



Addressing the Reproductive Health Needs  
and Rights of Young People since ICPD -  
**The Contribution of UNFPA and IPPF**



# Burkina Faso

Country Evaluation Report

# **Addressing the Reproductive Health Needs and Rights of Young People since ICPD: The contribution of UNFPA and IPPF**

## **Burkina Faso Country Evaluation Report**

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**Written by:**  
Olivier Weil  
Monique Munz  
Lydia Tapsoba

For:

**Options**



**EURO HEALTH GROUP**



**UNIVERSITY OF HEIDELBERG**

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## ACRONYMS

ABBEF	Association Burkinabè pour le Bien Etre Familial
AIDS	Auto Immune Deficiency Syndrome
ALAVI	Association Laafi la Vim
AMMIE	Appui Moral, Materiel et intellectuel à l'Enfant
APJ	Association pour la Promotion des Jeunes
AFAFSI	Association des Femmes Africaines de Lutte contre le SIDA
AfrDB	African Development Bank
APJAD	Association pour la Promotion de la Jeunesse Africaine et le Développement
ASED	Association pour le Secours des Enfants en Difficulté
BCC	Behaviour Change Communication
BMZ	Ministry of Economic Cooperation and Development of Germany
CAMEG	Central d'Achat des Médicaments Essentiels Génériques
CCC/SS/SRAJ	Communication pour le Changement de Comportement en Matière de Santé Sexuelle et Reproductive des Adolescents et des Jeunes
CEJ	Centre d'Ecoute pour Jeunes
CIC/DOC	Centre d'Information, de Conseil et de Documentation sur le SIDA et la Tuberculose
CIJEF	Centre d'Information des Jeunes sur l'Emploi et la Formation
CMLS	Comité Ministeriel de Lutte contre les IST et le SIDA
CNLPE	Comité National de Lutte contre la Pratique de l'Excision
CNLS	Conseil National de lutte Contre les IST et le SIDA
CO	Country Office
CONAPO	Comité National de la Population
CRSN	Centre de Recherche de la Santé a Nouna
CSPS	Centre de Santé et de Protection Sociale
CST	Country Support Team
DEmP	Direction de l'Education en Matière de Population
DFID	UK Department for International Development
DHS	Demographic Health Survey
DREP	Direction Régionale des Etudes et de la Planification
DRS	Direction Régionale de la Santé
DSF	Direction de la Santé de la Famille
EDS	Enquête Démographique et de Santé
EPJ	Ecole pour les jeunes
EU	European Union
FP	Family Planning
FPA	Family Planning Association
GDP	Gross Domestic Product
GNP	Gross National Product
GTZ	Gessel
HIPC	Highly Indebted Poor Countries
HIV	Human Immuno-deficiency Virus
ICPD	International Conference on Population and Development
IEC	Information, Education, Communication
INGO	International Non-Governmental Organisations
INSD	Institut National de la Statistique et de la Démographie
IUD	IntraUtrine Device
IPPF	International Planned Parenthood Federation
IsDB	Islamic Development Bank
JSI	John Snow Inc.
MCD	Medecin Chef de District
MoEF	Ministry of Economy and Finance

MoLEY	Ministry of Employment, Labour and Youth
MoH	Ministry of Health
MoSA	Ministry of Social Action
MPA	Minimum Package of Activities
NSPH	National School of Public Health
NGO	Non-governmental Organisation
NPP	National Population Policy
OMC	Organisation Moderne Communautaire
ONG	Organisation Non Gouvernementale
OMS	Organisation Mondiale de la Santé
ONU SIDA	Organisation des Nations Unis de SIDA
PAP	Populatoin Action Plan
PE	Peer Educator
PLWHA	People Living with HIV/AIDS
PNC	Pre Natal Care
PNDS	Plan National de Développement Sanitaire
PNP	Politique National de la Population
PO	Programme Officer
POA	Programme of Action
PPLS	Projet Population et Lutte contre le SIDA
PPTTE	Pays Pauvre Très endetté (Highly Indebted Poor Countries)
PROMACO	Projet de Marketing Social des Condoms
PSI	Population Services International
RAJS	Réseau Africain des Jeunes de Lutte contre le SIDA
RECIF-ONG	Réseau de Communication, d'Information et de Formation des Femmes dans les ONG
RH	Reproductive Health
SR	Santé de la Reproduction
SRH	Sexual Reproductive Health
SFPS	Santé Familiale Prévention du SIDA
STI	Sexually Transmitted Infection
SWAp	Sector Wide Approach
TYP	Three-Year Plan
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Programme
UERD	Unité d'Enseignement et de Recherche en Démographie
UNF	United Nations Fund
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
UNTG	United Nations Theme Group (on HIV/AIDS)
USAID	United States Agency for International Development
VHW	Village Health Worker
WB	World Bank
WHO	World Health Organisation

1 Euro = 655.57 Francs CFA

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We wish to emphasise that the views expressed herein are those of the authors alone, and not those of the evaluation sponsors.

## ANALYTICAL SUMMARY

### Introduction

The German Ministry for Economic Cooperation and Development (BMZ), the Danish Ministry of Foreign Affairs, the UK Department for International Development (DFID), the Netherlands Ministry of Foreign Affairs, and the Norwegian Ministry of Foreign Affairs have sponsored an evaluation of the contribution of the United Nations Population Fund (UNFPA) and the International Planned Parenthood Federation (IPPF) to addressing the reproductive rights and health needs of young people in the period since the finalisation of the Programme of Action (POA) developed at the International Conference on Population and Development (ICPD) in 1994. The goal of the evaluation is to contribute to a better understanding of the conditions necessary for achieving best practice, and to draw strategic lessons for the future; the purpose is to assess the performance of UNFPA country offices and FPAs in six selected countries in promoting the reproductive rights and health of adolescents and youth.

This analytical summary presents the main conclusions and lessons from the evaluation of the UNFPA Burkina Faso (BF) Country Office and ABBEF (the Burkina IPPF affiliate) against the five evaluation themes of strategic focus, institutional arrangements, policy and advocacy, service strengthening, and information and education. The summary highlights key findings against 10 key questions<sup>1</sup> set out in the original TORs for the evaluation under the following headings:

#### *Strategic Focus:*

The extent to which UNFPA and ABBEF:

- recognise and articulate the country-specific socio-cultural factors that impact on the reproductive rights and health of young people;
- recognise and articulate the diversity of needs of young people;
- promote the concept and practice of reproductive rights; and
- are gender-sensitive in addressing RH needs and rights of young people.

#### *Institutional Arrangements:*

The extent to which UNFPA and ABBEF:

- contribute to the response of government and civil society to the reproductive rights and health needs of young people;
- provide quality technical support and promote lesson learning and best practice in young people's reproductive rights and health;
- promote the participation and empowerment of young people;
- demonstrate complementarity, coherence and cooperation with each other; and
- demonstrate relevance, scope and effectiveness in coordination arrangements and partnerships with other actors in the field of reproductive rights and health.

#### *Policy and Advocacy:*

The extent to which UNFPA and ABBEF are:

- Stimulating enabling environments for policy development in relation to young people's reproductive health and rights.

A summary of the above issues is presented below followed by a set of key findings and recommendations, which are addressed to UNFPA and ABBEF.

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<sup>1</sup> See section 2.2 of Addressing Reproductive Rights and Health Needs of Young People After ICPD: The Contribution of UNFPA and IPPF. Description of the Evaluation/Substantive Requirements of the Bid/Description of Measures (issued by BMZ 2002). Of the eleven key questions one has not been addressed (with agreement of the Steering Group): "The extent to which both organisations are effective in promoting behavioural change... in particular safe and healthy sexual behaviour".

## Strategic Focus

UNFPA is a funding and technical partner of the Government of Burkina Faso, implementing activities through national institutions, while ABBEF is an implementing agency. Young people's RH needs were evident within both UNFPA and ABBEF programs well before ICPD, but the strategic attention to young people's sexual and reproductive health (SRH) has appreciably evolved in both organisations since 1994 through: (i) adapting to specific contexts and the changing needs of this target population; and (ii) drawing on lessons learned during the implementation of RH programmes in Burkina Faso (BF). Significant contributions have been made to the capacity of government and NGOs to target, and begin to meet, young peoples reproductive health needs; these successes reflect the ongoing work carried out by both UNFPA and ABBEF. Through studies and the implementation of projects, each of the two agencies have strengthened understanding of the determinants of young people's RH in BF, as well as ways to improve it.

### UNFPA

UNFPA's strategy in population and development and reproductive health, is comprised of the following activities: (i) institutional support and assistance in developing policies; (ii) strengthening RH services; and (iii) IEC/BCC. SRH and rights of young people have been a central focus for at least the last three programme cycles (1992-1996, 1997-2000 and 2001-2005). Particular attention has been accorded to young people (10–24 years old), during the period under evaluation and within the current programme cycle. Since 1999, projects have been designed and developed explicitly, and exclusively oriented to youth and adolescents. During this period, UNFPA's strategic focus has evolved as follows:

- (i) The programming process has shifted from a project-based approach to a results based programme approach, using a logical framework. This has ensured that projects are developed within the context of the overall programme, thereby ensuring more cohesion and synergy between projects and desired outcomes.
- (ii) The current programme cycle was developed in the context of the UN Development Assistance Framework (UNDAF), and was adapted to better complement interventions of other UN partners, and to coincide with the government's decentralisation process. As a result, projects are now concentrated in zones considered to be the poorest in Burkina Faso (regions of Fada, Tenkodogo and Dori). By respecting these geographic priorities, UNFPA has limited its direct support for services, for example, to a relatively restricted number of health centres. Although this lower profile has tended to reduce the visibility of UNFPA's actions in the eyes of the Burkinabé health authorities, the recent joint WHO/UNICEF/UNFPA monitoring visit (June 2003) revealed that the current strategy of more concentrated actions is making a measurable impact in the programme zones.
- (iii) The current strategy also emphasises a multi-sectoral approach. In addition to long-term cooperation with the Ministries of Primary and Secondary Education, work has expanded with Ministries of Higher Education and Research, Ministry of Labour, Employment and Youth (MoLEY), the Ministry of Social Action (MoSA) and the Ministry of Arts and Culture (MoAC). UNFPA has regularly participated in discussions and coordinated with governmental partners in the areas of Population and Development, RH and health in general. Nevertheless, UNFPA's actions in BF on the whole remain vertically structured and despite representation at committee level do not appear to be taking into account current moves made by other major donors towards a sectoral approach.



- (iv) UNFPA has also made a significant investment in building national capacity, institutionally strengthening several NGOs and improving knowledge and awareness within these institutions of issues such as gender and the use of a rights-based approach. In addition, findings from research supported by UNFPA are regularly shared with government partners and NGOs.

Despite the success of individual projects and the evolution in project planning approach, the principle weakness of UNFPA interventions during the last 3 cycles examined remains the lack of sustainable results. While this is a reflection of the difficulties associated with delivering population and RH programmes in a developing country with limited human and financial resources and with several institutional weaknesses, sustainability is a real concern for UNFPA and it will need to be addressed in the short-term to ensure the ongoing effectiveness and economic efficiency of UNFPA funded activities.

### ABBEF

Since its creation in 1979, ABBEF has played a pioneering role in improving the status and SRH of young people in BF. The association's activities target young people without distinction to ethnic group, or socio-economic status, and include marginalised young people. ABBEF's strategic focus on young people preceded, and often facilitated, the advancement of RH programming for young people by Government and other agencies. For example:

- (i) In the 1980's, ABBEF concentrated its efforts on sensitising stakeholders about the RH situation of young people and the importance of birth spacing, creating a favourable environment for evolving legal changes and practice. From 1986, when contraceptive use was legalised, ABBEF expanded its sensitisation activities to include family planning for young people.
- (ii) Preceding ICPD (i.e 1992), ABBEF opened two youth friendly centres, offering advice and care to young people in Ouagadougou and Bobo-Dioulasso. Centres based on the same principles were subsequently opened in Koudougou (1996) and Koupéla (1997). These first of their kind structures in Burkina Faso opened the door for other players (government, NGOs, etc) to create other structures targeting young people, and the ABBEF centres have served as a training ground for professionals to learn more about SRH approaches for young people.
- (iii) Since 2002 ABBEF has created an action-based research project in the northern region of Ouahigouya to elaborate and test new approaches to offering RH services in health care facilities, in which services are adapted to the specific needs of young people in rural areas.

In an effort to strengthen the long term sustainability of its actions, ABBEF has undertaken the following key strategies: (i) involving the community and mobilising young people from the outset of the conception phase of a project (these young people often become Peer Educators); (ii) widening membership to the association; (iii) establishing a cost recovery system (fees for clinical services and leisure activities); (iv) integrating services into government structures or that of the commune (land, buildings, equipment); (v) negotiating with government to have personnel seconded to the organisation; and (vi) securing government contracts (the government already grants about 1 million CFA per year to ABBEF).

Despite these efforts, overall financing of ABBEF activities remains strongly dependent on external funds that are directly linked to specific projects. These projects are constrained by the fact that they are often donor-driven rather than meeting the needs of the association, and financing comes to an end with the end of a project period. This situation undermines

the overall coherence of ABBEF's interventions as it creates a cluster of projects that run in parallel, rather than an integrated strategy. Without an organisation- and donor-wide commitment, both strategically and financially, to improving sustainability, ABBEF is at risk both financially and institutionally in the long-term.

### **Institutional Arrangements**

UNFPA and ABBEF interventions have, on the whole, been complementary. Despite the existence of separate institutional mandates there is good communication between the two agencies and with the government of Burkina Faso, which has facilitated the sharing of experiences and in certain cases permitted the development of common initiatives.

Both organisations have tapped into a common pool of personnel that have played a major role in creating a foundation for improving RH of young people in the country. They are particularly well acquainted with issues related to RH and young people, including gender issues, as reflected in part by the hiring and promotion practices within each institution (e.g. balanced male/female ratios in personnel, including high level management). At times the personnel may fall short of demands, as they are stretched to compensate for the overall limited human resources in government.

Where feasible, both organisations have integrated the participation of young people into the design and delivery of projects. For example, in RH service provision peer educators are often the first line of contact with other young people. In IEC young people, including the peer educators, are used to identify what information is lacking and they are consulted on the design, pre-testing and evaluation of materials. Youth also participate in defining new strategies through seminars, conferences and workshops, which also engage local youth associations and NGOs.

### **UNFPA**

Since 1994, UNFPA's cumulative budget in BF has totalled close to US\$18million. There has been a steady evolution of the budget during the period of 1994 – 2003. Even though UNFPA was faced with strong financial restrictions during this same period, BF has remained one of UNFPA's privileged countries. Funding for activities responding explicitly to the needs of young people have also risen, and are now at 20%. It should be noted that overall spending on young people is, in fact, greater than 20%, as they are also included in outreach to the general population.

UNFPA's Country Office and post descriptions have been organised and adapted to fit project needs, and to the specific role of the office on technical support to government and not direct implementation of projects. On the whole, staff appear to have a clear understanding of RH issues of young people in BF, as well as the cultural limitations and implications of programmes. Nevertheless, in spite of regular support from the CST office in Dakar, the human resources available in the office are insufficient for the current level of programming. Skills and competencies do not always match the needs for achieving tasks that are incumbent on some of the personnel, most especially as they must also make up for weaknesses within governmental structures. Training support to date has been insufficient and the office is conscious of this situation. The Country Office is currently elaborating a reorganisation plan that includes capacity-building in management and better follow-up of projects. With Headquarters in New York's approval, this plan should be put into place in the near future.

The monitoring and evaluation system of projects appears to be theoretically well conceived, and corresponds to common UNFPA norms and standards. However, it is not always

correctly applied, as a number of projects have not been evaluated and recommendations that may exist are not necessarily used to modify programming.

The office works in close collaboration with the government, other partners as well as NGOs and associations working in HIV/AIDS. With the Ministry of Primary and Secondary Education, UNFPA has since 1992 supported the introduction of sexual education and RH in secondary education. Similar work has recently been occurring at the primary level and is also being followed in higher education with the Ministry of Higher Education and Research. Since 2001, UNFPA has collaborated with the Ministry of Labour, Employment and Youth (MoLEY), the Ministry of Social Action (MoSA) and the Ministry of Arts and Culture (MoAC) in developing and implementing IEC/BCC activities in young people oriented structures.

### ABBEF

Created in 1979, ABBEF became a full member of IPPF in 1989, and was state approved (recognised as of benefit to the public) by the government of Burkina Faso in 1994. IPPF furnishes ABBEF with regular financial contributions (see below), material and consumables (contraceptives), and technical support. In addition, the clout of being a full member of IPPF assures ABBEF special recognition within the country.

ABBEF has an annual budget of more than 450 million CFA (685,000€). The budget has had a tendency to increase during the period studied. While IPPF's contribution has been stable in absolute value, it has declined as a proportion of the overall budget, from 63% in 1996 to 41% in 2002. The proportion of funds that ABBEF is able to raise from within the association (membership fees and cost recovery) has seen a modest increase from 7.4% to 10.3% during the same period, with the balance reflecting an increased proportion of project-specific external funds.

Unlike UNFPA, ABBEF implements the projects it funds; as such, it presently has 88 salaried people. On the whole, both professional staff and volunteers appear to be competent and motivated. There is a balance of men and women among volunteers (including elected board members) as well as among the professional staff. Training of all personnel in SRH of young people is part of its modus operandi, although this depends on the availability of funding. ABBEF professional salaries are slightly higher than that in public service, but lower than those offered by international NGOs and international organisations working in country.

ABBEF has put a monitoring and evaluation system into place that is based on regular reporting (monthly, quarterly, annual, mid-term and final), and supervisory missions. The logical framework and benchmarks used in the design of its projects and programmes make monitoring and evaluation more systematic and easier to control. Additionally, financial reporting is included in the regular reporting and an external audit is conducted annually.

ABBEF's competency in the field of SRH and young people is well known and recognised by the government, as well as national and international partners. Both staff and volunteers are regularly solicited to participate in training or workshops to conceive new strategies or initiatives, and they participate regularly in collaboration initiatives aimed at improving the development and co-ordination of SRH initiatives. In addition, ABBEF has been involved in implementing a wide range of RH projects for young people financed by diverse bi- and multilateral organisations, including UNFPA, the German government, international foundations and the Danish, Japanese and Dutch Embassies.

### **Policy and Advocacy**

The legal and political framework relative to the SRH rights of women and young people has evolved during the last two decades: the adoption of Personnel and Family Code and

particularly the rights and duties of spouses, the repeal of the law forbidding use and promotion of contraception, adoption of the law prohibiting excision, slight modifications to the law against abortions (still illegal except for specific circumstances). ABBEF's pioneering role in FP and women's SRH rights over the past 20 years has played an important part in these initiatives and their positive evolution. UNFPA has also contributed to these changes through the effective lobbying of high-level authorities, and by supporting the creation of other lobbying groups (National Advisory Group Against Excision) and awareness raising among parliamentarians. Besides this, UNFPA has brought pivotal support to the DSF in the development and production of RH policy documents on norms and protocols, particularly directed to young people. It has also been instrumental in bringing about the creation of key entities including National Advisory Council on Population (CONAPO), which co-ordinated the revision of the National Population Policy in 2000 to ensure integration of the ICPD PoA.

### UNFPA

UNFPA is the partner of the government of Burkina Faso in the field of population and development, RH and gender rights. It played a determining role in the establishment of the CONAPO and in the revision of the 1991 National Population Policy (PNP) in 2000, which since then explicitly mentions the needs and specifications of young people both in and out of school. UNFPA has equally contributed to introducing sexual and RH education in secondary schools and recently into primary schools (Direction of Population Education). In addition, UNFPA has been involved in defining the new National Health Policy (2000) as well as the elaboration of the National Health Development Plan (PNDS 2001-2010) and the Triennial Plan for the period of 2003-2005. Due to UNFPA's interventions and partnership in development, the "population" (reproductive health/rights) dimension has been taken into account in the strategic framework to eradicate poverty. UNFPA's interventions have also contributed to ensuring that SRH be taken into account in the PNDS; a Health Strategy for Young People has just been drafted as foreseen in the PNDS. Finally, UNFPA is a participating member of the UN Theme Group on HIV/AIDS.

One important area, however, that UNFPA has not been sufficiently proactive in, is the health sector wide approach. The World Bank, the European Union and Dutch Embassy have taken the lead in establishing this approach and it is expected to be fully adopted in the coming years by the principle partners contributing to the health sector.

### ABBEF

While acting at another level, ABBEF has been able to play a key role and has been a catalyst that has undeniably contributed to policy reform in population and RH. Its influence in debates on policy reform is well founded and respected as a result of its well-known RH pilot projects. Also, many members and former professional staff of ABBEF now work with government or international institutions and are responsible for developing new policies.

## **Reproductive Health Services**

UNFPA and ABBEF have each engaged in projects to develop RH services targeting young people, and their services are open to all, i.e. offered in such a way that both young women and men are able to use these services separately, or together. However, the approaches adopted by UNFPA and ABBEF to promote RH services for youth have differed significantly, with notable differences in outcome.

### UNFPA

During the 1992-1996 cycle, UNFPA foresaw setting up 10 youth friendly centres in major areas of the country. It began with the opening of 2 centres in Ouidi (Ouagadougou) and

Bobo-Dioulasso, but changes in government and a mid-term evaluation led to a recommendation that SRH services be integrated into the youth centres under the auspices of the Ministry of Youth. This recommendation was adopted and the two existing centres were devolved to the MoH in 1998, without further support from UNFPA. Due to the lack of MoH commitments, the centre in Bobo-Dioulasso closed, and the one in Ouidi only has marginal activities left.

Since 2001 (5th cycle), UNFPA adopted a more integrated approach and no longer looks to create new structures. They focus on strengthening overall MoH RH services in health centres (CSPS) – in hopes that these will reach youth, and introducing SRH into pre-existing structures explicitly geared to young people (e.g. youth centres). The latter centres are dependent on the Ministry of Social Action or the Ministry of Labour, Employment and Youth. These interventions are now concentrated in 3 zones (Fada, Tenkodogo et Dori), as well as Kombisiri.

The impact of the CSPS initiatives remains hindered by two major (and partly related) factors that UNFPA alone is unable to resolve:

- overall structural weaknesses within public health services (e.g. insufficient personnel, incomplete training, demotivation, lack of financial means, irregular supplies of medicines and consumables, lack of maintenance and equipment, dilapidated structures),
- and the exceedingly low level of use by young people of the CSPS for RH activities.

Despite these challenges within the CSPS interventions, it appears that there is also a reluctance on the part of the MoH to integrate SRH services into designated youth centres, resulting in financial and logistical problems. These challenges are currently being addressed with government counterparts.

UNFPA has played an important role in defining and promoting standards for youth SRH through several additional activities. They have supported a programme titled “Sympa”, introduced by the NGO “Family Health and AIDS Prevention” (SFPS), which adapts services to meet the specific needs of young people in a dozen health centres in Ouagadougou. UNFPA participates in trainings organised by the DSF to raise awareness among health professionals on issues of young peoples RH, and has provided technical assistance to DSF for development of a number of tools and documents (e.g. norms, check-lists, Minimum Package of Activities for RH services, etc.) to improve RH activities for young people.

### ABBEF

In 1992 ABBEF opened 2 centres specialising in receiving and offering SRH services to young people, one in Ouagadougou and the other in Bobo-Dioulasso. Two other centres were opened in Koudougou and Koupéla in 1996 and 1997, respectively. These centres are based on the following principles: (i) easy access of educational and leisure activities for young people; (ii) offer of clinical SRH services adapted to the needs and within reach (especially financial) of young people; and (iii) reliance on a youth-to-youth approach (peer educators) to raise awareness among young people and introduce them to the centre. An analysis of the clinical activities of these structures over the past 10 years shows that the number of young people who visit the centres continues to expand and the range of services offered has grown progressively to include: FP, gynaecology (including STI), prenatal care, psycho-social support, counselling (on various RH issues) and HIV/AIDS detection. ABBEF’s direct support assures regular and satisfactorily functioning (except perhaps in Koupéla) of the centres and strong motivation from staff and volunteers.

ABBEF began working in the region of Ouahigouya since 1999. An action research programme presently offers SRH services and advice for young people in rural areas. This programme is founded on results from a baseline study undertaken in 10 villages, and an

awareness raising pilot project that took place from October 2000 – March 2001. Subsequently, financial assistance from the Rockefeller Foundation was secured for a 3 year programme (2002-2005) that supports 5 villages. Interventions include: peer educators carrying out IEC/BCC activities; support to the health centres (CSPS) in the form of material and equipment, supply of medicine for the treatment of STI and opportunistic infections, and training of personnel in the SRH needs of young people. It is too early to state whether these interventions will increase the number of young people using the health centres.

In each of these RH service strategies (youth-designated centres or strengthening RH activities in public structures), sustainability of services and the possibility of expansion are greatly dependent on ABBEF's ability to mobilise external financial resources.

### **Promoting Reproduction Health Information and Education**

UNFPA (through technical support of the DSF) and ABBEF have separately and collaboratively produced a large quantity of IEC materials relating to SRH and young people, for use by government structures, NGOs and associations.

The major themes covered in the IEC material include: unwanted pregnancy and FP, sexuality, prevention of STI and HIV/AIDS, and communication between the sexes and with parents. These themes correspond to current laws and the expressed needs of the target audience, and young people have been systematically involved in the development of the material. However, while attention has been given to identifying suitable cultural and linguistic messages for the targeted audience, this has not always been adequate. Most brochures require a certain level of education (at times secondary school) to understand, and mastery of French. Moreover, while there are no flagrant contradictory messages, certain brochures carry moral overtones which may be inappropriate within the public health arena (e.g. attitudes about homosexuality).

There has been a steady increase in those involved in the development of SRH IEC/BCC activities. Many of the new players produce, to some degree, their own material. This has led to a duplication of efforts in some areas, and gaps in others (e.g. prevention of maternal mortality among young women, and the prevention of mother-child transmission of HIV).

Paradoxically, much of this IEC material is not available in the structures where it would be most useful. Public health centres and even UNFPA and ABBEF project sites rarely had any of this material available either on the walls or to give to young people. This situation closely resembles the weaknesses observed in the management and distribution of material and consumables at the central, regional and district levels of the MoH.

ABBEF and UNFPA both support the youth-to-youth approach that uses peer educators in IEC/BCC activities. ABBEF supports volunteers in their activities through remuneration for talks, monitoring, and involvement in other centre activities. This may explain the motivation and dynamism found among ABBEF volunteers that is not found among volunteers working on IEC/BCC activities with the UNFPA supported/government projects.

The impact of the IEC/BCC activities has been difficult to assess. It would be even more difficult to assess such an impact of UNFPA versus ABBEF activities in this domain, since there is such an overlap/collaboration of material. Interviews during this evaluation indicated that attitudes among both young people and adults are evolving, and information on a number of subjects (condoms, HIV/AIDS, contraceptives and the eradication of excision) is improving. However, social and religious pressures are still strong influences in society, especially in certain rural areas, and discussion of sexuality between the generations remains taboo. For the moment, there has been no study to examine the extent of young people's response to, or recall of, messages from IEC campaigns or materials produced

(other than in pre-testing of material). Nor has there been any objective study to determine if behaviour has evolved. The issue of reaching illiterate and out of school populations has also not been adequately addressed and requires review.

## KEY FINDINGS AND RECOMMENDATIONS

### Key Findings

The evaluation of UNFPA and ABBEF rights and RH for young people initiatives in BF indicates that the strategic focus of both of these organisations emphasised promoting reproductive health and rights of young people prior to ICPD. They continue to do so while also evolving in their respective search of finding optimal strategies to offer RH services for this population. The strategic focus of both agencies has appreciably evolved since 1994 in: (i) adapting to specific contexts and the changing needs of this target population; and, (ii) drawing on lessons learned during the implementation of RH programmes in Burkina Faso. UNFPA and ABBEF are well acquainted with the context and particular constraints of SRH and young people in BF.

### UNFPA

- Explicit attention has been accorded to young people (10 - 24 years old), especially during the period considered and in the current cycle (2001 - 2005), through projects explicitly and exclusively oriented to youth and adolescents, and through substantial budgetary commitments.
- UNFPA projects are now concentrated in 3 zones considered to be the poorest in BF and targeted by several UN agencies, and hence UNFPA has focused direct support to RH services to a relatively restricted number of health centres.
- UNFPA has reinforced a multi-sectoral approach by working with the Ministries of Education to support sexual and RH in secondary education, and this project has been adopted by, and integrated into, ongoing government programmes.
- Despite a good knowledge of SRH needs among programme staff, and regular support from the CST office in Dakar, the human resources available in the UNFPA CO are insufficient. Skills and competencies do not always match the needs for achieving tasks, and staff are stretched to make up for the weaknesses of the governmental structures they are supporting. The office is conscious of this situation and is presently elaborating a plan of reorganisation that includes capacity building in management, and follow-up of projects.
- UNFPA has contributed to changes in RH legislation through lobbying of high-level authorities, and by supporting the creation of other lobbying groups, and in defining the National Health Policy the elaboration of the National Health Development Plan. It has also brought pivotal support to the DSF in the development and production of RH policy documents on norms and protocols, particularly directed to young people. In addition UNFPA has made a significant investment in building national capacity strengthening both government and NGO partners.
- The monitoring and evaluation system of projects corresponds to common UNFPA norms and standards. However, a number of projects have not been evaluated reflecting the use of mid term reviews within the new programming approach. However, it was noted that recommendations that may exist are not necessarily used to modify programming.
- UNFPA investments in youth SRH services have been directed to building general SRH service capacity in CSPS-level services, and supporting SRH into youth centres. However investment in youth centres appears hindered by lack of government support for this programme.



- The impact of UNFPA service investments at CSPS-level appears limited due to the overall structural weaknesses of the public health service, the overall low utilisation rates, and the exceedingly low level of use by young people for RH needs.
- IEC investments have been well coordinated with ABBEF and government, but they are inefficient because they are only targeted to literate youth, and poorly distributed.
- UNFPA has not undertaken a study to look at the extent of young people's response to, or recall of, messages from IEC campaigns or materials produced or how behaviour may have evolved.

## **ABBEF**

- ABBEF has played a pioneering role in improving the status and SRH of young people in BF. Its interventions preceded and often facilitated the advancement of RH principles for young people. This has been undertaken at policy and legislative levels as well as offering services at national and regional levels.
- ABBEF staff has a clear understanding of the complexity and diversity of needs within the country context of rights, SRH and gender. Young people and the community are involved at all levels of project development and implementation. Efforts have also been made to respond to the diversity of needs among young people, including the most marginal and vulnerable.
- ABBEF has numerous initiatives to build sustainability including cost recovery, use of seconded personnel from government, and increased government contracts. Financing, however, remains strongly dependent on external funds that are directly linked to specific, time-limited projects. Cost recovery initiatives may be in conflict with increasing access of SRH services to youth in a poor country.
- ABBEF has put a monitoring and evaluation system into place that is based on regular reporting and supervisory missions. The logical framework and benchmarks used in the design of its projects and programmes makes monitoring and evaluation systematic and easy to control. Financial reporting is included in the regular reporting and an external audit is conducted annually.
- The government and national and international partners recognise ABBEF's competency in the field of SRH and young people. Their personnel are often sought after to assist in training and policy related groups.
- ABBEF has also played a revolutionary role in providing youth friendly RH services to young people. They presently have 4 centres in the country that show increasing rates of utilisation by young people. Other such centres would be advantageous if financial support would be identified.
- A new action-based research programme in the northern rural area of the country is looking at ways in which SRH needs may be addressed through public facilities and the community.
- ABBEF (like UNFPA) has undertaken a study to look at the extent of young people's response to, or recall of, messages from IEC campaigns or materials produced or how behaviour may have evolved.

## **Complementarity of UNFPA and ABBEF**

- UNFPA provides a technical (and policy) support to government, while ABBEF is a direct implementer of programmes. The two agencies cooperate in numerous activities, including development of IEC materials, where they both appear to have similar strengths and weaknesses.
- ABBEF appears to have developed a more effective strategy for reaching youth with SRH services, offering an opportunity for possible cooperation between the two agencies, and scaling up effective practice.

## **Recommendations**

### **UNFPA**

- UNFPA should begin to frame a new strategy so that it will make the transition into the sectoral approach quickly and easily in the next programme cycle. As one of the seven members of the sub-committee on Sector Wide Approach in health it should be able to bring into focus strong evidence based arguments to convince the MoH and its partners to allocate enough resources to SRH for youth.
- UNFPA should develop a realistic strategy of sustainability that includes clearly defined steps (benchmarks) for the devolution of successful programmes to government. This requires documenting success when it occurs, and encouraging government to apply lessons elsewhere in the country. Interventions in the zones of concentration (Fada, Tenkodogo and Dori) should be considered more as pilot projects and not simply a contribution to strengthen RH services in a limited geographical area. UNFPA needs to look at their own successes in sustaining the work they have supported in the education system, and see how this may be applied to the health system, as well as with other ministries and NGOs.
- UNFPA should make better use of its monitoring and evaluation procedures. When difficulties are discovered, it needs to quickly identify ways to address them with government. This is directly relevant to assessing young people's utilisation of UNFPA-supported SRH services at CSPS-level.
- An in-depth study and analysis of the reasons for low use of available health services needs to be undertaken, as well as an evaluation of what has been accomplished and its impact given inputs by UNFPA to these centres. UNFPA should also, with support from the CTS in Dakar and their regional experience, analyse the reasons for the weak rate of referrals from youth centres to health centres where RH services are delivered. Once an analysis is done, a more aggressive campaign to increase youth access should be carried out.
- Given that ABBEF appears to have developed a more effective strategy for reaching youth with SRH services, greater efforts are warranted to learn from that experience, and investigate possibilities for scaling up effective practice.
- Besides the regular support UNFPA offers to NGOs in RH and HIV/AIDS prevention, it should look closely into revitalising the NGO network on RH in order to strengthen coordination of project activities at the national and community levels. Alongside these activities, UNFPA should take the lead in a general reflection on the role of the civil society in SRH of young people, be it for information or education or actual provision of services.

- UNFPA should continue to pursue its lobbying activities with the vision of strengthening local awareness, adoption and application of recent legislative reforms prohibiting excision, violence and discrimination against women, and continuing reform of SRH legislation (including on abortion).
- UNFPA should take a proactive and leading role in addressing logistical problems as well as ensuring that financial resources are available for purchasing needed contraceptives. Although it has begun to address these issues with the government, more needs to be done.
- UNFPA needs to expand IEC messages to less literate target groups, explore interactive media, and improve distribution of existing IEC materials to places where youth congregate.

### **ABBEF**

- ABBEF, should with the support of IPPF, explore the framework of financial assistance they receive from donors, to ensure a more regular and even distribution of funding. In addition, the MoH could contribute to the financial stabilisation of ABBEF by applying the principle of contractual services foreseen in the PNDS, and setting aside supplementary resources that are to be used for the social sector Highly Indebted Poor Countries (HIPC) initiative. UNFPA, as a key partner of the government, could facilitate this process, i.e. they could assist in developing a contractualisation scheme between the MoH and ABBEF for the provision of a basic package of RH services focusing on the most vulnerable young people (e.g. marginalised, poorest, etc).
- In general, efforts should be made to better disseminate ABBEF expertise and lessons to other local NGOs and associations working in RH issues of young people. ABBEF should disseminate the process and results of its action-based research project in Ouahigouya to other players involved in SRH for young people.
- ABBEF's apparent success with SRH service delivery through designated youth centres should be analyzed, documented, and shared with UNFPA, government and other partners to explore the potential value of scaling-up the most effective components.
- ABBEF should continue to pursue its lobbying activities particularly in the areas of softening the law on abortion, prevention of mother-child transmission of HIV/AIDS, and protection of maternal health.
- ABBEF should intensify educational sessions about STIs and their relationship with HIV given by peer educators and within the youth centres, given the threat of HIV within Burkina Faso.

## INTRODUCTION

The Ministry for Economic Cooperation and Development (BMZ) of Germany, the Danish Ministry of Foreign Affairs, the UK Department for International Development (DFID), the Netherlands Ministry of Foreign Affairs, and the Norwegian Ministry of Foreign Affairs are jointly sponsoring an evaluation of the contribution of the United Nations Population Fund (UNFPA) and the International Planned Parenthood Federation (IPPF) to addressing the reproductive rights and health needs of young people<sup>2</sup> - and especially adolescents - in the period since the finalisation of the Programme of Action (POA) developed at the International Conference on Population and Development (ICPD) in 1994.

The evaluation focuses on six country case studies: Tanzania, Burkina Faso, Bangladesh, Egypt, Nicaragua and Vietnam undertaken between March and May 2003. The findings from these six country studies will be synthesised into a final report to be presented at an international workshop in December 2003.

### Overall Objectives of the Evaluation

The overall aim of the evaluation is to clarify how UNFPA and IPPF contribute to the implementation of key aspects of the ICPD Programme of Action, relating to the reproductive rights and health of young people. UNFPA and IPPF have affirmed their commitment to the ICPD framework; central to which are the notions of gender empowerment, equity, and a rights based approach. IPPF's commitment to a rights based approach is outlined in the IPPF Charter on Sexual and Reproductive Rights (1995), and in the objectives and strategies of Vision 2000.

The goal of the evaluation is to contribute to a better understanding of the conditions necessary for achieving best practice, and to draw strategic lessons for the future.

The purpose is to assess the performance of UNFPA country offices and FPAs in selected countries (see below) in promoting reproductive rights and health (with the aim of achieving behavioural change), with a particular emphasis on adolescents and youth.

### Composition, Timing and Schedule of the Burkina Faso Country Evaluation

The local partner for the Burkina Faso country evaluation was the Centre for Health Research in Nouna (CRSN - Centre de Recherche de la Santé a Nouna). CRSN undertook preliminary studies ahead of the international team's visit to Burkina Faso. The international team for the Burkina Faso country evaluation was: Dr Olivier Weil (team leader), Ms. Monique Munz (international team member) and Ms. Lydia Tapsoba (national team member). The international team members arrived in Burkina Faso on 9<sup>th</sup> May 2003, and departed in the evening of 26<sup>th</sup> May 2003.

The evaluation team met with UNFPA and ABBEF staff, as well as representatives of the Ministry of Health (MoH) and other ministries concerned with the reproductive health needs of young people. The team equally met with other principle partners, including bi and multilateral donors, international and national NGOs and others involved in reproductive health issues and young people. Site visits were made in Ouagadougou as well as to the field (Koudougou, Ouahigouya, Koupéla and the Fada Region), where UNFPA, ABBEF, public and private programmes were visited. In addition to these various visits and the stakeholder workshop, the team consulted a large quantity of documents, including project documents, thematic studies, policy and strategy documents, evaluation reports, etc (see

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<sup>2</sup> The evaluation adopts UN definitions: adolescents are those aged 10-19 years, youths are aged 15-24 years; while young people includes both categories (10-24 years).

annex 4). A list of key people met and site visits is at annex 1. A list of the participants at the stakeholder workshop held at the beginning of the evaluation may be found in annex 2. Examples of tools elaborated and used by the evaluation team for field visits and interviews are at annex 5.

### **Limitations and Constraints**

The in-country evaluation was to be 3 full weeks; however, due to unforeseen circumstances the mission had to be postponed by a week. Moreover, the schedule and timing of the evaluation team in country was cut down by several days. The time in country also included 3 weekends plus a national holiday. The team met with all appropriate staff of the UNFPA, ABBEF (the FPA) and most key partners; however, due to limitations of time and changes in schedule it was not possible to meet with all involved in young people's SRH. For example, the team was unable to meet with a representative of the Ministry of Economy and Development (of its dependent CONAPO), the MoSA or the MoLEY other than during the stakeholder workshop.

For reasons outside the control of CRSN, logistical difficulties (repeated and frequent electricity cuts limited use of computers, fax and telephone, and computer and internet problems) complicated and impeded the evaluation team's work.

### **Report Format**

The report is in six sections, relating respectively to the country context, the strategic focus of the two agencies' national programmes, institutional arrangements; and the contribution of each agency to policy reform, strengthening services and provision of information and education. Each section is structured around the criteria of the evaluation, which include relevance, integration of rights, capacity, efficiency, effectiveness, and sustainability. With the exception of sections 1 and 6, the remaining sections are divided into two separate sub-sections on UNFPA and ABBEF respectively.

## SECTION 1: THE COUNTRY SPECIFIC CONTEXT

### 1.1. Demographic and Socio-Economic Context

#### Poverty Profile

Burkina Faso is a landlocked country in the Sahel region of West Africa. It has a semi-arid climate, erratic rainfall, and limited natural resources. The climatic conditions, the deterioration of the market economy and the low performance of the productive sector (agriculture and industry) have all been major reasons for a lack of development and growth in Burkina Faso. Consequently, the country remains among the poorest in the world with a GNP per capita of US\$240 (1997) and a GDP per capita of US\$310<sup>3</sup>. It is estimated that 45% of the population is living below the absolute poverty line. In 2000 the Human Development Index was at 0.323 (169<sup>th</sup> rank). Owing to its heavy debt, Burkina Faso has been reclassified in the group of countries eligible for the Highly Indebted Poor Countries (HIPC) initiative.

Burkina's population of more than 12 million is predominantly rural, and the majority are engaged in subsistence agriculture (87.9%<sup>4</sup>) with a high proportion of women (91.5%<sup>3</sup>) working in agriculture, animal husbandry and fishing. Participation in these activities begins at an early age, with almost 96%<sup>5</sup> of 12-14 year olds actively working in these areas.

#### Demographic, Health and Nutrition Indicators

Burkina Faso's precarious health situation is characterised by high morbidity and mortality. In 1995, the overall mortality rate was 15.8% (source GCPH, '96) and infant mortality rose from 94 per thousand in 1993 to 105.3 per thousand in 1998 (DHS '98).

#### *General Characteristics of the Population:*<sup>6</sup>

Estimated population size	12.6 million (2002)
General annual growth rate	3% (2000) (2.37% '96 census)
Rate of Increase 2001-2050	172%
Population <15 years	49% (2002)
Proportion of adolescents compared to total population: <sup>7</sup>	
Girls: 10 – 14 years	7.3%
15 – 19 years	4.9%
Boys: 10 – 14 years	7.2%
15 – 19 years	4.7%
Total:	24.1%
Life expectancy at birth	46.7 (2000)
Infant Mortality Rate	105 (2000)
Natality Rate	47/1000 (2000)
Mortality Rate	17/1000 (2000)
Total population living in urban areas	15% (2002)

<sup>3</sup> INSD, 1996

<sup>4</sup> Politique Nationale de Population; Ministère de l'Économie et des Finances; December 2000

<sup>5</sup> Recensement Général de Population et de l'Habitat, Burkina Faso 1996

<sup>6</sup> Demographic and Health Survey; Burkina Faso 1998 – 99; September 2001

<sup>7</sup> Population Council (2002): analyse secondaires des données de l'EDS

Percentage of adolescents living in urban or rural areas<sup>5</sup>:

	Urban (%)	Rural (%)
Girls		
10-14 years	15.9	84.1
15-19 years	20.3	79.7
Boys		
10-14 years	13	87
15-19 years	19.9	80.1
Literacy Rate >15 years:		23.9% (2000)
Overall schooling rate (primary and secondary):		23% (1999)
Total fertility rate		6.8 (1994 – 1999)

### Sexual and Reproductive Health

While knowledge of modern methods of contraceptives seems to have improved (86% of boys and 70% of girls aged 15-19 years knew at least one form), usage remains weak. Only 5% of married women report using a modern method of contraception, and only 12% report using some form of contraception, modern or traditional. Culturally, large families are viewed as desirable and attitudes among both men and women reflect this. On average, women want 5.7 children while men would like 7 children.

High mortality rates are also impacted by the nutritional status of women in Burkina Faso. According to the most recent DHS, 13% of women between 15 and 44 years are severely malnourished. In addition, iron deficient anaemia, is a generalised pathology among pregnant women, predominantly due to poor nutrition and exacerbated by malaria and other parasitic diseases.

### HIV/AIDS

In addition to HIV<sub>1</sub> and HIV<sub>2</sub> being present, there are currently 5 known other virus subtypes involved in the HIV/AIDS epidemic in Burkina Faso. From sentinel surveillance among antenatal clients, it appears as if there has not been an increase in sero-prevalance since 1998, and the HIV prevalence rate is stabilising at approximately 6.5% (2001). The 2003 DHS includes a questionnaire on HIV/AIDS, with results expected in mid 2004.

### Health Service Provision

The health sector in Burkina is adversely impacted by a lack of both human and technical capacity. The current health professional/population ratio in Burkina falls far short of the WHO standard, with only one physician available per 29,000 population, and one midwife per 28,000.

The availability of trained personnel is made worse by the distribution of personnel between the cities of Ouagadougou and Bobo-Dioulasso and the rest of the country. These two cities alone contain 53.7% of the doctors, 57.3% of the midwives, 59% of the pharmacists and 33% of nurses, while covering about 10% of the population. District hospitals (CMA – Centre Medical avec Antena Chirurgicale) are normally the facility to address obstetrical complications (C-section, blood transfusion, etc). However, due to the lack of technical capacity and resources, and the poor state of equipment and infrastructure, these services are, for the most part, not available.

## Gender Relations and Status of Young Women

Consistent with a pattern of acute poverty and evident from the general and health indicators in the country, Burkina Faso is characterised by gender inequality and the low status of women. While the general level of education in Burkina Faso remains weak, this is especially apparent among young women.

Educational levels of adolescents<sup>8</sup>:

	No Education (%)	Primary Level (%)	Secondary Level or More (%)
Girls			
10-14 years	72.4	24.5	2.5
15-19 years	78	13.3	8.4
Boys			
10-14 years	59.2	37.8	2.7
15-19 years	62.9	22.2	14.7

In rural areas 90.8% of the female population compared to 45.3% in urban areas have not received any formal education. Not surprisingly, there is a higher level of paid employment among men than women. Women participate in the production of agricultural products but men remain responsible for financial transactions. Consequently, women are rarely in possession of their own financial resources and are dependent on their husbands (or parents) to pay for reproductive health services.

Unemployed Population:	49.2% <sup>2</sup>
Boys 10 – 19 years:	27.4%
Girls 10 – 19 years:	39.1%

Young People involved in paying or non-paying work: <sup>3</sup>	
Boys: 10 – 14 years	52.64%
15 – 19 years	81.4%
Girls: 10 – 14 years	43.3%
15 - 19 years	79.69%

The higher rate of unemployment among girls may be explained within the socio-cultural context where girls are accorded less freedom and have less accessibility to work outside the home.

Despite recent changes to legislation regarding excision, sexual violence and marital status these abuses remain widespread and there remains a significant gap between the legislation and its implementation (see sections 1.2. and 1.4. below).

## **1.2. National Policies, Strategies, Programmes and Laws**

### National Population Policy

The National Advisory Council on Population (CONAPO) is an inter-ministerial structure attached to the Ministry of Economy and Development (MoED) and responsible for population related issues. Its role is to monitor and coordinate the Population Action Programme (PAP) at the national level through various specialised commissions as well as ensuring the

<sup>8</sup> EDSBF 98/99



decentralisation of the programme through DRED, DRS, and NGOs and other local Associations. The component on reproductive health falls under the auspices of the FP commission.

In the early 1990's Burkina Faso adopted the National Population Policy to address population related issues. The Population Action Plan 1 covered 1991 – 1995, but effectiveness was weak due mostly to a lack of coordination, monitoring and evaluation. Based on recommendations from ICPD, the International Conference on Women (Beijing) as well as internal changes in country, the government updated the NPP, which has resulted in PAP II.

Among the six programmes developed in PAP II, is a sub-programme on reproductive health. This programme is designed to increase the number of structures offering RH services to young people in both urban and rural areas, and with the participation of the community.

CONAPO revised the 1991 National Population Policy in 2000. The revised Policy includes 6 major objectives, of which the following 2 objectives *indirectly* refer to the reproductive health of young people:

- (i) Improve the health status of the population, especially reproductive health.
- (ii) Improve the knowledge of the general population in population, gender and development issues.

Within these 2 general objectives, intermediate objectives and strategies *directly* related to young people include:

- (i) Increase the utilisation of reproductive health services, especially among women, adolescents and youth.
- (ii) Elimination of female genital mutilation by 2015
- (iii) Strengthen population and development issues in the formal and non formal educational system

Other objectives and strategies are more generally stated, however, these would include young people, e.g. reduction of maternal mortality rates, increase of literacy rates, promotion of reproductive health through IEC, etc.

A lobby network of parliamentary women and ministers (present or ex) has been established to advocate for sexual reproductive health issues among decision makers. Furthermore, an arm within the Parliament, known as "Population and Development", is responsible for ensuring that the Parliament considers population related aspects in government policies and laws. UNFPA works closely with the network, and was instrumental in its inception.

Despite this increased support and activity, the application of policies and laws that protect women is still an enormous challenge. Socio-cultural and traditional practices remain entrenched in many parts of the country and attempts to enforce new legislation is hampered by a weak judicial system.

### National Health Policy

A new National Health Policy was adopted in September 2000 and incorporated into the ten year National Health Sector Development Plan (PNDS) in 2001. In this plan reproductive health activities are included as part of strategies aimed at promoting health among specific groups. These strategies are broad based (e.g. improve quality and use of health care services), and HIV/AIDS is the only programme which is clearly mentioned as a specific strategy. Reproductive health in general is dealt with through the broader components. Young people's health needs are mentioned only as one of several other vulnerable groups,

whose needs are considered within an overall strategy. The MoH plans to adopt a national health policy for young people that will be part of the PNDS, which has just been drafted.

The National Health Sector Development Plan has been developed in collaboration with the MoH and key bilateral (Belgium, Canada, China, France, Germany, Italy, Luxemburg, Netherlands, Sweden) and multilateral partners (UNFPA, UNICEF, WHO, UNDP, WB, AfrDB, and IsDB) as well as civil society organisations (international and local NGOs and associations). Subsequent to this document, a round table was conducted to develop a Three Year Plan (TYP) establishing a financial plan that covers the period of 2003 – 2005 and is intended to operationalise the PNDS. According to a recent analysis undertaken by WHO (April 2003) the total budget of the TYP is 223,128,123,000CFA, external funds total 67,836,271,000CFA (30%). A monitoring committee is presided over by the General Health Direction (MoH), for which WHO is the secretariat; the committee is composed of two bilateral members (Belgium and the Netherlands), two multilateral members (UNICEF and WB) and two NGOs. Both UNFPA and ABBEF contributed to the development of the PNDS and the TYP.

The TYP reflects the gradual transition of a donor-coordinated strategy to move from project financing to sectoral financing. Nevertheless, more than 95% of external budget is still funding projects. The repercussions of this change will be felt particularly by ABBEF in June 2003 as their direct funding from the Netherlands will end reflecting the Netherlands decision to adopt the new sectoral approach. Defining the mechanisms of how this sectoral approach will actually function was still being debated during the evaluation. One possibility being considered is to allocate a part of the budget for civil society and non-governmental actors in the sector.

### HIV/AIDS

Burkina Faso has ratified several international legal conventions related to human rights that protect citizens' rights in general and outlaw discrimination against specific groups. Most laws that are used to protect PLWHA are found within various articles in the Constitution, e.g. article 2 consent of the individual must be ensured before taking blood (also included in article 2 of the medical code); article 1 prohibits all sorts of discriminatory practices; article 2 establishes the right to free movement; article 6 ensures privacy in particular concerning someone's sero-status (also included in the medical code and code of professional ethics); article 18 recognises that all Burkinabé have the right to health including access to health services and appropriate referrals etc.

The National Health Policy also makes provision for the consideration of issues relating to HIV/AIDS as well as STI's. Within the framework of measures aimed at preventing HIV transmission, women and young people are specifically included as being at high risk of HIV infection.

The government has taken a multisectoral horizontal approach to HIV/AIDS. The National AIDS/STI Control Committee (CNLS) is the highest coordinating and decision-making body for the national multisectoral plan. It is attached to the presidency, chaired by the President, and co-chaired by the Minister of Health. The Permanent Secretary of the CNLS is the rapporteur. The multisectoral Committee has members from 15 ministries and representatives from multi and bilateral organisations, UNTG, NGOs, civil society, private sector, religious and traditional community. The HIV/AIDS structure benefits from a decentralised coordination structure, and consists of sectoral committees in various ministries, as well as provincial, departmental, communal and village committees.

The government has committed itself to HIV/AIDS control through 4 principle approaches:

- Strengthening measures to prevent HIV transmission
- Strengthening surveillance of the epidemic
- Improving the quality of care and support for infected and affected people
- Promoting national and international partnerships and multisectoral coordination

### Legal Context

Since ICPD several changes in governmental legislation related to reproductive health have occurred.

*Reproductive Health Standards:* A decree adopted in 24<sup>th</sup> July 1997 specifies norms, protocols and policies related to the delivery of reproductive health services. The decree defines the minimal package of services to be provided at service provider level as well as population targets. UNFPA and ABBEF were actively involved in offering technical assistance in the development of these documents.

*Contraception:* The 1920 law prohibiting all forms of information and promotion, as well as the use of contraception was reformed in 24 October 1986. The new law permits contraception and its promotion without any limitation to sex, age or marital status. Article 85 of the Public Health Code adopted in May 1994, prior to ICPD, specified all contraceptive methods permitted, that they may be provided in all health facilities, public and private, and that the consent of the husband was no longer needed (except for definitive methods such as tubule ligation).

*Abortion:* Article 387 of the Penal Code, adopted in 1996, introduced a number of modifications that facilitate access for therapeutic abortions. The number of doctors needed to give their consent for the procedure was reduced to 2 from 3 (at least one from the public sector). Reasons for permitting therapeutic abortions have been extended to include: all situations in which the life of the mother is endangered, if the child is at risk of having serious congenital or fatal illness, or in the case of incest or rape. No limitations with regards to age or term of pregnancy are set for therapeutic abortions. In case of rape or incest, the term of pregnancy must not exceed 10 weeks. Voluntary abortion remains illegal in Burkina Faso; consequently, clandestine and dangerous practices remain a reality as well as migration to neighbouring countries where voluntary abortions are available (e.g. Ghana).

*Excision:* Article 380 of the Penal Code adopted in 1996 prohibits all forms of excision. The National Committee for the Fight Against Excision (CNLPE), set up subsequent to the Cairo conference, prepared this law. Since this new article has been ratified, a number of people who perform excisions have been arrested and imprisoned. Adults bringing the child for the excision at present are not penalised. Both UNFPA and ABBEF are founding members of CNLPE and were instrumental in the development of the article.

*Marriage:* The Family Penal Code stipulates the legal age of marriage at 17 and 20 for women and men respectively. Articles lay down other regulations concerning lowering of age for marriages with authorisation, nullification of marriages, punishment for non-consensual/forced marriages, interdiction of abandoning a pregnant woman, etc. In the case of divorce or death of one spouse, men and women have equal rights if an official marriage has taken place. The most common forms of marriage, traditional and religious, are not officially recognised by the law and elude such protective laws. Additionally, young girls who are forced into marriages often lack the information or education necessary to denounce such acts.

*HIV/AIDS:* There is no HIV/AIDS specific legislation against discrimination. However, high-level government support and political commitment is demonstrated in that HIV/AIDS has

been declared a national development issue, and the government has demonstrated its support to the programme through various restructuring measures and general articles within the constitution (see above 1.2.1 HIV/AIDS). Unlinked anonymous antenatal HIV screening takes place in sentinel sites. In addition, anonymous testing is available in various areas of the country, often through local NGOs.

*Violence - Rape:* Article 417 of the Penal Code considers all sexual relations with a minor (<15 years) to be rape. There is presently no law regarding conjugal rape, however, the Family Code does state that sexual relations are a conjugal duty. The penal code states that rape is punishable with 5 – 10 year sentences and may be doubled in the following circumstances:

- incest (grandparent or parent);
- if the guilty party has authority over the victim, e.g. teacher, employee, etc;
- gang rape;
- if the victim is vulnerable, e.g. pregnant, aged, handicapped, mentally ill or retarded, a minor;
- if the rape was committed with the threat of a weapon.

While laws against rape protect and support women's rights, the burden of proof makes it difficult to enforce these laws.

*Sexual Harassment:* While this very real phenomenon is especially visible in school environments, between students and their teachers/professors, its extent is not well known. Victims are for the most part minors. The law does not repress this practice. The legal void is partly due to the difficult and complex means of proving a claim, especially as victims do not dare to bring charges or even denounce the guilty party.

Existing legislation for many of these issues is not fully enforced or punished to the fullest extent of the law except in cases of fatal consequences, e.g. death in the case of excision or abortion.

### Rights within the Constitution

Article 1 of Burkina Faso's Constitution prohibits all forms of discrimination linked to age, gender, marital status, ethnicity, etc. Article 19 prohibits discrimination related to employment practices and remuneration based on sex, race, social or ethnic background or political opinion, (see above 1.2 National Policies, Strategies – HIV/AIDS).

### Young People's Participation in Policies and Programmes

The participation of young people in all areas of reproductive health in Burkina Faso is fairly well established. Young people are directly involved in the development of national policies, as well as members of high-level committees, e.g. RAJS-BF is a member of the National AIDS Committee (CNLS). In addition, their needs and ideas are taken into consideration through surveys, seminars and workshops. For example, the young people who participated at the conference in Cairo returned to Burkina and conducted seminars to sensitise other young people and adults. They assisted in defining the concept of reproductive health for young people in BF and preliminary ideas for strategies to control HIV/AIDS among young people.

At the programmatic level young people are directly involved with the design, development, implementation, and evaluation of activities. This extends from material development (design, conception and pre-testing of messages), to HIV/AIDS pre, post and support counselling, as well as peer educators at centres and within the community. This was particularly noted within the modus operandi of ABBEF where young people are volunteer

peer educators, and involved in the development and pre-testing of IEC material, as well as clients of the youth friendly centres.

### **1.3. Sexual and Reproductive Behaviour**

#### Social and Cultural Attitudes of Young People's Sexual Activity, Marriage, Fertility

Young women, married or single, have little power in their sexual relationships with men. At school, girls are often subjected to harassment by male teachers who wield significant control through exam results.

Within the context of marriage, husbands hold the family's finances are often the decision makers regarding the use of contraceptives and family planning in general, and particularly if condoms are used. Women often resort to using family planning measures clandestinely.

Outside of institutional relationships power is also exerted through wealth. As evidenced by the in-country study on youth opinion, many young girls have significantly older partners who provide them with financial support or material goods. "Many girls today show their desire for material goods; obviously this makes them more vulnerable as they prefer to go out with older men "Tontons", who are ready to give them money" (21 female from Koupela).<sup>9</sup>

The youth opinion study also noted a relatively high knowledge of modern contraceptive means in urban areas whereas in rural locations there was little or no awareness or understanding. One girl interviewed in a rural area cited tamarind juice as a contraceptive<sup>10</sup>. Awareness of HIV/AIDS was also reasonably high groups interviewed however again there were significant disparities between urban and rural areas as well as literate and illiterate groups, with the latter citing both the pill and injectables as both a contraceptive and a means of preventing STIs and HIV/AIDS.

#### Age Differences Within Sexual Unions

While forced marriage is prohibited, this practice remains in effect largely in rural areas. Marriage of young women to older men is not rare. Older men still prefer having sex with younger women/girls, thinking they run less risk of HIV/AIDS infection. Consequently, young women are infected with HIV at an earlier age than men.

Polygamy is widely practiced in Burkina Faso. This practice is more frequently found in rural areas where 58% of married women are in a polygamous union compared to 30% in urban areas. Polygamous relationships are also found among young people. Among those 15 – 19 years old, 2 out of 5 who are married (39%) are in a polygamous marriage. During the Demographic Health Survey (DHS) undertaken in 1999/1998, 24.9% of married adolescents between the ages of 15 and 19 already had a co-spouse, and 14% had two or more. If a civil marriage is performed, the couple must declare whether they are both in agreement that the marriage will be polygamous, otherwise the marriage will automatically be a monogamous one.

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<sup>9</sup> "Perception des Jeunes sur l'Accesibilite la Qualite de l'Information et des Services de Sante de la Reproduction au BF"; Zio Simplicite Batebie, CRSN; April 2003

<sup>10</sup> "Perception des Jeunes sur l'Accesibilite la Qualite de l'Information et des Services de Sante de la Reproduction au BF"; Zio Simplicite Batebie, CRSN; April 2003

## Sexual and Reproductive Risk-taking Among Young People

Early entry into sexual relations and the advent of the HIV epidemic, make young people vulnerable to infection. As elsewhere, Burkinabé young women are more at risk of sexual transmission of HIV because of biological, socio-cultural, education and economic reasons. STIs are also higher among young women, opening another door to risk of infection.

While knowledge regarding condoms, its efficacy against HIV is high and sales are on the increase, attitudes and use remain controversial. Young people still declare that they are ashamed to buy condoms regardless of where they may be sold. This is despite the fact that those interviewed for the youth survey were unanimous in their agreement that condoms were both available and accessible to them in both urban and rural areas. Consequently, a majority of young people have stated that they did not use condoms during their first sexual encounters, especially among those who began sexual relations early<sup>11</sup>. Condom usage is more probable when a new partner is concerned to prevent unwanted pregnancy and STIs. Once the relationship is considered to have “lasted” or is heading towards marriage, condom use disappears. Not surprisingly, one of the obstacles of condom use is the insinuation of a lack of confidence in the other partner.

Even though abortions are illegal, young women continue to seek out and have abortions done clandestinely or in neighbouring countries where it is legal.<sup>12</sup>

### **1.4. Priority Sexual and Reproductive Health Issues Facing Young People**

#### Marriage and Fertility

*Early Marriage:* Burkinabé women marry quite young. Results from the DHS show that the majority of young women 20 – 24 years old (88.3%) were married or living with a man at the time of the study. Among women included in the study between the ages of 25 – 49 years, 63% of them stated they were already married by the age of 18. However, only 1.4% of boys between 15 and 19 years are married. The percentage of girls married in this age group is higher than that of boys.

*Early and Unwanted Pregnancies:* The DHS showed that the overall rate of fertility among 15 – 19 year young women was 72/1000 in urban areas compared to 163/1000 in rural areas. This indicates that young women in rural areas are more liable to having a child than those in urban areas.

The frequency of early pregnancy is highest between 15 and 17 years. Age of adolescent at birth of first child:

< 15 years	2.2%
15 – 17 years	11.6%
18 – 19 years	6.3%

Adolescents less than 19 years old represent 20.1% of the total fertility in country.

Consequences of unwanted pregnancy among young women in school are clandestine abortions, refusal of young men to recognise their paternity, family problems and abandonment of school and the baby.

<sup>11</sup> Enquête de Connaissances, Attitudes et Pratiques (CAP) des Populations Burkinabé sur las Santé de la Reproduction et le Code des Personnes et de la Famille, Rapport Final Juillet '01

<sup>12</sup> Verbal communications from various health care professionals involved in ARH from government and NGO sectors, as well as volunteers working with ABBEF.

According to the Demographic Health Survey (DHS), the average age of first sexual relations is between 15 and 17 years for women. Forty-five percent of these take place in a marital context and 38% before marriage (WHO, UNICEF, UNAIDS, USAID, "Health of Young People" 2000).

*Patterns of Contraceptive Use:* Knowledge of modern contraception among 15 – 19 year old boys and girls in a couple relationships is 86.4 and 70.4% respectively. Of this group 13.8% use some form of contraception, 9.9% of which use a modern method. In general, prevalence of modern contraceptive use among married women is higher in urban areas (20%) than in rural areas (3%).

Predictably, knowledge about contraceptives is higher among those surveyed in school. Adolescents surveyed in informal settings indicate that only 13.4% know how to avoid pregnancy. This indicates that there is still insufficient FP information reaching young people in informal settings and has a direct effect on contraceptive use.

Among adolescents surveyed in a school environment, 79.3% approve of using modern contraceptive methods, especially condoms as they prevent both unwanted pregnancy and STI/HIV infection. Young men in schools who favour modern contraceptive methods (81.8%) do so for these same reasons. Those who disapprove of contraception base it on rumours, such as oral contraceptives can cause sterility or amenorrhoea, other contraceptives can cause illness and condoms are not effective because they can tear.<sup>13</sup>

Among schooled adolescent girls <18 years, more than half reported that they do not use any method of contraception. They consider themselves either too young or stated that they have not had any sexual relations. Adolescent boys of the same age group declared themselves to be more sexually active than girls, and 63.9% confirmed that they used some form of contraceptive.

According to the DHS the prevalence of contraceptive use remains low in BF: only 5% of women in a couple relationship and 13% of men in such relationships use a modern method of contraception. However, unmet needs in family planning are estimated by DHS to be at 26% of women in couple relations, consequently if this demand is to be met the percentage of women using modern contraceptives would be up to 38%.

### Access to Quality RH Services and to Education

Public health structures are organised in 3 levels:

- The first level is the Health District and consists of: (i) the first rung in the health structure is the Health and Social Promotion Centre (CSPS); and, (ii) the second rung is the District Medical Centre with the Surgical Annex (CMA) that serves as reference points for all CSPS of the district;
- The second level is represented by the Regional Hospital Centre (CHR) that serves as the reference point for the CMA; and,
- The third level is the National Hospital Centre located in Ouagadougou.

Despite the efforts undertaken (reform plan launched by the MoH and the importance of external aid in the sector), the quality of care at the secondary and tertiary levels (emergency care and referral levels) remains extremely weak. The poor quality of services may be explained by, insufficiencies of hospital management, the absence of norms in personnel, equipment and care, weak technical expertise and the absence of maintenance. The consequences of these weaknesses present strongly in the area of maternal health as essential obstetric needs are not generally covered and the majority of women do not have

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<sup>13</sup> Sida Retro-Infos "de la Connaissance a l'Action"; #006 2002; Burkina Faso

timely access to emergency care. The quality of care at the first level is also imbalanced (only 60% of CSPS and 40% of CMA respond to the established norms of needed personnel), explaining in part the weak rate of usage of public health services at this level.

Private health care is partly made up of associations and religious affiliations, which usually offer a package of services that mirror those offered in the CSPS but at a slightly higher price for a better quality of service. The other part of private health care is made up of private for profit providers. The quality of the latter structures are very heterogeneous, much more expensive and for the most part found in Ouagadougou and Bobo-Dioulasso.

Traditional medicine remains ever-present and extensively consulted. It is recognised by law (19 May 1994) within the Public Health Code. Nevertheless, these practices are neither controlled nor evaluated. Purchasing of medicine, including contraceptives, in the streets or market occurs widely in spite of CAMEG having been put into place and the government's adoption of a strategy to favour essential and generic drugs.

Basic primary and secondary public education also has its deficiencies: a lack of teachers (outside of Ouagadougou and Bobo-Dioulasso); schools that are either lacking or in poor states; absence of pedagogical material and schoolbooks; etc. Consequently, classes are overcrowded (up to a 100 students per class), the quality of teaching is mediocre and an important part of the young population does not have access to schooling. Private schools exist (some by local profitable-making NGOs) but are far from covering the needs of the population or within their geographical or financial reach.

### Safe Motherhood

The combined effects on young women of early sexual debut and marriage, early childbearing, poor access to services, complications arising from excision, and low contraceptive prevalence result in high levels of unwanted pregnancies and unsafe abortion. Data on the prevalence of unsafe abortion are difficult to obtain, as the practice remains illegal as well as the shame associated with it.

During the last 5 years 63.7% of young women <20 years gave birth at home and unassisted births in this population occur more frequently in rural areas (73.8%) than urban areas (9.3%)<sup>6</sup>.

In 1998 the maternal mortality rate remained high at 484 per 100,000 births. The contribution of adolescent maternal mortality was 23.4%.

Among mothers aged less than 20 years old 37.6% did not consult anyone for prenatal care during their pregnancy, compared to 60.8% who consulted a midwife or nurse, 1.4% who consulted a doctor, and 0.2% who consulted a traditional midwife. Infant mortality is at about 140/1000 when the mother is less than 20 years old.

### STI/HIV/AIDS

At present, the epidemiological system used to measure the rates of HIV and AIDS in Burkina Faso do not all consider age specific categories. However, basic data from 2001 from 5 sentinel sites, Bobo-Dioulasso, Ouagadougou, Ouahigouya, Tenkodogo and Gaoua indicate the following prevalence rates among 14 – 19 and 20 – 24 year olds:

14 – 19 years old:	#541	2.4% HIV+	<sup>14</sup>
20 – 24 years old:	#825	5.3% HIV+	

Young women are 4 times more likely to be HIV infected than young men of the same age.

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<sup>14</sup> Bulletin SIDA RETRO INFOS, No. 6; Dec. 2002, Burkina Faso



The distribution of STIs among young people is difficult to determine as the breakdown in by age is by 10-year increments: 10 – 19 years, 20 – 29 years, etc. The percentage of STIs diagnosed from January to September 2002 among 10 – 19 year olds and 20 –29 year olds was 13.7% and 52.5% respectively. The DHS reveals that in general 15 –19 year old adolescents are not well informed about STIs. Of adolescents in schools asked if they received information and advice about STIs, more than half of them said they did.

In rural areas 95% of adolescents stated that they did not know STIs, and a minority of those who said they had heard about them were unable to name them or give any signs or symptoms. By contrast AIDS is better known everywhere<sup>15</sup>. This indicates that there is still insufficient information about STIs while there is a larger impact from IEC campaigns on HIV/AIDS.

### Gender Based Violence

Young women are exposed to various forms of gender-based violence: genital mutilation, forced and early marriages, prostitution, rape, sexual harassment, conjugal violence, polygamy, rites at widowhood, etc. A study undertaken in 1998 by a network on IEC and training of women (RECIF-ONG) identified 3 categories of violence that young girls and women are subjected to: physical, psychological and moral. The study revealed that sexual violence is most often expressed by: excision, often practiced after rape and in conjunction with rape as part of the marriage process in certain ethnic groups; forced sex within marriage (rape); obliged sexual relations with a husband regardless of his STI or HIV status; early sexual relations subsequent to childbirth and without the woman's consent; sexual abuse of young female relations of the wife (sisters and cousins); young female students are often subjected to sexual aggression by young male students or teachers.

Economic, socio-cultural and religious obstacles limit the extent to which laws actually protect women's rights, especially against violence, including excision, rape, sexual harassment, prostitution, wife beating, early and forced marriage. Conjugal violence against women affects all social categories of women without distinction to age, ethnic or social origins. The law prohibiting excision is still new, and while verbal communications indicate that people are beginning to change their attitudes it is still a common practice in Burkina Faso. It is most commonly practiced among ethnic groups who are of the Islamic faith (78%) compared to Catholics (69%), others faiths (61%) and Protestants (56%). It is frequently practiced in rural areas, and particularly in the western and northern regions of the country (86% and 81% respectively). The ethnic groups with the highest percentage of women excised are: Dafing 93%, Sénoufo 90%, Lobi 89%, Samo 87%, Dagara 86%, Bobo 85%. Women among the remaining 6 major ethnic groups are excised 46 – 75% of the time (DHS '98-'99). Medical complications, the recent law and outspoken discussions on the subject appear to be changing attitudes; however, it is still too early to measure any difference in practices or determine if the procedure is being done clandestinely.

### Commercial and Transactional Sex Among Young People

As in any other low-income countries, young Burkinabé, for the most part women, as young as 15 are entering into sex work, usually due to poverty and lack of other employment opportunities. In addition, transactional sex is not uncommon, particularly among students and young girls seeking job opportunities.

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<sup>15</sup> Etude sur les adolescentes mariées et non mariées, Population Council, March 2002

### Risky Practices

The extent of drug abuse among young people is unclear. Verbal reports indicate that drug and alcohol use are on the rise among young people. The most common drug used is inhalants. This is particularly among youth in urban areas. Reports indicate that the use of alcohol and drugs also leads to sexual violence.

## SECTION 2: THE STRATEGIC PRIORITIES OF THE COUNTRY PROGRAMMES

### 2.1. The Strategic Priorities and Objectives of the UNFPA Country Programme

#### Relevance

##### *Overview*

UNFPA has held young people's RH and rights in high priority since before ICPD, but ICPD and ICPD+5 gave more focus and impetus into these issues, resulting in the elaboration of guidance notes and protocols for country level use.

Over the same period, a parallel evolution was occurring in Burkina Faso. UNFPA, as well as ABBEF and other partners, had already recognised and shifted the focus of RH activities and rights issues to young people. After 1999, RH needs of young people began to be an operational priority within the UNFPA country office. This priority is clearly evident within the current project cycle (2001 – 2005), which includes several projects specifically targeting young people, for example BKF/05/01/06 "BCC of Adolescents and Youth in SRH" and BKF/05/01/11 "Strengthening of Social and Health Services to Meet with SRH Adolescent Needs". The shift in focus is also reflected in the proportion of UNFPA's country budget devoted to activities aimed at improving young people's reproductive health. Within the current funding period of 2001-2005, those funds allocated specifically to programmes for young people total US\$ 1,628,000, accounting for 20.5% of the overall budget<sup>16</sup>. UNFPA and EU interests in maternal mortality are also converging in a project that will be launched in early 2004 to focus on young women and maternal mortality.

##### *Partners and Activities*

Since 1992 UNFPA has taken on a multisectoral approach to provide institutional support to more and more ministries in addition to the MoH, e.g. Ministry of Basic Education, Ministry of Higher Education and Research, Ministry of Employment, Labour and Youth, Ministry of Social Affairs, Ministry of Culture and Arts and Ministry of Economy and Development. NGOs and other civil society organisations are also supported by UNFPA but this is done through the government who is the executing agency for the programme. National capacity building has been a significant focus of UNFPA activities and the Agency has worked to strengthen both government and non-governmental partners. Areas of focus have included the integration into activities of a rights based approach and gender issues as well as promoting the involvement of men in RH planning.

During the 5<sup>th</sup> project cycle UNFPA is focusing its RH activities, including service support, in the 3 UN concentration regions (Fada, Dori and Tenkodogo) selected according to poverty criteria. This includes 11 districts, in which 5 centres per district are touched, totalling 55 centres in the country. This represents 7% of health centres (CSPS) in the country being addressed. The targeting of these areas was based on the overall UNDAF for Burkina and was intended to take into account the activities of other development partners as well as the government's decentralisation programme. The intent was to produce visible results in a defined area as opposed to scattered interventions.

Several people from both government services and the donor community voiced concern over limiting the support of services to these zones. However, a joint WHO/UNICEF/UNFPA impact assessment took place at the end of June 2003 and noted measurable impact in the programme zones. The proportion of the UNFPA country programme devoted to policy development was obvious in the 4<sup>th</sup> cycle (1997 – 2000) in that a specific sub-programme

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<sup>16</sup> Figures received from UNFPA country office

was dedicated to lobbying and supporting several policy changes relevant to youth: the Family Code, the Penal Code on Excision, and the Convention for the Eradication of All Discrimination Against Women. The current programme cycle has an integrated approach with a coherent balance among policy development, strengthening services and IEC activities. In addition to the shift in strategic priorities, UNFPA has also taken into account that programme planning had been project oriented rather than result oriented. The current country programme (5<sup>th</sup> cycle) reflects the “results based management” approach that UNFPA is instituting globally.

Contraceptive security has been a longstanding concern of UNFPA, and this area of work impacts the quality and accessibility of SRH services for all clients in Burkina, including youth. Until 2001 UNFPA and the World Bank were the major suppliers of all contraceptives in country (80%), except for condoms. Since the end of the WB credit (PPLS) UNFPA agreed to meet 70% of contraceptive needs. UNFPA has been playing an advocacy role so that appropriate government funds are used for this purpose, and has been instrumental in negotiations between MoH and WB to obtain financial resources (from the Health Support Programme) for the purchase of contraceptives. There have been significant logistical problems, but UNFPA has recently funded the training of one member of the Ministry of Health in contraceptive security with a view to providing support for the development of a security plan. This is an example of the degree to which UNFPA supports key components of the government SRH programme, and the challenge of sustainability in public services.

Coordination and collaboration among stakeholders and partners in the health sector in Burkina are strong. UNFPA works closely with development partners in the UN system as well as with partners working in education and themed areas (gender, HIV/AIDS). In addition to its involvement in monitoring the National Health Development Plan (PNDS), it also partakes in current discussions on the new sectoral approach being taken by the donors within the health sector. At the present time the UNFPA strategy remains vertical versus the new sectoral approach that is gradually being put in place (95% of all external health funding is still earmarked for specific programmes). The country office, however, is well aware of this new approach (which is in line with UNFPA headquarters policy), and is preparing to advocate and lobby to ensure that RH and population activities will be given due share from the common basket resources. UNFPA is currently tied to the country programme cycle and will only be able to modify its programming during the 6<sup>th</sup> cycle in 2006, (see 3.1 for further information on civil society).

### Integration of Rights

During the 4<sup>th</sup> country programme cycle there existed a “Sub-Programme Advocacy” whose objective was to bridge the gap between the existing legal framework and its application. This specifically addressed the Family Code, the Penal Code on excision, and the Convention on the Eradication on All Discrimination Against Women, (see 2.1). While these activities were at a high national level, they were also integrated into other sub-programmes during the 4<sup>th</sup> and current cycles. There has been extensive lobbying and promotion for the eradication of excision that has filtered down to community level activities, especially within IEC campaigns. UNFPA’s programmes coherently address young people’s SRH rights. While gender issues are in general properly addressed in strategies and the methodologies used to implement activities of the various projects, UNFPA staff do not receive any specific training in young people’s SRH rights. The project directors at government level have, however, received training in this issue.

### Sustainability

The principle weakness of UNFPA programming is poor project sustainability. This appears to be common to the various programme cycles as well as the specific projects within the

sub-programmes. The notable exception to this thus far is directly relevant to youth SRH: the work UNFPA has supported in the education sector with the Direction of Population Education (DEmP). Population and SRH issues have become an integral part of the primary and secondary systems and are also integrated into training of teachers. The Director of DEmp believes that the success of this intervention lies in the fact that it has moved beyond a project approach and facilitated the incorporation of SRH issues into the overall strategy of the educational system.

In the other projects the lack of sustainability has been due to a number of factors:

- During the planning process there has not been a clear transitional devolution process to government structures.
- Ministries with which UNFPA has worked have not been sufficiently involved in the planning and implementation stages of the projects. Consequently, there appears to be a lack of ownership and realistic means to assume the continuation of the activities.
- Revenue generating schemes that have progressively been integrated into projects in the 5<sup>th</sup> cycle are on the whole inefficient.
- The lack of resources allocated within project budgets to the maintenance and upkeep of equipment and vehicles has resulted in project owned material not being maintained and often not useable at the end of the project period. Project activities are also hampered or delayed by poor maintenance.
- A great deal of project success depends largely on volunteer commitment. There have been efforts to address maintaining volunteer participation and motivation, especially of young volunteers during the life of the project; however, when the project will have to be turned over to the corresponding ministry it is not apparent that the motivational methods used to continue working with volunteers will be available, i.e. monetary remuneration for educational sessions.

Although acknowledging the very real difficulties of promoting youth SRH in a developing country like Burkina Faso, there are areas where the sustainability of UNFPA's interventions can be improved and this should remain a priority.

## **2.2. The Strategic Priorities and Objectives of the FPA National Programme (ABBEF)**

### Relevance

#### *Background*

ABBEF was created at the end of 1979 and officially recognised by the government in early 1981. It was initially established to combat the practice of expelling pregnant girls from school and to sensitise the general population as well as national and local authorities on birth spacing. Initially, activities were conducted in Ouagadougou and Bobo-Dioulasso. In 1981 IPPF and ABBEF first began their collaboration with IPPF contributing financial and technical support for both the implementation of activities and recruitment of permanent staff. In 1985 IPPF supported the restructuring of ABBEF and its mission to support, advocate and deliver family planning matters in Burkina.

ABBEF's strategic objectives are:

- provision and delivery of FP services;
- development of IEC/BCC in SRH activities;
- development and strengthening of human, material and financial resources in the SRH area.

The majority of ABBEF's annual budget is dedicated to the provision of sexual and reproductive health services. The split among service provision and other activities in the 2002 budget was as follows:

- Administration: 12.7%;
- Advocacy: 8.67%;
- Reproductive and Sexual Health: 67.91%;
- Information, Education and Communication: 10.71%.

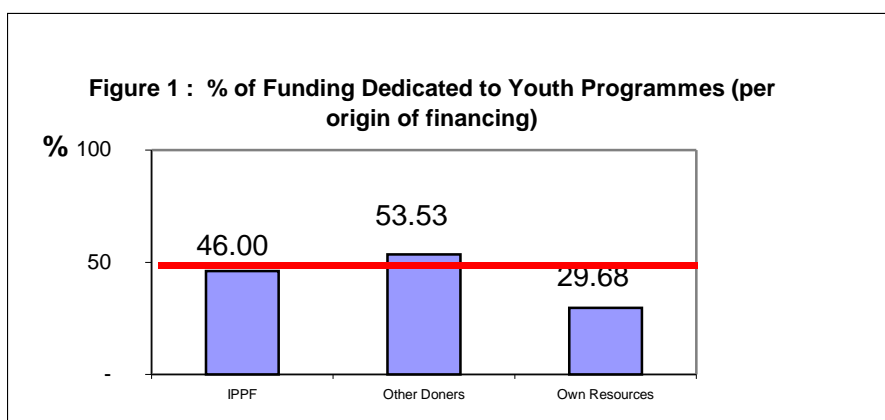
Both objectives and resources target young people. ABBEF has had a deep-seated philosophy and practice of working for and with young people since its inception, and this is demonstrated at all levels including the way in which it allocates its resources and financing. During the period of 1996 – 2002 the average percentage of funds earmarked specifically for youth programmes was 48.15% (see figure 1 below, where the red line represents the % of the ABBEF budget dedicated to youth programmes). Other ABBEF activities not reflected in this percentage also include young people, but within a wider target population.

Nearly 30% of income generated by the sale of contraceptives, consultation and membership fees and other revenue sources, was used to support young people programmes during this same period. Figure 1 illustrates the percentage of funding dedicated to young people's programmes according to the origin of financing. It is difficult to determine the percentage of time personnel spend on purely youth-related activities, due to the integrated programme approach that is taken.

ABBEF has a history of piloting new approaches to reproductive health at the policy level and through offering health services to young people. They pioneered policy and innovative reproductive health strategies directed to young people prior to ICPD. For example, ABBEF lobbied for the reform of the 1920 law prohibiting any form of use and promotion of contraception, which was finally achieved in 1986, and included a policy of access for youth. ABBEF were also a catalyst in advancing and supporting the development of the Family Planning policy for Burkina Faso with the first training of midwives and doctors in family planning techniques and practices in Burkina Faso.

#### *Youth Friendly Centres*

The first two youth friendly RH service centres were opened by ABBEF in 1992 in Ouagadougou and Bobo-Dioulasso. The centres began by offering services and information on SRH to young people and two further centres were opened in Koudougou and Koupela in 1996 and 1997 respectively. The centres cater to young people under 24 years of age. In addition to the youth friendly centre in Koudougou, a further centre exists providing RH services and information to a broader target group, which is also frequented by young people. These youth friendly centres have served as a model for the government and other partners working in the field of SRH needs of young people.



While the focus of ABBEF's activities is on young people under 24 ABBEF remains committed to ensuring that clients continue to seek care outside of the youth centres. The fact that ABBEF has made a clinic available for people >24 years demonstrates their keen perception to the needs of young people as they mature and pass the age at which they could continue to attend the <24 youth friendly services. Feedback from young women who are no longer within the age range to attend the youth services are often unhappy with having to leave the quality services offered by ABBEF. This particular response offers the possibility for continuity of such services to young women.

ABBEF has a clear and comprehensive understanding of the issues that young people face with regards to their sexuality and reproductive health. This is due to a confluence of several factors. Both staff and board members come from diverse backgrounds that lend themselves to such understanding (i.e. sociology, health, education, communication, media); these same people have or are presently working (in the case of volunteer board members) with government or other organisations that also work on RH and young people; planning is based on the monitoring and evaluation system that ABBEF has put into place as well as base-line information that they have gathered through punctual studies. Overall, ABBEF programmes encompass various groups of young people, including vulnerable ones. However, the focus by default is on those young people who are both literate and in school. Programmes targeting vulnerable young people including those not in school or those who are illiterate rely mainly on peer educators and have limited scope.

ABBEF has not been actively involved in the recent discussion and planning for the adoption of the new sectoral approach in the health sector.

### Integration of Rights

As mentioned earlier, ABBEF has been in the vanguard of many rights based issues concerning RH of young people, e.g. eradication of excision, rights of young girls to an education without regard to pregnancy, FP and youth friendly RH services, etc.

RH rights of young people are integrated into many of the activities that are carried out to disseminate information. In the strategic plan for 1998 – 2003, strategy #3 (“strengthen and develop actions for women to able to make decisions about their SRH”) has specific objectives that are rights based:

- reach 60% of women to become aware of their SRH statutes;
- reach 80% of people in positions of authority in the justice, health, social action systems as well as parliamentarians and religious and traditional leaders to set down actions that favour the rights of women in RH.

In the IEC/BCC project (2.01) “National Campaign of Sensitisation on FP and RH”, SRH rights are mentioned in both the general and specific objectives for 2000 – 2003. This includes improving knowledge about legal barriers regarding RH and rights of women, and providing legal assistance to at least 100 women who have rights related difficulties.

Various projects during this period include rights based objectives and activities, including the empowerment of women to have more control over their sexual and reproductive health; sensitising decision makers, leaders and men on traditional practices harmful to women's health; involvement in conferences and discussions on excision, and other harmful practices to women within the Consultative Group on Women. Many of these activities were at the national level, but regional offices were also involved with provincial committees addressing excision and issues within the family code.

Reproductive rights in general appear to be biased towards females given the nature of the problems in the socio-cultural context. While SRH services are available to all young people, the majority of users are female. Attention is paid to ensuring that both young women and men are PE; however, there are at times a larger number of men than women are recruited. This has more to do with who comes forward to be a volunteer PE and the socio-cultural limitations that are put on young women.

### Sustainability

Both institutional and financial sustainability are an issue for ABBEF. The organisation is heavily reliant on donor funding and although a cost recovery scheme is in place in 2002 the amount of revenues received totalled no more than 10% of overall costs within the youth programme. The principal growth of funds in the budget continues to be from donor driven projects and this may well be cause for concern as Burkina moves closer to adopting a SWAP approach. In 1996, 29.6% of the budget was from external sources, by 2002 this the percentage had increased to 48.5%.

A wide range of donors support the youth friendly centres, including both bi-lateral donors such as the German government, USAID, the World Bank and specific IPPF programmes. ABBEF also receives significant funding from international foundations and Embassies in country.

ABBEF does have a limited cost recovery scheme within its youth friendly services that contributes to the running of certain activities. This includes revenues from the sale of contraceptives, consultation and membership fees. Given the limited purchasing power of youth, cost-recovery objectives are in conflict with objectives to increase access for youth, especially poor and marginalised youth. ABBEF is also trying to increase its long-term sustainability through the construction of its facilities, and has secured a limited number of staff positions in the youth centres from the Ministry of Health. While sustainability is a noted concern among ABBEF senior management, the focus of activity remains on attracting new donors and securing external funding.

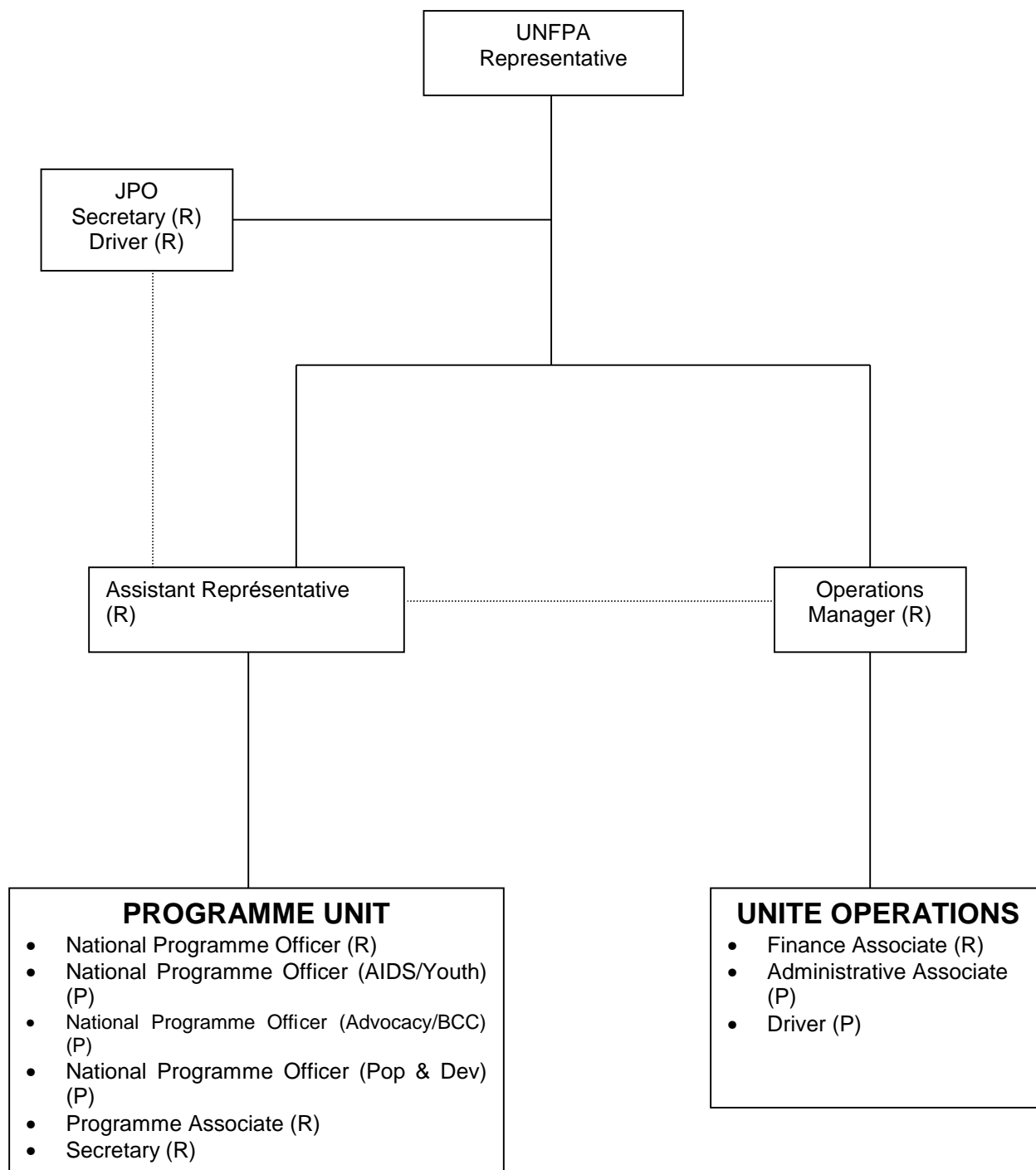


## SECTION 3: INSTITUTIONAL ARRANGEMENTS

### 3.1. UNFPA Country Office

Proposed Organogram of the UNFPA Office in Burkina Faso as of Sept 2003 (Type III)

(R) = REGULAR FUNDING  
(P) = programme funding



UNFPA staff in Burkina Faso CO comprises of 3 members of the professional category (2 nationals and 1 JPO) and 12 members of the general service category. At present the office is divided into programme (9 staff) and admin/finance/support (5 staff) sections. The organogram indicates that the programmatic section is broken down into 3 specific areas: Population and Development; Reproductive Health; and, Technical Support. These 3 sections each have a Programme Officer. The Programme Officer for RH has been detached to the Democratic Republic of Congo for one year, as such the Technical Support Officer has been given these additional responsibilities. The various projects of the sub-programmes and the overall country programme all fall under these three sections in one form or another.

Currently a restructuring of the office is occurring. The transition that is taking place includes: change of job profiles; movement within the office staff to ensure that roles and responsibilities are matched with expertise and capacity; and, the possible creation of 3 new programme positions. It also flattens the organisation so that the jobs are less compartmentalised. The new organogram (see above) was effective as of September 2003. The role of the UNFPA office staff is principally that of technical expertise. This restructuring and additional personnel will strengthen the capacity of both technical and administrative programme management.

In addition, UNFPA supports National Programme Coordinators who are based in the ministry that corresponds to the project being implemented. These Coordinators are responsible for implementation and monitoring of the projects and paid by the Programmes.

Additional expertise is available from the Country Support Team based at the regional office in Dakar, Senegal. This team intervenes at the request of the CO, such as to develop new projects or programmes, to complement office staff and assist in strengthening national counterparts. The CST offers expertise in RH, IEC, HIV/AIDS, youth, gender, population and development, monitoring and evaluation, and logistics. During the evaluation, CST members were present in country to assist in a workshop in the development of IEC material. Country staff are satisfied with the response they receive from the regional level.

The relationship between the CO and headquarters is also fruitful. The Africa Division provides strategic support related to global health and population priorities (ICPD, Poverty Eradication, sectoral approach, etc.). While technical and strategic support is available at various levels, the overall and final responsibility from the conception through to the final evaluation of country programmes belongs to the CO.

#### *Resource Allocation and Financing*

The total UNFPA country programme expenditures and allocations from 1994 to 2003 is \$17,951,358US. The budget has fluctuated slightly during the 10-year period, with a peak in 1997, but overall has increased since 1994 from \$1,199,382US to \$2,983,454US in 2003. During this period 77% of the budget has been from regular funds and the remaining 23% from trust funds. Even though UNFPA was faced with strong financial restrictions during this same period, BF has remained one of UNFPA's privileged countries. One of the two programmes that benefits from the trust fund targets adolescent girl's sexual and reproductive health needs. There are 5 additional programmes which specifically focus on young peoples reproductive health needs. The total budget allocation for the ten-year period specifically targeting young people has been \$2,121,104, which represents 12% of the entire UNFPA country programmes from 1994 to 2003. There has been a trend to increase project focus on young people over the years, such that in 2003, 20% of the annual budget is specifically devoted to young people. While the majority of activities tackle a broader population young people are also included in other country projects along with people older than 24 or younger than 10 years.

### *Monitoring and Evaluation*

There are several monitoring and evaluation systems in place at the national and project levels. Project teams report regularly to UNFPA PO through monthly, quarterly and annual reporting includes both programmatic and financial monitoring. There is a mid term and annual review for each project, which is carried out jointly with the corresponding ministry. Field visits are undertaken on a quarterly basis by the national coordinators. CO and/or CST at times attend these visits. An annual financial audit is conducted for each project. The government may also ask for project audits at any time during the project's life. This has recently been the case for the BCC project (BKF/05/01/06), which has had financial management problems.

The Ministry of Foreign Affairs and Cooperation hold quarterly meetings in which UNFPA and government partners examine the portfolio of country programmes to ensure effective implementation and address any problems that appear. UNFPA and the government undertake a joint annual review of the overall country programme.

Both the monitoring and evaluation systems are, for the most part, used effectively. For example, subsequent to the mid-term review of the 1997 – 2000 programme, a review took place in which oversight the youth friendly centres was transferred to the Ministry of Employment, Labour and Youth in order to strengthen the “Maisons des Jeunes et de la Culture” and set up a referral system to health facilities for young people.

However, not all projects are systematically evaluated although this is increasingly a reflection of the use of mid term reviews under the new programming approach.

### *Partnership and Collaboration*

As a technical and financial partner UNFPA actively participates in periodic meetings with other development partners in areas including health, education and HIV/AIDS. As a member of the UN group UNFPA attends periodic meetings held in the framework of the co-ordination committee, which brings together agency directors, relevant sub committees and theme groups. There is a strong solidarity and close relationship among UN agencies, specifically WHO, UNICEF and UNFPA and UNFPA attends regular monthly meetings for general health issues as well as the UN Theme Group for HIV/AIDS. Programme operations and site visits are jointly coordinated to complement one another in the three convergent zones (Fada, Dori and Tenkodogo). UNFPA is also a member of the committee designing and developing the SWAP approach for Burkina Faso.

There are two separate mechanisms of coordination that are used with government and key partners at the national and regional levels, one related to population issues and the other to reproductive health issues. The Commission on Family Planning, under the auspices of CONAPO, which coordinates activities related population issues in the country. An important element of their work is to elaborate national framework and policies on population matters. They are presently in the stages of preparing an assessment of the situation in country 10 years after ICPD. The Commission orchestrates government and key partners involved in population and reproductive health programmes in this endeavour. UNFPA has been actively involved in the technical aspects of developing this framework. At the regional level, population activities are coordinated and monitored under the umbrella of the Regional Direction of Economics and Development (DRED). UNFPA project staff participate in the quarterly meetings.

Coordination of reproductive health matters take place through bi-annual meetings that are called by the DSF, in the MoH. This group has developed a technical framework for the period of 1998 – 2008 on RH with the technical support of UNFPA.

UNFPA works closely with civil society through NGOs, associations, and community based organisations, most especially in their work with young people. UNFPA works through this channel to carry out project components. Among the many NGOs and associations that work with UNFPA several important ones working in the RH programme in the last two country cycles are ABBEF, Population Council, ALAVI, AFASI, et al. UNFPA has played a pivotal role in structuring the non-governmental partners, and establishing partnerships among this group. Following the ICPD, UNFPA initiated the creation of a national network of NGOs working in RH among adolescents and young people (RENAJEP/SRAJ). Unfortunately, this network faltered as a result of conflicts regarding leadership among the associations and their capacity to develop a realistic mandate. While this network still exists on paper, it is no longer functional. The African network of young people against HIV/AIDS (RAJS) is also supported financially by UNFPA as well as UNICEF. The network has more than 200 NGO members, and another 100 requests for membership. The financial support received is dispersed to network members who have worked together in an effort to co-ordinate and maximise their impact in terms of material and participative methods. UNFPA has a close relationship with ABBEF and supports them and supports them financially through specific training and contracts, for example sponsoring ABBEF staff for training in IEC/BCC, developing workshops on health for young people and also through government and other agency sub contracting.

### Integration of Rights

Following the ICPD UNFPA was one of the first to undertake an advocacy role in RH and rights, especially among young people. The government of Burkina Faso turned to UNFPA for assistance in the application of the Family Code, which addresses issues including marital status, forced marriages, women's rights, etc. UNFPA has also played a crucial role in offering technical assistance in the area of legislation against genital mutilation (see 1.2).

UNFPA has the highest rate of gender balance among UN agencies. This is also reflected in the CO. UNFPA follows the same lines of employment practices as other UN agencies, and often stipulates that women are encouraged to apply for positions.

Various routes are open for young people to work in UNFPA. The CO presently has a JPO in place. The office has also had a couple of young interns.

UNFPA follows UN policy regarding HIV/AIDS and personnel issues, including hiring, firing and health benefits.

### Capacity

Most of the UNFPA CO staff are Burkinabé and have worked either within the government reproductive health sector and/or with NGOs working in RH and young people. In addition, several of them have a background in sociology. This long time involvement and basic cultural understanding has been valuable in the understanding of the RH issues that young people face. However, this informal understanding has not been supported by formal training in the SRH needs and rights of young people. UNFPA staff do not receive any training on these issues although they provide it to project directors at government level.

The UNFPA staff have been instrumental in advocating and bringing about the creation of key entities such as the Direction de Sante Familiale, Direction de l'Education en matiere de Population and the CONAPO. The latter coordinated the revision of the National Population Policy in 2000 in order to ensure the integration of the ICPD PoA into the National Population Policy.

While there are no formal mechanisms aimed at involving young people in the planning, implementation or monitoring of the country projects/programmes, they are clearly active in these areas. Their needs in SRH are taken into consideration in defining projects, they are involved in the implementation phase at various levels (development of IEC material, PE activities, young people associations, etc.), and PE reports are used as a monitoring mechanism of projects. This informal methodology works well and feedback from young people indicates that they feel implicitly involved in SRH activities. Involvement tends to be on a project-by-project basis. Examples include: the CCC/SRAJ project, which has been designed and developed by the Ministry of Young People and Sports in close collaboration with young peoples' associations by involving the 'House of Young People and Culture' in Dori, Fada and Tenkodogo; and also the AIDS project, which has worked with three associations of young people (ALAVI, RAJS, APJAD) to develop, implement and monitor project activities. They report directly to the Permanent Secretary of the National Advisory Body for the fight against AIDS (SP/CNLS).

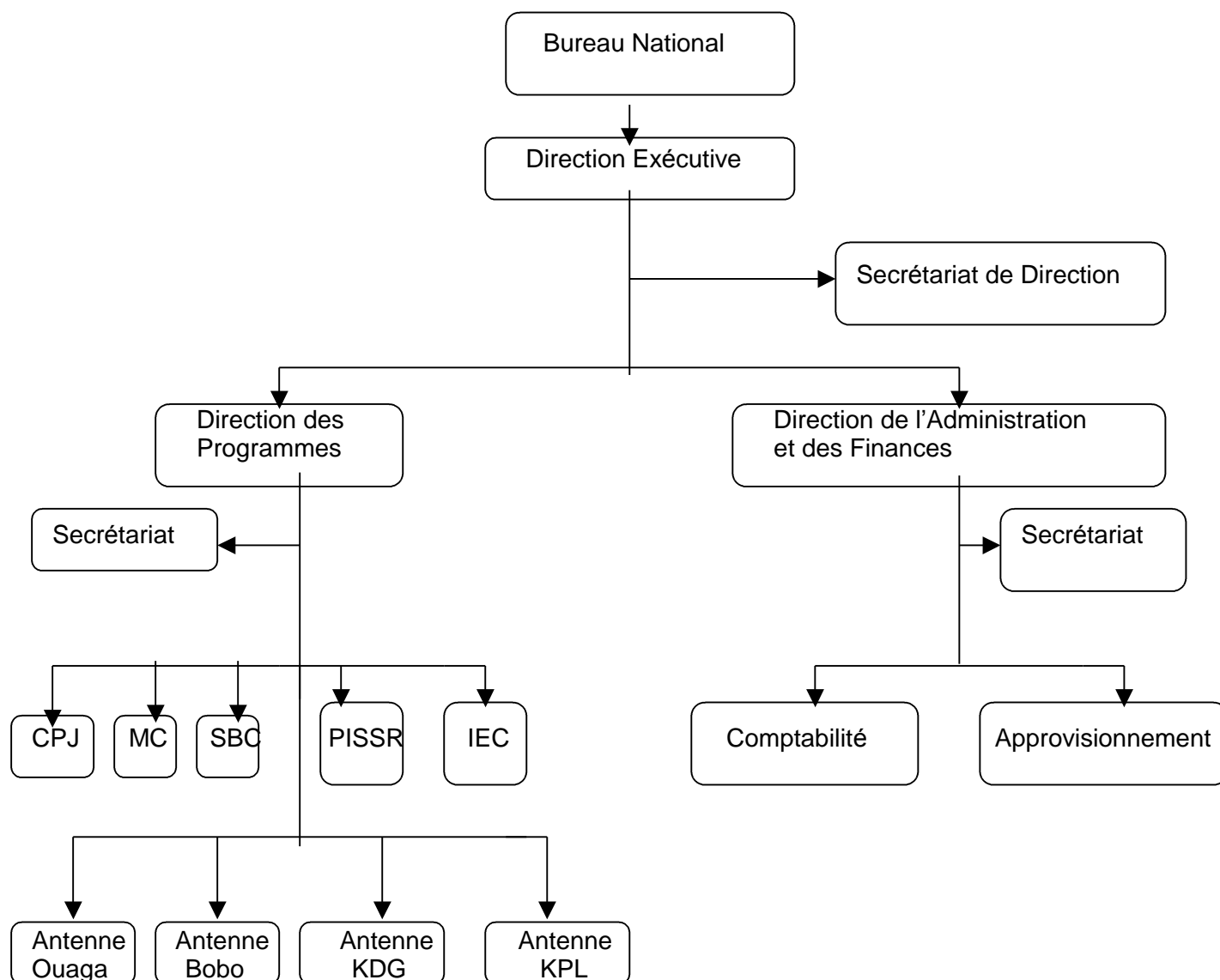
### *Planning*

Evidence based planning has been slow in reaching the CO, and in fact has been an issue for UNFPA in general. UNFPA began to address this challenge in 2000 through a series of training of UNFPA and national staff. Prior to the 5<sup>th</sup> cycle, planning was activity oriented; it has now become more results oriented. The shift from a project based to a programme approach was adopted to ensure that all projects are in synergy. The two sub-programmes are coordinated by two entities, with one overall coordinating body. This mechanism was established to ensure that projects do not operate in isolation and become "vertical". It is hoped that the adoption of this approach will facilitate UNFPA's involvement in the proposed sectoral approach. There is however no mechanism for the identification and adoption of best practice and the challenge remains of guaranteeing that lessons learned are extracted and used for future projects or to modify present ones.

As mentioned in 3.1 CST supports the UNFPA team in its technical needs.

### 3.2. The FPA (ABBEF)

#### FPA Organogram



- M&C** : **DIVISION MEDICALE ET CLINIQUE**
- SBC** : **SERVICES A BASE COMMUNAUTAIRE**
- IEC** : **INFORMATION EDUCATION COMMUNICATION**
- CPJ** : **COORDINATION PROGRAMME JEUNES**
- PISSR** : **PROJET INTEGRE DE PRESTATION DE SERVICES EN SANTE SEXUELLE ET DE LA REPRODUCTION**
- KDG** : **KOUDOUGOU**
- KPL** : **KOUEPELA**

ABBEF was created in 1979. They were awarded a full standing membership of the IPPF family in 1989. This membership affords ABBEF stability, sustainability, legitimacy and clout within the health and development community. In this status they participate in the annual regional council in Nairobi, and benefit from technical support, funding and material from IPPF. They produce bi-annual activity and financial reports as well as external audits that

are then sent to IPPF London. A logical framework with benchmarks is used to monitor on going activities in all projects. All ABBEF projects also have systematic mid-term and final evaluations.

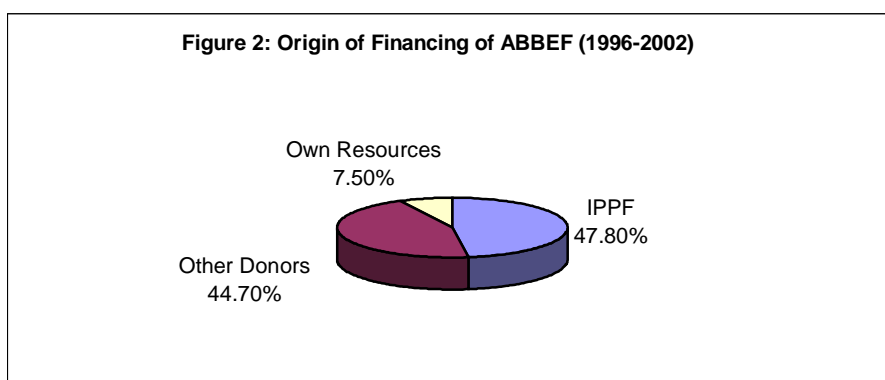
In 1994 ABBEF was state approved, offering them such privileges as having government personnel seconded to their centres as well as fiscal advantages, such as being given land to build on, the main office building was built with funds from a WB (PPLS) credit to the government and they benefit from a an exoneration of taxes on imported supplies and equipment.

There is a general assembly of all ABBEF members every two years, which elects 6 people to the Executive Committee, and 6 to the National Board. The National Board meets trimestrially for planning activities and for overall programme decision-making. The Executive Committee meets monthly to monitor programme activities, including recruitment. In each of the 10 ABBEF regions a regional assembly elects a regional board, which has to monitor their respective activities. The National Board is elected from among the regional representatives. At the local level “sections” elect their own committee members that identify needs and propose project activities. Board members at all levels contribute their time and work on a voluntary basis. The system works to ensure that the needs identified at community and grass roots level are incorporated into the decision making process and communicated up through the management structure.

Thirty volunteers are needed to create a “section” in a given area. A minimum of 3 sections is then needed in order to open a regional sub-office. Currently there are 4 regional sub-offices in the country. These sub-offices all have fully functional youth friendly centres that carry out SRH activities for young people, including FP/STI/HIV advice and clinical services, sensitisations campaigns on SRH and rights of women, peer educator activities and leisure activities.

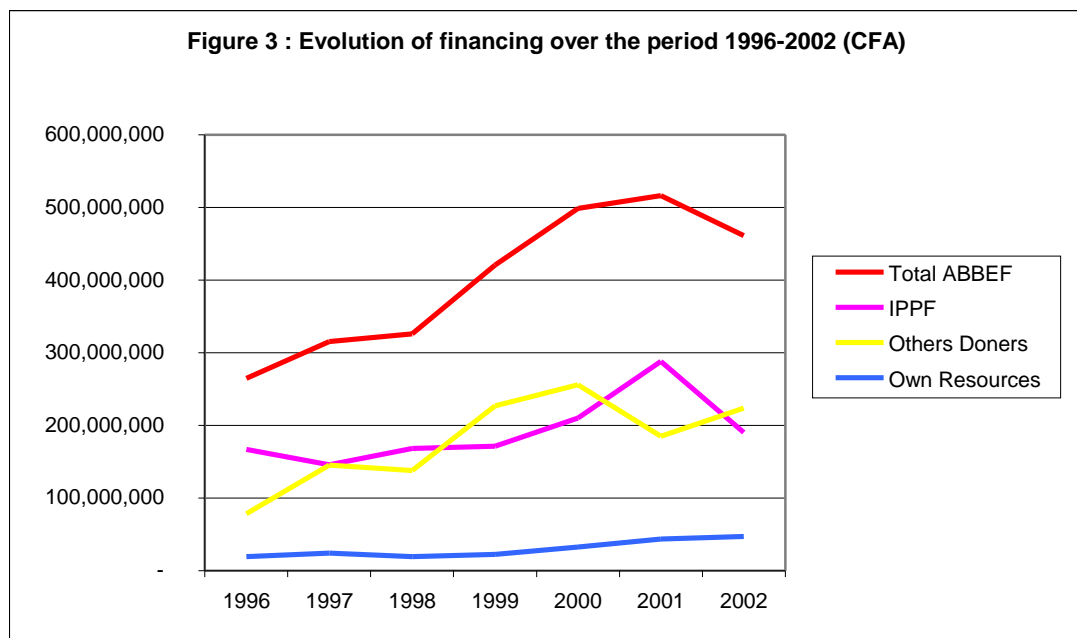
#### *Resource Allocation and Financing*

ABBEF’s overall budget has increased from 264,849,365CFA to 461,260,842CFA between 1996 and 2002; the cumulative total budget over this period was 2,803,170,292CFA (4,273,777 €) (see figure 2). Of the 2002 budget 12.7% was allocated to administrative costs, 8.67% for advocacy, 10.7% for information, education and communication line items and 67.91% to supporting youth programmes. Within the overall budget support for youth programmes constitutes approximately 50% (48.15% in 2002).



Funding that ABBEF has received from IPPF over the past 6 years has largely remained the same with slight fluctuations. However, due to expanding activities and a growth in other external and internal funding mechanisms, the percentage of contributions that IPPF makes to the overall ABBEF budget has steadily decreased from 63% in 1996, to 41% in 2002 (see figure 3) (excluding funding for specific projects such as Vision 2000, Sexwise, etc).

Earnings through the cost recovery system (sale of contraceptives, consultation fees, etc.) have shown a modest but continuous increase from 7.4% to 10.3% from '96 to '02 respectively.



The principal growth of funds in the budget is from donor driven projects. Numerous donors support the youth friendly centres including the German government, USAID, WB, Japan and specific IPPF programmes. Funding for youth programmes is also received from international foundations and Embassies in country. In 1996, 29.6% of the budget was received external sources; by 2002 this had increased to 48.5%. While this increase permits ABBEF to expand its programme to a wider population of young people, it poses a number of problems for ABBEF's long-term institutional and financial sustainability. Donors are keen to fund specific projects and are not in general concerned with ABBEF's overall organisational and financial capacity and strategy. Consequently, ABBEF has less flexibility in deciding how the funding may be best used, at times causing an imbalance in supporting centres and their activities. Table 1 illustrates these divergences. Moreover, donor financing often excludes basic expenses such as salaries, technical support and organisational development. This is a serious concern for ABBEF and their long-term sustainability and development as an organisation. Despite this ABBEF's fundraising strategy remains focused on attracting funds from external donors who have an interest in sexual and reproductive health. Although limited cost recovery schemes exist there is little focus on expanding these or developing a long-term strategy to improve ABBEF's financial and organisation sustainability.

Staff salaries in ABBEF are competitive to government and other national NGOs, however, they are considerably less than those paid by international NGOs. This discrepancy creates frustrations and to some extent staff movement to INGOs or UN agencies when the opportunity arises. Donor driven projects also results in irregular centre and activity funding as they are dependent on donor project start and end dates. The decision to support specific centres may be decided either by the donor or ABBEF at the national level.



**Table 1: Budget Allocated to ABBEF Youth Friendly Centres (in CFA)**

Centre Year	Ouagadougou	Bobo- Dioulasso	Koupela	Koudougou
1999	41,647,681	12,388,000	25,880,983	41,830,000
2000	12,469,618	7,125,730	16,242,428	14,166,770
2001	24,528,095	16,038,723	20,387,126	13,391,784
2002	32,943,998	15,903,577	13,069,946	9,260,109
2003	27,811,500	14,605,500	12,775,900	10,095,500

### *Monitoring and Evaluation*

ABBEF has a well developed monitoring and evaluation that includes monthly, trimestrial, annual, mid-term and final reporting. Financial reports are an integral part of this reporting, along with an annual external audit. Projects and programmes are based on a logical framework approach that consists of benchmarks and observations. The observations made during these activities are used when planning new programmes. For example, subsequent to a punctual evaluation undertaken, it was noted that young women coming in to the centres with an unwanted pregnancy were not offered appropriate counselling to prevent dangerous and clandestine abortions. In addition, it was noted that some were coming in subsequent to an abortion and the centres were unable to effectively address their complications. In the following programme, various activities were incorporated to address the situations, e.g. training of personnel and integration of the activities into the packet of services offered at the centres. Staff at the young people's centres supervise and monitor peer educators on a monthly basis, while the regional directors evaluate staff at the young people's centres on a quarterly basis. A monitoring tool has also been developed by ABBEF, which takes account of all project activities including the management of IEC activities both in and out of the centre as well as counselling and clinical services. Quality criteria related to services have also been developed in accordance with current national standards. Two ABBEF clinics have received a 'gold circle' award from the project 'Family Health and Prevention of HIV/AIDS' for the quality of services delivered to clients. Regular checks are carried out on the quality of clinical services and six monthly reviews are carried out by the Head of medical and clinical services to review and improve the capacity of clinics in the prevention of infection, syndromic management of STIs, contraception and opportunistic infections related to HIV.

ABBEF has a management and information system in place, which includes the relevant software for accounting, stock management, intangible assets and staff management. Monthly reports detailing stock supply and demand as well as the safety and expiry of managed stock are prepared by each clinic and centre and then sent to head office who manage allocation and supply.

### *Partnership and Collaboration*

ABBEF is formally under the Ministry of Health and is a highly respected and effective partner. It draws on the technical knowledge and experience of ABBEF. Cross-fertilisation and links between ABBEF and government can be observed in that ABBEF personnel and volunteers (e.g. board members) have or are working in government positions. For example, the Director of Population Education, MoEd worked for ABBEF in the 1980's and is still an associate member.

ABBEF is a member of several co-ordination structures at national level including the co-ordination team of RPH for young people, the Commission for the 'Well Being' of the National Advisory Committee for Population and a member of the team of national educators for the utilisation of the female condom. ABBEF's clinics are used for training by the Ministry of Health's education staff and ABBEF participates in workshops initiated by relevant ministries including the Ministry of Health, Education, Social Affairs and Economic Development.

ABBEF has relationships with several of the bi-lateral and multi-lateral agencies although these on the whole tend to be driven by funding. There is a close relationship between ABBEF and UNFPA. Both organisations have common objectives and similar strategies and they collaborate in the following ways:

- ABBEF receives project funding from UNFPA, for example UNFPA supported ABBEF in the amount of 5,546,375CFA during 1996 –1999 to finance an IEC and training project carried out with the Moslem community on RH for the general population.
- Each organisation invites the other to participate in training workshops, seminars and meetings

ABBEF also has relationships with a range of other NGOs and is a member of the Permanent Secretariat of NGOs at a local level and of IPPF at an international level. ABBEF has also been used as a model for the founding of two other local NGOs and Associations working on reproductive health targeting young people, e.g. ALAVI and PLAN. The founder of ALAVI worked as a Programme Director for ABBEF prior to establishing ALAVI and now works at UNFPA.

### Integration of Rights

ABBEF is an equal rights observer, regardless of age, sex, religion or ethnic background. Everyone has the right to apply for a job and to be a member of the association. ABBEF does not demand a test for HIV when applying for a position, nor does it ask for a person's sero status. The majority of staff at ABBEF also benefit from training in SRH and the related rights of young people.

### Capacity

#### *Staff*

Professional staff at ABBEF include doctors, midwives, psychologists, social workers, sociologists and nurses as well as those who have managerial or accounting qualifications. Staff at ABBEF benefit from training provided by IPPF and other organisations as funding allows. The majority receive training in how to work with young people and in reproductive and sexual health. Training is also provided to volunteers, which is supported by periodic meetings between staff and volunteers. This allows for an exchange of views and highlighting of concerns. There does not however appear to be any formal mechanism for incorporating volunteers concerns or views to ensure relevant feedback.

#### *Young People*

ABBEF is committed to participation by young people in the development of project activities and materials. They are involved in the development of strategies, establishing and monitoring of activities as well as the pretesting and development of IEC materials. ABBEF relies heavily on peer educators particularly to reach those young people not in school or who are otherwise marginalised. Plays, films and discussions are also used to reach those young people who are illiterate. However, there does not appear to be any system for evaluating the effectiveness of these interventions. The majority of peer educators are also male and while this may reflect socio-cultural norms it is of concern for young women who are marginalised or living in rural areas who are unable to access the centres or existing IEC materials. No formal system is currently in place to address this discrepancy although ABBEF encourages broader attendance at its clinics through couple days and integration of services.

#### *Regional Capacity*

The regional office of IPPF, based in Nairobi, offers technical and financial support to ABBEF. Technical support is provided in response to requests and needs identified. Areas of support have included: project management, strategic planning, monitoring and

evaluation, financial management and the integration of HIV related psycho and social issues in service provision and delivery. The regional office also intervenes in the purchasing of various office and bio-medical equipment and supplies, as well as contraceptive commodities. The resources used for these purchases are against the normal ABBEF subventions that IPPF donates to ABBEF. The regional office also offers long distant technical support on a regular basis in the form of reading the various reports and project documents and offering written inputs and feedback. They are available on a punctual basis as may be needed and requested by ABBEF.

## SECTION 4: ENABLING POLICY DEVELOPMENT AND REFORM

### 4.1. UNFPA Country Programme

#### Relevance

Following ICPD particular attention has been accorded to young people who are seen as part of a broader vulnerable population and who have specific needs to be met. Based on this, various advocacy, social mobilisation and training activities have been carried out by UNFPA in partnership with government and NGOs on SRH for young people. Among these activities certain have been steps in preparing policy and legislation reform. For example:

- A forum of RH needs of young people was held in Ouahigouya in September 1997. It was organised by national associations of young people with the support of UNFPA, the Teaching and Research in Demographic Unit (UERD) and the Embassy of the Netherlands.
- A workshop to elaborate a strategy on safe motherhood (1998).
- A baseline study on SRH needs of adolescents and youth in schools and universities was carried out in December 1997.

UNFPA was instrumental in the establishment of CONAPO, which is directly attached to the Minister of Economy and Development (MoED), to allow it to play an important role in the coordination of population actions. In 2000 it co-ordinated the revision of the National Population Policy to ensure the integration of the ICPD PoA. In addition to the stable and regular support from UNFPA, it should be noted that the budgetary contribution from the government has also been important and demonstrates the political commitment to support activities related to population issues, (see section 2.1.1. for further information).

UNFPA also played an important role in the establishment of the Direction of Education and Population (DEMP) in 1986. Its role is to elaborate and implement sexual and reproductive health education programmes in primary and secondary schools, training of teachers and sensitising parents. Specific technical support provided by UNFPA has included training of educators, the development of teaching materials, the co-ordination of activities and teachers at a regional level (Dori, Fada and Tenkodogo) and evaluation of the DemP. Through financial and technical assistance, UNFPA has played a major role in the successful achievement of these activities. All staff met at the UNFPA CO as well as all national structures involved in UNFPA programmes are well acquainted with policy and laws affecting young people's RH and rights.

#### Efficiency

It was not possible to assess the efficiency of the investments in youth-related policy development, in part because the present country programme integrates these into sub-programmes and projects on a routine bases. However, according to UNFPA staff, at least 30% of staff time is directed to advocacy and policy reform efforts. While this represents a substantial investment, the programme has contributed to major legislative reforms that will impact the SRH of young people in Burkina. As the current challenge will be to translate and transfer those reforms to the local level, a shift in policy-related investments may be warranted in future.

#### Effectiveness

UNFPA has played a key role in reforming national policies and laws in the field of population and RH in Burkina Faso through advocacy, technical expertise and institutional support, (see section 1.2.1 "National Policies"; 2.1.1 and 2.1.2).

Although a RH plan of action was drafted it was abandoned with the advent of the National Health Development Plan (PNDS). Although the RH theme group is being revived to take the draft RH plan further there does not yet exist a specific framework neither in dealing with RH in general in the National Health Development Plan (PNDS) nor targeting young people's RH issues, in particular.

All key partners encountered (e.g. WB, WHO, UNICEF, Denmark, the Netherlands, ABBEF, et al) recognise the central role that UNFPA has taken in the initiative and development of policies, protocols, norms and other documents related to SRH among young people.

## **4.2. The FPA (ABBEF)**

### Relevance

ABBEF has pioneered policy reform in reproductive health strategies directed to young people from before ICPD. For example, ABBEF lobbied for the reform of the 1920 law prohibiting any form of use and promotion of contraceptive, and this was finally accomplished in 1986. They were then a catalyst in advancing and supporting the development of the Family Planning policy for Burkina Faso, which included access for young people.

ABBEF has a strong relationship with, and is well regarded by, the government. It participates in a variety of national and regional committees concerning a cross section of sexual/reproductive health and education issues. ABBEF has often been used as a model by the government. This has extended to incorporating approaches into national strategies, e.g. the approach of special RH services was first introduced by ABBEF and then taken on by the MoH.

### Efficiency

Due to the way in which ABBEF structures its budget, by project, the extent to which resources are allocated to policy reform and advocacy is not clear-cut. However, based on ABBEF's 2002 budget activities devoted to advocacy constituted approximately 9% of the overall budget. All project/programmes have to a greater or lesser degree activities that are related to advocacy and policy reform at their particular level (national, regional or local). Personnel devote appropriate time to these areas according to their role and responsibilities (see section 2.2 Relevance and Integration of Rights). National Board members are also proactive in advocacy and policy reform, as they often hold official positions within the government. This is the same situation at the regional level, where regional board members hold positions of influence in the community. It was not possible to assess whether these investments were efficient, but they have resulted in important policy reforms for overall SRH, including youth.

### Effectiveness

As indicated above, ABBEF has been instrumental in influencing national policy and legislation, specifically in relation to:

- reforming the 1920 law prohibiting any form of use and promotion of contraceptive;
- reforming laws that permitted the expulsion of school going girls due to pregnancy;
- playing an extensive role in the push to eradicate excision in the country, ABBEF is a member of the National Committee Against Excision;
- influencing policy and ensuring appropriate monitoring and programming is carried out in the FP Commission within CONAPO through their membership in the same. They also represent the NGOs involved in RH in the Permanent Secretary of NGOs (SPONG) in CONAPO.

- defining and developing strategies on RH along with the DSF/MoH.

ABBEF, its main office and the four centres also serve as a place for students to do research on various RH issues that affect young people. This is far reaching, as these same research students are future decision-makers, judges, lawyers, doctors, administrators, etc.

## SECTION 5: STRENGTHENING RH SERVICES

Both UNFPA and ABBEF have been involved in developing and implementing RH services specifically for young people. The following 4 boxes illustrate different categories of centres that the evaluation team visited and include centres that are presently or have in the past been supported by either UNFPA or ABBEF, as well as one centre that has never had any support from either organisation. These centres are typical of and illustrate the strengths and weaknesses of the various approaches taken by UNFPA, ABBEF and/or the government in offering or strengthening RH service for young people.

**“Centre de Service Conseil pour les Jeunes de Ouidi” (Ouaga) Supported by: UNFPA (1996 - 1998)**

*Target Population:* Young people in Ouidi and the northern section of Ouagadougou

*Location of Centre:* The centre is poorly situated for easy access and visibility for the target population. There was little choice of location, as the project was caught between the MoH and MoSA when they became two separate ministries. MoSA offered the land to build a centre.

*Structure:* The building design was not appropriate or adapted to centre activity needs, e.g. lack of privacy (no door or room divider), lack of sanitary facilities, etc. It should be noted that the initial budget was not meant to build a centre but to renovate and/or build an extension if needed.

*Professional Staff:* MoH provides: 3 midwives (1 woman, 2 men); 1 psychologist (recently returned after being on official leave for the past 2 years); 1 maintenance person; MoSA provides: 1 educator and 1 social worker. All are more than 24 years old.

*Volunteer Peer Educators:* Two volunteers per sector were identified creating a pool of 60 volunteers for the 30 sectors. Due to a lack of financial support for out reach work in the sectors, the PE became progressively demotivated and disappeared from their roles and have not been replaced.

*Services Presently Being Offered:* FP, prenatal care, STI services, psycho and social support. IEC activities are virtually non-existent due to the lack of material at the centre. The only posters seen on the walls were from pharmaceutical companies. Due to the non-functioning or disappearance of television, video, games and books leisure activities no longer exist. Out reach services no longer take place as there is no budget for gasoline (provided by UNFPA); the minivan is now situated at the regional level of the Direction of Health Services.

*Current Level of Activities:* Based on the register for the first 4 months of 2003 (min – max #):

- Average number of contraceptive consultations per month: 38 (32 – 46)
- Average number of STI consultations per month 32 (19 – 61)
- 120 condoms were distributed during the 4 month period
- Psycho-social support: visit to one class in a high school
- No counselling nor referrals for HIV testing (staff have requested to be trained)

*Fees:* A cost recovery system for purchasing contraceptives has been established subsequent to UNFPA's withdrawal. In order to maintain accessibility the price has been kept low, e.g. 150CFA for a consultation, 100CFA for 1-month worth of oral contraceptives, about 300CFA depending on the treatment of IST, and 10CFA per condom.

*Budget:* The only monetary resources available for the centre are from the cost recovery scheme.

*Supplies and Equipment:* Bio-medical equipment is both lacking or in poor condition (rusty gynaecological instruments, no refrigerators for vaccines, etc). Contraceptives and essential drugs are purchased from the CAMEG through the district store with money earned from cost recovery scheme.

*Monitoring/Evaluation:* It appears that little or no supervision during the UNFPA project was undertaken (verbal communication). It is difficult to document the success of the centre while supported by UNFPA as no end of project evaluation took place.

*Staff Motivation:* In spite of the overwhelming difficulties faced by staff at the centre, they remain motivated and concerned about their work, and express their professional needs clearly.



**“Centre d’Ecoute pour Jeunes” Ouagadougou Supported by: ABBEF (1992 to present)**

*Target Population:* Young people in Ouagadougou

*Location of Centre:* The centre is situated for easy access and visibility for the target population, as there are several major schools in the area. It should be noted that the centre also attracts clients from outlying areas and as far as Ouidi.

*Structure:* The building is rented. Separate rooms are available for the various health services offered. A large open space and a courtyard is available for leisure and educative activities. A kiosk offers food, drinks and condoms. This space is rented out to a volunteer who keeps any profits made.

*Professional Staff:* ABBEF: directress; 1 educator; 1 part time psychologist; 1 guard; 1 reception; MoH provides: 1 mid-wife (woman); 1 part-time nurse (man). All are more than 24 years old.

*Volunteer Peer Educators:* 20 volunteers, all less than 24 years old.

*Services Presently Being Offered:* FP, prenatal care, STI services, psycho and social support, vaccination (tetanus) and nursing services (malaria, wounds, diarrhoea, etc.), IEC, counselling, leisure activities (library, television/video, games, etc). IEC materials on the walls and to be handed out are from ABBEF, MoH and other organisations including UNFPA.

*Current Level of Activities:* Based on the register for the first 4 months of 2003 (min – max #):

- Average number of midwife consultations per month (includes FP, STI, prenatal): 309 (241 – 384) 95% female and 5% male
  - Psycho-social support: 8 –10 per month
  - 9,887 condoms distributed during the 4 month period (sold in the centre and distributed by PE)
  - Referrals for HIV testing to CIC/DOC (NGO)
  - 14,731 using leisure activities (12,399 males and 2,332 females)
  - 356 information and educational sessions by PEs in and out of school setting
  - # of young people touched by PE sessions: 3,828 males, 3,438 females, total 7,266
- People >24 years old are referred to the ABBEF clinic for adults located at their main office.

*Fees:* A cost recovery system for purchasing contraceptives and other supplies has been established and standardised for all ABBEF centres. Consultation: gynaecological (including STI) 500CFA, PF 300CFA, psychologist 500CFA; IUD: 1000CFA; Norplant 1000CFA; Pill 100CFA month worth; 10CFA per condom; PNC: 200CFA; about 300CFA; Price of STI treatment varies.

*Budget:* In addition to the money recovered from consultations and sale of contraceptives ABBEF allocates complementary funds for the running of the centre depending on the externally funded projects of the centre; e.g. 2002 this centre received 32,943,998CFA.

*Supplies and Equipment:* Basic equipment is available, including refrigerator and sterilisation. Contraceptives are purchased from IPPF through ABBEF except spermicides. Essential drugs are directly purchased from CAMEG with money earned from cost recovery scheme and subsidised by ABBEF.

*Monitoring/Evaluation:* Activity and financial reports on a monthly, trimestrial and annual basis are prepared and sent to the main ABBEF office. Monthly supervisory visits.

*Staff Motivation:* Professional and volunteer staff at the centre appear motivated and dedicated.

**“CSPS Diabo”** Supported by: UNFPA RH Programme (50km from Fada) (opened 1999)

*Target Population:* approximately 30,000 inhabitants (all ages) of 32 villages

*Location of Centre:* Village of Diabo (rural area), the health facility services outlying areas.

*Structure:* Government buildings, a maternity and dispensary. The dispensary includes a consultation room, laboratory, stock room (vaccines, material, etc.), 2 in-patient rooms (2 beds in each). The maternity includes a birthing room, an examination room that doubles as a rest area for staff on guard duty and 2 recuperation rooms. Latrines are available. There is little evidence of any maintenance or cleaning of the building.

*Professional Staff:* 3 State Register nurses; 2 certificate nurses; 1 midwife; 1 birth attendant; 1 laboratory technician.

*Volunteers:* 32 VHW (1 per village). *Note:* these VHW are no longer functioning as they have no material or supplies and there have been no recent in-service trainings.

*Services Presently Being Offered:* General Consultations (including STI), immunisation, FP (IUD and Norplant not available), pre and post natal consultations, deliveries, laboratory services, educational sessions.

*Current Level of Activities:* Based on the register for the first 4 months of 2003(minimum – maximum #):

- Average number of 574 curative consultations per month (444 – 647) 40% adults, 60% <12 years
- Average number of STI 3.5 per month (2 – 5)
- Average number of FP consultations 34 per month (27 – 40)
- Average number of pre-natal consultations 156 per month (107 – 209)
- Average number of deliveries at centre 27 (22 – 30) and 9 home assisted deliveries (7 – 10) per month
- 90 condoms were distributed during the 4 month period (sold in the centre)

Very few young people use the RH services.

*Fees:* A cost recovery system for purchasing contraceptives and other supplies has been established and standardised for all government centres. Consultation: (including STI) 100CFA, PF 100CFA, PNC: 100CFA; delivery 500CFA; Pill 100CFA month worth; 10CFA per condom;

*Budget:* The cost recovery system is in place for material, FP and drugs. The average recovered is approximately 500,000CFA per month. Government support includes: supplies, material and salaries. UNFPA: fuel coupons, supplies and drugs, and basic equipment.

*Supplies and Equipment:* Basic equipment is available, including refrigerator. Material is decontaminated with chlorine, as there is no sterilisation equipment. Contraceptives and essential drugs are purchased from the health district (CAMEG) as well as given by UNFPA.

*Monitoring/Evaluation:* Activity reports are sent to the health district on a monthly basis where trimestrial reports are then sent to the national level. The MCD visits once per trimester. The UNPFA Project Coordinator visits once annually.

*Staff Motivation:* Professional and volunteer staff at the centre appear motivated and dedicated. *Note:* 3 absences at time of visit one for training and two for purchasing vaccines.

**“Government CSPS Boujounam”**, 25km from Ouahigouya (no support by ABBEF, UNFPA or others) (opened 1992)

*Target Population:* 6,142 inhabitants including outlying villages

*Location of Centre:* The centre is situated in the village.

*Structure:* There are two buildings, one for general consultations and one for the maternity. The dispensary includes a consultation room, stock room (vaccines, material, etc.), 1 in-patient room (2 beds). The maternity includes a birthing room, an examination room, 1 recuperation room.

*Professional Staff:* 1 State Register nurse; 1 certificate nurse; 1 birth attendant who has been on medical leave for 2 years.

*Volunteers:* Village health workers in surrounding villages.

*Services Presently Being Offered:* General Consultations (including STI), immunisation, FP (pills and depoprovera), pre and post natal consultations, deliveries, educational sessions.

*Current Level of Activities:* Based on the register for the first 4 months of 2003 (minimum – maximum #):

- Average number of 101 curative consultations per month (75 - 135)
- Average number of STI 1.5 per month (0 – 4)
- Average number of FP consultations 12 per month (10 - 17)
- Average number of pre-natal consultations 27 per month (19 – 40)
- Average number of deliveries at centre 7 (5 – 11) and 6 home assisted deliveries (5 - 7) per month
- Condoms are not made available at the dispensary as they are sold in the village according to staff

Young people only come for RH services if they are pregnant.

*Fees:* A cost recovery system for purchasing contraceptives and other supplies has been established and standardised for all government centres. Consultation: (including STI) 100CFA, PF 100CFA, PNC: 100CFA; delivery 750 - 1000CFA; Pill 125CFA month worth;

*Budget:* The cost recovery system is in place for material, FP and drugs. Government support includes: supplies, material and salaries.

*Supplies and Equipment:* Basic equipment is available, including refrigerator and a pressure cooker for sterilisation. An ambulance has been donated by Burkinabé migrants.

*Monitoring/Evaluation:* Activity reports are sent on a monthly to the district level. Maximum number of annual district visits is 2.

*Staff Motivation:* Professional and volunteer staff at the centre appear motivated and dedicated.

## 5.1. UNFPA Country Programme

### Relevance

In UNFPA's 3<sup>rd</sup> country programme cycle (1992 – 1996) the RH service strategy for young people was to create specific centres located in major cities in Burkina Faso. Two centres were initially piloted in Ouidi and Bobo Dioulasso. Following an initial evaluation of the project the establishment of a further 8 centres was abandoned. This reflected the view that the creation of separate centres would not achieve project objectives and that RSH services would be better integrated into existing youth centres. As a result these centres were devolved to the MoH in 1998, (respectively, Health District of Pissy under the Regional Health of Centre - Ouaga and in the Regional Health Centre of Bobo). The centres no longer receive any UNFPA financial or technical support.

UNFPA's approach became more integrated and multisectoral and the objective has been to reinforce RH services in existing public facilities (CSPS's), while at the same time supporting social and cultural structures within different ministries (the Ministries of Social Action and Employment, Labour and Youth) dedicated to young people. UNFPA began to work in 3 convergent zones (Fada, Dori and Tenkotogo) in collaboration with other UN agencies, UNICEF, WHO and UNDP. In addition to these 3 zones, UNFPA is also working in Kombissiri to strengthen health and social services. UNFPA projects in these zones continue to support RH services in collaboration with several ministries: MoH, MoSA, MoLEY and Ministry of Art and Culture.

These interventions were part of the following projects:

#### 4<sup>th</sup> Cycle (1997 – 2000):

- Joint UN Project to Strengthen Health Services
- Extension and Improvement of Quality RH Services (BKF/98/P01)
- Development of Community Based Services and Strengthening and Women's Access to RH Services (BKF/98/P03)

#### 5<sup>th</sup> Cycle (2001 – 2005):

- Support to RH Activities in the Region of Dori (BKF/05/01/03)
- Support to RH Activities in the Region of Fada (BKF/05/01/04)
- Support to RH Activities in the Region of Tenkodogo (BKF/05/01/05)
- Strengthening of Social and Health Services to Address SRH Needs of Adolescents (BKF/05/01/11)

UNFPA also assisted SFPS in 2001 in the preparation of a programmatic approach targeting young people and RH services. This programme, known as "Sympa", is based in 10 public health facilities and the university clinic in Ouagadougou. There are preset standards of services, such as adapted hours and fees, separate entrance, and "youth friendly services".

UNFPA's support in RH services at the CSPS-level includes: basic bio-medical equipment, an initial donation of contraceptives and essential drugs (including those related to IST), various consumable supplies and materials (e.g. gloves, injecting equipment, etc) and technical support. This appears to address basic needs that health facilities have in order to respond to people's RH needs, but structural weaknesses remain, affecting community perceptions and utilisation rates.

In addition, even good structural support does not mean that a CSPS is able to attract young people. Young people who do come to these centres, as well as other non-supported centres, are most often married women (below and above 24 years). There is little done at the health facility level to make young people more comfortable (i.e. less ashamed) in coming for SRH services. Difficulties in encouraging youth to access available services are

also a reflection of cultural/social norms, and a perceived reluctance of the MoH to integrate youth services more widely.

The challenge for UNFPA is how to increase use of health services for preventive and early curative treatment for people in general, and young people in particular. This will require both strengthening the available services, and also directing efforts to encourage young people to access the available services. The environment in which young people live, i.e. attitudes of young people and older family members concerning the SRH needs of young people, have not been extensively or consistently addressed.

In their efforts to strengthen SRH services in these centres, or to increase service utilisation by youth, UNFPA has not based its programming on evidence based data, nor have they undertaken an evaluation of their efforts.

Justification and rationale of creating centres targeting an entire population of young people in large urban areas (e.g. Ouidi centre in Ouagadougou was to serve approximately 500,000 young people) is questionable. Not all MoH personnel felt that the Ministry is effectively engaged at all stages of project development, i.e. conception and implementation, yet they are expected to provide personnel and to take over the activities (specifically the two centres that are now closed or barely functional).

### Integration of Rights

All the health centres have as part of their minimum package of activities (MPA) RH and FP services. Health personnel are well aware of the problems associated with female excision, abortion and other rights related issues and the corresponding laws associated with them, (see below – “Capacity” and section 6.1).

### Capacity

UNFPA has financially and technically supported training sessions organised by DSF and DRSs to sensitise health facility staff in the RH needs of young people and alternative approaches in addressing them (e.g. attitudes, rights of young people relations between young people and parents, etc).

FP and RH for young people have been integrated into the curricula for nurses and midwives at the National School of Public Health (NSPH), through the support of Family Care International. This is incorporated into the first through third years of study. In-service training is also conducted in health facilities.

Burkina Faso has 1 midwife for every 28,000 women. The low number of midwives is exacerbated by the fact that a good number of them go into non-obstetric roles in which their knowledge, skills and competencies are not tapped into, such as in the UNFPA CCB project which has appointed 3 midwives from the MoH to work as project coordinators in 3 Maison des Jeunes where they do not provide any obstetric services.

Other than establishing what young people’s RH needs are, little has been done to include them in the design, monitoring or evaluation of UNFPA supported service delivery activities. In the socio-cultural context of Burkina Faso, the role of young people in determining service delivery at a technical level is questionable, most especially when the health services are wrought with institutional, financial and logistical obstacles.

### Efficiency

UNFPA has supported the MoH in the elaboration of guidelines and strategic documents related to quality assurance in RH services directed towards young people. Specifically the development of:

- Policy Norms and Protocols (with DSF) (4<sup>th</sup> cycle);
- Strategic Plan on Health for Adolescents and Youth (with DHS) (4<sup>th</sup> cycle); and,
- Production of clinical check list for health needs of adolescents and youth adopted for each health care level; and the integration of adolescent and youth RH needs into the minimum package of activities (PMA) (with DSF and support from CST) (5<sup>th</sup> cycle).

To date no cost effectiveness studies have been undertaken specifically for or integrated into mid-term or final evaluations with regards to young people RH service investments.

### Effectiveness

UNFPA has contributed to attending to the contraceptive needs within the country and consequently for young people too. This has been undertaken cooperatively with WB (PPLS credit), as UNFPA was able to use this credit to buy the necessary commodities for the country. This credit became unavailable in 2001. Subsequently, the government of Burkina was unable to meet the demand for contraceptives from within their own financial resources and no substantive mechanism to tackle this matter presently exists in country. As a result, UNFPA has been filling gaps in order to avoid large or long-term ruptures of stock; however, it has been difficult to avoid fluctuations and some stock ruptures at the peripheral level. Assistance to the government to put into place a functional supply management system is long overdue. UNFPA is in a unique position to lobby the government to take on at least part of the responsibility of ensuring contraceptive supply and management, as well as to lobby the support of others in establishing a sustainable system.

In 2000, the MoH and UNFPA, with the technical assistance of JHPIEGO and the financial support of USAID, were able to develop and finalise a series of technical documents aimed at improving accessibility and quality of RH services. The documents developed include:

- *Policy and Standards of RH Services*: this document clearly specifies young people (10 – 24 years) as constituents in the description of the policies and the definition of the standards when setting up RH services. This guide is meant for senior management and decision makers in government services and international organisations supporting RH in Burkina Faso.
- *General Components to Reproductive Health*: this guide presents the various activities of RH that are part of the aforementioned policies. It is intended for personnel working in RH services and learning/training centres for such personnel.
- *Clinical Protocols on RH*: this manual covers pre-natal consultations, essentials on obstetric and neonatal care, case management of obstetrical emergencies, post partum surveillance, gynaecological services and case management of the most common gynaecological pathologies, and RH advice and protocols adapted for young people.
- *Protocols for Support Services in RH*: is a guide for support and supervision services related to RH activities such as: supervision of RH activities; health information systems; logistics of contraceptives; and, community participation. This document is intended for senior management teams working at district and regional levels.

These tools correspond to best practices in SRH, have been adapted for the audience for which it is intended, and are presented in a practical fashion. The question remains as to the extent to which these documents are disseminated and most importantly how effectively they are applied after almost 3 years of publication. It should be noted that not one professional encountered during this evaluation made mention of these guides or their usage.

A number of UNFPA initiatives regarding RH services remain heavily burdened by two major factors that UNFPA's actual interventions are not able to resolve:

- The exceedingly low level of use by young people of the CSPS for RH activities; according to the in country study on the opinions of youth, reasons mentioned by young for the limited use of services, include: the shame and fear of meeting sisters, aunts or other relatives at the centre, and financial obstacles. In view of the fact that official fees appear to be kept at a reasonably low rate, and many health care professionals indicated they overlook fees when it is too much of a burden, it is difficult to clearly establish if there really is a financial burden and to what extent.
- Structural difficulties that public health services confront (insufficient personnel, incomplete training, demotivation, lack of financial means, irregular supplies of medicines and consumables, lack of maintenance and equipment, dilapidated structures, etc).

### Sustainability

The devolution of the two centres in Ouidi and Bobo-Dioulasso from UNFPA to the government was abrupt and neither a transitional phase nor any sustainable strategy was included in the project from its outset. At the present time the government has still not integrated this centre into its district and regional level action and administrative plans. The Regional Director of Health Services in Bobo-Dioulasso decided to close the centre at the end of 2002 due to the lack of operational activities. The personnel have been re-allocated to other posts within the MoH (certain people have taken advantage of the occasion to have themselves transferred back to Ouagadougou).

In the current health or support services for young people given by UNFPA, there has been no realistic assurance or planning for sustainability (for maintenance of purchased equipment, for long term financing, or to motivate personnel and volunteers). This is short sighted and impacts adversely on the cost efficiency and effectiveness of funded projects. UNFPA need to devote more attention to ensuring the long-term institutional and financial sustainability of supported projects.

## **5.2. The FPA (ABBEF)**

### Relevance

ABBEF opened their first 2 centres in Ouagadougou and Bobo-Dioulasso in 1992, followed by Koudougou in 1996 and Koupela in 1997. In 1999, research in ten villages in the northern region of Ouahigouya undertook a study on the needs, behaviour, attitudes and practices of young people with regards to their sexual and reproductive health. Subsequent to the study, funding was identified to support a 3-year action based research project (2002 – 2005) addressing SRH in 5 of these villages. Activities include supporting the village health facilities, training and supervising PEs, and on going monitoring for research purposes.

All ABBEF centres are both discrete and youth friendly. There is no reference to clinical or reproductive orientation in the name of the centres it is also not evident if people are going to the centre for leisure or clinical reasons.

ABBEF also participated in the preparation of the "Sympa" initiative in 2001 (see above 5.1).

ABBEF assists these centres in the following ways: recruitment and training of personnel, technical support in the development and supervision of preventive and curative activities, and provision of equipment and consumables. ABBEF seeks out and negotiates projects with donors who are the major contributors of these centres, (see section 3.2). IPPF participates indirectly to the support of these youth friendly centres. The overall conditions of these centres are satisfactory. Nevertheless, there has been a problem of regular supplies



of contraception and other material donations. The irregularity of commodities affects the extent to which activities are carried out. For example, in the youth friendly centre in Ouagadougou the number of condoms sold in April 2003 was 4 times more than the average sold since the beginning of the year. A large part of this was due to the late arrival of condoms from IPPF.

### Integration of Rights

The centres run by ABBEF are open to all young people without regard to ethnic group or socio-economic status. If someone attends clinic and has difficulty in paying certain fees, staff have the flexibility to apply a sliding scale of payment as may be required. According to personnel and volunteers interviewed during the evaluation, young people who visit and use the centre come from all social categories and include youth and adolescents. The fact that the centres are based in town centres precludes young people coming from rural areas. However, the project in Ouahigouya is a step in addressing this discrepancy.

It is clear that within the ABBEF centres, as well as centres in general in the country, females are more apt to make use of RH services than males. This by nature is due to the more extensive reproductive health needs that women have than men and if FP methods are sought other than condoms or spermicides, an exam and prescription is necessary. However, ABBEF is addressing this issue through the organisation of couple days, to encourage women and their partners to attend. As has already been noted most of the peer educators employed by ABBEF are male and information and condoms are distributed to young men when they participate in leisure facilities offered at the clinics. The fees that ABBEF charges for services may be considered within the limits of young people's means as evidence in Table 2.

**Table 2: Example of Current ABBEF Fees in Youth Friendly Centres**

<b>Activities or Services</b>	<b>Prices (CFA)</b>
Medical Consultation	500
Midwife Consultation	300
Antenatal Consultation	200
Psychological Consultation	500
DIU	1000
Norplant	1000
Condoms per unit	10
Pills per month	100
Pregnancy Test	1500

### Capacity

ABBEF staff has a range of various backgrounds, including medical, social and educational. As appropriate, they receive training at the national level according to their role and responsibilities. All staff receive training in youth friendly approaches although the frequency of initial training and follow up training is often dependent upon external funding.

Peer Educators receive 10 days of training and are usually taken for a 2-year period. In addition to their training they are supervised regularly and assisted as required. There are 2 – 4 times more male PEs than female PEs. Cultural limitations play a role in this imbalance but ABBEF has not addressed this issue with any initiative to encourage more female peer

educators. PEs are expected to carry out a certain number of talks per month: in school 4 and out of school 6.

### Efficiency

Through its youth friendly centres, ABBEF directly contributes to making RH services more available to young people (the number of clients <24 years was estimated to be more than 35,0000 in 2002). Compared with other efforts made to service youth (e.g. those within the CSPS's), the ABBEF investments appear reasonably efficient. ABBEF has also enhanced the efficiency of investments by sharing their experience with others working in this field (see section 2.2).

### Effectiveness

The services offered at these centres and in the rural project area around Ouahigouga, as well as through PE in schools and at the community level are effective in reaching young people. The centres offer FP and STI clinical services that also include information and counselling in these areas as well as on HIV/AIDS, consequences of clandestine abortion and rights of women, as needed. PEs also disseminate information on reproductive health matters and women's rights along with selling condoms to a range of young people both in and out of school. These activities all contribute to raising the level of knowledge about FP and reproductive health and rights among young people, as well as responding to the articulated needs of the young population by offering easier access to these services.

The level of activities in the 4 youth friendly centres varies according to the length of time the centre has been open, the number of donor funded projects, staff and volunteer dynamism and environmental context (e.g. influence of religion). Table 2 illustrates the increased use of centres, when activities began and levels of their use.

**Table 2: Number of Users per Service/Activity Provided at Youth Friendly Centres**

Types of Services	1995	1996	1997	1998	1999	2000	2001	2002
FP	46	2,436	3,054	4,619	6,211	7,465	7,119	7,241
STI	22	48	957	1,375	1,675	1,953	2,361	2,618
Gyno	0	0	946	1,797	3,199	3,015	4,152	5,699
Preg Test	0	0	95	299	576	674	512	287
Counsel S & RH	0	0	411	568	1,246	1,686	3,952	4,177
HIV Mgmt	0	0	81	184	N/A	N/A	6	60
HIV Counsel	0	0	0	0	0	0	144	2,957
Tetanus	0	0	0	0	0	0	134	82
PNC	0	0	0	0	0	0	36	282
Nursing Care	0	0	0	0	0	0	482	853
Library	0	0	0	1,174	1,506	1,551	4,786	6,059
TV	0	0	0	0	0	8,220	16,454	14,658
Kiosk	0	0	0	0	0	0	4,593	4,118

Discussions with centre staff confirmed that both young people in and out of school use centre services. Not surprisingly, females are more numerous in accessing the clinical services while males take advantage of leisure activities. There does not appear to be any mechanism in place for the identification and adoption of best practice.

### Sustainability

Various mechanisms for improving sustainability of RH service have been put into place by ABBEF (cost recovery, implication of volunteers, partnerships with government and other local enterprises, etc.), these as well as their limits are presented in sections 2.2 and 3.2. ABBEF and the activities it supports remain dependent on external funding sources and existing strategies reflect this. As a result of this long-term institutional and financial sustainability has not been addressed by ABBEF in any formal or coherent way.

## SECTION 6: PROMOTING RH INFORMATION AND EDUCATION

### 6.1. UNFPA and The FPA (ABBEF)

UNFPA (through technical support of the DSF) and ABBEF have produced a notable quantity of IEC material that concerns SRH and young people. Some of the material has been worked on collaboratively. In addition, most of the material is intended for use by government structures, NGOs and associations. As a result, it is difficult to separate these interventions by UNFPA and ABBEF.

#### Relevance

During the 3<sup>rd</sup> cycle UNFPA worked collaboratively with MoSA in order to produce a national strategy of IEC/BCC population matters. The corresponding document (*“La Strategie d’IEC en matiere de Population”*) was finalised in the late 1990’s and includes a component that addresses FP needs of young people.

A good deal of IEC material has been produced in close collaboration with various partners, including UNFPA and ABBEF. Material developed includes: leaflets, posters booklets, stickers, flip charts and flannelographs. Interactive sessions include theatre, debates and talks. The media appears to be a willing and cooperative partner in many of the rights based issues. For example, they cover such special occasions as the day celebrating the eradication of excision. In addition, media has been exploited with radio and television spots, including an informational programme about ABBEF centres. Various themes targeting young people have been undertaken, including: FP, pregnancy and abortion, HIV/AIDS/STI, genital mutilation, communication between young people and parents, responsible sexuality, physiology, etc. These themes respond to the expressed needs of young people and were intimately developed with young people.

It is surprising that given the high rate of fertility among young women and burden of maternal morbidity/mortality <24 years, there are very few messages concerning the importance of pre-natal care, safe delivery procedures and measures to be taken for obstetric emergencies.

The material is for the most part correct, clear and explicit in the information offered. While the subject matter and information are relevant, the level of education needed to understand the material is rather high. Brochures, leaflets and most of the posters are not at all appropriate for non-literate audiences. Even literate audiences probably require some degree of secondary education to be able to read and understand the messages. In addition, most material seen needed mastery of French. A very limited amount of material has been translated into local languages.

Some of messages related to sexuality, i.e. homosexuality, early sexual relations, and abortions have moralistic overtones that may be attributed to socio-cultural context and religious pressures.

The development and production of IEC materials supported by UNFPA are undertaken by the government, which also defines how IEC materials are distributed to public service providers, NGOs and local associations. In the last three rounds of programming the amount spent on IEC activities has constituted 20%, 8% and 17% respectively. UNFPA’s financial support of IEC activities is complemented by that of the government, which also fund a portion of IEC activities and materials. In 2002 ABBEF allocated approximately 10% of its budget to IEC activities of which 7% was dedicated to young peoples programmes.

### Integration of Rights

Both UNFPA and ABBEF address the major RH rights issues in material development as well as in talks, debates and conferences. Excision, unwanted pregnancy (abortion) and women's SRH rights have all been addressed and kept within the laws that prevail. According to the in-country review of perceptions of young people, there does still appear to be misconceptions about the legal age of marriage and sexual relations. As has been noted above in some materials a moralistic tone regarding behaviours has been used.

### Capacity

The development and pre-testing of materials appears to be well thought out, except that it is targeting only the most literate youth. Use of the target audience has been made at various stages of development: determining messages, development of messages and images and in pre-testing. In addition, technical assistance by the UNFPA CST from Dakar was present for material development during this evaluation.

### Efficiency

IEC material is shared among the various actors working in RH. There are no apparent conflicting or contradictory messages that have occurred, but there is a lack of concrete coordination in deciding on the material and messages that are needed. Consequently, most organisations and projects develop and produce their own material, at times replicating one another's efforts and at other times leaving gaps.

UNFPA has produced tools to monitor IEC/BCC activities, including training in IEC/BCC. These are:

- Forms used in any IEC/BCC training session to establish participant's profile (age, sex, current and/or future position, use of training, etc).
- An inventory form sent annually to all structures involved with UNFPA and carrying out IEC/BCC activities to identify all material received during the year, and identify their needs for the following year.

While UNFPA has taken the initiative to develop such monitoring tools, overall distribution and subsequent use remains inefficient. This was especially noted within government services. Materials produced by government and other partners are stocked at central, regional and district levels. Distribution of materials are left to health personnel to pick up along with other needed supplies (e.g. medicine). Staff either do not realise that these materials are available or do not know where to obtain them. IEC material is evident in the ABBEF Youth Friendly Centres. However, the government health facilities that were visited and are supported by either ABBEF or UNFPA, showed no evidence of having such materials.

As previously stated, young people have been an integral part of the process of developing IEC material. Yet the major consensus is that the strategies they prefer are interactive ones, such as talks and debates where they can ask questions and discuss their own views and needs. This also included the use of peer educators within IEC/BCC strategies. Hence, efficiency of IEC efforts could most likely be improved.

A cost-effective study of the IEC strategies has not been conducted in country. There appears to be an abundance of workshops to develop material or messages, for which money is spent on travel and per diem, and the resulting material is neither tremendously innovative for the effort or cost that may have been spent, is targeted only to the most literate, and is inadequately distributed. At this point in time, enough material on the subject

has been developed that messages and images could be adapted to other languages, non-literate and different cultural target groups, and more effectively distributed.

### Effectiveness

It is difficult to determine the impact and extent to which IEC material and messages have on young people's attitudes and practices regarding SRH. Young people are more open about talking about sexuality and asking for information. While condom promotion is widespread, both the young and older generation (including ABBEF volunteers) stated that the promotion of condoms might incite young people into having casual sex.

While everyone agreed that attitudes have changed recently in terms of openly speaking about reproductive health issues and HIV/AIDS, it appears that intergenerational communication about sexual matters remains problematic. For example, one peer educator indicated that he does not disclose his volunteer activities to his parents, and feels it necessary to dispose of any condoms he may have.

The new law concerning the prohibition of excision has been accompanied by numerous media campaigns. The National Excision Day was instituted in 2001, it occurs on 18<sup>th</sup> May. Since it occurred during this evaluation, the team was able to witness the extent of the political commitment and media coverage. The First Lady and the Minister of Social Affairs were among a number of speakers at a national level ceremony that was covered throughout the media. It is still too early to ascertain the impact of this new law, and there are conflicting opinions about whether attitudes and practices are in fact changing or if the practice has become clandestine. As recently as 2000, women in Ouahigouya marched to maintain excision. It appears that in this region strong feelings are still attached to this practice and it will take quite a long time to change both attitudes and behaviour.

No formal study has been undertaken to determine the acceptability and effectiveness of IEC/BCC materials (the extent to which young people are able to recall messages or their appeal).

### Sustainability

UNFPA has financed the production of IEC material in each of the last three cycles of its programmes (1992 – 2005). Although the government provides some financial support for IEC activities and materials it is clear that the majority of government implemented IEC activities are financed with external funds.

ABBEF is also dependent on external financing in the implementation of IEC/BCC related activities, whether they be from IPPF aid or from other donors (see section 3.2).