



APAIB

**ASSOCIATION POUR LA PROMOTION DE L'ALIMENTATION INFANTILE
AU BURKINA FASO (Association for Child Feeding Promotion in Burkina Faso)**

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FINAL REPORT

**FINAL EVALUATION OF THE SAFER MOTHERHOOD PROJECT IN THE
DEOU DIVISION
OUDALAN PROVINCE**



DECEMBER 2007

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LIST OF ACRONYMS AND ABBREVIATIONS

AAD	: Home Assisted delivery
AAM	: Maternity Hospital Assisted delivery
AIS	: Itinerant Health Worker
APAIB	: Association for Child Food Promotion in Burkina
AMURT	: Ananda Marga Universal Relief Team
ANA	: Non-Assisted Delivery
ASC	: Community Health Worker
AV	: Village Birth Attendant
CISSE	: Health Information and Epidemiological Surveillance Centre
COGES	: Management Committee
CPN	: Antenatal Consultation
CSPS	: Health and Social Development Centre
DEP	: Research and Planning Department
DSF	: Family Health Department
DS	: Health District
DRS/S	: Regional Health Department for the Sahel Region (Dori)
FAP	: Child Bearing Age Woman
FAF	: Woman under Folic Acid
IEC	: Information Education Communication
ICP	: Post Chief Nurse
IDE	: State Registered Nurse
INSD	: National Statistics and Demography Institute
STI	: Sexually Transmitted Infection
MMR	: Safer Motherhood
MS	: Ministry of Health
NORAD	: Norwegian Agency for Development
NGO	: Non Governmental Organisation
UNDP	: United Nations Development Programme
SMI	: Mother and Child Health
AIDS	: Acquired Immunodeficiency Syndrome
HIV	: Human Immunodeficiency Virus

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INTRODUCTION

ANANDA MARGA UNIVERSAL RELIEF TEAM (AMURT) is a Non-Governmental Organization established in Burkina Faso since 1986. It is operating today in the Gorom-Gorom Health District and works closely with the Ministry of Health and the Ministry of Agriculture.

Since 2005, AMURT is implementing a project referred to as « Safer Motherhood » (MMR) Project for the Déou, Boulikessi and Gandafabou (Oudalan Province) populations. This action is made possible thanks to FOKUS¹ funding, an organization of the Norwegian Agency for Development (NORAD).

The « Safer Motherhood » Project, born from a partnership between the Ministry of Health and the AMURT NGO, consists in providing technical, logistic and financial support to the Health Sector. The goal of the project is to contribute in meeting needs in the area of mother and child health and health in general in the project intervention area.

The project enabled AMURT, in collaboration with the Déou area Health Officials, to train village Birth Attendants (AV). At the end of these training sessions, these workers developed a package of activities covering population health in general and especially pregnancy, and delivery care as well as women post-partum follow-up. In addition, awareness raising actions on targeted themes such breast feeding and HIV/AIDS, were also implemented for populations.

The General objective of the project was to provide technical, logistic and financial support for the operational capacity building of health care bodies and communities in the area of health.

At the end of the project, it would be interesting for the various actors to know about the level of achievement of the project objectives. The final evaluation, started by AMURT, aims at meeting this basic concern and proving the relevance of the action. This evaluation focuses on activities implemented over the 2005-2007 period (i.e. 3 years).

The evaluation results will be used for the consolidation of the NGO and its partners approach within the context of problem analysis and quest for solutions by AMURT, partners and target beneficiaries. This evaluation took place from 5 to 25 November 2007 in the Déou Division. It was conducted by the Association for Child Feeding Promotion in Burkina Faso (APAIB).

¹ FOKUS is an NGO Association based in Norway and AMURT Norway is a member of this Association. Thus under this Project, AMURT Norway served as an intermediary for the transfer of funds from FOKUS to AMURT-BURKINA

I – DESCRIPTION OF THE PROJECT

This project, initiated by the Gorom Gorom Health District, aimed at reducing risks associated with motherhood through the selection and training of community health workers and the implementation of a scheme for building the capacities of community bodies. It was executed in close collaboration with the three (3) health institutions namely the Primary Health Care Centres of Déou, Boulikessi and Gandafabou. The implementation of this project is made under the Cooperation Agreement signed on 11 July 1986 between the "ANANDA MARGA UNIVERSAL RELIEF TEAM" (AMURT) Association and the Health Department of Burkina Faso.

1.1. Purpose of the project

This Project aims at contributing to the development of behaviour likely to contribute to the improvement the health status of women and populations in general,.

1.2. Goal of the project

The goal of the Project is to develop first emergency health care bodies and curative care. Furthermore, it aims at improving the health of communities in the project intervention area.

1.3. Expected Results

1.3.1. Short term Expected Results

- ✓ Improvement of community health workers knowledge and skills in mother and child health as well as in IEC and social mobilisation techniques ;
- ✓ Development of a Mobile Mother and Child Health (SMI) Mechanism, as well as social mobilization and IEC for Health tools ;
- ✓ Support by community actors to health workers in population awareness raising and education activities on health issues ;
- ✓ Capitalization of experience.

1.3.2. Long term expected results

- Behavioural change and realization of the importance of preventive health among populations covered by the Primary Health Care Centres of the three villages, i.e. Déou, Boulikessi and Gandafabou, in the areas of mother and child health, planning, individual and collective health, nutrition, STI/HIV/AIDS control, diseases avoidable through immunization, etc.
- Effective empowerment of populations for the management of their health issues.

1.4. Intervention Strategy

- ↪ The Project intervention strategy has been materialized through the development of Village Birth Attendants Selection and training Mechanism.
- ↪ Logistic and financial support to health bodies in the implementation of community based activities for populations.
- ↪ Implementation of mobile "Mother and Child Health" Mechanism for mother and child health and advanced strategies activities.

Activities were conducted, with special emphasis on the application of knowledge acquired by village Birth Attendants through:

- Pregnancy and delivery follow-up,
- support and referring of women with motherhood risk to Health and Social Development Centres (CSPS),
- Awareness raising of populations on female genitals mutilation and HIV/AIDS,
- Health care body operational capacity building,
- Project administration and management.

II – EVALUATION OBJECTIVES

The final evaluation arises from the commitments made by AMURT-BURKINA and the various partners in the implementation plan, which provides for an evaluation by an external resource. Then, this evaluation translates the heartfelt desire of each of the parties to measure the level of achievement of the objectives and highlight achievements, weaknesses and, finally, to draw maximum lessons from the project for future potential interventions.

2.1. General Objective

The purpose of the evaluation is to make an appraisal of results achieved and the impact of the project in the village, in terms of women condition improvement, behavioural change favourable for women health, empowerment and capacity building, as well as in terms of education in safer motherhood and health in general.

2.2. Specific Objectives

They include:

1. Evaluating the project activity implementation progress by highlighting the strengths, the weaknesses and adjustments to be made ;
2. identifying changes that occurred in the life of women and girls resulting directly from the project ;
3. Analysing the impact on women organizational capacities or on their social standing within their community ;
4. Appraising the quality of training provided over the project life time ;
5. Evaluating the implementation strategy and methodology by highlighting the strengths and weaknesses as well as adjustments to be made ;
6. Appraising the relevance, and the consistence of services provided by the project and their use by target groups ;
7. Evaluating the level of the various partners involvement and participation ;
8. Appraising the technical long lasting aspects in terms of capacity building to ensure its sustainability ;
9. Appraising the social long lasting aspects (effects/impacts) in terms of ownership by populations ;
10. Making recommendations for experience and achievement consolidation and sustainability.

III – EVALUATION METHODOLOGY

3.1. Methodological Approach

This is a basically a crosscutting qualitative descriptive and analytic approach. Thus, three (3) data collection techniques were used for information collection with target groupss involved in the evaluation. These techniques include: documentary review, detailed discussions with individuals and managed group discussions known as « Focus Group ».

3.2. Evaluation target groups

Target groups covered during this evaluation include the following:

- Officials of the project within the AMURT National Coordinating Unit;
- Officials of the Regional Health Department for the Sahel Regional (Dori) ;
- Déou Health District Chief Doctor ;
- Officials from Déou, Boulikessi and Gandafabou health care bodies;
- AMURT Focal Point in Déou ;
- Community health workers (AV) ;
- Resource persons and leaders within the project communities ;
- Populations.

3.3. Data collection tools

Instruments developed for information collection included an interview manual for each target group, a framework for the Focus Group and a scheme for using documentation on the project at the National Coordinating Unit and within local bodies. Interview manuals include open or semi-open questions, with no limitation for answers by people interviewed and more room for evaluators to make the link with the other questions and/or change them to make them understandable for the person interviewed. The validation of the data collection tools was conducted with the effective participation of the project officials.

3.4. Sample / Sampling

The main purpose of the evaluation was to assess the effects or impacts of the project of methodology, empowerment approach health care bodies' capacity building in the area of "safer motherhood" and health education.

To this end, the privileged approach was basically a qualitative approach. Therefore, the size of the sample was not important. The essential thing was rather the quality of target groups involved and information collected. Thus, the sampling was exhaustive for village Birth Attendants and reasonable for the Gorom-Gorom health district officials and resource persons. Focus Groups were formed with the populations. The main concern was then to make an assessment of the project action impact. The final evaluation mission met a total of 72 persons involved in one way or other in the project implementation.

Table N° I : Persons met by partners

Partners	Number of persons met
DRS/D Officials	01
AMURT Officials	03
Resource Persons	22
Gorom Gorom Health District Official	01
CSPS Health workers	10
Déou AMURT Focal Point	01
Village Birth Attendants (AVs)	34
Total	72

Source: Final Evaluation, 2007

3.5. Data processing and Analysis

Collected data entry, processing and analysis were made with the « Epi Info » software (Windows model) and SPSS (Model 10). The word processing of results was made with Microsoft Word (2003) software.

3.6. Difficulties encountered

Generally speaking, the evaluation was conducted smoothly. The major difficulty was the unavailability of some target groups involved in the evaluation. Indeed, village Birth Attendants left their usual place of residence for areas difficult to accede or for social reasons (funerals). Furthermore, the evaluation team couldn't meet the Gorom Gorom District Chief Doctor and the State Registered Obstetrician, the person directly concerned by the supervision activities related to safer motherhood in the District. However, these difficulties did not have impacts neither on the smooth running of data collection nor on the validity of the evaluation results.



**PRESENTATION AND COMMENTS ON THE EVALUATION
RESULTS**



V – APPRAISAL OF THE PROJECT SUCCESS STORIES



All in all, 36 Community Health Workers (ASC) (including 34 village Birth Attendants (AVs) and 2 village health workers (ASV) were interviewed during the evaluation. Besides, twenty one (21) resource persons from all kinds of social and professional categories answered the questions of the evaluators. For populations, fifteen (15) managed group discussions (Focus groups), attended by 293 persons (including 165 men and 128 women), i.e. an average of 20 persons by Focus group were held in fifteen (15) villages out of 33 villages covered by the project.

5.1. Community Health Workers Profile

The breakdown of village Birth Attendants by ethnic group reveals that fulani came first (52 %), followed by Bellahs (32 %) and Mossis (16 %)- (Chart N° I).

CHART N° I : BREAKDOWN OF VILLAGE BIRTH ATTENDANTS BY ETHNIC GROUP
(n = 37)

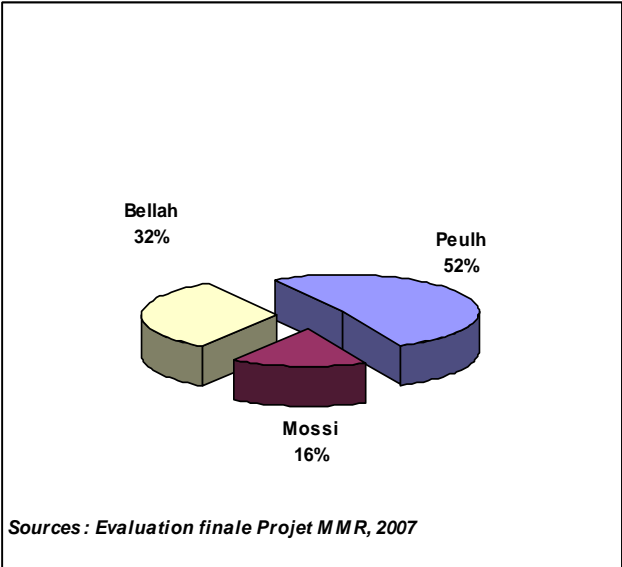
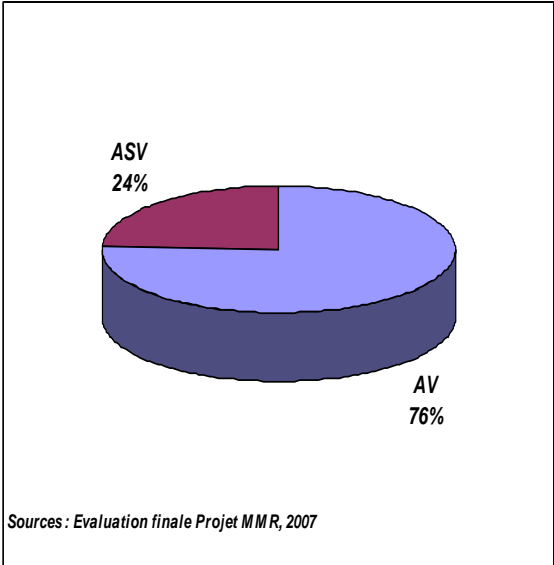


Chart N° II : Breakdown of community health workers by duties (n = 49)



The average age of the village Birth Attendants is 38.58 with highs and lows ranging from 22 years old for the minimum to 57 years for the maximum. The average age variance is about eight (8) years old and the most common average age encountered is 35 years old. The majority of Birth Attendants (91.43 %) are housewives. It has been reported that almost all of them have learn to read and write. The average length of service as birth attendant is two (2) years and the maximum length is six (6) years.

In conclusion, village Birth Attendants profile shows that they are relatively old (average age: 38.59 years). They form a population where new knowledge acquisition is relatively limited, given the fact that, in our case, almost all Birth Attendants interviewed are not educated.

In addition, the average age variance of eight (8) years indicates that village Birth Attendants of completely different age groups or generations may operate side by side. This is likely to make exchanges in group discussions difficult.

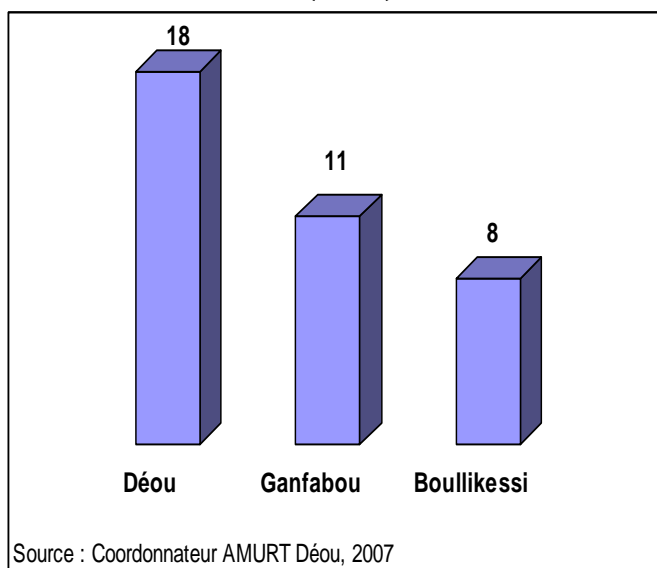
For the selection of village Birth Attendants to train, the age variance must be taken into account. Therefore, it is advisable to include the age criteria (25 to 30 years) to guide populations in the selection of women. Finally, given the great number of literate Birth Attendants, the transfer of knowledge on "Mother-Child" health will be rather easier.

5.2. Evaluation of the activity implementation progress

At the beginning, the support project to "safer motherhood" aimed at building the operational capacities of health care bodies in Déou, Boulikessi and Gandafabou. Generally speaking the aim was to contribute to the development of behaviours likely to contribute to the improvement of individual and family health.

The project, implemented over three (3) years (2005 – 2007), provided an opportunity to support three (3) Health and Social Development Centres (CSPS) under the supervision of the Déou Division (Chart N° III). From a philosophical angle, the project has been a feasibility and social sustainability test for the involvement and empowerment of communities.

CHART N° III : BREAKDOWN of VILLAGE BIRTH ATTENDANT BY HEALTH AREA
(n = 37)



The project activities were conducted through three (3) integrated and complementary components including :

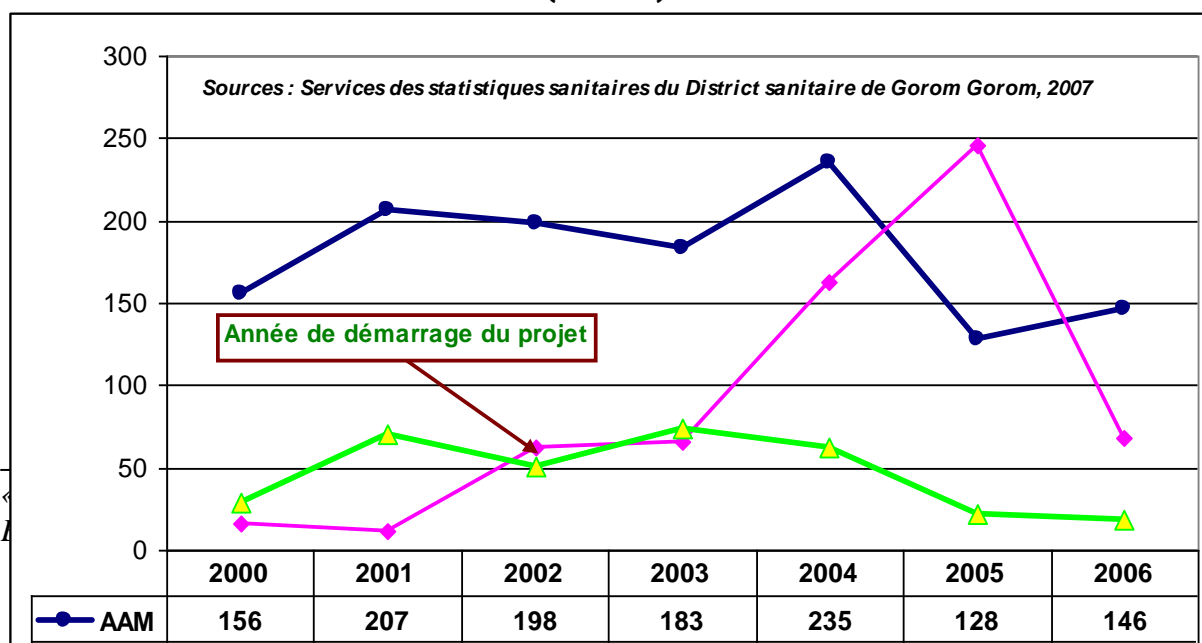
the technical support (selection and training of village Birth Attendants village), the logistic support (purchasing of technical, and rolling material), the financial support (incentive for workers, the administrative and financial management of the project).

As part of the implementation of the first sub-component, i.e. the technical support, the project encouraged the selection and training of village Birth Attendant and the development of documents for supervision (supervision scheme). In terms of results. Thanks to the support provided by the project, all the villages in the Déou Division (33 villages in total), with an expansion to cover four (4) villages, including three (3) in the Tinakoff Division (Northern part of *Fadar Fadar*, Southern part of *Fadar Fadar Sud* and *Rafnamam*) and one (1) in the Soum Division (*Boulikessi Soum*) were covered.

The village Birth Attendants activities focused on three (3) aspects in mother and child health : antenatal and postnatal consultation, delivery, education for health and population awareness raising on key themes such as female genitals mutilation, breast feeding, HIV/AIDS, etc.

According to interviewed Birth Attendants, they enjoy great esteem and respect from populations for their actions on the field. Indeed, these women have become over the years the only persons to turn to for health matters within their communities who are generally far away from any health facility. Thus, the trend curb below materializes, needless to say, the scope of the results of their activities.

CHART N° IV: TREND CURB OF SERVICES PROVIDED BY DÉOU DEPARTMENT BIRTH ATTENDANT BY YEAR
(n = 2 212)



Legend : **AAM** =Maternal Hospitality Assisted Deliveries
: **AAD** =Home Assisted Deliveries
: **ANA** = Non-Assisted Deliveries

Actually, out of a total of 2 212 deliveries recorded over the 2000-2006 period, 57 % of these deliveries occurred in maternity hospitals of the three (3) health centres in the Déou Division, whereas 29% occurred at home with the assistance of the project village Birth Attendants. However, it appears that 15 % of births occurred at home without any assistance. Hence village Birth Attendant activities are continuing and consolidating within their community.

Furthermore, there is a net increase in home assisted deliveries by village Birth Attendants as from the year 2002, which corresponds to the year where the "safer motherhood" Project was effectively launched. This shows the relevance and effectiveness of the village Birth Attendants action and thereby the relevance and effectiveness of AMURT-BURKINA intervention.

For the second component, i.e. the follow-up of women attending antenatal and postnatal consultation, the table below shows the results for the 2004 - 2007.

**TABLE N° II : BREAKDOWN OF ANTENATAL-POSTNATAL CONSULTATION SERVICES
BY VILLAGE BIRTH ATTENDANT BY YEAR**

Status	Year				Total	Percentage
	2004	2005	2006	2007		
Pregnant women attending antenatal consultation	179	623	589	1 145	2 536	58.05 %
Pregnant women not attending antenatal consultation	94	272	125	327	818	18.72 %
Women attending postnatal consultation	126	251	182	456	1 015	23.23 %
ACCRUED TOTAL					4 369	100.00 %

Source: Village birth attendants supervision Report

Out of a total of 4 369 of women recorded over the four (4) years before the end of the project, 58.05 % were pregnant women who were being followed in antenatal consultation by village Birth Attendants, against 18.72 % who were not being followed. Postpartum consultation involved 23.23 % of women who gave birth over this period.

Advanced strategy activities were developed with the setting up of a mobile mother and child health team (SMI). The goal of such approach is to provide proximity health services centre for far remote populations. Services provided during these trips include: Antenatal consultation (Antenatal Consultation 1, Antenatal Consultation 2, Antenatal Consultation 3), malaria and anaemia prevention, and, finally, discussions focused on various health themes with audio-visual equipment.

TABLE N° III: SUMMARY OF SERVICES PROVIDED BY MOBILE MOTHER AND CHILD HEALTH SERVICES OVER THE LAST SIX MONTHS OF THE YEAR 2006

Range of Antenatal Consultation (CPN)			Total	People involved in discussions		Total	Malaria and anaemia Prevention	
CPN1	CPN2	CPN3		Women	Men		FAF	Fchloro
95	64	16	175	302	92	394	5 050	4 150
54.29 %	36.57 %	9.14 %	100 %	76.65 %	23.35 %	100 %		

Source: Monthly Report of Mobile Mother and Child Health Services (SMI), CSPS of Déou for the year 2006

Table N°III results, though not exhaustive all over the project period, reflect just a little bit the contribution of « mobile SMI ». However, there is considerable loss between CPN1 and CPN3 of 54.29 % and 9.14 % respectively (i.e. 45.15 % of "women who never showed up again"). This explains the need for strengthening mobile SMI activities and women awareness raising for a better observance of the three (3) periods of CPN. Therefore, it would wise to set up a Mechanism for tracing women who never showed up again for antenatal consultation (CPN). For malaria prevention, 4 150 persons received chloroquine and 5 050 persons received folic acid for the prevention of anaemia caused by iron deficiency.

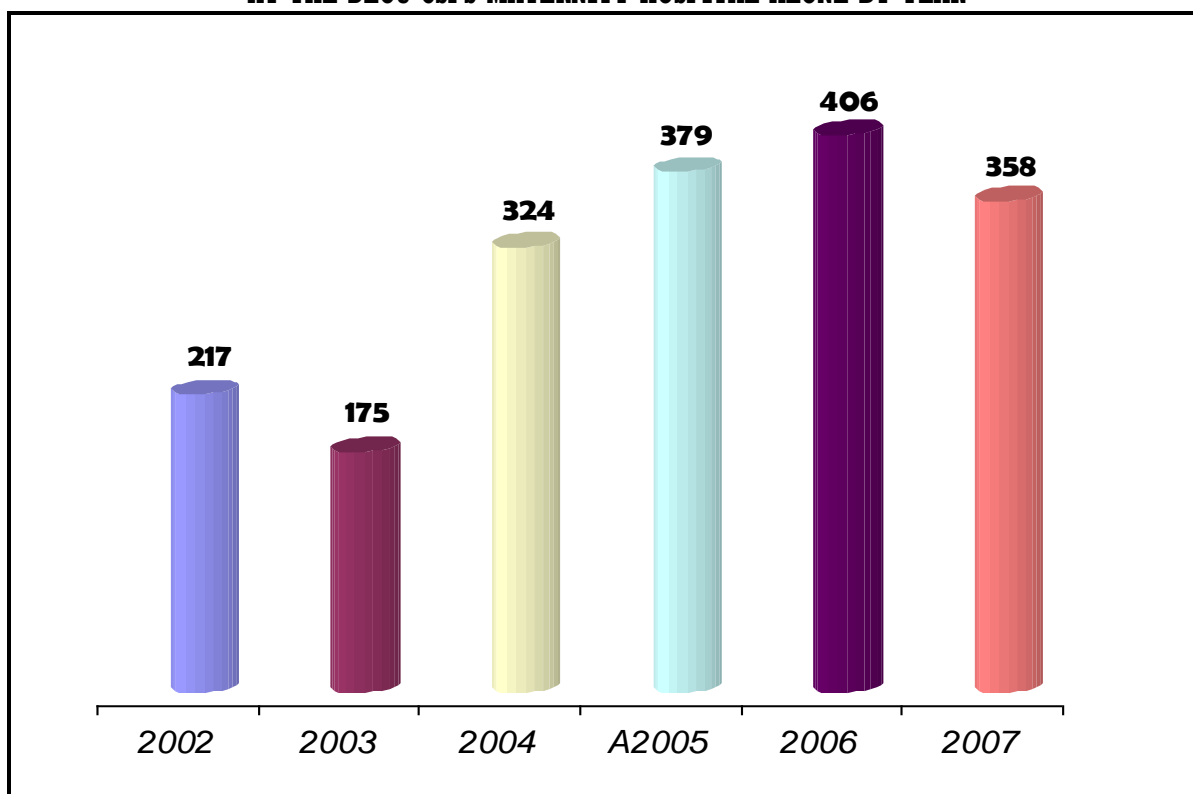
Discussions on themes related to female genitals mutilation, HIV/AIDS, "breast feeding", antenatal and postnatal consultation advantages, infant consultation and vaccination involved a total of 394 persons, including 76/65% of women against 23.35% of men, as far as the year 2006 is concerned. This leads to believe that men were less interested by

awareness raising activities. Indeed, despite their numerous tasks, women showed their readiness and interest for village Birth Attendants activities.

Hence the need for identifying the potential causes of the poor involvement of men in village Birth Attendants activities to find adequate solutions.

The project success is also reflected through the improvement, year after year, of the main performance indicators as stated by health centres officials interviewed. This is evidenced by the results presented in the Chart below.

**CHART N° V: TREND IN THE NUMBER OF DELIVERIES
AT THE DÉOU CSPS MATERNITY HOSPITAL ALONE BY YEAR**



Source: Déou CSPS Quarterly Reports

NB: Data for the year 2007 cover the first three (3) terms of the year

The project contributed to the funding of the Micro-plans of actions of the three (3) health centres in the Déou Division. The table below summaries AMURT contribution for the implementation of activities provided in the above health centres plans of action over the last three (3) years.

**TABLE N° IV: SUMMARY OF AMURT CONTRIBUTION FOR THE FUNDING OF THE THREE (3) CSPS
MICRO-PLANS BY YEAR**

YEARS	PLANS OF ACTION BUDGET (F CFA)	HEALTH CENTRES			Accrued Total (F CFA)
		Déou	Boulikessi	Gandafabou	
2005	Total Budget	8 819 550	2 655 580	5 524 876	17 000 006
	AMURT contribution	2 160 000	759 000	1 300 000	4 219 000
	Percentages	24.49 %	28.58 %	23.53 %	24.82 %
2006	Total Budget	9 093 350	2 850 580	4 795 000	16 738 930
	AMURT contribution	1 350 000	759 000	900 000	3 009 000
	Percentages	14.85 %	26.63 %	18.77 %	17.98 %
2007	Total Budget	9 176 100	2 828 840	4 735 900	16 740 840
	AMURT	2 700 000	919 000	680 000	4 299 000

	Percentages	29.42 %	32.49 %	14.36 %	25.68 %
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Source : Annal Micro-plans of action of the three (3) CSPS (Déou, Boulikessi & Gandafabou), 2007
Results presented on the table above show that for an accrued total budget of F CFA 50 479 776 for the three years, AMURT-BURKINA contribution accounts for 22.83 % (i.e. F CFA 11 527 000). This is significant as contribution by an NGO.

5.3. Identification of the project achievements by the various actors

Among outstanding changes that occurred in the life of women and girls as direct impact of the project, it is worth mentioning the number of women using health centres, as stated by all people interviewed. This is the case for instance with the Bellah community who, according to people interviewed, were not going to health centres for delivery and other care. But, with village Birth Attendants activities, people became aware of the importance of antenatal and post-natal consultation for smooth motherhood and better health for all populations in general.

The actions of the project also led to a better consideration of women by their husbands, as evidenced by the following statements by women interviewed:

"Our husbands now accept to accompany us to the birth attendant home or to the health centre and this was not the case in the past".

" Our husbands have become more careful than before, as they are now showing a great deal of interest in us when we are pregnant or sick".

"Village Birth Attendants enlightened us about many things on our health and about things related to pregnant women we did not know before. Thanks to them, we now know the importance of seeing a health worker when we are pregnant".

Training sessions and refresher courses organized for community health workers were very positively appreciated by the various actors at all levels. Indeed, according to beneficiaries and project officials, trainings were of good quality since they provided an opportunity for participants to acquire knowledge and skills required for the fulfilment of their mission.

They also favourably appreciated the mastery of the various themes addressed by trainers during these training sessions. However, some themes such as female genitals mutilation need to be sufficiently explained because some village Birth Attendants stated that they had difficulties to address some issues related to these themes. This may be explained partly by the fact that some people strongly believe that female genitals mutilation is an integral part of their culture. Furthermore, the low level of education of women may relatively obstruct an adequate ownership of knowledge.

Some actors expressed concerns on the absence of formal frameworks for consultations between the project coordinating unit, institutional actors and administrative authorities, on the one hand, and between the project and populations, on the other hand. Such frameworks are important in many respects because they are privileged instruments for experience sharing and seeking solutions to problems encountered.

Indeed, MURT-BURKINA officials may brief populations on the project achievements from time to time through these frameworks. To this end, it would be wise to consider the setting up of a formal consultation framework gathering the project main actors for a greater visibility of the project actions.

VI – APPRAISAL OF THE PROJECT IMPORTANCE

According to women interviewed, one of the primary important projects in the Déou Division, if not the primary important project, is obviously AMURT-BURKINA project. Through its action, the project helped to raise awareness about women standing in Déou area.

Thus communities who were not using health centres changed their mind towards health services. Discussions with persons met reveal that people gave up some practices harmful to health. They include:

- ↗ female genitals mutilations,
- ↗ practices related to child delivery (breast massaging, forced-feeding of women who gave birth with hot water, prohibition to eat certain food during pregnancy, etc.),
- ↗ scarification, gum and tattooing of lips,
- ↗ Sharpening of teeth, etc.

Thus, the net drop in these practices that were considered in the past as cultural facts is a sign of some improvement in women condition.

The project intervention strategy and methodology focused on technical and logistic support adapted to rural area context and on an iterative approach for the involvement of field actors. Therefore, the project intervention was implemented by providing great room for the application of knowledge acquired by village Birth Attendants to manage population health needs.

All actors unanimously recognized that the project strategy and methodology enabled to make important achievements by encouraging village Birth Attendants capacity building in social mobilization and IEC techniques. The project approach enabled to achieve a greater anchorage of AMURT-BURKINA in the environment and to acquire detailed knowledge on the intervention area. The "support-training" approach helped to achieve efficient mobilization of actors and develop an operational partnership, which may guarantee a technical and social sustainability for the project achievements.

The involvement and empowerment of beneficiaries in mobilization and awareness raising actions on health are, according to people met, undisputable achievements of the project. AMURT-BURKINA approach enabled, according to people interviewed, to develop and test an operational mechanism for providing "safer motherhood" services. This mechanism is adapted to the context and realities of rural area and can be duplicated and generalized.

The following statements, collected with grass-root organizations, institutional actors and the project officials illustrate the relevance of the intervention.

"The approach is innovative because it builds on the policy of decentralization and formalization of contract-based links. They are topical issues, and aim at ensuring greater involvement and empowerment of grass-root communities".

"The project enabled to build capacities, which makes us feel today that we can manage our health". And "though the project is now ending, we feel that we are able to carry on the activities. Briefly speaking the project has been very useful for us".

The various institutional partners at all levels positively appreciated this strategy during the evaluation process. However, there were some failures in its implementation. Indeed, the lack of communication among actors created some misunderstanding on the vision of the project implementation strategy at the beginning.

In addition, the non-clarification of the role of populations in the memorandum of understanding, and the inadequate monitoring-evaluation of the impact of activities are weaknesses which need to be addressed in the future.

VII – APPRAISAL OF THE PROJECT VIABILITY

The National "safer motherhood" strategy (MMR) launched in 1998 by the Ministry of Health Authorities targeted the following objectives:

- improving the quality and access by target groups² to services within the community and within health centres,
- reducing social and cultural barriers for the use of "safer motherhood" services
- further involving communities and other sectors in the management of "safer motherhood" (MMR) services.

Thus, for health officials interviewed, the project fits perfectly into the national policy on MMR, which consists in reducing significantly maternal and neonatal morbidity and mortality rates in Burkina Faso.

"The viability of the project refers to the basic question on how the project met the needs and concerns affecting AMURT-BURKINA partner communities during the project implementation period"

To answer this question, it is worth mentioning that, in addition the above mentioned achievements, the Support-counselling services and the capacity building approach adopted by AMURT-BURKINA enabled actors to select and train village Birth Attendants in almost all the villages in the Déou Division and beyond.

- ↪ The relevance of this intervention lies in the fact that AMURT-BURKINA had to provide its support for the implementation of this initiative provided in the Gorom-Gorom Health District Plans of action, upon request by the health authorities of the Ministry of Health.
- ↪ The consistence of the project lies in the fact that it fits perfectly into the grass-root community empowerment policy for a greater involvement of populations in health services management. So, through this project, AMURT-BURKINA helped to develop and strengthen community capacities through community health workers who thereby became informed and equipped interlocutors in the implementation of actions for sustainable human development durable.

"For the question on whether there is an opportunity for village birth attendants to be integrated and monitored by the Ministry of Health at the local level"

² Pregnant women, parturient women, women who gave birth and new-borns.

The answer is yes. Actually, activities achieved by health workers in villages are taken into account and effectively integrated in the calculation of performance indicators by the Ministry of Health at the local level, notwithstanding national guidelines that almost ignore them, and even remove them. This shows the importance of the contribution of these workers who, to date, serve as "door" and "first contact" for local populations with health system.

Prospects related to the project viability and sustainability are also materialized by statements made by some persons met who believe that, at the end of project now ending, they are able to develop project and seek funding with other donors through to AMURT-BURKINA.

Though they believe that achievement must be strengthened, they say that they feel confident for future actions. The project provided populations with technically competent resources capable of efficiently meeting their communities' health needs.

VIII – APPRAISAL OF THE PROJECT EFFECTIVENESS

Regarding the project effectiveness, the question is whether the project made an efficient use of the funds for the implementation of the outputs? How the project implementation was planned with the various actors during the implementation process to guarantee a sound utilisation of technical and management resources of AMURT-BURKINA? In other words, what is the effectiveness of the major outputs implementation?

It should be recalled that AMURT-BURKINA in the approach adopted for the implementation of this project, acted as "support and counselling" provider. Therefore, a memorandum of cooperation was signed with the authorities in charge of health at the local level. This agreement defines the obligations of the two parties (health district and AMURT-BURKINA).

By signing this memorandum of expectation and partnership with the institutional actors, AMURT-BURKINA wanted to strengthen the accountability of the various actors intervening in the actions aiming at improving the populations' health status.

The definition of the responsibilities of each actor in these memorandums enabled to achieve a rational and optimal use of material resources for the implementation of the project activities. Indeed, with relatively modest means, AMURT-BURKINA and local actors have shown that it is possible to achieve considerable outputs with limited means, if each actor plays his role.

The analysis conducted on the financial balance sheet of the projected budget, estimated at *forty-seven million, nine hundred and thirty-three thousand (F CFA 47,933,000)* to cover the financing of the project over the three (3) years, reveals that a total of *forty-four million, eight hundred and eighteen thousand, seven hundred and nine ((F CFA 44,818,709)* were actually used for the implementation of the project activities (i.e. a rate of achievement of **93.50 %**) (See financial balance sheet table).

In the light of these outputs, and considering the achievements of the project, we can affirm that the objectives, the strategies and working methods within the project were profitable in every respect.

Besides, when we refer to the conclusions of the two (2) audits conducted during the project implementation (these audits did not reveal any abnormality regarding the project financial management), we can conclude that the project organisation and management were effective if not efficient.

As for the question on whether AMURT-BURKINA has the appropriate technical and administrative capacities to effectively establish this project

The interviews revealed that AMURT-BURKINA has only five (5) persons directly involved in the project management (table N° IV).

TABLE N° V: SUMMARY OF AMURT-BURKINA STAFF

Function	Number	Observations
Director	01	
National Coordinator (NC) in Ouagadougou	01	
Local Coordinator (LC) in Déou	01	
Driver in Ouagadougou	01	
Local driver in Déou	01	
Total	05	

In the light of the outputs on the above table, the technical and administrative capacities of AMURT-BURKINA are relatively limited. According to the actors, this situation may be the cause for the weakness noted in the documentation and capitalisation on the project achievements at all levels, notably in terms of reporting and dissemination of outputs. Even though the achievements of the projects over the three (3) years are relatively satisfactory, the facts remain that the project could have reached a better achievement if the appropriate competences (human and financial resources) were available. Therefore, it is vital to strengthen the technical and administrative skills in view to effectively establishing the project.

On the question regarding the way the administrative relations between AMURT-BURKINA, AMURT NORWAY and FOKUS were organised

According to the officials, these relations are excellent and did not experience any major hindrance harmful to or likely to compromise the project implementation.

Indeed, AMURT-NORWAY acting as an intermediary between FOKUS and AMURT-BURKINA was involved in the project implementation. Still better, project supervision field visits were carried out by AMURT-NORWAY officials on two (2) occasions³. Telephone calls are also made on a permanent basis (two (2) calls per month) between AMURT-NORWAY and AMURT-BURKINA.

However, it should be underscored that the non-consideration of some activities in the financial resources allocated by donors and the delays in the transfer of funds, impacted the implementation or even the non-implementation of some activities. This was the case for example with the building of eleven (11) “maternity huts” for the most dynamic birth attendants.

³The first visit occurred in February 2006 and the second in October 2007

Gender equality and gender balance are prerequisite conditions for sustainable human development. AMURT-BURKINA through the implementation of the support project for « safer motherhood » adopted this precept in its strategy of intervention by placing “gender” dimension at the heart of its concerns. The choice of the project intervention area is, in itself, a living proof. Thus, thirty-seven (37) community health workers out of forty-nine (49) persons involved in the project are women.

TABLE N° VI: FINANCIAL BALANCE SHEET OF THE « SAFER MOTHERHOOD » PROJECT, AS OF NOVEMBER 15TH,

N° COMPTES	INTITULE DES COMPTE	PREVISIONS (2005)	REALISATIONS		PREVISIONS (2006)	REALISATIONS		PREVISIONS (2007)	REALISATIONS	
			Montants	%		Montants	%		Montants	%
	Food assistance									
	Assistance mil - 1 sac/AV	350 000	207 000	59,14	696 000	475 000	68,25	680 000	494 000	72,65
	Carburant & Entretien de véhicules									
	Carburant	960 000	1 805 407	188,06	960 000	1 500 536	156,31	2 640 000	715 484	27,10
	Entretien Pick up & Patrol & DT 125	1 260 000	2 258 499	179,25	1 260 000	2 294 817	182,13	1 920 000	1 509 570	78,62
				0,00			0,00			0,00
	Administration									
	Coordinator Deou Salary	540 000	447 780	82,92	540 000	511 984	94,81	720 000	501 100	69,60
	Coordinator Ouaga salary	1 200 000	808 655	67,39	1 200 000	1 058 540	88,21	1 200 000	803 655	66,97
	Driver Ouaga Salary		422 705	422 705,00	540 000	581 265	107,64	540 000	422 705	78,28
	Internet	240 000	10 800	4,50	240 000	34 000	14,17	240 000	34 125	14,22
	C.N.S.S	228 000	116 100	50,92	228 000	367 650	161,25	246 000	290 250	117,99
	Telephone	240 000	240 000	100,00	240 000	257 750	107,40	600 000	291 475	48,58
	Audit			0,00	200 000	200 000	100,00		390 000	390 000,00
	SMI Mobile									
	SMI Diverse	2 280 000	1 573 553	69,02	960 000		0,00			0,00
	Agents CSPS			0,00		80 000	80 000,00		80 000	80 000,00
	SMI Ambulance driver salary			0,00		470 380	470 380,00	540 000	450 000	83,33
	CNSS			0,00			0,00	54 000		0,00
	SMI Ambulance repair		3 646 504	3 646 504,00		957 852	957 852,00	600 000	975 939	162,66
	SMI carburant			0,00	720 000	463 330	64,35	700 000	259 600	37,09
	SMI Materials			0,00	600 000	209 730	34,96	150 000	176 000	117,33
										0,00
	Supervision AV									0,00
	Agents CSPS	630 000	507 500	80,56	750 000	507 500	67,67	750 000	472 500	63,00
	Carburant pour DT125	600 000	425 000	70,83	600 000	525 525	87,59	960 000	355 100	36,99
				0,00						
	Formation recyclage for AV									
	Recyclage diverse	425 000	722 526	170,01			0,00			0,00
	AV's Per Diem			0,00	725 000	725 000	100,00	1 600 000	1 575 000	98,44
	CSPS agent formateurs			0,00	140 000	180 000	128,57	360 000	360 000	100,00
	Interpretes			0,00	15 000	30 000	200,00	60 000	85 500	142,50
	Materials			0,00	20 000	31 700	158,50	130 000	332 335	255,64
	DT carburant pour informer			0,00		25 000	25 000,00		25 500	25 500,00
	Superviseur de Gorom			0,00		30 000	30 000,00		200 000	200 000,00
	Formatrice de Ouaga Mme. OUBDA								200 000	200 000,00
	Formation Basic for AV									
	Formation de base des AV	1 990 000	338 000	16,98			0,00			0,00
	AV's Per Diem			0,00	300 000	300 000	100,00	200 000	200 000	100,00
	Formateurs			0,00	240 000	180 000	75,00	180 000	180 000	100,00
	Interpretes			0,00	30 000	45 000	150,00	30 000	36 000	120,00
	Materials			0,00	740 000	362 888	49,04	570 000	434 012	76,14
	DT carburant pour informer					15 000	15 000,00			0,00
	Formatrice de Ouaga Mme. BERRE								200 000	200 000,00
	Alphabetization									
	Alphabetization				650 000	574 525	88,39	446 000		
	To be paid by AMURT-BURKINA									0,00
	Director Ouaga	1 800 000	1 626 089	90,34	1 800 000	1 626 089	90,34	1 800 000	271 680	15,09
	Rent	960 000	960 000	100,00	960 000	960 000	100,00	960 000	800 000	83,33
	Totaux	13 703 000	16 116 118	117,61	15 354 000	15 581 061	101,48	18 876 000	13 121 530	69,51
	Total A1 (2005)	13 703 000	16 116 118	117,61						
	Total A2 (2006)	15 354 000	15 581 061	101,48						
	Total A3 (2007)	18 876 000	13 121 530	69,51						
	BUDGET GLOBAL (2005 +2006+2007)	47 933 000	44 818 709	93,50						

07

VIV – APPRAISAL OF THE PROJECT PARTNERSHIP

The various partners' involvement was the key word in the project implementation strategy. Thus, the responsibilities of the parties were clearly described in the document entitled "Cooperation Agreement" of the project. However, some gaps actually appeared in the process of involvement and participation of the stakeholders. While the involvement of institutional partners was relatively effective at various levels, it was not the case with the local council partners and education actors. Indeed, the latter almost did not take part in the activities.

The non-definition of anchorage point of these partners with the project was put forward to explain this situation. Also, the non-availability of actors at the level of the Gorom Gorom Health District, did not allow for an effective participation and monitoring of village birth attendants' activities on the ground. While the support provided by CSPA health workers in the activities was positively approved by the operational actors, the capitalisation of their work on the ground was a failure.

In terms of transparency and mutual trust, how was the cooperation between AMURT-BURKINA and AMURT NORWAY?

The cooperation between AMURT-BURKINA and AMURT NORWAY within the framework of the « safer motherhood » project implementation was done in transparency and mutual trust. AMURT NORWAY was the spokesperson of AMURT-BURKINA with FOKUS, which is the final donor in the financing of the project. The fact of requesting the services of an external auditor in order to audit the accounts of the project on two (2) occasions (these audits did not reveal any irregularity in the management of the funds earmarked for the project implementation), is proof of the transparency that prevailed in the management of the intervention.

Besides, the submission of periodic reports by AMURT-BURKINA to AMURT NORWAY (for FOKUS), and the supervisions of activities on the ground, made it possible for FOKUS to be fully briefed on the progress of the project implementation. In the same vein, AMURT-BURKINA made two (2) trips⁴ in Norway to present its report to AMURT-NORWAY. This contributed to create a climate of confidence between AMURT-NORWAY and AMURT-BURKINA.

All in all, the various actors recognize that they have participated in the project implementation at various levels. This explains the adoption of the participatory approach as intervention strategy, enabling each stakeholder to feel concerned, to have opportunity to express his concerns and propose remedial solutions.

The first visit occurred in June 2005 and the second on in July 2007.

IX – APPRAISAL OF THE TECHNICAL AND SOCIAL SUSTAINABILITY OF THE PROJECT

Technical sustainability refers to the capacity of the stakeholders to remain performing and effective in the provision of services to the community, after the completion of the project. Thus, the appraisal of technical sustainability consists in identifying all elements in order to affirm that all stakeholders who benefited from capacity building are in a position to provide quality services in the area of “safer motherhood” and social mobilisation in the health domain. For this project, subject of this evaluation, the favourable elements that guarantee the project technical sustainability are structured around the following points:

- ✕ Training sessions organised for the community, competent persons likely to ensure the continuation of actions. Therefore, these persons constitute human resources trained in proximity maternal and infant health for the populations;
- ✕ Involvement of health institutional actors and populations is an asset that guarantees viability and sustainability of activities. Even though some gaps emerged in the participation of some actors in the project implementation, they were nonetheless already educated for birth attendants’ future activities.
- ✕ Control of some blights (female genitals mutilation, HIV/AIDS, hygiene and sanitation, etc) by birth attendants within the community, made these women more credible in the eyes of these populations. Therefore, these women have become reference persons for the populations in the area of health.

Regarding social sustainability, the objective is to comprehend the impacts of the projects in terms of appropriation of the project achievements by birth attendants on the one hand, and by the communities who benefited from the intervention on the other hand.

The activities of birth attendants were planned endogenously and adapted to the realities of the quite complex context of the rural environment. At the end of the project, elements favourable to the intervention social sustainability are:

- Better knowledge of rural environment complexity,
- Better knowledge of the issues related to the involvement of populations in the management of health.
- Support of communities to the activities of birth attendants
- Dynamism and motivation of birth attendants for future actions
- Availability of competent human resources among birth attendants
- Partnership between birth attendants and institutional actors
- Opportunities for duplicating the approach and the actions.

In addition to these achievements, which guarantees social sustainability, behaviour changes of primary beneficiaries were reported to us by some birth attendants. These notably include the adoption of pro-health behaviours observed in some communities following the actions of birth attendants. Besides, the support and interest expressed by the populations in the continuation of the project are conclusive evidences favourable for securing achievements sustainability.

X - DIFFICULTIES ENCOUNTERED BY VILLAGE BIRTH ATTENDANTS

10.1. NEEDS EXPRESSED BY VILLAGE BIRTH ATTENDANTS

The evaluation made it possible to highlight the difficulties encountered by birth attendants in conducting their activities, and also with the populations. Indeed the poor level of education of birth attendants, the poverty of populations, the inadequate funding of activities undertaken by birth attendants, the insufficient number of drinkable water points, the poor conditions of hygiene and sanitation, the lack of road and the poor state of existing roads, undermine the sustainability of actions. More specifically, the discussions with the birth attendants enable to make an inventory of their difficulties structured around the following aspects:

- Lack of maternity houses
- Lack of transportation means to deliver services
- Poor incentives and support
- Difficulties to mobilise populations around health activities
- Persistence of some practices harmful⁵ to health within the community
- Long distances from one concession to another and from one village to another.
- Lack of technical material, drugs and medical consumables.
- Inadequate monitoring – evaluation conducted by the project coordination on birth attendants' activities.
- etc.

10.2. NEEDS EXPRESSED BY POPULATIONS

During the Focus Groups discussions, populations expressed some concerns which may be considered as guidelines for future activities of AMURT-BURKINA:

- ☒ poor collaboration and partnership on the ground among birth attendants
- ☒ inadequate staff in the coordinating unit to provide support – counselling services and to monitor / evaluate the activities conducted by birth attendants
- ☒ poor consideration by the project of some concerns of the moment raised by the populations
- ☒ mobility of resource persons and institutional actors
- ☒ poor involvement of local council authorities and opinions leaders
- ☒ lack of registration and issuance of birth certificates for children
- ☒ limitation of activities package provided by birth attendants
- ☒ lack of pharmaceutical products
- ☒ poor health coverage
- ☒ the project actions may be taken over by politicians and can therefore loose its credibility among the populations.

⁵ Female genitals mutilation, tattooing of lips, sharpening of teeth, early marriage, etc.

XI – RECOMMENDATIONS

Besides the suggestions contained in the various sections of the document, these recommendations are related to the project as a whole and to the various actors of the intervention.

TO AMURT NORWAY

1. Increase in the future, financial resources allocation for the project activities by taking into account, the concerns and needs expressed by beneficiary grass-root populations.
2. Accelerate in a timely manner, funds disbursement and transfer procedures for AMURT-BURKINA, to allow for a greater promptness in the implementation of activities on the ground.

TO THE PROJECT COORDINATING UNIT (AMURT)

1. Take measures for a capitalisation and broad dissemination of the project achievements for the actors involved in the project implementation.
2. Build the coordinating unit human capacities notably through the recruitment of a specialist in monitoring / evaluation.
3. Strengthen support for birth attendants by putting in place a mechanism of partnership between birth attendants and health institutional actors
4. Establish consultation and exchange frameworks among birth attendants on one hand, and between institutional actors, the coordinating unit and birth attendants.
5. Improve the literacy of birth attendants and populations.
6. Acquire transportation means (bicycles or cars) for birth attendants.
7. Build « maternity houses » for the most dynamic birth attendants, taking into account the size of the population covered.
8. Increase the allocation of technical materials and drugs for birth attendants.
9. Diversify the sources of financing and support for the activities of birth attendants.
10. Involve other actors (local council authorities, Education Department, Agriculture Department...) in the support for the activities of birth attendants.
11. Increase the purchasing power of birth attendants through the promotion of income generating activities.
12. Advocacy with local council and district authorities to set up a mechanism for registration and issuance of birth certificates for delivery carried out by birth attendants, in order to enhance the value of their activities.

TO THE POPULATIONS IN THE PROJECT INTERVENTION AREA

1. Support community-based activities of birth attendants,
2. Responsibly use the project competences and achievements within the framework of other projects implementation,
3. Endeavour to diversify financing resources for community development activities,
4. Work towards a better participation and involvement of populations in the activities of birth attendants,
5. Adopt behaviours likely to contribute to the abandonment of practices harmful to health.

TO INSTITUTIONAL ACTORS

1. Advocate for the maintenance and the support of birth attendants' activities to respond to the specificity of the context of the project intervention area (poor health coverage)
2. Strengthen IEC activities towards men to obtain their support and full participation in the activities of birth attendants and the project.
3. Work towards the creation of consultation frameworks of the various actors of the project.
4. Take into account, the experience of the project to ensure ownership the approach in the implementation of health actions at the community level.
5. Improve the "formative" and "support – counselling" monitoring – supervision of birth attendants
6. Set up a mechanism to capitalise the activities of birth attendants.
7. Train birth attendants in other health themes (family planning, malaria, diarrheic diseases, etc)
8. Further integrate the concerns of the community in birth attendants activity planning and notably in AMURT support.
9. Design and implement activities on environment hygiene and sanitation.
10. Improve the content of the training of birth attendants and develop evaluation tools on the impact of the training conducted.

CONCLUSIONS

The need to design and implement the "safer motherhood" project started with a contextual reality. Indeed, in a report by "SAVE THE CHILDREN", "STATE OF THE WORLD'S MOTHERS" (2004), Burkina Faso was ranked 104th on a list of 105 countries, in where comparison is made on the situation of the needs of mothers and children.

The project intervention area is one of the most landlocked and underdeveloped regions of Burkina Faso. There is no road, no electricity and no telephone. The health infrastructure coverage in this area remains one of the poorest in the country. Indeed the inaccessibility and non-availability of health services in this part of the country lead populations to walk 40 km or to travel on cart for their health problems. The analysis made in this evaluation reveals that the involvement of actors at the level of the Gorom Gorom health district in the implementation of the project appears as an unfinished work. The architecture is rational but the elements composing it show some technical weaknesses or gaps. At some time, it looks like a house of cards, where things are started over and over again due to actor's mobility and change.

After three (3) years of activities in partnership with the health and grassroots community actors, the initial dream has come true. The quality of outcomes achieved is a real source of satisfaction. Indeed, after the implementation, the situation is more than reassuring. AMURT-BURKINA is accepted by the communities. Operational methodologies and tools are available today to serve as dynamic references in the implementation by AMURT-BURKINA of future actions in the field of health and/or any other initiative that takes over. In the light of the various analyses, AMURT-BURKINA merit is that it had faith and audacity.

The project « support in strengthening the activities of safer motherhood » and operational capacities of health centres of Déou, Boulikessi and Gandafabou, as well as the Gorom Gorom District, after three years of experience by the sides of the courageous populations of rural areas is now ending. As support experience, (technical, logistic and financial), the outcomes achieved are encouraging.

But how about the numerous expectations aroused at the level of these populations?

The change of behaviour is a long term work and actors have understood this through the support provided by AMURT-BURKINA. It is undoubtedly with this conviction that many of us affirmed during the final appraisal of the project that the duration of the intervention is too short. These implicit but legitimate interrogations raise the eternal issue of the mechanisms to be put in place in order to sustain or secure an actual ownership of the project achievements by beneficiary populations. Due to its specificity, the experience of AMURT-

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SCHEDULES

SCHEDULE N° I

LIST OF BIRTH ATTENDANT BY HEALTH ARE

N°	Villages	Full Name	Ethnic Group	Year
FORMATION DE DEOU (CSPS)				
01	Tounteri pouli 1	ALGADI Alwitani	Bellah	2006
02	Gountoure gné gné	SAFI W. Moussa	Bellah	2003
03	Tounteri pouli 2	FATIMATA Saïdou	Bellah	2007
04	Tioffa	ZORE Safiatou	Mossi	2006
05	Wende wolde	CISSE Awa	Mossi	2002
06	Bamgelday	OUEDRAOGO Fati	Mossi	2002
07	Ayagorou I	OUEDRAOGO Kama	Mossi	2004
08	Gorolbay	ZORE Habibou	Mossi	2002
09	Ayagorou II	SAWADOGO Amina	Mossi	2005
10	Loukodou	HASSANE Fatimata	Peulh	2006
11	Njahoye	HOURETA Pate	Peulh	2002
12	Petel	SALAMATA Djiboutou	Peulh	2003
13	Lilla	AMINATA Salou	Peulh	2004
14	Gouba I	HAIBAKE Issji	Peulh	2005
15	Gouba II	WATTARGOUN Sic	Peulh	2005
16	Marel	AMINATE Woroune	Peulh	2007
17	Countoure kiri	TANABOGORT Chefo	Peulh	2007
18	Simbangou	RAMATA Djadjo	Peulh	2005
TRAINING AT GANDAFABOU (CSPS)				
01	Fadar Fadar Nord	AWA TIRIKIRAM	Beulah	2006
02	Gargassa	HADJIATOU Hamzu	Beulah	2006
03	Ferrio	HADJIATOU Marha	Beulah	2006
04	Gandafabou	SALAMATA Abdoulaye	Beulah	2006
05	Bibissi	ABUCAR Fatimata	Beulah	2006
06	Boula Est	RABI W Siel Mohamed	Beulah	2004
07	Rafnoman	Wtashni W Lithir	Beulah	2004
08	Fadar Fadar Sud	ADOURUSITA W Abdoulaye	Beulah	2004
09	Coulorou	KAJTOUTOU Saïdou	Peulh	2007
10	Forage Christine	KAJATOU Alhadji	Peulh	2007
11	Suba	FATIMATA Ifram	Beulah	2007
TRAINING AT BOULIKESSI (CSPS)				
01	Gountawala II	ADAMU Hamadou	Peulh	2006
02	Kitagou	FATIMATA Nassirou	Peulh	2006
03	Bamguel	AMINATA Hamadou	Peulh	2006
04	Boulikessi Soum	KEREGUE Fanta	Peulh	2005
05	Ajarafara	MARIAMI Paedari	Peulh	2005
06	Gountawala I	ASSETOU Goro	Peulh	2005
07	Dossenou	ASSIATOU Nouhoun	Peulh	2007
08	Tailare	ASIATOU Boureima	Peulh	2007

SCHEDULE N° II

LIST OF RESOURCE PERSONS MET

N°	Surnames	Forenames	Title/Function	Villages/Place
01	AGUENAT	Ag Anafou	Village Chief	Fadar fadar Sud
02	AG ZEBAILE	Litim	Village Chief	Boula Est
03	AG ZAI	Ousouba	Village Chief	Fadar Fadar Nord
04	AMADOU	Assana	Village Chief	Loukoudou
05	SORE	Issouf	Village Chief	Déou
06	SONDE	Liadié	Director of school	Kitagou
07	KOUDA	Nobila Sidiki	Director of school	Countoure kiri
08	TRAORE	Alphonse	Director of school	Touteri Poli I
09	YAMEOGO	François de Salle	Director of school	Déou
10	GNANOU	Ousmane	Director of school	Rafnaman
11	BADINI	Jean Didier	Director of school	Wende wolde
12	BAYAMBA	Moussa	Director of school	Fadar Fadar Sud
13	SAWADOGO	Samuel	Pastor	Déou
14	NACANABO	Irméan Dieudonné	Catechist	Déou
15	BOUREIMA	Fatimata	Chairperson of the Women	Déou
16	SAWADOGO	Fatimata	Translator at the CSPS	Déou
17	MAIGA	Tassere	Chairman of COGES	Déou
18	GNAMPA	Mamadou	Mayor	Déou
19	AG ASSALEK	Drissa	1 st Deputy Mayor	Déou
20	SAWADOGO	Moussa	Regional town Counsellor (Mayor Office)	Déou
21	ZAMTAKO	Issouf	Imam	Déou

SCHEDULE N° III

LIST OF HEALTH WORKERS MET DURING THE EVALUATION PROCESS

N°	Surnames	Forenames	Title/Function	Heath Centre
01	TIENDREBEOGO	Claude Evariste	IDE /ICP	CSPS, Déou
02	KOALA	Valentin	IDE/Deputy ICP	CSPS, Déou
03	OUROKUI	Mariam	AA	CSPS, Déou
04	CISSE	Aissata	Essential Drug Unit Manager	CSPS, Déou
05	DICKO	Ramatou	Ward	CSPS, Déou
06	SAWADOGO	Yabré	IDE / ICP	CSPS, Gandafabou
07	DICKO	Hamidou	AI	CSPS, Gandafabou
08	NIKIEMA	Alassane	IDE / ICP	CSPS, Boulikessi
09	KOAMA	Parfait	IDE / CISSE	Gorom District
10	SOGLI	Mahamadi	Heath Assistant, CISSE	DRS

SCHEDULE N° IV

LIST OF AMURT STAFF MET DURING THE EVALUATION PROCESS

N°	Surnames	Forenames	Title/Function
01	Lisa	VIKANE	AMURT-NORWAY
02	Bjorsensen	TOR Egil	AMURT-BURKINA Director
03	Pierre Louis	RICARDO	AMURT-OUAGA Coordinator
04	SAWADOGO	Mohamadi dit N° 1	AMURT-DEOU Coordinator
05	LONFO	Boureima	AMURT-OUAGA Driver
06	SORE	Boureima	AMURT-DEOU (CSPS Déou)Driver

SCHEDULE N° V

LIST OF TECHNICAL EQUIPMENT AND CROP ACQUIRED BY THE PROJECT

N°	Designation	Quantity	Year of acquisition	Status	
				Good	Bad
01	Television set-Sharp	01	2005	x	
02	Video Recorder- Sharp	01	2005		x
03	Generator (Yamaha)	01	2005	x	
04	DVD Reader- Sony	01	2007	x	
05	Generator (Yamaha)	01	2007	x	
06	Tent	01	2005	x	
07	Examination Bed	01	2005	x	
08	Tensiometer	01	2005		x
09	Dummy with placenta, bone, pelvis	01	2007	x	
10	Dummy for intensive care	01	2007	x	
11	Mould wells drilling	01	1990	x	
12	Millet & Beans	4.5 tonnes	2005	x	

SCHEDULE N° VI

LIST OF ROLLING LOGISTICS ACQUIRED BY THE PROJECT

N°	Designation	Quantity	Year of acquisition	Status	
				Good	Bad
01	Motorbike- YAMAHA DT 125	01	2003	x	
02	Car- NISSAN Pick Up	01	2004		x
03	Car - NISSAN PATROL	01	2005	x	
04	Motorbike- BEST ACCESS ALLO	01	2005	x	
05	Ambulance	01	2005		x



**A VILLAGE BIRTH ATTENDANT FROM BOULIKESSI VILLAGE- SOUM - WITH HER
« CHILD DELIVERY KIT »**



THE TEAM OF EVALUATORS, TRANSLATORS, GUIDES AND DRIVERS