

**PROGRAM AND MANAGEMENT REVIEW
OF THE FAMILY HEALTH AND AIDS
IN WEST AND CENTRAL AFRICA PROJECT
(FHA-WCA)**

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by

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The observations, conclusions, and recommendations set forth in this document are those of the authors and do not represent the views or opinions of POPTECH, BHM International, The Futures Group International, or the staffs of these organizations.

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LIST OF ABBREVIATIONS

AIDSCAP	AIDS Control and Prevention project
BASICS	Basic Support for Institutionalizing Child Survival project
CA	Cooperating Agency
CAFS	Center for African Family Studies
CEFOREP	<i>Centre de Formation et de Recherche en Santé de la Reproduction</i>
CERCOM	<i>Centre d'Enseignement et de Recherche en Communication</i>
CERPOD	Centre d'Etudes et de Recherches sur la Population pour le Developpement
CHP	Cameroon Health Project
CS	child survival
CYP	couple years of protection
DHS	demographic and health survey
ECODEV	Ecoform Development
ENSEA	<i>Ecole Nationale de la Statistique et de l'Economie Appliquée</i>
FESADE	<i>Association des Femmes-Santé-Développement en Afrique Sub Saharienne</i>
FHA-WCA	Family Health and AIDS in West and Central Africa
FP	family planning
FPLM	Family Planning Logistics Management
IEC	information, education, and communication
IFORD	Institut de Formation et de Recherche Demographiques
INTRAH	International Program for Training in Health
IR	Intermediate Result
IRESO	<i>Institute de Recherche sur les Comportements</i>
JHU/CCP	The Johns Hopkins University/Center for Communication Programs
JSI/R&T	John Snow, Inc./Research and Training
KfW	<i>Kredietanstalt Für Wiederaufbau</i> (German Development Bank)
MCH	maternal and child health
MIS	Management Information System
MOH	ministry of health
MOU	Memorandum of Understanding
NGO	nongovernmental organization
ORS	oral rehydration salt
PI	performance indicators
PHN	population, health, and nutrition
PROMACO	Projet de Marketing Social de Condoms

PSAMAO	<i>Prevention de SIDA sur les Axes Migratoires de l'Afrique de l'Ouest</i>
PSI	Population Services International
REDSO/WCA	Regional Economic Development Services Office for West and Central Africa
RFA	Request for Application
SANFAM	<i>Santé de la Famille</i> (Dakar)
SPSC	senior personal service contractor
STI	sexually transmitted infection
UMT	Unified Management Team
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
USAID/AFR/SD	USAID Africa Bureau/Sustainable Development
USAID/G/PHN/OFPS	USAID Global Bureau/Population, Health and Nutrition/Office of Field and Program Support
USAID/PPC/CDIE	USAID Program Planning and Coordination/Center for Development Information and Evaluation
USAID/RIG/WAF	USAID Regional Inspector General for Audit, Dakar
WHO	World Health Organization
WCA	West and Central Africa

PROJECT IDENTIFICATION DATA SHEET

1. **Project Title:** Family Health and AIDS
2. **Country:** West and Central Africa Region
3. **Project Number:** 624-0440
4. **Project Dates:**
Project Authorization: July 19, 1995
End Date: September 30, 2000
5. **Project Funding:**
Initial Authorized LOP: \$40 million
Amendment Increasing LOP to
\$69 Million: June 8, 1998
Obligation to Date: \$28,849 million
Host-Country Funding: N/A
6. **Mode of Implementation:** Cooperative Agreements with four
U.S. NGOs
7. **Responsible USAID Officials:**
Mission Director: William Pearson
Assistant Director for Health
and Human Resources: Lois Bradshaw
Agreement Officer: John Taber
Project Manager: Dr. Souleymane Martial Barry
8. **Previous Evaluation(s):** Government Performance Results Act
(GPRA) Audit (October - December
1997) by Regional Inspector General
for Audit Dakar (Senegal)
Final Report No. 7-624-98-002-P dated
March 24, 1998

EXECUTIVE SUMMARY

At the request of the U.S. Agency for International Development's (USAID) Regional Economic Development Services Office for West and Central Africa (REDSO/WCA), a six-person team conducted an external program and management review from January 14 to February 5, 1998, of REDSO/WCA's five-year \$40 million Family Health and AIDS in West and Central Africa (FHA-WCA) regional project. The review was conducted two years after initial project implementation and examined the mission's Results Framework for its Strategic Objective (SO) in population, health, and nutrition (PHN); the main programmatic results achieved; and the effectiveness of the management model and systems. REDSO also asked the team to identify critical issues and lessons learned and to make recommendations.

The FHA project provides health and population assistance in the context of USAID's reduced presence in West and Central Africa, and is the principal vehicle for achieving USAID's SO *to improve access to and use of family planning (FP), maternal and child health (MCH), and HIV/AIDS prevention services in the region*. On the path to achieving this SO, three intermediate results are sought: (1) increased availability of and demand for FP, MCH, and STI/AIDS prevention services in target areas; (2) increased regional capacity for program development and implementation; and (3) more efficient use of resources through improved donor collaboration.

The FHA project is regional in scope and effort, focusing on issues and problems that are common across the WCA region and supporting identification and application of the best health and family planning practices throughout the region. Furthermore, because USAID designed this activity in part to mitigate the adverse consequences of the withdrawal of several bilateral programs in the WCA region, the project also includes limited but effective country-specific efforts in four USAID non-presence countries. Additionally, the project also emphasizes partnering African organizations with U.S. Cooperating Agencies (CA).

The FHA project has just finished its second year of implementation, and despite some important early management and implementation problems, the project has made a strong start:

- Partnering and networking with African institutions and organizations are well underway. Regional capacity for program development and implementation is increasing, and targeted intermediate results are being reached:
 - Strengthened institutional capacity of selected service delivery; information, education, and communication (IEC); training and operations research organizations.
 - Improved regional FP, MCH, and STI/AIDS communication materials.

- Strengthened regional training sites for FP, MCH, and STI/AIDS programs.
- Integrated FP-, MCH-, and STI/AIDS-related curricula developed and placed in selected institutions.
- Strengthened national and regional training teams for FP-, MCH-, and STI/AIDS-related programs.
- Increased regional pool and use of African expertise.
- Regional brands of contraceptives and regional production and marketing of oral rehydration salts (ORS) developed.
- Implementation of a program to target groups at high risk of HIV/AIDS infection on major international migratory routes in the region.
- In the four targeted non-presence countries, the FHA project has initiated promising activities to accomplish the following:
 - Improve the quality and use of service delivery in 190 health centers;
 - Increase social marketing of contraceptives and ORS; and
 - Strengthen national training sites, improve contraceptive forecasting and logistic management, and support policy development.

These activities contribute to the increased national capacity of ministries of health (MOH) and national nongovernmental organizations (NGO) to develop and implement health programs providing FP, MCH, and STI/AIDS prevention services. They also increase the capability of governments to achieve and consolidate ownership of these programs rather than being passive recipients of donor-driven assistance. Moreover, project activities are mitigating some of the negative effects of the abrupt closeouts of USAID bilateral programs and are maintaining some of the gains produced through previous USAID investments.

The mission's management of this program demonstrates some innovative ways of doing business as USAID's financial and human resources become more limited, and as reengineering increasingly emphasizes partnership, planning for sustainability, and accountability. Senior personal service contractors provide technical leadership within the mission, and four U.S. nonprofit CAs with complementary technical expertise work as strategic partners under separate performance-based cooperative agreements. These four strategic partners and their regional partners operate through a Unified Management Team (UMT) with integrated annual workplans.

Together, these approaches reduce USAID's management burden and its requirements for direct-hire technical staff, yet they ensure performance, flexibility, and accountability. In retrospect, the FHA project might have begun faster and more effectively if REDSO and its strategic partners had devoted more time and resources to organization and management at the outset. The capability of the UMT was substantially strengthened during the phaseout of one of the CAs in the summer of 1997, and the team now appears adequate to manage the program.

REDSO's current Results Framework is dated February 1997. In their review of the performance part of REDSO's FY1999 Results Review and Resource Request (R4), USAID's Africa and Global Bureaus suggested changes in this Results Framework, and a recent review by the Regional Inspector General (RIG) also recommended changes. The review team's concern is that the current Results Framework does not sufficiently present regional results or the program's emphasis on the development of sustainable systems through African partnerships and institution building. Also, a particular concern is that the Strategic Objective performance indicators (PI) deal almost exclusively with service delivery in the target areas in four countries, while the project is contributing to improved service delivery throughout the region.

Therefore, there are several recommendations that REDSO, the Africa Bureau, and the FHA-WCA's strategic partners should address:

- **Agreement on USAID's program in WCA:** There have been discussions about expanding the FHA project to include broader child survival and infectious diseases control programs. There have also been discussions about providing direct assistance to other countries in the region, such as the Democratic Republic of Congo, that have new USAID programs. This decision needs to be made at two levels. For example, decisions should be made on how much the program should be expanded, and if it is expanded, which if any of the expanded activities should be implemented through the FHA project. (See Chapter 2, Section 2.2.)
- **Program Focus:** The FHA project has the specialized expertise needed to make a unique contribution to family planning and HIV/AIDS prevention programs in West and Central Africa. It should therefore maintain this focus. However, REDSO's Strategic Objective and the project's structure and partners offer clear opportunities for various extensions in the technical scope of the project's interventions, such as in child survival, reproductive health, emerging infectious diseases, or even in strengthening basic health systems. Such extensions should build on the results achieved in family planning and HIV/AIDS prevention. (See Chapter 4 and Chapter 6.)
- **Agreement on a Revised Results Framework and Related Performance Indicators and Targets:** The present framework does not fully capture the program's directions and impacts. Once agreement is reached on the magnitude of the program, the Results Framework should be revised one last time and the

indicators and performance targets adjusted accordingly. Such revisions should articulate the program elements of sustainability, regional impact, and African program ownership. (See Chapter 2.)

- **Dissemination of Improved Regional Approaches and Products:** The FHA project is developing good regional materials and improved service delivery approaches that have broad applicability in the region. The FHA project should work with its African regional partners and other donors to ensure that these materials and approaches are adopted in other countries in the region, including those countries with bilateral programs. (See Chapter 4, Section 4.2.)
- **Constituency:** There is a need for a greater understanding of the FHA project, and of the scope and opportunities this project offers for continued support of increased availability and use of FP/MCH and HIV/AIDS preventive services in the WCA region.
- **Funding Levels and Management Configuration:** The mission estimates that an additional \$29 million in project funding is needed. The Africa Bureau has recently notified REDSO that this funding authorization is being approved. Along with this increased funding, USAID/Washington needs to make final decisions on how to manage this program once REDSO is closed. This program requires a continued strong project management office in Abidjan. (See Chapter 6.)
- **Program Length:** The original program design specified that a second five-year phase would be needed to achieve the Strategic Objective. As decisions are being made about program scope and funding, it is appropriate to make decisions about a possible program extension. It is time to begin planning for the second phase. (See Chapter 6.)

The review team concludes that the FHA project is on the right course and should continue its effort toward the agreed objectives.

LIST OF RECOMMENDATIONS

Recommendation 1: REDSO should redefine its Strategic Objective to include regional impact and sustainability. Intermediate results should reflect achievements sought in developing African program ownership and mobilizing host-government and other donor resources. Performance indicators and targets should be updated accordingly.

Recommendation 2: REDSO and the UMT should clearly define the scope of “regional” approaches to realize the Strategic Objective and develop indicators of regional impact.

Recommendation 3: REDSO should consider how to monitor assistance to non-presence countries within the new guidance developed by USAID’s Program Planning and Coordination (PPC) and Management (M) Bureaus.

Recommendation 4: The UMT and country office staff should involve U.S. Embassy personnel in functions and activities, when appropriate, to raise the visibility of U.S. Government support in USAID’s absence.

Recommendation 5: The UMT should develop guidelines indicating the types of decisions to make jointly and the types of decisions to delegate to each strategic partner.

Recommendation 6: The FHA-WCA project should continue to focus on improving the quality of existing family planning services within the selected sites.

Recommendation 7: The UMT should document the populations served by the selected sites and set country-specific performance targets in family planning use related to the estimated population served by these clinics.

Recommendation 8: The UMT should evaluate the feasibility of introducing a clinic-based performance monitoring system using tickler files to register new and continuing acceptors. This system has the advantage of helping service providers manage their client base and focus on continuity of care, and therefore of helping them promote quality of care.

Recommendation 9: The UMT should define indicators of service quality, in addition to indicators of use, to measure results from its clinic-based service delivery programs.

Recommendation 10: The UMT should build into its incentive program requirements for quality of care, client counseling, and protection of reproductive rights.

Recommendation 11: The FHA project should confirm its continued support for contraceptive implants with the project’s country office staff and with the network of trained service providers.

Recommendation 12: The FHA project should continue to develop outreach and community-based distribution programs, particularly in the catchment area of the selected clinics.

Recommendation 13: The UMT should disseminate the findings of the project's studies and analyses among all the Project partners and among other African and donor organizations in the WCA region.

Recommendation 14: The UMT should define a clear strategy and establish the basic principles and objectives for extending FP promotion and services through large private enterprises throughout the region.

Recommendation 15: The UMT should strengthen selected national organizations in priority countries, in addition to strengthening the regional African partners.

Recommendation 16: The UMT should continue to develop action plans with African partners that take into account the technical, strategic, managerial, and financial aspects of institution building.

Recommendation 17: The UMT should systematically assist its African partners in making FHA-WCA outputs widely available throughout the WCA region.

Recommendation 18: The UMT and resident advisors should more actively promote country-driven donor coordination by planning its activities with national-level partners.

Recommendation 19: The FHA project should develop new strategies and increase leveraging of other donor resources.

Recommendation 20: The UMT should identify the technical constraints and opportunities, and test and document strategies to improve donor coordination at the regional and country level.

Recommendation 21: The UMT should ensure that Memoranda of Understanding with the African regional partners include clearly defined roles and technical and financial responsibilities.

Recommendation 22: REDSO and the UMT should establish monitoring and accountability systems for field support activities, in consultation with USAID/G/PHN.

Recommendation 23: The FHA project should extend access to regional expertise, best practices, and collaboration on specific transnational activities to countries of the region with bilateral USAID presence.

Recommendation 24: The Memoranda of Understanding with ministries of health should reflect the project's intentions to work through African institutions as much as possible.

Recommendation 25: The UMT reporting system should include a more comprehensive annual report of achievements and impact that would incorporate information presently provided by the second semiannual performance report.

Recommendation 26: REDSO and the UMT should institute multiyear planning of FHA project activities. Funding decisions can still be made annually based on performance.

Recommendation 27: The program and management review team was unanimous in its conclusion that given the progress achieved, USAID should stay the course and implement the FHA project over the five years as planned.

Recommendation 28: In light of the agency's Strategic Plan (September 1997), the Africa Bureau should plan for continued health and population assistance in the WCA region through a regional effort similar to that of the FHA project.

1. INTRODUCTION

At the request of the U.S. Agency for International Development's (USAID) Regional Economic Development Services Office for West and Central Africa (REDSO/WCA), a six-person team carried out a midterm program and management review of the mission's regional project, the Family Health and AIDS in West and Central Africa (FHA-WCA) project, from January 14 to February 5, 1998.

1.1 Synopsis of the FHA Project

REDSO/WCA designed the FHA project to provide a flexible mechanism to continue limited strategic support for essential health and population activities with reduced USAID presence in the region. This \$40 million, five year regional effort was authorized in July 1995 and began activities in September 1995, with headquarters in Abidjan. USAID is implementing the FHA project through an innovative procurement and management approach with separate cooperative agreements with four Cooperating Agencies as strategic partners. These strategic partners share responsibility for program management, coordination, and implementation through the Unified Management Team (UMT). Each CA must annually apply for continued funding of their cooperative agreement based on actual and planned performance. The project supports REDSO/WCA's Strategic Objective (SO) to increase accessibility to and use of family planning (FP), maternal and child health (MCH), and HIV/AIDS prevention services in West and Central Africa. As designed and implemented to date, the program primarily addresses family planning and HIV/AIDS through technical support in five functional areas:

- Clinical service delivery,
- Social marketing,
- Training,
- IEC, and
- Operations research.

A focused child survival (CS) component promotes greater use of oral rehydration salts (ORS) through social marketing.

This regionally operated project is primarily supporting activities in four non-presence countries: Burkina Faso, Cameroon, Côte d'Ivoire, and Togo. It also develops and promotes regional products and best practices throughout the region. The FHA project particularly emphasizes

developing sustainable systems through partnerships with African institutions, the private sector, and other donors.

In December 1997, USAID decided to restructure and close out REDSO/WCA as an independent operating unit. Although USAID/Washington and REDSO/WCA have committed to continuing the current program, they have not made final decisions on USAID's management of the program.

1.2 Scope of Work for Program and Management Review

The objective of this external program and management review was to provide a critical analysis of the project's first two years of implementation. In the review Scope of Work (see Appendix A), REDSO/WCA specifically identified 14 analytic tasks for the review. These tasks were as follows:

- Review and comment on the Results Framework for this regional initiative with regard to its pertinence to challenges facing U.S. assistance in this sector in WCA and to exploiting USAID's comparative advantages in this sector (Task 1);
- Review and comment on the programmatic results achieved by the strategic partners (Task 2);
- Examine the collaboration among the strategic partners, between the strategic partners and their African institutions and commercial sector partners, between the strategic partners and USAID field support partners, and between the strategic partners and USAID/Benin and USAID/Senegal (Tasks 3,4,5, and 6);
- Examine the effectiveness of the project's management model and the monitoring and supervision systems (Tasks 7 and 8);
- Discuss the constraints, challenges, and opportunities of the assistance model as developed by REDSO (Task 9);
- Identify critical issues meriting REDSO or strategic partners' attention; document the project's process, mechanisms, and achievements; and discuss the lessons learned through the regional model (Task 10, 12, and 13);
- Examine the various perspectives and strategic ideas regarding the sustainability of the regional initiative (Task 11); and
- Make recommendations for optimal program focus, management, and sustainability of the regional initiative (Task 14).

1.3 Composition of the Review Team

- The team comprised two independent consultants provided by the Population Technical Assistance Project (POPTECH) and four USAID specialists:
- Marc Debay, reproductive health consultant and team leader;
- Albert Baron, management consultant for health and population programs;
- Sambe Duale, Research Manager, Support for Analysis and Research in Africa (SARA) project, Academy for Educational Development, assigned to USAID/AFR/Bureau of Sustainable Development (SD);
- Harriett Destler, Chief, Performance Measurement and Evaluation Division, USAID/Bureau for Program and Policy Coordination (PPC)/Center for Development Information and Evaluation (CDIE), and health, population, and nutrition specialist;
- Pamela Wolf, Senior Analyst for Africa, USAID/G/Center for Population, Health and Nutrition (PHN)/Office of Field and Program Support (OFPS); and
- Gary Merritt, PHN Officer, USAID/Senegal.

1.4 Methodology of Review

The team reviewed essential project documents, including the Request For Application (RFA), the CAs' applications and cooperative agreements, and the UMT's annual workplans and progress reports. The team began its review with three days of visits and conference calls in Washington and Baltimore, interviewing U.S.-based CA headquarters staff. These activities were followed by a two-day briefing in Abidjan with REDSO and its Strategic Objective Team and with the UMT. The review team then split up for a week of country visits to Côte d'Ivoire, Togo, Cameroon, Burkina Faso, and Benin to consult with collaborating government agencies, local and national nongovernmental organizations (NGO), and FHA-WCA resident advisors and staff. Additionally, Dr. Merritt visited African regional partners in Senegal and Mali. A project time line was prepared (Appendix D). Before leaving Abidjan, the review team presented its preliminary findings and recommendations to the Strategic Objective Team and the UMT. (The team did not review any issues concerning financial management or cost effectiveness.) Dr. Debay and Mr. Baron prepared the final report, which draws on written contributions prepared by each team member.

1.5 Organization of the Report

The review team's analyses, findings, and recommendations are presented in four main sections as follows:

- Chapter 2: REDSO's Strategic Objective and Results Framework are discussed in the context of current U.S. assistance in the WCA region, and reviewed against actual program implementation.
- Chapter 3: The assumptions underlying REDSO's assistance model are identified and validated.
- Chapter 4: The main programmatic results after two years of project implementation are reviewed in reference to REDSO's Results Framework.
- Chapter 5: the various collaborative mechanisms and partnerships involved in the FHA/WCA project are examined.
- Chapter 6: The adequacy and effectiveness of FHA's current management systems are assessed.

These five chapters present the review team's main findings, followed by comments, evidence, and any recommendations. All recommendations are numbered sequentially throughout the report and are also listed in a separate section at the beginning of the report.

Because many partners share responsibility in the FHA project's management and implementation, the following appellations are adopted to distinguish specific parties when necessary:

- "REDSO" used alone refers to all REDSO/WCA management staff in charge of the project;
- "The UMT" refers specifically to the management staff of the Unified Management Team;
- "The CAs" refers to the U.S.-based management staff of the CAs; and
- "The FHA project," when used as a subject organizational entity, refers to the management staff of REDSO/WCA, the UMT, and the U.S.-based CAs.

2. REDSO/WCA'S HEALTH AND POPULATION PROGRAM

2.1 Background

In 1994 and 1995 when REDSO was developing its strategic plan for 1995 to 2000, it faced difficult decisions on whether to continue population, health, and nutrition assistance in the region and how to continue such assistance. Declining budgets were forcing USAID to close or cut back on bilateral programs in Africa and elsewhere in the world. Thus, any new REDSO strategy had to deal explicitly with the problem of reduced program and management resources. Although it might be possible to generate sufficient resources for a strong regional PHN intervention, overall funding levels would be below those previously provided to each of the bilateral programs in the closeout countries. REDSO was particularly concerned about how it might help its partners in these countries sustain some of the benefits obtained through prior USAID support. Since 1994, 7 of the 16 bilateral missions in the 24 countries in the region have been closed.

West and Central African countries have some of the highest fertility and mortality rates in the world. Thus, it was not surprising that in 1994, 14 of the 16 bilateral missions had strategic objectives in health and family planning. However, the early and abrupt termination of these programs poses a particular threat to the region, since in most of these countries USAID was the lead donor and provided critical leadership and support for programs such as family planning and contraceptive supply. In addition, the critical transnational health and population issues in these countries threaten the success of bilateral programs in neighboring countries. WCA borders are artificial and porous, and there is a high volume of cross-border trade and seasonal and permanent migration that facilitates the spread of HIV/AIDS among countries. Therefore, reducing the transmission of HIV/AIDS requires regional strategies and joint actions by a number of sovereign nations.

At the same time that REDSO was developing its new regional strategy with a strategic objective in population and health, USAID systems and worldwide programming were changing. The agency's strategy and its management and operating systems were being reviewed, revised, and reengineered. Several countries in the region were very active as "country experimental laboratories" to test USAID's new approaches. In this context, REDSO developed alternative ways of managing its program to reflect the agency's core values and increased emphasis on partnership, planning for sustainability, and accountability.

Furthermore, USAID's long involvement in the region created a number of positive reasons for continued assistance. These reasons included a rich body of experience, tested and proven service delivery models, and well-established partnerships with African private and public sector groups. Finally, common traditions and languages among countries made it feasible to develop regional program approaches and training and information materials for use in multiple national settings.

2.2 Strategic Objective and Results Framework

REDSO/WCA's strategy in health and population is presented in two documents: the "Provisional Regional Program Strategy Paper, 1995-2000," from March 1995, and the "FHA/WCA Project Paper," from July 1995. This strategy has continued to evolve as more bilateral missions have closed; REDSO/WCA's FY1999 Results Review and Resources Request (R4) provides an update as of February 1997.

The project paper provides authorization for a 5-year, \$40 million program as the first segment of a planned 10-year effort. The project's purpose as stated in this document is "to increase the availability and use of quality family planning/reproductive health, HIV/AIDS, and maternal and child health services in concert with other donor and host-country efforts, building on successful USAID-funded initiatives in West and Central Africa." This purpose statement was modified slightly when it was presented as a Strategic Objective. REDSO's February 1997 Interim Results Framework (Appendix E) has the following Strategic Objective: "Improve access to and use of the family planning, maternal and child health, and HIV/AIDS prevention services."

This February 1997 Interim Results Framework has three key intermediate results:

- IR1, increased availability of and demand for FP/MCH and STI/AIDS services in target areas;
- IR2, increased regional capacity for program development and implementation; and
- IR3, efficient use of resources through improved donor collaboration.

Each of these three intermediate results have at least three lower-level intermediate results that incorporate the strategy for achieving the intermediate results and ultimately the Strategic Objective:

- For IR1 (increased availability of and demand for FP/MCH and STI/AIDS services in target areas) the lower-level results include an improved policy environment, increased client knowledge, integrated service delivery, improved service delivery quality, and increased access to services for special groups.
- For IR2 (increased regional capacity for program development and implementation) the lower-level results include strengthened national and regional institutions and organizations; improved information, education, and communication (IEC) materials and FP/MCH and STI/AIDS curricula; and increased use of African experts in program designs and implementation.

- For IR3, the lower-level results include a regional model developed for delivering USAID assistance in non-presence countries, strengthened technical and financial collaboration with other donors, and improved regional consultation and collaboration.

REDSO only has SO-level performance indicators that measure access and use of key FP, HIV/AIDS, and CS practices in project target areas. These four indicators are (1) contraceptive prevalence rate (CPR), (2) proportion of men of reproductive age using condoms during the last sex act, (3) ORS use in target areas, and (4) number of social marketing service delivery points. However, it is clear from the project paper and the Results Framework that it was REDSO's intention from the start to develop approaches and products for use throughout the region. The intermediate results statements clearly convey REDSO's commitment to a regional program with benefits beyond the increases in the use of family planning and selected child survival and HIV/AIDS risk reduction practices in non-presence countries. It was also clearly REDSO's intention to promote sustainability through policy change, institutional development, and encouragement of program support by other donors and partners. REDSO was committed to program approaches that increased African ownership and decreased dependence on USAID resources.

These regional and sustainability elements, however, were not included in the Strategic Objective statement. This may have resulted in some misunderstandings about the mission's strategy and the results the program produces. These misunderstandings may have been inadvertently exacerbated by the prominence given to standards of use of FP/CS/HIV services in the performance-based cooperative agreements. It may also have contributed to the observed divergence between REDSO's Results Framework and the UMT's Results Framework. Increased use of critical FP/CS/HIV practices in non-presence countries is a critical program result, but it is not the only important result that REDSO is seeking and achieving.

Although the project supports integrated service delivery to strengthen FP, MCH, and HIV/AIDS prevention programs, most of the project's efforts are aimed at improving family planning and HIV/AIDS services. Approximately 50 percent of the program funds support family planning, 30 percent support HIV/AIDS, and 20 percent support child survival programs. The FHA project paper states explicitly that REDSO should concentrate the majority of its resources on family planning and HIV/AIDS prevention activities because other donors are active and continuing their support for MCH in non-presence countries. Child survival assistance is primarily provided through the Basic Support for Institutionalizing Child Survival project (BASICS) and focuses on ensuring that a reliable supply of ORS is available in the region and to consumers through a public/private partnership in local production and through inclusion of this product in social marketing programs. REDSO is also supporting maternal and child health networking and an assessment of key issues and lessons learned in MCH in the region. REDSO is currently considering whether to expand its child survival focus and whether to add a component on infectious disease to its strategy and program. If these changes are made, the revised REDSO Results Framework would need to incorporate these elements explicitly at the SO and IR levels.

The review by the Regional Inspector General for Audit, Dakar (USAID/RIG/WAF) appears to have focused on the UMT's Results Framework rather than on REDSO's. They correctly noted that the UMT's framework mistakenly uses performance indicators from REDSO's framework as intermediate results. The RIG/WAF review noted the work done to verify and set good baseline data, the mission's use of performance data to manage for results, and the satisfactory progress toward achieving intended benefits. In response to RIG/WAF's recommendations (and USAID requirements), the mission will design and maintain a performance monitoring plan to document both its performance measures and its baseline, target, and actual results. REDSO will need to communicate with RIG/WAF on its findings to clarify the technical bases for the analyses used to track performance in the PHN sector.

Both USAID/Washington's review of the mission's R4 and the more recent review by the RIG/WAF raised concerns about REDSO's Results Framework. Recently, AFR/SD sent REDSO a revised Results Framework that included some suggested wording to incorporate REDSO's commitment to sustainability. It is essential that all the partners—REDSO, USAID/W, the UMT and each U.S.-based CA, U.S. Embassy officials, other USAID missions, and African institutions and ministries—have a common understanding of the program's purpose, priorities, and expected results. This understanding can be gained beginning with REDSO's Strategic Objective, which states the highest framework level that the mission holds itself accountable for achieving with its partners, and continues with the rest of the Results Framework's critical assumptions and intermediate results. There is a danger that too great an emphasis on the quantitative measures of use in non-presence countries may skew results and obscure success. Finally, there are differences between REDSO's and the UMT's results frameworks that may affect joint implementation.

Recommendation 1: REDSO should redefine its Strategic Objective to include regional impact and sustainability. Intermediate results should reflect achievements sought in developing African program ownership and mobilizing host-government and other donor resources. Performance indicators and targets should be updated accordingly.

3. THE ASSISTANCE MODEL

The FHA project is based on three critical assumptions:

- Regional impact can be achieved through a blend of country and regional programming based on replication of best practices;
- Assistance can be provided efficiently and effectively in non-presence countries; and
- Innovative procurement and implementation arrangements can enable USAID to manage complex and significant programs with reduced human and financial resources.

3.1 Regional versus Country Focus

The FHA project was designed to address a development problem on a regional basis. This approach assumes that time and money can be saved if certain proven cost-effective interventions or best practices are planned, implemented, and replicated regionally. A regional program includes actions involving two or more countries, but it may also include parallel country-specific actions based on a common approach.

Finding: The FHA project provides a concerted and systematic regional approach to addressing service delivery and its attendant problems and challenges that can and do influence and enhance activities in USAID non-presence countries and those with bilateral programs.

The project has already demonstrated that it can develop regional approaches that have an impact at the country level. There are numerous examples of promising interventions that represent not just regional activities, but a regional process:

- IEC efforts easily lend themselves to this approach. The FHA-WCA regional African partners, for example, participated in developing, testing, and producing IEC kits for service providers and community health workers to better inform their clients. This process promotes wider acceptance and ownership of the intervention.
- The *Projet de Prevention du SIDA sur les Axes Migratoires de l’Africa de l’Ouest* (PSAMAO) is a migrant project designed to facilitate responsible sexual behavior by providing information and services to populations along international trade routes in West Africa. The target groups for this project include truck drivers,

seasonal workers, commercial sex workers, and individuals in the communities along these routes.

- In social marketing efforts, there are regional brand development of family planning products and regional procurement, supply, and production plans for ORS.
- Other examples of regional activities include networking, development of registers of regional consultants with specific areas of expertise, standardization of tools to assess quality of care, capacity building of regional institutions, and conferences with participants from countries in which the FHA project works, as well as from as many as 18 countries in the region.

Finding: The bulk of FHA’s activities affects a few, selected priority countries.

Although the FHA project successfully developed regional-level activities, it acknowledges that for the most part service delivery is implemented locally through public/private programs that are the ultimate responsibility of each country’s MOH. Therefore, in non-presence countries the FHA project works at the national level to strengthen training sites, improve contraceptive forecasting and logistic management, support the development of service delivery guidelines, and promote donor coordination. It also provides direct assistance to selected clinics in target areas.

One of the project’s challenges is to develop regional approaches based on lessons learned from successes and failures in country programs, and selectively scale up activities when they have the potential to make a regional impact.

Because the FHA project has both regional- and country-specific mandates, there will continue to be tension between regional and country-specific activities. Also, the lack of a clear definition about what constitutes acceptable actions under a regional project may result in delays in project implementation.

Recommendation 2: REDSO and the UMT should clearly define the scope of “regional” approaches to realize the Strategic Objective and develop indicators of regional impact.

3.2 Assistance in Non-presence Countries

One of the major issues currently under discussion in the agency concerns assistance in non-presence countries and what this means from the standpoint of implementation, management burden, and achievement of results. Some have expressed concern that significant USAID activities in a country where there is no mission will create an undue burden on the U.S. Embassy in that country.

Finding: REDSO's assistance model has been able to provide effective support to non-presence countries and prevent or limit the loss of previous U.S. investments in the population and health sector.

Regional- and country-level project personnel reported no difficulties associated with the absence of a USAID mission. Of some concern, however, is that USAID's credibility has diminished as it has terminated support and then "reappeared" supporting regional projects. Also, local authorities fear the uncertain time frame.

USAID/Washington's recent preliminary review of assistance in non-presence countries suggested that there was significant underreporting of resource allocations and results in non-presence countries.

Recommendation 3: REDSO should consider how to monitor assistance to non-presence countries within the new guidance developed by USAID's Program Planning and Coordination (PPC) and Management (M) Bureaus.

Finding: The ambassadors in the four countries where the FHA project operates know about and seemed eager to enhance the project, and are advocates of the regional model.

The team found this to be the case because there has been support from REDSO in Abidjan, and advisors in each country have prior experience in working with U.S. Government-funded projects. During the project transition period in the summer of 1997, the embassies provided assistance and suggestions for establishing local administrative procedures.

From the embassies' view, the drawbacks of having U.S. Government-funded activities in a non-presence country are the insufficient involvement of U.S. Government officials and little or no public awareness of the source of support. The embassies in Cameroon and Togo specifically requested that they be invited more frequently to participate in project functions when appropriate.

Recommendation 4: The UMT and country office staff should involve U.S. Embassy personnel in functions and activities, when appropriate, to raise the visibility of U.S. Government support in USAID's absence.

3.3 Procurement Mechanism and Implementation Arrangements

To implement the FHA project, REDSO requested assistance in four technical areas. In September 1995, it awarded separate cooperative agreements to John Snow Inc., Research and Training (JSI/R&T) for the service delivery component; to Johns Hopkins University/Center for Communication Programs (JHU/CCP) for IEC; to Johns Hopkins Program for International

Education in Reproductive Health (JHPIEGO) for training; and to Tulane University for operations research, which included responsibility for project monitoring and evaluation. Each of these organizations had subrecipient arrangements with multiple U.S. and African partners. In 1997, REDSO did not renew its cooperative agreement with JSI/R&T because of a lack of performance, but awarded a new separate cooperative agreement to Population Services International (PSI), a subrecipient to JSI/R&T. REDSO/WCA also draws upon various CAs that are centrally managed by the Global Bureau's Office of Field and Program Support (USAID/G/OFPS) for supplementary technical assistance and procures commodities such as contraceptives through central mechanisms.

Finding: The FHA project is successfully implemented through competitively awarded cooperative agreements with multiple independent CAs with highly specialized complementary expertise.

Such separate solicitations promote competition and ultimately greater potential for each technical aspect of the project. An alternative procurement arrangement frequently employed in bilateral projects uses a single prime institutional contractor with several subcontractors. With this arrangement, when there is a solicitation for a broad-based project with several technical foci, organizations that do not have the full capability to handle these foci partner with other firms to capitalize on each firm's comparative advantage. When the best proposal is selected, it is judged in its entirety—sometimes at the expense of a technical aspect of the project. Therefore, although the prime contractor approach presents clearly defined lines of authority between the prime contractor and its subcontractors, it raises questions about whether the combination of partner organizations is the best possible from a technical standpoint.

Finding: Although each recipient CA has prime responsibility for particular aspects of the project, they are all committed to and accountable for the overall project results and success.

In its Request For Application (RFA), REDSO/WCA required that the winning award recipients propose and establish a unified management and reporting structure that “fosters technical and financial collaboration among implementing and development partners in the region under the leadership of the Unified Management Team.” Furthermore, although initially each technical partner was required to have component-specific objectives, REDSO recognized the need for shared objectives and joint workplans and modified the cooperative agreements when the second-year agreements were signed (9/30/96). These revised agreements commit each partner to consolidating travel and technical assistance plans and to pooling resources for the regional and country offices. Each partner, however, has prime responsibility for specific milestones and critical events that are determined by the UMT.

When the UMT was established, the CAs chose a lead agency. JSI/R&T assumed the leadership of the UMT until the end of its cooperative agreement. JSI/R&T was then replaced by JHPIEGO, and a strengthened financial and administrative support system was established (see Chapter 6).

This project structure has distinct advantages in that it fosters teamwork and coordination, increases flexibility, and ensures shared accountability. Furthermore, the UMT's presence removed some of the management burden from REDSO, a not insignificant consideration in the face of the ongoing restructuring. In comparison, Nigeria's Family Health Services Project also featured four separate technical components, but the absence of a unifying structure meant that there was a heavy day-to-day management burden on the mission, as well as serious coordination problems.

Conversely, for this management model to succeed, the UMT needs strong leadership and good management skills. When one or more partners does not reach their milestones on time, the consequences for the remaining partners are serious and can mean a failure to reach common results. Furthermore, consensus can be difficult and teamwork takes time.

Recommendation 5: The UMT should develop guidelines indicating the types of decisions to make jointly and the types of decisions to delegate to each strategic partner.

Finding: Annual performance-based renewals of each cooperative agreement call for constant attention to performance evaluated against the milestones set by the CAs.

The FHA project's award process and management structure reflect REDSO's intention to enter an innovative relationship with its strategic partners. The cooperative agreement awards are performance-based and funded through a continuous application process whereby the CAs must reapply each year with a budget and workplan to continue to participate in the program. REDSO reviews the CAs' performances and decides whether to continue to provide support. This mechanism allows USAID to call for the achievement of annual performance targets, although the targets are set by the CAs. If after review of the application USAID determines that a CA's performance has been unacceptable, USAID can renegotiate a new workplan that incorporates corrections to the deficiencies noted, or it can decide not to renew the CA's agreement for the next year. REDSO/WCA requires that CAs re-apply by April 1 of every year, allowing six months for a thorough review and discussion with the partners before the continuing award is made for the next fiscal year.

Finding: The continuing application and annual renewal of the cooperative agreement has created a perception, at least among some African partners, that the project time line is very short.

It is USAID's clear intention, however, to continue this program for the full authorized period. Therefore, it is important to consider this longer-term perspective in program planning and to not overemphasize the annual workplans. This issue is developed further in Chapter 6.

4. PROGRAM RESULTS

The FHA-WCA's resources and activities primarily support REDSO's Strategic Objective of *increasing access to and use of family planning and HIV/AIDS prevention and services in the region*. It also supports one child survival intervention: Increasing the use of oral rehydration salts through social marketing.

There is a region-wide effort to promote best practices in FP/MCH and HIV/AIDS service delivery, IEC, training, and operations research, and more direct assistance to approximately 190 service delivery sites in the four emphasis countries. These delivery sites serve a target population of approximately eight million individuals in four priority non-presence countries: Burkina Faso, Cameroon, Côte d'Ivoire, and Togo. The FHA project also conducts significant country-specific activities in Benin at the mission's request.

The three sections of this chapter present the review team's main findings on program results after two years of project implementation. Each section corresponds to one intermediate result of the February 1997 Interim Results Framework (see Appendix E). To the extent possible, each finding relates to a lower-level results.

4.1 Increased Availability of and Demand for FP/MCH and STI/AIDS Services

This first intermediate result under REDSO's Strategic Objective is sought through the following lower-level results:

- IR1.1, improved policy environment for FP/MCH and STI/AIDS services;
- IR1.2, increased knowledge of selected FP/MCH and STI/AIDS products;
- IR1.3, increased knowledge of STI/AIDS, its transmission, and its prevention;
- IR1.4, integrated provision of FP/MCH and STI/AIDS services;
- IR1.5, increased quality of FP/MCH and STI/AIDS services; and
- IR1.6, increased access to FP/MCH and STI/AIDS services for special groups.

Finding: The FHA project significantly improved the policy environment for FP/MCH and STI/AIDS services in four priority countries, as well as in other countries in the region.

At the beginning of the project, ministers of health and deans of schools and universities from 18 countries gathered to plan the introduction of reproductive health curricula in their pre-service training institutions. UMT staff and consultants promptly followed up on this symposium, and the curriculum revision process has progressed in several institutions in several countries in the region.

Furthermore, through support from the POLICY project, the FHA project organized or sponsored participants to attend several international conferences with high potential for policy change. For instance, in March 1997 the FHA project significantly contributed to the Cotonou Symposium on legal and medical barriers to family planning for francophone Africa. Also, innovative conferences on best practices successfully gathered the major organizations involved in activities, such as social marketing and radio communications for health behavior change.

Finding: The social marketing of contraceptives and ORS achieved significant results in the four priority countries and in Benin.

Total condom sales remained stable at around 32 million in 1995 and 1996, but reached almost 40 million in 1997. In Côte d'Ivoire, total sales increased from 11 to 15 million between 1995 and 1997, of which about 90 percent was channeled through the wholesalers and retailers network managed by PSI and its partner ECODEV. In Burkina Faso, sales of Prudence condoms through the Projet de Marketing Social de Condoms (PROMACO) project increased from 6 million in 1995 to 9.5 million in 1997. Although these two programs are primarily financed by the German Development Bank (*Kredietanstalt Für Wiederaufbau* [KfW]), the FHA project contributes to their success through the technical assistance provided by PSI and through the regional migrant project, which promotes condom use. In Cameroon, sales also increased from seven to nine million in two years.

Building on the successful condom sales, the FHA project started the social marketing of pills in Cameroon and Côte d'Ivoire. Furthermore, Togo and Benin will implement OC social marketing programs in the coming year.

Sales of ORS in Benin gradually increased from 163 thousand in 1995 to 1.7 million in 1997, and totaled about 600 thousand in Togo in 1997.

Finding: The FHA project supported several regional and national innovative mass media campaigns to increase knowledge of family planning, prevention of HIV/AIDS, and use of related services and products.

The FHA project funded and provided technical assistance for the production and dissemination of the song "Wake-up Africa," which involved over a dozen of West and Central Africa's famous musicians. "*Les Clefs de la Vie, Yamba-Songo*," a 26-part radio series on family planning, adolescent sexual responsibility, STI/AIDS prevention, and the promotion of ORS was broadcast on one regional and several national radio stations. The FHA project also sponsored a quiz show

following each episode of the television series, "*SIDA dans la cité*," a soap opera based on the theme of HIV/AIDS.

Finding: To increase access to clinic-based services, the FHA project focuses its support on improving the quality of existing family planning services in a limited number of clinics selected on the basis of prior performance.

The project strategy, to focus its support on a limited number of family planning clinical service delivery sites, is appropriate for two main reasons. First, USAID and its CAs have the specialized expertise needed to develop national family planning programs in developing countries and can therefore make a unique contribution in this sector in West and Central Africa. Only a few other donor agencies can offer such assistance, and often do so within broader health sector programs or projects in which family planning is either left behind or constrained to the pace of the program within which it is included.

Second, existing family planning services in WCA often do not meet the minimum standards of quality and remain poorly used. Providing specialized support to these services and bringing them up to standard is more cost-effective than creating new sites. Also, developing existing family planning services to accepted standards not only meets the demand of the population in the catchment areas, but also creates opportunities for training, demonstration, and operations research. By developing model sites and local expertise, the project sets the ground for replicating similar services in other areas by African partners, with or without the support of other donors.

Recommendation 6: The FHA-WCA project should continue to focus on improving the quality of existing family planning services within the selected sites.

Finding: The FHA project only agreed on a final list of clinics and target areas in mid-1997.

The more than a year of delay in selecting the sites was unexpected since the initial lead CAs, also responsible for the service delivery component, had proposed to start their application rapidly, based on their prior involvement in service delivery activities in the four priority countries. This delay was not justified by any particular needs assessment or strategic planning exercise.

The clinics finally selected in 1997 were those with the best family planning services in the region, generally as the result of support from USAID-funded projects before the closeout of the missions and the end of the bilateral programs.

Finding: A total of about eight million people living in the catchment areas of the selected clinics is now considered the target population for clinic-based project activities.

The selection of a limited number of the family planning clinics is appropriate for the reasons stated. Since these clinics are already functional and serve populations with high unmet needs, the review team believes that a five percentage point increase in contraceptive prevalence by the end

of the project is achievable in these target areas. Although perfect information on the proportion of the population with actual access to these clinics is not yet available, the FHA project needs to commit to performance targets, including clients served and increases in contraceptive prevalence, for its priority, non-presence countries. These performance targets can be country-based rather than site targets, although these targets would be estimated and set assuming a population equivalent to that believed to be served by all the clinics in each country. In addition, the annual performance targets can be scaled to reflect a greater rate of increase later in the project.

Recommendation 7: The UMT should document the populations served by the selected sites and set country-specific performance targets in family planning use related to the estimated population served by these clinics.

Finding: Building on information systems established during previous USAID bilateral programs in the four emphasis countries, the FHA project reports the total couple years of protection (CYP) data from all its selected sites since mid-1995, by country and method.

After project sites were selected, these reports were established retroactively and therefore constitute a useful baseline. The quarterly number of CYPs produced in those sites remained stable throughout most of the first year of the project and significantly increased during the last two quarters of FY1997. This increase is primarily the result of the introduction of NORPLANT® in Togo and Cameroon.

The reporting system based on clinic-based CYPs has the advantage of being a relatively simple way to monitor performance and contraceptive supply and is already in place in most of the clinics. This system has drawbacks, however, such as the tendencies to overestimate the contribution of long-term and permanent methods to the derived contraceptive prevalence estimates and to focus primarily on supply of methods rather than actual use.

Recommendation 8: The UMT should evaluate the feasibility of introducing a clinic-based performance monitoring system using tickler files to register new and continuing acceptors. This system has the advantage of helping service providers manage their client base and focus on continuity of care, and therefore of helping them promote quality of care.

Finding: The FHA project is developing a sound strategy for improving family planning services based on developing local standards and related training, supervision, and monitoring activities.

Since the beginning of the project, 1,380 service providers received training in various areas such as contraceptive technology, infection prevention, interpersonal communication and counseling, and management information systems. The project is currently distributing equipment in about

100 sites, and IEC kits developed at the regional level will be distributed this year at the same time as training in interpersonal communication and counseling is conducted.

In 1996, the project launched a series of continuous quality improvement workshops in 40 service delivery points. These workshops were organized around developing and implementing problem-solving projects in each clinic. More recently, the project emphasized supervision and quality control in all the selected sites. Supervising guidelines have been developed based on accepted standards of care, national supervisory teams have been selected and trained, and supervisory visits have already started in three countries.

Recommendation 9: The UMT should define indicators of service quality, in addition to indicators of use, to measure results from its clinic-based service delivery programs.

Finding: The FHA project is launching a promising incentive and performance-based program in the clinics selected for direct project support.

This initiative is innovative in the WCA region and, therefore, is commendable. However, the performance indicators rely mainly on clinic-based CYPs. Although it is important to reward performance, there are dangers in performance-based systems if they are too narrowly defined.

Recommendation 10: The UMT should build into its incentive program requirements for quality of care, client counseling, and protection of reproductive rights.

Finding: The introduction of NORPLANT in Togo and Cameroon has rapidly created a significant demand for and use of this method.

Although USAID has recently questioned the continued support of NORPLANT, the success of this newly introduced method in Togo and Cameroon calls for continued training and supply from the FHA project. The ill-defined rumor that the project would terminate these activities has created confusion and frustration among project staff and service providers.

Recommendation 11: The FHA project should confirm its continued support for contraceptive implants with the project's country office staff and with the network of trained service providers.

Finding: The FHA project has started sponsoring community mobilization or outreach activities to disseminate information and motivate the population to seek information or services around clinics.

Pilot activities have been carried out in one area in Cameroon with the *Association des Femmes-Santé-Développement en Afrique Sub-Saharienne* (FESADE), and in Burkina Faso with the

Association Burkinabe pour le Bien-Etre Familial and the *Association Burkinabe des Sages-Femmes*. These projects include a research component and will be documented for future replication in two "blueprint" manuals and one video. In its third-year workplan, the UMT proposed to begin a promising regional outreach program for promoting and delivering hormonal products outside of the clinics selected by the project for direct support. One Memorandum of Understanding (MOU) was signed with INTRAH to develop and test community-based distribution strategies for West and Central Africa (see Togo report).

Recommendation 12: The FHA project should continue to develop outreach and community-based distribution programs, particularly in the catchment area of the selected clinics.

Finding: To better understand the needs for and constraints to providing FP/MCH and STI/AIDS services and products, the FHA project has compiled the existing information and completed secondary analyses of available data in WCA.

The POLICY Project completed secondary analyses of demographic and health survey (DHS) data from the four priority countries to furnish FHA-WCA partners with information about family planning and reproductive health demand and to help shape strategies for service delivery, training, IEC, and operations research. The *Centre d'Etudes et de Recherches sur la Population pour le Developpement* (CERPOD) in collaboration with JHU, conducted an analysis of the determinants of condom use and knowledge in sub-Saharan Africa. They also mapped 50 family health and demographic indicators using DHS data from several WCA countries. The demonstration of the disparate geographic distribution of health status will help to improve resource allocation. Finally, Tulane has completed a literature review of published and unpublished studies. This review is being compiled in a user-friendly format allowing partners to easily access region-specific information on selected family planning and reproductive health issues.

Recommendation 13: The UMT should disseminate the findings of the project's studies and analyses among all the Project partners and among other African and donor organizations in the WCA region.

Finding: *Santé de la Famille* (SANFAM) and Africare have undertaken needs assessments and planning visits in the four emphasis countries, and have established agreements with seven large companies in Côte d'Ivoire to develop family planning services in large private sector companies.

These activities were based on the successful experience in Senegal. Although commercial retail social marketing is very well developed by the project and is contributing greatly to increasing use of FP/MCH and HIV/AIDS services in priority countries, there is no evidence of an overall FHA-WCA private sector appraisal or strategy including large companies.

Recommendation 14: The UMT should define a clear strategy and establish the basic principles and objectives for extending FP promotion and services through large private companies throughout the region.

Finding: The FHA project has maintained or improved contraceptive supply at the national level, as well as at the level of the selected sites in the four emphasis countries.

This achievement has been brought about by establishing and maintaining logistic and management systems under a field support agreement with FPLM, and by REDSO's procuring contraceptives. Noteworthy are the successful efforts of the FHA project in leveraging funding for contraceptives from other donors, including UNFPA and KfW.

Finding: The FHA project initiated various innovative activities to reach special groups.

With inputs from the AIDSCAP project, the FHA project developed the *Projet de Prevention du SIDA sur les Axes Migratoires de l' Afrique de l'Ouest* (PSAMAO) as an HIV/AIDS prevention initiative implemented along international travel routes in West Africa targeting long-distance truck drivers and their aides, commercial sex workers, and seasonal migrant workers. Africare has coordinated initial IEC and social marketing activities with regional and national partners in Burkina Faso and Côte d'Ivoire. Ghana, Togo, and Benin have expressed interest in joining the PSAMAO initiative, and discussions are underway with Togo.

The FHA project is implementing the “*Entre Nous Jeunes*” program in the city of Nkongsamba, Cameroon, to increase the knowledge and awareness of family planning and STI/AIDS prevention and the use of related services and products among the youth. This program includes a research component meant to demonstrate the effectiveness of the peer education strategy in bringing about desired changes in knowledge and in safe sexual practices. In partnership with Africare and the FOCUS project, the FHA project has also developed other promising programs targeting youth in Burkina Faso and Togo.

4.2 Increased Regional Capacity for Program Development and Implementation

The second intermediate result is sought through the following related lower-level intermediate results:

- IR2.1, strengthened institutional development of selected service delivery, IEC, training, and operations research organizations;
- IR2.2, improved regional FP, MCH, and STI/AIDS materials;
- IR2.3, strengthened regional training sites for FP/MCH and STI/AIDS interventions;

- IR2.4, integrated FP/MCH and related curricula in selected institutions;
- IR2.5, strengthened national and regional training teams for FP/MCH- and STI/AIDS-related programs; and
- IR2.6, increased regional pool and use of African expertise.

Appendix F presents a list of the project's African regional and national partners.

Finding: The four CAs are partnering and working systematically to augment the capabilities of 14 regional African partners.

Per their cooperative agreement, each CA has undertaken and continued to pursue efforts to partner with and develop selected African organizations. Progress is registered in the strengthening and use of these organizations to develop and implement regional and national activities supporting results sought by the FHA project. The UMT's Annual Workplan includes this effort.

The four CAs have made partnership arrangements with regional African institutions located in Senegal, Mali, Burkina Faso, Cameroon, Côte d'Ivoire, and Togo. These partnering agreements involve measures to achieve the following:

- Strengthen partners institutionally,
- Employ partners regularly and increasingly to develop and implement activities under the project workplan, and
- Support their marketing and use by other donor organizations.

Institutional strengthening is understood to involve not only technical competencies but managerial and financial development. A systematic institutional development assessment of the partner institutions revealed a set of common weaknesses, such as the lack of strategic vision, marketing plans, and skills in grant and proposal writing. After a careful review of these results, institutional development targets for 10 regional partners were established. The number of designated regional African partners has now grown to 14 and is expected to grow by several more in the next three years.

The FHA project has been training and hiring local staff as consultants on project activities as a means of strengthening the technical capacity of regional institutions. Additional efforts to strengthen partner institutions include installing electronic communication and providing training in website development.

Trip reports of the review team visits to Togo, Côte d'Ivoire, Burkina Faso, and Cameroon include further information and observations on partnering, and collaboration with and development of specific African organizations (Appendices G and H).

Example 1 (Senegal report): "The FHA-WCA Project is achieving excellent results with the *Centre de Formation et de Recherche en Santé de la Reproduction* (CEFOREP). A well-staffed, skilled, and productive organization is growing and is capably responding to regional (and Senegalese) demands for clinical training—especially for minilaparotomy and NORPLANT—and is establishing research capabilities (e.g., postabortion care issues). CEFOREP personnel attribute their growth and sense of confidence over the past two years directly to the FHA project and JHPIEGO."

Example 2 (Côte d'Ivoire report): "*The Centre de Recherche en Communication* (CERCOM) is part of the University of Côte d'Ivoire and a regional partner of JHU/CCP for the IEC component of the FHA-WCA Project. The director and staff of CERCOM expressed intense satisfaction with their collaboration with the FHA-WCA Project and JHU/CCP, which they consider critical for their short- and long-term research and teaching development."

Example 3 (Côte d'Ivoire report): "The *Ecole Nationale Supérieure de Statistique et d'Economie Appliquée* (ENSEA) is one of the regional African partners for the operations research component of the FHA-WCA Project, and thus partnering with Tulane University. ENSEA provides training to students from about 20 francophone African countries. ENSEA has conducted two evaluation studies for the project, one for the PSAMAO project, the other for the '*SIDA dans la cité*' television series. To date, through the provision of networking and e-mail software, technical support, and training, the FHA-WCA Project has made internal e-mail and Internet connectivity available to ENSEA's faculty, staff, and students. Additional training is offered to ENSEA staff in developing and maintaining ENSEA's website, with plans for ENSEA to assist other partner institutions in developing and maintaining their own websites."

Finding: The FHA project is strengthening the organizational capacity of a large number of its national African partners, but not systematically.

In Cameroon, the review team noted an excellent partnership with African institutions, which contributes to both the in-country and regional achievements of the project. One organization that began as a country partner—the Cameroon Health Program (CHP)—is now involved as a regional African partner in developing interpersonal communication training curricula. Additionally, the project provides assistance to several university medical schools to introduce pre-service reproductive health and family planning training modules into their teaching programs.

Recommendation 15: The UMT should strengthen selected national organizations in priority countries, in addition to strengthening the regional African partners.

Finding: The FHA project capacity building efforts have so far focused on technical areas.

Although the benefits of these technical efforts are recognized, they are likely to be limited without the proper institutional environment. African partners are still not fully engaged in conceptualizing and developing the project's activities. Furthermore, it appears that some regional and national partners are not well informed about the project itself.

Recommendation 16: The UMT should continue to develop action plans with African partners that take into account the technical, strategic, managerial, and financial aspects of institution building.

Finding: The FHA project has expanded the regional pool of training resources by strengthening existing training sites and raising the level of competency among trainers.

Two FHA-WCA partner institutions, CAFS and CEFOREP, have incorporated integrated reproductive health curricula into their programs and are now able to provide technical assistance in the region for training in reproductive health. Appendix G presents a review of the results achieved through the project's partnership with CEFOREP.

In collaboration with the United Nations Population Fund's (UNFPA) Dakar-based technical support team, the FHA project successfully incorporated a 30-hour operations research module into the curriculum at Institut de Formation et de Recherche Demographiques (IFORD) and ENSEA. To date, IFORD has trained 27 students and ENSEA has trained 14 students in operations research using this module. Furthermore, the FHA project will train ENSEA and IFORD faculty in the coming year so that they depend less on technical assistance from the project.

Finding: The FHA project has produced and made available through African NGOs improved IEC regional materials on FP, MCH, and STI/AIDS.

Examples of such materials include the interpersonal communication training modules, IEC kits, and several mass-media programs referred to in various sections of this report.

Finding: The FHA project has created a database of qualified regional professionals and increased the proportion of technical assistance provided by African regional consultants.

The FHA project has purposely identified, trained, and used a large number of consultants for project activities. The *Réseau de Recherche and Santé de la Reproduction en Afrique*, Dakar,

recently produced a register of about 72 consultants with expertise in 24 specific technical areas. This register will be distributed among other potential clients. In FY1998, the UMT will organize a workshop to further build these consultants' marketing and business skills. In addition to building the expertise and confidence of the consultants, this activity facilitates the exchange of information and expertise in the region.

Finding: Only organizations collaborating with the FHA project are aware of and have access to its regional products and services, such as the African expert consultant roster, the IEC kits, and the training modules and curricula.

It would be beneficial if a wide range of national, regional, and international organizations could easily purchase products developed by the FHA project. Such broad dissemination would help institutionalize or adapt these materials and approaches, increase their use, and contribute to the sustainability of the African partner institutions.

Recommendation 17: The UMT should systematically assist its African partners in making FHA-WCA outputs widely available throughout the WCA region.

Finding: The sustainability of project efforts and results will be largely a function of the project's success in developing the capacity and networking of African institutions.

Sustainability should be seen not as financial security or endowment but as the ability of African institutions to continue functioning effectively and dynamically in the marketplace and making an impact on health. Another condition that favors sustainability and use of services will be the development of a larger effective demand for these services by individuals and families.

4.3 Efficient Use of Resources through Improved Donor Collaboration

This result is supported by the following related lower-level intermediate results:

- IR3.1, regional model developed for delivering USAID assistance in non-presence countries;
- IR3.2, strengthened technical and financial collaboration with other donor agencies; and
- IR3.3, improved regional consultation and collaboration mechanisms.

The establishment of an innovative regional assistance model successful in delivering assistance in non-presence countries is discussed in Chapter 3.

Finding: Networking is an important component of FHA-WCA's activities. Given its many partners, the FHA project has developed reliable mechanisms for communication among its partners. One mechanism has been the annual partners' meeting, which brings together all project partners for several days of intensive program planning. The project has also developed a multipronged dissemination and networking strategy that includes the FHA-WCA newsletter; an FHA-WCA Internet homepage; national, regional, and international seminars and conferences; promotion and development of regional consultants; best practices exchange visits; joint activities with African professional associations; and electronic connectivity.

Finding: The FHA-WCA's country plans do not always demonstrate that a thorough consultative process was undertaken to ensure support to national programs and priorities.

In several countries, the team received complaints from technical officers in the MOH or in donor agencies that the FHA-WCA's activities were planned and conducted without full consultation with other national partners or beneficiary organizations. In other instances, technical officers or representatives did not seem to be well acquainted with the project.

Recommendation 18: The UMT and resident advisors should more actively promote country-driven donor coordination by planning its activities with national-level partners.

Finding: Several donors are collaborating with the FHA project to develop and fund key activities at regional and country levels.

National governments, KfW, UNFPA, UNICEF, the World Health Organization (WHO), and the World Bank are the main donors that collaborate with the FHA project in various areas, including the provision of adequate contraceptive supply and distribution channels; regional conferences, such as the forum on pre-service training for reproductive health; IEC campaigns; and social marketing of condoms and ORS. By January 1998, the project had been able to leverage a total of \$3.5 million.

Recommendation 19: The FHA project should develop new strategies and increase leveraging of other donor resources.

Finding: The FHA project recently produced a valuable analysis of donor coordination in the health and population sector in WCA.

There are multilateral, bilateral, and nongovernmental organizations providing assistance to West African countries to develop and implement family planning, maternal and child health, and HIV/AIDS projects and programs. In non-presence countries, a number of donors have come

forward to take over funding of activities formerly supported by USAID. However, none of these donors has been able to provide strong technical expertise in such areas as contraceptive logistics, family planning programs, quality assurance of clinical services, operations research, social marketing, and involvement of the private sector and community-based groups.

Although the FHA project is not a donor itself, it brings together a core of technical expertise and is in a unique position to develop the tools and mechanisms to improve donor collaboration and coordination in a few key technical areas. Therefore, the donor coordination study provides useful concepts and information.

Recommendation 20: The UMT should identify the technical constraints and opportunities, and test and document strategies to improve donor coordination at the regional and country level.

5. COLLABORATION AMONG STRATEGIC PARTNERS

Good collaboration is important in all management systems; it becomes critical, however, when the number of players becomes very large, as is the case with the FHA project. For this reason, from the conception of this project, REDSO was concerned with establishing effective collaboration mechanisms among all its strategic partners. It asked the review team to examine the following collaboration systems:

- Among the four CAs,
- Between the CAs and their African partners,
- Between the CAs and USAID Field Support agencies, and
- Between the UMT and USAID/Benin.

Finding: The effective functioning of the UMT indicates good collaboration among the CAs and other strategic partners.

REDSO viewed this close collaboration among the four CAs as essential and built such collaboration into the cooperative agreements as one aspect of performance on which to base the CAs annual renewal.

Finding: The CAs have collaborated effectively with many of their 14 African regional partners.

As mentioned, the CAs are collaborating effectively with CEFORP, CERCOM, and ENSEA. However, work still needs to be done in developing collaboration with others, such as SANFAM.

Recommendation 21: The UMT should ensure that Memoranda of Understanding with the African regional partners include clearly defined roles and technical and financial responsibilities.

Finding: The CAs' collaboration with national partners is mainly a function of the country-specific activities, including service delivery efforts and social marketing.

This collaboration depends largely on the scope of country-specific efforts and the office of the resident advisor. The review team observed many examples of close and effective collaboration in several countries but concluded that the project further emphasizes the institutional development of national partner institutions to effectively contribute to the achievement of project results.

Finding: Collaboration with local NGOs in the social marketing program is excellent, although this collaboration may be based on the NGOs' dependence on PSI.

Collaboration between local NGOs and PSI presents a special case within the project. For the most part, PSI hires staff locally and registers as a local NGO to carry out the country's social marketing activities. The degree to which these local organizations can become self-sustaining, viable organizations depends on (1) the success of their social marketing programs and (2) their own fundraising capacity. Progress is registered toward achieving these two conditions.

Finding: Field support agencies significantly contribute to the project's objectives through selected collaborative activities.

REDSO/WCA has made extensive use of field support resources to complement and enhance the capacity of FHA-WCA partners in the areas of STI/HIV/AIDS, child survival, contraceptive logistics and management, youth reproductive health, and networking. About \$3.5 million per year is channeled through USAID/G/PHN for collaborative activities with the FHA project.

Examples: AIDSCAP and IMPACT strengthen the PSAMAO initiative by organizing HIV/AIDS education among key target populations (commercial sex workers, seasonal workers, and truck drivers) through peer education. FPLM provides technical assistance for contraceptive forecasting, systems evaluation, contraceptive assurance through donor collaboration, and skills transfer in procurement. BASICS builds regional capacity for ORS promotion by the commercial sector, designs and implements a child survival IEC and behavior change program, and develops networking among child survival and MCH organizations in the region.

Finding: Under the third annual workplan, the UMT is attempting to clarify the roles of and strengthen collaboration with selected field support agencies.

There are at least 10 field support agencies involved in the FHA project. As many of them have strong agendas and approaches of their own and programming that fits in more or less easily with that of the project, consensus building on collaborative activities requires coordination, time, and effort. In its current workplan, the UMT established a useful set of guidelines to avoid duplication and improve collaboration on project objectives. The UMT has designated staff to coordinate and be primary contacts for each field support agency with whom it collaborates. By the time of this review, the UMT had signed MOUs with most of the field support agencies involved in the project.

Recommendation 22: REDSO and the UMT should establish monitoring and accountability systems for field support activities, in consultation with USAID/G/PHN.

Finding: Countries with a bilateral USAID mission can benefit from the FHA project through increased access to regional know-how and from regional collaboration on specific transnational activities such as the migrant project.

Despite this positive finding, a word of caution is required since the UMT may not be able to absorb the financial and human resource implications of any significant involvement in new activities.

Recommendation 29: The FHA project should extend access to regional expertise, best practices, and collaboration on specific transnational activities to countries of the region with bilateral USAID presence.

6. PROJECT MANAGEMENT

The FHA project has an effective system to manage a far-reaching program of regional activities in many countries, including several without USAID presence, involving a large number of players, and with substantial resources. A key element in this project from its inception has been REDSO's emphasis on the formation of a UMT, jointly responsible for developing and implementing a coordinated program with consolidated management, supervision, monitoring, and reporting systems.

Finding: An effective unified management system is established, with excellent monitoring, collaboration, and support from REDSO's backstopping office and Strategic Objective team.

This finding is based on the review team's observations of the UMT's operations and procedures and on a review of the UMT's recent history. The development of a unified management system by the four CAs required some time. This process was centered around developing a common vision for project results, developing a joint workplan, relying on an integrated monitoring and evaluation plan and procedures, developing an integrated schedule for travel and planning meetings, preparing common quarterly and semiannual reports, and sharing common office facilities.

Development of the UMT is one of the specific objectives of the project as reported in the first UMT progress report dated May 1996. The third annual workplan maintains the following as revised specific objectives: To develop a partnership for technical and financial assistance for all components of the FHA-WCA project (service delivery, training, IEC, and operations research).

Finding: The UMT's organization and management capability has recently been strengthened.

The limitations of the UMT's management and organizational capability surfaced when the level of activity increased in the second year of project implementation. After JSI/R&T's cooperative agreement was renewed in June 1997, a transition plan was put into effect (July-September 1997.) This plan included the designation of JHPIEGO to be responsible for service delivery, as well as for training, and the award of a cooperative agreement to PSI for social marketing. The transition plan, put into effect and largely completed by the end of December 1997, provided the CAs, REDSO, and the UMT an opportunity to examine the limitations of the project's organization and management structure. This transition plan primarily added staff to improve the project's capabilities to develop and implement the program effectively and efficiently in the three remaining years of the project. The following steps have been taken:

- Establishment of a **Leadership Unit**, including a **full-time team leader**, a program coordinator, and an administrative assistant;

- Establishment of a **Clinical Service Delivery Unit** headed by a full-time director (a function previously held part-time by the team leader), and assisted by a full-time regional training advisor and a regional quality of service delivery advisor. Training activities for service delivery are currently handled by the clinical service director, pending review later in 1998;
- Establishment of a central **Finance and Administrative Unit** with a director, project administrator, financial analyst, office and procurement manager, and logistics and maintenance assistant. To eliminate a complex and inefficient back-billing system and to reduce the administrative burden on the team leader, the UMT operations costs are now managed by JHPIEGO through this Financial and Administrative Unit.
- Strengthening of the **Social Marketing Unit**, whose staff now includes the social marketing program director, a hormonal brand manager, a social marketing program assistant, and an accountant.
- Transfer of the responsibility for project monitoring and evaluation from the team leader to the operations research director, and creation of a new position: **regional monitoring and evaluation coordinator**.

Finding: The organization and management capabilities of the resident advisor offices in priority countries have been considerably strengthened under the transition plan.

The transition plan also addressed the difficulties experienced in priority countries during 1996 and 1997, and provided steps to strengthen the management of project activities. These steps, largely implemented by the time of the review team's country visits, were as follows:

- Augmenting staff of the resident advisor offices to include a program assistant, administrative assistant, financial assistant, and MIS coordinator;
- Establishing accounts through which to pay for country operations; and
- Amplifying the resident advisor's job description to specify responsibilities for implementation and funding.

Finding: Supervision of country office staff is adequate.

Regular meetings with resident advisors and in-country coordinating visits ensure that supervision of operations and management at the country-level offices are supervised by members of the UMT, including the newly established Financial and Administrative Unit. The third workplan specifies the duties and responsibilities of the resident advisor and his staff, thus facilitating supervision by the UMT.

Finding: Social marketing programs are based on PSI-budgeted, in-country project staff and a management structure that appear to be appropriate and operating effectively.

Based on limited observations by the review team during its brief country visits, each PSI country office has sufficient staff in administration and finance to procure needed program inputs while assuring proper accounting practices, internal controls, and implementation of the workplan.

Finding: The team's country visits indicate for the most part carefully orchestrated coordination and collaboration with host-government agencies, as well as with local nongovernmental institutions.

The establishment of country-level offices required and still requires a balance between effective planning, coordination, and management of country-level activities; strengthening of local institutions; and African ownership of programs.

Recommendation 24: The Memoranda of Understanding with ministries of health should reflect the project's intentions to work through African institutions as much as possible.

Finding: The UMT has a well-established annual programming system that provides a solid basis for planning, program execution, and performance monitoring.

Current project operations are based on a well-designed FY1998 comprehensive program of operations with milestones. The detail and quality of the workplans has steadily improved. The UMT reporting system consists of quarterly progress reports, financial reporting, and semiannual performance reports. The UMT manages the execution of the program by monitoring the implementation of activities and identifying the modifications of plans as needed. The project's performance toward intermediate results is assessed semiannually using performance indicators. This system provides project and REDSO management staff with prompt information on milestone activities to be accomplished each quarter and on problems in execution or non-performance. The quality of annual work planning for priority country activities was improved under the transition plan.

Recommendation 25: The UMT reporting system should include a more comprehensive annual report of achievements and impact that would incorporate information presently provided by the second semiannual performance report.

Finding: The UMT has not carried out multiyear planning

The first workplan for FY1996 covered the period from April through September 1996, the second workplan for FY1997 covered the period from October through September 1997, and the third in-progress workplan for FY1998 covers October through September 1998. The fourth

annual workplan is due to REDSO for review and approval by April 1998. This approach to the annual workplans seems closely related to the process of annually renewing the cooperating agreements and its performance-based character. However, an opportunity exists in April 1998 to submit the draft project workplan for the following FY1999 in a two-year planning time frame, covering FY2000. Planning would then correspond to a three-year activity planning cycle, covering the latter part of FY1998, FY1999, and FY2000. Such multiyear planning would target end-of-project results in a more comprehensive fashion, and would take into account total project resources including those obligated by REDSO annually for field support. In addition, it would foster a longer-term vision of the FHA project among its implementation partners.

Recommendation 26: REDSO and the UMT should institute multiyear planning of FHA project activities. Funding decisions can still be made annually based on performance.

Finding: Maintaining project momentum and progress toward results will require an additional project funding authorization for obligations required in the coming year and after.

Obligations for the project are made in the year preceding implementation under the approved annual workplan. Under the five-year life-of-project, final obligations will take place by September 1999. Implementation will be carried on through September 2000. Table 1 shows obligations made so far under the July 1995 \$40 million authorization for the FHA-WCA project, and those projected for the duration of the project.

Table 1

Project Obligations

Obligation Year	Cooperative Agreement (usually in September)	Field Support (including contraceptives)	Total Obligations
FY1995	13.4	0.0	13.4
FY1996	7.8	4.3	12.1
FY1997	7.5	5.6	13.1
FY1998 (in process)	10.6	4.0	14.6
FY1999 (requested)	10.0	4.0	14.0
Totals	49.3	17.9	67.2

Since the indicated total funding for the five-year period surpasses the \$40.0 million budget authorized by USAID in July 1995, REDSO requested an increase in the authorization to \$69 million (as noted in the FY1999 Results Review and Resources Request (R4) report dated March 1997).

Recommendation 27: The program and management review team was unanimous in its conclusion that given the progress achieved, USAID should stay the course and implement the FHA project over the five years as planned.

Finding: The longer-term perspective is a critical element in forward planning now.

During the Africa Bureau’s new project description’s review in June 1994, REDSO proposed that the project (former terminology) or Strategic Objective (new agency terminology) be funded in two phases over a ten-year period. The FHA project was the first phase. The rationale for this longer-term funding and a second phase is that no region of the world has a higher priority for strategic assistance in population and health than West and Central Africa; continuing USAID resources, provided effectively and efficiently, could play a critical and increasing role in the development nexus of the region. It may be too early to judge the effectiveness and merit of the project’s assistance model, but interim results in the first two years are promising.

Recommendation 28: In light of the agency’s Strategic Plan (September 1997), the Africa Bureau should plan for continued health and population assistance in the WCA region through a regional effort similar to that of the FHA project.

7. CRITICAL ISSUES

7.1 Revision of the Results Framework

With regard to revising the Results Framework, although a sound, agreed-upon, well-understood Results Framework is essential, revision may be a lengthy process, involving many higher-level managerial resources and creating unnecessary confusion and insecurity among program personnel. In addition, as appropriate as the revision of performance indicators may be, it will necessarily put in question fundamental elements built into the cooperative agreements with the strategic partners.

7.2 Restructuring of REDSO

The recent decision to discontinue REDSO as a regional office working out of Abidjan, and to continue certain functions with staff located in several missions, raised questions on how to provide appropriate backstopping for the FHA project and how to continue informed strategic planning for health and population assistance in West and Central Africa. The decisions made by the Africa Bureau were critical to ensuring continued strong project management in Abidjan, directed and supervised by the proposed Bamako-based USAID Regional Unit.

7.3 Expansion of the Actual Scope of Project

Although REDSO's Strategic Objective refers to family planning, maternal and child health, and HIV/AIDS prevention services, the FHA project focuses primarily on family planning activities. Although this focus is appropriate, the project's structure offers clear opportunities for various extensions in the technical scope of interventions such as in child survival, reproductive health, emerging infectious diseases, or even in basic health systems strengthening. Because these opportunities may turn into mandates as resources become available, the UMT should develop its model of "integrated health services," or "*paquet minimum d'activités*," to guide any expansion in the scope of services for which it seeks to increase access and services. A clear conceptual model would help to keep an appropriate program focus and would facilitate negotiation and coordination efforts with other partners (including field support agencies) and donors.

8. LESSONS LEARNED

8.1 Procurement of U.S. Cooperating Agencies

Mobilizing U.S. CAs with different functional expertise (service delivery, social marketing, training, IEC, operations research) rather than programmatic expertise (child survival, maternal and child health, family planning, HIV/AIDS prevention) appears to be a feasible and promising approach to procuring assistance in a broad-based program.

8.2 Project Management by a Consortium of Specialized Cooperating Agencies

Given the need to access various but highly specialized technical expertise usually not available in a single organization, the unified management set up used by the FHA project provides a workable mechanism that preserves the independence of the CAs, yet ensures efficient coordination of efforts toward common project objectives.

8.3 Performance-Based Cooperative Agreements

The system of performance-based annual renewal of cooperative agreements has proved a workable and effective tool to ensure performance, while maintaining flexibility and placing increased accountability on the CAs.

8.4 Continued Assistance in Non-presence Countries

The FHA project demonstrates the feasibility of using CAs as a mechanism for working in non-presence countries, provided that resources being engaged are limited, that activities are based on application of best practices, and that CAs have country offices.

8.5 Partnership with Regional African Organizations

Contractual partnering between CAs and African institutions appears to be a promising approach to increasing regional capacity for health and population program development and implementation in West and Central Africa.

8.6 Partnering as a Means to Promote the Sustainability of Results

Partnering and institutional development contribute to the sustainability of program results by increasing African organizations' capacities to market the health and population development services needed by governments, donors, or private organizations.

8.7 Partnering as a Means to Promote African Ownership of Health and Population Programs

Developing African organizations technically and managerially contributes to their empowerment to plan, design, and manage their own programs to improve access to and use of FP, MCH, and HIV/AIDS prevention services.

8.8 Donor Collaboration

Successful and well-documented programs, including social marketing, contraceptive supply and logistics management, and IEC programs such as AFRICA ALIVE, can attract and leverage additional donor assistance.

8.9 Regional Approaches to Working in a Variety of National Settings

The FHA project provides numerous examples of the added value of regional products developed and adapted for use in various countries: revised training curricula for regional institutions; regional social marketing brands (and production); regional IEC materials (video and kits); regional approaches to solving common problems in service delivery (infection control, quality of care, and contraceptive supply); and regional strategies to addressing transnational problems (cross-border movement of groups at high-risk for AIDS).

APPENDIX A

Scope of Work

1. BACKGROUND

In July 1995, USAID authorized the \$40 million five-year regional Family Health and AIDS in West and Central Africa (FHA-WCA) project, based at REDSO/WCA, Abidjan. Four (4) U.S. Agencies among twelve (12) applicants were awarded grants by September 30, 1995 to carry out the project, each managing one of the following four (4) components of the project:

Service Delivery:

- John Snow, Inc. (JSI) Research and Training, Inc., lead
- Population Services International (PSI)
- Africare
- Association For Voluntary and Safe Contraception (AVSC)

Training:

- JHPIEGO, Lead
- Africare
- Morehouse School of Medicine & Tulane University

IEC:

- John Hopkins University/Center for Communications Programs, Lead
- Academy for Educational Development (AED)
- Florida Agriculture and Mechanical University (FAMU)

Operations Research:

- Tulane University, Lead
- Morehouse School of Medicine
- John Hopkins University

1.1 Project Design and Focus

The FHA-WCA project provides health development assistance in the context of reduced USAID presence in West and Central Africa. The FHA-WCA:

- develops NGO partnerships ("franchising");
- promotes performance-based assistance; and,
- strengthens donor collaboration.

The objective is to increase accessibility to and use of quality services for family planning and other aspects of reproductive health (FP/RH), HIV/AIDS, and maternal & child health (MCH). The project focuses on issues and problems common across the region, includes some cross-

border interventions, and supports country-specific programs in non-presence countries (Togo, Cote d'Ivoire, Burkina Faso, and Cameroon) and in Benin. The project:

- capitalizes on best practices of the region;
- develops and implements strategies to improve use of best practices by public and private organizations throughout the region;
- develops institutional capacity of organizations that produce results; and
- generates economies of scale through regional interventions.

The FHA-WCA relies on the capacity and commitment of four (4) U.S. agencies' partnership to:

- develop and/or build on direct agreements with public and private institutions and organizations such as ministries of health, universities, voluntary and for-profit organizations and regional institutions in West and Central Africa; and
- develop mechanisms of operation that allow consultation and coordinated implementation of partnership programs among the four (4) partner USPVO and with other donors and local, regional and international implementing partners.

Accordingly, the project's strategic partners (grantees) manage their activities together under a Unified Management Team (UMT) and report to REDSO/WCA as a team through integrated progress and semi-annual performance reports, as well as integrated annual workplans. In consultation with REDSO/WCA, these partners also have developed complementary agreements with USAID/Global Bureau's PHN program using Field Support mechanisms.

The partnership between these REDSO grantees and selected African private and public organizations is the core of this regional initiative. An important condition for realizing the project objectives is the ability of African institutions to develop and implement family planning, maternal/child health and HIV/AIDS programs and the establishment of an expanded team of African expertise to sustain them.

The FHA-WCA is a performance-based grant mechanism developed by REDSO/WCA which requires an annual, consolidated continuation application with associated budgets from the U.S. partners. These applications are reviewed against the achievement of results agreed with the U.S. partners.

1.2 Corrective Actions to Address Performance Issues

Consistent with its performance-based approach, REDSO/WCA undertook corrective actions to address key issues related to the performance of the service delivery component of the project in May 1997. Following a careful review of JSI's responses to our concerns, REDSO/WCA decided not to renew the grant to JSI after September 30, 1997. Accordingly, REDSO/WCA terminated the JSI element and completed arrangements with the remaining partners (JHPIEGO, JHU/CCP, Tulane and PSI) and agreed to important programmatic and management changes to improve the lagging performance of the clinic-based service delivery program and overall project management.

ARTICLE I - Objectives

REDSO/WCA plans to conduct an external project review in January, 1998, the objectives of which are to provide a critical analysis of the regional program, including:

- 1- management, supervision, and collaboration systems developed by REDSO/WCA and its strategic partners with respect to the regional environment and challenges facing U.S. assistance;
- 2- comparative advantages of USAID assistance vis a vis other regional donors;
- 3- identify critical issues facing the project;
- 4- recommend optimal program focus, management, and sustainability; and
- 5- document the process and lessons learned from this regional initiative.

ARTICLE II - Scope of Work

The review team shall perform the following tasks:

- 1- review and comment on the Results Frameworks of the regional and the country-specific initiatives for pertinence to challenges facing U.S. assistance in this sector in West Africa and to exploiting comparative U.S. advantages;
- 2- review and comment on the programmatic results achieved by the strategic partners;
- 3- examine the collaboration among the strategic partners of REDSO;
- 4- examine the collaboration between the strategic partners and their African PVO and commercial sector partners;
- 5- examine the collaboration between the partners and USAID Field Support partners;
- 6- examine the collaboration between this project and USAID/Benin and USAID/Senegal;
- 7- examine the collaboration and resources leveraging activities of the strategic partners with other donors;

- 8- examine the effectiveness of the management model and supervision systems developed by the partners;
- 9- examine the effectiveness of the management model and monitoring system of the project;
- 10- discuss constraints, challenges and opportunities (if any) of the assistance model developed by REDSO/WCA;
- 11- identify critical issues (if any) that merit particular attention from REDSO and/or strategic partners;
- 12- examine the questions and various perspectives and strategic ideas regarding the sustainability of this regional initiative;
- 13- discuss the lessons learned;
- 14- based on the above analysis, make recommendations for optimal program focus, management and sustainability of this regional initiative; and,
- 15- document the process, mechanisms, achievements/failures and lessons learned of the regional model.

ARTICLE III - Background and Materials

REDSO/WCA will provide the following resources, background, and materials for the review team, prior to or immediately upon arrival on-site:

- 1- the FHA-WCA project paper including the RFA and USAID/W authorization/approval cable;
- 2- quarterly and semi-annual performance reports;
- 3- annual continuation applications and related REDSO reviews/comments;
- 4- cooperative agreements documents and amendments;
- 5- REDSO Interim Strategy;
- 6- SO#1 Interim Result framework; REDSO R4 and reviews from Washington;
- 7- Government Performance Act Audit report (Audit is currently on-going. Report should be available at the time of the review);
- 8- Nancy Harris's letter to Joyce Holfeld raising interesting questions related to the regional model (see attachment);
- 9- Other pertinent documents from REDSO and NGO partners.

ARTICLE IV - Review Team

1. The review team will include representatives from (1) USAID/Global - PHN; (2) CDIE; (3) AFRICA/SD- PHN; (4) USAID/Senegal; and (5) two independent consultants comprising of a management expert and a public health specialist who is also the team leader/facilitator. The team leader will be responsible for the final consolidated report. REDSO/WCA Operating Expenses (OE) and program funds will cover costs associated with this review.

2. Two teams will be organized. The first will visit Burkina and Cameroon and the second group (Togo/Benin, Senegal). All members of the team will spend three working days in Cote d'Ivoire before forming into teams. Members will participate in a one-day retreat to report and discuss findings and recommendations on January 29/30, 1997.
3. Prior to the field assignment, the team leader and the management expert will have the prime responsibility to meet with relevant staff of the NGO partners' headquarters. The Washington-based representatives of USAID may participate in the meetings as their time and schedules permit. Below are the list of key headquarters staff:

NGO Strategic Partners:

JSI Inc.: Nancy Harris, Cassandra Cisse, Don Lauro and Peter Wondergem;
 JHPIEGO: Bob Johnson, Amy Romig, Noel McIntosh and Anita Gosh ;
 JHU/CCP: Phyllis Piotrow and Jane Brown and other backstop staff of FHA;
 Tulane: Jane Bertrand, Lisanne Brown, Sean O'Mahony and Bill Bertrand
 PSI: Alex Brown and Jeff Barnes

Field Support Partners/Subcontractors

AFRICARE: Laura Hoemecke
 Policy Project: Nomine Jewel
 AIDSCAP: Julien Denakpo
 FPLM Project: Gary Steele
 DHS/Macro: Mohamad Ayad
 Focus Project: Eunyong Chung
 BASICS: Camille Saade and Karyn Blyth
 INTRAH: Pape Gaye (Lome Regional Office)

QUALIFICATION

Team Leader/Management Specialist:

1. Degree in BA and/or public health and/or related field;
2. Strong analytical skills
3. Extensive experience as team leader for project design review, assessment and evaluation;
4. Extensive experience in working with NGOs;
5. Solid experience in organizational development;
5. Extensive experience in Francophone/West and Central Africa.
6. Fluency in English and French
7. Excellent writing skills in English and solid experience in report packaging

Public Health Expert

1. Degree in Public Health and/or related field;

2. Strong analytical skills;
3. Extensive experience in program planning and implementation of reproductive health/HIV/AIDS/STD services and social marketing programs;
4. Solid experience in working both with public and private organizations;
5. Fluency in English and fair understanding of French.

APPENDIX B

Bibliography

FHA-WCA Project Paper, March 95.

REDSO/WCA Provisional Regional Program Strategy Paper 1995-2000, March 1995.

Cooperating Agencies Technical Proposals (JSI/RT, JHPIEGO, JHU/CCP, Tulane: July 1995; PSI: September 1997)

Cooperative agreements and amendments between REDSO/WCA and JSI/R&T, JHPIEGO, JHU/CCP, PSI, TULANE University.

FHA-WCA project's workplans for the 1st, 2nd and 3rd years, along with some comments from the Strategic Objective Team (SOT).

Quarterly progress reports submitted in FY96 and FY97:

- 1st report: October 1st, 1995 to June 30, 1996;
- 2nd report: July 1st to September 30, 1996;
- 3rd report: October 1st to December 31st, 1996;
- 4th report: January 1st to March 31st, 1997;
- 5th report: April 1st to September 30, 1997.

Semi-annual performance reports submitted in Fiscal Year (FY) 97.

- Period October 1st, 1996 - March 30, 1997;
- Period April 1st - September 30, 1997.

FHA-WCA project's Monitoring and Evaluation plan, revised August 1997.

FY1999 Results Review and Resource Request (R4) report, March 97.

Audit of REDSO/WCA's implementation of the Government Performance and Results Act in its Family and Health and AIDS -West and Central Africa project. Regional Inspector General for Audit, Dakar. Discussion draft, January 1998.

Memoranda of Understanding with Field Support agencies.

Service Delivery Component, Final Report. JSI/RT, 1997.

The analysis of donor coordination in the population/health sector in West and Central Africa. Draft. SFPS, January 1998.

SFPS Briefing Papers (47), circa January 1998.

APPENDIX C

List of Contacts

Meetings and conference calls in Washington and Baltimore (January 14-16, 1998)

Nancy Harris, Vice-President, JSI
Linda Ippolito, Senior Training and Technical Advisor, JSI
Bob Johnson, Director, JHPIEGO
Anita Gosh, Program Development Officer, JHPIEGO
Kathy Jesencky, Africa Division, Director, JHPIEGO
Amy Romig, Financial Analyst, JHPIEGO
Jane Bertrand, Chair, International Health and Development Department, Tulane SPH&TM,
Lisanne Brown, Research Assistant Professor, Tulane SPH&TM
Phyllis Piotrow, Director, JHU/CCP
Susan Krenn, Chief, Africa Division, JHU/CCP
Alex Brown, Executive Vice-President, PSI
Karen Blyth, Technical Officer, BASICS
David McGuire, Technical Officer/Commercial Sector, BASICS
Michel Pacqué, Technical Officer for West-Africa, BASICS
Noreen Jewell, The Futures Group, POLICY Project
Laura Hoemecke, Health Program Manager, Africare

Briefing meetings in Abidjan (January 19-20, 1998)

REDSO/WCA:

William Pearson, Director
Paul Tuebner, Deputy Director
John Taber, Agreement Officer
Souleymane Barry, FHA-WCA Project Manager

Unified Management Team (UMT):

Alain Damiba, Team Leader, JHPIEGO
Bob Forsythe, Senior Finance and Administration Advisor, JHPIEGO
Susi Wyss, Program Development Officer, JHPIEGO
Meba Kagoné, Director, Clinical Services and acting Training Director, JHPIEGO
Jean-Claude Crinot, Project Administrator, JHPIEGO
Claudia Vondrasek, Director, Programme, JHU/CCP
Basile Oleko Tambashe, Director, Operations Research, Tulane
Jaqueline Devine, Director, Social Marketing, PSI

Eddy Momat, Conseiller Technique, JHU/CCP
Martha Priedeman, Michigan Fellow, Tulane
Tom Scialfa, Monitoring and Evaluation Coordinator, Tulane
Moussa Abo, Hormonal Brands Manager, PSI
Natasha Sokolosky, Michigan Fellow, JHU/CCP

Burkina Faso

US Embassy
H.E Sharon Wilkinson, U.S. Ambassador
Mr. Stephen Brundage, First Counselor and DCM

Ministry of Health
Dr. Ouedraogo Boureheima, Director General
Dr. Bamouni Blaise Antoine, Director Department of Studies and Planning (DEP)
Dr. Nebie Paul Stanislas, Director, Family Health Directorate (DFS)
Mr. Ouedraogo Toussaint, Technician, DFS
Mme Sorgho Ouoba Aiguieba, Agent, Department of Preventive Medicine (DMP)
Dr. Bazie, Conseil National Pour La Lutte Contre Le Sida
Mme Augustine Zona, Midwife, Service Delivery Supervisor (SFLS Project)
Mme Habibou Ouedraogo, Midwife, Service Delivery Supervisor (SFLS Project)
Mme Gone Nougara, Midwife, Service Delivery Supervisor (SFLS Project)
Dr. Olga Sankara, Medecin - Sociologue, Service Delivery Supervisor (SFLS Project)
Dr. Ouedraogo Chieck Omar, Medecin Chef, Centre Medical Samandin (SFLS Clinic)
Dr. Oudraogo Cheick, District Medecin Chef, Centre Medical Kossodo, (SFLS Clinic)
Mme Traore Awa, Midwife, Medical Center, Kossodo District
Mme Oudda Eve Alice, Midwife, Medical Center, Kossodo District
Dr. Thieba Blandine, OB-GYN, National Hospital, Family Planning Center, RH Services
Mme Somda Cecile, Service Coordinator, National Hospital Yalgado Ouedraogo, FP Center

SFPS Office/Burkina Faso
Yousoufou Ouedraogo, Resident Advisor
Rosine Kibora, Administrative Assistant/Secretary
Justine Belem, Training Advisor
Kabora Yimian, MIS/Or Coordinator

Project Population and Lutte Contre Le SIDA (World Bank)
M. Seydou K. Kabre, Project Coordinator

UNFPA
Mme Therese Zeba, Program Officer
Mme Celestine Sawadogo, Program Assistant
PSI/Burkina Faso

M. Conombo Boukari, Manager
Mlle Toe Lea, Stagiaire
Mlle Alex Curtis, Volunteer (Vision in Action)

AFRICARE
Samdgo Nana

ABBEF
Kabare Seyidou, Acting Director
Key Staff

ABSF
Mrs Brigitte Thombiano, Representative
PROMACO (Social Marketing of Condoms)
Mr. Hamidou Salogo, IEC manager

URBLS (Union des Routiers Burkinabe de Lutte Contre Le Sida)
Mr. Paul Sawadogo, President

AFASI (Association de Femmes Africaines En Face du SIDA)
Mrs. Boyarm, Representative

Togo

US Embassy
Ms. Schoonover, Ambassador
Mr. McCulley, Terrence, DCM

Ministry of Health
Dr. Attisso, S. Kossi, Assistant Director General
Dr. Ayessou, V. Akouete, FP Technical Advisor, Family Health Division-DSF

Centre de Sante ATBEF de Lome
Ms. Alonou, Irene, Sage-femme, Chargee de Services
Ms. Amouzou, Leontine, Sage-femme, Chargee de l'IEC

Hopital de Prefecture Agou-Gare
Dr. Trom, Degboyi Emmanuel, Medecin-Chef
Ms. Knou, Veronique, Sage-femme, Chargee de Services
Ms. Kedjani, Akpe, Aide

Hopital de Kpalime
Dr. Wottor, Adjeoda, Medecin-Chirurgien

Ms. Lovi, Brassier, Sage-femme, Chargee de Services
Mr. Komedza, Epiphane, Assistant de Chirurgie

Centre de Sante de N'Digbe
Mr. Comla, Koudolo, Infirmier d'Etat
Ms. Womeko, Adzo, Aide-Accoucheuse
Ms. Yanu, Maza, Aide-Pharmacienne

SFPS Office/Togo
Dr. Sossa, Paul, Resident Advisor
Mr. Kpognon, Auguste, PSI Resident Advisor
Dr. Agbodjavou, John Brie, Regional Quality Advisor
Mr. Edah, Parfait, FPLM Advisor
Mr. Abalo, Kokou, Financial Specialist
Mr. Kodjo, Kotokou, MIS Coordinator
Ms. Ameseffe, Marie, Administrative Assistant
Ms. Odou, Rose, Bilingual Secretary
Mr. Lissa, Koffi, Driver/Expeditor

PSI-Togo
Mr. Auguste Kpognon, Representant Resident
Mr. Koassi, Kontini, Administration et Finances
Ms. Perillo, Megan, IEC (Peace Corps)

UNICEF
Dr. Latifou Salami, Adminstrateur des Projets Sante

Centre d'Etudes de la Famille Africaine (CEFA - CAFS)
Dr. Sangare, Mariam, Senior Program Officer
Mr. Mabilia, Ma-Umba, Progam Officer, IEC
Ms. Kazadi, Salwa, Program Officer, Service Delivery
Dr. Tchagafou, Moukaila, Technical Advisor, Counseling
Ms. Ayeva, Jacquie, Finances and Administration Officer
Ms. Tetekpor, Mireille, Program Associate
Ms. Ahadzi, Delali, Program Associate

INTRAH/PRIME
Ms. Perle Combarry, Regional Program Evaluation Officer
Mr. Joanny Kabore, Consultant, Community-based Distribution
Dr. Atike Stanley, Program Officer, Community-based Distribution

GTZ
Dr. Susanne Pritze, Directeur, Projet Soins de Sante Urbaine a Be (Lome)

CARE International, Togo
Mr. Jean Michel Vigreux, Director
Mr. Guillaume Aguetant, Deputy Director

ATBEF
Mr. Koudaya, Nyedzy, Directeur Executif
Ms. Sokpon, Messan, Aprovisionnement et Gestion Stocks
Mr. Afondanyi, Administration et Finances
Mr. Sipokpey, Senali, Comptabilite et Finances

Côte d'Ivoire

US Embassy
Lannon Walker, U.S. Ambassador

Ministry of Health
Dr. Darret Seheri Bernard, Conseiller du Ministre, Coordonateur du PDSSI
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Mr. Andoh, PNSR/PF

SFPS Office/Cote d'Ivoire
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PSI Office/Cote d'Ivoire
Mr. Rob Eiger

UNFPA
Dr Robert Tezzo, Technical Advisor

GTZ
Dr. Philippe Swennen, Technical Advisor

AIBEF
Mr. Pamphile Alli Kouadio, Directeur Executif
Mr. Kouame Koffi, Chef, Recherche et Evaluation /Formation
Mr. Koukou Lucien, Chef, Distribution a Base Communautaire

Abobo clinic
Nurse-midwife in charge

ENSEA

Mr. N'Guessan Koffi, Directeur
Mr. Kwaku, Information System Specialist

CERCOM
Mme Regina Traore, Directrice

Cameroon

US Embassy
Mr. Leroy Smith, Premier Secetaire, US Embassy

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Prof. Monekosso, Minister of Health
Dr. Doris Kamwa, Chief, District Health Services and Hospital, NkolIndono

SFPS Office/Cameroon
Dr. Matthew Kamwa, Country Advisor
Mr. Albert Niba, MIS Coordinator

UNFPA Representative
Mr. Francois Farah, a.i.

Centre de Recherche en Reproduction Humaine
Dr. Robert Leke, Professor

Cameroon Development Corporation
Dr. Edmund Agbor, Chief Medical Officer
Dr. Fon S.T.,

FEMEC
Mme. Jeannette Bollanga,, Project Coordinator

IRESKO
Mr. Jean-Paul Tchupo, Research Specialist
Mr. Claude Cheta, Executive Director

Cameroon Health Program, CHP
Mr. Boupda Kuate Aubin Alexis, Executive Director
Mr. Michel Ella, Program Officer

Ad Lucem
Dr Marcel Boa, Medical Director

APPENDIX E

REDSO Interim Result Framework, February 1997

Improve Access to and use of Family Planning, Maternal and Child Health and HIV/AIDS prevention services

R#1 Increased availability of and demand for FP/MCH and STI/AIDS services in target areas

IR#1 1 Improved policy environment for FP/MCH and STI/AIDS services

IR#1 2 Increased knowledge of selected FP/MCH and STI/AIDS products

IR#1 3 Increased knowledge of STD/AIDS, its transmission and prevention

IR#1 4 Integrated provision of FP/MCH and STI/AIDS services

IR#1 5 Increased quality of FP/MCH and STI/AIDS services

IR#1 6 Increased access of FP/MCH and STI/AIDS services for special groups

R#2 Increased regional capacity for program development and implementation

IR#2 1 Strengthened institutional development of selected SD, IEC, Training and OR organizations

IR#2 2 Improved regional FP MCH and STI/AIDS materials

IR#2 3 Strengthened regional training sites for FP/MCH and STI/AIDS programs

IR#2 4 Integrated FP/MCH and STI/AIDS related curricula in selected institutions

IR#2 5 Strengthened national and regional training teams for FP/MCH and STI/AIDS related program

IR#2 6 Increased regional pool and use of African expertise

R#3 Efficient use of resources through improved donor collaboration

IR#3 1 Regional model developed for delivering USAID assistance in non presence countries

IR#3 2 Strengthened technical and financial collaboration with other donor agencies

IR#3 3 Improved Regional consultation and collaboration mechanisms

Indicators related to SO

- 1 CPR increased by at least 1 percentage point in project targeted areas
- 2 Increased proportion of MRA using condoms during last sex act by at least one percentage point per year in project targeted areas
- 3 ORS utilization improved by 2.5% per year in target areas
- 4 Increased # of SM points from 1700 to 2700

Improve Access to and use of Family Planning,
Maternal and Child Health and HIV/AIDS
prevention services

R#1 Increased availability
of and demand for RH services
in target areas

R#2 Increased regional
capacity for program
development and
implementation

R#3 Efficient use of
resource through improved
donor collaboration

Key Activities

- A 1 Regional Social marketing and community based distribution of condoms, OCs and ORS
- A 2 Establish regional model clinics
- A 3 Mass media campaigns
- A 4 Facility based training interventions to promote long term and permanent FP methods
- A 5 Application of quality improvement and management tools including sharing of regional SD best practices
- A 6 Regional assessment for Integrated Management of Childhood Illness (IMCI)
- A 7 Action plans to improve case management of childhood illness
- A 8 Promote syndromic diagnosis and management of STI
- A 9 Establish regional reference center for HIV testing/counseling
- A 10 Limited Supply of contraceptives/condoms and ORS
- A 11 Limited Supply of equipment

Key activities

- A 1 Institutional assessment of selected African organizations
- A 2 Development of composite indicators for institutional development and quality of services
- A 3 Establish partnership programs/working agreements with African organizations
- A 4 Provide sub grants to African organizations
- A 5 Linking selected African org with management and audit firms
- A 6 Promote networking among African organizations
- A 7 Establish regional technical committees/working groups to review pertinent FP/MCH and STI/AIDS programs and data base
- A 8 Conduct regional DHS, situation analysis and multi site studies
- A 9 Regional workshops to review and share best practices
- A 10 Promote adoption of new relevant tools technologies and best practices by selected African partners

Key Activities

- A 1 Establish strategic partnerships with selected US organizations
- A 2 Establish routine consultation and reporting with US embassies and USAID bilateral missions
- A 3 Establish partnership programs with other donors on selected regional issues
- A 4 Develop coordination frameworks/tools with other donors
- A 5 Support multi donor funded reviews and studies
- A 6 Development of a composite indicator for donor collaboration
- A 7 Linking with USAID/W to support development and operationalization of common agendas with selected donors

2/24/97

INTERIM RESULTS FRAMEWORK

APPENDIX D

Project Time Line

June 94	Review of New Project Description by USAID/W
Oct-Nov 94	Technical analyses carried-out and completed (REDSO/WCA/HHR)
Mar 95	REDSO/WCA Provisional Regional Program Strategy Paper, 1995-2000 FHA-WCA Project authorized
May 95	Request for Applications (RFA) issued
July 95	Submission of Technical Proposals (JSI, JHPIEGO, JHU-CCP, Tulane)
Oct 95	USAID/REDSO Awards - Cooperative Agreements Executed Cooperating Agency (CA) representatives Meeting in Washington D.C.
Nov 95	First meeting of CA representatives with REDSO in Abidjan; establishment of Unified Management Team (UMT); Memorandum of Understanding signed among UMT partners
Dec 95	CA representatives join to set up project offices REDSO/UMT visits to 4 priority countries to plan for bridging activities; Shortages of and urgent need for contraceptive supply noted
Jan 96	Annual FY1996 workplan drafted and submitted to REDSO
Jan-Jun 96	Project development trips to priority countries Meetings with African partner organizations in Abidjan, March 17-20 Confirmation of African regional partners for service delivery, training, IEC and Operations Research Final version of 1st FY1996 Work Plan approved by REDSO (March) Development of collaborative agreements with Field Support agencies, including BASICS, FPLM, Population Council, AIDSCAP, and FOCUS Finalization of country plans for BF, Cameroon, Togo (March through June) UMT visit to Cotonou to discuss project activities in Benin Revision of Specific Project Objectives from 15 to 5 Audit of management, financial, and technical systems at Le Dantec (CEFOREP) Development of draft project Results Framework Preliminary planning meeting in Ouagadougou on pre-service training with 20 experts and representatives from BASICS, UNFPA/BF, WHO/BF, and WHO/AFRO RETRO-CI identified as African partner to conduct an epidemiological (AIDs spread and control) training course in 1996 Training of regional RH clinical trainers (20), in May in Abidjan In Togo, Sub-agreement signed PSI to continue condom social marketing Collection of regional IEC materials on FP, Child Survival and HIV/AIDs prevention by CERCOM Development of a regional 26 episode radio serial on family health with ATB

Work on a regional training curriculum integrating IEC, FP, STD, AIDS and Child Survival

July 96 First Progress Report (Period October 1, 1995 - June 30, 1996)
Draft 2nd FY1997 Work Plan (Oct 1, 1996- Sep 30, 1997) submitted to REDSO

Jul-Sep 96 REDSO review of 2nd Year Work Plan and draft Five Year Results Framework
Negotiations completed with 3 of the priority countries: Burkina Faso, Cameroon and Togo
First selection of project sites for improvement of clinical service delivery
Pre-service RH forum for WCA held in Burkina Faso (200 participants from 18 countries)
First IEC sub regional workshop ?Working With the Media?
Work continued on development of IEC Kits for use in clinics
Operations research workshop (researchers from 7 WCA countries - 8 research protocols on reproductive health; participation of adolescents and men in family planning)
Inventory of reproductive health research in Cameroon completed
Second draft of project Results Framework prepared

Sep 96 JSI advised of REDSO's concerns over delays in project implementation

Oct 96 Cooperative agreements renewed for Second Year
Quarterly Progress Report (July 1, 1996 - September 30, 1996)

Oct-Dec 96 2nd year project work plan, revised and re-submitted in October, approved by REDSO
Ivory Coast country plan finalized with MOH/IC and AIBEF
SANFAM worked to identify private firms for employment-based FP service delivery in Ivory Coast
CEFOREP received management and technical assistance in October to develop a strategic plan and to install a management system to market training services
CERPOD training course in operations research conducted at ISED and
ENSEA SAGO (African OB/GYN Society) conference co-sponsored (December)
CEFOREP provides training in NORPLANT/Minilap in Lome
FPLM organized a regional contraceptive supply/logistics workshop in Lome (22 participants from 7 countries)

Jan-Mar 97 Arrangements to monitor FP development (CYP) in public sector in Togo
1st Quarter FY1997 (Oct-Dec 1996) Progress Report submitted in February
PSI/Lome started social marketing of ORS in Togo
Memorandum of Understanding signed with BASICS for preparation of long term strategy for regional ORS production and distribution by social marketing; BASICS, SFPS and PSI/CI contacted Rhone-Poulenc-Rorer, largest pharmaceutical producer in Africa re production and distribution of ORS in WCA.
ORS marketing plan developed for Benin, fine tuned for BF, CI, Cameroon

10 clinics in each priority country selected for accelerated access and quality improvement initiative (carried out in Togo)

Training for over 120 service providers in FP methods and contraceptive technology in Ivory Coast

Needs assessment for materials and equipment in targeted clinics in priority countries, and initiation of \$600,000 procurement

Design and approval of study of results of Mwangaza Action's program for community based health management in BF (USAID funded)

SANFAM carried out visits to Benin and Ivory coast to asses/develop programs for FH services in private sector firms, and implemented a program in seven firms in the Ivory Coast with AIBEF

FPLM organized second FP logistics management course (Abidjan, March)

Continued planning of AIDs Prevention Migrant (PSAMAO) Project in Ivory Coast and Burkina Faso

Continued work on Radio Serial, Les Cles de la Vie, Yamba-Songa, and for broadcasting in 4 priority countries and over Africa No. 1, the francophone regional radio station

STD and AIDs messages prepared and finalized for broadcast on regional radio and five national radio stations.

Regional mass media campaign PSAMAO project to start on highway linking Ouagadougou and Abidjan

Retro-CI training course in AIDS epidemiology

Pre-testing of IEC kits for use by service providers carried out in 4 countries

Regional Social Marketing team building for Social Marketing directors from Benin, BF, CI, Cameroon and Togo

AIDSCAP conducted needs assessment in STD diagnostics and management, followed by a training course, in Ivory Coast

Apr-Jun 97 Monitoring and Evaluation Plan issued

REDSO notification to JSI of non-renewal of its cooperation agreement (May)

African Partners meeting

Regional workshop conducted with Population Council Africa OR/TA project in Dakar (June) on programmatic use of data from country situational analyses

BASICS regional IEC needs assessment completed

Seminars on Service Delivery in Ivory Coast and Togo

Country-level training of health professionals in priority countries

Regional Strategic IEC Summit organized with BASICS

First round of workshops on ACQUIS quality initiative for service delivery completed in 4 countries

Regional technical working group meeting on pre-service training

July 97 JSI Close-out

Jul-Sep 97 Regional workshop on Program Structure, Costs and Performance, comparing vertical and integrated programs organized with Evaluation project (in Abidjan; representatives from 8 Francophone and Anglophone countries)

Subcontracts signed with ECODEV, FAFASO/BF, and URBL/BA for PSAMAO migrant project

Continued preparations for 1998 demographic and health surveys with MACRO

Evaluation of Regional Course in Epidemiology organized by RETRO-CI

Assessments of research needs of ten university teaching hospitals

Continued country level training of health professionals in priority countries

Second round of workshops on ACQUIS quality initiative completed in 4 priority countries.

Two IEC training curricula suitable for region wide francophone use completed

Institutional assessment of 11 regional African partners completed

Transition Plan with new management structure for UMT and priority country offices approved by REDSO

Monitoring and Evaluation Plan revised and re-issued

PSI technical proposal submitted to REDSO (September)

Seminar on contraceptive supply and management in Lome (September)

Sep 97 Revised Third Year Work Plan issued

Oct 97 Annual cooperative agreements awarded to JHPIEGO, JHU/CCP, TULANE, PSI.

Oct-Dec 97 Semi-Annual Performance Report (April-September) submitted to REDSO

Clinical Service Delivery Unit and Central Finance and Administrative Unit of UMT staffed; Social Marketing Unit of UMT strengthened

Priority country resident advisors offices strengthened with additional staff

Country seminar on contraceptive supply management and logistics in Ouagadougou

Action plans for institutional strengthening/development of 11 SFPS African regional partners in preparation

Donor coordination study completed (issued January, 1998)

Registry of African consultants qualified in reproductive health published

Social marketing of ORS in BF and IC programmed to start in 1998

Participation to Tenth AIDs Conference held in Abidjan in December (“Wake Up Africa” song and public service announcements featuring testimonials by prominent artists, and a video clip broadcast on national and regional radio and TV”

APPENDIX F

List of African Regional and National Partners

REGIONAL AFRICAN PARTNERS

- Centre de Formation et de Recherche en Santé de la Reproduction (CEFOREP)(Dakar)
- Center for African Family Studies (CAFS)(Loom)
- Centre d'Etudes et de Recherches sur la Communication (CERCOM)(Abidjan)
- Femmes et Santé pour le Développement (FESADE)(Yaoundé)
- Atelier Théâtre Burkinabé (ATB)(Ouagadougou)
- Ecole Nationale Supérieure de Statistiques et d'Economie Appliquée (ENSEA)(Abidjan)
- Centre d'Etudes et de Recherche sur la Population pour le Développement (CERPOD)(Bamako)
- Institut de Santé et de Développement (ISED)(Dakar)
- Santé Familiale (SANFAM)(Dakar)
- Réseau Africain de Recherche en Santé de la Reproduction (RARSR)(Cotonou)
- Center for Research in Human Reproduction (CRHR)(Yaoundé)
- Cameroon Health Program (CHP)(Yaoundé)
- Institut de Recherche des Etudes du Comportement (IRESCO)(Yaoundé)
- Mwangaza (Ouagadougou)

NATIONAL PARTNERS

BURKINA FASO

- Ministry of Health
- Association Burkinabè pour le Bien Etre Familial (ABBEF)
- Association des Femmes Africaine Face au SIDA (AFAFSI)
- Union des Routiers Burkinabè en Lutte contre le SIDA (URBLS)
- Programme de Marketing Social de Condoms (PROMACO)
- Institut National de Statistique (INSD)
- Ecole Nationale de Santé Publique (ENSP)
- Unité d'Etudes et de Recherche Démographiques (UERD)
- Faculté de Médecine & Ecoles paramédicales

COTE D'IVOIRE

- Association Ivoirienne pour le Bien Etre Familial (AIBEF)
- Ministry of Health/Direction Nationale de la Santé de la Reproduction/Programme National de Lutte contre le Sida et les MST et la Tuberculose (PNLS/MST/TUB)
- ECODEV
- Corps de la Paix
- Lumière Action
- Renaissance Santé Bouaké
- Faculté de Médecine & Ecoles paramédicales

CAMEROON

- Ministry of Health
- Fondation Ad Lucem
- Fédération des Eglises et Missions Evangéliques du Cameroun (FEMEC)
- Cameroon Development Corporation (CDC)
- Programme de Marketing Social au Cameroun (PMSC)
- Cameroon National Association for Family Welfare (CAMNAFAW)
- Faculté de Médecine & Ecoles paramédicales

TOGO

- Ministry of Health
- Faculté de Médecine & Ecoles paramédicales

BENIN

- Association Béninoise pour le Marketing Social et la Communication pour la Santé (ABMSC)
- Faculté de Médecine
- Institut National Médico-Social (INMES)
- Ministry of Health/Direction de la Santé Familiale (DSF)

APPENDIX G

Review of Selected Regional Partners: CEFOREP, SANFAM, and CERPOD

(Site visit conducted and report prepared by Gary Merritt)

I. Centre de Formation et de Recherche en Sante de la Reproduction (CEFOREP) - Le Dantec, Hopital Maternite, University of Cheikh Anta Diop.

APPROACH:

Two interviews with Director, Prof. Fadel Diadhio; one with chief administrative officer, Cheikh MBangue; one each with consultants for JHPIEGO (Jean-Robert Brutus) and Tulane (Jan Danniovic); 14-17 January.

BACKGROUND:

Le Dantec/Maternite is well-known as a center of comparative excellence in the sub-region. Recent evolution of CEFORP at Le Dantec was born of the need for more freedom of action than is characteristic of the university. CEFORP for the moment remains physically located in Le Dantec and, wisely, remains closely affiliated with the teaching hospital.

FINDINGS:

SFPS is achieving excellent results with CEFORP, fully attaining expectations under Result #2, especially IR#2.1, IR#2.3, IR#2.5 and IR#2.6, and indirectly adding importantly to SFPS attainment of service delivery Result #1.

A well-staffed, skilled, and productive organization is growing and is capably responding to regional (and Senegalese) demands for clinical training--especially for mini-laparotomy and NORPLANT--and is establishing research capabilities (e.g., post-abortion care issues). International collaborative arrangements--often with written accords--have been established with six UN and bilateral agencies, eight USAID CA's, and with two agencies of the Government of Senegal.

SFPS-related training completed includes: four workshops in Cameroon (two on CCV and two on NORPLANT); two in Togo (one each CCV and NORPLANT); one in Burkina Faso (CCV); two workshops for Cote d'Ivoire (NORPLANT); and two in Senegal (NORPLANT). CEFORP's 1998 work plan includes about 12 SFPS training workshops, and seminars on the new (Indonesia) "U" technique for NORPLANT extraction. Their research agenda includes clinical studies with Population Council and Project SARA on emergency obstetric care and fertility control.

CEFOREP has virtually completed legal and regulatory requirements for establishing itself as a quasi-private entity closely affiliated with the university; all that remains is a two-year waiting period during which normal functions and competencies as a personalite juridique are demonstrated without significant problems. CEFOPREP already has begun to independently administer grants and contracts from the Government of Senegal, U.S. CAs (JHPIEGO, Tulane, and Population Council), and soon could have agreements directly with African institutions in other countries. Quality French and English language business/corporate brochures have been produced and will soon be distributed as part of promotion/marketing.

CEFOREP personnel attribute their growth and sense of confidence over the past two years directly to the SFPS. USAID/Dakar played an early role in catalyzing CEFOPREP formation and today provides some limited funding through the GOS national family planning program, but CEFOPREP people were clear that the SFPS is what has boosted their growth. They did not differentiate importantly between the quality of technical assistance before and after the changes of 1997. They valued the contributions of AVSC (earlier) and of JHPIEGO on the technical side, and of Tulane on strategy planning and administration.

CEFOREP placed special stress on the excellence of assistance they received from Barkey Diallo whose management advice and active participation with them in drawing up CEFOPREP organizational design and paperwork (even team formation) were praised as "indispensable, highest quality."

Interviews with SFPS personnel and host country officials in Burkina Faso and Togo confirm that CEFOPREP--solely through SFPS support--has made major contributions to their national programs and is highly valued in those countries. Host country interlocutors stated unequivocally that the technical skills, interpersonal qualities, and impact of the CEFOPREP trainers were unsurpassed in their experience.

Interviews in Togo and Senegal suggest that CEFOPREP's collaboration with CAFS/Lome fully met intended complementarities in training of trainers. This collaboration provides an outstanding example of unique SFPS contributions to evolution and dissemination of regional competencies in a high-technology field.

CEFOREP is concerned about the closeout of SFPS support expected in little more than two years, and wishes to use SFPS more aggressively to find support from other funding sources. SFPS efforts to leverage other donor support under accords with CEFOPREP have been effective in Burkina Faso and in Cote d'Ivoire, but not yet elsewhere.

RECOMMENDATIONS:

(1) SFPS should improve concertation of SFPS decision-making and communication with CEFOPREP, possibly with one SFPS responsible officer charged to ensure better coherence, cost savings and time-effectiveness in management and collaboration.

(2) SFPS should encourage CEFOREP to identify the TA it needs and sources for this.

(3) SFPS should highlight CEFOREP in future international symposia it organizes to further mobilize non-USAID funding support.

II. Santé Familiale (SANFAM)

APPROACH:

Two-hour interview with Alpha Dieng, Director, at his office.

BACKGROUND:

SANFAM established some years ago a fully staffed and functioning office providing family planning and other, largely non-clinical reproductive health promotion and services in large, mostly private sector enterprises in Senegal. SANFAM was established within the Government of Senegal's family planning policies and program with funding from USAID's Senegal mission bilateral program. Africare has served until 1997 as the mechanism for funding and provided a resident physician expatriate advisor. SANFAM's program makes a substantial contribution to total family planning service delivery in Senegal. Its delivery system for condoms and oral contraceptives--typically a subsidized supplement to emergency or other health services offered by large companies--fills a unique niche in the potential service delivery environment. USAID assessments have judged SANFAM to be a valued element in Senegal's family planning efforts, and comparatively cost-effective.

FINDINGS:

SFPS engaged SANFAM in the early days of the SFPS project in concert with SFPS's Cooperative Agreement with John Snow, Inc. SANFAM has welcomed the possibilities of extending their type of program to other countries in the sub-region under funding and collaboration with SFPS.

SANFAM has participated in all SFPS annual partners' coordination meetings since project inception. With SFPS initiation and funding, they have undertaken assessments and planning expeditions to Cote d'Ivoire, Cameroon, Burkina Faso, and Togo. Accords have been developed with seven enterprises in Cote d'Ivoire, and for some months are awaiting SFPS actions.

Their funding and coordination since the 1997 transition has shifted, with all private sector initiatives, to Population Services International. SANFAM's SFPS budget for 1998 recently was reduced from \$105,000 to \$55,000, much to their chagrin.

They have experienced no benefits to date of efforts to leverage other donor support in the region.

SANFAM reported that they find it often difficult to deal with SFPS due to the multiplicity of managerial units and uncertain lines of decision-making. They also reported excessive delays in reaching accords and authorization for action and funding, especially in Cote d'Ivoire and Cameroon.

III. CERPOD

APPROACH:

- CERPOD Director, Baba TRAORE;
- Chef de Division Recherche, Mouhamadou GUEYE;
- Chef de Division Operations, Fara MBODJI; and
- The Mitchell Group Coordinator, Wilbur THOMAS.
- brief session at USAID/Bamako with Karen Hawkins Reed

Key background material consulted:

- SFPS Third Year Work Plan (9/97);
- Politiques et Programmes de Population au Sahel: Bilan et Perspectives (10/97)
- Accord de cooperation CERPOD - Tulane (12/96)
- Materials for 2e Seminaire de Formation en Recherche Operationelle
- Briefing Paper: Use of GIS methodology...(no date)
- Terms of Reference: POLICY Project - CERPOD (6/97)
- SFPS strategy paper (95)
- West Africa Spatial Analysis Prototype: Development of a Geo-Referenced Regional Database (DHS/MACRO, no date)

FINDINGS:

CERPOD staff were quite knowledgeable about the origins and orientation of SFPS, values its collaboration with SFPS, and looks forward to future work together.

CERPOD provided the 1996 letter of five-year accord between Tulane and CERPOD with 8 key points, leading accent on operational research in reproductive health and exchange of information and studies; also including promotion of Tulane training and degree programs, CERPOD mentoring of Tulane PhD students, and Tulane provision of technical assistance from Tulane or from African institutions.

CERPOD receives rare mention in recent SFPS documents (e.g. 1998 Work Plan). SFPS receives rare mention in CERPOD planning documents.

There are NO written plans of action nor annual agreements on activities. CERPOD wishes there to be such agreements for normal program and budget planning purposes. This issue aside, CERPOD finds SFPS management (e.g., paperwork, visits by SFPS staff) efficient and effective.

The management assessor noted that Burkina Faso is the only CILSS country that is common to the four SFPS priority countries and that neither CERPOD nor SFPS had explored possibilities of collaborative focus in Burkina Faso in terms of common mandates. CERPOD confirmed its capability to so focalize were SFPS in Ouagadougou interested.

CERPOD, as part of CILSS', does not fit the SFPS category of an African institution needing basic management assistance for institution building (as, e.g., CEFOREP, CERCOM), or at least is in a special category in which SFPS' usual resources and approaches are least likely to bear fruit. CILSS has its own well-formed personnel and financial systems established under international accords (Club de Paris) and French administrative systems; these have been rather thoroughly reengineered over the past two years.

CERPOD presents itself as a possibly special case of African partner, perhaps somewhat futuristic in comparison with the other SFPS African partners. The underlying model with CERPOD is that of buyers and sellers trading and sharing—which, in principle, is where we wish to be, overall, in the future.

The Futures Group (TFGI) engagement with CERPOD in supporting the 1st Conference of CILSS Ministers (Burkina Faso: 10/97) stimulated fairly keen interest at CERPOD in adapting RAPID-style presentations to CILSS countries.

Training provided to date in operations research by CERPOD, Tulane, and Population Council has been noted in country visits and interviews with other African institutions to have been interesting and stimulating. No follow-up has been done with the teams who have been trained to learn what they did upon return with the problems they developed during their training.

USAID/Bamako is not yet engaged in nor especially cognizant of details of the SFPS - CERPOD collaboration but so far as they can judge are pleased with this feature of SFPS

RECOMMENDATIONS:

SFPS as a unit or as Tulane University should formalize its planning with CERPOD in annual letters indicating what work is to be done by whom, when and where, and with what budget contributions by each party; these need not be tedious documents, just a page or two. Overall work plans could be shared in planning stages so points of contact might be clarified.

SFPS might profitably pursue CERPOD's alliance with TFGI; consider ways SFPS mandates in policy and analyses could be met—perhaps first or especially in the case of Burkina Faso—by more intensive collaboration in developing a RAPID-style presentation with country-

specific features. (Note: this also is an altogether appropriate approach for two special non-presence countries that have expressed interest: Gambia and Niger).

APPENDIX H

Country Reports: Burkina Faso, Togo, Côte d'Ivoire, Cameroon, and Benin

BURKINA FASO

(January 21 -24, 1998 - Review Team Group: A. Baron, S. Duale, G. Merritt)

Summary. The Review Team visits and work in Burkina Faso consisted of meetings including representatives of institutions cooperating in the execution of the FHA/WCA project, review of briefing papers and reports on the program, and clinic site visits. The principal finding is that the SFPS program in Burkina seemed well conceived and its objectives should be largely achieved in Burkina Faso. The project is providing significant inputs to national efforts to promote family health, family planning, child survival, and prevention of HIV-AIDS. Systems of management, supervision, monitoring, and reporting are deemed adequate. The SFPS is valued by the Burkinabe with whom the team met. Main observations and recommendations are presented below.

I. Adequacy of SFPS Management, Supervision, Monitoring, and Reporting Systems

- The SFPS/Abidjan transition plan includes steps to strengthen management, supervision, monitoring, and reporting in the four country programs. In Burkina Faso, these have been introduced effectively, appear adequate for effective program implementation.
- SFPS/BK Office Organization, Staffing, and Functioning: SFPS/BF is well organized with a full complement of competent personnel (as of February 1997) and satisfactory quarters, equipment, and logistics.
- Country Plan: The FY1997 and FY1998 Country Plans for Burkina Faso amplify SFPS's overall work plan, and were judged to provide appropriate details about planned program activities.

- Memorandum of Understanding with MOH: SFPS/BF activities are covered by a Memorandum of Understanding, annually renewable. The second one, covering FY1998 was recently signed by MOH. It is judged largely appropriate for the needs of the respective agencies.
- Monitoring: SFPS/Abidjan monitoring of SFPS/BF activities includes frequent working visits by Abidjan employees and consultants of each of the four US Cooperating Agencies, and occasional visits by REDSO/WCA staff. Overall, SFPS monitoring was judged adequate across program levels.
- Reporting: The 40 clinic sites participating in the Project report service delivery performance monthly. These are provided in standardized form to SFPS/Abidjan quarterly and semi-annually. Reporting on SFPS activities in Burkina Faso was judged ample across program levels.
- Management Information System (MIS): An evidently competent MIS coordinator provides reports and briefing materials. A computerized database soon is to be installed for SFPS and MOH use. The team found no evident MIS problems and judged the system adequate. [Management information and project indicator baselines commencing, as possible, with data prior to closure of the USAID Mission in 1994 will be analytically useful]
- Financial Management: Overall financial data were not accessible at SFPS/BF aside from accounts and expenditures under JHPIEGO's cooperative agreement. The review team did not study financial records. The SFPS/BF Resident Advisor reported that finances are managed more efficiently now than before the transition plan was implemented. There now is a local bank account for funding the SFPS/Office, managed by JHPIEGO. Separate financial management arrangements have been made for each US Cooperating Agency.
- Management of the Program to Improve Service Delivery: Implementation of measures to improve sites (38) are managed jointly by the SFPS/BK Office and MOH/DSF.

- Condom Social Marketing. PSI staff attached to PROMOACO Project, which is operated as a Government Project and funded by German AID (KfW), manages implementation.
- Oral Rehydration Therapy (ORT) Social Marketing. Managed by a newly established and recently staffed PSI/BK Office. This initiative was judged promising and appropriately designed and managed.
- PSAMAO Migrant Project. The AFRICARE/BF office and SFPS/JHU, in collaboration with the PROMOACO Social Marketing Project, UERD, URBLIS, and AFASI, have coordinated implementation under a Memorandum of Understanding with the *Conseil National Pour La Lutte Contre le SIDA*.

II. Programmatic Results

A. Service Delivery (Through Clinic Based Sites)

Thirty-Eight Sites (mainly “*centres medicaux*”) are being up-graded in a joint program by SFPS/BF and MOH/DSF. District Medical Officers (of which there are 53) manage 27 of the centers. Improvements include introduction of best regional practices for improved quality of care, improved counseling clinic based IEC, use of most modern methods of contraception, integrated services. Inputs include training, establishment of improved supply systems, some equipment, regular quarterly supervision, and data collection and analysis. Ten sites are being used to demonstrate methods to mobilize community action for improved family health. The 38 sites are estimated to provide about half the clinic-based family planning services being extended in the country.

The 38 centers constitute demonstration and referral centers for the MOH, which views the SFPS project as a means of demonstrating and encouraging quality service delivery in all (896) medical facilities of the country. Implementation of this SFPS program began about April 1997 and is proceeding well. Visits to selected sites indicate local enthusiasm and local increases in contraceptive use.

Other donors, especially the UNFPA, the Netherlands, and the World Bank (with Denmark and Norway grants) are supporting MOH efforts to improve FP/MCH/RH/HIV-AIDS in its health units throughout the country. UNFPA has been providing contraceptive supplies. The MOH-World Bank Project *Population et Lutte Contre le SIDA* (PPLS, 1995-1999, \$34.5 million) is designed to expand national actions to prevent transmission of HIV, AIDS and STDs and to improve FP/MCH/HIV-AIDS services in MOH health facilities. Under the PPLS, the World Bank and MOH seek to increase contraceptive prevalence from 1.5 to 9% in rural areas, from 17 to 32% in urban area and to increase the number of FP users from 80,000 to 350,000. Effective programming and implementation of the PPLS project funding is critical to the national effort to improve national access and use of FP/MCH/HIV-AIDS services in the next

few years. The MOH/DSF is working to develop concrete plans to use PPLS funding (most of it available) to increase access to and use of FP/MCH/AIDs services.

The combined impact of these donor-funded programs, if implemented as planned, should bring about large increases in Family Planning and in MCH and AID services by year 2000.

B. Preventing HIV transmission through Social Marketing of Condoms, IEC and Targeting High Risk Groups.

Social Marketing of Condoms: PSI has continued as a consultant (since 1991) to the government to manage the PROMACO project to socially market Prudence condoms. Sales increased to 2.4 million in 1997 compared to 2.0 million in 1996, 1.3 million in 1995 and 0.3 million in 1992. This project, including supply of socially marketed condoms, is financially supported by German AID (KfW). The effort is being implemented with PSI managerial and technical assistance. Clearly, the program is having impact on protecting couples from AIDS and impeding HIV transmission.

Targeting High Risk Groups for AIDs Prevention: The STD/AIDS prevention Migrant Project (PSAMAO = *Projet de Prevention du SIDA dans les Axes Migratoire de l'Afrique de l'Ouest*) is targeting high risk groups including truck drivers and seasonal workers on the highway from Burkina Faso to Ivory Coast. Implementation in Burkina Faso is well under way. The expectation is that the PSAMAO project will next be extended to the highway between Cotonou and Lome. In addition, the SFPS program includes support of a well-designed activity to inform youth (aged 12 to 20) of the dangers of AIDS being carried out by ABBEF in three major urban areas.

Strengthening clinic-based STD and AID services, including counseling: - see above.

C. Promoting Child Survival Through Strengthening Clinic-based Services for MCH and Through Social Marketing of Oral Rehydration Salts and Promotion of Oral Rehydration Treatment

Strengthening Clinic Based MCH Services: See item above.

Social Marketing of ORS: PSI and SFPS with UNICEF collaboration has established and staffed a PSI/BK office to initiate social marketing of ORS starting in March 1998. REDSO has provided the first year's supply of ORS. SFPS/PSI has provided a budget of \$263,000 for 1998 operations. UNICEF has provided a first year grant of \$59,000 and has earmarked modest funds for a second year grant. PSI is projecting first year sales of up to two million packages of ORS. The new effort is strongly supported by the Department of Preventive Medicine.

- Social Marketing of Oral Contraceptives - SFPS/BF and the MOH/DFS are considering introduction of social marketing of oral contraceptives to be launched in 1999, using the newly established PSI/BK office.
- IEC - Efforts to induce positive behavioral changes are being pursued regularly by the MOH with its partners including SFPS/BF through use of interpersonal counseling, IEC social marketing, IEC as part of clinic based services, mass media (radio and TV), youth groups and the migrant project. There are 10 radio stations broadcasting in BF. 75% of urban and 35% of rural households have a radio. In 1997, the national radio and one private radio station broadcast the radio series Yamba-Songa from May to November. Two radio stations in Ouagadougou and Burkina Faso broadcast two sixty minute radio talk shows on family planning with four spots in French and the widely spoken local language, Moore. In 1998, the radio shows will be continued with new spots and broadcasts in French, Moore, Djoula and Peul, beginning in February for 4 months. A nationwide launch of an IEC program for Reproductive Health took place on January 24, with the President presiding.
- Institution Building - Logical targets are the Burkinabe Regional African Partner, ATB, and local NGO partners including ABBEF, ABSF, AFAFSI, CRESAR and CHNYO [Association Burkinabe Pour Le Bien-Etre Familiale, Association Burkinabe des Sage Femmes, Association des Femmes Africaines en Face du Sida, Centre de Recherche en Sante de Reproduction, and Centre Hospitalier National Yalgado Ouedraogo], Mwanga Action (a local NGO involved in community mobilization and community management of Health Care Services) and PSI/BK. SFPS should consider institution building for selected local NGOs as well as for designated African regional partners such as ATB.

III. Effectiveness of Collaboration with African PVO and Commercial Sector Partners, and Donor Collaboration and Leveraging Donor Assistance

SFPS/BF has used several practical steps being used to promote effective collaboration and good exchange of information:

- Report of activities of different projects
- Short presentations of each institution interventions in collaboration with SFPS
- Briefing Sheets
- Updates
- Quarterly meetings

- Quarterly bulletin of SFPS

IV. Issues Impinging on Programming

- Health Program Decentralization - The process of health program decentralization / deconcentration by the MOH to the District is underway. This creates a need to adapt to a changing situation for clinic-based service delivery planning and MOH funding arrangements at the regional and district level.
- Coordination and Mobilization of donor funding at the national level - A continuing issue, particular the need to mobilize funds from the PPLS project MOH service delivery improvement of family health, family planning, AIDs Prevention services.
- Installation of the national contraceptive supply logistical system (in 1998 and 1999 - based on the workshop carried out in 1997 with FPLM/SFPS assistance. This is a high priority for MOH/DSF.
- An Increase in the rate of contraceptive prevalence in accordance with fixed objectives - The SFPS objective is to increase CPR in catchment areas of priority medical centers by 5 percentage points, 1995-2000 from about 7%. The MOH national objective as reported by the PPLS project is to increase CPR from 1.5 to 9% in rural areas and 17 to 32% in urban areas by the end of the Project (1999/2000). The ABBEF goal is to increase CPR in its clientele from 9% to 15%.

V. Lessons Learned

The REDSO assistance model appears to pose no problems for effective collaboration and program implementation in Burkina Faso. There is an expectation by MOH authorities as expressed by the Director General of Health that they should be able to continue to count on a continuing degree of USAID assistance through SFPS.

The role of the Department of Family Health has been important in coordination and in implementing SFPS activities in Burkina Faso.

A small resident office is required to monitor, expedite, and coordinate program activities at the country level. Early use of a resident advisor and office appears a desirable and cost effective strategy to expedite and coordinate project activity.

The role of Africare/BF and other local NGOs has been a key factor in developing an effective SFPS program for Burkina Faso.

The availability of high quality technical assistance and advice through SFPS is a key element in enhancing the role of SFPS at the country level and in supporting development efforts in population and health.

Steps to build up local competence of participating national/local NGOs and other institutions should be considered in the SFPS program and more generally in replications of the REDSO model.

A regional program based on the REDSO model and providing high quality TA and technical information can have an important multiplier impact on the national development effort of participating countries.

The advice and assistance from the US Embassy for consultants, for the SFPS/BF office to ease the problem of clearances for imports, has been important to project implementation.

VI. Development of African Leadership and Ownership of the Program.

Donor support and activities for PHN programs in Burkina Faso is carefully monitored by the Government and increasingly appears being based on national plans reflecting African ownership of the program. NGO participation and support appears welcome. The MOH is currently working on a comprehensive RH plan.

VII. Expected Results in terms of sustainable improvement in access and use of FP/MCH/HIV-AIDS services in Burkina Faso.

The review team would expect a sustainable improvement in access and use of FP/MCH/HIV-AIDS services to be achieved in the period 1995-2000 in its project sites in BF and possibly more broadly through out the country thanks to the synergetic effect of coordinated inputs by

several donors including the SFPS project (USAID), the World Bank/Norway/Denmark PPLS Project, and programs of the Netherlands, WHO, UNICEF, and UNFPA.

A factor favoring increased sustainability of services and use will be the establishment of larger effective demand by individuals and families, which can be expected to continue into the future.

A second factor favoring sustainability of FH/RH/FP/AIDs services is institutional strengthening of MOH departments at central, regional, district, and clinic levels and strengthening of selected NGOs.

The ability of the MOH and its Health Districts, the ABBEF clinics, and the ASBF clinics to sustain quality FP/MCH/RH/HIV-AIDS services financially may be expected to be a function of cost recovery, increased private funding of FP services, increased allocations of national/district budget funds, and continued donor support.

VIII. Recommendations

SFPS should find ways to intensify local institution building for selected local NGOs as well as for designated African Regional Partners.

SFPS/BK should seek donor leveraging to extend the community mobilization effort in conjunction with medical centers in all 27 districts where SFPS supports improved service delivery.

SFPS should respond to requests from MOH for assistance in developing practical plans for extending improved service delivery more widely in other MOH health facilities and districts throughout the country, helping the MOH under its funded agreements with WB and UNFPA to realize its plans for deconcentration of MOH organization and funding.

Longitudinal analysis of service delivery and couple-years protection should include data from years prior to termination of USAID/Ouagadougou mission support in 1994 (e.g., commencing in 1991 or 1992), at least for sentinel surveillance sites or an indicative sample of clinic sites. This analysis also should include particular attention to estimating prevalence of use of

contraception by year when data are available from the next Demographic & Health Survey in 1998.

TOGO

(January 25-28, 1998 - Review Team Group: A. Baron, S. Duale, G. Merritt)

Summary. The Program and Management Review of the SFPS Project in Togo was conducted through a review of briefing papers and reports, a series of meetings with SFPS and other development partners, and a few site visits. The SFPS program in Togo combines clinic-based, community-based, mobile team, and social marketing approaches to deliver the FP/MCH/HIV-AIDS services. The 70 project sites in Togo include mainly clinics and referral hospitals that have previously been the focus of the USAID-funded SEATS project support. The SFPS project is currently providing significant inputs to national efforts to promote and to improve quality of family planning services. Systems of management, supervision, monitoring, and reporting are in place. The location of INTRAH/PRIME, CAFS, and two SFPS Regional Advisors (1 for Quality of services & one for FPLM) in Lome provided the Review Team an opportunity to look into selected SFPS regional initiatives. Main observations and recommendations are presented below.

I. Adequacy of SFPS Management, Supervision and Monitoring Systems Established

SFPS-Togo Office: The SFPS -Togo has introduced the main steps of the SFPS transition plan to strengthen management, supervision, monitoring, and reporting of country programs. SFPS/Togo is fully staffed. The SFPS Resident Advisor has been in place since mid-1996. A Regional Quality Advisor and a FPLM Advisor are also located in the SFPS Togo Office.

Country Plan: SFPS Togo has a detailed FY1998 country plan structured around the SFPS results framework and functional domains (service delivery, IEC, operation research, training, and social marketing). The FY1998 country plan includes a proposed budget for service delivery and training activities.

Memorandum of Understanding with the Government of Togo and Other Partners: Division de Sante Familiale-DSF (Family Health Division) of the Ministry of Health is the prime partner of SFPS in Togo. The first Memorandum of Understanding between DSF and SFPS has expired, but a new draft is being examined by the MOH. The legal status of the SFPS office in Togo is not clear!

Monitoring and Reporting: Monitoring of program implementation is carried out regularly. Project sites keep good records and service delivery performance is based on monthly reporting to the SFPS Office. Reporting is standardized for all the centres providing family planning services in Togo.

Supervision: Staff from the SFPS office visits the sites at least every two months. A core of supervisors, especially from MOH, will assure most of the supervision in the near future.

Management Information System: the MIS Coordinator is developing A computerized database.

Financial Management: Finances are managed more efficiently under the transition plan, with a local bank account. Funding for the SFPS office operations and training is managed by JHPIEGO. Separate financial management arrangements have been made for PSI, JHU/CCP, and Tulane. JHU/CCP has provided the SFPS-Togo Office with about \$10,000 to cover IEC activities such as radio series on family planning, TV spots for HIV prevention, and the development of selected IEC materials. PSI has at least three local bank accounts being managed by the PSI country representative.

Institution Building of Partners: SFPS/Togo is functioning as a technical support office of the DSF. SFPS-Togo has no plan for institutional capacity building of national partner institutions.

II. Programmatic Results:

A. Supporting and Improving Delivery of FP/FH/HIV-AIDS Services

There are about 450 health facilities in the six health regions of Togo. Clinic-based MCH services are being strengthened by the Ministry of Health with the help of UNICEF in the Maritime, Kara and Savane regions, by CARE International in Savane and Plateau regions, by GTZ in the Central and Lome Commune Regions, and by SFPS in the 70 clinics selected in the 6 regions. The 70 SFPS project sites include dispensaries, clinics, including the ATBEF clinic, and referral hospitals. Most of these health centers had previously been the focus of the USAID-funded SEATS project support. By sustaining and improving these centers, the SFPS project is providing significant input to national efforts to improve quality of family planning services. Service providers are motivated and dedicated to the cause of improved reproductive health.

SFPS/Togo combines clinic-based, community-based, mobile team and social marketing approaches to deliver the FP/MCH/HIV-AIDS services. Project inputs include training, equipment, contraceptives, establishment of improved supply, supervision and quality assurance systems, data collection, and analysis.

Increased contraceptive prevalence is being achieved in the 70 centers supported by SFPS, as well as in many of the other 159 centers providing FP services in the country (for example in the 76 health centers supported by CARE international). During site visits, the Review Team was impressed with the demand for long-term and permanent methods of contraception. Access to permanent methods is still limited, especially in Lome.

B. Assuring Contraceptive Supply For FP/FH/HIV-AIDS Programs

The key players in assuring essential contraceptive supplies have been USAID/SFPS and UNFPA. USAID was the main supplier until 1995. UNFPA assured clinic based service delivery requirements in 1996. USAID and UNFPA have jointly assured supplies needed in 1997 and 1998. Condom supplies required for the social marketing program have been provided by USAID/SFPS. Orals required for the social marketing program in 1998 will be requested of USAID. IPPF provides contraceptive supplies needed by ATBEF. Other donor funding for supply of condoms for the social marketing program starting in 1999 is to be sought during in 1998 (European Union, GTZ, KfW, World Bank).

A workshop on planning and managing contraceptive supplies in Togo was organized by SFPS with the DSF in September 1997. Participants included MOH/DSF, UNFPA, CARE, GTZ, and PSI/Lome. Results included: (1) coordination (2) development of a uniform approach to estimating country requirements through the preparation of Contraceptive Procurement Tables, and (3) arrangements for shipping contraceptives by the Ministry of Health to Regional Health Warehouses from Lome (by truck provided by UNFPA).

C. Social Marketing

Social Marketing of Condoms: This program underway since 1991, is strongly endorsed by the Ministry of Health's National Program for the Prevention of AIDS (PNPS). The program was re-structured the first half of 1997, with PSI/Lome replacing the role of a previous commercial partner in managing distribution and marketing. PSI intends to establish its office in Lome as a locally registered NGO during 1998 to continue the social marketing program indefinitely. Reorganization of the program was managed without serious disruption. Marketing of condoms amounted to 3.0 million sold in 1996 and 3.6 million sold in 1997. The 3.6 million condoms sold in 1997 are equivalent to 30,000 couple years of protection. Marketing includes use of volunteers and community based distribution. SFPS has arranged for INTRAH assistance to help improve impact of the CBD program, starting in March 1998. Targets for the next years are 5.1 million condoms in 1998 and 5.6 million in 1999.

Social Marketing of ORS: In Togo, diarrhea and malaria are two of the critical maladies afflicting children under five years of age. Clinic-based ORT is estimated by UNICEF/Lome to reach about 20-30% of sick children. Social marketing is expected to provide product to households to treat about 60% of children (800,000 under 5). Social Marketing of ORS began in March 1997 with distribution launched initially in the Maritime health region and extended nationally during the year. PSI, SFPS, and UNICEF support the program. UNICEF provided a grant of \$60,000 in 1997 and one of \$100,000 in 1998 (pending), and is providing the product (through WHO). To meet a shortfall in stocks early in 1998, PSI received an emergency shipment of 150,000 packets from USAID/REDSO and a loan of 200,000 packets from USAID/Benin.

PSI/Lome sold 713,744 ORS packages during 1997. With a distribution system established and marketing based of radio and TV spots, and community based IEC, PSI/Lome is planning sales of 1.5 million paquets in 1998 and 2 million in 1999. A distribution of 2 million paquets is estimated sufficient to treat 500,000 children a year or about 60% of children under five years of age. The ORASEL brand packages contains three treatments (paquets) at a time. Usually a diarrhea episode requires two paquets leaving one in reserve in the household.

Marketing of Oral Contraceptives and Injectables: Social marketing by PSI/Lome of oral contraceptives (re-supply) is planned to start in 1998. The marketing target is 65,000 cycles of Duo-Fem sold in 1998 and 90,000 cycles sold in 1998. Marketing of injectables is being studied for a launch in 1999. The supply of orals for the program in 1999 will be included in requests for USAID supply during 1998.

D. HIV/AIDS Prevention Interventions

Targeting High Risk Groups: Starting in March 1998, PSI/Lome in association with CARE International will launch the STD/AID Prevention Migrant Project in Togo (PSAMAO Project). Groups targeted will include truck drivers, prostitutes, and bar girls along the north south route from Lome to the Border Town with Burkina Faso of Sankanse. (PSI/Ouagadougou will undertake targeting the risk groups from Ouagadougou to its side of the border). A local NGO, FAMME, will work with PSI/Lome and CARE in executing the program.

Information, Education, and Communication: IEC efforts include radio spots, billboards, posters, and broadcast of the television film, AIDS in the City.

III. Togo-based Regional SFPS Partners and Initiatives

A. Centre d'Etudes de la Famille Africaine (CEFA) - The Centre for African Studies (CAFS)

CAFS is among the primary African regional partners that were originally designated at the beginning of the SFPS project to receive institutional development support and to play a major role in the implementation and continuation of project activities.

The Review Team met with Dr. Mariam Sangare, Acting Head of CAFS-Lome, and selected members of the staff to discuss the state of CAFS and SFPS collaboration. CAFS is currently going through organizational and programmatic changes, creating an opportunity to significantly develop and market its services in WCA. CAFS is an SFPS partner for reproductive health service delivery, training, and IEC. CAFS has signed a Memorandum of Understanding with JHPIEGO, as well as with JHU/CCP for IEC.

SFPS conducted an institutional development assessment of CAFS last year. SFPS has not formally presented results of the assessment to CAFS. Preliminary feedback has helped CAFS to initiate the establishment of improved management systems. The findings and recommendations of a recently completed evaluation of CAFS conducted by POPTECH at the request of REDSO/WCA are expected to guide some of the institutional development efforts of CAFS.

SFPS/Togo has made use of CAFS and CEFORP's technical support in its training efforts to improve and maintain good quality clinical

B. INTRAH/PRIME

The Review Team had an opportunity to meet with Ms. Perle Combarry, Regional Program Evaluation Officer, and two of her colleagues at the Regional Office for Francophone Africa of The Program for International Training in Health (INTRAH), to discuss INTRAH/PRIME's collaboration with SFPS.

With Field Support resources allocated by REDSO/WCA to INTRAH/PRIME to supplement the INTRAH/Chapel Hill core funds, INTRAH/Lome is collaborating with SFPS in the implementation of two-phased approach initiative on the expansion of community-based distribution and non-clinic based reproductive health services in WCA. The first phase has consisted of a literature review, consultations with program managers, researchers, and

resource persons attending a regional meeting organized by the Population Council last year in Dakar, and the development of a framework for a CBD regional initiative in WCA. INTRAH hopes to complete phase 1 with regional meeting to share findings of the literature review and to discuss and validate the framework.

In the meantime, INTRAH has submitted a request for additional FY1998 Field Support funds (about \$200,000) to pilot test its CBD framework in Togo and Burkina Faso. INTRAH proposes to test three CBD approaches in Togo. First, in collaboration with PSI and other partners such as CARE International and Peace Corps, INTRAH proposes to support improved use of village health workers for social marketing of condoms, ORS, and pills. Second, INTRAH proposes to test an outreach (CBD) program around the 10 SFPS "model" clinics. The third approach will be to apply the INTRAH CBD systemic framework in two urban areas. In Burkina Faso, INTRAH proposes to apply its CBD framework in rural areas. It is expected that the interventions (pilot) will positively influence SFPS intermediate results 1.1.

INTRAH/Lome and SFPS/Togo are waiting funding allocations negotiated between REDSO/WCA, SFPS/UMT and US-based interested parties.

IV. Lessons Learned

SFPS bridging role after USAID mission closeout: SFPS has played an important role of sustaining interest and commitment within the Ministry of Health and among health providers to reproductive health after the suspension of USAID bilateral assistance. The momentum for expanding and maintaining good quality family planning services, initiated under the SEATS project and other bilateral programs, has continued with SFPS support.

Resident Advisor and country office: The identification and placement of a Resident Advisor who knows the field and the actors played an important role in organizing and directing SFPS assistance in Togo toward the expected results of the project. SFPS/Togo office is now fully staffed. PSI has a separate fully staffed office. The two offices are playing important roles in the implementation of SFPS activities. The legal status, the long-term role, and sustainability perspectives of the two offices are not clear yet.

Coordination with other partners: SFPS, PSI/Lome, UNFPA, CARE, European Community, GTZ, KfW, UNICEF, and WHO are all working with the MOH/DSF to expand and increase access to reproductive health services in Togo. There is no functional mechanism of coordination and of exchange of information among donors supporting reproductive health

program. SFPS-Togo can play a catalytic role as a technical support office of MOH/DSF in mastering greater coordination among donors. The Workshop on planning and managing contraceptive supplies in Togo organized by SFPS with the DSF in September 1997 illustrates one of the approaches that can be used to foster coordination.

Development of African Leadership and Ownership of the Program: The SFPS project is currently providing significant inputs to national efforts to promote and to improve quality of family planning services. The focus on improved quality, self-evaluation and regular supervision is instilling a sense of ownership among health providers at the project sites. SFPS collaboration with national institutions is still informal and weak.

Expected Results in terms of sustainable improvement in access and use of FP/MCH/HIV-AIDS services: The SFPS interventions in the 70 project sites fit in nicely with the overall government approach of expanding integrated health services, especially MCH, through district health care systems. Increased contraceptive prevalence is being achieved in the 70 sites supported directly by SFPS as well as many of the other 159 centers providing FP services in the country.

VI. Recommendations:

SFPS-Togo should continue to work closely with the MOH/DSF in developing plans for extending improved service delivery widely in other health facilities throughout the country. SFPS should assist DSF to set up a computerized management system for storing and analyzing service delivery data.

SFPS should critically review the legal and managerial options that will facilitate the continuation and sustainability of SFPS approaches and impact in Togo.

SFPS-Togo should build capacity and establish a strong partnership with the Association Togolaise du Bien-Etre Familial (ATBEF) and other national institutions involved in reproductive health. SFPS can assist ATBEF to conduct a strategic planning exercise.

A number of NGOs are promoting and delivering community-based reproductive health services in Togo, SFPS-Togo should explore the possibility of building a network of those institutions as a way of promoting information exchange and quality assurance.

SFPS-Togo should consider, in collaboration with ATBEF and other interested parties, the establishment of at least one service delivery point for voluntary surgical contraception in Lome.

SFPS-Togo should set some challenging and achievable objectives in developing its annual action plan. The “one percentage point per year increase in the use of modern family planning methods among WRAs” is not challenging enough for some of the target areas.

SFPS/UMT should assist the Resident Advisor to understand how much SFPS resources, especially financial, are being used for activities in Togo. US and regional partners should identify themselves with SFPS while working in Togo.

COTE D'IVOIRE

(January 21 -24, 1998 - Review Team Group: M. Debay, H. Destler, P. Wolf)

Background: The Ivory Coast has a population of 14 million (1997), a population growth rate of 3.8%, and a total fertility rate (TFR) of approximately 6.6. Other health status indicators are suggestive of the need for efforts in HIV/AIDS/STD prevention and MCH in addition to interventions in family planning: the national HIV prevalence rate is 12%+, the infant mortality rate is 92/1000, and the maternal mortality rate is 597 per 100,000 live births. The 1994 DHS has shown that 70% of married Ivorian women want to space or limit their births, although use of modern methods of family planning is quite low (4%). One of the challenges of SPFS will be to move women along the continuum of knowledge and desire to actual use and continuation.

The US Embassy expressed strong support for REDSO's strategy in the region, for the emphasis on African partnership of the FHA-WCA project, and for the cooperative agreement and performance-based nature of the procurement.

I. Adequacy of SFPS Management, Supervision, Monitoring, and Reporting Systems Established

The Cote d'Ivoire SFPS office staff is composed of the Resident Advisor, a financial and administrative assistant, a secretary, and a driver. The Resident Advisor has the qualifications and professional experience for the position. There seems to be lack of clarity on budget figures and flow of funds.

II. Programmatic Results

SFPS in Ivory Coast provides support to 20 clinical sites (60 if the satellite clinics are included), which represents about three-quarters of all FP clinics in the country. Seven of the (main) sites are AIBEF clinics (the local IPPF affiliate) and the remaining 13 sites are Ministry sites that are managed by AIBEF. The sites were selected between September and December 1996. For a site to be selected, it had to meet the following criteria:

- Family planning services already present
- Sites among the better performing
- Support from other donors

- Geographic balance
- Institutional selection

The team visited one MOH clinic in Abobo selected by SFPS. The main support from SFPS consist in training, supervision, contraceptives supply. Three staff memeber of this clinic also participated, with staff from ten other AIBEF clinics, to the ACQUIS workshop, and developed a quality improvement project to improve waiting time in their clinic.

The total sales of condoms in Ivory Coast increased from about 50,000 in 1991 to 15,000,000 in 1997, of which about 90% was channeled through the wholesalers and retailers network managed by PSI and its partner ECODEV. These amounts represent about two condoms per year and per adult. Sales and use are lower in rural areas, among the migrant populations, and among women. KfW support. IEC materials production center.

III. Effectiveness of collaboration with African institutions and other partners

The Ecole Nationale de Statistique et d'Economie Appliquee (ENSEA) is one of the regional African partners for the OR component of the SFPS. It was created in 1961 as part of the Universite of Cote d'Ivoire, and has received long-term support from a variety of donors including the European Union and UNFPA. It provides training to students from about 20 countries in the African Region. SFPS (Tulane University) signed a three-year Memorandum of Understanding with ENSEA in January 1997, and conducted an assessment of this institution at the end of 1997. Several faculty members participated to a regional training of trainers workshop on operations research organized by CERPOD. This training, based on the Population Council manual on Operations Research in Family Planning, definitively brings new approaches to the quantitative orientation of the current ENSEA OR curriculum, introducing qualitative methods, and broader reproductive health issues. Given the limited number of faculty members at ENSEA, however, CERPOD still sends faculty to teach students according to this curriculum during annual two weeks workshops. ENSEA has conducted two evaluation studies for SFPS, one for the PSAMA project, and the other for the SIDA dans la cite television series. Tulane is also working with ENSEA to establish a very much-appreciated email and Internet capability in this institution.

The Centre de Recherche en Communication (CERCOM) is also part of the University de Cote d'Ivoire, and a regional partner for the IEC component of SFPS. The Director and staff expressed intense satisfaction with their collaboration with SFPS and JHU/CCP, which they consider critical for their short- and long-term research and teaching development.

The MOH just signed the first Memorandum of Understanding with SFPS in January 1998. The family planning program only began in Cote d'Ivoire in 1991, with the creation of the Bureau de Planning Familial in the MOH and the beginning of the USAID bilateral program. The newly appointed director and her assistant at the Direction de la Planification Familiale recognize the expertise available through SFPS, and to a certain extent the value of its program in Cote d'Ivoire (i.e. operations of seven AIBF clinics, various support activities including provision of contraceptives to about 13 MOH clinics, and invitations of MOH staff to various conferences and training events). However, they wish to be closely associated in the definition of at least the main orientation of future activities supported by SFPS.

The team also met with the Director of the National Programme on HIV/AIDS. In addition to its support to the social marketing program, SFPS has brought significant contributions to the HIV/AIDS program through the PSAMAO project, support to the CISMA conference, to training and supervision for STD in 14 MOH clinics, support for training on gender and AIDS prevention, and support to training in HIV/AIDS epidemiology at RETRO-CI for two MOH staff. Although the Director was invited and participated to the SFPS partners meeting in September 1997, he considers that the request from MOH partners should be better taken in consideration, and that the overall resources available should be increased.

The Association Ivoirienne de Bien-Etre Familial (AIBEF) has been the main USAID partner during the bilateral program from 1991 to 1994. It received technical assistance from numerous USAID CAs including JSI, Pathfinder, and Population Council, JHU/CCP. The level of activities decreased at the end of USAID support in 1994. In 1997, AIBEF received funding from the MOH to maintain its support to family planning in MOH clinics. This funding maybe renewed in the coming years but will be interrupted as soon as the MOH takes charge of the FP activities in these clinics. AIBEF also received funds from SFPS to conduct training, provide small equipment and contraceptive supply, and to support community distribution programs in three sites. At the time of this Review, no budget had been approved yet for FY1998.

UNFPA is the main other donor active in family planning activities in Cote d'Ivoire. The activities to conduct under the new 1998-2002 program are still being defined, but will provide continued support to about 30 clinics in one region already included in the previous reproductive health project. UNFPA provides one resident advisor in the Family Planning Direction of the MOH. Realizing the need for donor coordination in the area of family planning in Cote d'Ivoire, UNFPA organized a large coordination meeting in 1997 but which was not followed by any systematic collaboration process.

The Projet de Development des Services de Sante Integres (PDSSI) supported by the World Bank represents a total funding of about 53 millions in five years. This projet will support the

Minimum Package of Activities in 14 Districts, Reproductive Health (including HIV/AIDS) services in 106 MOH clinics, as well as management and information systems at the central level. This projet will also provide a large amount of international and Ivorian long- and short-term technical assistance, and the expertise at SFPS is likely to be able to meet the coming requests.

The GTZ Primary Health Care and Family Planning project provides support to 30 family planning services in the Region Ouest. GTZ also provides one technical advisor in the MOH.

Recommendation: Given the new staff at the Direction of Family Planning and the other resources available in Ivory Coast in the reproductive health area, in particular through the World Bank-sponsored PDSSI, it seems timely and appropriate to reassess the priorities for SFPS interventions in this country. The role of AIBF in this intervention should also be reassessed.

CAMEROON

(January 26 -29, 1998 - Review Team Group: M. Debay, H. Destler, P. Wolf)

I. Adequacy of SFPS Management, Supervision, Monitoring, and Reporting Systems Established

The country office in Cameroon is headed by a Resident Advisor supported by a financial specialist, a MIS program officer, and secretarial/administrative support. Both the RA and the program assistant joined the staff very recently, within the past three months. The RA has previously held senior positions in the Ministry of Health, is very knowledgeable of ongoing programs in the country. This will serve the project well as the major program functions of the RA include coordination, liaison, and planning.

The Roles and Responsibilities of the Resident Advisor (as identified in the third year workplan) call for the RA to be responsible for coordination, supervision, and management of SFPS activities. Duties go beyond supervision and monitoring of project activities. They include identification of technical assistance needs, opportunities for leveraging donor funding, coordination with other USAID activities (field support), and provision of feedback to local partners and the UMT on in-country activities. The Resident Advisor has the experience and commitment necessary to conduct these additional duties, but currently focuses on coordination and administration.

Recommendation: SFPS/A should work with the RA to clarify his role. The country program and the project could benefit if he was given more opportunities to be involved in planning and implementation, including regional activities conducted in Cameroon.

Technical support from SFPS/A and the US partners has been good, but the financial situation is inadequate. One African partner (FEMAC) reports that there have been no funds for the subproject, hence some salaries have not been paid for three months and project activities are severely threatened. Activities have been approved, but the corresponding funds have not yet been made available.

Two partners (IRESCO and CHP) are finding planning difficult. SFPS has not brought them into the planning process; i.e. they do not know what their role in the project will be in the next 4-6 months. One CHP activity has been the development of a curriculum for training service providers in IEC. CHP does not know whether they will be conducting future training sessions utilizing these materials, but they feel that they are very much capable of doing so. Part of strengthening of the African partners is improving their management and planning capability.

They must operate with more than a 4-month horizon, or be participants in the planning of future SFPS activities with the four main partners in Abidjan.

A memorandum of understanding between SFPS/C and the Ministry of Health has not yet been signed.

The team investigated the source of CYP data reported in SFPS semi-annual reports. Although all family planning clinics seem to use MOH registers to report on methods provided, using a system established around 1991 with support from SEATS, the MOH is currently unable to provide consolidated reports from project sites on a timely basis. Although data from 1997 are available at the project office, neither the Resident Advisor nor the MIS coordinator, both new at their posts, knew how data from mid-1995 to the end of FY97 reached SFPS/A. After further research, it appeared that SFPS/A sent one staff member in 1997, probably after the final selection of sites, to collect data retroactively in each clinic. This very useful initiative allowed constructing baseline data for the remaining of the project. This retroactive data collection was possible since most service providers do keep accurate registers of family planning client visits. JSI&RT's *Service Delivery Supplement to the Application for Funding Continuation of FY1998* do mention in its section on Cameroon, however, that "only 30 of the 62 SFPS target sites had sufficiently complete data to be included in this exercise to assess and project SFPS progress." At the time of this Review, the staff from the SFPS country office still go to each clinic to collect service statistics reports.

II. Programmatic Results

The team visited a very interesting employer-based program, of which three SFPS clinical sites are a part. The Cameroon Development Corporation (CDC) is comprised of several plantations including bananas, tea, palm, rubber, and pepper with locations in four provinces within Cameroon. There are about 52 health posts/clinics, which provide services for a nominal fee (300CFA). The number of clients these clinics serve is approximately 50,000, which includes employees, their dependents, and additional individuals in the community (who are required to pay for the services they receive). In addition to meeting with the Chief Medical Officer, we met with the family planning nurse, the director of laboratory services, and the director of the pharmacy. All these staff were top notch and capable of identifying emerging problems (e.g. the high rate of STDs and the number of these infections which are recurrent). Such an arrangement with employer-based services could serve as a model for other programs. Partnering with organizations outside the public sector is an important feature of the SFPS project and reduces the burden on the already stretched Ministry of Health.

SFPS has supported the training of CDC clinic staff in infection prevention, supervision, MIS, supply of contraceptives, etc. When these individuals return to the clinic, there is not the financial or managerial support for in-service training.

Recommendation: SFPS/C should work with CDC management to gain the support for in-service training in order to capitalize on and multiply the effects of SFPS investments in training.

IEC materials in French have been developed and provided to these sites. Because Cameroon has a distinct English-speaking area, materials should be provided in English as well.

In the CDC clinic, it was clear that there is an enormous problem with STD infection (estimated to be 45% for syphilis). Because services are provided free, or at a nominal fee, clients do not finish the treatment course and do not take necessary protective measures resulting in a very high rate of recurrent infections.

Recommendation: Prevention, diagnosis, and treatment services, especially education efforts should be offered at these sites through channels additional to the family planning services.

The team also visited the family planning unit of the FEMEC-run EPC Hospital of Djoungolo in Yaounde. This unit is run by three paramedical staff and supervised by the resident OBGYN. It receives an average of 20 clients per day. All staff involved in this FP unit participated in one or several SFPS-sponsored training events, in infection prevention, permanent methods counseling and minilaparotomy, or family planning updates. Some of the staff of this unit also participated in the ACQUIS quality assurance program and started working on the issue of low frequentation that they identified as a problem. The unit orders and receives its contraceptives from SFPS. The staff reported a stock-out of spermicides for more than a year. This unit also remained without IUDs for about three months because of a labeling problem which remained unsolved during that period. The SFPS project provided basic operating room equipment and minilap, IUD, and NORPLANT kits.

The team visited one family planning clinic managed by Ad Lucem Foundation in EfoK District. Part of the LPA Hospital, this clinic is a NORPLANT and minilap training site. Four paramedical staff works in the family planning unit. NORPLANT and minilap methods were introduced in 1997, and are offered on a regular basis by the clinic staff. In addition, several other sites register candidates for minilap or NORPLANT methods and send them to EfoK when a training session is organized, usually when about 40 clients are identified. Training sessions usually include four teams of three providers from the same clinic. These training

events are quite popular because the NORPLANT insertions or minilaps are provided free of charge during these training events. The SFPS project provided basic equipment for the outpatient family planning unit. Ad Lucem received a series of new IEC kits for its family planning units but still waits for SFPS/A to organize the announced training before distributing them in the clinics. The EfoK outpatient currently has one FP flipchart and one poster with methods, and the staff has samples of each method ready for presentation to clients. Ad Lucem Medical Director recently participated in the supervision-training workshop organized by SFPS/A to launch the country supervision team. He already supervised two clinics outside his organization, and other members of the country team came to supervise some of the clinics he is in charge of. This new supervision system seems to be highly appreciated.

The team visited the MOH family planning unit in the District Hospital in Nkolndongo. This unit is considered as one of the best in the country, and appeared likely to be so to the team. In addition to useful discussions about service statistics, the team had the opportunity to discover how in a well-run clinic the sale of contraceptives at a nominal fee can generate funds to help cover small maintenance costs. Also, the law in Cameroon that forbids service providers to hand over any drugs free of charge may induce a reluctance from clinic managers to give contraceptives to health worker unable to manage funds.

III. Effectiveness and Collaboration with African Partners and other donors

The team observed that there has been an excellent partnership built with the African institutions and that they contribute both to in-country achievements as well as to the regional vision of SFPS. Issues related to strategic planning and financing have been mentioned in section. The African institutions have received technical assistance and training from SFPS partner organizations and as a consequence feel that they have been strengthened substantially. One organization began as a country partner (CHP) and they are now involved in regional efforts.

UNFPA just conducted its 1998-2002 Program Review and Strategy Development and is now defining activities to conduct during that period. Reproductive health will represent two third of this USD 12 millions programs. Service delivery support will remain focussed in the same five regions of the country as during the previous program. The new program will give more emphasis on other aspects of reproductive health than family planning, and will specifically address the needs of the adolescent population. Beside potential donor meetings, there are no well-established coordination mechanisms yet. The coming SFPS-sponsored workshop on contraceptive supply might be an opportunity to set common needs assesment system.

The World Bank only launched a sectoral program in Cameroon last year. The potential links with SFPS have not yet been explored.

IV. Other Issues/Recommendations

The staff at the SFPS country office is new (2-3 months). Their ability to effectively coordinate, manage, and provide technical input remains to be seen and will have to be monitored.

The team found appropriate the following activities that the Resident Advisor will propose at the next Partner Meeting in Abidjan: (1) revising of the "Politiques et Standards", and the "Protocoles de services"; (2) improving the current project MIS with closer integration into the MOH system; (3) improving the contraceptive logistics at the national level; and (4) strengthening the new national supervision and training teams.

There are good partnership models and replication of these models should be considered. If funds permit, there are some good opportunities for expansion of services (e.g. CDC).

The US Embassy has been supportive of the project and has provided some administrative guidance to SFPS staff. They should be engaged at times in SFPS activities to represent the US government; this should be done modestly so as not to create an excessive burden on the US Embassy in the absence of a USAID mission.

V. African Leadership and Ownership

Although the Memorandum of Understanding with Ministry of Health has not yet been signed, the relationship is good. The Ministry, including the Minister, fully supports the program. SFPS supported activities are in conformance with the national plan of Cameroon.

BENIN

(January 28-29, 1998 - Review Team Group 2: A. Baron, S. Duale, G. Merrit)

APPROACH/CONTEXT: This country report is abbreviated as there is not much of SFPS (or other USAID family planning and HIV control) to assess in Benin. Contacts consisted of a meeting with the mission's technical advisor, Susan Woolf, and working lunch with the PSI resident representative, Steven Lutterbeck; an ad hoc encounter was devised with The Futures Group representative, Timothée Gandaho, and an extended chance encounter occurred with one of the original REDSO SFPS project paper writers, Rodolphe Ellert-Beck. Finally, a chance encounter by the team with the World Bank representative, Michael Azefor, provided useful insights. The USAID Representative, Thomas Parks, was unavailable.

BACKGROUND: Benin is unlike other SFPS countries in that USAID activities in the population and health domain have begun almost exclusively during the past two and one-half years; there is no long record of investments nor prior presence of any of the SFPS U.S. or African partners. In the other four countries, USAID had been making substantial, leading contributions to family planning and HIV/AIDS control for years prior to mission closings. Benin also differs in having a small USAID mission, established recently (in 1994) with a strategy only authorizing a bilateral program in education.

When USAID/W offered to provide start-up funding for PHN, in the absence of a mission authorizing mechanism, SFPS was engaged firstly as a "pass through" mechanism serving to permit enlargement of PSI's pre-existing (non-USAID-funded) social marketing and, secondly, as a means of undertaking extensive analytical work to lay foundations for a future mission strategy.

USAID/Benin received about \$2.1 million of FY1996 and 1997 funds (\$1.7 million for population/family planning; \$0.17m for child survival, and \$.55m for HIV/AIDS control). Most of the population funds and all of the HIV/AIDS funds went through SFPS as a buy-in to PSI for condom social marketing; the last \$275,000 of population funds are now being transferred to PSI under a new USAID/Benin grant.

During late 1996 and early 1997, each of the other three SFPS CAs had several visits to Benin to explore new program development. The only good fit found was with the JHPIEGO training component (pre-service medical curriculum), to which USAID now is to provide the remaining \$404,000 of the original funds allocation for activities that may be of several years duration.

REDSO also decided in 1997 that use of the SFPS simply as a funding "pass-thru" for Benin activities was not in the "true spirit of the regional program", which does seem consistent with SFPS's original authorization.

Despite normal "turf contests" whenever regional programs come into jurisdictional contact with mission country program authority and personnel, relationships between SFPS and USAID/Benin now seem in a respectful equilibrium, albeit one based on little evident mutual planning or program expectations.

The mission's new strategy plan draft includes an objective in population and health but no mention of SFPS in the background nor prospectus, though it is understood that Beninois may participate in SFPS regional seminars and symposia.

Gondaho made enthusiastic mention of the importance in his mind of SFPS's cross-border migrant and transport work in HIV control, the potential relevance of SANFAM's private enterprise initiatives, the appeal of some of SFPS's IEC work, the importance of collaboration in regional demographic and epidemiological analyses, and the practical utility of the regional, African consultants database. He was an eloquent advocate for close collaboration with SFPS.

It turns out that Benin's social marketing program may already have benefited considerably from SFPS. The PSI representative could not be sure since he has been in Benin only since late 1996 but believes it fully possible that PSI's corporate approach may have changed, favoring more cross-country exchanges between PSI staff at all levels. With probing, he listed many visits over recent months between Benin and all neighboring PSI countries and at all operational levels (e.g., warehousing, logistics, finance, marketing, and sales). Recent visits from Cameroon greatly sobered and helped prepare PSI/Benin staff for the serious challenges presented by introduction of oral contraceptives in coming months. The Best Practices in Social Marketing workshop in Abidjan last year was cited several times as useful (same remark in other SFPS countries) though the Rep had not been able to attend. Some, many, perhaps most of this high level of sub-regional interchange within PSI may well have occurred without SFPS; we can not be sure from this perspective. We believe, however, that SFPS has made a discernable, positive contribution to this feature of PSI's "corporate culture" in subsidizing the costs of and encouraging intensive cross-national exchanges.

Superficial evidence suggests that Benin's program is at an earlier stage of development in comparison to its neighbors. It also has comparatively more donor investment. Possibly predatory statist influences directed toward the Bamako Initiative, local health committees, is worrisome and does not bode well for the viability of a bilateral program oriented towards

community level delivery systems. At the same time, from our discussions and reading, service delivery seems to be the highest priority

Recommendation: Respecting protocol and programmatic authorities, and insofar as feasible managerially, SFPS should renew its contacts with USAID/Benin to identify those elements of its program that should be noted in SFPS planning and accountancy documents, and so that USAID/Benin may determine what elements, if any, of the SFPS should be included in its Results monitoring plan.