

Lessons from the Field

Building Grassroots Capacity in Reproductive Health: Burkina Faso Case Study



This report details the introduction of a reproductive health component to World Neighbors' rural development programs in Burkina Faso, West Africa. The programs were initiated in 2000 with support from the Bill and Melinda Gates Foundation. This document describes the setting, the design, unique aspects of the program, key accomplishments, and lessons learned.

Preface and Acknowledgements

World Neighbors includes reproductive health as a key aspect of its integrated development program strategy. In 2000, with the support of the Bill and Melinda Gates Foundation, World Neighbors began a systematic effort to further develop and document the lessons learned from this program experience. The World Neighbors' program in Burkina Faso was one of six programs in five countries in which we sought to strengthen reproductive health and to develop a model that would have application to similar contexts.

This document describes the effectiveness of World Neighbors' approaches to supporting reproductive health in two sites in rural Burkina Faso. It includes a programmatic framework (applied in all World Neighbors' program sites), which was developed and modified over the implementation period, as well as lessons learned through program experience.

World Neighbors West Africa would like to thank all the partners in the field who have contributed to the results presented in this case study.

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These expressions of gratitude are equally extended to the programs, which have included individual and collective engagement that have permitted the realization of the results presented here.

- ◆ The program teams APDC and PRECAP/K respectively in the provinces of Gnagna and Koupeologo.
- ◆ The International Program team based in Oklahoma City for their support and counsel
- ◆ The World Neighbors Area Team



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Key to Acronyms

Abbreviations Used

APDC - association for promoting rural development in Gnagna
AIDS - acquired immunodeficiency syndrome
AL - action learning
CBD - community based distribution
CBD workers - community based distribution workers
CHW - community health workers
FP - family planning
FGM - female genital mutilation
HIV - human immunodeficiency virus
IEC - information, education, and communication
IGA - income generating activities
IUD - intra-uterine device
MOH - Ministry of Health
Precap/K - program for building capacity/Koupeologo
RH - reproductive health
STI - sexually transmitted infections
TBA - trained birth attendant
WN - World Neighbors

Executive Summary

During the four-year period from 2000-2004, two World Neighbors-supported programs in Burkina Faso undertook a focused effort to support reproductive health initiatives. These initiatives were part of integrated rural development programs that aimed at building the capacity of community-based organizations to sustain local development processes. Thus the reproductive health efforts also sought to develop capacity by training and supporting community volunteers in the provision of information and services, as well as ensuring the long-term commitment of organizational leaders. The programs worked in close collaboration with the local health districts and health dispensary staff.

Some of the most effective aspects of the programs included:

- 1) The identification of local reproductive health needs and priorities through a participatory learning approach. Through this approach, community members themselves identified problems, priorities, and ways to address them.
- 2) The application of a programmatic framework to ensure a comprehensive strategy aimed at improving reproductive health in these isolated, rural communities. While this framework was developed as a guide for World Neighbors' reproductive health work globally, its application in Burkina Faso highlighted the following areas:

Service delivery: The introduction of long-term contraceptive methods at the health dispensary level. These methods included Norplant and intra-uterine devices (IUDs) which are not commonly available in rural areas of Burkina Faso.

Education and counseling: The programs actively involved influential people in the reproductive health component, including religious and traditional leaders

Integration: The program sought to support women's priorities beyond reproductive health. These priorities included reducing their heavy workloads and increasing their access to credit for small scale income generation activities.

Evaluation findings were positive, demonstrating increases in knowledge and use of family planning methods as well as awareness of key maternal care services for program participants.

Introduction

Rural West Africa is arguably one of the most difficult areas in the world to implement a meaningful and sustainable reproductive health program. Exceedingly poor reproductive health status and limited health infrastructure combine with strong social norms valuing fertility and low status of women to create a setting in which discussions of reproductive health typically only occur in whispers. Yet, this is the setting in which a World Neighbors (WN) program incorporated a vibrant reproductive health component in a unique partnership with the Ministry of Health (MOH) and three community-based organizations.

In West Africa, local capacity building is fundamental to the WN approach. The strategy aims to ensure that strong, representative, and well-organized community-based structures are capable of leading sustainable development processes in their areas. The focus is on increasing the capacities of local structures to diagnose, plan,

link, and mobilize the required resources to implement and address the priority problems of their communities.

WN works in two program areas located in remote and marginalized areas with limited or even non-existent health infrastructures. Program activities are integrated with a focus on sustainable agriculture, food security, income generation, and community and maternal health. However, due to a number of factors, program strategies had been weak in addressing reproductive health needs, particularly family planning.

The reproductive health component was implemented in 2000 with support from the Bill and Melinda Gates Foundation and was meant to strengthen the program in addressing reproductive health needs in two provinces in eastern Burkina Faso. This document describes the setting, the design, and unique aspects of the program, key accomplishments and lessons learned.



Setting/Map of Program Area

In rural Burkina Faso, many needs are compelling. The country ranks near the bottom, 175 out of 177 countries, for key human development indicators (income, life expectancy, and education) according to the United Nations Development Program (UNDP) Human Development Report for 2004.¹

First, there is poverty. The UNDP report indicates that 45% of the population lives on less than one dollar a day with 77% living in rural areas, dependent on subsistence agriculture. Grinding poverty is reflected in malnutrition rates with more than one third of children under weight for age.

Second, health indicators are poor. According to the UNDP report, infant and child mortality are 107/1,000 and 207/1,000 respectively. The adjusted maternal mortality ratio is 1,000.² Life expectancy is just under 46 years, among the lowest

in Africa. The fertility rate of 6.7 is among the highest in the region and drives the population growth rate of 2.8%. Nationally, contraceptive prevalence is 12%, with only 5.8% using modern methods. Adult HIV/AIDS prevalence is currently 4.2%, the second highest rate in the West Africa region.

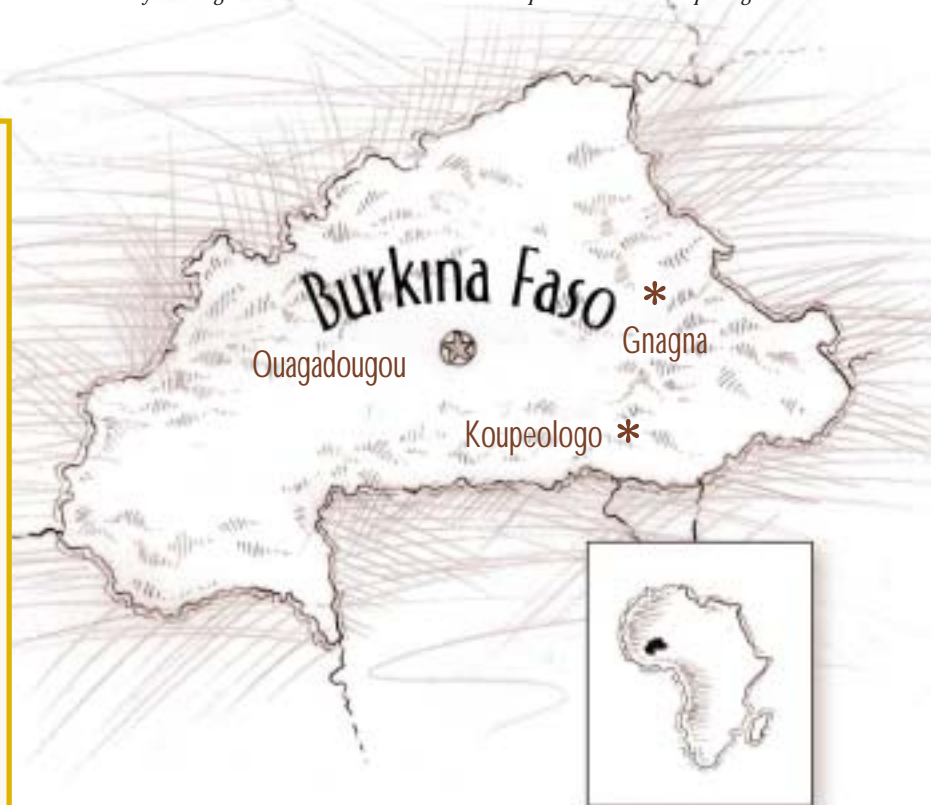
Third, education indicators are also low. According to the UNDP report, only 12% of adults are literate with significant differences by gender. Only 8% of women are literate compared to 18% of men. The net primary school enrollment rate is only 35%.

These indicators demonstrate significant need, yet it should be kept in mind that these rates are the national averages and conditions are significantly worse in the rural areas.

¹ *Human Development Report 2004. Cultural Liberty in Today's Diverse World. United Nations Development Program. New York, New York.*

² *Adjusted maternal mortality ratio-adjusted figure based on reviews by UN agencies to account for well-documented problems of under-reporting and misclassification.*

<p>Programs Areas</p> <p>Gnagna Province</p> <ul style="list-style-type: none">◆ Liptougou Department◆ Koalla Department◆ Mani Department <p>Koupeologo Province</p> <ul style="list-style-type: none">◆ Soudougou Department◆ Yargalenga Department <p>Program Partners</p> <p>Gnagna Province</p> <ul style="list-style-type: none">◆ Torim Mani Intervillage Association◆ Koalla/Mani Intervillage Association◆ APDC - Association for Promoting Sustainable Community Development (former WN Program) <p>Koupeologo Province</p> <ul style="list-style-type: none">◆ Neerwaya Intervillage Association◆ Precap/K - Program for Strengthening Rural Community Organizations
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Program Context

World Neighbors (WN) works in two rural provinces of Burkina Faso—Gnagna and Koulpeologo—which are among the most marginalized in the country. Indeed, they exhibit some of the worst indicators in the country as far as education and health are concerned. According to the 1999 Demographic and Health Survey, the total fertility rate is 7.3 and contraceptive use is only 2.6% for the eastern area in which Gnagna and Koupeologo are located. Child and infant mortality are 234/1,000 and 107.8/1,000 respectively.

The school enrollment rates in Gnagna and Koulpeologo Provinces are 7% and 12% respectively. Adult literacy levels are similarly low at 7% and 2%.³

WN began implementation of two reproductive health components in 2000. In Gnagna the program covers 47 villages with a population of over 56,000 people. In Koulpeologo, it covers 25 villages with a population of over 26,000.

In each of these areas, the WN-supported program teams work with communities to establish community-based organizations and then to build organizational capacity and support technical approaches aimed at accomplishing development objectives. The program team that provides this support typically consists of a team leader and technical staff specialized in the areas of sustainable agriculture, health, and literacy.

The overriding objective of WN work in West Africa is the development of effective, autonomous, and legitimate inter-village associations, which allow participants to meet their own basic needs in a sustainable way.

WN West Africa has an effective track record in this regard. In Gnagna Province a key accomplishment has been the emergence of a democratically run inter-village association called “Torim Mani,”

which includes over 40,000 members from 24 villages. This association has significantly improved

food security and health in the area. Strengthening local capacity and avoiding the creation of dependency is central to the WN approach. This includes helping members to determine their own development priorities, to act on these priorities, to spearhead development in their communities, and to organize for the expansion and sustainability of the work after the departure of WN.

While WN programs have been leaders in the area of capacity building and organizational development, as well as sustainable agriculture, they have been weak in the reproductive health sector. In 1997, a program evaluation carried out in Gnagna Province was instrumental in identifying reproductive health needs. Women community members criticized the program at that time saying they needed more than information; they wanted access to services as well.⁴

	Gnagna Province	Koulpeologo Province	Total
Population Totals	119,707 people in three departments (Koala, Mani, Liptougou)	62,611 people in two departments (Yargatenga and Soudougou)	182,318 people in two provinces and five departments
Direct Program Participants	56,727 persons in 47 villages	26,846 people in 25 villages	83,573 people in 72 villages

³ *Departments of Adult Literacy, Koulpeologo and Gnagna, 2003*

⁴ *World Neighbors, Rapport d'évaluation participative du program triennal de Liptougou 1994-1997. Septembre 1997.*

Identifying Needs

In response to the program evaluation results, participatory action research was undertaken in 1998 in Gnagna Province to better understand the social and cultural context of reproductive health needs as well as to develop strategies to address them.⁵ With the establishment of a new program in Koupeologo Province in 1999, similar research was undertaken there.⁶

This process of action research was carried out with a sample of villages chosen according to specific geographic criteria and implicated various subgroups. The participants included representatives of different sections of the villages as well as ethnic groups. They were divided according to gender and age to facilitate open discussions. The groups included:

- ◆ Adolescents aged 12-19 years (girls and boys separate)
- ◆ Young married women aged 16-24 years
- ◆ Women aged 25-34
- ◆ Young men aged 20-34
- ◆ Men and women aged 35-45 years
- ◆ Men and women aged 46 years and older

To ensure that the concerns of each subgroup were taken into account, subgroups focused on the problems concerning them. For example, adolescents focused on reproductive health problems faced by adolescents while young women discussed problems faced by young women, the mixed group (men and women) included problems for small children in addition to reproductive health, and the groups 46 years and older discussed problems faced by older people.

In addition to the WN team, the facilitators for these groups included MOH staff and representa-

tives from other peer organizations working in the area.

The results from the focus groups demonstrated the following issues:

- ◆ Morbidities during pregnancy, child birth, and postnatal periods
- ◆ Numerous and closely spaced pregnancies
- ◆ Unwanted pregnancies
- ◆ Sexually transmitted infections (STIs) (gonorrhea, syphilis, and herpes) and AIDS
- ◆ Primary and secondary sterility
- ◆ Child deaths and diseases (malaria, diarrhea, edema, malnutrition, etc....)
- ◆ Anemia (adults and children)
- ◆ Forced and early marriage as well as female genital mutilation (FGM) and violence against women⁷
- ◆ Inadequacy of men's involvement in taking care of children
- ◆ Lack of freedom for women to go for health care
- ◆ Weak organizational capacities and unskilled health promoters limit access to reliable information and services

Further analysis of these issues with the communities revealed many negative factors that compromised good reproductive health. These factors included:

- ◆ Difficult physical access to health centers (in many cases more than two hours, or unreachable during the rainy season)
- ◆ Insufficient reliable source of drinking water
- ◆ The workload of women and their under-nutrition



⁵ Lankoande, F. Rapport de la recherche-action participative. Plannification famille et sante sexuelle. Juillet 1998.

⁶ Lankoande, F. Rapport du diagnostic en sante de la reproduction du PRECAP/K. Avril 2000. (This survey, conducted in 1999, provides the baseline for results from Koupeologo Province.)

⁷ FGM and violence against women are cited because of their consequences on women's health. For example, early marriages result in the pregnancy of adolescents who are not yet fully mature physically. FGM can result in cheloids and a scarring of the urinary meatus or also become a source of recto-vaginal tearing during birth.

Identifying Needs

- ◆ The lack of financial means, particularly poverty which limits their access to health care
- ◆ Food insecurity
- ◆ The degradation of natural resources (distance traveled to get wood, water scarcity, need to cultivate more space to produce)
- ◆ Illiteracy

To complement quantitative findings, a knowledge, attitudes, and practices survey was carried out in Koulpeologo Province.⁸ Among the results, the survey found:

- ◆ 34% of reproductive age women had experienced at least one unwanted pregnancy
- ◆ Only 16% of reproductive age women knew about modern contraceptive methods

⁸ Lankoande, F. Rappoport du-diagnostic en sante, p.9.

- ◆ 96% had never used a modern contraceptive method to delay another pregnancy
- ◆ 73% expressed the need to use modern contraceptive to delay or stop childbearing.
- ◆ 83% didn't know how sexually transmitted diseases were treated
- ◆ More than 80% had never discussed with their partner about family planning and contraceptive use

Further to these action research studies conducted in Gnagna and Koulpeologo Provinces, two action plans were developed and implemented by the community members, with support of WN program staff. These plans aimed at increasing local capacity in terms of qualified human resources and appropriate equipment to carry out key reproductive health activities.



Community meeting - Poka Village, Koalla Department



Health volunteers, Poka Village, Koalla Department

RH Objectives and Component Design

In keeping with the overall World Neighbors' strategy, the program goal was to strengthen communities' technical and organizational capacities to address their reproductive health issues. The specific objectives included:

- ◆ To improve the knowledge and practices of community members through information, education, and communication (IEC).
- ◆ To increase access to and use of reproductive health services by community members. Specifically to increase the use of prenatal and post-natal care services, assisted deliveries by trained staff, and use of contraceptive methods.
- ◆ To contribute to the reduction of negative practices that affect women's health. Specifically, female genital mutilation (FGM), forced and early marriage, rape, and other types of gender-based violence.

- ◆ To improve households' and especially women's access to reproductive health services by increasing their income and advocating communication within couples.
- ◆ To reduce women's workload by introducing appropriate technologies and making safe drinking water available.

The following table describes how the program design addressed the key elements of the WN integrated development program approach. These key elements are used to guide all of WN reproductive health efforts. They include: integration linkages, information and counseling, quality reproductive health services, community and local capacity building, action learning, gender, and efforts to address the needs of special groups.

Key Element	How is the element addressed in the program?
<p>Integration:</p> <p>How is this accomplished and structured?</p>	<p>As community problems are inter-related, integration is accomplished within various program sectors and through linkages with government services and other organizations. The following are examples.</p> <ul style="list-style-type: none"> ◆ Integration of activities is taken into account through program analysis (needs assessment, monitoring and evaluation, and planning). During these exercises community members are encouraged to discuss linkages and interactions between problems and to plan accordingly. ◆ A health committee is established under the village association structure to coordinate, plan, organize, and follow-up on reproductive health activities in the village in collaboration with the inter-village coordination association. ◆ Trained community-based distributors (CBDs) and health promoters provide various primary and reproductive health care such as treatment of wounds, counselling, distribution of chloroquine and iron tablets to pregnant women, assisted deliveries, distribution of contraceptives, health promotion through information, education, and communication. They also provide treatment for malaria and dehydration due to diarrheal disease which are the two leading causes of child mortality in rural areas. According to community representatives, the provision of such integrated services meets their priority needs and expectations.

RH Objectives and Component Design

Key Element	How is the element addressed in the program?
<p>Integration, cont'd:</p> <p>How is this accomplished and structured?</p>	<ul style="list-style-type: none"> ◆ Loans have been granted to women for income generating activities. This has been an important means to increase women's access to services. ◆ The main agricultural innovations introduced by the program include improved varieties of peanuts and beans, which are the main ingredients to improve children's diets. Peanuts also are the main source of income for women in both provinces and the income facilitates their access to services. ◆ Participants in literacy classes are also trained on reproductive health issues.
<p>RH information and counseling:</p> <p>How is information and counseling provided?</p>	<ul style="list-style-type: none"> ◆ IEC activities are conducted by a variety of local volunteers including community-based distributors and village health promoters, trained community leaders (religious, traditional, and association leaders), peer educators, traditional singers, theatre groups, literacy trainers, local resource persons, government health workers, and the State Welfare department. ◆ IEC sessions are provided through video sessions, drama, group discussions, literacy sessions, contests with reproductive health messages, and cultural evenings. ◆ Home visits and individual and couple counselling are conducted by CBDs using visual aids. ◆ Organization of reproductive health days
<p>Quality RH services:</p> <ul style="list-style-type: none"> ◆ Community ◆ Outreach ◆ Health facility levels <p>How are services provided at these three levels?</p>	<ul style="list-style-type: none"> ◆ Training sessions for community-based distributors and other health promoters supported with necessary equipment have allowed them to promote and ensure quality health care in their villages. Supervision for CBDs is provided both by the local dispensary nurses and the inter-village association health leaders. ◆ Regular meetings have been held between CBDs and dispensary nurses, the district health team, and inter-village association leaders to analyze progress and learn lessons for improvement. ◆ Training and equipping dispensary nurses and increasing referral services have improved their technical skills and their capacities to plan and monitor CBD activities as well as ensuring service availability and quality to communities. These services include family planning and long-term methods such as Norplant and IUDs. ◆ Regular supervision of CBDs' activities by health services workers has ensured quality services at the village level. Linkages with the dispensary nurses and knowledge about service standards have improved the quality of care provided to the communities. ◆ Follow-up and supervision of dispensary nurses trained in family planning, Norplant, and IUD service provision by the Director of the District Health Services and by the National Directorate of Family Health. ◆ Follow-up of CDBs by WN teams and partners.

RH Objectives and Component Design

Key Element	How is the element addressed in the program?
<p>Capacity building:</p> <p>How does this approach lead to capacity building in RH?</p>	<ul style="list-style-type: none"> ◆ Program continuity and sustainability requires the existence of strong community organizations capable of leading the process after the program phases out. Therefore, strengthening the capacities of these organizations is a key to achieving results. Also, strengthening the partnership between the community organizations and the government health system is an important step to ensure program continuity, as local and provincial health staff will provide technical services. ◆ The health committee plays an important role within the village association in coordinating, planning, organizing, and following-up reproductive health activities in the village. This is done in collaboration with the inter-village association and with support from local MOH services. The committee supervises the CBD and assures the submission of reports. It also coordinates and helps facilitate health needs assessments, identification of solutions and prioritization, implementation of activities, monitoring/evaluation, and planning in the village. ◆ At the same time, the WN program strengthens the institutional capacity of state health facilities and provides training to the staff in order to increase the quality and availability of RH services at the community level.
<p>Action learning:</p> <p>How is AL included in the program?</p>	<ul style="list-style-type: none"> ◆ Participatory tools are used to engage community members in problem identification, intervention planning and implementation, as well as evaluation. ◆ To address program weaknesses in responding to RH needs, two action research studies were conducted to better understand problems and issues related to RH services and obstacles to overcome. ◆ The extension of RH activities to new communities is completed after an action research study is conducted. Moreover, constraints identified in the course of the implementation of the activities are targeted for an in-depth analysis; i.e., a study is ongoing on “uterus prolapse” in Koulpeologo Province. ◆ Guided self-assessment with partners is undertaken annually to assess program activities and strategies and to identify appropriate steps for improvement. ◆ In addition, RH program impact evaluation results are shared with other organizations intervening in RH activities. ◆ Exchange visits are organized for village leaders and program staff to learn from others’ experience in implementing community-based RH services delivery.
<p>Gender-related aspects:</p> <p>How is gender taken into consideration in the programs?</p>	<ul style="list-style-type: none"> ◆ Gender issues are considered when conducting problem analysis during needs assessment and planning, as well as during the implementation of program activities. Special activities include: IEC on communication within couples, strategies aimed at decreasing women’s workload and increasing their participation in decision making. In addition, special IEC and training sessions are held for influential persons, men, and young people on reproductive health issues in order to engage them in analyzing these issues.

RH Objectives and Component Design

Key Element	How is the element addressed in the program?
<p>Gender-related aspects, cont'd:</p> <p>How is gender taken into consideration in the programs?</p>	<ul style="list-style-type: none"> ◆ Gender aspects are also taken into account through the promotion of appropriate technologies such as water carts, and by increasing in the number of drinking water points to reduce women's workload so they can participate in development initiatives. One of the RH component's objectives is to reduce women's workloads. ◆ Credit is allocated mainly to women for income generation activities with the aim to facilitate their financial access to health care. ◆ The recruitment of health promoters takes into account gender aspects in terms of maintaining a balance between men and women, i.e., CBDs, peer educators.
<p>Special groups:</p> <p>Who are the special groups? How are their needs met?</p>	<p>Youth</p> <ul style="list-style-type: none"> ◆ Training and special IEC sessions for young people – introduction of peer educators' component in program activities. ◆ Provision of information and services on sexual and reproductive health through peer educators. <p>Influential persons (traditional chiefs, elders, heads of household, religious leaders, etc.)</p> <ul style="list-style-type: none"> ◆ IEC and training sessions for influential persons and their wives (traditional chiefs, singers, elders/mothers-in-law, religious leaders, literacy trainers, etc.) who are decision makers on RH issues so as to raise their commitment in promoting RH in their communities. ◆ IEC during sessions within literacy centers.



Neerwaya leaders and Precap/K staff planning meeting

Special Program Initiatives

Within this framework there are several aspects of the Burkina Faso program that are unique. These include: community organization, community-based distribution of contraceptives, training of health staff for long-term method provision, involvement of influential leaders, reproductive health days, and examining “other” factors affecting women’s reproductive health.

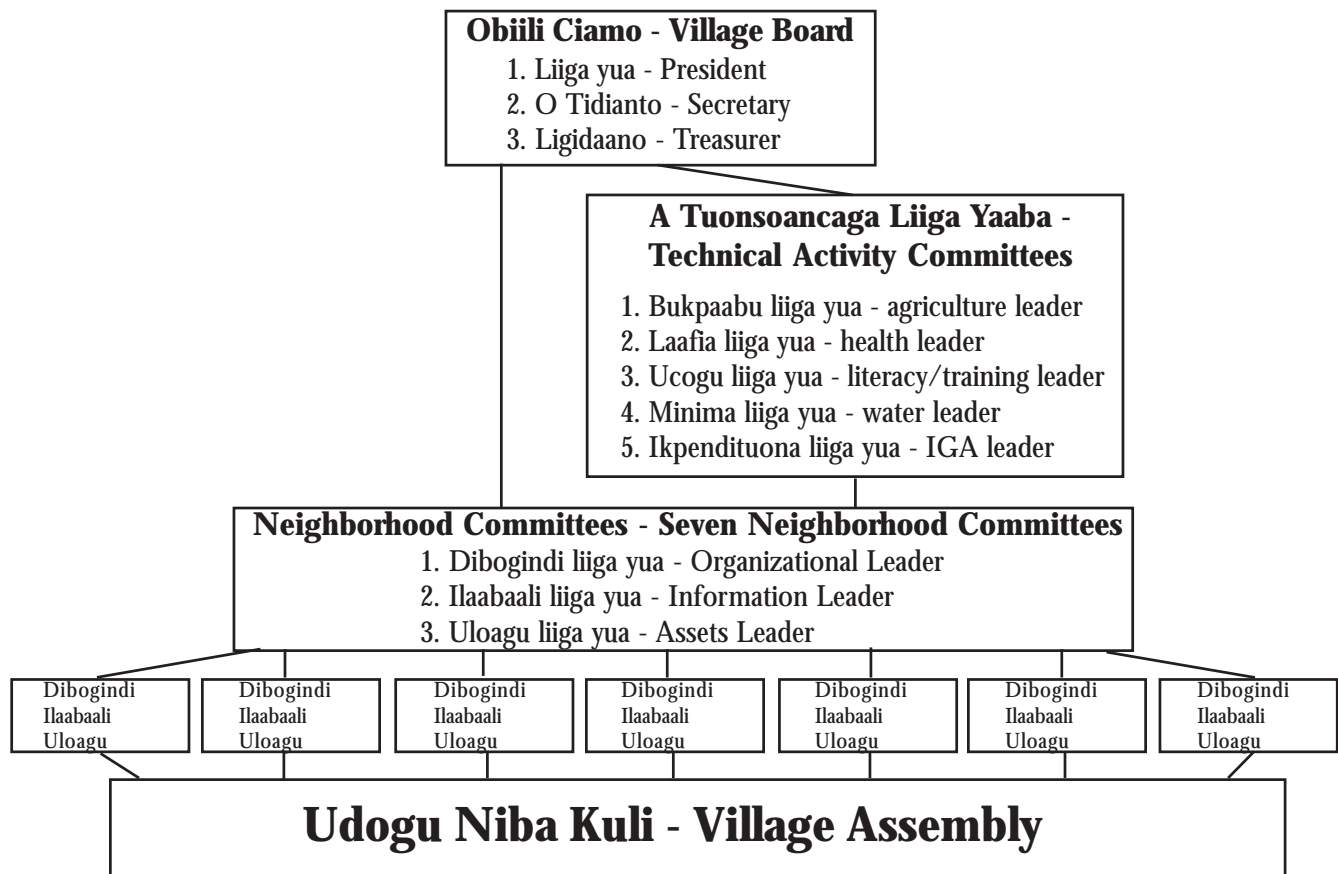
a) Community organization

In accomplishing its goal, WN ensures that communities are responsible for not only identifying and analyzing their problems, but also for monitoring and evaluating activities and results. Thus, the communities themselves were organized to manage the reproductive health activities.

In Burkina Faso, the community organizations supported by WN programs have the following structures:

- ◆ In each village, there is a village board for development activities, consisting of a president, a treasurer, and a secretary.
- ◆ Different technical activity committees in each village are responsible for the organization of activities in specific sectors, such as agriculture, health, literacy, water, IGA, etc. (The members of the health technical committee include community health volunteers, trained birth attendants, community based distributors, peer educators, and nutrition promoters, who are responsible for providing information and training in health matters as well as basic

Organigram for the Wabuadi Village Organization



Special Program Initiatives

community-based health care.) Committee members are chosen by the communities during general assembly meetings.

- ◆ There are committees from each neighborhood in the village to assure representation from different groups.

Villages in the departments come together to form inter-village associations. These inter-village associations also have a coordination unit and committees that are responsible for coordinating technical activities (including health).

In order to build sustainable capacity in reproductive health, training was carried out at multiple levels of the community organization. This included training members of the health committees at the village level, the health committees at the

The training in RH was beneficial for our own households first, then for our villages. At 25 years old, my wife has 4 children. Thanks to the information we received during the training, we decided that she should rest and we chose Norplant because of its long term nature. I accompanied my wife myself to the health center for that. I also accompanied other women from my village, including the wife of my brother for the insertion of Norplant.

Namoano Yiendé, President of the Intervillage Association of Torim Mani, Liptougou Department, Gnagna Province

inter-village level, the health promoters, other community volunteers in other sectors such as literacy, as well as selected influential persons. With a view to sustainability, the program also sought to reinforce linkages between the community organizations and the government health services. Local dispensary health staff have regular meetings with the health volunteers to discuss their activities. The dispensary staff also carry out training and follow-up with the CBD workers. The community organization leaders negotiate directly with the health staff for their support, particularly for meetings, follow-up, trainings, and basic supplies.

b) Community-based distribution of contraceptives

Recognizing that the health infrastructure was weak and inaccessible, particularly for rural women without means of transportation, the communities proposed meeting their contraceptive needs through a community-based distribution strategy. Although CBD pilot projects already existed in Burkina Faso in a few areas, they were not well known by the health officials in the intervention areas. This lack of experience made local officials skeptical about implementing CBD activities. To address this issue, WN organized two exchange visits for the program team and health staff to other NGOs and MOH projects working with CBD strategies. In collaboration with the National Directorate of Family Health, two training sessions in CBD strategies were organized for health staff in the two provinces.

After the trainings, the local MOH staff were ready to collaborate with WN in this effort. This collaboration included the training and equipping of health volunteers to provide basic maternal and child health services including family planning. In total, the program trained 267 CBD workers in the two provinces and equipped them with the necessary supplies including pills, condoms, spermicide, screening guidelines, and IEC support materials.

Thus, the program was able to make pills and condoms available not only centrally in the villages, but in different areas of large villages, allowing

many more women and men access.



CBD agent with family planning supplies

Special Program Initiatives

c) Training of district health professionals in selected long-term contraceptive methods

WN programs were also pioneers in introducing Norplant and IUDs at the rural dispensaries to respond to the needs expressed by the population to have access to long lasting modern methods of contraception. Prior to this initiative, these methods were only available at the provincial hospitals, located between 100 and 200 kilometers away from the program areas.

As a result, more than 30 nurses from 18 rural dispensaries were trained in contraceptive technology, specifically modern methods of family planning, including the insertion and removal of Norplant and IUDs, as well as on infection prevention. This training has permitted many women to



have access to long-term methods such as Norplant and IUDs. However, the turnover of nursing staff continues to adversely affect these activities.

d) Strategy for involving influential people

The participatory action research revealed that various leaders in the community influenced the attitudes of people regarding reproductive health. Also, initial discussions at the community level, exposed the expressed opposition of some traditional and religious leaders to certain reproductive health themes like family planning and FGM. The researchers recommended involving these leaders in program activities as a way of garnering their support.

As a result, the program developed a strategy for involving influential persons. The identification of influential persons was done in collaboration with leaders of the inter-village associations. These

leaders included religious and traditional leaders, traditional singers, the literacy center trainers and supervisors, community-based organization leaders, the heads of selected large households, some elders, and some untrained traditional birth attendants.

I am very happy to have been trained in RH. This training was very useful for me and I even suggested that we would have a refresher course with our wives. The benefit was first for us – my wife and myself – and then for the parishioners of the church and then the entire village.

Right after my training, I carried out educational talks in the church for those who attended. At the same time, I profited also during sermons for starting to talk about RH. I had also individual meetings and I even visited homes to talk about some of the themes of the training. Following that, I worked with the trained health volunteers to organize their educational sessions for the communities. I was right to have requested the training for my wife, because she has been very helpful for women in the church in this regard.

Pastor Tindano, Gnagna Province

These leaders have a strong influence on decision-making related to RH. Thus, organizing special information and training sessions for them aimed at raising their awareness on RH also provided them with the skills to become local promoters. By organizing trainings for these influential persons, the programs sought to gain their support rather than their opposition.

Training for leaders addressed the following themes: family planning, control of sexually transmitted infections (STI's), HIV/AIDS, FGM, early and forced marriages, the importance of information, education and communication and how to organize IEC sessions. These leaders were so happy with what they were learning that they wanted their wives to join them during the trainings.

Special Program Initiatives

After the training of my husband, he told me about the sessions and it really interested me. That is why, when they had a follow-up training, I didn't hesitate to join the training. Since, many things have changed for us as a couple. My husband and I have discussed family planning and I have a Norplant. I have also counselled many women from our church to use a modern family planning method. Many of them have small children less than three years old, and now they don't have either a pregnancy or another baby. This is something which was rare before.

Wife of Pastor Tindano

A pastor of one church said, “reproductive health concerns the couple and training only the man limits the impact of the IEC which we will carry out. In our communities, many women suffer with health problems and our wives are better informed of these points. Our wives can be very useful to these women.”

Many of the leaders organized sessions for their communities on what they had learned. Some, particularly the religious leaders, organized discussion groups in their churches on specific reproductive health themes. Others carried out individual and couple counselling in reproductive health for those with specific questions.

Local leaders also provided support to the CBDs and the community health promoters. They helped them in organizing the sessions and also attended the sessions to show their support.

The traditional singers created songs about reproductive health themes such as family planning, control of STI/HIV, FGM, and forced and early marriages. They sang these songs at general assemblies, cultural evenings, reproductive health days, funerals, and other traditional ceremonies, as a means of popularizing the information.

e) Reproductive health days

Reproductive health days were intensive one to two week IEC campaigns organized by the

program's technical partners and the village associations. The general objective was to raise the visibility of reproductive health with the population and partners, as well as with the provincial and department administration. The principle activities included:

- ♦ IEC sessions in the villages: group discussions, videos, theatre groups, and traditional singers.



Traditional Singers

- ♦ Contests in each village using reproductive health messages. Winners went on to compete in inter-village contests. Prizes included envelopes with messages encouraging positive reproductive health behaviors.
- ♦ Cultural evenings including contests between several villages.
- ♦ Organization of an official ceremony that included administrative and traditional authorities, government partners, the general public, and health promoters. During this ceremony, a summary of reproductive health activities carried out in the program area during the year was presented. The winners of the village and inter-village competitions were acknowledged. The best health promoters in the villages (chosen based on the results of their work during the year) were congratulated and awarded prizes to help them in their work.

Special Program Initiatives

These reproductive health days achieved several key outcomes:

- ♦ They facilitated the mobilization of a large number of people in a few days around reproductive health and made the activities better known.
- ♦ They solicited an active engagement on the part of communities and partners.
- ♦ They encouraged excellence through official recognition of the top health promoters.

f) Addressing other factors affecting women's health

Community problems are inter-related. For women in particular, there is a strong link between their social conditions and the reproductive health problems that they face. In an effort to address these inter-related problems, several tools were used to help communities identify and analyze priorities affecting women's reproductive health (see Appendix).

In one exercise, women listed the major problems that they face in the community. They then categorized the problems according to their influence on reproductive health (problems that have a large effect and problems that have less of an effect on women's reproductive health). The richness of the exercise is in the discussion about the criteria or the reasons they used to rate each problem.



Examples of Women's Problems/Priorities

	Problems with a large effect on reproductive health	Problems with less of an effect on reproductive health
Health dispensaries not easily accessible (distance, conditions of the road/path, lack of transportation)	X	
Women's workload (fetching water, gathering wood, etc.)		X
Poverty	X	
Hunger	X	
Illiteracy		X

The problems they prioritized as having a large effect on RH included 1) the distance to health dispensaries, 2) poverty and the lack of access to cash, and 3) hunger. They classified heavy workloads and illiteracy as important, but as having less of an effect.

By using these tools, the program design took into consideration the priority needs of women, even when at first glance they may not appear directly related to reproductive health concerns.

g) Action learning

The action learning studies carried out in the program areas have contributed to a better understanding of the reproductive health problems, the social and cultural constraints, and priority needs. In turn, this led to improvements in program design. In addition, the participation of the local health staff in these action learning activities contributed to convincing the medical doctors and other health professionals at the district level of the value of the CBD strategy. This was crucial in prompting them to allow the program teams to initiate the distribution of contraceptive methods in the community by non health professionals.

Key Accomplishments and Results

Evaluations were undertaken for the Koulpeologo and Gnagna programs. The evaluations were done by external consultants and included program and non-program areas to facilitate comparisons aimed at measuring program impact. Comparison villages were selected in the same provinces where the programs are located to ensure shared social and cultural backgrounds. Probability-sampling procedures were used to select the sample villages for the evaluations. The evaluation design included both participatory and survey methodologies.

- ♦ The Koulpeologo evaluation had a total sample size of 1,265 of which 938 (516 women and 422 men) were program participants and 327 (150 women and 177 men) were from comparison villages.⁹
- ♦ The Gnagna evaluation had a sample of 520 of which 400 (250 women and 150 men) were from program villages and 120 (75 women and 45 men) were from comparison villages.¹⁰

This section presents program results as demonstrated by the evaluations and complemented as appropriate by qualitative and service delivery data. Results are presented by reproductive health topic. These include: family planning, STI/HIV and AIDS, maternal health care, and practices affecting women's health

a) Family planning

Because these communities were generally isolated, one of the primary activities of the programs was to provide family planning information and services.

⁹ Ouedrago, M., Cassalom, P. and Z. Congo. Evaluation du volet sante de la reproduction de programme de renforcement des capacites d'autopromotion du Koulpeologo (PRECAP/K), *Rapport final*. Avril 2003.

¹⁰ Societe Africaine d'Etudes et Conseils (SAEC), Evaluation d'impact du programme sante de la reproduction de Voisins Mondiaux/PAPRI. *Rapport definitive*. Aout 2002.

Aminata is about 35 years old although she doesn't know her exact age. She married when she was 17 and has eight children. Her oldest child is 19 and her youngest is a thin 18 month-old girl that she holds in her lap as we talk. It is almost 8pm and dark. Aminata has agreed to talk with us to tell us her story about the service that has changed her life.

Aminata says that she had heard about family planning and had been interested. She said that people were more open now that World Neighbors has been working in the area. She said her neighbors were spacing their children and she saw that it helped them. She said, "I have already had eight children and I knew that another pregnancy would be a problem and it would not be easy to take care of another child."

Aminata is the second wife of her husband. Her first co-wife had died, leaving seven children in addition to her own that she cares for. She added, "It is better to take care of the children we have, than to have other children."

She had heard about Norplant from the son of her first co-wife. He knew that she was interested in family planning, and gave her name to the health worker. She sold the soya beans she had grown for the 2,500 CFA needed (about \$5).

She said she had tried to talk to her husband about family planning that morning. "He said that our religion didn't permit it and forbid me to use it." Although he had said no, she knew that the nurse was coming only for one day and she didn't want to miss her chance. She decided to get the method anyway.

She went to clinic and with over 40 women, and she waited her turn to get Norplant. She was determined to get a method and she said it was evening when it was inserted. She said it didn't hurt, and she shows us where it was inserted. There are six small bumps in the back of her left upper arm.

It was late when she returned home, and her husband was waiting. He blocked her entrance to the compound and told her to "go back to where you have come from." He was angry with her and told her to leave his house.

She spent the night at her relatives' house. The next day she went to the clinic. The nurse offered to remove it, but she refused. She says because "I wanted to save my life."

After two days, her relatives asked her husband to come to talk with them. They spent time talking with him and convinced him about the importance of family planning for Aminata.

Key Accomplishments and Results

In both areas, the evaluation found that since the beginning of the programs, people's knowledge regarding modern methods of family planning had increased. Table 1 compares the program and non-program areas.

Table 1: Family planning knowledge by district and program participation

Variable	Gnagna		Koulpeologo	
	Program	Non-program	Program	Non-program
Knowledge of modern methods	90%	71%	56%	35%

The most well known methods are pills, injectables, and condoms. Norplant, IUDs, and spermicides are less well known.

In Koulpeologo, the evaluation included a specific question regarding sources of information. It was found that 45% of those interviewed in the program area said they received family planning information from program activities.

Both programs reported increases in contraceptive use among program participants. In 1999, according to the MOH, less than 3% of the population of Gnagna was using a modern family planning method. In the program area in 2002, over 18% of those surveyed were using a modern method. The evaluation survey also found that 60% of contraceptive users obtained their contraceptive method from the CBD program managed by WN programs. The following table compares contraceptive use by program and non-program areas. Higher rates of family planning use were observed for both program areas.

Table 2: Family planning use by district and program participation

Variable	Gnagna		Koulpeologo	
	Program	Non-program	Program	Non-program
Modern contraceptive use	18%	3%	14%	8%

According to respondents, the major reasons for contraception use included delaying pregnancy, avoiding unwanted pregnancy, and preventing STIs and HIV/AIDS.

Service data from the rural dispensaries supports this increase in contraceptive use. It indicates that dispensary nurses have inserted 1248 Norplants and 430 IUDs. They did not provide this service prior to the training supported by the program.

My name is Awa. I come from the village of Kokou in Liptougou Department in Gnagna Province. I am 28 years old and have five living children. The space between my children is less than two years. Following different informational sessions organized in our village on family planning, my husband and I decided to plan our family. As a result, I adopted the pill with the CBD volunteer in 2001. However, after a few months, because I forgot to take the pill, he referred me to the dispensary where I opted for the injectable. When we learned that the nurses were trained and could insert long-term contraceptive methods, I went back to the dispensary and got a Norplant, because we had decided we didn't want any more children. I plan to replace it after five years.

b) STIs and HIV/AIDS:

Knowledge levels regarding STIs and HIV/AIDS are high in both program and non-program areas (Table 3). However, it is notable that there are significant differences in knowledge regarding condom use as a means to prevent infection.

Table 3: Knowledge regarding STIs and HIV/AIDS by district and program participation

Variable	Gnagna		Koulpeologo	
	Program	Non-program	Program	Non-program
Knowledge of STIs	99%	97%	61%	54%
Knowledge about HIV/AIDS	99%	97%	96%	87%
Condom provides protection	58%	5%	63%	34%

Key Accomplishments and Results

The focus groups in both evaluations found that the communities in the program areas know more signs of STIs than those in the comparison areas.

The Koulpeologo evaluation went into more detail regarding this aspect. Findings included:

- ♦ Men have higher levels of knowledge than women about STIs (72% compared to 49%).
- ♦ Youth (15-19) have less knowledge (40%) about STIs than adults.
- ♦ Illiterate people have less knowledge about STIs than literate (53% to 82%).

Respondents reported that WN program activities constitute the first source of information (64%) regarding these issues in the program area.

Although 60% of people in program areas have discussed HIV/AIDS issues during the last six months, only 45% reported discussions in the control villages. Most of people who reported discussing HIV/AIDS are men (67% compared to 49% of women) and they are literate (79% against 52% illiterate). Friends and sexual partners are the main groups with whom they discussed HIV/AIDS problems (59% and 43%). Youth and single people are those who discussed most with their friends (78% and 86%).

In Gnagna, more than 50% of people who have heard about STIs/HIV/AIDS said they received information through the program activities. Similarly, the CBD workers are the second source of condoms with 40% reporting getting condoms from them compared to 46% from the market. The MOH services are the third source for condoms with 14%.

In Koulpeologo Province, 3% (out of a total 1,181) of surveyed people declared they had experienced an STI during the last 12 months. Among

these people, 62% of women and only 30% of men in the program areas have discussed STIs with their partners. No communication about infections was reported in the comparison villages. Most of those (83%) who suffered from STIs during the last 12 months sought care from the MOH dispensaries.

c) Maternal health

Maternal health care was a key element of both programs. Reported use of prenatal care for the last pregnancy was 88% in the Koulpeologo program area compared to 76% in the comparison area.

According to health service information included in the evaluations, there was an 11% to 58% (varying according to the dispensary) increase in the rate of prenatal care use for the health facilities in the program areas between 1999 and 2002.

Evaluation results demonstrate significant differences between program participants and others in the use of iron folate and malaria prophylaxis, two key components of quality prenatal care (Table 4).

Table 4: Prenatal care by district and program participation

Variable	Gnagna		Koulpeologo	
	Program	Non-program	Program	Non-program
Iron folate use	73%	30%	45%	4%
Malaria prophylaxis	72%	33%	58%	16%

According to the MOH, 48% of women in general and 78% of pregnant women suffer from anemia in Burkina Faso, so these differences in iron foliate use are significant.¹¹ Similarly, malaria is the most common endemic disease in Burkina Faso, making the use of malaria prophylaxis particularly important during pregnancy.

¹¹Rapport de l'enquête épidémiologique sur les carences en micro-nutriments, Mars 1997

Key Accomplishments and Results

One of the tasks of the trained birth attendants (TBAs) was to distribute iron folate and chloroquine to pregnant women. This is reflected in the rates of use which are much greater in program areas than in non-program areas.

Another key aspect of the programs was education on danger signs during pregnancy and delivery. Table 5 presents results for key indicators on the knowledge of selected danger signs.

Table 5: Knowledge of danger signs during pregnancy and delivery by program participation in Koulpeologo program area

Variable	Pregnancy		Delivery	
	Program	Non-program	Program	Non-program
Hemorrhage	15%	5%	34%	13%
Fever	27%	16%	22%	13%
Anemia	14%	5%	16%	6%
Edema - hands and face	18%	11%	7%	0.9%

The most commonly known warning signs are: hemorrhage, high fever, anemia, and edema. The communities in the program area generally have better knowledge of these signs compared to the non-program villages. However, it is notable that many people in both program areas don't know all the signs of complications.

In these isolated rural areas, delivery care poses a particular risk because access to clinical delivery services is so limited. The programs encouraged deliveries in health centers, but also trained traditional birth attendants in clean and safe delivery. As Table 6 demonstrates, while more deliveries were assisted by trained persons in the program area, it should be noted that this includes non-medically trained TBAs.

Trained birth attendants were instrumental in increasing the number of attended pregnancies by

referring complicated cases to the health facilities. The evaluation found an 18% referral rate of pregnant women to health facilities.

Table 6: Delivery care and place by district and program participation

Variable	Gnagna		Koulpeologo	
	Program	Non-program	Program	Non-program
Deliveries in health centers	25%	40%	43%	19%
Deliveries assisted by trained medical personnel or trained birth attendants	64%	40%	65%	40%

d) Practices affecting women's health

Forced and early marriages: Forced marriage is defined here as the conjugal union of two individuals without the consent of one or both of the parties. Early marriage is defined as a matrimonial union in which one or both of the partners is younger than the legal age of marriage in Burkina Faso (17 years for the woman and 20 years for the man).

According to respondents in focus group discussions, these practices are decreasing. They reported that the major factor in this decrease was the community awareness raising done through WN programs.

Female genital mutilation: According to survey results in Gnagna Province, only 18% of respondents in the program areas and 7% in comparison areas said that FGM exists in their villages. However, according to local authorities, this does not mean that the practice is greater in the program areas, but rather that people are more open in discussing FGM and admit to the practice. Focus

Key Accomplishments and Results

group discussions indicated that while community members acknowledged that FGM is still practiced, many families are abandoning the practice.

According to the respondents, the main reasons for continuing the practice of FGM include: tradition, girls' protection against diseases, religion, insufficient awareness, and avoidance of early sexual intercourse. Some people said that women who do not undergo FGM have low status in the community. They also said that they believe that the clitoris causes the death of the newly born baby when it touches its head. However, many people acknowledge that FGM has bad effects (77% in program areas and 66% in comparison villages). Some of the risks experienced by women and cited by respondents include: complications during pregnancy, hemorrhage, STI and HIV/AIDS. Some people still want to continue this practice (7% of women and 6% of men). Generally, attitudes are positive towards the government's decision to outlaw FGM (83% in program areas versus 80% in comparison areas).

Communication within couples: Another important aspect of the program was couple communication. Table 7 presents results from the Koulpeologo evaluation regarding discussions between spouses. For most topics, there are notable differences between program participants and non-participants.



Table 7: Communication between spouses in past 12 months: Koulpeologo

Variable	Program	Non-Program
Discussed STIs	60%	0%
Discussed HIV/AIDS	46%	30%
Discussed number of children	38%	25%
Discussed family planning	31%	14%

Family planning discussion in the program area compares favourably to the baseline information collected in 1999, when only 19% of spouses had discussed using contraceptive methods.

Decision-making regarding contraceptive use: In both program areas, there is a contrast between program participants and non-participants regarding discussions between spouses who are contraceptive users. Among these contraceptive users, over 90% in the program areas (93% in Gnagna and 92% in Koulpeologo) versus 21% in the comparison villages (for both programs) decided on using a family planning method with their partner.

According to the evaluation reports, focus group participants in Koulpeologo mentioned increased dialogue between spouses, discussions regarding decision making, use of contraceptive methods, and women's participation in household expenses as changes in the lives of couples. For them, the main factors that contributed to such changes include contextual changes—such as openness to new ideas and more sharing of information—in addition to literacy. These changes were reported more frequently in the program area.

Key Accomplishments and Results

Income Generation Activities (IGA) and reproductive health

In the Koulpeologo program, evaluation results show that 58% of respondents in the program areas and 27% in comparison areas conducted IGAs such as trading, breeding, animal fattening, and food selling. During the last three years, 10% in program areas and 0.6% in control areas of surveyed people had benefited from loans for IGA activities. Women are 61% of the loan beneficiaries.

The sources of loans included WN program (56%), community chests (27%), other NGOs (19%) and community members' contributions (1%). The vast majority of loan beneficiaries in the program area (94%) acknowledged that their income has increased. IGA revenues are used primarily for food, clothing, and health needs. Health needs ranked third in terms of use for IGA revenues.

My name is Pobena. I am 29 years old and from the village of Yarga in Mani Department. The program helped us obtain carts for carrying water in 2000. Since then, I have used this cart to get water for my house. With one trip I can transport two jerry cans of water of 20 liters each. That allows me to make a maximum of two or three trips in a day to cover all the needs of the family in potable water (drinking, washing, cooking, etc). In the past I had to make between 5 and 6 trips a day with a bucket of 15 liters on my head and I still wasn't able to have the necessary amount of water in a day. My friends also come and borrow my cart and we use it also to fetch water for the school students.

According to participants in the evaluation, women's access to loans for IGA has increased their financial autonomy, their participation in household expenses (for health, food, clothes and children school) and consequently their participation in decision making within the household.

Lessons Learned

The implementation of the RH component has been an important source of learning for the program. Some of the key lessons learned include:

The participatory action learning approach:

This approach helped build a collective understanding of RH needs and issues, and established a sound, community based foundation for developing an effective, sustainable RH component.

Involving influential persons in program activities:

The training of influential persons in reproductive health and involving them in mobilizing the communities contributed to a positive change in people's attitudes. Not only did this strategy help to curb rumors and active resistance but it increased access to information and positive reproductive health practices through the leaders' normal activities.

Increasing women's income is likely to increase their access to reproductive health services:

When women have access to income, they can pay for transportation costs, contraceptives, and other health-related services. Therefore, providing loans to reproductive age women for

income generating activities has been an important means to facilitate access to contraception. According to focus group discussions in all areas, women's access to credit for income generating activities and the revenue generated enhanced their social status. In fact, women who were involved in these activities and have increased their purchasing power are given more consideration by their husbands, as well as by other family members. As a result, they say they are consulted and their points of view are taken into account in household decision making. In addition, these women feel they have more freedom to participate in community activities both within and outside of their villages.

Demand for long-term methods in rural areas:

Both programs tapped into a strong demand for long-term methods of contraception. Prior to the program, only short-term methods were available in these areas. These methods did not respond to the needs of many women who wanted to avoid another pregnancy over a longer period, or permanently. By making Norplant and IUD available, the needs of these women were addressed. By combining the short-term method approach of the CBD strategy with availability of long-term methods



Sogji and Kadija Tindano live in Kokou village in Liptougou District in Burkina Faso. Sumai is the health leader for the Torim Mani Intervillage Association. He is 39 years old and Kadija is 36. He

works as a farmer and also raises cattle and sheep. Kadija works as a nutrition volunteer for the health program. She helps Sumai with family farm work, but she also has her plot where she grows peanuts to sell. She has a few sheep of her own and she does some mini-commerce selling cakes.

Sumai says he went to Fuga to work for his family's inlaws. They first met when Sumai was 14 and Kadija was 10. Sumai and Kadija have*

been married for 17 years and they have four children. Their oldest child is 14 and the youngest is four. The couple has another co-wife who has six children. She has just given birth and is at home today.

When asked if they will have more children, Kadija says she would like to have two more children. He says the number they have now is sufficient. We ask them how they will settle this difference of opinion? Sumai says they will discuss it and exchange opinions. (Later a WN staff member explains, "since her co-wife has six children, it is common to want to have the same number. There is a kind of competition between wives in this regard.")

She is currently using family planning and she says it was her idea since she wanted to rest between pregnancies. Sumai adds, without family planning Kadija gets pregnant every three years. Kadija shows us her Norplant in her upper inside left arm. She says she has been very happy with it and hasn't had any problems.

**In this part of Burkina Faso, people have the tradition of doing field work for their in-laws as part of bride price.*

Lessons Learned

through the health facilities, the programs were able to address a broader range of contraceptive needs.

Couple communication: The programs appear to have had a positive effect on couple communication. Seventy-five percent of those who participated in program activities consult their partners on reproductive health issues compared to 10% among non-participants. Communication between couples for contraceptive use is higher among literate than illiterate couples in program and non-program areas—68% and 57% literate persons respectively consult their partners for contraceptive use, versus 69% and 82% among illiterate.

Effects of literacy: Literacy appears to be a strong enabling factor for providing quality reproductive health services, keeping good records, and adopting practices. Literate health promoters have demonstrated better knowledge and skills in the implementation of their tasks and in mastering the monitoring tools.

Credibility of programs at health district level: WN is a pioneer in initiating the CBD strategy in these two provinces. As a result of this initiative, the health data reported by the district, especially in family planning, have been improved and constitute a source of motivation for the staff at the district level as they see the impact of their activities at the community level.

Targeting different groups with IEC messages: Another successful strategy was targeting different groups with different trainings and messages. In addition to influential people, the programs also tailored special IEC activities to the needs of young men, young women and the wives of leaders.

Because these messages addressed the group specifically, there was greater interest and enthusiasm for activities.

Audio-visual IEC sessions: IEC sessions that are backed up with visual and audio-visual aids—especially movies/theaters followed with discussions—are among the best ways to convince rural communities of the advantages of positive reproductive health and to encourage the adoption of new practices.

Survey information for sensitive subjects is not reliable: The programs tried to use survey tools to assess changes in practices related to FGM. Based on the staff knowledge of communities and that of key informants from those communities, the survey findings seemed to underestimate the practice of FGM. Most likely, this was due to the fact that FGM is now illegal in Burkina Faso and respondents didn't want to acknowledge the practice. Interviews with key informants appears to be a better strategy for estimating change with regard to sensitive practices.

“Openness” as an indicator of social change: During the focus group discussions carried out as part of the evaluation, respondents repeatedly referred to “openness” or an “opening of the spirit” in the community with regard to reproductive health as an indicator of social change. While it is difficult to measure or attribute this kind of change, the fact that role plays about family planning and songs regarding stopping FGM are now performed openly at community meetings points to a significant change in these formerly very conservative communities.

I am Awa Guitanga, a trained birth attendant in Yarga village in Mani Department. I benefited from a 25,000 CFA credit (\$50) from the program. I bought a young billy goat for 20,000 CFA and I used the rest to buy flour and make small cakes to sell. The sale of the cakes allowed me to have some daily income which I used to take care of my children by buying malaria medicine and paracetamol. The goat, I sold at 55,000 CFA one year later. I reimbursed a part of the credit, and I bought another young goat which allowed me to reimburse all the credit. I used the rest of the money for daily needs including buying spare parts to repair my bicycle. In that way, I didn't have to depend entirely on the village to take care of the costs for my travel as a volunteer.

Conclusion

The evaluation results demonstrated important changes in reproductive health in the communities in which the program worked. Specifically,

- Communities' knowledge has improved on RH issues compared to baseline and comparison areas.
- Adoption rates of RH innovations are higher in program areas than in comparison areas and there is an increase in the use of RH services both at village and health center levels compared to baseline data.
- Communication about RH issues is higher in program areas than in comparison areas and more couples in program areas than in comparison areas have recognized that they decide together on some RH issues.

Most importantly, stakeholders also recognize the contribution of the programs in terms of access to services and improvements in health indicators.

“WN program has contributed to improved communities' health; since program implementation, attendance at the health center is higher than in the past. Populations come earlier to seek out health care. Now we receive couples who come for family planning and we receive more people seeking care for STIs than in the past.”

- a public health nurse in Koulpeologo

“It is a good program. Some years ago, we didn't have health promoters in the villages. Thanks to WN programs, health care is available in the villages. Since their assistance, people have their eyes and spirit opened. Many of them didn't know that it was possible to plan births. Today, many of us use family planning methods and are interested in using them.”

- a trained TBA

“There is a significant change in communities' health; now first aid drugs are available at reasonable prices in our villages and at any moment one can access the services of trained TBAs, CHWs and CBDs because they are always available. We don't know when pregnant women face risks of complications, but now trained TBAs know that and request rapid referral to health centers.”

- a religious leader

Appendix: Participatory Tools

Tool #1: Women's Priorities That Affect Their Reproductive Health

This tool is designed to help women's groups analyze the factors that affect their reproductive health.

Objective:

Identify and analyze women's priorities that significantly influence their reproductive health

Participants:

Women of reproductive age and women of menopausal age, in separate groups

Materials:

Cards (multiple colors), flip chart paper or newsprint, markers, tape

Steps:

1. Problem Identification

Ask the participants to list the major problems that women in the community face. Write each problem on a card.

2. Categorization of the Problems According to their Influence on Reproductive Health

Group the problem cards into two categories:

- Problems that have a large effect on women's reproductive health
- Problems that have less of an effect on women's reproductive health

3. Semi-Structured Interview about the Reasons for the Categorization

Ask the participants to describe the criteria or reasons they used to place each problem in its

category, taking problems from each group as examples.

4. Follow-up

If the participants worked in separate groups, bring them back together to review the results and synthesize the information.

If there are drastic differences in the results of the various groups, facilitate a large-group discussion to prioritize or classify the problems for consideration at the action-planning stage.

When prioritizing, consider the seriousness of the problems, their frequency or scope/extent, their overall importance and the possibility of taking action to address them.

Results:

	Problems with a large effect on reproductive health	Problems with less of an effect on reproductive health
Health dispensaries not easily accessible (distance, conditions of the road/path, lack of transportation)	X	
Women's workload (fetching water, gathering wood, etc.)		X
Poverty	X	
Hunger	X	
Illiteracy		X

Appendix: Participatory Tools

Tool #2: Community Survey Regarding Questions of Population and Environment

Facilitators used a community survey to collect precise information that provides an in-depth understanding of the subjects/themes presented. This information helps with planning, and serves as a baseline for future program evaluations.

Only the section of the community survey that addressed reproductive health and environment is presented here. Facilitators conducted individual interviews using a questionnaire designed to evaluate the local populations' knowledge, attitudes, and practices relating to reproductive health.

Objective:

To assess the local level of knowledge regarding population and environment

Participants:

Individuals of reproductive age from a sample of households chosen randomly in both program villages and in comparison villages.

Note:

- Local resource people, as well as external resource people who have a strong knowledge of the local language, can be trained to administer the questionnaire.
- This article will not address all of the steps involved in developing the survey, collecting and analyzing the responses or the contents of the different parts of the questionnaire. We focus here only on the parts of the survey relevant to the theme of population and environment.

Knowledge of the Connection Between Population and Environment

1. How would you describe the change in each of the following environmental components in your community over the past 10 years? Would you say that it has significantly improved, improved, has not changed, has gotten worse, or has gotten significantly worse? **(Check the box corresponding to the response for each component.)**

Component	Significantly improved	Improved	No change/same	Worse	Significantly worse
Condition of the forest					
Cover vegetation					
Conditions of the soils/cultivated areas					
Wild animal resources					
Availability of water					

Appendix: Participatory Tools

2. **(Referring to question 1, ask about components that have significantly improved or improved.)** What do you think are the reasons why the environmental component in your community has improved in the last 10 years?

Reason for Improvement in component (from 1)	Check here
a. Increase in knowledge/awareness of environmental conservation	
b. Good programs for rehabilitation/management of resources	
c. Reduction in the rate of abusive tree cutting	
d. Reduction in the rate of brush burning	
e. Protection of cover vegetation/efforts to protect the forests	
f. Use of appropriate agricultural practices	
g. Reforestation	
h. Decrease in pollution/waste	
i. Other (specify)	

3. **(Referring to question 1, ask about components that have gotten worse or significantly worse.)** What do you think are the reasons why the environmental component in your community has gotten worse in the last 10 years?

Reason for Deterioration of component (from 1)	Check here
a. Lack/insufficient knowledge/awareness on environmental conservation	
b. Lack/insufficient programs for rehabilitation/management of resources	
c. Illegal activities (i.e., tree cutting)	
d. Increase in population	
e. Increase in the utilization of resources	
f. Detrimental use of technical advancement	
g. Weak enforcement of laws and ordinances	
h. Modification in farming methods	
i. Increase in pollution/waste	
j. Other (specify)	

4. In the past 10 years, has the number of people in your community... **(circle only one response)**
- Increased
 - Decreased
 - Stayed the same
 - Don't know

Appendix: Participatory Tools

5. Over the past 10 years, what are the environmental changes that have been influenced by population growth in your community? (Circle all that apply.)
 - a. Loss of soil fertility
 - b. Deforestation
 - c. Insufficient water supply
 - d. Increase of pollution/waste
 - e. Limited space/land in the community (cultivated)
 - f. Other (specify)
 - g. Don't know

6. What is the ideal number of children for couples to live in harmony with the environment?





More RH Resources from World Neighbors

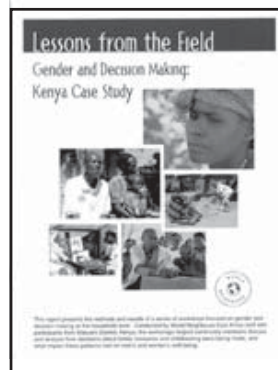
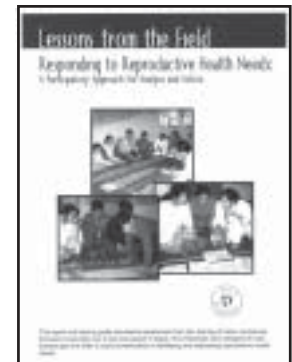


Evaluating an Integrated Reproductive Health Program: India Case Study

This report details the methods and findings of a participatory evaluation of integrated reproductive health programs in two villages in India, with comparisons to a third village that had no reproductive health programming. The results suggest that the integrated approach used by World Neighbors - India and its partners is effective in achieving high rates of reproductive health knowledge and positive practice, improvements in women's status, and significant benefits from participation in savings and credit programs. **60 pages, available in English. \$10.00 plus shipping; 2002**

Responding to Reproductive Health Needs: A Participatory Approach for Analysis and Action

This report and training guide documents experiences from two training of trainer workshops that were conducted over a two year period in Nepal. The workshops were designed to help trainers gain the skills to assist communities in identifying and addressing reproductive health needs. The guide is well illustrated with graphics and photos, and includes 15 training exercises with clear explanations of procedures for facilitating the workshops. **54 pages, available in English, Spanish, and French. \$10.00, plus shipping; 2001**



Gender and Decision Making: Kenya Case Study

This report presents the methods and results of a series of workshops focused on gender and decision making at the household level. Conducted by World Neighbors staff with participants from Makueni District, Kenya, the workshops helped community members discuss and analyze how decisions about family resources and childbearing were being made, and what impact these patterns had on men's and women's well-being. The publication outlines three participatory exercises as well as the results and key lessons learned from the process. **24 pages, available in English. \$5.00, plus shipping; 2000**

These and other World Neighbors publications can be ordered by calling 800/242-6387 or 405/752-9700; by sending an email to order@wn.org; or by ordering online at www.wn.org

World Neighbors

World Neighbors is a not-for-profit community development organization working in partnership with the rural poor in hundreds of villages throughout Asia, Africa, and Latin America. Through World Neighbors' programs, people come together to solve their priority problems and meet their basic needs. By supporting community self-reliance, leadership development, and organization building, World Neighbors helps people address the root causes of hunger, poverty, and disease.

World Neighbors helps people develop, manage, and sustain their own programs. Most programs begin using locally available resources and simple, low-cost technologies. As people gain skills and confidence, local leaders and organizations emerge to carry on the work, multiply the results, and participate in coalitions advocating for wider change. World Neighbors' role is to strengthen these basic human and organizational resources for long-term development.

World Neighbors does not give away food or material aid. Instead, it provides training so that people gain the skills and leadership to work together for change. The result is self-reliance, rather than dependence on external aid. World Neighbors does not determine the focus of the program, but asks people to set their own agenda. Programs include: food security, farming, literacy, health, family planning, water and sanitation, environmental conservation, savings and credit, non-formal education, and income generation activities.

Our approach is simple. In cooperation with our global neighbors, we:

1. Select the communities where we work on the basis of need and opportunity.
2. Establish a relationship of trust by listening to what people say and learning what limits their success.
3. Help strengthen the capacity of communities to identify, analyze, and solve their own problems using local resources and the simplest tools to do the job.
4. Try new ideas on a small scale. Stay practical to generate early enthusiasm and success.
5. Strengthen the community's ability to evaluate and document the results, applying lessons learned to improve their programs.
6. Reinforce the community's capacity to multiply their results and maintain the problem-solving process by coordinating with other villages and local organizations and forming partnerships.
7. Widen program impact by sharing the results and process with larger-scale organizations, villages, networks, coalitions, and governments to influence policies and actions.

Since 1951, World Neighbors has helped more than 25 million people in 65 nations. Today, World Neighbors works with partners in approximately 64 programs in 16 countries: Haiti, Honduras, Guatemala, Bolivia, Ecuador, Peru, Kenya, Tanzania, Uganda, Mali, Burkina Faso, Ghana, India, Nepal, Indonesia, and the Philippines.

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