COUNTRY NOTE

EVALUATION OF UNFPA SUPPORT TO FAMILY PLANNING 2008-2013

COUNTRY CASE STUDY
BURKINA FASO

EVALUATION OFFICE
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Evaluation of UNFPA Support to Family Planning Services 2008-2013

Burkina Faso Case Study Note

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ABBREVIATIONS AND ACRONYMS

ABBEF	Association Burkinabé pour le Bien-Etre Familial (Burkina Association for Family Health)
AFD	Agence Française de Développement (French Development Agency)
AFP	Advance Family Planning
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-natal care
AYSRH	Adolescent and Youth Sexual and Reproductive Health
BCC	Behaviour change communication
BURCASO	Burkina Council of AIDS Services Organizations
CAMEG	Centrale d'Achat des Médicaments Essentiels et Génériques et des Consommables Médicaux (Central Store for Essential Medicines and Commodities)
CBD	Community-based distribution
CBO	Community-based organization
CHW	Community health worker
CMA	Centre Médical avec Antenne chirurgicale (Medical centre with surgical annex)
CO	Country Office
COAR	Country Office Annual Report
CONAPO	Conseil National de la Population (National Population Council)
CP	Country Programme
CPD	Country programme document
CPE	Country Programme Evaluation
CPN	Consultation Prénatale (Prenatal Consultation)
CPR	Contraceptive Prevalence Rate
CSB	Commodity Security Branch
CSO	Civil Society Organisation
CSPS	Centre de Santé et Promotion Sociale (Centre for Health and Social Promotion)
CSW	Commercial sex workers
CYP	Couple years of protection
DHS	Demographic Health Survey
DP	Development Partners
DPS	Direction de la Promotion de la Santé (Directorate of Health Promotion)
DRS	Direction Régionale de la Santé (Regional Health Directorate)
DSF	Direction de la Santé de la Famille (Family Health Directorate)
EC	Emergency Contraception
ECD	Equipe Cadre de District (district health team)
EmO(N)C	Emergency obstetric (neonatal) care
EQUIPOP	Équilibres et Populations
FCI	Family Care International
FEBAH	Fédération Burkinabé des Associations de Personnes Handicapées (Burkinabé Federation of Associations for the promotion of persons with disabilities)
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
FP	Family Planning
FP2020	Family Planning 2020
GBV	Gender Based Violence

GDP	Gross domestic product
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit (German Society for International Cooperation)
GNP	Gross National Product
GPRHCS	Global Programme for Reproductive Health Commodity Security
HIV	Human Immunodeficiency Virus
HQ	UNFPA Headquarters
HRBA	Human Rights Based Approach
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
INGO	International Non-Government Organisation
IP(s)	Implementing Partner(s)
IPC	Initiative Privée Communautaire de lutte contre le VIH/SIDA
IPPF	International Planned Parenthood Federation
ISSP	Institut Supérieur des Sciences de la Population (Institute of Population Sciences)
IUCD	Intra-Uterine Contraceptive Device
JSI	John Snow, Inc. (US health NGO)
KII	Key Informant Interview
LARC	Long-acting reversible contraceptives
LMIS	Logistics management information system
MCH	Mother and child health
mCPR	Modern Contraceptive Prevalence Rate
M&E	Monitoring and evaluation
MDG	Millennium Development Goals
MISP	Minimum integrated service package
MMR	Maternal mortality rate
MoH	Ministry of Health
MSI	Marie Stopes International
MVA	Manual vacuum aspiration
MWRA	Married Women of Reproductive Age
NGO	Non-Government Organisation
OBC	Organisations à base communautaire (community-based organisations)
OF	Obstetric fistula
PAC	Post abortion Care
PADS	Programme d'Appui au Développement Sanitaire (Programme to support health development)
PIC	Plan Intégré de Communication (Integrated Communication Plan)
PLWHIV	People Living with HIV
PMA	Performance, Monitoring and Accountability
PNC	post-natal care
PNDS	Plan National de Développement Sanitaire (National Health Development Plan)
PNP	Politique Nationale de Population (National Population Policy)
PPFP	Postpartum Family Planning
PPIUD	Postpartum Intrauterine Device
PROMACO	*Programme de Marketing Social et de Communication pour la Santé* (Social Marketing and Health Communication Programme)
PSSPSR	Plan Stratégique de Sécurisation des Produits de la Santé de la Reproduction (Strategic Plan to secure reproductive health commodity security)
RBA	Rights based approach
RBF	Results-based financing

RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
RO	UNFPA Regional Office
SCADD	Sustainable Development and Accelerated Growth Strategy
SDP	Service Delivery Point
SP-CNLS	Secrétariat Permanent du Conseil National de Lutte contre le Sida est les IST *(*Permanent Secrétariat of the National Council for the Fight against HIV/AIDS and STI)
SRAJ	Santé de la Reproduction des Adolescents et des Jeunes (Adolescent and youth reproductive health)
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually transmitted infection
SWAp	Sector Wide Approaches
TA	Technical Assistance
TAC	Tableau d'Acquisition des Contraceptifs (Contraceptive Acquisition Table)
TFR	Total fertility rate
TMA	Total market approach
ToC	Theory of Change
ToR	Terms of Reference
ToT	Training of trainers
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Populations Fund
UNHCR	United Nations High Commission on Refugees
USAID	United States Agency for International Development
VMG	Vulnerable and Marginalised Group
WCARO	West and Central Africa Regional Office
WHO	World Health Organisation
WRA	Women of Reproductive Age
YFS	Youth friendly services

INTERVENTION MAP

KEY FACTS – BURKINA FASO

Indicator	2014	Source of Data
Population and Development		
Population, total	17,589,198	World Bank[1]
Population growth (annual %)	2.9	World Bank[1]
Urban Population (% of total)	29	World Bank[1]
Population Density (per sq. km of land area)	64	World Bank[1]
Life Expectancy at birth, total (years)	58 (2013 data)	World Bank[1]
Literacy rate, population 15+ years (%)	-	World Bank[1]
Human Development Index (HDI)	0.402 (Rank 183 out of 188)	Human Development Report[2]
Economic growth rate (GDP growth annual %)	4.0	World Bank[1]
GINI Index	-	World Bank[1]
Gender Equality and Empowerment		
Gender Inequality Index	0.631 (Rank 144 out of 155)	Human Development Report[3]
Women representation in parliament, total (%)	13	World Bank[1]
Violence against women ever experienced (%)	15.4	Human Development Report[3]
Employment to population ratio, 15+, female (%) (modeled ILO estimate)	75	World Bank[1]
Ratio of girls to boys in primary and secondary education (%)[4]	-	World Bank[1]
Reproductive Rights and Reproductive Health		
Adolescent fertility rate (births per 1,000 women ages 15-19)	-	World Bank[1]
Teenage mothers (% of women ages 15-19 who have had children or are currently pregnant)	-	World Bank[1]
Prevalence of HIV, both sexes (% ages 15-49)	0.9	World Bank[1]
Maternal mortality rate (per 100,000 live births)	379	World Bank[1]
Under 5 mortality rate (per 1,000 live births)	92	World Bank[1]
Contraceptive use, modern methods (%)	28.0	UN DESA[5]
Unmet need for family planning (%)	25.2	UN DESA[6]
Births attended by skilled health staff (% of total)	-	World Bank[1]

[1] World Bank. (2016). Burkina Faso. Retrieved from http://data.worldbank.org/country/ burkinafaso

[2] United Nations Development Programme. (2016). Burkina Faso. Retrieved from http://hdr.undp.org/en/countries/profiles

[3] United Nations Development Programme. (2016). Table 5: Gender Inequality Index. Retrieved from http://hdr.undp.org/en/composite/GII

[4] This indicator is also labelled as *"Gross enrolment ratio, primary and secondary, gender parity index (GPI)"* by the World Bank. World Bank. (2016). Burkina Faso. Retrieved from http://data.worldbank.org/country/ burkinafaso

[5] United Nations. (2016). UN DESA Population Division Estimates and Projections of Family Planning Indicators. Retrieved from http://www.un.org/en/development/desa/population/theme/family-planning/cp_model.shtml

1 INTRODUCTION

Family planning (FP) is a principal focus of the work of UNFPA worldwide. This country case study is part of a thematic evaluation of UNFPA support to family planning 2008-2013, whose objective is to assess progress against past and current strategic plans and inform future decision-making and policy formulation in family planning.

1.1 Objectives of the evaluation

Purpose

The purpose of the evaluation is to assess the performance of UNFPA in the field of family planning during the period covered by the Strategic Plan 2008-2013 and to provide learning to inform the implementation of the current UNFPA Family Planning Strategy Choices not Chance (2012-2020). The evaluation will also inform other relevant programmes such as the Global Programme for Reproductive Health Commodity Security (GPRHCS) (2013-2020) and the HIV/Unintended pregnancies framework (2011-2015). Finally, the evaluation results will feed into the mid-term review of UNFPA current Strategic Plan 2014-2017.

Objectives

The primary objectives of the evaluation are to:

1. Assess how the framework as set out in UNFPA Strategic Plan (and revised Development Results Framework) 2008-2013 and further specified in the reproductive rights and sexual and reproductive health framework (2008-2011) as well as in the GPRHCS (2007-2012) and the HIV/Unintended Pregnancies framework (2011-2015), has guided the programming and implementation of UNFPA interventions in the field of FP.
2. Facilitate learning and capture good practices from UNFPA experience across a range of key programmatic interventions in the field of FP during the 2008-2013 period to inform the implementation of both outcome 1 of UNFPA current Strategic Plan and the Choices not Chance 2012-2020 strategy; inform the GPRHCS (2013-2020) and the HIV/Unintended Pregnancies framework (2011-2015) as well as future programming of interventions in the field of FP.

1.2 Scope of the evaluation

The evaluation covers the period 2008-2013, taking into account information from 2014 when pertinent and necessary. It is both retrospective and forward-looking, including evaluation of past performance, analysis of lessons learnt, and conclusions and recommendations for future interventions.

The geographical scope covers all countries where UNFPA has carried out FP interventions, focusing on the 69 poorest countries with low rates of contraception use and high unmet need for FP identified by the 2012 London Summit on Family Planning and FP2020 partnership, and also covering middle income countries where FP needs are still high due to inequality of access. Data collection and case studies cover all six UNFPA regions (Eastern and Southern Africa, Western and Central Africa, Asia and the Pacific, Latin America and the Caribbean, the Arab States, and Eastern Europe and Central Asia).

All UNFPA FP interventions are included in the evaluation, including those covered by core and non-core resources and those financed through the GPRHCS. Family planning is an integral part of UNFPA interventions in maternal health, adolescent and young people's sexual and reproductive health (SRH), HIV and AIDS, gender and humanitarian support. Family planning activities in these areas are included in the evaluation where appropriate, taking care not to duplicate work carried out in the Thematic Evaluation UNFPA Support to Maternal Health 2000-2011, and the Adolescent and Youth

Sexual and Reproductive Health (AYSRH) evaluation which is being carried out concurrently with this evaluation.

The evaluation covers eight principal areas of investigation:

- UNFPA support to integration of FP with other sexual and reproductive health (SRH) services
- UNFPA efforts for coordination to ensure national ownership and institutionalisation of FP programmes
- Extent of UNFPA efforts as a broker to promote FP, with particular attention to partnerships
- Extent of UNFPA support to creation of an enabling environment
- Level of focus on the needs of the most vulnerable groups and marginalised populations
- Extent of implementation of a human-rights based approach
- UNFPA choice of different modes of engagement
- The extent to which UNFPA support for supply-side activities (including training, procurement and logistic systems) promotes rights-based and sustainable approaches and contributes to improved access.

1.3 Overview

The evaluation uses a Contribution Analysis approach based on a reconstructed theory of change, which is being tested through collection of data and information at different levels, and analysis of the eight evaluation areas and their associated assumptions.

There are twelve country case studies (five in-country and seven desk studies) in the data collection phase, which also includes review of documentation, key informant interviews (KII) at global and regional levels with UNFPA staff and other stakeholders, two on-line surveys and additional financial analysis.

The case studies are not evaluations of the FP effort in each country and do not present recommendations for on-going or future FP work. They are one important input into the data collection and analysis process for the eight areas of the UNFPA FP evaluation as a whole, and contribute to the overall evaluation through:

- Providing input from the country perspective for addressing the global evaluation questions
- Generating data for triangulation with other sources
- Contributing to identifying more clearly “how” and “why” change occurs and contributions of UNFPA to this
- Providing insights to the eight principal evaluation areas
- Identifying lessons learned across different contexts.

The contribution analysis was originally presented as an approach to programme design and monitoring and, to a lesser extent, to evaluation. This has left considerable freedom for evaluators to explore different approaches to operationalizing CA and the use of Theories of Change (ToC). Different approaches have been used to apply contribution analysis in evaluations which include both country and sub-programme and global or synthesis levels of analysis.

For this evaluation’s work at country level the team has organised the country case study notes around the eight evaluation areas and has attempted to address most or all of the key assumptions in the overall ToC as they are realised (or not) at the country level. This method has the following strengths:

- It draws a clear link from the overall ToC as developed and presented in the inception report while allowing the country cases to reflect local contexts and realities and the UNFPA response

- It allows the country cases to include areas of UNFPA engagement and support and positive or negative results which may not have been captured in the reconstructed ToC[6]
- It simplifies the reporting of findings at country case level since it does not require the development of separate, country level ToC
- It still allows for a strong testing/challenge of the ToC at country level because it allows the evaluation team to verify the validity of key assumptions. In effect, this combines analysis of assumptions and risks (the main risks are usually that key assumptions are not realised)
- Using the common structure of the eight issues areas and their associated key assumptions will facilitate synthesizing the findings and conclusions of the country studies during the preparation of the overall evaluation report.

In this way the country case study notes are able to establish the link from the country level evaluation results to the overall Theory of Change for UNFPA support to FP.

This report covers the case study in Burkina Faso.

1.4 Structure of the country note

Section 2 of the report outlines the case study methodology. Section 3 gives a short overview of key elements of FP in Burkina Faso and the UNFPA response and provides the necessary context for discussion of the specific evaluation questions and UNFPA contributions. Section 4 presents the findings of the case study along the eight evaluation questions, including progress and changes during the evaluation period and the UNFPA contribution to those changes. Section 5 presents a set of conclusions.

2 METHODOLOGY

2.1 Selection of country case studies

The five in-country case studies include three from West and Central/Eastern and Southern Africa regions, one from Asia-Pacific region, and one from Latin America and Caribbean region. The sample maximises the breadth and depth of insights into the evaluation questions and gives a broad picture of the UNFPA contribution to family planning (FP) over time in different contexts, giving insights into the country perspective on the evaluation questions, providing examples of externalities and risks and how they have been addressed, and complementing the information collected from other sources. This section summarises the process and results of country selection for visits and desk studies. A full description of the case study selection is given in the Evaluation Inception Report (UNFPA 2014c).

The selection started with a purposeful sample based on criteria which cover the dual purpose of the evaluation: looking back to assess UNFPA performance in the field of FP, and providing learning for the on-going UNFPA Strategic Plan. Criteria included poverty indices, levels of UNFPA spending and past performance in FP taking into account both change in modern contraceptive prevalence rate (mCPR) and unmet need.

From the purposeful sample, countries were selected for in-country and desk studies taking into account the following criteria, to ensure a spread and contrast in the set of case studies:

[6] The reconstructed ToC was developed in the inception phase of the evaluation, based on the pertinent UNFPA strategy documents, which include family planning during the period. Expected pathways of change were identified and mapped for each of the 8 evaluation areas (see annex of inception report).

- Overall UNFPA spending per capita
- The need to include at least one country with Global Programme for Reproductive Health Commodity Security (GPRHCS) Phase 1 Stream 1 support[7]
- Availability of sufficient and sufficiently reliable data and information on past UNFPA support and the overall country context
- The need to include at least one fragile state or humanitarian situation, at least one high-population country and one or more countries with a One UN (delivering as one country) programme
- Varying degrees of government support for FP
- Changes in UNFPA modes of engagement and implementation risks
- The need to avoid concurrent implementation of in-country case studies with other UNFPA thematic and country evaluations
- The potential of the country study to contribute to analysis of the hypotheses in the evaluation matrix.

The resulting sample is spread across the UNFPA Strategic Plan business model's four quadrants, which show need for FP interventions vs. capacity to finance such interventions, although application of the sample selection criteria clearly favours countries in the quadrants representing countries with relatively higher levels of need and lower levels of financing ability (UNFPA 2013). Aside from Burkina Faso, the other countries selected for the field phase are: Bolivia, Cambodia, Ethiopia, and Zimbabwe.[8]

2.2 Selection of Burkina Faso as a case study

Burkina Faso was selected for a case study as it has characteristics regarding UNFPA support to FP that offer important insights into the country perspective on the evaluation questions in a specific context. Relevant characteristics of the country and the UNFPA country programmes in the evaluation period include:

- Strong national commitment for FP and engagement in regional and global partnerships in family planning (the Ouagadougou Partnership and FP2020 respectively)
- A mostly rural population with diversity in religious and cultural characteristics, which affect the context for FP and the UNFPA response
- Participation in the GPRHCS (Phases 1 and 2)
- Large number of donors in FP operating from a global or regional base, with UNFPA as the major donor with a national presence
- Existence of humanitarian crises during the period under evaluation

2.3 Scope of the study and data collection methods

The country study covered all UNFPA FP work during the evaluation period: projects fully dedicated to FP as well as those in which FP activities are a component of other sexual and reproductive health (SRH) projects were captured. Core and non-core funding (including funding from the GPRHCS thematic trust fund) was covered by the analysis.

The study was carried out during April 2015 by a team of two consultants (one international and one national) and a national translator. UNFPA Country Office (CO) staff participated fully in the preparation of the study and logistics, internal discussions and interviews within the CO, collection and analysis of information and financial data, and in the de-briefing workshop session. CO staff organised visits to health facilities in a rural area.

[7] Stream 1 countries are those selected for priority attention by GPRHCS for multi-year, flexible and predictable funds to help countries develop more sustainable approaches to Reproductive Health Commodity Security (RCHS)

[8] See inception report for discussion of country selection.

Preliminary work (prior to the country visit) included:

- Collection and review of key data of Burkina Faso including country background; country health sector and other sectors relevant for SRH/FP; health and other SRH/FP-relevant indicators
- Desk analysis of UNFPA response in the country; overview of UNFPA interventions (2008-2013)
- Initial analysis of financial data by Evaluation Office
- Preparation of detailed timetable for interviews and other activities during the country visit (in consultation with Country Office).

In-country work was designed to provide input to the eight evaluation areas. Activities included briefing and de-briefing with CO staff and interviews with UNFPA staff, government officers, bilateral donors, national and international non-government organisations (NGOs), health service delivery personnel and clients, to give a balance of different points of view of UNFPA support to FP and the current context of FP programmes and services. Focus group discussions (FGDs) were held with young people, FP users and non-users, and men. The team worked with CO staff to identify FP budgets and spending over the evaluation period, including FP spending within other thematic areas.

There was a field visit of two days to Dédougou Region, where UNFPA has supported FP activities. The purpose of the field trips was to gain insights on rights holders' needs, duty bearers' responses, and programme successes and challenges in the decentralised country context and to add context-specific examples to the overall country picture.

Data and information collected from documents, interviews, field trips and FGDs was collated in an evaluation matrix (see Annex 3). Activities and progress in each evaluation area were analysed to identify the changes which have occurred and the UNFPA contribution to those changes. At the end of the visit the team presented preliminary findings to the UNFPA CO staff for their comments and feedback which are included in the analysis in section 4 of this report.

Documents consulted are shown in the list of references (Annex 1). A list of people interviewed and FGD participants is given in Annex 2. Interview guides and FGD guides are presented in the Evaluation Inception Report.

Limitations on the data collected include:

- Inconsistency in data available on the status of FP and contraceptive prevalence. The most recent demographic health survey (DHS) was conducted in 2010, and there have been two interim efforts to estimate prevalence before the next survey takes place. These two studies have very different results, with one showing progress and the other indicating stagnation in prevalence.
- The FGDs for users and non-users and men attracted many more participants than expected, which made it difficult to manage the dialogue and address all the issues the team wanted to cover.
- Detailed financial information on FP spending within other SRH projects is based on estimates by CO staff. This approach was chosen due, primarily, to challenges in obtaining FP expenditure through the use of the UNFPA financial management platform (Atlas). For the period under evaluation, the UNFPA financial management platform did not consistently track FP expenditure and, when it did, it did not capture the full range of expenditure given that FP was often integrated within other projects.

3 SHORT DESCRIPTION OF FAMILY PLANNING IN BURKINA FASO

Country background

Burkina Faso, a landlocked, arid country in Western Africa, is one of the poorest and least developed countries in the world. The population, estimated at 17.9 million in mid-2014, grows at an annual rate of 3.1 percent, and will more than double by 2050 (PRB 2014). The total fertility rate (TFR) of Burkina Faso has declined over the past two decades from 6.9 in 1993 to 6.0 children in 2010 (INSD, MEF et al. 2012), but still remains high. The population has a young age structure, with 46 percent below 15 years of age. Burkina Faso is largely rural, with approximately 77 percent of its people living in rural areas and relying on subsistence agriculture. The Sahel climate, with one rainy season, frequent drought, and poor soil, contributes to difficult economic conditions for much of the population. Rural areas are sparsely populated and the overall average population density for the country is 60.3 people per square kilometre; however, Burkina Faso is experiencing rapid urbanisation, with the urban growth rates estimated at 6 percent per year (compared to 1.8 percent in rural areas) (United Nations 2014).

Burkina Faso is one of the poorest countries in the world and ranks 181 of 187 countries on the United Nations Development Index (2014). Gross National Product (GNP) per capita is very low, although it has increased in recent years from US$407 in 2005 to US$649.3 in 2012. Similarly, the economy has grown, as evidenced by annual growth rates in the gross domestic product (GDP) of 8.7 percent in 2005, 8.4 percent in 2010 and 6.2 percent in 2012 (United Nations 2014). Adult literacy rates are low at 28.7 percent; and gender inequality is high, with a Gender Inequality Index (GII) of 0.607 (higher than the average for least developed countries at 0.570) (UNDP 2014).

The administrative structure of Burkina Faso is decentralised to 13 administrative regions. The present government is an interim government until elections are held in October 2015.

Health System

The health system in Burkina Faso is organised into three levels. At the central, national level, the Ministry of Health (MoH) is responsible for overseeing three national university hospitals; the development of government health policies, norms and standards; the coordination and evaluation of public health programmes; and support for the regional directorates (Direction Régionale de la Santé – DRS). In each of the 13 regions, a DRS is responsible for coordination and supervision of all health services, including provision of technical assistance to districts. There are nine regional hospitals (*Centres Hospitaliers Régionaux*) in the country. At the primary, or peripheral tier, there are 63 health districts with a district health team (*Equipe Cadre de District* - ECD) responsible for the oversight of health activities within the district. District facilities provide medical, surgical, laboratory and pharmacy services, including emergency surgery and complications from birth. Within the districts, there are approximately 1,400 health centres (*Centre de Santé et de Promotion Sociale* - CSPS).

The CSPS is responsible for the provision of a minimum package of preventive and curative care, including mother and child health (MCH) care. MCH care includes pre- and post-natal consultations, labour and delivery, immunisations and family planning (FP). Health committees support community participation in collaboration with the CSPS in healthcare, including the promotion of health education and serving as a link between community and CSPS staff. Each CSPS covers approximately a population of 10,000 within a 10 km radius.

In Burkina Faso, the private sector is small and its contribution to the provision of health services is limited. Approximately 20 percent of the health facilities are private and deliver mostly primary or secondary level services. Private provision of care is concentrated in the urban centres of Ouagadougou and Bobo Dioulasso; and it is estimated that only 13 percent of people seeking

healthcare go to these facilities. Contraceptive use is highest among the richest quintile (18 percent) at twice that of the poorest quintile (9 percent). Contraceptive users pay a fee for commodities, although these were recently halved in 2015.[9] The share of supply of modern contraceptives by the public sector has increased from 53.9 percent in 2003 to 73.7 percent in 2010, with the remainder provided by private providers or "other" private sources (DHS 2015). Private sources include the service provided by international non-government organisation (NGO) affiliates, such as the Burkina association for family health (*Association Burkinabé pour le Bien-Etre Familial* - ABBEF) and Marie Stopes International (MSI). MSI estimates that since its opening in 2009, it has become a significant source of contraceptive information and services (serving 19,000 women in 2010), signalling a trend toward increased private sector engagement in FP in Burkina Faso (MSI 2015).

A major problem in the public health sector is the severe shortage of health providers. This lack of capacity is exacerbated by a concentration of providers in urban areas, high turnover of all medical staff especially in remote areas, and insufficient training of health workers in quality of services for different groups. These problems also affect FP service provision.

Health sector spending in Burkina Faso

Overall spending in the health sector in Burkina Faso was estimated to be 6 percent of its GNP, with government spending 58.5 percent of total health expenditures and 22.7 percent coming from external resources (WHO 2015). Donor funds for population assistance[10] have increased dramatically and have more than doubled over the period of evaluation from US$31.3 million in 2008 to US$ 67.9 million (UNFPA 2014b).

UNFPA spending on sexual and reproductive health and rights (SRHR), including FP is estimated at US$18.29 million for the period 2008-2013, of which approximately US$4 million was core funding and US$14.25 million was non-core funding. Annual levels of SRHR funding increased during the period of evaluation and reached their highest level in 2012 at US$4.34 million, ending up at US$3.98 million in 2013.[11] UNFPA funding for SRHR, including family planning, in 2012 accounted for 6 percent of the aforementioned amount of donor assistance in 2012 (67.9 million).

The UNFPA Country Office (CO) coded its SRHR expenditures as 100 percent in support of FP; however, one can argue this is an overestimate. For example, approximately US$1 million is in support of the prevention and treatment of obstetric fistula, which is considered a maternal health intervention. Regardless, the expenditures show an increased trend in the allocation by UNFPA of funds for sexual and reproductive health (SRH) and FP activities, in alignment with an increase in overall donor and government commitment to reposition FP.[12]

UNFPA has had to position itself within a growing set of development partners including bilateral and foundation donors (some working at the regional level) and international NGOs (INGOs) to advance FP in Burkina Faso. For example, a five year US$22 million project by the World Bank was started in 2011 to improve the delivery and quality of a reproductive health service package through results-based financing, complemented by a US$19 million project to build the capacity of health staff to deliver reproductive health (RH) services. Other resources leveraged for family planning have increased in recent years, including *Agir pour la Planification Familiale* (Agir-PF), a USAID project, led by EngenderHealth; increased resources from Marie Stopes International and ABBEF, the

[9] Annex 3 - Assumption 2.3

[10] Population assistance includes funding for family planning, maternal health programme and system related costs, HIV AIDS and basic research/data/policy analysis.

[11] Country Office financial data (Annex 4)

[12] Country Office financial data (Annex 4)

International Planned Parenthood (IPPF) member association; as well as many other civil society organizations (Maiga 2012).

SRH and family planning

The most recent demographic and health survey (DHS) was conducted in 2010 and another one is underway in 2015 with preliminary results to be available in late 2015-early 2016. Contraceptive prevalence rose steadily from 4.2 percent in 1993 to 8.6 percent in 2003 to 15.0 percent in 2010 (PMA2020 2015). The method mix is dominated by hormonal methods, with very low use of IUCDs and female sterilisation. Use of modern methods is lowest among rural women and those with lowest educational levels. There are large disparities in contraceptive use between the lowest and highest wealth quintiles, 7.1 percent and 33.6 percent respectively (DHS 2015). Unmet need for FP was 23.8 percent in 2010. Teenage pregnancy rates are high (23.6 percent of adolescents age 15-19 who are mothers or pregnant), but have declined from 31.1 percent in 1993 and 25.4 percent in 2003 (DHS 2015).

Maternal mortality rate (MMR) in Burkina Faso is high at 341 per 100,000 live births (INSD, MEF et al. 2012); however, progress has been made, with a 49 percent reduction in the MMR since 1990 (WHO, UNICEF et al. 2014). There have also been reductions in HIV prevalence from 1.8 percent of the general population (age 15-49) to 1 percent in 2010, although disparities remain with a higher prevalence rate for women (1.8 percent) than for men (0.8 percent) (UNFPA 2015).

Although indicators are improving, principal problems in SRH, including those dealing with FP, are high fertility, high maternal mortality and adolescent pregnancy, low use of modern FP methods, and unsafe abortion. It is estimated that one-third of all pregnancies are unintended and one-third of unintended pregnancies are ended by abortion (Guttmacher Institute 2014) and Burkinabé women face a 1 in 44 lifetime risk of maternal death (WHO, UNICEF et al. 2014). The high population growth rate over the last 20 years, an unevenly distributed population, rampant urbanisation, and an extremely young population contribute to supply-side problems of limited capacity and inadequate service provision (UNFPA 2015).

During the period under evaluation, Burkina Faso experienced two major humanitarian crises – catastrophic floods in September 2009 affected 150,000 people with damage and loss, and rendered 50,000 homeless. In 2012, there was an influx of Malian refugees, which further weakened already vulnerable populations in the northern regions of Burkina Faso. In January 2013, the United Nations High Commission for Refugees (UNHCR) registered approximately 50,000 Malian refugees in three official camps (UNFPA Burkina Faso 2014d).

Government policy on family planning

The principal laws and policies relevant to family planning are shown in Table 1 below.

Table 1: Strategic Documents related to family planning

2004	Decree No. 2004-486/PRES/MPF
2005	Law 049-2005 045-2005 AN (explicit approval for contraceptive provision)
2005	Decree No. 2005-398/PRES/PM/MS regarding private health practices
2007-2010	Strategic Plan for RH Communications
2009-2015	Strategic Plan for RH Commodity Security
2010	Reproductive Health Protocols
2011-2015	Strategy for Accelerated Growth and Sustainable Development (SCADD)
2011-2015	National Policy for Health Development
2011-2020	National Plan for Health Development

2012	Community Health Policy
2013-2015	National FP Revitalization Plan (*Plan de Relance)*

The national population policy of Burkina Faso was first operationalised as a programme in 1991-1995 and focused priorities for action in MCH/FP, the advancement of women, youth development and environmental protection. The current policy seeks to address the high rate of population growth; high levels of maternal and infant mortality; internal and external migration, including rapid urbanisation; and the marginalisation or women. Moreover, the policy is aligned with international conference recommendations, including but not limited to the United Nations International Conference on Population and Development (ICPD) (Cairo, 1994) and the International Conference on Women (Beijing, 1995). It also calls for improved reproductive health by promoting increased use of RH services by women, adolescents and youth with objectives related to safe motherhood, FP, HIV/STI and Female Genital Mutilation (FGM) (MEF and CNP 2000).

In 2005, Burkina Faso passed the law on reproductive health, hence repealing the French anti-contraceptive law (1920), which was still in effect in policy and/or practice in many post-independent countries in West Africa, despite the existence of programmes to support family planning and contraception. The law on reproductive health is based on the principles adopted at the 1994 ICPD in Cairo and enshrines the rights of individuals and couples to freely decide the number of children and spacing of their births. Family planning is also included within many plans and policies from the mid-1990s on, including but not limited to the National Health Development Plan (*Plan National de Développement Sanitaire* - PNDS) 2001-2010, the Strategic Plan for Reproductive Health Commodity Security (*Plan Stratégique de Sécurisation des Produits de la Sante de la Reproduction* - PSSPSR) 2009-2015, and the Community Health Policy (2012). Family planning is also one of the priority actions of the National Health Development Plan 2011-2020, which seeks to fulfil the Millennium Development Goals (MDGs) and is aligned with the Sustainable Development and Accelerated Growth Strategy (SCADD) 2011-2015.

Although FP is fully incorporated into the relevant laws, policies and normative documents, the main challenge remains operationalisation and ensuring full implementation.

UNFPA responses

Overview

The period under evaluation (2008-2013) covers the 6th and 7th Country Programmes (CPs), which ran from 2006-2010 (United Nations 2005) and 2011-2015 (United Nations 2010) respectively. Both programmes address the principal SRH priorities in the country, and increased availability of and access to high-quality, reproductive health services, including maternal health (and within this, emergency obstetric and fistula care), FP, and adolescent reproductive health. In the 6th CP, FP was integrated within the basic package of integrated RH services (which included all of these areas), whereas within the 7th CP, there was a more explicit focus on reproductive rights, including FP services.

The 6th CP had a total budget of US$18 million, US$14.5 million from regular (core) resources and US$3.5 million from non-core funding. Of the three focus areas (RH, population and development and gender equality), the RH component had the largest share of the budget at US$10 million. The programme was aligned with government efforts to improve sexual and reproductive health, particularly among mothers and adolescents and youth; prevent HIV and AIDS; integrate population, gender and human rights dimensions into development policies and programmes; and promote gender equity and women's empowerment. The key strategies were to pursue a decentralised approach in a few targeted regions, to reinforce the capacities of national institutions and systems,

and to strengthen gender, cultural and human rights approaches to SRH. The 6th Country Programme Evaluation (CPE) concluded that UNFPA contributed to building national capacity, mainly in accelerating the reduction of maternal mortality through interventions in emergency obstetric and neonatal care (EmONC), fistula care and RH commodity security (RHCS); however, implementation issues such as vertical management of programme areas as separate "siloes", inefficient coordination and a weak monitoring system hampered progress (UNFPA Burkina Faso 2009b).

The 7th CP (2011-2015) had over twice the budget at US$31.7 million, US$16.7 million from core resources and US$15 million from non-core funding. The RH allocation was doubled with an infusion of non-core resources, mainly from the thematic fund for Global Programme for Reproductive Health Commodity Security (GPRHCS). Following the groundwork in FP policy and advocacy accomplished during the 6th CP, the strategies under the 7th CP were to advocate to close the gap between policy and implementation, the repositioning of FP on the development agenda, and to strengthen partnerships with civil society organisations; to support the implementation of PSSPSR; develop a comprehensive package to address youth and adolescent health needs; strengthen programmes to promote male and female condoms; and integrate reproductive health issues into emergency response operations.

The draft 7th CPE (UNFPA 2015) found that UNFPA contributed through its strong emphasis on capacity development and major work in terms of advocacy, awareness, communication and engagement of community organisations. Through its partnerships with NGOs and civil society, UNFPA was able to extend its reach both geographically and with marginalised populations including refugees. UNFPA also served as a catalyst for innovation through a wide range of activities and partners. Information collected on the CO FP work during this case study triangulates well with the overall 6th and 7th CPE conclusions.

Global Programme for Reproductive Health Commodity Security

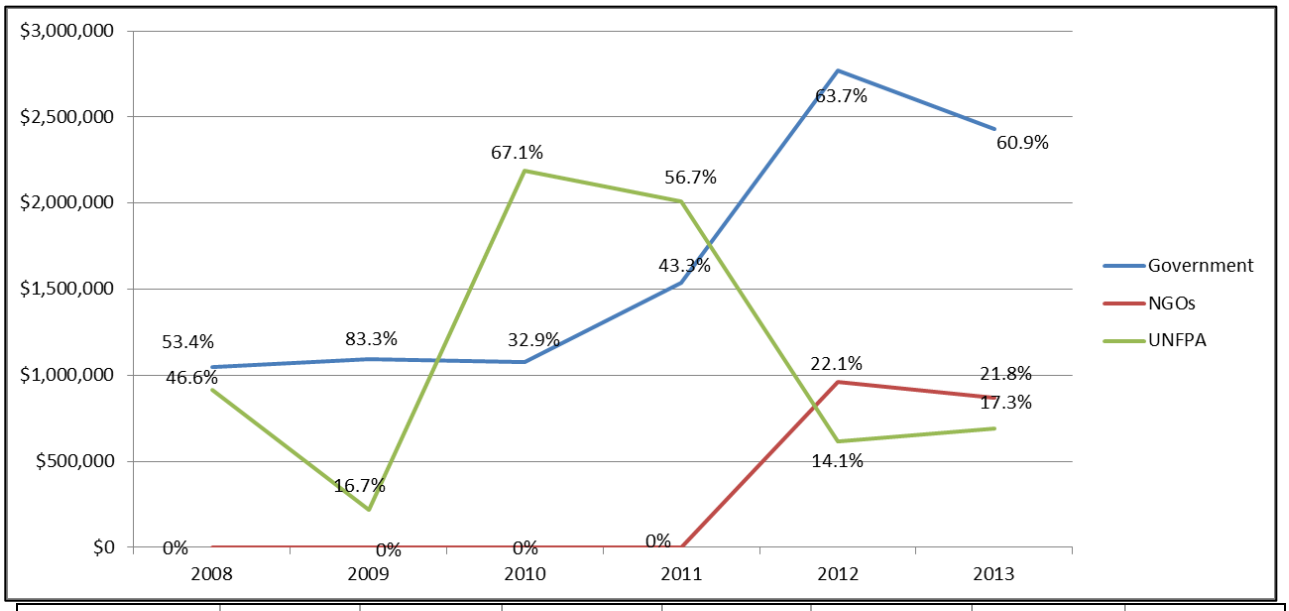
Burkina Faso first received GPRHCS funding in 2010 and is now participating in GPRHCS Phase 2 (2013-2017). GPRHCS funds have been used for procurement, capacity building on the supply side through strengthening commodity monitoring and coordination, service provider training, and for other training and capacity building which the CO could not support previously due to lack of funds. Interventions supported under GPRHCS included a strategic focus on Logistics Management Information System (LMIS), capacity building of pharmacists and the implementation of CHANNEL, a UNFPA-developed monitoring software to track stockouts; support for community-based distribution in all regions and covering almost all districts through capacity development and financial support for NGOs and the local associations that they support; support for mobile outreach services, including an annual FP week to mobilise advocacy and service delivery activities; and the conduct of a journalists caravan to support accurate messages about FP in the national print, television and radio media (UNFPA 2014c).

Implementing partners

The MoH, including the Directorate of Family Health (*Direction de la Santé de la Famille* - DSF), the Directorate for Health Promotion (*Direction de la Promotion de la Santé* - DPS), and the Permanent Secretariat for the Fight against HIV and AIDS and STI (*Secrétariat Permanent du Conseil National de Lutte contre le Sida et les IST* - SP-CNLS/IST), were the main implementing partners during the period under evaluation. During the 6th CP, the partnership extended to three regional directorates as part of the targeted geographic strategies for both fistula care and SRHR activities. However, with expanded funding through GPRHCS, UNFPA extended its partnerships to include several international and national NGOs to support the SRH and capacity development across all 13 regions

in Burkina Faso (see complete list in Annex 5). Figure 1 shows trends in UNFPA financial support to implementing sectors during the period under evaluation.[13]

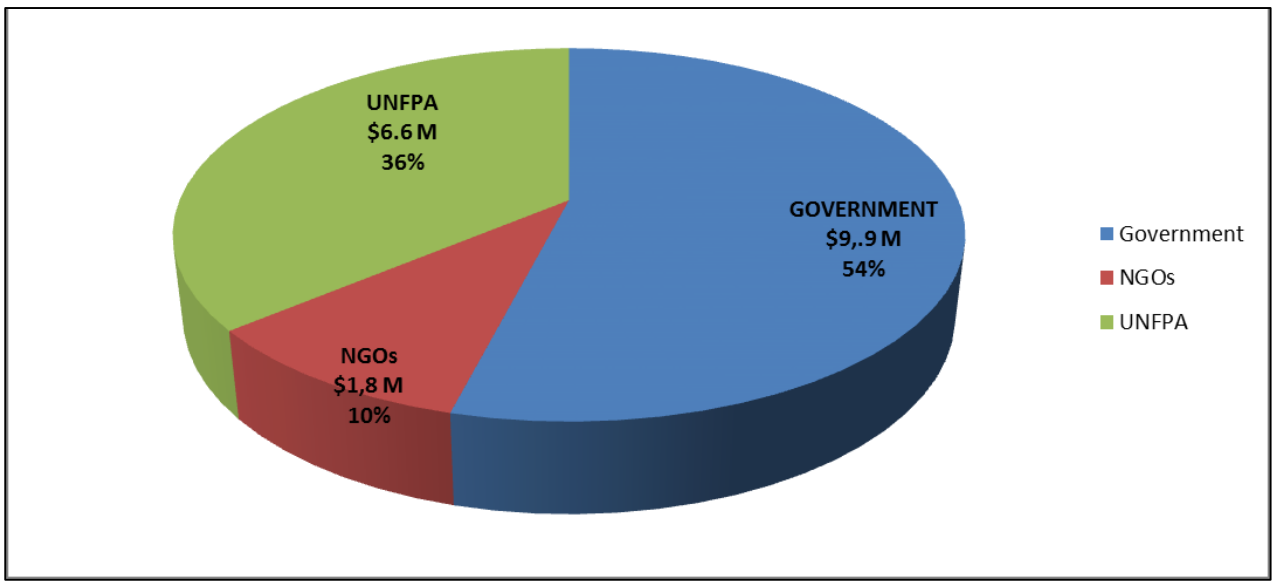
Figure 1: UNFPA Support for Family Planning by Implementing Agency Type (2008-2013) (USD)



	2008	2009	2010	2011	2012	2013	TOTAL
GOVERNMENT	$1,050,350	$1,092,686	$1,074,462	$1,535,377	$2,770,136	$2,427,755	$9,950,766
NGOs	$0	$0	$0	$0	$962,682	$866,962	$1,829,644
UNFPA	$916,147	$218,998	$2,190,336	$2,009,332	$613,401	$690,344	$6,638,558
	$1,966,497	$1,311,684	$3,264,798	$3,544,709	$4,346,219	$3,985,061	$18,418,968

Source: Burkina Faso Country Office

Figure 2: Support to family planning, spending by implementing Sector (2008 – 2013) (USD millions)



[13] UNFPA support to Programme D'appui au Développement Sanitaire (PADS) is included in the government category, although some of this funding flowed to NGOs via contracts.

Annex 4 shows the estimated spending of UNFPA core and non-core resources within each project. These figures may be overestimated, as some of the projects and partners are implementing activities that go beyond FP, such as fistula care and HIV/AIDS prevention. Nevertheless, the expenditures for FP are high, even if one discounts for spending in these other technical areas. Most projects are jointly implemented by UNFPA and the implementing partners (IPs), with public and NGO sectors participating jointly in several major projects, including access to services via community-based FP and mobile outreach, capacity building and demand promotion. Availability of GPRHCS funds (non-core funding) enabled the CO to intensify its work on the supply-side, including procurement and capacity building in the supply chain, and training for service providers, especially in 2012-2013. The top three implementing agencies by expenditure on FP (2008-2013) are (from highest to lowest): UNFPA, Programme to support health development (*Programme d'Appui au Développement Sanitaire* - PADS), MoH (DSF, DPS and SP-CNLS).

4 FINDINGS

The country case study findings for each of the eight evaluation areas are presented in sub-sections 4.1 to 4.8 below. For each area, we present an overview of progress and UNFPA responses in the period under evaluation, followed by an analysis of the contribution made by UNFPA. Each sub-section concludes with a paragraph relating the findings directly to the assumptions of the evaluation matrix. This approach allows the evaluation team to test the validity of the assumptions at the country level, and facilitates synthesis of the findings from the case studies and other data collection elements for the overall evaluation analysis and report.

The findings presented here build on information collected during fieldwork and document review, and take into account feedback and comments from UNFPA Burkina Faso and other stakeholders. Points in the text are referenced through footnotes to the corresponding section of the Evaluation Matrix presented in Annex 3. The annex shows the key data and information on which the analysis was based, ordered by evaluation question and by assumption.

The case study was designed to provide evaluative information and illustrative examples for the eight evaluation questions. It does not aim to assess the performance of the Burkina Faso country office (CO) in relation to the family planning (FP) outputs of the two country programmes, which span the period under evaluation.

4.1 Integration of family planning with other Sexual Reproductive Health services

Q1) To what extent has UNFPA supported integration of family planning with maternal health, HIV/STI and GBV services in health plans and at primary health care level, in services for adolescents, and in emergency and humanitarian situations?
Summary of the relation between the findings and the assumptions of the evaluation matrix: • UNFPA staff and partners agree on the meaning and importance of integration. • UNFPA has stimulated and supported efforts toward integration at the policy level and in service provision, and within humanitarian assistance activities, but these are at early stages and not yet scaled up. • UNFPA has catalysed FP integration into maternal health, through support of partners to pilot post-partum family planning and to strengthen FP in post abortion care. • There is insufficient data to conclude to improvements in access and service quality, particularly from the users' perspective.

Progress and Activities

The growing interest in family planning within Burkina Faso and among donors has spurred the National FP Revitalisation Plan, *Plan de Relance* 2013-2015. The plan squarely focuses on FP as a key priority intervention and does not explicitly include reference to integrated service delivery (Ministère de la Santé 2013b), although integration is implicit in the components related to youth education and advanced service delivery strategies.

UNFPA provides leadership and promotes activities that support integrated sexual reproductive health (SRH) services and outcomes, including the integration of FP within maternal/child health and HIV/AIDS activities. The expected outcome from the reproductive health (RH) components in both the 6th and 7th country programmes (CPs) is increased utilization of integrated RH services, including FP, maternal care, STIs and HIV and AIDS, although these were defined slightly differently from one programme to the next. The 7th CP had a greater focus and emphasis on FP.[14] CO staff made linkages among the different components, for example linking FP as a prevention strategy in the campaign against obstetric fistula, and ensuring that FP is included in pre-service training of midwives in safe motherhood and in the minimum integrated service package (MISP) in humanitarian services.[15]

The UNFPA youth strategy to promote SRH among adolescents and youth is integrated, given the high vulnerability of this population to unintended pregnancy, unsafe abortion, STI and HIV infections, and gender-based violence.[16] The "school for husbands" (*Ecoles des Maris*) intervention piloted in Niger to increase men's engagement in safe motherhood and FP decision-making is being implemented in Burkina Faso as a regional best practice. The UNFPA strategy to extend access to FP at a national scale through its partnerships with civil society organisations (CSOs) and non-government organisations (NGOs) also includes several integration efforts. These include working with partners such as the organisation *Initiative Privée Communautaire de lute contre le VIH/SIDA (IPC), Plan Burkina*, Burkina Council of AIDS Services Organisations (BURCASO), and SP-CNLS to build capacity for community-based services that integrate FP into safe motherhood and/or HIV and AIDS prevention activities. UNFPA specifically has partnered with groups that enable them to not only reach more communities with contraceptive information and services, but also to embed FP within an integrated context that responds to community-level needs.

Two major initiatives to advance integrated services in Burkina Faso were undertaken by UNFPA during the period under evaluation. The first, in 2009, was a joint national assessment with International Planned Parenthood Federation (IPPF) of SRH/HIV integration and linkages at the policy, systems and service levels.[17] UNFPA provided the technical and financial support to bring together stakeholders from the *Direction de la Santé de la Famille* (DSF), the National AIDS Committee, UNICEF, UNFPA WHO and community-based organisations (CBOs). Burkina Faso was one of several countries to use the IPPF linkages tool, however, it is not clear how the findings or results were used in programmes to stimulate or improve integration.

The second major effort by UNFPA is a pilot programme to advance postpartum contraception in partnership with Jhpiego.[18] With a strong maternal/child health rationale for FP, increased awareness of birth-spacing among communities and leaders, and a large share of FP services provided by the public sector effort, postpartum contraception is a good strategy for improving access and use of contraception (WHO 2013). The first phase of the project started in October 2013 and included nine sites; the second phase is covering an additional 12 sites.

14 Annex 3, Assumption 1.1
15 Annex 3, Assumption 1.1
16 Annex 3, Assumption 5.1
17 Annex 3, Assumption 1.3
18 Jhpiego is an international, non-profit health organisation affiliated with the Johns Hopkins University.

Contribution of UNFPA to Family Planning outputs and outcomes

UNFPA, as the key technical partner of the public sector and the DSF, has played a major role in supporting integration of FP within SRH services in policies, plans and services. Integration is a key feature of the UNFPA youth, humanitarian, and community-based strategies. The CO is partnering with a range of international and national CSOs to leverage its resources (human and financial) to take advantage of opportunities to add FP to existing activities and services, thereby extending its reach beyond what it can do on its own through integration. UNFPA leadership has resulted in the development of policies and national plans that promote integration.

In the absence of specific indicators related to FP/SRH integration during the period under evaluation, there is not an easy way to identify or track progress on the integration of FP in other SRH activities over time through UNFPA country programme reports in which the narrative is limited. The CO has identified a new indicator in 2015 to track progress on integration of FP into emergency obstetric and neonatal care (EmONC) facilities. Special studies are more promising for understanding the process and outcome of integration strategies. The IPPF assessment tool was used as a baseline, yet was not repeated to see how the context for integration improved or changed over time. However, the findings contributed to knowledge management although the recommendations reported were fairly general, e.g. developing guidelines and plans, training providers, establishing coordination mechanisms. In a study of youth-friendly services seven percent of facilities were found to have a specific unit devoted to SRH of young people, and 70 percent stated they were able to provide integrated SRH and HIV and AIDS information and services (UNFPA 2015).

Outcomes from the Jhpiego postpartum family planning (PPFP) project are promising and will be useful to demonstrate the opportunities and challenges to consider in scaling up PPFP, in particular the postpartum intrauterine device (PPIUD), in Burkina Faso and other West African countries with similar contexts. Postpartum contraception services were well-integrated into the maternity setting at the Dédougou Referral Hospital, where UNFPA supported Jhpiego to train providers in PPPIUD clinical, counselling and infection prevention skills and provide supportive supervision. Jhpiego reports that in the 14 active sites involved in the project, there was a 14.3 percent uptake for this method (Jhpiego 2015). Given the relatively low share of IUCD in the overall contraceptive method mix in the country (0.8%) (PMA2020 2015), this activity demonstrates that there is potential for improving use of this long-acting option. As a public sector initiative, challenges include frequent staff turnover following training and, in general, the need to improve quality of care within the facilities before introducing the PPIUD. However, sustainability is possible if and once services become part of the norm. No other groups are working on this topic in-country; therefore the UNFPA contribution in this area is potentially significant. By its own admittance as well as confirmed by stakeholders, the CO could improve its documentation of the process and outcomes of interventions,[19] particularly those that have potential for scale-up.

Strengthening capacity of the public health sector in post abortion care (PAC), with particular attention to the FP component of PAC, has been recommended in Burkina Faso.[20] UNFPA is credited with working with Ipas[21] and Jhpiego to integrate PAC into the training curricula for the National School of Public Health, as well as including PAC in its humanitarian assistance plans and working with Family Care International (FCI), although there are other groups working to strengthen PAC capacity (Fikree, Mugore et al. 2014). In addition, UNFPA strengthened its own readiness to respond to humanitarian crises from 2012 to 2014, including the development and stocking of an emergency dignity kit (with items such as sanitary towels, soap, cloth, etc.). These kits were in high demand and

[19] Annex 3, Assumption 7.3

[20] Annex 3, Assumption 1.1

[21] Ipas is a global NGO dedicated to ending preventable deaths and disabilities from unsafe abortion

provided an entry point for providing other RH and gender based violence (GBV) services to refugees.[22]

4.2 Coordination and National Ownership

Q2) To what extent has UNFPA successfully contributed on its own and in coordination with others to strengthening national leadership of family planning and improving sustainability?
Summary of the relation between the findings and the assumptions of the evaluation matrix: • UNFPA has actively supported the revitalisation of FP at the national level through its advocacy and technical support for policies, plans and strategies, and at decentralised levels through its work with CSOs and support for FP Week. • UNFPA has worked with government and other partners to mobilise resources for FP and to make FP services more sustainable but this has not always been successful given other political priorities and national budgeting processes. • UNFPA has supported national ownership through its technical support of the Ministry of Health Department of Family Health (DSF), and through its leadership in coordination including the engagement of civil society organizations. • UNFPA has contributed to cultural sustainability through its support of social and community mobilisation and demand creation activities in partnership with civil society.

Progress and activities

There has existed a strong national commitment by the Government of Burkina Faso, particularly since the mid-2000s, to expand access and use of contraceptive information and services as an essential element of maternal health and, more recently, a factor in economic development. The mother and child health (MCH) rationale for FP has been a major factor in its increased political and cultural acceptability over the past several years, although an economic rationale is increasingly part of the dialogue at the community level.[23]

UNFPA has been the major partner of the Ministry of Health (MoH) and has provided technical support for policy and plan development, including the National Health Development Plan (*Plan National de Développement Sanitaire* -PNDS) 2001-2010 and 2011-2020, the Strategic Plan to Secure Reproductive Health Commodities (*Plan Stratégique de Sécurisation des Produits de la Santé de la Reproduction* - PSSPSR) 2006-2015, the Strategic Plan for RH Communications 2009-2015 and the Community Health Policy 2012.[24] In addition, the CO supported overall coordination of FP and leadership by the MoH via the (RH) Technical Committee. UNFPA has also supported the engagement of CSOs to participate in programming and advocacy.

Although reinforcement of FP had been underway, the government reaffirmed its support for FP during its hosting of the Ouagadougou Conference on FP in 2011 and again during the FP Summit in London in 2012. These commitments were elaborated in detail within the resulting *Plan de Relance 2013-2015,* the overall plan guiding government and partner FP activities and the blueprint used for coordination led by the MoH. The plan includes the government stated intent to commit financial resources (500 million CFA annually) for commodities, provide policy support for innovation in service delivery, and enhance implementation through partnership and governance. However, while political support is strong, there remain some critical implementation gaps. The government has not been able to maintain the 500 million CFA budget line for contraceptives, and there are concerns

[22] Annex 3, Assumption 1.1
23 Annex 3, Assumption 4.2
24 Annex 3, Assumption 2.2

that it is unlikely that it will be able to do so in the coming year or so, given the financial constraints during the political transition. The current budget for commodities is 70 percent supported by donors (UNFPA and USAID) and 30 percent by the government. The MoH indicated a desire to see these percentages "flipped," in the interest of sustainability: "*Parliament does not question the budget line for immunisation. Why should they for FP?*"[25]

The lack of sustained capacity within the health system to offer contraceptive services and information on a routine basis is another critical gap, which affects MoH capacity to take leadership in practice. To satisfy unmet need and raise the profile of FP, UNFPA has supported the MoH to conduct an annual Family Planning Week to stimulate use and demand for FP services. First conducted in 2012 and annually thereafter, the FP week engages national authorities, civil society, technical and financial partners and the private sector at the central level and in all 13 regions to mobilise resources, conduct social mobilisation and increase the supply of contraceptives.[26]

UNFPA contribution to results on government leadership and sustainability

As its main technical partner in FP, UNFPA supports the government in the implementation of its priorities, but also has a role in shaping the priorities of the government. UNFPA has contributed to the development of favourable policies, the partially successful mobilisation of funding for FP, the reduction of contraceptive fees (by 50 percent), and has supported capacity development in contraceptive security (the latter in coordination with United States Agency for International Development (USAID) and its DELIVER Project implemented by John Snow, Inc. (JSI). UNFPA has also played an important role in advocating for increased engagement of CSOs in planning and coordination, an important feature of programme sustainability.

The role UNFPA plays is greatly appreciated by its partners in government and civil society. Partners praised the CO for its technical competence in FP, its willingness to problem-solve, and its deep understanding of the social, political and health system context. Country Office support to the DSF is considered to be a unique strategic asset that has contributed in many areas, although not used to its greatest strategic advantage, for example to push the government regarding maintaining its commitment to budget for contraceptive commodities. The government appreciates the continuity of support provided by UNFPA over the years ("*It is always with us*"). The DSF also expressed a desire for UNFPA to extend advocacy for resource mobilisation beyond the MoH and to Parliament and other ministries (such as Finance). CSOs considered the closeness between the CO and DSF an advantage and expressed willingness for UNFPA to lead coordination and to harness their voice on important issues within the FP programme, including advocating for the aforementioned accountability for maintaining the commitment to contraceptive commodities within the national budget.

During the period under evaluation, UNFPA successfully conducted advocacy on a range of innovative programme ideas and approaches to expand contraceptive services, including the introduction of Sayana Press,[27] task shifting, social franchising and postpartum contraception. This advocacy resulted in government approvals for pilot programmes that have already led or will likely lead to improved policies, guidelines and access. The CO conducted much of this advocacy with civil society and NGO partners, and as such, has extended its technical and programmatic reach beyond what it could do on its own. Also, UNFPA expanded its partnerships with CBOs to generate demand and provide contraceptive information and services in culturally acceptable ways. Civil society

25 Annex 3, Assumption 2.1

[26] Annex 3, Assumption 2.1

[27] Sayana Press is a three-month, progestin-only injectable contraceptive product packaged in the Uniject™ injection system, a small prefilled device that cannot be re-used. It is administered via subcutaneous injection and can be considered for task shifting to lower levels of health workers.

partners have a good understanding of cultural norms and barriers in the geographic regions in which they work, and have employed strategies that are tailored to the local context. In addition UNFPA engaged with the national affiliates of international NGOs, such as IPPF and Marie Stopes International (MSI), to conduct mobile outreach to meet unmet demand and create new demand for contraception information and services.

While generally an advantage as noted above, civil society partners considered that the close relationship between UNFPA and DSF is also a possible weakness, as raising difficult issues could jeopardize future relations. For example, both the DSF and CSOs expressed interest in UNFPA leading the process to evaluate the *Plan de Relance,* as the current plan ends in 2015. This would necessitate a frank and direct dialogue about the reasons for not reaching the stated goal of 25 percent contraceptive prevalence rate (CPR) by 2015, as well as to address the discrepancies between the prevalence rate estimated by PMA2020 (17 percent of the women) and an MoH supported study (21.9 percent of the women). Given the national (and international) visibility for the FP programme, CSOs expressed concern about how performance at a lower than expected level might be viewed during this time of political transition.

4.3 Brokerage and partnerships

Q3) To what extent has UNFPA acted as a broker at global, regional and country levels to promote family planning, acting in partnership with the public, private and non-state sector service providers?
Summary of the relation between the findings and the assumptions of the evaluation matrix: • UNFPA has been an important broker of relationships for family planning between the Ministry of Health and Civil Society Organisations and other NGO partners, especially in relation to contraceptive commodity security and engaging with a broad range of partners to extend FP info and access at the community-level. • The strategic position and profile of UNFPA at the country level are highly visible, despite the crowded landscape for FP, and allow the CO to broker relations effectively. • UNFPA, in collaboration with partners, could be more effective in producing and disseminating knowledge products in support of advocacy for FP.

Progress and activities
Governmental and non-governmental partners consider UNFPA to be a key, strategic actor for FP and SRH issues in Burkina Faso. The two main platforms for family planning repositioning and brokerage in Burkina Faso are the Ouagadougou Partnership, a regional initiative launched in 2011 to accelerate progress in family planning in West Africa, and the coordination of the *Plan de Relance* which represents the Costed Implementation Plan that is monitored as Burkina Faso's FP2020 commitment.[28]

UNFPA actively participates in both of these forums, although its leadership is more behind the scenes through its technical assistance (TA) to the DSF as the lead convener of coordination meetings, including the technical committee. The quarterly meeting of the technical committee, also called the "Partners' Forum," is an important venue for overall coordination, including raising problems, monitoring progress, and exchanging lessons and experiences. NGO and development partners credit UNFPA with expanding the group to include CSOs and for serving as a strong technical resource.[29]

28 Annex 3, Assumption 3.3
[29] Annex 3, Assumption 3.2

The current strategy for UNFPA under the 7th CP includes strengthening partnership with NGOs and CSOs as a means to extend its geographic and technical reach. It is supporting 20 capacity-building NGOs, which in turn support 160 CBOs in FP service delivery at the village level. Under the previous programme, UNFPA partnered with just one organisation, BURCASO, but during the latter half of the period under evaluation, the CO has increased its partnership portfolio to include groups with a wide range of diverse and complementary skills, which allows for testing various approaches across a wide geographical area and in different contexts.[30]

Contribution of UNFPA to results in brokerage and promotion of family planning
As a precursor to the London Summit on FP and the FP2020 movement, the Ouagadougou conference held in Burkina Faso was an important and visible vehicle for FP repositioning and the mobilisation of resources, commitment and advocacy. At the launch of the Ouagadougou Partnership, UNFPA was not among the core partners, which included the French Ministry of European and Foreign Affairs, the Bill and Melinda Gates Foundation (BMGF), the William and Flora Hewlett Foundation and USAID. However, UNFPA later joined in the partnership because of its close working relationship with the government and its role on the global stage in FP2020.

While UNFPA is a known broker for FP in Burkina Faso, several other actors, such as the Futures Group and Advance Family Planning (AFP), share the role of convening groups to address FP needs and issues. These groups have contributed to the conduct of important assessments and analyses to guide the FP repositioning effort within Burkina Faso.[31] Moreover, others, such as EQUIPOP, are playing a highly visible role coordinating FP advocacy with support from AFP. Nevertheless, UNFPA is seen by its NGO partners being critical to advocacy efforts as the CO is deemed to "*have the ear*" of the DSF and the capacity to broker difficult issues.[32]

UNFPA visibility as a broker during the period under evaluation was in the domain of FP product availability, which is monitored quarterly and is a standing item on the donor coordination meeting agenda. It is also a visible champion for promoting access to under-served groups, in particular youth. NGO and government partners also credited the CO with brokering MoH approval to move forward with the introduction of the Sayana Press, approval of pilots to explore social franchising and the delivery of Sayana Press by community health workers, and engagement of CSOs to receive government funding under the programme to support health development (*Programme d'Appui au Développement Sanitaire* - PADS).[33] However, reports by external partners do not always explicitly acknowledge the role UNFPA plays, and instead attribute results to the partners who are supported by UNFPA (in part or in whole) to implement the work, such as with the delivery of mobile services.[34]

The partnership strategy for UNFPA has resulted in increased geographic scope and access to contraceptive information and services. However, UNFPA partners highlighted its cumbersome financial and bureaucratic processes as a major weakness and potential challenge for maintaining and further expanding and diversifying partnerships.[35] Another weakness was a perceived lack of strategic knowledge management to contribute to advocacy for FP. Partners felt that UNFPA could use its position as a convener and broker to facilitate the sharing of experiences, data collection and south-south collaboration. More readily available and well-documented evidence is required for effective advocacy and brokering. UNFPA, its partners and other organizations produce many reports and studies on FP in Burkina Faso; however, the results are not always disseminated or

[30] Annex 3, Assumption 3.2
[31] Annex 3, Assumption 3.3
[32] Annex 3, Assumption 3.2
[33] Annex 3, Assumption 3.2
[34] Annex 3, Assumption 3.3
35 Annex 3, Assumption 3.2

shared in a coordinated manner leading to duplication of effort and missed opportunities to collaborate and advance an issue or programme area.[36]

4.4 Enabling Environment

Q4) To what extent has UNFPA supported the creation of an enabling environment at national and community levels to ensure family planning information and exercise of rights?
Summary of the relation between the findings and the assumptions of the evaluation matrix: • UNFPA has identified key enabling factors at policy and implementation levels, but there remains a gap between policy and implementation, due to a limited capacity to provide quality contraceptive services and information, including a broad method mix, at all levels in the health system. This also has implications for the achievement of integration of FP into other services. • UNFPA has supported partners to conduct appropriate and targeted demand creation activities, with shift in focus during the evaluation period from mass media to community-based interventions. • CO staff identified key enabling factors without support or technical assistance from HQs or the RO.

Activities and progress
As discussed in previous sections, the enabling environment is positive for family planning at the legal and policy levels. The country has many policies and plans that promote access to contraceptive information and services. The new national health policy (*Plan National de Développement Sanitaire* - PNDS), the Strategic Plan to Secure RH Commodities and the Integrated Communication Plan (*Plan Intégré de Communication* - PIC) give priority to promoting FP.[37] The monitoring mechanisms in place to monitor the *Plan de Relance*, including the annual indicators produced by PMA2020 are enabling factors for maintaining the focus on and commitment to FP.

Another enabling factor is the increased commitment of donor resources as a result of the robust global and regional efforts to reposition family planning during the period under evaluation. There are other health financing mechanisms that have emerged during the evaluation period. The results-based financing (RBF) mechanism supports the utilisation and quality of reproductive health services in 15 pilot health districts in six regions with funding from the World Bank. PADS is a mechanism for channelling basket funds from the sector-wide approach (SWAp) to contract with CSOs to support a workplan at the district level. UNFPA participates in PADS (but not the RBF) and only provides a relatively small amount to the basket, US$1.3 million between 2011 and 2013. This funding enables UNFPA representation on the technical group that oversees the work and provides leverage to influence use of the total amount of funding.

However, despite the progress made in the policy and resource mobilization, implementation remains a challenge. Challenges include the capacity of health workers to delivery contraceptive information and services for a broad range of methods and lack of support or active resistance from community-level political, religious and cultural leaders. The situation analysis conducted to inform the 7th CP noted that health indicators remain poor, despite efforts to strengthen the health system by constructing, renovating and equipping facilities and by training health workers. With regard to capacity, the increase in Centres for Health and Social Promotion (*Centres de Santé et de Promotion Sociale* - CSPS), or primary health centres, has outstripped the numbers of health workers and

36 Annex 3, Assumption 3.3
37 Annex 3, Assumption 2.2

midwives needed to staff them.[38] There remain many gender and cultural barriers that affect FP access, particularly for women and young people, including early childbearing and marriage, low levels of education and literacy.[39]

Contribution of UNFPA to the development of an enabling environment for family planning information and exercise of rights

UNFPA has identified several key factors for an enabling environment and this has shaped the country programme over the course of the period under evaluation and beyond. The CO has been working on FP repositioning since 2008. It conducted advocacy with policy makers, parliamentarians, and opinion leaders at central and decentralized levels to mobilize resources and commitment for FP, including a journalists' caravan to support accurate FP information and media coverage.[40]

As noted earlier, UNFPA has provided technical support and contributed to the development of strong policies by the government. The CO has aligned its own programme to contribute to implementation of these plans and policies and in an attempt to close the gap between policy and implementation. An example of this alignment was the shift by UNFPA to expand its scope from three regions in the 6th CP to national in the 7th CP. UNFPA adopted a partnership strategy to extend its reach and coverage, which contributed to improving both capacity (supply) and socio-cultural barriers (demand). This strategy supported mobile outreach teams in partnership with affiliates of international NGOs (MSI and Burkina Association for Family Health (*Association Burkinabé pour le Bien Etre Familial* - ABBEF) to bring services to under-served, rural areas and broaden the contraceptive method mix. The strategy contributed to an increase from 3.9 percent of all women using long-acting contraception in 2010 to 7.9 percent women in 2014 (PMA2020 2015).

UNFPA has contributed to advocacy for increased engagement of the private sector in FP provision, which led to approval for MSI to launch a social franchise network to partner with private health providers to offer FP services.[41]

In addition, to address the enabling environment at community level, the CO contributed to increased demand for FP by providing financial and technical support to 20 umbrella national NGOs to build capacity for 160 CBOs to both create and satisfy demand. This, too, represented a shift in the demand/behaviour change communication (BCC) strategy from a focus on mass media (through radio broadcasts, film screening, information talks) to a community-based strategy that features interpersonal communication and engagement with local religious and community leaders.[42] The strategy supports NGOs that are familiar with the local contexts and can tailor community sensitisation in culturally appropriate and sensitive ways. The contribution of demand activities to specific results or outcomes is difficult to assess, as UNFPA reports generally provide information at the activity and output level, although partners considered the community-based strategy as promising and likely to address persistent access barriers.[43]

The identification of enabling factors has been managed at the CO level, with input from RO and HQ in the form of document review and requests for clarification during the country programme document and annual workplan development process. HQ and RO reviews do not normally include technical input to FP programming planning.[44]

38 Annex 3, Assumption 4.1
39 Annex 3, Assumption 5.1
40 Annex 3, Assumption 4.1
41 Annex 3, Assumption 4.2
42 Annex 3, Assumption 2.3
43 Annex 3, Assumption 4.1
44 Annex 3, Assumption 4.3

4.5 Vulnerable and marginalised populations

Q5) To what extent has UNFPA focused on the family planning needs of the most vulnerable and marginalised groups, including identification of needs, allocation of resources, and promotion of rights, equity and access?
Summary of the relation between the findings and the assumptions of the evaluation matrix: • UNFPA has conducted or supported assessments to identify the needs of VMGs, with special attention to youth and adolescents, to inform advocacy and programming. Good practices have been selectively developed, but not evaluated or scaled up. • UNFPA has allocated resources and programme effort to support VMGs, but there is no data to determine the percentage of resources allocated or effectiveness. • UNFPA has effectively advocated for the SRH rights of VMGs and has supported interventions to empower individuals and develop health system capacity to improve access to SRH information and services. • UNFPA does not have a consistent approach for proactively encouraging participation, including that of VMGs, in programming; however, some work through community-based and civil society partners includes participation and capacity-building. • UNFPA has not developed information on improvements in access and utilization of services by VMGs according to reproductive intentions. However, information collected in this evaluation suggests that access has improved for youth and rural populations in general and this can be attributed in part to the advocacy and intervention support provided by UNFPA.

Progress and activities

The vulnerable and marginalised groups (VMGs) in Burkina Faso are young people including disabled youth and youth living with HIV and AIDS (PLWHIV), women living with fistula, the urban poor and people living in remote, rural areas. These groups experience access barriers to SRH and contraceptive information and services as a result of poor health system capacity to meet their needs, cultural and gender norms, and stigma and discrimination. The needs of young people are most pressing, with young girls vulnerable to early marriage, unintended pregnancy, STI and HIV infections, unsafe abortion, female genital cutting, and gender-based violence.[45] Persons displaced by conflict or natural disasters are also highly vulnerable to unintended pregnancy, STI and HIV infection, and gender and other forms of violence and are in dire need of SRH and other services, including FP and emergency contraception. In Burkina Faso, two major humanitarian crises occurred during the period of this evaluation – devastating floods in 2009 and an influx of Malian refugees in 2012.[46]

Within national plans and strategies related to family planning such as *Plan de Relance*, priority is given to addressing unmet demand in rural populations and among urban poor, as well as to address the needs of young people. However, there remain major gaps in responding to these needs due to weak national implementation capacity, particularly in the area of youth-friendly services.[47] The national priority to strengthen community-based interventions and community participation has led to increased engagement, public-private partnership and engagement of NGOs to meet the needs of Burkina Faso's predominantly rural population.

UNFPA contribution to family planning needs of vulnerable and marginalised groups

UNFPA has supported programmes for vulnerable and marginalised groups with the promotion of SRH among adolescents and youth occupying a prominent place in annual workplans throughout the

45 Annex 3, Assumption 5.1
46 Annex 3, Assumption 5.1
47 Annex 3, Assumption 5.2

period under evaluation. UNFPA has also implemented programmes to repair fistula, address early marriage within the context of female genital mutilation (FGM), and respond to humanitarian crises. The briefs reviewed for this evaluation focused on adolescent and youth, but did not focus on SRH issues for vulnerable groups affected by the HIV epidemic, such as commercial sex workers (CSW), sexual minorities and injecting drug users.[48]

UNFPA has contributed to raising awareness of the needs of VMGs and has supported programming to address their SRH needs and rights. UNFPA has been a leader in raising awareness about the rights and needs of VMGs, and has conducted effective advocacy for integrating principles related to universal access within national policies and plans related to FP. UNFPA is well known in Burkina Faso for advocating for SRH for young people across several ministries to increase commitment and financial contributions.

UNFPA has supported assessments and the development of advocacy briefs and brochures to heighten policy makers' and public awareness of the SRH needs of VMGs, including youth with disabilities and women living with obstetric fistula. Examples of FP programming for VMGs include support for youth-friendly services or listening centres within public sector facilities, as well as support for community-based programmes in partnership with the Permanent Secretariat for the Fight against HIV and AIDS (*Secrétariat Permanent du Conseil National de Lutte contre le Sida* - SP-CNLS), BURCASO and Plan Burkina that focus on the reducing socio-cultural barriers and improving access to SRH services, including FP for youth.[49] The data collected for this evaluation did not shed light on how UNFPA advocates for and encourages VMGs or youth participation or voice in policy or programme assessment and design.

UNFPA has made its mark more clearly in the policy and advocacy realm, whereas it is more difficult to determine how access to FP information and services has been improved (in general and for VMGs specifically) as a result of programme implementation. UNFPA reports "*noticeable contraceptive prevalence improvement*" across all age groups, including 15-19 and 20-24 years, and "*remarkable contraceptive prevalence improvement*" in rural areas (UNFPA Burkina Faso 2013b). However the data used to make these statements are derived from a dataset that is not aligned with the most recent CPR estimates from PMA2020 (PMA2020 2015).

Regarding UNFPA strategies to reach youth, the priority during the evaluation period was given to supporting information campaigns mainly for condom distribution and use, and less so to developing youth-friendly services. For example, UNFPA and the German international development cooperation (*Deutsche Gesellschaft für Internationale Zusammenarbeit* – GIZ) collaborated in 2011 on a promising approach to adapt health facilities to better serve youth, but this did not go beyond the pilot phase. As noted earlier, the UNFPA strategy shift from information campaigns to community-based interventions shows promise to reach youth more effectively.[50] The programme on meeting the SRH needs of handicapped youth is still in early stages, however, UNFPA reports that information on rights related to FP, RH and HIV are available and are being integrated into training, education and communication activities.[51]

4.6 Human rights-based approach

48 Annex 3, Assumption 5.1
49 Annex 3, Assumption 2.3
50 Annex 3, Assumption 5.2
51 Annex 3, Assumption 5.2

Q6) To what extent has UNFPA implemented a human rights-based approach to family planning, in particular regarding access to and quality of care, and through support from HQ and RO for a rights-based approach?
Summary of the relation between the findings and the assumptions of the evaluation matrix: • UNFPA, government and NGO partners do not have a common understanding of an HRBA to family planning, although there are varying elements of rights principles and definitions of HRBA applied by different groups. The opportunity exists for UNFPA to advance a HRBA for FP in Burkina Faso given the country context where FP is a high priority and there are ambitious goals to increase CPR. • UNFPA programming incorporates elements of a rights-based approach, but not in a consistent manner that can be monitored or evaluated; support in this area from HQ or RO is not evident. • UNFPA has contributed to the evidence base for specific groups (mainly via assessments to support advocacy regarding VMGs); there is room for advancing knowledge management in this area. • Anecdotal information suggests that providers (duty bearers) lack awareness and understanding about how to operationalize human rights within FP services for rights holders.

Progress and activities

The rationale for family planning in Burkina Faso is squarely embedded in economic, development and public health perspectives. When the government elevated family planning to a priority in 2007, it was in recognition of the serious health risks to women and children that were posed by continued high levels of fertility.[52] Human rights principles are neither mentioned specifically in the National Population Policy, nor are there explicit principles underpinning the *Plan de Relance,* the document that serves as the principle guide for FP coordination and programming in Burkina Faso. However, these documents include a strong emphasis on improving access, availability, acceptability and quality of services, consistent with the definition of the right to the highest attainable standard of health and to reproductive self-determination, i.e. the right to use or not use contraception absent of coercion or pressure. The documents, however, do not address the broader rights such as the right to control one's sexuality, or to a safe abortion.[53]

Given low levels of contraceptive prevalence and high levels of fertility and unmet need,[54] the stated imperative of the national FP programme is to rapidly expand access to and use of quality contraceptive information and services.[55] Progress in expanding access has been made over the course of the period under evaluation, but contraceptive prevalence is not likely to reach the 25 percent goal by 2015. Within this context, UNFPA has supported its partners to undertake a range of strategies to improve contraceptive method choice and rights, such as outreach services to extend long-acting methods, introducing and expanding access to new contraceptives such as Sayana Press, and/or new approaches (postpartum contraception), and ensuring contraceptive availability at the point of service.[56]

UNFPA uses human rights language in several of its planning and strategy documents; these terms are generally employed when addressing broader issues, such as FGM, gender mainstreaming, and advocacy for legal frameworks. With regard to FP, UNFPA considers broadening method choice, universal access and addressing the needs of VMGs as critical components of taking a rights-based

[52] Annex X, Key Indicators
53 Annex 3, Assumption 6.1
[54] Annex X, Key Indicators
55 Annex 3, Assumption 2.2
56 Annex 3, Assumption 6.2

approach to contraceptive information and services. As noted in the section on VMGs, UNFPA uses a human rights language, including rights principles of empowerment, equity and non-discrimination, in discussing or writing about its work on SRH for disabled youth, reproductive health for adolescents and youth (*Santé de la reproduction des adolescents et des jeunes* - SRAJ), fistula, humanitarian assistance and outreach to rural and underserved areas.

UNFPA partners with like-minded civil society organisations that also advocate for a rights-based approach. ABBEF, the IPPF affiliate Family Care International, and others are champions for rights and use a rights-based approach to SRH, in particular in order to empower individuals and communities to exercise their rights to quality SRH services in a culturally appropriate manner. UNFPA and its CSO partners are addressing acceptability through community-based interventions, and together form a strong coalition to advance a rights-based approach. The Global Programme for Reproductive Health Commodity Security (GPRHCS) has supported facility surveys since 2010; from 2013 the tools were expanded to include client interviews, which could provide data on client satisfaction and some aspects of quality of care.

UNFPA contribution to results on a rights-based approach to family planning
UNFPA has developed a solid foundation for advancing a human rights-based approach to family planning. Through its advocacy and communications, UNFPA has been called "a beacon" for SRH rights, especially for women and girls and VMG. Further, UNFPA position as a multilateral and the main partner of the ministry are assets for the promotion of rights, which have not been used to the fullest. Civil society partners, in particular, expressed a desire for UNFPA to coordinate and harness their voices to promote rights and accountability within the national programme.

Promotion of a human rights-based approach (HRBA) in family planning is hampered by a lack of common understanding on what it means to take a rights-based approach, either within the CO or externally with its partners. CO and partners staff gave varied definitions of what constitutes an HRBA, which were often conflated with other concepts such as quality of care, gender equality, and universal access and access to safe abortion.[57] Without a consistent or clear definition, there are no means to conduct a gap analysis to determine where action is needed to strengthen rights. UNFPA has provided global leadership in defining an HRBA, but this training has not yet reached the CO.[58] However, CO staff mentioned a recent workshop organised by the RO to identify lessons learned on the integration of FP, GBV and human rights which preceded the development of a plan to reinforce partners' capacity in gender and human rights programming.[59] In addition, the UNFPA "Choices not Chance" FP strategy provides a platform for working on human rights in FP.

There are potential challenges to ensuring rights within an environment of quantitative goals and indicators and/or programming which focuses on a specific contraceptive method, as is the case in Burkina Faso. Quality assurance and monitoring of voluntarism are elements of a rights-based approach within this context, but this was not being implemented. Information collected in this evaluation did not find any serious problems, although there were consistent findings regarding lack of counselling regarding side effects, provider biases for/against specific methods, and lack of privacy or confidentiality.[60]

4.7 Different modes of engagement

57 Annex 3, Assumption 6.1
58 Annex 3, Assumption 6.4
59 Annex 3, Assumption 1.2
60 Annex 3, Assumption 6.5

Q7) To what extent has UNFPA adapted its mode of engagement[61] to evolving country needs in different settings, using evidence and best practice?

Summary of the relation between the findings and the assumptions of the evaluation matrix:

- UNFPA shifted its strategies in response to changes in the country context.
- UNFPA interventions in service delivery support, advocacy, and capacity-building support political, social and financial sustainability. However, lack of a clear strategy for knowledge management limits UNFPA contributions to programme sustainability.
- UNFPA identifies and adapts best practices from outside Burkina Faso to the local context; there is room for improvement for the documentation and dissemination of best practices from the CO to others within or external to UNFPA.

Changing country context and modes of engagement

The major change in the country context for Burkina Faso during the period under evaluation was an increase in political support and commitment at the national level for family planning as a national development priority. The conference to launch the Ouagadougou Partnership occurred in 2011, midway through the period under evaluation, followed by the London Summit in 2012. These conferences and resulting commitments heralded increases in donor support and an influx of additional partners to support the FP effort. Under the current UNFPA strategy and business model, Burkina Faso is characterised in the red quadrant, meaning it has high need and low ability to finance programming, thereby qualifying for a greater share of resources as compared to countries in the other quadrants. Countries in the red quadrant are considered to be more complex to manage, and require technical strategies which include a focus on capacity building, service delivery support rather than a focus on "upstream" engagements that are characterized more by partnerships and negotiations (UNFPA 2013).

As noted in earlier sections, the government's FP commitment was operationalized in the *Plan de Relance*, and UNFPA shifted its programme to align and support the goals of the revitalised FP programme. The major shift undertaken by UNFPA was to move from a geographic focus that concentrated efforts in three regions, to a national focus in support of the ambitious contraceptive prevalence goal of the government. To effectively manage a national focus without a concomitant increase in the amount of resources, UNFPA adapted its partnership strategy and expanded the number of civil society partners it supported to conduct service delivery and build the capacity of community-level organizations.[62] It continued to maintain its focus on and to play a major leadership role in contraceptive security, and strengthened its approach through the application of good practices and support from GPRHCS (such as the adoption of CHANNEL software for monitoring contraceptive commodities).[63]

UNFPA contribution to sustainability of family planning and SRH interventions

UNFPA has contributed to sustainability through its work to build the capacity of public and civil society partners in service delivery and demand creation. UNFPA effectively advocated for the

61 "Modes of engagement" refers to the four modes of engagement in the current UNFPA strategic plan (support for service delivery, capacity building, advocacy, knowledge management). This concept is fully discussed in the evaluation inception report (UNFPA 2014a: 14, 17).

62 Annex 3, Assumption 7.1

63 Annex 3, Assumption 7.4

government to include a budget line for commodities, a major step in ownership of FP programme responsibility (although there is an issue with meeting the commitments in the resulting budget line).[64] UNFPA also advocated for a change in the fee structure for contraceptive commodities, to reduce fees by half, effective in 2015. While this will generate less revenue for the government, the losses expect to be offset by increases in number of paying users who can now afford the price of methods. The removal of economic barriers is also expected to contribute to an increased and more sustainable demand for contraceptive services in the long run. UNFPA also contributed to sustainability through its participation in the common basket fund[65] and its successful advocacy to secure contracts for CSO partners to expand FP services.[66]

UNFPA contribution to the identification and application of best practices

UNFPA has contributed to the application of global or regional best practices in Burkina Faso. These include, but are not limited to, the introduction of postpartum contraception in partnership with Jhpiego and the piloting of Depo-provera in Uniject (Sayana Press), with the plan to eventually task shift its delivery by lower level health workers. Both innovations have the potential to increase service access and use. The information collected during the evaluation points to a strong drive by the CO staff to be strategic and on the lookout for new approaches to apply and adapt, coupled with the capacity to partner effectively in order to get them implemented. The GPRHCS meetings organised by HQ have served as an important means for sharing knowledge on best practices and personal visits from RO advisors have supported the CO to adapt approaches to the local context. In addition the CO is making efforts to generate knowledge through the implementation of facility surveys and monitoring the adoption of CHANNEL as a best practice.[67]

The CO routinely identifies lessons learned on an annual basis as part of its routine reporting requirements for its annual progress report, although the descriptions tend to be general, retrospective in nature and lacking data review and analysis.[68] The CO also provides technical and financial support to the MoH for an annual RH good practices workshop as a step in identifying, documenting and sharing best practices. The CO receives little feedback on the information they share from either the RO or HQ. One weakness is the monitoring and evaluation system, which makes it difficult to assess progress towards the achievement of results.[69] The CO did not present or use a theory of change or logical framework to describe its progress, nor does it have a knowledge management agenda that could assist in being strategic about where to invest scarce resources for research and dissemination efforts.

4.8 Supply-side activities

Q8) To what extent has UNFPA support for supply-side activities promoted rights-based and sustainable approaches and contributed to improved access to quality family planning?
Summary of the relation between the findings and the assumptions of the evaluation matrix: • UNFPA has supported extensive skills training, but without adequate post-training follow-up or quality monitoring. • UNFPA has supported the development of a broadened method mix in both the public and NGO sector. • UNFPA has contributed to the sustainability of contraceptive security.

[64] Annex 3, Assumption 2.2
[65] Annex 3, Assumption 3.2
[66] Annex 3, Assumption 3.2
67 Annex 3, Assumption 7.4
68 Annex 3, Assumption 7.4
69 Annex 3, Assumption 7.4

- UNFPA CO has utilized technical guidance, particularly on procurement management and logistics, from HQ and RO mainly via GPRHCS.

Activities and progress

Human capacity in health is a major challenge in Burkina Faso as elsewhere in Africa. Service provider training in FP and other SRH services is an uphill battle as the results are constrained by high turnover of staff and poor incentives to change or adapt following training. Training by itself is necessary, but not sufficient, to ensure that providers have and maintain the skills to offer quality contraceptive information and services to their clientele. For FP clinical and counselling training to "stick", follow-up and supervision or mentoring is needed to ensure that trainees gain confidence and competence. UNFPA has supported the training of hundreds of health workers during the period under evaluation in a range of topics, including clinical FP, community-based distribution (CBD), logistics and procurement, BCC/ Information, Education and Communication (IEC), supervision and logistics management information system (LMIS). [70]

However, beyond numbers of individuals trained, there is no information on longer-term results regarding the use of skills or the quality of information or services provided, particularly from the perspective of the individual user. Information collected during the evaluation suggests that there are weaknesses in the quality and accuracy of information and counselling given by providers, especially about the existence and management of side effects. Yet, there have been gains in contraceptive choice and method availability, e.g. facilities that offered at least three modern contraceptive methods increased from 69.9 percent in 2009 to 95 percent in 2013.[71] Furthermore, the use of long-acting methods – dependent on provider capacity to deliver – rose from 3 percent in 2010 to 7.9 percent in 2014.[72] In addition to training, UNFPA worked to expand method mix through the introduction of Sayana Press, the pilot introduction of PPIUDs in partnership with Jhpiego, and the support of ABBEF and MSI mobile teams to extend long-acting reversible contraceptives (LARC) access in remote, rural areas.[73]

UNFPA plays an important leadership role in contraceptive security in Burkina Faso, by supporting the monitoring of contraceptive security and availability and acting as the main supplier of contraceptives. UNFPA advocated and supported the government to develop the Strategic Plan for Reproductive Health Commodity Security 2009-2015, which includes policies for funding and sustainability of commodities.[74] In addition, UNFPA supports extensive training in logistics and procurement and intensive monitoring and stock surveillance to ensure accountability to support financial and programme sustainability for FP.[75]

UNFPA contribution to supply-side strengthening

UNFPA TA in the area of contraceptive procurement and logistics is one of its major strengths and contributions to the FP effort in Burkina Faso. The introduction by UNFPA of the CHANNEL software system, developed and supported by the GPRHCS, including the training of users at national, regional and district levels, is an important tool for monitoring contraceptive stocks in real time. Technical assistance from UNFPA and the USAID-funded DELIVER project has improved forecasting, quantification and monitoring. Stockouts have decreased dramatically from an estimated level of 87.5 percent in 2011 to 12 percent in 2014.[76]

70 Annex 3, Assumption 8.1
71 Annex 3, Assumption 8.2
72 Annex 3, Assumption 8.2
73 Annex 3, Assumption 8.2
74 Annex 3, Assumption 8.2
75 Annex 3, Assumption 8.3
76 Annex 3, Assumption 8.2

The extensive support to health worker training by UNFPA has contributed to improved availability and choice. In addition, the UNFPA work to expand engagement of private sector providers contributed to the expansion of service delivery options. However, CO work on the supply-side did not include a strong focus on quality of care. For example, discontinuation rates, which are tied to quality of care and contraceptive choice, are not being monitored or addressed within programmes. There is room for improvement in this area, given the indications from focus group discussions (FGD) and PMA2020 findings that less than half of the women are counselled about contraceptive side effects. Although training of supervisors is done, there has been no assessment on the effectiveness or quality of supervision provided and whether or how it improved service outcomes.

5 CONCLUSIONS

5.1 Effective support for integration of family planning within sexual and reproductive health at policy level and within some service settings

UNFPA has supported integration of family planning (FP) at the policy level and in service provision within a variety of sexual and reproductive health (SRH) areas, such as maternal and child health, HIV and AIDS and STI prevention and treatment, fistula care, and gender and youth programming; and through the integration of a minimum integrated package of SRH services within humanitarian assistance plans. The country office has approached integration of FP in a strategic manner and through partnership with civil society organisations (CSOs), in order take advantage of "missed opportunities" for the provision of contraceptive information and services and to leverage the technical and/or community-based expertise of others. However, there is limited evidence that the level of integration achieved in policies and guidelines, as well as in training, is maintained during the implementation of services. Furthermore, there are opportunities for best practices documentation and dissemination (such as postpartum contraception and integration of FP within community-based health and development programmes), which the CO has not yet seized.

- Origin: Evaluation question 1 (section 4.1)

5.2 Strategic coordination and leadership supportive of national ownership

UNFPA has played a leadership role in supporting the national government to take a strong and positive stance on family planning through its repositioning efforts in collaboration with others, notably the Ouagadougou Partnership. UNFPA provided technical assistance to the government to support the implementation of family planning activities as set forth in *Plan de Relance 2013-2015.* It successfully advocated for the inclusion and provision of a budget line for commodities and for greater engagement of CSOs in coordination mechanisms and implementation. As the main partner of the Ministry of Health (MoH), UNFPA is in a unique position to influence the government's implementation of the FP programme, including the renewal of the *Plan de Relance.*

- Origin: Evaluation question 2 (section 4.2)

5.3 Effective brokerage and partnership between government and other partners

UNFPA has been an important broker between the government and other partners on a range of FP issues that support enhanced access and utilisation of contraceptive information and services. These included the introduction of the injectable contraceptive (Sayana Press) and approvals to pilot task shifting and social franchising. UNFPA partnership with non-government organisations (NGOs) to

support mobile outreach services and capacity building for community-based health and development organisations has supplemented public sector services and leveraged both funding and technical capacity through strategically targeted efforts. This strategy holds great promise, but expanding UNFPA partnership portfolio is dependent on finding solutions to cumbersome bureaucratic contracting and financial processes which compromise the ability of the CO to support and mobilise new actors.

- Origin: Evaluation question 3 (section 4.3)

5.4 Contributions to an enabling environment at national and community levels

UNFPA has strengthened the enabling environment at national and community levels through its identification of key enabling factors and programming to address them accordingly. In Burkina Faso, policy support for FP at the national level is strong, but implementation capacity is weak. UNFPA has focused on brokering and facilitating the engagement of NGOs and civil society partners to support demand creation and service delivery tailored to diverse communities and in ways that reduce cultural and religious barriers to FP. The CO currently operates in a moving environment where policy and financial support for FP could be affected by the political transition underway, leading to a change in context and enabling environment.

- Origin: Evaluation question 4 (section 4.4)

5.5 Focus on vulnerable groups and marginalised populations

UNFPA has done important work to increase awareness of and advocate for meeting the SRH needs of select vulnerable and marginalized groups (VMGs) in Burkina Faso as an important manifestation of its organisational commitment to support human rights and universal access. However, certain VMGs (commercial sex workers, sexual minorities) were not an explicit focus within FP programming. The contribution of UNFPA has been more visible at the policy and advocacy level than at outcomes related to access and transformed norms. Operationally, UNFPA addressed several different groups and issues (young people, handicapped youth, women with fistula, etc.), yet priorities for resource allocation, mainstreaming and documentation were not evident, compromising knowledge management and future scale-up.

- Origin: Evaluation question 5 (section 4.5)

5.6 Promotion of a human rights-based approach for family planning

UNFPA has provided leadership on and supported some elements of a human rights-based approach for family planning, including activities to broaden contraceptive choice, improve access for specific groups of VMGs, and ensure access to sexual and reproductive health and rights (SRHR), including contraceptive information and services. In the context of FP in Burkina Faso, the most urgent rights issue is access to services, to broaden the method mix and to ensure voluntarism as services scale up; however, the lack of attention to SRHR access for sexual minorities and CSWs remains a gap in UNFPA support for universal access. UNFPA and its partners lack a consensus on what constitutes a rights-based approach, its importance, and how to operationalise rights within FP programmes. With increased attention and priority given to FP, there exists an opportunity to advance a common understanding and approach to advance rights-based FP programming, and to assess gaps and recommend actions to in the revision of *Plan de Relance /* costed implementation plan.

- Origin: Evaluation question 6 (section 4.6)

5.7 Shifts in modes of engagement to address changes in country context

UNFPA has monitored changes in the programme and country context during the period of evaluation, and responded with shifts in strategies. With the improved political environment, UNFPA continued to conduct advocacy activities, while increasing its support for capacity-building and service delivery, particularly at the community level which are considered "downstream" activities in the UNFPA Strategic Plan. UNFPA showed nimbleness and strategic savvy in response to several key opportunities; however, it has not contributed to the programmatic evidence base because of the lack of a knowledge management strategy.

- Origin: Evaluation question 7 (section 4.7)

5.8 Strengthening supply of contraceptive information and services

With the global programme for reproductive health commodity security (GPRHCS) funding and technical support, UNFPA has strengthened its support for FP service delivery in alignment with the national goal to increase contraceptive prevalence to 25 percent by 2015. UNFPA work focused on expanding service delivery approaches and introducing new contraceptive methods. UNFPA also expanded partnerships with CSOs in order to extend and build capacity for services in a broader geographic scope. UNFPA provided valuable support for commodity security and helped open the door to increased involvement of the private sector. This supply side work focused primarily on promoting availability and acceptability of services; however, there was not a similar focus on quality improvement. As services scale up, there are potential adverse implications for the attainment of clients' rights and programme effectiveness if quality improvement mechanisms are not in place, such as increased contraceptive discontinuation or decreased trust by communities in the health system.

- Origin: Evaluation question 8 (section 4.7)

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ANNEX 2 – LIST OF PEOPLE INTERVIEWED

Name	Title
UNFPA Burkina Faso	
Dr. Edwige ADEKAMBI DOMINGO	Country Representative
Dalomi BAHAN	Monitoring and Evaluation manager
Néné BARRY	National Programme Associate
Seydou BELEMVIRE	Programme Analyst RH
Dr Norbert COULIBALY	Programme Officer FP
Alain KABORE	Programme Manager Sayana Press
Ali KONE	National Programme Officer
Julien OUEDRAOGO	Programme Officer, Adolescents/Youth/HIV
Soumaila OUEDRAOGO	Monitoring and Evaluation
Olga SANKARA	Assistant Country Representative
Serge SARY	Programme Administrator, Sayana Press Programme
Siaka TRAORE	Programme Analyst, Advocacy/Communication
Aoua ZERBO	Programme Analyst, Midwifery
Lacina ZERBO	National Programme Associate
Ministry of Health	
Dr Issa BARA	Pharmacist (DSF)
Dr Isabelle BICABA	Director, Directrice de la Santé de la Famille
Dr Jean Chrisostome KADEBA	Acting Executive Director, Centrale d'Achat des Médicaments Essential et Génériques de des Consommables Médicaux (CAMEG)
Dr Cheick OUEDRAOGO	FP Manager (DSF)
Dr Djénéba SANON-OUEDRAOGO	Secretary General, Ministry Of Health
University of Ouagadougou	
Dr. George GUIELLA	Head of Population and Health Department, Institut Supérieur des Sciences de la Population and Director, PMA2020
Mr. Moussa ZAN	PMA Data manager
Development Partners and NGOs	
Roch AHOUNOU	Jhpiego, Finance Manager
Bali BAKO	JSI/DELIVER, Programme Officer
Dr. Brahima BASSANE	Family Care International, National Director
Mathieu BILGO	BURCASO, M&E Officer
Georges COULIBALY	Marie Stopes International, Programme Officer

Nicolette van DUURSEN	Marie Stopes International, Country Director
Oscar D. KOALGA	Agir-PF, Country manager
Firmin NACOULMA	Marie Stopes International, Monitoring and Evaluation
Dr. Dieudonné NARE	Plan Burkina, Interim Health Advisor
Jovith NDAHINYUKA	JSI/DELIVER, Regional Technical Advisor
Dr Stanislas Paul NEBIE	Jhpiego, Country Director
Dr Geneviève ONADJA	Initiative Privée et Communautaire (IPC), Director
Boureihima OUEDRAOGO	Association Burkinabé pour la Bien-Etre de la Famille (ABBEF), Executive Director
Habibou OUEDRAOGO	Agir-PF, Executive Director
Ousmane OUEDRAOGO	BURCASO, Coordinator
Yacouba OUEDRAOGO	Jhpiego, Programme Officer
Nana SANOGO	Initiative Privée et Communication (IPC), Programme Officer
Nomgma SAWADOGO	Family Care International, Programme Manager
Ladiama SERME	JSI/DELIVER, Programme Officer
Brigitte SYAN	Equilibre et Population, Advocacy Officer
Caroline TRAORE	Equilibre et Population, Organizational Support Officer
Dr. Guy Evariste André ZOUNGRANA	Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), Coordinator/Senior Technical Advisor for SayanaPress
Dédougou Regional Health Directorate (Field visit)	
Innocent GYENKANI	Dédougou Regional health Directorate, Pharmacist
Souleymane KABORE	Physician, Tougan district health
Robert KARAMA	Regional health Director, Dedougou Regional Health Directorate
Elisabeth KONDE	Midwilfe, RH focal point, Régional Heath directorate
Pierre Thomas MILLOGO	Pharmacist, Toma health district
Oumar OUATTARA	Physician, Solenzo health district
Jean François OUEDRAOGO	Pharmacist, Boromo health district
W. A. Aziz OUEDRAOGO	Physician, Nouna health district
Dapla PALENFO	Pharmacist, Solenzo health district
Sibila SAMBA	Pharmacist, Dédougou health district
Ibrahima SANOU	Pharmacist, Tougan health district
Aboubacar SIRIBIE	Physician, Boromo health district
Dr Oumarou THIOMBIANO	Family planning service manager, Dédougou Regional hospital
Johanny TRAORE	Epidemiology, Dédougou regional health directorate
Biessan YARO	Physician, Dédougou health district

NGO Dédougou	
Hamidou DABARE	MSI Dédougou, Focal Point Coordinator
Inoussa COULIBALY	MSI, Dédougou, Social Marketing agent
T. Laurent GUIRE	Director, SOS Sahel
Focus Groups-Dédougou	
Dona village	52 participants (22 men and 30 women, in two separate groups)
Dédougou Sector 6	9 young people (one group)
MSI Dédougou	9 unmarried girls (MSI clients)

ANNEX 3 – EVALUATION MATRIX

The data and information produced through the document review, and collected through interviews and focus groups during the field visit in Burkina Faso are presented in the evaluation matrix below. Data and information are categorized along the evaluation questions and related assumptions for verifications and support the findings analysis presented in Section 4 of the present country note.

Area of Investigation 1: Integration

To what extent has UNFPA supported integration of family planning with maternal health, HIV/STI and GBV services in health plans and at primary health care level, in services for adolescents, and in emergency and humanitarian situations?

Date Collection Methods:
Document review
Key informant interviews (KII)
Focus Group Discussions (FGD)
Site Visits

Assumption 1.1: **UNFPA headquarters (HQ), regional office (RO) and country office (CO) staff and in-country partners are working towards a common understanding of the meaning and importance of service integration.**	**Information sources:**
Indicators: • Knowledge generated and shared regarding nature of and lessons learned from integration interventions • UNFPA staff, partners' and users' (women's and men's) perception of meaning and importance of service integration.	
UNFPA CO staff have a shared understanding of integration, and work at integrating family planning (FP) into the various sexual and reproductive health (SRH) activities that are undertaken by the CO. Examples include: the integration of contraception and safe motherhood in emergency humanitarian services; the community-based FP/HIV services supported through several partners (see section 2.3), and the integration of gender across the different SRH program areas (FP, fistula, sage-femmes (midwives), maternal health).	UNFPA staff
The expected outcome of the reproductive health (RH) component in both the 2006-2010 and the 2011-2015 Country Programme Document (CPD) is increased utilisation of integrated RH services, including FP, maternal care, sexually transmitted infections (STIs) and HIV and AIDS. However, in 2006-2010, the focus was on a basic package of services (including FP, adolescent RH, emergency obstetric care and obstetric fistula), whereas in 2011-2015, the outputs were	(United Nations 2005, United Nations 2010)

expressed into three distinct components (basic maternal health services, reproductive rights and access to comprehensive services including/focusing on FP, and knowledge and safe behaviour in RH, including HIV and AIDS). Integration is a key concept in both plans, and FP is mentioned in both plans, however there was greater emphasis on FP in the latter plan.	
The UNFPA youth strategy in Burkina Faso is integrated, given the risks of unplanned pregnancy and sexually transmitted infections, including HIV and AIDS. A recent programme being implemented in Burkina Faso is the SRH programme for handicapped youth to reduce sexual violence and unintended pregnancy, and offers rights education and integrated information and services in preventing pregnancy, STIs and HIV and AIDS.	(UNFPA Burkina Faso 2014b)
Since 2008, UNFPA strengthened its role in humanitarian assistance. The CO developed a readiness plan and organised workshops (with regional experts from Johannesburg and Dakar). Family planning is currently well integrated into UNFPA humanitarian assistance. In 2012, in response to the influx of refugees from Mali, UNFPA conducted reproductive health training to strengthen the capacity of communities and health districts to respond to provide the minimum integrated service package (MISP).	(UNFPA Burkina Faso 2014d)
The rationale for FP in Burkina Faso is tied to maternal health. Integrating FP services within postpartum and post abortion care (PAC) services is a "best practice" to address unmet need among these groups. With regard to Postpartum Family Planning (PPFP), unmet need among women in Burkina Faso is affected by "postpartum insusceptibility" to pregnancy due to high levels of postpartum abstinence and breastfeeding. There are substantial gaps in access to postpartum FP in primary health settings. A recent study found that postpartum FP and breastfeeding are not discussed during ante-natal care (ANC) sessions, counselling does not occur postpartum, post-natal care (PNC) is poorly attended, and for those who attend the 6th hour or 6 day check, FP is not discussed. When contraception is offered at the 6-week check, women are unprepared to make a choice or to pay for contraception services. Regarding post abortion care, abortion is not legal except in cases to save the life of the mother, or in cases of rape or incest. One-third of all pregnancies each year in Burkina Faso are unintended, and one-third of unintended pregnancies are ended by abortion. The vast majority of women who end unintended pregnancies do so clandestinely; most clandestine abortions are carried out in unsafe conditions that jeopardise women's health and sometimes their lives. UNFPA is working to expand access to postpartum contraception (See Assumption 1.3). No other group appears to be working on this topic. With regard to post abortion care and FP, UNFPA is credited with working with Jhpiego and Ipas to integrate PAC into the training curricula for the National School of Public Health and to support training of health providers and the provision of manual vacuum aspiration (MVA) kits. At present, PAC did not appear to be a focused strategy for UNFPA in Burkina Faso, except in the case of humanitarian assistance and through support for Family Care International (FCI). The CO did not share any documents or projects addressing PAC services, although the adverse consequences of unsafe abortion and the importance of offering contraception to women who have had an abortion are well-known.	(Daniele 2014, Fikree, Mugore et al. 2014, Guttmacher Institute 2014)

Assumption 1.2: **Country offices receive and put into practice technical guidance from HQ and ROs to support partners in delivering quality, integrated services.**	**Information sources:**
Indicators: • Number, frequency and type of technical assistance (TA) provided • RO plans address COs' needs for support in promoting service integration where appropriate • CO plans and programmes reflect current technical guidance and best practices for integrated services • Evidence-based guidance developed to support the integration of FP or more in the following SRH services (in policies, plans, actual service delivery): ▪ Maternal health ▪ HIV/STIs ▪ Gender-based violence (GBV) ▪ Level of emergency preparedness to address FP needs in emergency situations ▪ Adolescent SRH (girls and boys).	
"Most health policy documents include family planning, usually as part of maternal and child health. Examples are the Plan to Prevent Mother-to-child Transmission of HIV, the Strategic Plan to Secure RH Products 2009-2015, the Plan to Accelerate the Reduction of maternal and Neonatal Mortality in Burkina Faso, the PNDS 2011-2015, and the Reproductive Health Protocols issues in May 2010. Family planning is also taken into account in the Strategy for Accelerated Growth and Sustainable Development (SCADD) 2011-2030, the Strategic Framework on HIV/AIDS and STIs 2011-2015, the National Health Policy (2011-2030), and within the policy statement for the National Gender Policy for Burkina Faso adopted in 2009". p.14	(Maiga 2012)
The CO receives strategic guidance from both HQ and the RO: guidance from HQ on integration and other matters comes in the form of documents, evaluations, and feedback on reporting (although this was not considered substantive, but rather more of a back and forth to clarify information in the reports). An example of RO guidance is a workshop conducted recently by the RO on the integration of FP, GBV and human rights held in Bamako to review what has been working, identify commonalities across countries and develop different proposals on integration. Staff indicated that plans are being developed to reinforce partners' capacity in gender and human rights programming.	Interviews with CO staff
The global campaign to eradicate obstetric fistula (OF) launched by UNFPA in 2002 has guided CO efforts. When asked how FP is integrated into the OF work, it was noted that FP is considered a prevention strategy. According to the UNFPA website, the project against OF in the Sahel region resulted in treating 433 women with a success rate estimated at 89 percent and increased antenatal contraceptive coverage by 30 percent points in five years (from 58 to 88%) between 2007 and 2011.	UNFPA Burkina Faso CO website

The CO is replicating a project conducted by UNFPA in Niger, the "school for husbands", *Ecoles des Maris*, in the Central North region, to improve men's knowledge and attitudes regarding SRH issues (integrating FP with maternal and child health), as they are key decision-makers on women's access to health services.	Interviews with CO staff UNFPA, 2015

Assumption 1.3: **UNFPA support has been effective in stimulating service integration by in-country partners; government, civil society organisations (CSOs), private in policies, plans and actual services.**	**Information sources:**
Indicators: • Number and type of FP service providers trained on service integration • Number and percentage of service delivery points that offer FP integrated with other services (and acknowledge UNFPA guidance for this) • Integrated service provision included in provider training programmes (with acknowledgement of UNFPA guidance for this) • Inclusion of integrated service provision in government policies and health plans.	
UNFPA collaborated with International Planned Parenthood Federation (IPPF) to conduct a national assessment of SRH/HIV integration and linkages at the policy, systems and service levels in Burkina Faso in 2009. UNFPA provided technical and financial support for the assessment which included a desk review, provider and client interviews and service-level data from 60 service sites. It was implemented by a committee of key stakeholders from the Ministry of Health (MoH), National AIDS Committee, UNICEF, UNFPA, WHO and community based organisations (CBOs). The key findings that emerged were fairly general: developing guidelines and plans to further integration (including situational analysis, feasibility studies, tools to evaluate service quality, etc.); training stakeholders at different levels of the system on how to integrate activities; and establishing coordinating mechanisms to integrate SRH and HIV. This assessment was not mentioned in CO staff interviews, so it is not clear what follow-up or programme actions occurred following the assessment.	(IPPF, UNFPA et al. 2011)
UNFPA is partnering with Jhpiego to expand access to PPFP, a good strategy for the integration of FP within maternal and child health services. In Burkina Faso, the underlying rationale for providing FP services is to protect the welfare of the mother and child, and approximately 80 percent of women deliver in hospitals, making PPFP a strategy with great potential. UNFPA is supporting financial and technical assistance to enable regional level hospitals, *Centres de Reference* and tertiary institutions to introduce postpartum contraception, with a focus on Postpartum Intrauterine Device (PPIUD) insertion in the immediate postpartum period. The training is focused on skills competency in clinical, infection prevention and counselling domains, but could be extended to include the organisation and management approach required to ensure that the facility staff are committed to supporting the service which requires teamwork and coordination. The Reference Hospital in Dédougou has good experiences that can be documented and shared more widely. In addition, Jhpiego is working to integrate PPFP into pre-	Interviews with NGO and MoH implementing partners in Ouaga and Dédougou (Jhpiego) (WHO 2013, Jhpiego 2015)

service training curricula in training schools and universities in order to institutionalise the provision of PPFP within services offered by the Ministry of Health (MoH). More effort is needed for PPFP advocacy with hospital directors to convince them that the programme will result in fewer deaths and ultimately save resources. The programme focus is on immediate PPIUD insertion, but a broader strategy in keeping with the latest programming best practices (WHO, 2013) could be considered to reduce the high levels of unmet need among postpartum women.	

Assumption 1.4: **Service integration leads to improved user access and quality of services.**	**Information sources:**
Indicators: • Evidence of user consultations • Perception of different user groups – women and men, vulnerable and marginalised groups (VMG), people living with HIV (PLHIV) that access[77] and quality have improved by integration.	
The UNFPA supported IPPF assessment of SRH/HIV linkages in Burkina Faso found that 80 percent of clients interviewed discussed something other than the primary purpose of their visit with the provider (32% FP, 26% vaccinations and 24% HIV prevention). The main improvements that clients required were increased availability of information and advice, more friendly services, reduced waiting times and greater availability of medicines and commodities.	(IPPF, UNFPA et al. 2011)
See 1.2 above re obstetric fistula results.	

Area of Investigation 2: Coordination

To what extent has UNFPA successfully contributed on its own and in coordination with others to strengthening national leadership of family planning and improving sustainability?

Data collection methods:
Document review
Key informant interviews (KII)
Focus Group Discussions (FGD)
Site visits

Assumption 2.1:	**Information sources:**

[77] Access: availability, accessibility (distance, transport, time), affordability (willingness and ability to pay incl. opportunity cost) and socio-cultural acceptability

UNFPA has developed and/or actively supported mechanisms to raise the profile of family planning in coordination with other FP/SRH stakeholders at: • **Global** • **Regional** • **National levels.**	
Indicators: • Type of existing and emerging coordination mechanisms at each level with evidence of UNFPA support and FP-relevant contents of meetings and initiatives.	
The commitment of the Government of Burkina Faso at the London Summit reads: "*Burkina Faso, through the leadership and advocacy of the First Lady, pledges to take action in terms of policy, funding and programming. The aim will be to maintain family planning as a central priority of development policies, effectively enforcing existing legal instruments on reproductive health and reducing the cost of contraceptive commodities. Burkina Faso will work toward increasing the resources allocated to family planning in state budgets. It will also seek to boost partnerships with the private sector and civil society organizations for service provision, to define and develop strategies for engaging men, and to establish regular and active monitoring of the availability of contraceptive commodities at all levels*".	(FP2020 2015)
UNFPA provided technical support to the MoH to develop its "*Plan de Relance*", the costed implementation plan which grew out of the Ouagadougou Conference to revitalise FP in the region and which was the model used to develop road maps for country commitments as part of the FP 2020 "movement". The strategy itself is seen as relevant and sound; however, the gap is with implementation ("*It is just a document"*). Implementation is hampered by lack of human resources at the local level, especially in a country with a predominantly rural population.	Donor, NGO and CO staff
Stakeholders noted two main routine coordination forums for FP coordination: the donor forum, coordinated by WHO, and the Partner forum (also known as the Technical Committee), coordinated by UNFPA.	Donor, NGO and CO staff

The *Plan de Relance* outlines a series of governance and coordination mechanisms to support implementation of the plan:
• Central Level:
  ○ Semi-annual steering committee
  ○ Technical Committee (quarterly)
  ○ National TAC (Contraceptive Acquisition Tables)
• Regional Level:
  ○ Board of management
  ○ Regional TAC
• Health District Level
	(Ministère de la Santé 2013b)

○ Quarterly meeting of Health District management team ○ Health District Council meetings (open to CSOs)	
"Meetings of the technical Committee (once per trimester) and the Steering Committee for Reproductive Health Commodity Security Strategy (once every six months) indicate that national multisectoral mechanisms to promote and implement RH programmes are in place. Within these mechanisms, under the leadership of the MoH, other sectors are mobilizing to become more involved in the national processes to design FP policies and coordinate programme interventions. Such is the case with the Network of Parliamentarians, the Group of Partners led by AFD, the Coalition of Private Sector organizations, the network of Religious and Traditional Leaders, and the Technical Group for RH, including NGOs and national RH networks". p.15	(Maiga 2012)
As the main technical partner the government, UNFPA is seen as working at two levels – to support the government implement its priorities and to influence the priorities of the government. Several stakeholders said that UNFPA is stronger at the former than the latter. UNFPA has supported the development of favourable policies (Assumption 2.2) and the mobilisation of funds for commodities, although it is considered a setback that the government gave less than their proposed commitment of 500 million CFA this year. UNFPA is in a good position to support increased commitment from the government, especially to advocate for the inclusion of FP within local development plans. Also, UNFPA has the convening authority to bring partners together to develop and implement lessons learned to improve advocacy. "*When UNFPA is an advocate for innovation, it works"* (e.g., community-based distribution and youth integration).	NGO staff
UNFPA supports a major intervention that contributes to increased advocacy, communication and service delivery for family planning: an annual national FP week. The general objective of the national week of family planning is to stimulate demand and increase the use of family planning services. Its sub-objectives are: to strengthen the commitment of national authorities, civil society, technical and financial partners and the private sector at the central level and in 13 regions; to mobilise CSOs in the implementation of the FP Week; to conduct substantial social mobilisation at the national level to promote FP; to strengthen the awareness of the population, civil society, opinion leaders and media on the importance of FP; and to increase the supply of long-acting contraceptives to respond to demand for services. It was first conducted in 2012 as a key intervention to reposition FP. Its annual implementation results in the mobilisation of resources that provides a boost in acceptance of FP methods and services.	(UNFPA 2015, UNFPA Burkina Faso nd-b)

Assumption 2.2: **UNFPA and other donors (including those influenced by UNFPA advocacy) have effectively supported national governments to assume ownership of family planning-related policies and programmes.**	**Information sources:**
Indicators: • Existence of national FP policy and programme (separate or integrated with other SRH areas)	

• National budget allocations to FP • Number of other major donors actively supporting national ownership of FP (on their own account or as a result of UNFPA advocacy).	
The Strategic Plan to Secure Contraceptive Commodities (PSSPC) 2006-2015 was introduced to address stockouts and weak monitoring and supervision. This plan further advances the National Pharmaceutical Policy enacted in 1996 to ensure that essential medicines are safe, of high quality and available through low cost throughout the country, including contraceptives. The policy also integrates contraceptive purchasing into the broader health commodities system.	(Ministère de la Santé 2010)
The Strategic Plan for Reproductive Health (1998-2008) called for a rapid increase in contraceptive use. Another policy, the National Health Development Plan 2001-2010 (PNDS) also sets a goal for increasing the contraceptive prevalence rate (CPR), but the goal was not reached. The PNDS was revised in 2006 to cover 2006 to 2010 and set an even higher goal by 2010 and this, too, was not reached. In light of these, the *Plan de Relance* 2013-2015 includes four main points of action: • Creating demand (in rural and urban areas, and among young people) • Strengthening supply (reduce stockouts) • Improving access (improve quality, increase coverage through advanced strategies [postpartum, mobile outreach], and community based services) • Improving monitoring and evaluation (identify indicators, train personnel, and control the quality of data). The PNDS commits the government to the following: • To maintain the 500 Million CFA budget line for contraceptives (first established in 2008) • To engage in innovation, for example by authorising the introduction of Sayana Press • To support implementation and follow-up through partnership, active monitoring and engagement at all levels (national, regional, district, health facility)	(Ministère de la Santé 2013b)
The government has contributed funds to the budget for contraceptive commodities; commodities are also supported by other donors (mainly UNFPA and less so, USAID). UNFPA advocacy was helpful in getting the government to commit to a budget line for contraceptive commodities in 2008. The MoH would like to see UNFPA assist with broader advocacy for parliamentarians and other ministries to ensure necessary resources are available for FP and especially that the budget line for contraceptives is maintained and increased. At present, 70 percent of the FP budget comes from partners and 30 percent from the government. The MoH expressed its desire to flip these percentages in 2015 in order to be less dependent on partners. *"We would like to see FP considered a routine budget component, as is immunization. No one questions the budget line for immunisation, and FP should be the same way."* 60 percent of the contraceptive commodities is covered by UNFPA.	MoH staff (UNFPA 2015)

One of the major commitments made by Burkina Faso was to maintain a 500,000,000 CFA allocation for commodities. Unfortunately, this was not met in 2014-15, and given the recent political events and resulting financial constraints, there are concerns whether the financial commitments for FP can be maintained.	CO staff
UNFPA played an important role in advocacy on how to engage the private sector. It supported Marie Stopes International (MSI) to conduct a study on the feasibility of franchising for FP service delivery. According to this report, the private sector accounted for only 14 percent of FP use in 2003, but could play a role especially in urban areas in Ouagadougou and Bobo (the two largest cities) where there are more private clinics.	CO and NGO staff (Mazzilli 2010)

Assumption 2.3: **Programmes are culturally/socially, institutionally and economically sustainable in different national contexts.**	**Information sources:**
Indicators: • Trends in modern contraceptive prevalence rate (mCPR) • Percent of FP provided by the public, NGO and private sector • Government spending as percent of total expenditure on FP • Evidence of participation by CSOs (including end user groups, VMGs) and private sector in FP policy, planning and accountability mechanisms at national level.	
The government reduced the price of FP services by 50 percent by decree within the past year; e.g. reduced the cost of pills from 100 CFA to 50 CFA to support increased access and create/sustain demand for services. Fees are collected at the service delivery point (SDP) and pooled at the central level to be reinvested in FP. Although lower fees will result in less return, it is envisioned that use will increase. Advocacy by UNFPA and other donors (e.g. the Ouaga Partnership) supported this change.	MoH staff in Ouagadougou and Dédougou
"It is not easy to find the full amount of financial resources allocated to family planning, especially given the dearth of national reports focused on this field. It is, however, important to highlight the existence of a specific budget line for the purchase of contraceptives, which have been regularly supplied by the government since 2008. Several partners support FP programs in Burkina Faso, including UNFPA, USAID, KFW, the World Bank and several international NGOs".	(Maiga 2012)
There is a willingness of the government to support and involve the private sector in promoting FP.	(Maiga 2012: 14)
The current strategy of UNFPA includes strengthening community-based partnerships and working through local level CSOs to generate demand in culturally appropriate ways and to support community-based services. Examples include: • MSI and the Burkina association for family health (ABBEF): outreach services through mobile teams organized by MSI and ABBEF.	NGO and CSO staff (IPCBF 2014, BURCASO nd)

• Plan Burkina: community-based service programmes, including behaviour change communication (BCC) and school/peer education, plus linking sponsored children supported by Plan with mothers supported by UNFPA via counselling, household security and micro credit. • Family Care International: to deliver community-based services in the Sahel region and develop the capacity of community health workers to address socio-cultural barriers to access via the "individual, family, community – or IFC" approach. • Burkina Council of AIDS services organisations (BURCASO): technical support and funding via the project to support health development (PADS) for community based distribution (CBD) in 3 regions in the East region and to conduct interventions for young girls and market women near the border of Cote D'Ivoire and Togo, areas of major migration. • The National Council against HIV and AIDS (SPCNLS): community sensitisation with religious and local leaders about unintended pregnancy among youth, in 2009, ran a radio campaign of 156 shows in two local languages called, "A Plan for Life" which was rebroadcast in 2014. It will run a new campaign before and during the 2015 FP Week which will use testimonials from satisfied clients interviewed during FP Week last year, "What FP Week meant to you" as part of the promotion. • *Initiative Privée et Communautaire* (IPC): technical support and funds (via PADS) to integrate SRH and HIV by supporting an expanded group of local organisations. IPC is an "umbrella" NGO that works in 6 districts. They do social mapping that identifies each family/household and they support facilitators to track the nutrition, vaccination and growth of children under 5, and track women of reproductive age (one facilitator per 100 households). One of the 14 IPC associations has a project funded by UNFPA for the "school for husbands", *Ecole des Maris*.	
See assumption 4.2 on FGD results related to improved community attitudes towards FP (contributing to social and cultural sustainability)	

Area of Investigation 3: Brokerage and Partnership

To what extent has UNFPA acted as a broker at global, regional and country levels to promote family planning, acting in partnership with the public, private and non-state sector service providers?

Data collection methods:
Document review
Key Informant Interviews (KII)
Focus Group Discussions (FGD)
Site visits

Assumption 3.2:	**Information sources:**

At the country level, UNFPA COs brokered partnerships between public agencies, CSOs and private sector entities to promote FP and its integration with other SRH programmes.	
Indicators: • Other stakeholders and partners recognise the comparative advantages of UNFPA, its positioning and its potential contribution at global, regional and country levels, and respond to UNFPA initiatives in bringing them together • UNFPA participation and role in policy forums, networks, and other partnership mechanisms at global, regional and country levels.	
Partnerships are a specific strategy for UNFPA SRH and gender programme components. UNFPA works with a wide range of actors with diverse and complementary skills, which allows for testing various approaches across a wide geography and in different local contexts.	(UNFPA 2015)
UNFPA is considered by many stakeholders to be a key strategic partner on FP and SRH in Burkina Faso. UNFPA is a crucial duty bearer for FP and has the means to influence the government to address important issues and encourage innovation in FP. UNFPA is mainly seen as a government partner; however, in the past five years, it has made a concerted effort to reach and provide strong support to civil society organisations. In 2008, FCI was the only CSO that UNFPA worked with; today, the list is much longer and includes MSI, Jhpiego, Plan BF, ABBEF. UNFPA has understood the strategic value of adding civil society to their portfolio, and harnessing the voice of civil society in advocacy will help shape the debate as well as support increased accountability for ensuring that the government follows through on its commitments and resource allocations.	NGO staff
UNFPA provides technical assistance and guidance to the government (the family health directorate of the Ministry of Health – DSF) in its role to coordinate FP donors and implementing partners (WHO leads the monthly meetings of donors). These quarterly meetings provide an excellent forum to openly discuss difficult issues between the MoH and donors. For example, UNFPA has been instrumental in raising the issue of FP product availability which is monitored quarterly and is a standing item on the coordination meeting agenda. However, it was also noted that more could be done to forge a more strategic agenda and to tackle some really critical issues, such as the lack of compliance by health facility/provider with the current pricing structure resulting in overcharging clients and poor quality of services in spite of the availability of funding through the PADS.	Donor staff
UNFPA is a leading partner in the introduction of Sayana Press in Burkina Faso. It was instrumental in obtaining MoH approval to move forward with a pilot to explore the delivery of Sayana Press by community health workers in collaboration with GIZ, as community health workers (CHWs) are not authorised to provide injectable services despite the emerging evidence that it is acceptable in other African countries (Stanback, Mbonye et al. 2007). With GIZ, each partner is playing to its strengths: GIZ is working on the demand component, while UNFPA is working on supply (health product availability and service delivery).	Donor, MOH and NGO staff

UNFPA supported the development of the MoH project for the initial introduction of Sayana Press. This introduction will be widely integrated in the activities of the partners currently implementing FP programmes. The plan sets out a strategy for distribution, training, monitoring and evaluation, and donor roles and implementation partners who are supposed to be part of this introduction. The initial introduction began in October 2013 and will continue until December 2016. According to the national health policy, the product will be available in health facilities in the public and NGO sectors, including ABBEF and MSI (with UNFPA support), PROMACO for social marketing, GIZ to lead communication activities and creation of demand as well as community-based distribution through a network of CHWs.	(Stanback, Mbonye et al. 2007, Ministère de la Santé 2013c)
UNFPA is a leading partner in commodity security (see Area of Investigation No. 8)	
The heavy and slow bureaucratic processes UNFPA must adhere to, particularly regarding financial reimbursements, hamper their reputation as a partner. Partners felt that the CO receives very little support from HQ and used the example of late notice in November 2014 of budget cuts effective January 2015. This abrupt notice, coupled with what was described as an "out-of-cycle" quarterly expense review process, resulted in a 6-month gap in reimbursement of expenses. This gap, while difficult for the international NGOs supported by UNFPA, is particularly challenging for small NGOs. Given the UNFPA strategy to do more community-based work in FP with CSOs, the reimbursement procedure is a key barrier for effective support and mobilisation of partners.	NGO partner staff

Assumption 3.3: **The visibility of UNFPA is sufficiently high at global, regional and country levels to bring together potential partners to increase commitment to family planning.**	**Information sources:**
Indicators: • Other stakeholders and partners recognise the comparative advantages of UNFPA, its positioning and its potential contribution at global, regional and country levels, and respond to UNFPA initiatives in bringing them together • UNFPA participation and role in policy forums, networks, and other partnership mechanisms at global, regional and country levels.	
UNFPA is effective and visible in its role as a key partner in FP. It plays an important leadership role as a champion for FP and strong on advocacy for protecting girls. It has the advantage of working with MoH and other partners; it is "*always there.*" Examples include its advocacy on task shifting, financial commodities and the introduction of Sayana Press. UNFPA works hand in hand with the government and "*plays both sides*" which is seen by some as an advantage. The government approach is not seen as consensus-oriented. UNFPA could be doing more to set the agenda and engage a broader range of partners.	NGO staff

Given the position and visibility of UNFPA, it is in an excellent position to facilitate the sharing of experience, data collection, and south-to-south collaboration. Partners noted UNFPA could be more strategic about disseminating results of their and others' work for advocacy and to scale-up effective approaches and interventions.	NGO and donor staff
The Ouagadougou Partnership is an important forum in West Africa for donors and partners, yet UNFPA was not invited to serve as core partner (although it participated in the meeting and the MoH encouraged them to be brought into the Partnership given the support they provide in Burkina Faso). This partnership was formed prior to the UNFPA "Choices not Chance" FP strategy, and the shift in UNFPA strategy to increase attention to FP. Each country developed an action plan that would guide investments and programming in FP. The Ouagadougou conference declaration included the following points for action which are closely aligned with what emerged in the Costed Implementation Plan/*Plan de Relance*: *"1) Integrate population issues, as well as reproductive health (RH) and family planning (FP), into national development plans and strategies for growth and poverty reduction.* *2) Accelerate the implementation of national strategies for RH and FP to address the unmet needs expressed by the populations, through best practices identified at the Ouagadougou conference.* *3) Continuously disseminate culturally appropriate messages about population issues and FP to promote major changes in attitudes and reproductive behaviour, with emphasis on the quality of life.* *4) Increase by 30 percent the number of health professionals capable and authorized to offer the range of FP/RH services.* *5) Ensure a steady increase in contributions of national budgets to support the cost of contraceptives.* *6) Regularly monitor and evaluate the actions and measures implemented to ensure the achievement of the goal to reduce, by 2015, the maternal mortality ratio and the level of unmet family planning needs by at least 25 percent for the entire French-speaking region of West Africa.* *7) Raise the institutional placement of family planning programs with the goal of obtaining a high-level commitment".*	CO staff (PRB nd: 6)
The Ouagadougou Partnership and its partners, such as Advance Family Planning, are providing support to Burkina Faso for the implementation of its *Plan de Relance*. A baseline of the *Plan de Relance* was supported by the USAID Health Policy Project (The Futures Group) and a landscape analysis was conducted by Advance FP (a Gates Institute project, implemented with Futures Group and *Équilibres et Populations* - EquiPop). Several of the activities supported by UNFPA (such as the FP week, support for mobile services, introduction of Sayana Press) are not explicitly attributed to UNFPA but rather to its partners such as MSI and ABBEF. It is not clear whether UNFPA intended to take a behind-the-scenes role and whether this affects how the UNFPA contribution is perceived by others are less significant that it actually is.	(Maiga 2012, AFP 2015, Partenariat de Ouagadougou 2015)

Area of Investigation 4: Enabling Environment

To what extent has UNFPA supported the creation of an enabling environment at national and community levels to ensure family planning information and exercise of rights?

Data collection methods:
Document review
Key Informant Interviews (KII)
Focus Group Discussions (FGD)
Site visits

Assumption 4.1: **UNFPA has identified key enabling factors in different country contexts and developed effective interventions to strengthen these.**	**Information sources:**
Indicators: • Identification of enabling factors in CO annual reports • Interventions in CO plans at the national and community levels designed to strengthen the enabling environment • Evidence of enablers being strengthened at national and community levels (e.g. political commitment, community support) • Evidence of how enablers have facilitated strengthened FP information and services.	
The Government has made FP a cornerstone of its development strategy and there is strong commitment in policies and plans for FP. The main rationale for FP is to improve maternal/child health, but increasingly, there is recognition that FP contributes to economic development. FP is one of the priorities within the National Health Development Plan (PNDS 2011-2020) and the National Population Policy. The *Plan de Relance* (FP Stimulus Plan) is aligned with these larger plans and policies. Within it, the government has set an ambitious goal to reach 25 percent CPR by 2015. Even with the recent political upheaval, the new minister remains committed to fulfil the four pillars of *Plan de Relance* (demand creation, contraceptive security, access to contraceptives and monitoring and evaluation).	(Ministère de la Santé 2013b, AFP 2015)
PADS is a mechanism for channelling basket funds from the sector-wide approach (SWAp). UNFPA advocated for FP to be included in the basket funding and this has resulted in a strategic partnership with CSOs to support scale up. PADS provides technical and financial assistance to districts, and they contract with CSOs (through bidding on providing coverage for geographic "lots") to support a workplan at the district level. UNFPA has provided a relatively small amount of money (US$ 1.3 million between 2011 and 2013) for the SWAp, which allows the CO to sit on the technical group that oversees work and where it can influence the use of this funding for FP.	(Ministère de la Santé 2011)

UNFPA uses the health sector common fund (PADS) to support the development of peripheral level of the health system. It is a preferred modality for a number of technical and financial partners. The mechanism comprises a common basket and a set of targeted funding. PADS funds action plans of autonomous health facilities as well as those of the Regional Directorates of Health (DRS) and the Health District Framework teams (ECD). 80 percent of the funds are targeted (for specific activities).	(UNFPA 2015)
The MoH sees UNFPA as a key partner on supporting the policy and funding environment for FP in Burkina Faso. UNFPA supported the MoH to develop the *Plan de Relance*. The MoH as well as several other partners, are looking to UNFPA to support an evaluation of the plan that ends in 2015 to identify lessons learned to feed into the new plan. Moreover, the MoH would like UNFPA to support efforts to conduct advocacy with other ministries (finance, education, youth, etc.) and Parliament to broaden commitment to resource mobilization for FP commodities and programmes.	MoH, donor and NGO staff
Some partners felt that UNFPA could do more work to technically support quality of care and strengthen supervision of quality. However, it was thought that it might be difficult for UNFPA to provide critical feedback to the MoH, given that several key UNFPA staff have worked within the MoH and have been close colleagues. This proximity to MoH is seen as both an advantage and disadvantage for UNFPA.	Donor staff
Barriers to FP are numerous in Burkina Faso, as in most African countries; many women, youth and teenagers have little control over their fertility and sexuality. The low CPR levels indicate that there are social and structural barriers that prevent access to contraception, maternity car, postpartum care and the prevention of HIV/AIDs and STIs.	CO staff
"The health system is characterized by a scarcity of skilled providers in the field of maternal and reproductive health. In the last decade, the increase in the number of CSPS has not been matched by a corresponding increase in the number of midwives. The number of midwives per capita is still considerably lower (at 1/12702) than the WHO standard of 1/3000. The government's response has been the recruitment of auxiliary midwives and their deployment to rural areas, whilst midwives have been concentrated in referral hospitals. *All professionals involved in maternity care are authorised to administer natural FP methods, barrier methods and combined oral contraceptives (COC). This includes midwives and community health workers (agents itinérants de santé or AIS), although the latter can administer but not provide. However, injectables, implants and IUDs, can only be given by a category of highly qualified nurses (Infirmier d'Etat or IDE), female and male midwives (Sage Femme d'Etat or SFE and Maiieuticien d'Etat or ME), mid-level providers (Attaches de Santé) and doctors. In practice, midwives also provide injectables".*	(Daniele 2014: 3)
In 2009, the demand creation strategy was integrated and included various mass media approaches: Activities included: • 370 theatrical performances with an audience of about 110,200 people (unwanted pregnancies and PF); • 6800 talks were held with about 136,000 affected people for all four (4) themes (CPN, PF, fistulas, unwanted pregnancies); • 500 film screenings followed by discussions with approximately 82,000 people affected (fistulas and PF);	(UNFPA Burkina Faso 2009a) FGD

• 234 radio programs were conducted with about 612,500 people affected (CPN, unwanted pregnancies, fistula and PF); • 12,720 radio spots broadcasts made with about 6.42 million people affected (postnatal consultation (CPN), unwanted pregnancies, fistula and PF). • Six radio shows ("*émissions*") were carried out in local languages (Gulmantchéma, Bissa, Fulfulde, Moore, Jula, Bwamu) in six villages in the regions of the Mouhoun (Bondokuy), Central East (Gangla), Eastern (Natiabouani), the Sahel (Gangaol), the High Basins (Banankélédaga) and Central West (Poa). Per UNFPA reports, the combination of these activities helped to reach a significant proportion of the population with awareness messages. These actions undoubtedly helped increase the availability of information on FP and RH influencing demand. This seemed to be borne out in the focus group discussions, as the groups recalled the films and radio shows and spots and talked about how there has been a shift in attitude re FP over the past few years.	
During 2013, UNFPA paid particular emphasis on advocacy and demand creation for family planning. Actions taken were: • The development of an implementation of the guidance document of the community-based distribution (CBD) of contraceptives • The development of a training curriculum distribution for CBD workers • Adapting training modules on Sayana Press • Capacity building providers in partnership with 18 NGOs to strengthen capacity and 161 local associations and 9 maternity houses. For this purpose, 346 providers were trained in clinical FP in public health facilities throughout the year. With the financial support of the World Health Organization (WHO), sixty state qualified nurses were trained in clinical family planning. Also in 2013, three new strategies were supported by the program to boost the availability and access of landlocked populations and/ or disadvantaged groups to FP services including long-term methods. Setting up two mobile teams in Bobo Dioulasso and Dedougou in partnership with ABBEF and MSI, a pilot project on PPIUD in 20 public health facilities in partnership with JHPIEGO, and integration of FP through Burkina PLAN's, the child sponsorship network for CBD in the Boulsa health district.	(Ministère de la Santé 2013c)
In the 7th Country Programme (CP), the evaluators questioned the wisdom of undertaking a large number of activities which limits the amount of funding for and programmatic strength of each activity. The volume of results produced was "impressive" especially in terms of the hundreds of health professionals trained (as facilitators, supervisors, BCC, monitoring and evaluation (M&E), contraceptive logistics, etc.). However, evaluators also questioned the selection of partners and the fact that it did not follow set procedures but, rather was based on available opportunities. The example given was the radio project that developed 2 soap operas at a cost of $1.6 million over 2 years, with no "positive return".	(UNFPA 2015)

In 2008, UNFPA conducted advocacy with policy makers, parliamentarians, opinion leaders at central and decentralized levels for repositioning FP and resource mobilization to finance the commodity security plan. These various advocacies contributed a part in creating an environment conducive to the practice of family planning and also the mobilisation of funds from the national budget; the common basket and cost recovery from user fees for commodities. This advocacy pre-dated the inclusion of FP in various national plans as well as the repositioning efforts that began in 2010.	(UNFPA Burkina Faso 2008b)
In support of the *Plan de Relance* 2013-2015, UNFPA supported a Journalists Caravan to brief journalists on FP and orient them to the FP needs of clients so that they could provide better coverage on FP issues. The caravan visited six of thirteen regions in 2013 and included nine journalists from seven newspapers. One of the journalists received an award for excellent journalism on FP at the International Conference on Family Planning in Ethiopia in 2013.	(UNFPA Burkina Faso 2014c)
"The performance-based financing (PBF) component of the project is being piloted in 15 districts in six regions and targets the rural poor through a community-based approach and mutual health insurance. *On the supply side, the project supports performance-based incentives for health facilities for the delivery of packages of basic health care services, focusing mostly on maternal and neonatal health, but also including child and adolescent services, nutrition, HIV/AIDS, tuberculosis and malaria. Payment is on a fee-for-service basis and takes place monthly after assessment by external reviewers and verification for quantity and quality of care. Facilities have autonomy to decide how to use the RBF payments. In 2014, the project introduced PBF technical assistance agencies in each region (Contracting and Verification Agencies), supervised by a national-level international TA.* *On the demand side, community-based targeting and mutual health insurance have been introduced, so that poor people can be identified and offered a package of free services, and free enrolment into the insurance scheme.* *The project will build partnerships with UNICEF and UNFPA, and other agencies which are present in the same regions".*	(World Bank 2015)

Assumption 4.2: **UNFPA has successfully supported partners at country and community levels to improve demand creation and access to services, thus enabling people to exercise their rights better.**	**Information sources:**
Indicators: • Improved service use and FP uptake (especially where unmet need is high and by VMGs) • Change in unmet need of different groups • Access barriers reduced, equity improved • Increased responsiveness to the needs of VMGs.	
UNFPA has supported advocacy on how to engage the private sector in FP by financing a study by MSI on how to introduce FP in the private sector and to start franchising services, as well as to broker financing for the study. The assessment suggested	CO and NGO staff

that although the private sector is not a major actor, it is beginning to develop as the country is experiencing rapid urbanisation. The private sector's contribution to the health sector is limited; per the demographic health survey (DHS), only 11.4 percent of use is satisfied by private medical providers. The assessment also noted that the political context for the development of the private sector has become more favourable since 2010, but implementation has been limited until now. This report paved the way for an MSI pilot programme on social franchising.	(Eldridge and Cissé 2014, DHS 2015)
Prior to 2014, UNFPA cooperated with GIZ in two regions (Southwest and East) on SRH/FP for young people and HIV mainstreaming. They worked closely together to share ideas on how to improve quality of services and how to implement programs and avoid duplication. Together, GIZ and UNFPA tested an approach for how health facilities could better serve youth, shared villages to be covered (equipment and joint training), designed the training curricula together, and wrote a strategy paper in 2011. However, the report was not disseminated widely, and there appeared to be no effort to move from pilot to scale.	Donor staff
See notes on community-based activities under Assumption 2.3 above. Since 2001, UNFPA has expanded its work at the community level. It is working with 20 umbrella NGOs to conduct capacity-building of 160 community-based organizations, thereby extending the reach through a partnership strategy. The international NGOs work in different regions and each one is expected to build capacity of and monitor and supervise the local community groups.	CO staff
With UNFPA support, Burkina Faso is piloting task shifting for Sayana Press and Implanon. To date, these efforts have reached more than 26,000 new users in a few months of operation only. Burkina Faso has also made a 50 percent reduction in prices of contraceptives, thereby facilitating access to contraception by thousands of women.	(IntraHealth International 2014)
The FGD participants reflected on the change over the past several years regarding the availability of information on FP and improved changes in attitudes and awareness as a result of it. These changes were recounted by all focus groups, including the men's FGD. Participants reflected that the improved attitudes towards FP were a result of the worsened economic conditions and pressures regarding land availability. Mostly, however, the narratives reflected on the participants' increased awareness regarding the importance of birth spacing for the health and well-being of mothers and children and how FP contributes to improved health. Religion was not reported to be a barrier, as the health consequences of high fertility are better understood. This improved environment did not always translate into increased use of contraception by participants, especially the older participants. They mentioned serious health concerns and side effects regarding contraception, especially regarding its effect on future fertility. Side effects related to bleeding and concerns that the IUD would migrate within the body were mentioned by all three focus groups that included women. Younger participants were still concerned about side effects, although were more willing to try contraception to avoid (additional) unwanted pregnancies and complete or return to school. Only one of the three FGDs with women mentioned that health workers provided information on side effects; the two other groups of women said that providers did not talk specifically about side effects and health concerns during counselling. This is in contrast to the UNFPA CO 2013 annual report that said that 88.9 percent of women interviewed were	FGD (UNFPA 2013, PMA2020 2015)

informed about common side effects during a counselling session. PMA 2020's brief on key FP indicators reported less than half of women (45.6%) were counselled on side effects.	

Assumption 4.3: **HQ and ROs have supported COs in identifying needs, creating an enabling environment and promoting demand and access in different contexts.**	**Information sources:**
Indicators: • Frequency and nature of technical assistance (TA) visits and communications with focus on factors related to creation of enabling environment and promoting demand and access.	
UNFPA CO staff appreciate the assistance they receive from HQ and the RO. They see the role of HQ as providing guidance via overall strategies and plans. Technical assistance is usually provided in association with thematic funds, as these provide an organised mechanism for HQ to reach out to COs. However, staff described the key interaction with HQ as requesting information or conducting reviews of CO reports. There were no substantive examples provided. The RO is seen as providing important updates and trainings, but CO staff did not provide any examples of specific in-country TA from the RO. The CO has strong technical capacity in FP.	CO staff

Area of Investigation 5: Vulnerable and Marginalised Groups

To what extent has UNFPA focused on the family planning needs of the most vulnerable and marginalised groups, including identification of needs, allocation of resources, and promotion of rights, equity and access?

Data collection methods:
Document review
Key Informant Interviews (KII)
Focus Group Discussions (FGD)
Site visits

Assumption 5.1: **UNFPA globally and at country-level performs situation analyses to identify needs, challenges and rights violations forms, and identifies good practices on how to address these.**	**Information sources:**
Indicators • Evidence of gender-sensitive needs assessment of target groups for UNFPA supported interventions including identification of rights violations • Availability of accurate and sufficiently disaggregated data for targeting most vulnerable and marginalised groups • HQ/RO TA visits to support assessment, design, implementation, monitoring (including results-oriented monitoring) and evaluation of interventions to address the needs of VMGs	

• Evidence that good practices have been identified and disseminated.	
Principles related to fairness and equity of access of rural households and access to RH services for disadvantaged groups underpin the reproductive health commodity security (RHCS) strategy. Universal access is an increasingly important theme in CO programming.	(Ministère de la Santé 2010) CO staff
UNFPA work on VMGs is mostly focused on adolescents and youth to address issues of early marriage, gender-based violence, the SRH needs of handicapped youth. UNFPA work to address fistula both through prevention (FP and emergency obstetric, neonatal care (EmONC) and repair services is addressing the needs of a very marginalised population. Finally, UNFPA has strengthened its response and planning for humanitarian assistance, and has provided important integrated services to vulnerable populations. UNFPA work on preventing GBV and early marriage are also considered as components of a human rights based approach (HRBA).	CO and NGO staff
Female genital mutilation (FGM) and child marriage is an issue in the North and Sahel communities. UNFPA is supporting the annual UN Zero Tolerance campaign for FGM (global campaign, implemented in Burkina Faso). UNFPA has provided special training for midwives on how to work in communities on FGM. Their strategy, based on lessons learned, is to start where the practice is prevalent and to achieve some success before scaling up. For example, they work to identify practitioners of FGM who are willing to publically abandon the practice; they work to change the norms more broadly.	CO staff (UNFPA and UNICEF 2013)
In Burkina Faso, UNFPA provided emergency support for floods that occurred in September 2009. It developed and procured dignity kits, and supported capacity-building workshops for its staff and partners on providing emergency assistance to support SRH, including prevention of unintended pregnancy and STI/HIV, support for safe delivery, the prevention and control against GBV, and the collection and management of data in emergency situations. Activities focused both on emergency preparedness, emergency response and the coordination of humanitarian actions.	(UNFPA 2014c)
UNFPA conducted an evaluation of its model for youth listening centres to define a model for improving SRAJ access to services by adolescents and youth, including how these centres meet the SRH-HIV integration and FP needs of this group. This evaluation found that these centres were not meeting their potential, and recommended actions to: improve awareness of the offerings at these centres, to build capacity to ensure adherence to guidelines and standards for youth-friendly services, to expand public-private partnerships, and to improve monitoring and evaluation.	(UNFPA Burkina Faso 2014a)
UNFPA supported a review of the youth strategy from 2004-2008 in five districts (Batié, Bogodogo, Boulsa, Orodara and Pô) as a foundation for developing a new strategy. This review found that *"there was no document to guide the priority actions"* needed to improve the health of adolescents and youth which constitute the largest proportion of the population and updating the strategic is of paramount importance. The review recommended the need for broad consultation of stakeholders and involvement of youth organizations to advance SRAJ.	(UNFPA Burkina Faso 2014e)

"Though many programs and services exist to help Burkinabé adolescents protect their SRH, certain barriers keep adolescents from taking advantage of these services. A study in Ouagadougou found that while cost is not a major obstacle, adolescents fear being judged and will talk to a friend about a health problem – and then perhaps to a group of friends—before going to an adult. When they do go to a clinic, they prefer to go to one where they are less well known. Parental restrictions also pose a barrier to adolescent use of health facilities". The same study in Ouagadougou noted the issue of adolescents having sex with older men in return for money or presents (two in ten unmarried women aged 15-19 and three in ten unmarried men 15-19). It also found that while cost is not a major obstacle, adolescents fear being judged and are afraid to go to a health clinic where they might be known. Parental restrictions also pose a barrier to adolescent use of health facilities. These issues were also mentioned by youth in the FGDs conducted in Dédougou. *"Access is difficult unless one is married."*	(Guttmacher Institute 2004: 4) FGD (Dédougou)
UNFPA supported the Federation of Burkinabé associations for the promotion of the disabled (FEBAH) to conduct a situational assessment study of people living with disabilities. Two-thirds of respondents reported difficult access to information due to their disability and lack of trained staff to properly support their use of SRH services.	(UNFPA Burkina Faso 2014b)

Assumption 5.2: **UNFPA allocates resources to effective and targeted programming for the most vulnerable and marginalised groups.**	**Information sources:**
Indicators: • Number and type of program interventions targeted to VMGs percent of total budget allocations to partner activities which focus on VMGs.	
The promotion of SRH among adolescents and youth (SRAJ) occupies a prominent place in the annual workplans throughout the period under evaluation. Youth are highly vulnerable to unintended pregnancy, STI and HIV/AIDS infection, unsafe abortion and gender-based violence. The consequences of early marriage accompanied by early first pregnancy, early and unwanted pregnancies among girls in school, early and unprotected sex all provide a context and rationale for the focus by UNFPA on the sexual and reproductive health of young people. Actions undertaken for the development of RH services for adolescents and youth are within the national framework which notes that these phenomena are aggravated by the low use of contraception by young people and the lack of provision of adolescent-friendly health services. While The 7th CP focuses on these issues, it gives priority to IEC/BCC (mainly for condom distribution and use) and less to the establishment of youth-friendly services. The work has targeted youth listening centres (at universities) and more could be done to support improved reception, counselling and support for health issues at the level	(UNFPA Burkina Faso 2008a, UNFPA Burkina Faso 2009a, UNFPA Burkina Faso 2010a, UNFPA Burkina Faso 2011a, UNFPA Burkina Faso 2012a, UNFPA Burkina Faso 2013a, UNFPA 2015)

of PHC services. The 7th evaluation notes that the CP supported the development of a policy framework for youth, but this has not been updated since 2008.	
Disabled youth is a highly vulnerable subset of an already vulnerable group. The brief is based on an analysis of the needs of disabled youth conducted by the Burkinabé Federation of Associations for the promotion of persons with disabilities (FEBAH) in 2008. The 2013 workplan included several activities to train 25 regional trainers on life skills-building, to establish 20 youth centres, and to train educators and supervisors from special schools for disabled youth. BCC materials on SRH were translated into braille, sign language, audio media, simple French and distributed through the youth centres and trained personnel.	(UNFPA Burkina Faso 2013c, UNFPA Burkina Faso 2014b)
UNFPA developed a brochure on the rape of young girls to highlight the consequences of early and unintended pregnancy among this vulnerable group as part of a campaign against gender violence.	(UNFPA Burkina Faso nd-a)

Assumption 5.3: **UNFPA promotes reproductive rights and supports capacity development to remove barriers and improve access, quality and integration of FP services with other services for the most vulnerable and marginalised groups.**	**Information sources:**
Indicators: • Rights of, and services for VMGs actively promoted in advocacy strategies with specific attention to gender issues • Type of capacity building interventions to address service barriers and improve access for, and enable exercise of rights by the most disadvantaged groups.	
A major barrier for youth is that they will not go to health facilities. UNFPA is working in partnership with GTZ and ABBEF, as well as working directly to create 9 youth-friendly centres and train the MoH in youth-friendly services. WHO developed a National Handbook, which was updated by DSF on youth friendly services (YFS). The CO is working on a survey to determine how many facilities are supporting YFS in accordance with the WHO guidance.	CO staff
For disabled youth, UNFPA has supported rights education and training and orientation of teachers, health workers, monitors of special schools and facilitators in literacy centres about the SRH needs of disabled youth. This is supported under the 7th programme through an action plan developed by FEBAH under the Permanent Committee for the Fight Against AIDS.	(UNFPA Burkina Faso 2014b)
For emergency preparedness, UNFPA conducted 5 sessions since 2011 to train teams in health districts of Sahel Hauts-Bassins, Boucle du Mouhoun, Cascades to build capacity in MISP and GBV prevention (funding allocated was 24.7M CFA). It has also pre-ordered humanitarian and dignity kits to have on store with the central store for essential medicines and commodities (CAMEG) as part of the emergency preparedness plan.	(UNFPA Burkina Faso 2014d)
In response to humanitarian crisis in 2008, where there were many unintended pregnancies with two generations of women (mothers and daughters) pregnant and giving birth at the same time. In response to this crisis, UNFPA created an emergency	CO staff

dignity kit, the content of which includes sanitary towels, soaps cloth; an entry point to work on gender based violence. These kits were in high demand.	

Assumption 5.4: **UNFPA actively encourages VMGs to participate in programme planning, implementation and monitoring and VMGs receive capacity building to this end.**	**Information sources:**
Indicators: • Evidence for gender sensitive participation by VMG • Evidence for UNFPA support for training in participation.	
A key aspect of the UNFPA strategy is to engage with CSOs, is to get closer to the community and its needs. The assumption is that the CSOs actively engage with communities and encourage the participation of beneficiaries in programme assessment and design.	CSO partners

Assumption 5.5: **Access to and utilization of services by VMGs, according to their sexual and reproductive intentions, has improved.**	**Information sources:**
Indicators: • Documented evidence on improved VMG access and utilization of services (link with area 1 - integration) • VMG user (women and men) satisfaction with service access and quality.	
See Assumption 1.2 for results on Fistula.	
FP outcomes do not appear to be disaggregated or focused on youth in CO reports.	

Area of Investigation 6: Rights-Based Approach

To what extent has UNFPA implemented a human rights-based approach to family planning, in particular regarding access to and quality of care, and through support from HQ and RO for a rights-based approach in country?

Data collection methods:
Document review
Key Informant Interviews (KII)
Focus Group Discussions (FGD)
Site visits

Assumption 6.1: **UNFPA staff and key partners have a shared understanding of the meaning and importance of a rights-based approach to FP.**	**Information sources:**
Indicators: • Identification of definitions/descriptions of rights-based approaches • Perception of UNFPA and partners' staff of the meaning and importance of the rights-based approach.	
There appears to be no common definition within UNFPA and among UNFPA partners about what constitutes a human rights-based approach in family planning. Some felt that rights is about access to safe abortion; others, including UNFPA, spoke of rights in terms of universal access, access for marginalized and vulnerable groups, including adolescents, areas for which UNFPA is well known. One partner noted that the FP needs in Burkina are framed around a maternal and child health rationale, and not on human rights *per se.*	NGO staff
UNFPA uses a rights frame in its programmes and advocacy, e.g., SRH for disabled youth, SRH for adolescents and youth, fistula, humanitarian assistance, outreach to rural and underserved areas. Rights principles of empowerment, non-discrimination and equity underpin UNFPA activities, especially in its work with VMGs. UNFPA is seen as a beacon by its partners on these issues.	CO and NGO staff
The World Bank is funding a performance-based financing of health services which includes FP in fifteen districts in six regions, including Dédougou. This programme began in 2011, is modelled on a similar initiative in Rwanda ("*mutuelles"*) and is intended to increase equity and efficiency of services offered, motivate providers, systematize supervision and monitoring, and ensure community participation. The PBF programme is organised so that service providers (health workers and community health workers) deliver a minimum package of services (including FP and PAC services) appropriate for the level of the health facility. A Technical Service/PBF Team is the coordinating body and establishes contracts which include quantitative and qualitative indicators to evaluate the participating districts. Family planning is included as a qualitative indicator at the three levels (health facility, district hospital and regional hospital) for maternal health; however, during discussions in Dédougou, providers indicated that FP was measured using a quantitative indicator (Couple years of protection - CYP). The dynamics of how incentives affect provider behaviour and the promotion of specific contraceptives, particularly if they are quantitative (or interpreted to be quantitative in nature), have the potential to affect contraceptive choice and individual autonomy. While the evaluators have not observed any, there was no evidence that there was any subtle bias or coercion at play, however, this could present a vulnerability in the programme in terms of individual choice and rights.	(Ministère de la Santé 2013a) Interviews with MOH Dédougou Regional staff.
"The value of a rights-based approach to family planning is that it treats individuals as full human beings in their own right, as active agents, not as passive beneficiaries. This approach is built upon the explicit identification of rights-holders (individuals)	(UNFPA 2012: 5, 13, 11, 14)

and the duty-bearers (governments and others) that are responsible for delivering on rights. Today, family planning is widely accepted as a foundation for a range of rights" (UNFPA 2012: 5) *"In recent years, consensus has emerged on what ensuring quality means in the context of family planning and human rights. It includes:* *• Providing family planning as part of other reproductive health services, such as prevention and treatment of sexually transmitted infections, and post-abortion care (Mora et al., 1993);* *• Disallowing family planning targets, incentives and disincentives, such as providing money to women who undergo sterilisation or to health-care providers on the basis of number of women "recruited" for family planning;* *• Including assessments of gender relations in plans and budgeting for family planning services (AbouZahr et al., 1996);* *• Accounting for factors such as the distance clients must travel, affordability and attitudes of providers"* (UNFPA 2012: 13) *"The committee on Economic Social and Cultural Rights in its General Comment Number 14 on the right to the highest attainable standard of physical and mental health has defined the following normative elements that apply to all the underlying determinants of health: Availability, Accessibility, Acceptability and Quality"* (UNFPA 2012: 11) *"Three cross-cutting principles contribute to building strong, rights-based family planning programmes:* *• Participation— a commitment to engaging key stakeholders, especially the most vulnerable beneficiaries, at all stages of decision making, from policies to programme implementation to monitoring (UNFPA, 2005).* *• Equality and non-discrimination—a commitment to ensuring that all individuals enjoy their human rights independent of sex, race, age, or any other status.* *• Accountability—mechanisms must be in place for ensuring that governments are fulfilling their responsibilities with regard to family planning information and services. Accountability includes monitoring and evaluation systems, with clear benchmarks and targets in order to assess government policy efforts in meeting people's rights. Monitoring and evaluation are essential for giving governments the means to identify the major barriers to family planning and the groups that have the greatest difficulty with these barriers. Monitoring and evaluation also provide individuals—rights holders—and communities with information to hold governments to account when rights are not being upheld"* (UNFPA 2012: 14)	

Assumption 6.2: **UNFPA programming incorporates human rights principles in the assessment, design, implementation and evaluation of FP program interventions.**	**Information sources:**
Indicators: • Evidence of a rights-focused needs assessment, quality assurance mechanisms, participatory processes, and accountability mechanisms within programmes	

• Evidence of attention to barriers and protocols for addressing coercion • User satisfaction with FP access and quality (men, women, VMGs).	
Language about human rights is found within most of UNFPA plans and documents and is linked to the "Cairo Agenda" from the International Conference on Population and Development (ICPD) in 1994. However, there is no concrete reference found on how to operationalise a rights based approach to FP or what this might entail or look like or how the rights principles can be operationalised within programmes.	CO staff
Training in the HRBA recommended by UNFPA has not reached the CO yet. The CO was not aware of key references related to programming for a HRBA approach, although staff recently attended an RO training on integrating rights and gender.	CO staff
According to UNFPA an HRBA includes the following: • Emphasises the process as well as the outcomes of programming • Draws attention to the most marginalised populations • Works toward equitable service delivery • Extends and deepens participation of those targeted by programmes • Ensures local ownership of development processes • Strengthens accountability of all actors.	(UNFPA 2010)
The "IFC – individual, family and community" approach includes a participatory community diagnosis which is used to identify issues important in a local context in the Sahel region with Family Care International (FCI). The IFC approach contributed to improvements in women's access to health care, including the fixing of access roads to health facilities, maternity huts to allow pregnant women to be near childbirth services, and support to identify and refer women with obstetric fistula.	(UNFPA 2015)

Assumption 6.3: **UNFPA is developing a body of evidence and lessons learned regarding human rights-based approaches for FP**	**Information sources:**
Indicators: • Identification of evaluation and research and/or briefs on lessons learned related to human rights-based programming	
Human rights entries are about broader issues, e.g. FGM, working with men and boys on gender norms, gender mainstreaming, advocacy for legal frameworks, but not specifically related to human rights in FP. Rights elements are not incorporated into the reporting for Outcome 3 (Increased access to and utilisation of quality family planning services for individuals and couples according to their reproductive intentions). Most of the indicators relate to contraceptive security and procurement. While quality and method mix availability (proxy for choice) are indicators, no data is available to support these indicators.	(UNFPA Burkina Faso 2008a, UNFPA Burkina Faso 2009a, UNFPA Burkina Faso 2010a, UNFPA Burkina Faso 2011a, UNFPA Burkina

	Faso 2012a, UNFPA Burkina Faso 2013a)

Assumption 6.4: **Country offices receive and put into practice technical guidance from HQs and ROs to support rights-based FP.**	**Information sources:**
Indicators: • Number, frequency and type of TA provided • RO plans address capacity gaps and support needs of COs, and ROs provide timely support • CO strategies and programmes reflect current technical guidance and best practices for rights-based FP.	
Given the lack of a consistent understanding of HRBA and its importance within FP programmes, and UNFPA leadership in this area, the CO is open to additional training and guidance from HQ and ROs on how to apply and operationalize HRBA to FP programmes.	CO staff

Assumption 6.5: **Rights holders consider that duty bearers understand their rights to family planning and SRH.**	**Information sources:**
Indicators: • User satisfaction with FP availability and quality (men, women, VMGs).	
The FGD clients from the MSI programme in Dédougou (young, unmarried women) expressed the concept that they had a right to quality FP services. They felt that they were treated with dignity and respect; that MSI ensured their confidentiality, and provided them with information about what to expect in terms of side effects. The participants of the other FGDs seem less aware that they were entitled to access to quality services, but each group mentioned the importance of having a health centre nearby that could offer services closer to their home. Their narratives suggested that the health providers were not concerned about privacy or confidentiality (this was a particular barrier and issue for youth). Further, many participants reported that they did not receive information about the potential side effects.	

Area of Investigation 7: Modes of Engagement

To what extent has UNFPA adapted its mode of engagement[78] to evolving country needs in different settings, using evidence and best practice?

Data collection methods:
Document review
Key Informant Interviews (KII)
Focus Group Discussions (FGD)
Site visits

Assumption 7.1: **UNFPA COs monitor changes in country context and needs over time and adapt their mode of engagement and programme development accordingly.**	**Information sources:**
Indicators: • Number of visits and TA input from ROs and HQ to collection and analysis of evidence on changing needs in FP engagement • Other activities (staff workshops, training, etc.) conducted by HQ and ROs) to support program innovation and/or incorporation of best practices into programmes.	
The *Plan de Relance* has four major areas: create demand in partnership with other organisations, including advocacy with local leaders and youth; procurement and commodities; improve service access; and evaluation and monitoring. The current programme portfolio in FP mirrors closely the priorities within the MoH.	MoH and CO staff
Between 2008 and 2010, the FP activities of UNFPA were in a few regions; the major components included contraceptive security, advocacy for FP resource mobilisation, and demand creation through BCC using mass media. These expanded to a national scale under the 7th CP even though resources did not increase dramatically to support a programme of national scale. Advocacy and contraceptive security remained key programme components for UNFPA throughout the 6th and 7th CPs. During the 7th CP, demand creation shifted from a focus on mass media to one more focused on community engagement. On direct training of providers see Assumption 8.1.	(United Nations 2005, United Nations 2010)

Assumption7.2: **UNFPA monitors changes in country context and needs over time and adapt their mode of engagement and programme development accordingly.**	**Information sources:**

[78] "Modes of engagement" refers to the four modes of engagement in the current UNFPA strategic plan (support for service delivery, capacity building, advocacy, knowledge management). These modes of engagement have been included in the ToC diagram and discussion in section 3.2.1

Indicators: • Evidence of continued monitoring of country context and needs • Evidence collected and analysed on the appropriateness of the mix • Change of engagement modes used over time • Existence and frequency of coordination on engagement modes with national stakeholders and development partners.	
Country programme documents reflect that lessons learned were used and taken into consideration in subsequent plans; however, the team did not find information explicitly on the process(es) used by UNFPA to analyse and determine changes in modes of engagement.	
Lessons learned from the 6th CP are: a) the value of participating in common basket funding, b) the need to reposition FP in the national development agenda, c) the importance of building the capacity of government institutions and forging partnerships with civil society, d) the need to enhance the use of results-based management and knowledge management, and e) the importance of emphasising security issues given the instability in the region.	(United Nations 2010)
Lessons learned from the 5th CP are: the need to promote a programme approach; the importance of developing youth-friendly strategies and tools; the need to involve men and parents to reach young people and especially young adolescents; evidence-based interventions developed are key to ensuring local ownership, improving maternal health and increasing the use of RH services.	(United Nations 2005)

Assumption 7.3: **UNFPA interventions and engagement modes support country moves towards increased sustainability of FP and SRH interventions.**	**Information sources:**
Indicators: • Evidence of change in engagement modes supporting moves towards sustainability • Percent of overall FP financial needs covered by national budget • Allocation of funds to FP in medium and long-term health sector plans.	
The UNFPA strategy to engage with "umbrella" organisations to leverage health sector funding while building capacity of civil society and partners to extend RH services is an adaptation that encourages sustainability.	
See Assumption 2.2 for information on overall financial needs covered by national budget (30% of commodity costs)	

Assumption 7.4: **UNFPA identifies and applies good practice at country, regional and global levels.**	**Information sources**

Indicators: • Results-oriented monitoring and evaluation systems are in place and inform programming • Evidence of good practices identified with attention for rights and gender issues • Examples of application of good practice at country, regional, global level.	
There are limitations in applying best practices from elsewhere, as each country context is so different. Regular visits from RO staff are used to transfer experiences and best practices. Personal visits enable RO experts to adapt their input to take into account the country context and local needs. Global Programme for Reproductive Health Commodity Security (GPRHCS) regional meetings are used to share experience and best practices.	CO staff
The monitoring and evaluation system is a major weakness of the programme. The contribution of UNFPA to the effects of the strategic plan and the UN Development Assistance Framework (UNDAF) is not clear and there is a lack of adequate means of measurement. (Formulation of low and insufficient measures)	(UNFPA 2015)
The CO has identified a few best practices related to FP in its annual progress reports (mostly related to contraceptive procurement and advocacy activities). With the exception of the *Rapport Conjoint* in 2011, the entries are so general it is difficult to evaluate the practices reported on, unless there are other reports to amplify results and lessons. Specific good practices/lessons learned identified include: • In 2009, best practices included: using multiple channels for BCC (mass media, group talks, and individual counselling) to reinforce messages in ways that encourage behaviour change and contracting with NGOs on SRH/FP activities in order to expand reach. • 2010: the adoption of CHANNEL software, monitoring and training personnel in RH commodities security was reported to have been well received by players at different levels of the health system. Use of the software in 2010 has improved the quality of management reporting and supported improved forecasting of contraceptive needs. Stakeholders expressed the desire to extend its use for monitoring all the pharmaceutical products available. • 2011: this report included three extensive write-ups on best practices related to the pre-service training and mentoring of midwives, the fistula programme and social mapping as a tool for collaboration between the health sector and communities. The latter practice is the one relevant to FP, as it included the development of the contracting mechanisms whereby the Ministry of Health contracted with civil society to support activities that had high potential for improving maternal and child health. *Initiative Privé Communautaire* (IPC) was identified as an umbrella NGO to support local CBOs in the Central East Region. It was a successful pilot which was replicated by the MoH. (Also see Assumption 4.1). • 2012, four good practices were identified: the weekly monitoring of stocks in the Mouhoun District resulted in improved awareness of the importance of commodity security; weekly monitoring of maternal deaths to support better registration,	(UNFPA Burkina Faso 2008b, UNFPA Burkina Faso 2008a, UNFPA Burkina Faso 2009c, UNFPA Burkina Faso 2009a, UNFPA Burkina Faso 2010b, UNFPA Burkina Faso 2010a, UNFPA Burkina Faso 2011a, UNFPA Burkina Faso 2011b, UNFPA Burkina Faso 2012a, UNFPA Burkina Faso 2012b, UNFPA Burkina Faso 2013a, UNFPA Burkina Faso 2013c)

auditing and follow-up to limit occurrence in the future; the organisation of emergency obstetric care in Tugan District/ Mouhoun Region; and strengthening access to SRH services and prevention and response to GBV in humanitarian crises. • In 2013, good practices that are qualified in the report as "deserve to be documented" included: Capacity building for midwifery students, story-telling in advocacy, the IFC (individual, families, communities) approach, establishment of FP Week, strengthening the logistics management information system (LMIS) (presumably through CHANNEL and surveillance/monitoring), and the use of mobile teams to increase access and utilization of FP services.	
There is room for improvement in documentation of good practices. UNFPA is committed to monitoring programmes and looking at results, but has not quite put this into practice yet. The CO identified good practices in the annual report for the thematic funds, however, the practices are not systematically documented in a way that would allow for dissemination and exchange with other COs or external partners.	NGO staff (UNFPA Burkina Faso 2008b, UNFPA Burkina Faso 2009c, UNFPA Burkina Faso 2010b, UNFPA Burkina Faso 2011b, UNFPA Burkina Faso 2012b, UNFPA Burkina Faso 2013c)

Area of Investigation 8: Supply-side Activities

To what extent has UNFPA support for supply-side activities promoted rights-based and sustainable approaches and contributed to improved access to quality voluntary family planning?

Data collection methods:
Document review
Key Informant Interviews (KII)
Focus Group Discussions (FGD)
Site visits

Assumption 8.1: **Provider training supported by UNFPA is client-centred, quality-focused and promoting rights and freedom of choice in FP.**	**Information sources:**
Indicators: • Nature of training programmes offered by MoH and other partners • Behaviour change communication and client counselling included in training, including gender perspectives.	

UNFPA has trained hundreds of health providers, facilitators, and supervisors in CBD, clinical FP, supervision, logistics and procurement and BCC/IEC. The result is an increase in capacity and results in quality are measured through routine indicators related to method mix (SDPs with three or more contraceptive methods), SDPs that do not experience stock-outs. It is mentioned in reports as well as in interviews that the impact and sustainability of training is challenged the by frequent rotations of health personnel in the public sector.	(UNFPA 2015)
In 2009, UNFPA reported that training supported improved quality by strengthening of skills providers and upgrading health centre facilities. This included: training in FP of 800 providers in districts, including the female condom and the IUCD; training 50 teams at district and regional levels in supportive supervision; training 25 teachers from National School of Public Health for FP education; the conduct of an orientation workshop for 23 officers of private pharmacies in contraceptive products; and the initiation of community-based distribution of contraceptives through the contracting of these activities with NGOs and associations.	(UNFPA Burkina Faso 2009c)
In 2010, UNFPA reported: • Continued training of providers of health districts in clinical PF (including the female condom, IUD). In total, 192 providers were trained in nine (9) health districts; • Training of trainers (20 health workers and 20 facilitators from community-based organisations (*organisations à base communautaire* - OBCs) in promoting the use of condoms, male and female. This training has strengthened the capacity of 180 health workers and other leaders of CBOs to promote the use of both male and female condoms; • Training of doctors in six HIV prevention and management of people living with HIV, attested by a diploma Interuniversity (IUD).	(UNFPA Burkina Faso 2009c)
In 2011, UNFPA reported: • Training of 380 providers in clinical FP (IUD and implants) and supervision • Training of CBD workers, facilitators and supervisors by 14 capacity-building NGOs for 150 community-based organisations • Training in CHANNEL for 13 officers (stock managers and pharmacists) • LMIS training for 281 health workers/depot managers	(UNFPA Burkina Faso 2011b)
In 2012, UNFPA reported: • Training of 75 regional trainers and providers in FP provision and supervision • Training of 27 facilitators in CBD • Training of 20 procurement officers in procurement of RH commodities.	(UNFPA Burkina Faso 2012b)
In 2013, UNFPA reported: • Training in clinical FP for 346 providers from public facilities • Training in PPIUD for staff from 20 public health facilities (with Jhpiego) • Training in supervision for 20 district health officers	(UNFPA Burkina Faso 2013c)

• Training of 45 pharmacists in procurement, 25 in CHANNEL • Training of 240 officers in LMIS	

Assumption 8.2: **UNFPA support to procurement promotes availability of a wider method mix.**	**Information sources:**
Indicators: • Range of methods procured by UNFPA, development partners and national governments • Range of methods available at service delivery points for all user groups.	
UNFPA is seen as a major contributor to contraceptive security in Burkina Faso, by supporting monitoring of commodity security and contraceptive availability in the country and as a main supplier of contraceptives. UNFPA advocated for and supported the government to develop the Strategic Plan for Reproductive Health Commodity Security 2009-2015, to serve as the main framework for reproductive health supply and the provision of services. The key domains in this plan include: the policies for funding and sustainability of commodities; the RH services offered; logistics management; demand creation; and partnership, coordination, monitoring and evaluation. The principles that guided the development and content of the plan included: leadership and ownership by the Government of Burkina Faso; a multi-sectoral approach, with participation by stakeholders; equitable access, especially for rural and disadvantaged populations; and alignment with other initiatives and programmes, e.g. integration of resources and services.	Interviews with NGO partners, CAMEG, JSI (Ministère de la Santé 2010)
In 2009, a study of RHCS in Burkina commissioned by UNFPA showed improvements in contraceptive supplies in health facilities, namely, 90.8 percent of facilities had contraceptives in stock at the time of the investigation against 81.3 percent in the last 6 months. Other data included: • 69.9 percent of health facilities offer at least three modern methods of contraception • Health facilities in rural areas offer more choice in contraceptive methods than those of urban areas • 72 percent of health facilities do not provide some reversible methods due to a lack of availability of trained staff. • 51.5 percent of health facilities offer at least five of the seven vital medicines for maternal and reproductive health • The most common reasons for stockouts: a break in the supply source (61.2%) followed distantly by financial problems (11.4%) In 2013, UNFPA reported that over 95 percent of health facilities offered at least three methods of contraception and 88 percent offer at least five.	(UNFPA Burkina Faso 2010b) (UNFPA Burkina Faso 2013c)
UNFPA has promoted an expansion of method mix through the introduction of Sayana Press, the conduct of clinical training in IUDs and implants, the support of mobile teams to extend long-acting reversible contraceptives (LARCs) to rural areas, and the pilot introduction of PPIUDs. Also see Assumptions 1.3, 3.2 and 4.2.	(PMA2020 2015)

Between the DHS in 2010 and the PMA2020 2014 Survey, while overall CPR among women in union increased only from 16.2 to 17.0 percent, long-acting CPR increased from 3 to 7.9 percent.	
UNFPA advocacy with the general secretaries of ministries of finance and health in November 2006 contributed to significant increases in contributions to the state budget for the purchase of contraceptives: 359 million CFA in 2006; 410 million CFA in 2007; 450 million CFA in 2008; and 500 million CFA in 2009 and beyond, although this commitment was not realised in 2014. In addition, UNFPA focuses on the monitoring and evaluation of the RCHS plan and through these actions it promotes accountability for contraceptive security.	(UNFPA 2015)

Assumption 8.3: **Strengthened procurement and logistics systems and related health system improvements are designed to be financially sustained by national governments.**	**Information sources:**
Indicators: • Trend in FP methods (as percentage of MoH budget) • Trends in contributions by other development partners • Value-for-money in method mix, which meets user needs (men and women, adolescents, VMGs).	
The comprehensive strategy on contraceptive security, which includes advocacy for mobilisation of resources for commodities, extensive training in logistics and procurement, intensive monitoring and stock surveillance to ensure accountability, is designed to support sustainability from both a financial and programmatic level.	Interviews with CO staff, NGO and Government stakeholders

ANNEX 4 – SRHR AND FAMILY PLANNING EXPENDITURE (2008-2013)

PROJECT	IMPLEMENTING PARTNER	Spending per year SRHR INCL Family Planning						TOTAL SPENDING SRHR INCL FAMILY PLANNING FROM 2008-2013	% FAMILY PLANNING OF TOTAL SPENDING	TOTAL FAMILY PLANNING SPENDING
		2008	2009	2010	2011	2012	2013			
BFA6R11B: Programme Global de Sécurisation des produits de SR	**GOVT, UNFPA**	**$652,924.00**	**$1,184,586.00**	**$2,654,988.00**				**$4,492,498.00**		
Non-Core		$652,924.00	$1,184,586.00	$2,654,988.00				$4,492,498.00	100.00%	$4,492,498.00
BFA6R202: Minimum d'activité en Santé de la Reproductio	**GOVT, UNFPA**	**$963,201.00**		**$609,810.00**				**$1,573,011.00**		
Core		$963,201.00		$609,810.00				$1,573,011.00	100.00%	$1,573,011.00
BFA7R11A: Lutte contre les Fistules Obsétricales	**GOVT, NGO, UNFPA**				**$558,719.00**	**$525,174.00**		**$1,083,893.00**		
Core					$558,719.00	$525,174.00		$1,083,893.00	100.00%	$1,083,893.00
BFA7R31A: Renforcement des systèmes nationaux pour la sécurisation et l'approvisionnement en produits de santé de la reproduction	**GOVT, NGO, UNFPA**				**$2,985,990.00**	**$3,821,045.00**	**$3,985,061.00**	**$10,792,096.00**		
Core					$265,571.00	$776,695.00	$345,320.00	$1,387,586.00	100.00%	$1,387,586.00
Non-Core					$2,720,419.00	$3,044,350.00	$3,639,741.00	$9,404,510.00	100.00%	$9,404,510.00
BKF5R203: Promotion de la Maternité à Moindre Risque	**GOVT, UNFPA**	**$350,372.00**						**$350,372.00**		
Non-Core		$350,372.00						$350,372.00	100.00%	$350,372.00
TOTAL CORE SPENDING ON SRHR INCLUDING FP		**$963,201.00**		**$609,810.00**	**$824,290.00**	**$1,301,869.00**	**$345,320.00**	**$4,044,490.00**		**$4,044,490.00**
TOTAL NON-CORE SPENDING ON SRHR INCLUDING FP		**$1,003,296.00**	**$1,184,586.00**	**$2,654,988.00**	**$2,720,419.00**	**$3,044,350.00**	**$3,639,741.00**	**$14,247,380.00**		**$14,247,380.00**
TOTAL SPENDING ON FAMILY PLANNING COMMODITIES (NON-CORE)										
TOTAL SPENDING SRHR AND FAMILY PLANNING		**$1,966,497.00**	**$1,184,586.00**	**$3,264,798.00**	**$3,544,709.00**	**$4,346,219.00**	**$3,985,061.00**	**$18,291,870.00**		**$18,291,870.00**

The information presented in the above table was contributed by the UNFPA Burkina Faso Country Office. Under the guidance of the UNFPA Evaluation Office, the CO identified projects in support of family planning – those fully dedicated to family planning as well as those in which family planning activities were mainstreamed – and reported the amount spent (annually) under each project. Project expenditure was disaggregated into core and non-core funding. The country office was then asked to estimate the percentage (%) of the project in support of family planning – 100% in cases where projects were fully dedicated to family planning and an estimated percentage for projects in which family planning activities were an aspect of the project (mainstreamed). The type of implementing partner (NGO, government and/or UNFPA) – information also provided by the country office - is captured in the table, as well.

The above approach was chosen due, primarily, to challenges in obtaining family planning expenditure through the use of the UNFPA financial management platform (Atlas). For the period under evaluation, the UNFPA financial management platform did not explicitly track family planning expenditure and, when it did so, did not capture all/the full range of family planning expenditure. Prior to 2011, there was no dedicated family planning project outcome code within Atlas. Instead, activities advancing family planning were embedded in other projects, posing significant challenges to capturing family planning expenditure. In 2012 this changed: reflecting a shift in UNFPA outcomes, a dedicated family planning project outcome code was introduced in Atlas (the U3 code). While this contributed to an improved ability to track family planning expenditure, the code does not capture expenses corresponding to family planning activities that are mainstreamed/ included within other interventions, with the attendant challenges remaining.

As mainstreaming poses particular challenges to accurately identifying the entirety of projects and activities in support of family planning in Atlas, and subsequently, in determining the amount spent in support of family planning, country offices – deeply familiar with the specifics of a project - were requested to report on family planning expenditure. A degree of subjectivity exists in, inter alia, selecting family planning projects and estimating/assigning the percentage of a project dedicated to family planning (in cases where the activities have been embedded). However, the country office is best positioned to address this, offering a sound determination based on intimate knowledge of a project and its implementation.

The country office was provided with two guidance notes: one focusing on which activities should be considered family planning and the other on estimating percentages. On the former, guidance listed the expenses that should be considered expenditure in support of family planning, including projects with a U3 code, projects funded through the Thematic Fund for Reproductive Health Commodity Security, expenses incurred to strengthen information systems pertaining to family planning or expenses incurred to create enabled environments for human-rights family planning.

A typology/percentage guidance note was also provided. This note listed activities - under different Strategic Plan (2014-2017) outputs - that can be considered to have a family planning component, with the corresponding suggested percentage included. While this was offered as a tool to support the country office, the country office was encouraged to offer the percentages that best reflected the actual expenses related to family planning in Burkina Faso.

ANNEX 5 – IMPLEMENTING PARTNERS

Implementing Partner	Project ID
Ministère de la Santé (DSF, DPS, SP-CNLS)	BFA6R11B: Programme Global de Sécurisation des produit de SR *(*Régions du sahel, Centre-Est et EST) BKF5R203: Promotion de la Maternité à Moindre Risque *(*Régions du sahel, Centre-Est et EST)
Direction Régionale de la santé du sahel	BFA6R202: Disponibilité du Paquet Minimum d'activité en Santé de la Reproduction *(*Régions du sahel, Centre-Est et EST) BKF5R203: Promotion de la Maternité à Moindre Risque *(*Régions du sahel, Centre-Est et EST)
Direction Régionale de la santé de L'Est	BKF5R203: Promotion de la Maternité à Moindre Risque *(*Régions du sahel, Centre-Est et EST)
Direction Régionale de la santé de Centre-Est	BKF5R203: Promotion de la Maternité à Moindre Risque *(*Régions du sahel, Centre-Est et EST)
Direction de la Promotion de la Santé (DPS)	BFA7R11A: Lutte contre les Fistules Obstétricales (toutes les 13 régions du Burkina Faso) BFA7R31A: Renforcement des systèmes nationaux pour la sécurisation et l'approvisionnement en produits de santé de la reproduction (toutes les 13 régions du Burkina Faso)
Direction de la Santé de la Famille (DSF)	BFA7R11A: Lutte contre les Fistules Obstétricales (toutes les 13 régions du Burkina Faso) BFA7R31A: Renforcement des systèmes nationaux pour la sécurisation et l'approvisionnement en produits de santé de la reproduction (toutes les 13 régions du Burkina Faso)
Programme D'appui au Développement Sanitaire (PADS)	BFA7R11A: Lutte contre les Fistules Obstétricales (toutes les 13 régions du Burkina Faso) BFA7R31A: Renforcement des systèmes nationaux pour la sécurisation et l'approvisionnement en produits de santé de la reproduction (toutes les 13 régions du Burkina Faso)
Family Care International	BFA7R11A: Lutte contre les Fistules Obstétricales (toutes les 13 régions du Burkina Faso)
Secrétariat Premanent de Lutte contre le SIDA (SP-CNLS)	BFA7R11A: Lutte contre les Fistules Obstétricales (toutes les 13 régions du Burkina Faso)
Population Media Center	BFA7R11A: Lutte contre les Fistules Obstétricales (toutes les 13 régions du Burkina Faso) BFA7R31A: Renforcement des systèmes nationaux pour la sécurisation et l'approvisionnement en produits de santé de la reproduction (toutes les 13 régions du Burkina Faso)
Secrétariat Permanent de Lutte contre le SIDA (SP-CNLS	BFA7R31A: Renforcement des systèmes nationaux pour la sécurisation et l'approvisionnement en produits de santé de la reproduction (toutes les 13 régions du Burkina Faso)

AFRICSANTE	BFA7R31A: Renforcement des systèmes nationaux pour la sécurisation et l'approvisionnement en produits de santé de la reproduction (toutes les 13 régions du Burkina Faso)
Institut Recherche en SCES Santé (IRSS)	BFA7R31A: Renforcement des systèmes nationaux pour la sécurisation et l'approvisionnement en produits de santé de la reproduction (toutes les 13 régions du Burkina Faso)
Association Burkinabé pour le Bien Etre Familial	BFA7R31A: Renforcement des systèmes nationaux pour la sécurisation et l'approvisionnement en produits de santé de la reproduction (toutes les 13 régions du Burkina Faso)
Jhpiego	BFA7R31A: Renforcement des systèmes nationaux pour la sécurisation et l'approvisionnement en produits de santé de la reproduction (toutes les 13 régions du Burkina Faso)
Promotion de marketing Social de Condom et Sante	BFA7R31A: Renforcement des systèmes nationaux pour la sécurisation et l'approvisionnement en produits de santé de la reproduction (toutes les 13 régions du Burkina Faso)
Marie Stopes International	BFA7R31A: Renforcement des systèmes nationaux pour la sécurisation et l'approvisionnement en produits de santé de la reproduction (toutes les 13 régions du Burkina Faso)
Plan Burkina Faso	BFA7R31A: Renforcement des systèmes nationaux pour la sécurisation et l'approvisionnement en produits de santé de la reproduction (toutes les 13 régions du Burkina Faso)

ANNEX 6 – KEY FACTS – EXPANDED

Indicator	2012	2014	Source of Data
Population and Development			
Population, total	16,590,813	17,589,198	World Bank[1]
Population, aged 0-14 (% of total)	46	46	World Bank[1]
Population, aged 15-64 (% of total)	51	52	World Bank[1]
Population, ages 65+ (% of total)	2	2	World Bank[1]
Population growth (annual %)	3.0	2.9	World Bank[1]
Urban Population (% of total)	27	29	World Bank[1]
Population Density (per sq. km of land area)	61	64	World Bank[1]
Life Expectancy at birth, total (years)	58	58 (2013 data)	World Bank[1]
Literacy rate, population 15+ years, both sexes (%)	-	-	World Bank[1]
Youth Literacy rate, population 15-24, both sexes (%)	-	-	World Bank[1]
Human Development Index (HDI)	0.343 (183 out of 187)	0.402 (Rank 183 out of 188)	Human Development Report[2]
Human Development Classification (very high, high, medium, low, upper middle, high)	Low	Low	Human Development Report[79]
Total GDP at market price (current US$)	11,166,061,508	12,542,221,942	World Bank[1]
Economic growth rate (GDP growth annual %)	6.5	4.0	World Bank[1]
GINI Index	-	-	World Bank[1]
Multidimensional Poverty Index (MPI), HDRO specifications	0.535	0.508	Human Development Report[3]
Government Effectiveness			
World Bank CPIA Quality of Public Administration rating (1=low to 6 = high)	3.5	3.5	World Bank[1]
UNFPA: Need and Ability to Finance			

[79] United Nations Development Programme. (2016). Country Classification. Retrieved from https://pharmacoepi.org/pub/1c08ab60-2354-d714-5192-9cc81d38354f

UNFPA country quadrant	-	Red	UNFPA Strategic Plan[80]
Gender Equality and Empowerment			
Gender Inequality Index	0.609 (Rank 131 out of 148)	0.631 (Rank 144 out of 155)	Human Development Report[3]
Women representation in parliament, total (%)	16	13	World Bank[1]
Violence against women ever experienced (%)	-	15.4	Human Development Report[3]
Employment to population ratio, 15+, female (%) (modeled ILO estimate)	75	75	World Bank[1]
Ratio of girls to boys in primary and secondary education (%)[4]	0.91	-	World Bank[1]
Reproductive Rights and Reproductive Health			
Fertility rate, total (births per woman)	5.7	-	World Bank[1]
Adolescent fertility rate (births per 1,000 women ages 15-19)	-	-	World Bank[1]
Teenage mothers (% of women ages 15-19 who have had children or are currently pregnant)	-	-	World Bank[1]
Prevalence of HIV, female (% ages 15-49)	0.5	0.5	World Bank[1]
Prevalence of HIV, male (% ages 15-49)	0.4	0.4	World Bank[1]
Maternal mortality rate (per 100,000 live births)	398	379	World Bank[1]
Under 5 mortality rate (per 1,000 live births)	101	92	World Bank[1]
Contraceptive use, modern methods (%)	-	28.0	UN DESA Population Division Estimates and Projections of Family Planning Indicators[5]
Unmet need for family planning (number of married or in-union women aged 15 to 49 who want to stop or delay childbearing but	-	25.2	UN DESA Population Division Estimates and Projections of

[80] United Nations Population Fund. (2015). UNFPA Strategic Plan. Retrieved from https://webcache.googleusercontent.com/search?q=cache:PBcjL1D-HDYJ:https://www.unfpa.org/sites/default/files/about-us/Annex%25204%2520(funding%2520arrangements).docx+&cd=1&hl=en&ct=clnk&gl=ca

are not using a method of contraception, %)			Family Planning Indicators[5]
Demand for family planning satisfied (% of total demand for family planning among married or in-union women aged 15 to 49 that is satisfied)	-	52.9	UN DESA Population Division Estimates and Projections of Family Planning Indicators[5]
Births attended by skilled health staff (% of total)	-	-	World Bank[1]
Antenatal care (any skilled provider)	-	-	World Bank[1]