et l'accoucheuse auxiliaire.

Peut être Chef d'un C.S.P.S.

### 3.7. Adjointe Sociale

Au niveau d'un Centre Social s'occupe de :

- Couture
- Tricotage
- Cuisine

### 3.8. Infirmiers/es Brevetés spécialistes

#### - Laboratoire

Examens courants de laboratoire.

- Bactériologie
- Parasitologie
- Chimie
- Biologie
- Sang
- Selles
- Crachats
- LCR
- Urines
- Autres prélèvements.

- Radiologie

Prise de clichés simples et développement

- Ophthalmologie

- Dépistage des affections oculaires contagieuses courantes ; exemple : le Trachome
- Traitement.

- Anesthésistes

- . Aider à la préparation du malade en vue d'une intervention.
- . Mettre le matériel en place
- . Fait l'Anesthésie générale et assiste le Médecin Anesthésiologiste si besoin.

- Pharmacie

- . Stockage et gestion des médicaments et produits pharmaceutiques.

- O.R.L.

- . Diagnostic et traitement des affections ORL courantes non compliquées.
- . Assiste le Médecin Spécialiste ORL.

- Aide-Opérateurs

- Travaillent sous le contrôle du Chirurgien
- Pratiquent certaines interventions chirurgicales  
Hernie, hydrocèle, réduction de fracture fermées, dénudation, circoncision.

3.9. Infirmiers/es Diplômés d'Etat.

- Complète les activités de l'infirmier breveté par :
  - Rôle administratif : rédaction de rapports
  - . Supervise et assiste le personnel placé sous ses ordres.
  - . Participe à la formation de l'Agent de Santé de village et des Infirmiers Brevetés.
  - . Peut-être surveillant(e) d'un Service hospitalier ou Chef d'un Centre de Santé.

3.13. Assistant de Santé

- . Moniteur dans les Ecoles de formation
- . Major d'un service hospitalier.

3.14. Assistant Dentaire

- . Diagnostic et traitement des affections dentaires courantes non compliquées.

3.15. Assistante Sociale.

- Supervision
- Coordination
- Conception planification nationale
- Direction
- Formation des autres sous-groupes

3.16. Technicien de Laboratoire.

- . Examens courants de laboratoire
- Bactériologie
- Parasitologie
- Chimie
- Biologie
- Sang
- Selles
- Crachats
- LCR
- Urines
- Autres prélèvements.

3.17. Ingrénieur Sanitaire

- Genie sanitaire
- Assainissement

3.18. Médecins

- Médecine curative et préventive

Chirurgiens dentistes

" " "

Chirurgiens

" " "

Pharmaciens

- Gestion d'Officine et Laboratoire

Nutritionnistes

- Elaboration des Programmes de nutrition  
(Santé Publique et Nutrition)

- Organisation des C.E.R.N.

116

Annex 7

JOB DESCRIPTION FOR USAID POPULATION OFFICER (DRAFT)

1. Have primary responsibility, with guidance from the Ambassador & Mission Director or their delegates, for the development of an AID supported population/family planning program in Upper Volta.
2. Development and maintain contacts with GOUV officials in the relevant ministries such as Plan, Health, Rural Development, Social Welfare, Education and Youth and Sports.
3. Develop and maintain contacts with other relevant international donors and potential donors such as UNFPA, IBRD, UNICEF, UNESCO, PAM and FAO.
4. Develop and maintain contacts with relevant private sector groups such as AVBEF (IPPF), OXFAM, Foster Parents, Seventh Day Adventists and Catholic groups providing natural family planning.
5. Develop and maintain contacts with AID centrally funded intermediaries such as FPIA, Pathfinder, INTRAH, IPAVS and JHPIEGO.
6. Provide technical assistance in all the elements of a population/family planning program to both the public and private sector programs of P/FP in Upper Volta.
7. Assist the USAID in the preparation of necessary documentation with primary responsibility for its technical validity.

## Recommended qualifications

1. An advanced degree in a subject relevant to P/FP with preference for degrees in public health and medicine, nursing or midwifery.
2. At least 3 years experience in Africa or at least 5 years experience in developing countries.
3. Experience with broad responsibilities for the various aspects of P/FP at a managerial level.
4. Ability to work in a foreign culture.
5. Ability to negotiate with high officials and work with all levels of technical workers including PHC staff.
6. Physical ability and willingness to endure the hardships of frequent travel in rural areas of a developing country.
7. An FSI S-3 R-3 level in speaking and reading French.

118

ANNEX 8  
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ANNEXE NO.9  
ANALYSE DES PRINCIPAUX PROBLEMES  
SANITAIRES DE LA HAUTE-VOLTA

4.1. Recensement et analyse des problèmes prioritaires

Sur le point de vue de la santé publique, les principaux problèmes auxquels se heurte la Haute-Volta peuvent être divisés en quatre grands groupes :

- 1 - Les problèmes de fourniture d'eau saine et d'assainissement
- 2 - Insuffisance alimentaire et carences nutritionnelles
- 3 - Morbidité générale élevée due spécialement aux maladies transmissibles
- 4 - Insuffisance quantitative et qualitative de la couverture sanitaire.

4.2. Problèmes de fourniture d'eau saine et d'assainissement

Il y a un énorme écart entre les zones urbaines et rurales. Sept villes en Haute-Volta disposent d'adduction d'eau et sept centres semi-urbains possèdent un embryon de réseau.

Pour l'ensemble des populations, 12 à 17% peuvent avoir un accès raisonnable à l'eau.

En 1977, sur une population d'environ 5.836.000 habitants, 2,7% ont de l'eau courante à domicile. La consommation moyenne est estimée à 34 litres habitant/jour (70 litres par habitant/jour pour Ouagadougou) et 4,5% s'approvisionnent par des bornes-fontaines publiques, et la consommation serait de 14 litres par habitant/jour.

Les prix de l'eau vendue est de 70 CFA/m<sup>3</sup> et en saison chaude, il est de 90 jusqu'à 130 CFA/m<sup>3</sup>.

Le reste de la population s'approvisionne en eau soit des puits en dur existants, soit des puits traditionnels, soit des marres environnantes.

La consommation réelle des habitants est fonction de la distance aux points d'eau. Elle s'établit à environ 23 litres/habitant/jour pour une distance de moins de 500m et s'abaisse à 5 litres/habitant/jour pour des portages de 2 à 4 km et plus.

La pénurie d'eau est telle que de très nombreux villages ne disposent que de 5 litres/habitant/jour en fin de saison sèche et des

conditions sanitaires souvent mauvaises (marigots et puisards) que l'objectif de toute première importance est d'assurer à chaque village au moins un point d'eau saine et d'abandonner le débit suffisant.

Quant à l'assainissement, il n'existe à Ouagadougou aucun service public d'évacuation des eaux usées. Et ce qui est des eaux domestiques, les parcelles, en prévoit une latrine, parfois une fosse à eau, parfois une fosse septique avec puits. L'entretien de ces moyens d'évacuation est rendu inefficace par manque de ressources mais la solution d'évacuation est en général latrine ou les lits des canaux pluviales.

A Ouagadougou et Bobo-Dioulasso il existe un réseau d'eaux pluviales ; certains canaux collecteurs prévus, mais l'ensemble est très mal entretenu, les services d'hygiène sont mal équipés avec budgets insuffisants et donc peu efficaces. La collecte et l'évacuation des déchets sont très mal organisées ou inexistantes, sauf à Bobo-Dioulasso où la situation d'assainissement est mieux contrôlée.

### 3.1.2. Insuffisance alimentaire et carences nutritionnelles

Parmi les problèmes de santé publique auxquels se heurte la Haute-Volta, les maladies et les carences nutritionnelles représentent la base qui maintient un taux élevé de mortalité et une très haute létalité.

Les carences nutritionnelles découlent aussi bien de l'insuffisance de production que des problèmes de commercialisation et de distribution, ainsi que de la méconnaissance des populations et au faible pouvoir d'achat. On pourrait dire que des enfants qui sont examinés aux dispensaires présentent des degrés plus ou moins marqués de malnutrition.

Sur le point de vue quantitatif le nombre de calories à la disposition de chaque habitant est limité ou légèrement inférieur aux besoins.

D'une manière générale, la consommation quantitative de protéines paraît suffisante. Le seul aspect qui pose un problème particulier réside dans la qualité de ces protéines.

### 3.1.3. Morbidité générale élevée et spécialement aux maladies transmissibles.

Les taux de morbidité en Haute-Volta sont élevés en raison de la prévalence des nombreuses maladies transmissibles et des carences nutritionnelles. Ces maladies résultent de la mauvaise qualité de l'eau

(diarrhées), de la présence des vecteurs et du bas niveau socio-économique.

- la paludisme avec de très faibles oscillations annuelles garde la première place et sensiblement la même ampleur ;
- l'ampleur de la rougeole malgré une variation cyclique de quatre ans montre une tendance assez nette à l'augmentation. Peut-on expliquer cette tendance uniquement par l'accroissement de la population ?
- l'examen de l'évolution annuelle du nombre de cas de méningite laisse supposer l'existence d'un rythme à grandes périodes dont on ne peut pas préciser l'ordre de grandeur par manque de recul
- l'examen des répartitions mensuelles du nombre de cas constatés chaque année fait apparaître un rythme saisonnier très net : maximum - février, mars, avril, décroissance rapide jusqu'à un minimum se situant en juillet, août ou septembre et remontée nette et rapide à partir de novembre, décembre ;
- la lèpre présente une diminution notable ;
- le nombre de cas connus de tuberculose est très faible ;
- une amélioration de la déclaration s'observe dans les autres maladies.

Des chiffres précis sur la mortalité ne sont pas disponibles. Néanmoins des estimations ont été faites sur les taux de mortalité imputables aux principales causes suivant les groupes d'âge (rapport du malade, décès imputables à la cause en question sur l'effectif du groupe d'âge).

Ces estimations sont données dans le tableau ci-dessous pour 1.000 personnes décédées au total :

Cause de décès ou maladie	GROUPE D'AGE						Ensemble
	0-1 an	1 - 4	5 - 14	15 - 44	45 - 64	65 et +	
Rougeole	26,1	26,1	4,6	0,4	0,1	-	5,7
Paludisme	40,5	4,9	0,5	0,6	1,8	6,0	3,2
Diarrhée	19,2	13,4	2,1	2,3	7,4	17,8	5,6
Infection respiratoires pulmonaires	11,2	1,4	0,3	1,9	8,0	16,0	3,1
Infections abdominales	7,8	2,1	0,6	1,0	2,8		1,8
Méningite	4,5	1,8	1,1	1,1	1,1	2,5	1,4
Infections cardiaques	2,6	0,7	0,3	0,7	2,9	5,0	1,1
Eléphantiasis	11,9	1,8	0,3	0,1	0,2	0,7	0,9

124

## Insuffisance quantitative et qualitative de la couverture sanitaire

Pour couvrir une population avoisinant six millions d'habitants, répartie sur une superficie de 174.000 Km<sup>2</sup>, la Haute-Volta disposait en 1975, pour l'ensemble des dix secteurs sanitaires du Pays :

- De formations sanitaires fixes, avec cinq hôpitaux (dont deux nationaux et trois régionaux) ; 65 centres de santé (sous-préfectures ou arrondissement) ; 254 dispensaires seuls ou associés à des maternités ; 24 maternités seules, dispensaires ophtalmologiques, PMI, 48 formations spécialisées (hypo-léproseries, centres auxiliaires).

Le pourcentage de réalisation des normes, de la Décennie des Nations unies pour le Développement, par rapport à la population à charge est :

- . Hôpitaux... .. 8 à 16%
- . Centres médicaux..... 28 à 35%
- . Maternités..... 80 à 90%

Formations mobiles ;

- . Le Groupe Ophtalmologique Mobile (G.O.M.)
- . Les Equipes Mobiles de Prospection
- . Les Equipes Nationales de Vaccinations
- . 20 Equipes de Contrôle-Lèpre
- . 125 Circuits de Traitement Lèpre
- . 16 Equipes Mobiles du Sahel
- . 28 Equipes Mobiles de PMI

L'analyse des formations sanitaires en Haute-Volta nous montre :

a) L'absence totale d'hôpitaux dans cinq départements donc, grande déficience du réseau hospitalier ;

b) Une population moyenne à charge par hôpital (là où il en existe) variant de 300.000 à 500.000 personnes, ce qui dénote une charge théorique excessive par hôpital. Le taux d'occupation des lits est de 70% dans les formations sous surveillance d'un médecin (hôpitaux nationaux : 82%).

- . sans compter les importantes disparités au niveau départemental tant au plan des formations sanitaires que de leur capacité d'hospitalisation ou de consultation ;
- . sans oublier que les deux seuls hôpitaux (Ouagadougou et Bobo-Dioulasso) desservent la population de la Haute-Volta alors qu'ils ne devraient en desservir que 1/3.

125

c) Des disparités quant à la répartition sectorielle du personnel de santé qui, par lui-même, est déjà cruellement insuffisant.

L'objectif mondial "La Santé pour tous d'ici l'An 2000" doit passer à l'échelon national par l'extension des structures visant à l'amélioration de la santé des collectivités rurales, complétés par un encadrement correct tant quantitatif que qualitatif, et arriver nécessairement à l'auto-suffisance dans le domaine sanitaire.

Pour arriver à cette extension et à cet encadrement corrects, la nécessité d'un personnel techniquement qualifié est indubitable.

La qualité et la quantité de ce personnel, c'est-à-dire les normes, doivent être définies par chaque pays en fonction de la politique sanitaire réellement adaptée aux besoins. Il faut prendre en conséquence les mesures indispensables en matière de formation de personnel, capacité du réseau d'établissement de formations, etc...

Naturellement, il faut tenir compte aussi de la capacité d'absorption du personnel qui n'est pas seulement dépendant des moyens financiers du budgets du personnel ; en réalité, elle dépend de trois facteurs :

- la capacité du budget du personnel
- la capacité du budget de fonctionnement et matériel
- des structures adaptées à la pyramide de la qualification du personnel.

En effet, il est essentiel que le personnel formé ait les moyens adéquats pour exercer ses fonctions. Il faut donc que le budget de fonctionnement et matériel ait un niveau équivalent au budget du personnel. En second lieu, il est indispensable que la pyramide de qualification permette un taux d'encadrement efficace. Ceci est une garantie indispensable de la qualité réelle des services rendus par ce personnel.

Le concept de taux d'encadrement signifie que les différentes catégories du personnel ne sont pas chacune dans des domaines séparés, mais que chaque catégorie a des responsabilités importantes de supervision et de conseil permanents du personnel moins qualifié de son service.

Il est évident que la pyramide et le taux d'encadrement ont des caractéristiques différentes selon les services et les activités.

126

En se rapportant aux normes et objectifs de la première Décennie des Nations Unies pour le Développement reconduite par la deuxième Décennie (1971/1980) nous pouvons constater que le degré de réalisation des normes en Haute-Volta exprimé en pourcentage s'établit comme suit :

Catégories de personnel	Normes pour les 1 <sup>ère</sup> et 2 <sup>e</sup> décennies des Nations Unies pour le Développement	Normes en Haute - Volta	% de réalisation des normes des Nations Unies en Haute-Volta
1 Méd. Nat. pour	10.000 habitants	150.000 52.081 (Médecins nationaux plus méd. expatriés)	7% 19%
!Pharmaciens	-	550.000	-
!Dentistes	-	87.000	-
!Sages-Femmes	5.000	62.000	9%
!Infirmiers d'Etat	5.000	17.000	32%
!Tech. de la santé	5.000	-	-
!Ingénieurs Sanitaires	250.000	-	-

Le rapport entre les différentes catégories de personnel sanitaire révèle les données suivantes :

- . Médecin : Infirmier diplômé d'Etat..... 1 :3,3
- . Médecin : Sage-femme d'Etat..... 1 :0,9
- . Médecin : Infirmier breveté..... 1 :8,8
- . Infirmier diplômé d'Etat : infirmier breveté..... 1 :2,6
- . Sage-Femme diplômé d'Etat : matrone..... 1 :2,4
- . Infirmier diplômé d'Etat : Distributeur de comprimé  
mé 1,7 :1
- . Infirmier breveté : Distributeur de comprimés..... 4,6 :1
- . Médecin : Technicien de la santé qualifié..... 1 :No

N.B. : Depuis ces deux dernières années, on assiste en Haute-Volta à une meilleure répartition des médecins et autre personnel de santé à travers le Pays, ce qui rendrait plus juste ce degré de réalisation des normes.