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End of program evaluation report:

Population Services International (PSI) Burundi

Expanding Family Planning and Integrated Sexual and Reproductive Health Services in Burundi, Phase II

23 November 2020

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Table of contents

1. Executive summary 1

2. Program description 11

3. Purpose and scope of the evaluation 14

4. Evaluation design and data collection methods 15

5. Performance against the results framework 16

6. Relevance 26

7. Impact 28

8. Effectiveness 39

9. Efficiency 45

10. Sustainability 50

11. Gender considerations 53

12. SWOT analysis 56

14. Budget analysis 58

15. Lessons learned 61

16. Recommendations 63

Abbreviations

ACIP	Youth Peer Educator
AMT	Tunza Mobiliser
ASRH	Adolescent Sexual and Reproductive Health
CSW	Commercial Sex Worker
CYP	Couple Years of Protection
DHS	Demographic and Health Survey
DMPA-SC	Sub-Cutaneous Depo-Provera
DALY	Disability Adjusted Life Year
DFID	UK Department for International Development
DHS	Demographic and Health Survey
EKN	Embassy of the Kingdom of the Netherlands
EC	Emergency Contraception
EQ	Evaluation Questions
FGD	Focus Group Discussion
FP	Family Planning
GBV	Gender Based Violence
GoB	Government of Burundi
IDP	Internally Displaced Person
KII	Key Informant Interview
M&E	Monitoring and Evaluation
OC	Oral Contraceptive
ODK	Open Data Kit
OECD-DAC	Organization for Economic Co-operation and Development's Development Assistance Committee
PMC	Population Media Center
PSI	Population Services International
SBCC	Social Behavior Change Communication
SMART	Specific, Measurable, Achievable, Realistic, Timebound
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SW	Sex Worker
ToC	Theory of Change
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VfM	Value for Money
WRA	Women of Reproductive Age
YFS	Youth Friendly Service

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1. Executive summary

The purpose of the evaluation is to carry out a comprehensive assessment of the Expanding Family Planning (FP) and Integrated Sexual and Reproductive Health (SRH) Services in Burundi, Phase II program, describing its level of success in achieving its objectives, program efficiency and effectiveness, the sustainability of its interventions, the impact attributable to the program, identifying key weaknesses and assessing its contribution to national SRH priorities. To this end, the evaluation was conducted between May and the end of November 2020, and primary data was collected across Burundi in October and early November 2020.

Phase two of the program has run from 2017 to 2020 with support worth $7.78m from the Embassy of the Kingdom of the Netherlands (EKN) and has been managed by Population Services International (PSI) Burundi. The program's objective is to increase Burundi's contraceptive prevalence rate (CPR) through expanding the delivery of high quality SRH products and services to women of reproductive age (WRA) and youth aged 15 – 24.

The program was intended to increase Burundi's CPR through expanding the deliverable of high quality SRH products and services to WRA and youth in particular. The program was also intended to address the limited availability of high-quality and affordable FP services and products in Burundi, especially through the private sector, and improve knowledge, attitudes and practices (KAP) regarding SRH and reduce negative socio-cultural barriers.

The program is responsible for delivering four key results and three outputs,which are relevant to the SRH needs and gaps in Burundi.

1.1. Program performance against the Results Framework

Overall, the program performance has been impressive – especially when factors such as the government closures of international non-governmental organisations (INGOs) in 2018 and the COVID-19 pandemic, which has extended throughout most of 2020 –are taken into account. Almost two thirds of the indicators have either achieved or exceeded the targets.

- 27 indicators were achieved or surpassed
- Four indicartors were almost met
- 11 indicators were not met
- Four indicators could not be met due to data not being available at the time of the evaluation

Most of the indicators that were not reached were tied to activities that have not progressed much

over the life of the program – and could have either been revised or removed from the Results Framework at key stages of the program, and in agreement between EKN and PSI.[1]

Table 1: Summary of the program's performance against the indicators Results Framework

Level	Description	Performance summary
Goal	Burundi's CPR increased through expanding the delivery of high- quality SRH products and services to WRA and youth in particular	G1, G2, G3, G4
Result Area 1	Young people are better informed and are thus able to make healthier choices regarding their sexuality.	R1, R2, R3, R4, R5
Result Area 2	A growing number of people have access to anti-retroviral drugs, contraceptives and other commodities required for good SRH	R8
Result Area 3	Public and private clinics provide better SRH services, which more and more people are using	R10, R11
Result Area 4	Greater respect for the sexual and reproductive rights of people to whom these rights are denied	R12
Output 1.1	Increased knowledge around SRHR	1.1.1, 1.1.2, 1.1.3, 1.1.4, 1.1.5, 1.1.6, 1.1.7, 1.1.8, 1.1.9
Output 1.2	Increased motivation to access SRHR services	1.2.1, 1.2.2, 1.2.3
Output 1.3	Increased agency/self-efficacy for integrated SRHR services	1.3.1, 1.3.2, 1.3.3
Output 2.1	Increased affordability of wide range of FP	2.1.1
Output 3.2	Improved service delivery	3.1.1, 3.1.2, 3.1.3, 3.1.4
Output 3.2	Increased availability of integrated SRHR services	3.2.1, 3.2.2, 3.2.3, 3.2.4, 3.2.5, 3.2.6, 3.2.7, 3.2.8
Output 4.1	Increased community social support for SRHR services	4.1.1, 4.1.2, 4.1.3, 4.1.4

Key: **Green** indicates that the target was achieved or surpassed; **amber** signifies that the target was almost met; **red** indicates that the target was not met and grey means that no data is available to calculate performance. The number of cells in a row is equal to the number of indicators for the

[1] Although some indicators could have been modified and/or removed from the Results Framework, this evaluation finds that there were no discussions between PSI and EKN regarding any modifications.

goal, result area or output. The codes in the cells refer to the indicators (i.e. Goal indicator 1 is G1).

1.2 Impact

The program contributed to Burundi's CPR and other impact-level indicators, including the reduction in teenage pregnancies, HIV prevalence and total fertility rate (TFR). This has been achieved in several ways, most notably through the increase in couple years of protection (CYPs) delivered by the progam: the program accounts for almost 10% of Burundi's total CYPs. Over the life of the program there has been a 46.7% increase of new clients that received a FP service. Male condoms and injectable contraceptives have accounted for the majority of the program's CYPs.

The program has contributed to an increase in the access and use of high-quality services for young people. The program has enabled 57 Tunza clinics to provide youth friendly services (YFS), and 20 of them have designated youth spaces that offer HIV counseling and testing. As a result, 89% of youth respondents in Tunza locations report having high levels of contraceptive availability.

The program has contributed significantly to SRH KAP among young people. Approximately 43,000 young Burundians received SRH messages and participated in peer counselling. One out of every two young people interviewed had heard of PSI's *Tube Class* radio program, and 93% of those said it had given them sufficient understanding of RH issues. Forty-five percent of young people said that there were very satisfied with the quality of the show and an additional 44% said they were satisfied.

At the beginning of phase two, only 75% of young people within the PSI area of operation agreed that modern FP methods are safe to use. This increased to 89% by the time of this report. Similarly, the percentage of young people who know that condoms are effective in preventing HIV/AIDS and unintended pregnancies has increased from 57% at the start of the program to 92%. This can be attributed to the availability of condoms in the Tunza clinics and at more than 1,500 points-of-sale around the country, as well as the program's social behavior change communication (SBCC) and interpersonal communication (IPC) interventions.

The program has made some useful contributions to the private health sector in Burundi's urban and peri-urban areas. *Prudence Class* condoms are now sold in more almost 10,000 venues throughout the country – a significant increase from 4,000 in 2016. The program also helped launch and strengthen the clinic owners' *Association Nationale de Franchise Sociale* (National Association of Social Franchises, ANFS) through various forms of technical and structural capacity building. PSI helped the ANFS to develop an annual action plan and to organize regular meetings of its management committee. As a result, the ANFS is positioning itself as a key player in improving the quality of private clinics and becoming a credible voice for and within the private sector.

Young people face a multitude of challenges and barriers accessing SRH services, including those that are determined by political, social, cultural and religious contexts. PSI has worked closely with the Ministry of Health (MoH) to advocate for changes to national health policies and regulations of the market that prevent oral contraceptives (OCs) and emergency contraceptive (EC) being sold through pharmacies – often the first choice for young people to anonymously obtain FP. The program also carried out some activities that were intended to address social and religious barriers and increase community support. For example, between 2017 and 2018, some parents and religious leaders attended SRHR workshops and participated in advocacy activities. The impact from these activities is

not known, however. The program's Youth Advisory Board has been set up recently, and needs to be scaled so that it delivers results. It is important that interventions that support the wider environment for SRH rights and service delivery for Burundi's youth are strengthened in future phases.

1.3 Relevance

Overall, the design and delivery of the program have been relevant to addressing the main FP and SRH problems that WRA and young people face in Burundi. Program interventions have helped to address Burundi's high maternal mortality rate, high fertility rate, unmet contraceptive need especially for young women of reproductive age, unwanted pregnancies that often lead to abortion complications.[2]

The geographic zones and areas of activity in phase two were appropriate – and they are broadly in line with the contents of the phase two proposal. The clinical interventions to support private sector health care are located in urban and peri-urban locations where there is a larger client base, especially those that can typically afford to pay something for their services and products through private sector outlets. Many interventions, particularly the social marketing of condoms and the mass media activities, have had an impact throughout Burundi.

1.4 Effectiveness

The program effectively met most of the needs of the target group – WRA, men and young women. Tunza staff and clinic owners interviewed to inform this evaluation said that clients came to Tunza facilities because of confidentiality, the warm reception the received, the availability of qualified staff and short waiting times. Furthermore, all social franchises have achieved the minimum standards for offering youth-friendly services, and more than 50,000 youth received a contraceptive method in Tunza clinics.

The program has effectively reached peri-urban women and some rural women. Phase one of the program operated in urban and peri-urban areas, and five Tunza clinics were located in rural areas. In phase two, the Tunza network expanded into new provinces: Muyinga, Bubanza, Cibitoke. These provinces were selected due to their low CPR and their relatively higher concentration of private health facilities compared to other provinces. Here, the focus on urban and peri-urban remained. Six per cent of Tunza clinics are in rural areas and, as is typical for private sector programs working in such locations, client numbers are typically lower than in urban and peri-urban areas.[3]

The program could have reached more Sex Workers (SWs) and other marginalized groups. Interviews with PSI suggest that the program started working with SWs at the beginning of phase two, but due laws criminalizing sex work and the related stigma it was a challenge for the program

[2] WHO 2015. Trends in Maternal Mortality 1990-2015. Estimates by WHO, UNICEF, UNFPA, World Bank Group and United Nations Population Division. Geneva

[3] Data from Tunza clinics in Kenya, for example, also indicate the same trend: rural clinics tend to have lower clients that those located in urban areas.

to do more. Engagement with other NGOs that have experience working with SWs might have enhanced PSI's work in this area. Indigenous Batwa populations are said to have been reached through a campaign once or twice a year, and efforts to work with international displaced people (IDPs) were explored with the International Organization for Migration but program interventions did not materialize. The voucher program that has been used on "Tunza Days"[4] failed to target and benefit the most vulnerable groups. No objective poverty criteria was established with which to determine if a client is poor or vulnerable, and no specific disaggregated program data regarding which vulnerable groups benefitted from the vouchers has been collected.

1.5 Efficiency

Some interventions have offered good cost-effectiveness. For example, some underspend has been experienced for certain program running costs – and savings of $203,490 have been realized. Program data reports the cost per DALY to be $37.34, which is good compared to other available benchmarks, including on other PSI programs in other African countries. Program reports also indicate the cost per CYP to be $38.39 which is higher than comparable benchmarks.[5]

Client numbers at Tunza clinics are increasing overall throughout phase two – and the expected end of program targets have been surpassed. In total, more than 50,000 young people received their contraceptive method at Tunza[6] and more than 50,000 new FP users have visited Tunza. PSI has increased the number of clients by working with Tunza Mobilizing Agents (AMTs) and youth peer-mobilizer (ACIPs) to increase awareness of the available services and products. The reduction of prices made possible through "Tunza Days" has also increased the number of clients.

Tunza has not been as successful in creating access and use for EC as was expected. A total of 8,547 clients used EC at Tunza compared to a target of 12,000. EC use each year has steadily been increasing, however. Additionally, implant use in Tunza clinics has not been as significant as expected. Less than 8,000 implants have been inserted over the program, against a target of 10,000. Numbers increased steadily each year, but slowed between 2019 and 2020 (only 9% growth compared to 23% the year before).

The program experienced a near-stockout of male *Prudence Class* condoms between March and September 2019. Program reports and stakeholder interviews carried out to inform this evaluation indicate that the stock out was caused by the change in the supplier of the condom, as well as changes in the PSI staff that were in charge of supplies and logistics. During the stock out, other condoms were still available in the country, in particular the free condoms that are supplied by the MoH. PSI ensured that Tunza facilities had a stock of the free supplies to ensure that young people could still access condoms. Condoms were still available in the market although not at the same scale as before the

[4] "Tunza Days" are promotional days that are carried out in areas of operation near to the clinics, and which increase awareness of the clinic and carry out SBCC activities with the intention of increasing the number of clients that use services that are available in the Tunza clinics.

[5] Typically, on most programs, the cost per DALY is more than the cost per CYP.

[6] This includes male condoms too.

stock out. PSI also worked to ensure a fair and equal distribution of the limited numbers of the *Prudence Class* product that were available during the stockout and they also held discussions with stakeholders engaged in the distribution of free condoms to inform them of the situation and to ask them to assist in increasing the availability and accessibility of condoms throughout the country during the stockout.

Two contractual partners worked on the second phase of the program. The partners presented good innovations, but their their activities were not fully integrated into the project in the case of Population Media Center (PMC) and had technical challenges, in the case of Triggerise. Triggerise's *Movercado* platform leveraged the increasing availability and use of mobile phones among young people across most of Burundi, although their system suffered from a series of glitches and technology challenges. Overall, the results that were tied to the *Movercado* platform were not achieved. PMC, which was a partner on phase one of the program, continued into phase two to promote SRH messages to young people through their radio *Agashi* program. In total, almost 600 episodes of *Agashi* were produced and aired against a target of slightly under 300, and program data indicates that almost half of Tunza clients listened to *Agashi*. However, according to program reports, *Agashi* was not able to directly promote Tunza clinics to young people due to governments restrictions that prevent the direct advertisement of FP, and due to PMC's model which was designed to promote FP generically and not to promote specific brands. It was determined that the direct linkage between to *Agashi* and the uptake of PSI services and products was not extensive enough to justify the continued partnership.

1.6 Sustainability

Actions to improve sustainability have been made. Clinical quality training and business skills capacity building have supported Tunza clinic owners and managers to better understand franchise costs, introduce data-tracking systems and leverage data for decision-making to explore program sustainability. Additionally, as part of improving the skills of human resources and systems, a wholesaler model to cut supply chain costs was introduced while simultaneously empowering Tunza "hubs" to act as distributors to smaller facilities in their catchment areas.

The overall sustainability of socially marketed products has not been an extensive feature of this evaluation, and neither has the sustainability of some other interventions such as behavior change activities. There is a degree of cost-recovery in the sale of social marketing products and this has resulted in a total of more than $150,000 of program income generated over the life of the program. EKN has allowed PSI to use these funds to support other program activities and this therefore serves as an important asset for the sustainability of some interventions. Demand creation activities, which are significant in the program – and which deliver attributable results - will require continued support.

1.7 Gender considerations

The program contributed to gender equity for SRH access by balancing the number of male and female ACIPs and AMTs that were hired. Gender considerations were also included during their training. Training sessions facilitated by the AMTs and ACIPs covered SRHR issues specific to both girls and boys, including mutual respect of sexual rights for both sexes. During the empowerment sessions, girls were trained to address cultural taboos that impede their access to SRHR. The program should continue to support gender mainstreaming at all levels on subsequent program phases.

Some gender aspects of the program design could have been improved. For instance, some advocacy activities did not consider messages tailored to different ages i.e. messages tailored for a 16-year-old girl should be different to one for a 20-year youth. Additionally, some indicators in the Result Framework were not disaggregated by sex therefore preventing the monitoring and analysis of the effects of the intervention on boys and girls. However, data collected to inform this evaluation indicates broadly that there is no significant difference in the knowledge and use of SRH KAP between young men and women aged 15 to 24.

1.8 Recommendations

Based on the above findings, this evaluation makes a number of recommendations regarding the next phase of the program. Recommendations relate to the scale and reach of the program; expanding the FP method mix; sustainability; SBCC and engaging youths; the private sector and the total SRH market; Value for Money (VfM); the Results Framework and monitoring and evaluation (M&E), and routine PSI and EKN engagements.

1.8.1 Take the program to scale

The first and second program phases have put in place key foundations. Good results have been achieved and the program has created important momentum that should now lead to greater SRH outcomes. PSI is a major SRH player in Burundi and has an important role to play in positively changing behaviors, creating more access and use of services and contributing to improvements in the country's health market and CPR growth. The third phase should be taken to be a game-changing program that accelerates SRH across the country in a way that has not been seen before.

1.8.2 Expand SRH and products services to rural areas

The program should go beyond the current urban and peri-urban areas to reach rural (and therefore poorer) Burundians with more quality SRH services. To do this, a combination of modified service delivery side models will likely be required. A combined approach that includes private clinics that are either Tunza "Light" and/or non-branded clinics accredited to a quality network (could be ANFS), and perhaps combined with some targeted subsidies to reach more vulnerable and poorer groups, would be the best combination. Technical support to increase improved SRH outcomes in selected high volume MoH facilities might also be considered to reach more rural clients.

1.8.3 Expand SRH services and products to urban and peri-urban areas

There remains a significant need for SRH services and products to be taken to greater scale in Burundi's urban and peri-urban locations. Service delivery results through Tunza have improved on the program, and the number of private sector outlets stocking PSI products has also increased - and both have contributed to good program results and Burundi's CPR. Both Tunza (or equivalent Tunza "Light" or non-branded clinics as in 1.7.3) and social marketing should be taken to greater scale, while taking on board considerations for greater sustainability.

1.8.4 Modify and improve the voucher scheme to more poor and vulnerable groups

Reviewing the costs, benefits and rationale for having a voucher scheme should carried to inform if one is required for the subsequent program phase, and if it is, clear guidelines and eligibility criteria should be developed and used. Targeted subsidies should be used to benefit the poorest and most vulnerable groups that cannot afford to pay for services, rather than as a way of increasing the overall

number of clients using program clinics. Disaggregated data that tracks and measures which client groups benefit from the vouchers should be captured and reviewed routinely to ensure the intended groups benefit appropriately.

1.8.5 Integrate sustainability into all program interventions meaningfully

Sustainability should be built into the program as a core principle. A sustainability plan should be developed before the start of the next phase and agreed with EKN as part of its contract with PSI. The plan should clearly articulate what is the overall exit strategy of key interventions, and what will be sustained at certain intervals in the program. Meaningful, "SMART"7 indicators for sustainability should be developed and included in the Results Framework and contractual KPIs. The cost-recovery of socially marketed products should also be included in the sustainability plan, as should other sustainability outcomes such as the use of project income, Tunza owners paying for demand creation support from AMTs and ACIPs – as well as sliding payment scales from Tunza owners for all other future inputs from the program (e.g. training, commodities, materials, branding, equipment) as well as graduating clinics as noted in 1.7.6 below.

1.8.6 "Graduate" sustainable Tunza clinics that are ready to operate independently

The subsequent program phase should put in place clear transition criteria and plans that would support a selected number of Tunza clinics to be strengthened and then "graduated" so that they do not require the same – or any – support from the program. The program should learn and adapt from the experiences from other PSI countries from within the region that have graduated clinics.

1.8.7 Scale up the availability and use of implants

During phase two, it is male condoms and injectables and that have resulted in the most CYPs, while implant use has also increased in Tunza clinics. As part of an overall drive to improve choice and access to a full method mix, and through an expanded clinic network, the program should focus on increasing the use of implants. Not only will this support users to have more FP protection over the longer-term,[8] it will contribute significantly to national CPR growth, as has been witnessed in other countries in the region.[9] The use of implants will be possible through increased Tunza and other clinics and with a greater emphasis on counselling WRA on the benefits of switching to longer acting methods, the cost benefits to clients of investing in an implant rather than relying on short-acting methods. The cost of implants can be a barrier to use, although if Tunza receives the product for free or at a reduced cost then it will be important for the prices to clients to remain affordable. Targeted subsidies for implants in rural locations may also be explored.

1.8.8 Consider the introduction of subcutaneous contraceptive injectables

Injectables remain the most popular FP method in Burundi and they are still the key driver of CPR

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[7] **S**pecific, **M**easurable, **A**chievable, **R**ealistic and **T**imebound.

[8] One implant typically offers between 2.5 and 3.8 CYPs and therefore offers users much more protection that short-term methods such as injectables (one injectable offers 0.25 CYP).

[9] In Kenya, for example, national CPR growth has increased dramatically over recent years (now 61.4% according to FP2020) and this growth is largely due to the increased use of implants – for both urban and rural clients.

growth.[10] Injectables are also a key engine of CYP growth on the program. Subcutaneous contraceptive injectables (DMPA-SC) are currently available in Burundi through UNFPA but currently for the public sector only. PSI is providing DMPA-SC to clients through its USAID program, and this should be expanded with EKN support into the next program phase. Given the potential for DMPA-SC to be widely used as part of self-care initiatives, it will be important for the product to become available in Burundi through non-clinical outlets, such as pharmacies. This evaluation recognizes the difficulty of this being possible, and so extensive advocacy will be required (please see 1.7.9 for further details).

1.8.9 Advocate for greater use of FP products through the private sector

Extensive government restrictions on which FP products can be imported and sold through which categories of health outlets in the country impede Burundi's CPR growth and significantly limit reproductive choices. The program should partner with effective strategic advocacy organizations to improve the policy and regulatory environment so that more quality approved products can be sold through the private sector – especially OCs and EC. Given the restrictions on OCs and EC, DMPA-SC will also require advocacy efforts for it to be made available outside of the public sector, especially if there are intentions for the product to be made available in time outside of clinical settings. Self-care and task-shifting are likely to be key themes for such advocacy efforts.

1.8.10 Scale up mass media, SBCC and peer education to support the program and grow the total demand in Burundi

Evidence demonstrates that program's demand creation also benefitted other clinics, in both private and public sectors. Increased demand therefore contributed to the overall growth of CYPs and CPR in Burundi. Feedback from young people also indicates that radio programs and peer education are very effective in improving behaviours and increasing the use of services. The current configuration of SBCC interventions on the program should be continued and scaled for urban and peri-urban groups. The program should explore and test the most appropriate interventions to reach rural clients, although evidence indicates that radio and IPC are popular and effective.

Mass communications in the next phase should also focus on growing the total market and the national demand for SRH. Rather than only promoting the program's brands and products only, messages should promote the wider benefits of FP, including the different methods, and tackling myths and rumors. Generic messaging would help to increase the overall use of SRH services and products across a multiplicity of private providers throughout Burundi, including PSI, and others including the public sector.

1.8.11 Increase the focus on tackling socio-cultural, religious and other barriers

If the program is to scale up its work to reach more rural communities, including young girls, then socio-cultural, religious and other such barriers will need to be tackled. Working with faith-based clinics to deliver FP services (as proposed as part of 2021-23 activities) will be a good entry point, but a comprehensive demand-side strategy will be required to support girls to access and use services without socio-cultural and religious backlash.

[10] Approximately 50% of Burundi's CPR is accounted for by injectables (Track20).

1.8.12 Work inclusively with young people as partners

The Youth Advisory Board should be expanded. There is an opportunity for it to provide important perspectives to PSI on the program design and interventions, and for PSI to be more accountable to young Burundians. Youth representatives could also attend key program meetings (see 1.7.19 below).

1.8.13 Increase the focus on Burundi's total SRH market

The program should expand its focus on supporting, advancing and strengthening Burundi's SRH market. Given the limited number of players in Burundi that work with and through the private sector, PSI has an opportunity to demonstrate leadership in this domain It will be important to advocate with the government of Burundi on the increased role of the private sector as part of the overall increased focus on the market.

1.8.14 Continue to scale up and strengthen ANFS and expand private sector outlets

ANFS could become an important new market player in Burundi with specific and time-bound support from the program. The ANFS could serve as the main network for Tunza clinics, including those that are graduated and other clinics that may be brought on during the next phase of the program. The program's work with wholesalers and pharmacies should be expanded in the next phase, especially regarding the expansion of products, such as OCs, EC and potentially DMPA-SC.

1.8.15 Use a VfM framework to develop and maintain cost effectiveness

A comprehensive and meaningful VfM framework should be developed and used on the program – building on the cost effectiveness analysis that resulted in a pricing list for services carried out by PSI in mid-2020. This framework would include key indicators and financial milestones that can be monitored over the life of the program to assess how well the program is functioning vis-à-vis VFM targets. Program sustainability indicators could be added to such a framework. VfM indicators should be included in the Results Framework, and reported against routinely.

1.8.16 Actively manage the Results Framework and Theory of Change (ToC)

The Results Framework and ToC should be managed more actively and routinely at key intervals throughout the program cycle. Indicators that are not relevant to the program should be adjusted and removed from the Results Framework -if required and justified. Indicators with milestones and targets that are easily being met should be reviewed and perhaps revised upwards.

1.8.17 Hold routine, monthly meetings with EKN

To support a more active management and engagement of the program, PSI and EKN should consider holding monthly meetings. Other stakeholders and program partner could also attend such meetings every six months.

2. Program description

2.1 Program context

Approximately 65% of the Burundian population is under 25 years old and 33% is between 10-24 years of age. Many of the young people have their sexual debut during puberty as a result of high peer pressure and increased risk taking behaviours. This transition to adulthood is characterized by a variety of Adolescent Sexual and Reproductive Health (ASRH) challenges, such as teenage pregnancy, abortion, and gender-based violence (SGBV).[11] According to Burundian law, the minimum age for marriage is 18 for women and 21 for men, but clandestine marriages below this age often take place. Premarital sex in the Burundian context is a taboo subject, hence limited information on key SRH indicators, such as: age of first sexual intercourse, age at marriage, and age at first birth. In addition, the concept of "single motherhood" does not exist in the local language. As a result, many unmarried women do not register their children with the Civil Registry. Abortions and infanticide are as a result of women being stigmatized, and are accused of dishonoring the family. Burundi faces a slight decline in the HIV prevalence rate (from 2.9 percent in 2007 to 1.4 percent in 2010 for the population aged 15-49). Adolescents and young people, especially girls, are a vulnerable group because of the non-use of condoms, the lack of information on HIV, and their socio-economic vulnerability.

GBV is a major problem in Burundi and young people are among the most vulnerable groups. Logically, many victims do not report the violence for fear of social stigmatization, having to testify in court or simply retribution by the perpetrators, abandonment by the families and loss of financial means.

Recent studies[12] show that some of the SRH challenges Burundian youth face include:

1. **Limited access to reliable and comprehensive information on SRHR**. Good information on SRHR is limited and not accessible to all population groups and presented in formats and through channels that are easily used by young people. Information can be inaccurate and biased. Marginalized groups such as rural population, poorer young people without access to radios or phones or who may be out of school are left behind with regards to reliable access to information. Peers are an important source, but often they also lack the correct information and so inadvertently can spread misinformation.
2. **Limited access to youth-friendly services.** SRH services for adolescents and youth are not included in the package of medical services and activities of most health services. Medical staff do not have sufficient capacity to provide these services, and very few health centers are equipped for ASRH. Unmarried youth have difficulty accessing family planning services. Condom use is generally unacceptable, and the dominant message is abstinence. Girls face additional constraints, such as

[11] https://www.rutgers.international/sites/rutgersorg/files/PDF/French_material/2017_Rapport_etude_de_base%20programme_conjoint_Burundi_FR.pdf

[12] MSPLS, Banque Mondiale, OMS, Enquête d'évaluation de la disponibilité et de la capacité opérationnelle des services de santé (SARA), Bujumbura, 2017

limited mobility and social control from society, which increasingly limit their access to these services.

3. **Limited support from parents, teachers, religious and traditional leaders in young peoples' efforts access SRH information and services.** Discussions around sexuality, especially that of adolescents, is considered taboo, and many parents find it appropriate to discuss sexuality with their children. Misconceptions about ASRH (e.g. that certain types of FP methods leads to infertility) are supported by the traditional positions of religious institutions on ASRH, hindering young people's informed and objective decisions about SRH and the exercise of related rights.

4. **Biased gender norms** are one of the causes of lack of gender justice, and contribute to poor communication in the family, inequality in decision-making, in the distribution of tasks and responsibilities and GBV. For example, gender inequality exposes vulnerable girls to abuse and limits their ability to make decisions related to their sexuality. At the same time, boys are negatively affected by social norms that promote male domination and influence their behavior (e.g., macho behavior, early and unprotected sex, boys are rarely considered vulnerable or victims of violence).

2.2 EKN priorities

Empowering women and youth by making SRH information, products and services widely available is one of EKN's main development priorities. EKN recognizes that this is critical to controlling population growth rates. This will in turn reduce land pressures , which are often a source of conflict in Burundi, and potentially improve economic outcomes.

Box 1: Program result areas and outputs

Result Area 1: Young people are better informed and are thus able to make healthier choices regarding their sexuality.
Result Area 2: A growing number of people have access to anti-retroviral drugs, contraceptives and other commodities required for good SRH
Result Area 3: Public and private clinics provide better sexual and reproductive healthcare services, which more and more people are using
Result Area 4: Greater respect for the sexual and reproductive rights of people to whom these rights are denied
Output 1: Increase demand for SRH products and services among WRA with an accent on youth (15-24 years old)
Output 2: Increase quality of care and access to SRH products and services among WRA, and particularly youth (15-24 years old)
Output 3: Strengthen the favorable environment for SRH rights and service delivery for youth (15-24 years old).

By 2022, the following results are expected as part of the EKN Strategy for Burundi:

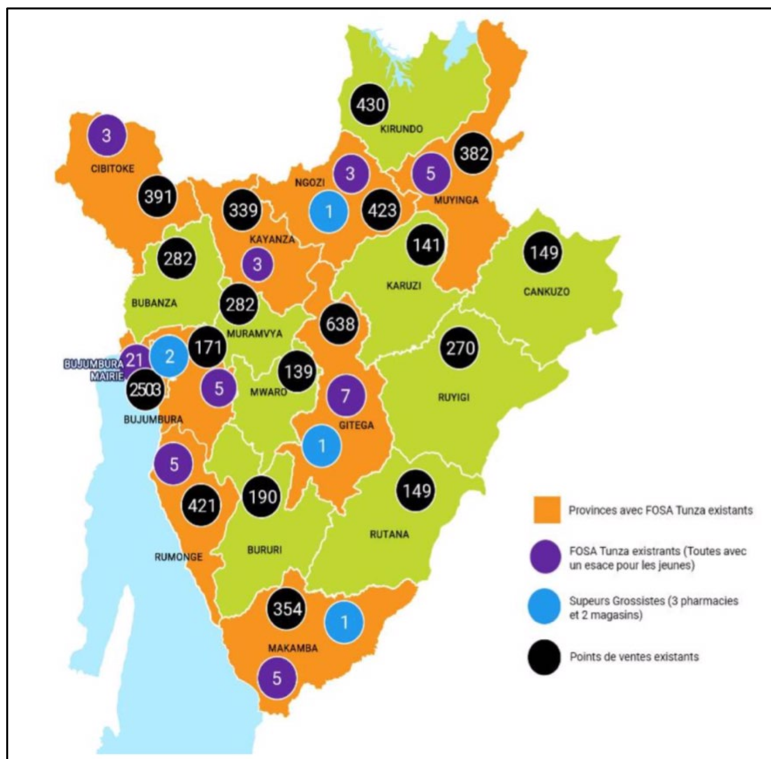
1. Improved government commitment to reduced improve contraceptive use
2. Improved government commitment to prevent and halt all forms of GBV
3. Increased availability and access to modern FP products and services, and contraceptive surgery
4. Increased availability of and access to safe post-abortion care
5. Improved informed choice and reduced GBV at the family level
6. Availability of youth-friendly safe SRHR spaces in and out of school
7. Effective societal support systems promoting SRHR among youth and adolescents

2.3 Expanding SRH program, phase II

The EKN has supported PSI's SRH and FP program since 2013. The most recent phase runs from

2017 to 2020. The program's objective is to increase Burundi's CPR through expanding the delivery of high quality SRH products and services to WRA and youth. The program contributes to four key result areas and three outputs as shown in box 1.

Figure 1: Map of Burundi indicating PSI program operation areas



In phase two of the program, PSI expanded its operations to three additional provinces, meaning that the program has a footprint across all of Burundi – as shown in figure 1.

3. Purpose and scope of the evaluation

3.1 Purpose

The purpose of the evaluation is to *make a comprehensive assessment of the FP and SRH program describing its level of success in achieving its objectives, program efficiency and effectiveness, the sustainability of its interventions, the impact attributable to the program, identifying key weaknesses and assessing its contribution to national SRH priorities.* The evaluation also seeks to document lessons learned (including identified weakness and missteps) and best practices, and to offer concrete recommendations for strengthening future programming – including a potential third phase of support from EKN to PSI Burundi.

3.2 Scope

The evaluation has assessed the collective performance, implementation, and impact of all program activities, including those carried out by sub-awardees PMC and Triggerise. The evaluation has address the relevance, cost effectiveness, efficiency, sustainability, and Impact of the program while assessing how effectively gender concerns and issues specific to youth were part of program planning and implementation.

In addition, as discussed during the initial meetings with PSI and EKN representatives held in June 2020, it is evident that the evaluation is expected to be real, comprehensive, robust, deep and balanced, and that it should investigate areas that the program may not have been able to cover significantly during implementation, such as the inclusion of voices and opinions of young people on the program, for example.

Other important and specific issues that have been highlighted for the scope of the evaluation included the perceived low numbers of clients at Tunza facilities, gender issues, the roles and performance of PMC and Triggerise, on the program's impact, sustainability and cost-effectiveness – including between phases I and II – as well clear recommendations for phase III.

4. Evaluation design and data collection methods

The evaluation was conducted by a team of four experts, including an international Team Leader and three Burundian consultants. As per the evaluation workplan agreed with PSI, primary data collection was expected to take place in Burundi in September. However, this was not possible due to a lengthy ethical approval process which ended up in pushing the data collection to end of October. As the evaluation was conducted in the context of COVID-19, in-person data collection approval was received from PSI, thereby allowing in person data to be collected while adhering to the COVID-19 protocols.

The evaluation was carried out in five phases:

Phase 1: preparation

- Kick-off meeting with PSI and EKN
- Collection of key documents, literature and data has been a continuous process

Phase 2: inception

- Desk review
- Development of a comprehensive inception report and ethical protocol.
- Hired high quality Burundian enumerators
- Logistical arrangements for the travel to the provinces

Phase 3: primary data collection

- Training of enumerators in Bujumbura
- Collection of primary data across selected provinces

Phase 4: data analysis

- Data cleaning and analysis

Phase 5: reporting and finalization

- Report drafting
- Finalization of evaluation report and development of PowerPoint presentation

5. Performance against the results framework

This section of the report highlights the overall performance of the program againt the results framework. All the 47 indicators have been evaluated and compared to the baseline data as well as the end of program targets. The results are presented in a colored matrix whereby a red-amber-green color coding system has been used to indicate how the programme has performed against the agreed cumulative targets.

Green indicates that the program has achieved or surpassed the target. **(95% and above)**	**Amber** indicates the program has almost hit the target. **(80% - 94%)**	**Red** indicates that the program has failed to achieve the target. **(Below 80%)**

5.1 Overall, the program performance has been impressive. Almost two thirds of the indicators have either exceeded or achieved targets

- 27 indicators were achieved or surpassed
- Four indicartors were almost met
- 10 indicators were not met
- Four indicators could not be met due to data not being available at the time of the evaluation

Most of the indicators that were not reached were tied to activities that have not progressed much over the life of the program. It should have been possible during program to have these indicators revised and modified appropriately – as part of active management of a program's results framework, especially at the end of each programming year.

Goal: Burundi's CPR increased through expanding the delivery of high-quality SRH products and services to WRA and youth in particular

	Indicators	Baseline 2016	2017	2018	2019	2020	Target	Performance
G1	Percentage of teenage pregnancies	25.90%	8.3% (DHS 2017)	Data not yet available	Data not yet available	Data not yet available	20%[13]	
G2	HIV prevelance	1.30%	0.9% (DHS 2017)	0.9% (UNAIDS)	0.9% (UNAIDS)	Data not yet available	1%	
G3	Total Fertility Rate	6.12 births per woman	5.5 births per woman (DHS 2017)	Data not yet available	Data not yet available	Data not yet available	3 births per woman[14]	
G4	Percentage of unmet need for FP among adolescents in PSI Burundi areas of operation	Baseline not taken[15]	Data not captured	Data not captured	Data not captured	Data not captured	No target set (see footnote 15)	

[13] The evaluation is unable to determine the impact of the program on teenage pregnancies as reliable data since the 2017 Burundi DHS is not available. Attempts have been made to secure additional sources, and the evaluation team has sought the inputs of the program, although additional and alternative sources have not been identified. The next Burundi DHS data will not be available until 2022.

[14] The evaluation is unable to determine the impact of the program on total fertility rate as reliable data since the 2017 Burundi DHS is not available. Attempts have been made to secure additional sources, and the evaluation team has sought the inputs of the program, although additional and alternative sources have not been identified.

[15] No baseline was taken because the government of Burundi does not gather such data. Alternative indicators should have been used, or the indicator removed altogether.

Result area I: Young people are better informed and are thus able to make healthier choices regarding their sexuality

	Indicators	Baseline 2016	Target 2020	2020 survey findings	Performance
R1	Percentage of young people within PSI Burundi area of operation who report contraceptive availability	87.10%	90%	89%	99%
R2	Percentage of young people within PSI Burundi area of operation who agree with the statement "I can talk to my partner about using modern contraception to prevent unwanted pregnancy"	90.60%	92%	97%	105%
R3	Percentage of young people within PSI Burundi area of operation who agree with the statement "modern family planning methods are safe to use"	75.40%	80%	89%	111%
R4	Percentage of young people within PSI Burundi area of operation who agree with the statement "spacing births is good for the health of the mother."	95.30%	98%	97%	99%
R5	Percentage of young people within PSI Burundi area of operation who report that they feel comfortable accessing RH services[16]	87.90%	90%	80%	89%
R6	Percentage of young people within PSI Burundi area of operation who know that condoms are effective in preventing HIV/STI and unintended pregnancy	57.10%	62%	92%	148%

[16] Data from the household survey that was carried out to inform this evaluation indicates that the "percentage of young people within PSI Burundi area of operation who report that they feel comfortable accessing RH services" has fallen to 80%. However, given that the same survey indicates that there has been good improvements in the KAP, behaviour and contraceptive availability in the same PSI Burundi areas of operation, a drop in a similar indicator is an anomoly and an outlier. For these reasons, this finding should be interpreted lightly and for these reasons, the 89% performance against the indicator has been ranked as green.

Result area II: A growing number of people have access to anti-retroviral drugs, contraceptives and other commodities required for good sexual and reproductive health

	Indicators	Baseline 2016	2017	2018	2019	2020	Target 2020	Performance (Cumulative)
R8	Number of couple years of protection (CYPs) by each contraceptive method	167,347	212,100	300,212	362,675	400,217	316,225	126%

Result area III: Public and private clinics provide better sexual and reproductive healthcare services, which more and more people are using

	Indicators	Baseline 2016	2017	2018	2019	2020	Target 2020	Performance
R10	Percentage of franchise network providers score at least 80% during PSI internal quality audits	84%	82%	90%	80%	Data will be available in December 2020	90%	84% (average score taken)[17]
R11	Percentage of social marketing and social franchise network contribution to national CYPs	8%	No data	9.7%	No data	Data will be available in December 2020	10%	9% (average score taken)

[17] The 2020 data regarding the PSI internal quality audit were not ready in time for this evaluation, and so an average of the 2017, 2018 and 2019 score was used to arrive at the final score for the purpose of this evaluation.

Result area IV: Greater respect for the sexual and reproductive rights of people to whom these rights are denied

Indicators		Baseline 2016	2017	2018	2019	Target 2020	Performance (cumulative)
R12	Percentage of adults in community who have a favorable view of SRHR program (by type: parents, religious leader)	20%	Data not captured	Data not captured	Data not captured	25%	0

Output 1.1: Increased knowledge around SRHR

Indicators		Baseline 2016	2017	2018	2019	2020	Target 2020	Performance (cumulative)
O1.1	Number of youth sensitized by youth AMTs	65,647	134,447	215,343	258,122	277,661	152,007	182%
O1.1.2	Number of WRA sensitized by AMTs	124,630	204,398	281,521	326,978	349,301	316,154	110%
O1.1.3	Number of radio episodes of Tube produced and aired	208	314	406	510	584	624	94%
O1.1.4	Number of radio episodes of *Agashi* produced and aired	81	186	406	510	584	289	202%
O1.1.5	Number of youth participating in Tube Class listening clubs	285	392	830	1207	1260	1,200	105%
O1.1.6	Number of youth who have heard Tube Class amongst youth participating in *Movercado* quiz campaign	7,225	20,238	37,004	50,169	59,436[18]	100,000	59%

[18] Triggerise was responsible for managing the *Movercado* platform on the program until September 2019 when their role ended. No adjustment have been made to the final 2020 target for this indicator as there were no discussions that took place between PSI and EKN regarding any potential modifications or reductions. However, even if

O1.1.7	Percentage of Tunza clients who have listened to	5%	No data	47%	47%	47%	15%	350%
O1.1.8	Number of youth who like SRHR messages through Facebook	0	4,877	13,379	50,374	81,793	12,000	682%
O1.1.9	Number of articles on key Tunza activites produced and shared with partners	0	30	52	64	64	16	400%

Output 1.2: Increased motivation to access SRHR services

Indicators		Baseline 2016	2017	2018	2019	2020	Target 2020	Performance (cumulative)
O1.2.1	Percentage of referrals made by AMTs that are used by clients (redemption rate)	15%	17%	37.5%	77%	60%	22.5%	267%
O1.2.2	Number of messages sent via *Movercado*	30,871	85,914	78,057	98,779	98,779[19]	320,000	31%

the final year of implementation against this indicator is taken into account, and the target pro-rata'd down, the performance equals 79% of the total target and is still categorised as red.

[19] The 2020 results presented for indicator O1.2.2 are therefore the final results carried over from the September 2019, which is when Triggerise's role on the program ended. No adjustment have been made to the final 2020 target for this indicator as there were no discussions that took place between PSI and EKN regarding any potential modifications or reductions. However, even if the final year of implementation against this indicator is taken into account, and the target pro-rata'd down, the performance equals 41% of the total target and is still categorised as red.

O1.2.3	Number of social franchises achieving minimum standards for offering youth-friendly services	10	19	22	57	57	60	95%

Output 1.3: Increased agency/self-efficacy for integrated SRHR services

Indicators		Baseline 2016	2017	2018	2019	2020	Target	Performance (cumulative)
O1.3.1	Number of youth (15-24) who receive a contraceptive method in Tunza clinics	8,000	16,505	26,558	39,263	50,603	20,000	253%
O1.3.2	Number of new FP users at Tunza Clinics	930 (M) 9,098 (F)	1,499 (M) 15,951 (F)	1,577 (M) 27,180 (F)	2,776 (M) 41,152 (F)	55,935	2,392 (M) 35,512 (F)	147%
O1.3.3	Number of Tunza clients accepting emergency contraceptive (EC) method	0	459	2,540	5,968	8,547	12,000	71%

Output 2.1: Increased affordability of wide range of FP

Indicators		Baseline 2016	2017	2018	2019	2020	Target	Performance (cumulative)
O2.1.1	Percentage of vouchers redeemed	15%	17%	27%	23%	38%	22.5%	168%

Output 3.1: Improved service delivery (e.g. quality, youth-friendly)

	Indicators	Baseline 2016	2017	2018	2019	2020	Target 2020	Performance Cumulative
O3.1.1	Number of new youth AMTs trained	77	120	188	294	298	211	141%
O3.1.2	Percentage of Tunza clients attending facilities for SRH services who are youth (disaggregated by sex, age, and marital status)	35%	36%	33%	34%	35%	40%	87.5%
O3.1.3	Number of clinics owners trained in business skills	48	60	60	60	60	60	100%
O3.1.4	Number of piloted clinics that achieve 50% of Tunza 2.0 model criteria	0	12	14	14	15	20	75%

Output 3.2 Increased availability of integrated SRHR services (short and long-term FP methods, PAC, HIV, STIs, SGBV)

Indicators			Baseline 2016	2017	2018	2019	2020	Target 2020	Performance
O3.2.1	# of products distributed	Male condom	11,052,584	14,629,544	19,763,604	23,506,524	25,379,424	25,735,784	98%
		Implants	2857	4428	5,841	7,126	7,762	10691	73%
		OC	36,289	50131	66,553	86,101	98,743	114,366	86%
		Injectable	32,933	51,431	74,818	101,466	126,176	100,331	126%

		IUD	1465	2205	2,875	4,999	5,377	6,355	85%
		EC	0	459	6,158	11,038	14,820	12,000	123%
		Miso-prostol	214	1,780	4,403	5,306	6,046	2,144	282%
O3.2.2	Number of pharmacies stocking Confiance in the reporting period		0	0	0	0	0	40	0
O3.2.3	Number of private Points of Sales distributing PSI-branded condoms		4,000	6,696	8,000	8,455	9,779	6,000	163%
O3.2.4	Number of franchise network facilities offering EC method		0	60	58	57	57	60	95%
O3.2.5	Percentage of franchise network facilities offering PAC services		15%	31%	25%	26%	79%	31%	254%
O3.2.6	Number of clients tested for HIV and receive their test results		2,090	5,253	14,779	18,293	21,779	10000	218%
O3.2.7	Number of clients tested for STI		2776	7174	12659	18,650	23,611	10,000	236%
O3.2.8	Number of youth empowered via VSLA model		0	0	168	168	228	500	46%

Output 4.1 Increased community social support for SRHR services

	Indicators	Baseline 2016	2017	2018	2019	2020	Target 2020	Performance (cumulative)
O4.1.1	Number of parents who have attended SRHR workshops during the reporting period	0	24	132	132	132	600	22%
O4.1.2	Number of parents who participated in advocacy activities	0	0	28	28	28	100	28%
O4.1.3	Number of religious leaders who have attended SRHR workshops during the reporting period	0	10	55	55	55	120	46%
O4.1.4	Number of religious ambassadors who participated in advocacy activities	0	0	7	7	7	30	23%

6. Relevance

The program and interventions were consistent with the overall goal and objectives, addressed the SRH challenges faced by WRA and young people, and were generally in line with the project proposal.

6.1 Overall, the design and intervention have been relevant to the problem

Burundi is among the poorest countries in the world with a high maternal mortality rate, a high fertility rate, unmet contraceptive need especially for young women of reproductive age, unwanted pregnancies and unsafe abortion.20 The program is relevant to this context as it intends to address the above-mentioned issues.

The program was intended to increase Burundi's CPR through expanding the deliverable of high quality SRH products and services to WRA and youth in particular. The program was also intended to address the limited availability of high-quality and affordable services and products in Burundi, especially through the private sector, and the limited KAP for SRH and the negative socio-cultural barriers. This has been affected by extending FP and integrated SRH services within the private sector. According to PSI research conducted in 2014, there was low uptake of modern FP methods and services and demand for SRH products were low.21

6.2 The geographic zones and areas of activity are appropriate

> *"We are now informed about FP/SRH by AMTs and ACIP and we go to Tunza or other health services knowing what we need. Before the program we had to manage these problems ourselves".*
> **Youth male FGD participant, Rumonge**

The geographic zones and areas of activity in phase two were appropriate – and they are broadly in line with the contents of the phase two proposal. Many interventions, particularly the social marketing of condoms and the mass media activities, have had an impact throughout the Burundian territory (as shown in figure 1), the clinical interventions to support private sector health care are located in urban and peri-urban locations where there is a larger client base, especially those that can typically afford to pay something for their services and products through private sector outlets.

In many cases, the program has certainly increased access to quality SRH services, products and information for many target groups across the country. The program's reach into rural areas could have been greater, and this is covered in subsequent sections of this report.

[20] WHO 2015. Trends in Maternal Mortality 1990-2015. Estimates by WHO, UNICEF, UNFPA, World Bank Group and United Nations Population Division. Geneva

[21] PSI Research division (2014) : Enquête TRaC sur l'utilisation et les déterminants de l'utilisation du condom chez les jeunes de 15-24 ans au Burundi. PSI Social Marketing Research series

6.3 Partners, stakeholders and beneficiaries are typically satisfied with the program

> *"Now we are not obliged to go to public health facilities or ABUBEF centers for FP/SRH services, we have many Tunza clinics so we can make our choice easily. The choice of the provider is granted according to what service we need."*
> **FGD WRA participant, Rumonge**

Most of the program clients indicate that they satisfied with the services provided by the Tunza clinics. They also mentioned that there are adequate SRH services offered at the clinics at a satisfactory-to-high level of quality. The young FGD participants also mentioned that they were satisfied with trainings conducted at facilities on youth-friendly health services. Data also indicates that young people are satisfied with the quality of the SBCC interventions on the program. Respondents from focus group discussions (FGDs) also agreed that the program was relevant in contributing to the welfare of families country wide.

However, interviews with some MoH representatives suggested that national and regional staff thought that they were not sufficiently involved in the planning and implementation of the program. Involvement of the government entities would be beneficial in building their capacity, encouraging ownership and serving as a sustainability strategy for reinforcing activities after the end of the program. They also noted the absence of coordination meetings which would have given PSI the opportunity to share best practices with other stakeholders especially the MoH staff. Several stakeholders interviewed were not conversant with the program except for the social marketing of *Prudence Class* condoms.

7. Impact

The program has delivered the expected levels of impact. It has made some important contributions at the goal level of the Results Framework, and has delivered good results on the KAP of WRA and young people for SRH, increased service delivery and products, and supported the wider public sector.

7.1 The program has contributed to Burundi's CPR[22]

"The value of this project is to contribute to national objectives in FP/SRH by introducing these services in private sector. This has led to improved access to services for a certain category of population."
Representatives from PNSR and ABUBEF

The program contributed to CPR and other impact-level indicators. The 2016- 2017 Demographic and Health Survey (DHS), which became available in 2018, shows how the efforts of PSI and others working in SRH contributed to improvement in the following indicators:

- **Reduction of the percentage of teenage pregnancies:** the early fertility rate (% of adolescent girls having started their reproductive life) decreased from 11.6% in 2012[23] to 8.3% in 2016/17.[24]
- **HIV prevalence:** decreased from 1.30%[25] in 2012 to 0.9%[26] in 2016 – 17
- **TFR**: decreased from 6.12 births per woman in 2012[27] to 5.5 births per woman in 2016 -17.[28]
- **Percentage of unmet need for FP among adolescents in PSI Burundi areas of operation:** while the average of unmet need for FP among WRA is 30%, this figure varies by province, by zone (urban or rural) and by level of education.

7.2 Increased CYPs particularly contributed to the goal

The contribution to CPR has been achieved through a comprehensive demand- and supply-side interventions that have increased the number of WRA and young people who have accessed FP services. This is evidenced by the increase in CYPs especially those which directly contribute to the increase in CPR. The program accounts for almost 10% of all of Burundi's CYPs. Between 2018 and 2019 there was a 46.7% increase of new clients that received an FP service – and which contributed to the goal. Male condoms and injectables have resulted in the most CYPs. There should be opportunities to drive up CPR in subsequent years through the increased use of implants, which has

[22] While the program has contributed to the national CPR and other key national indicators, it is not possible for this evaluation to qualify or attribute the extent to which the program has contributed. As highlighted in section 6, the contribution to the goal and national indicators cannot be measured at the time of this evaluation report because much of the data that is required is not available, and no alternative sources were agreed with EKN.

[23] Burundi Demographic and Health Survey, 2012

[24] Burundi Demographic and Health Survey, 2016 – 17

[25] Burundi Demographic and Health Survey, 2012

[26] Burundi Demographic and Health Survey, 2016 – 17

[27] Burundi Demographic and Health Survey, 2012

[28] Burundi Demographic and Health Survey, 2016 – 17

been achieved in other countries in the region, such as Kenya.

The contribution of the "vouchers" to the CYP growth could not be quantified for this evaluation, although it is assumed that the provision of free services through the voucher system helped to increase the total number of clients using services.[29] The spill over from the program's demand creation also benefitted other clinics, in both the private and public sectors. Increased demand therefore contributed to the overall growth of CYPs and CPR in the country.

7.3 Some factors impeded the contribution to the overall goal

The suspension of international NGOs activities for three months by the Burundian government delayed the program activities, and resulted in no service delivery results for one quarter. It can also be suggested that the government's restrictions on advertising and mass media for health promotion also undermined the program's ability to have a greater increase in the number of women and girls who received a service, although this could not be confirmed with beneficiaries interviewed for this evaluation. Government restrictions on which products can be sold where in the country have also impeded the achievements on CPR. During the program, no pharmacies were able to stock and sell OC or EC likely reduced the number of women and girls using the products.

7.4 SRH services are more accessible to young people

The program has contributed to an increase in access and use of high-quality services for young people, primary through the training and support that was provided to Tunza clinics to establish and maintain youth friendly services. Comments collected during FGDs in all evaluated provinces of Burundi indicated that Tunza clinics encouraged visits from young people by extending their operating hours to times that were deemed to more convenient to young people-- typically late evenings--when young people are more likely to be able to access SRH services with greater anonymity and confidentiality.

The program has intentionally and comprehensively expanded services offered in Tunza clinics in ways that are aligned with the needs of young Burundians. In total, there are 57 clinics offering FP and diagnosis and treatment of sexually transmitted infections (STIs). YFS are available in all clinics, with 20 offering designated youth spaces that offer HIV counseling and testing. The program also supports 120 youth mobilizers. Service providers at all 57 Tunza clinics were trained and supervised for the provision of quality adolescents and YFS.

The household survey carried out as part of this evaluation found that 89% of youth respondents in Tunza locations report having high levels of contraceptive availability. The Mountainous Region[30] reports the highest contraceptive availability (97%) while the Plain Region[31] reports the lowest availability (80%). Respondents reported a generally high contraceptive availability in Tunza

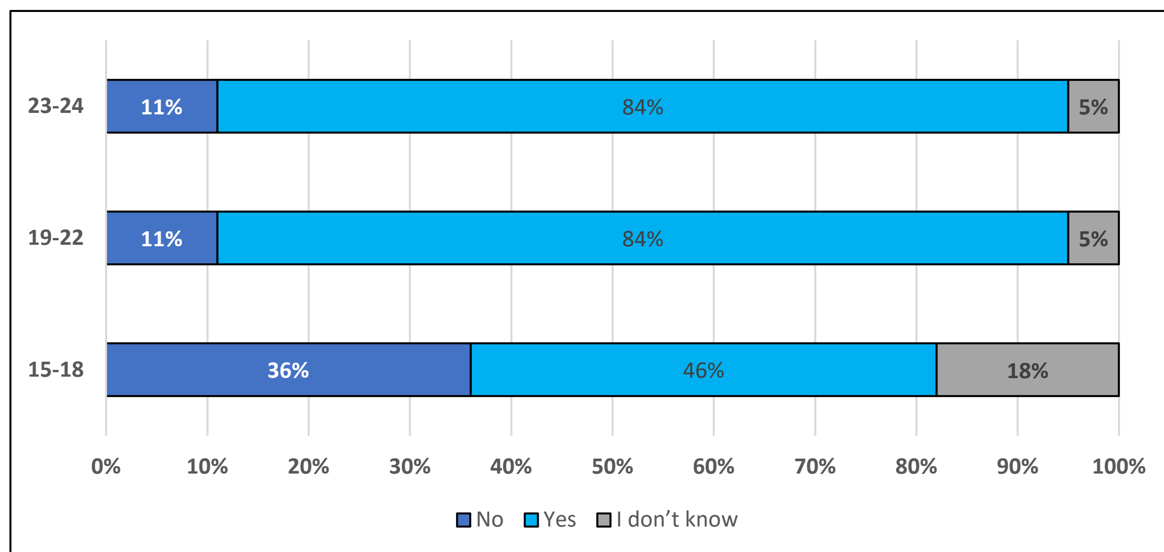
[29] However, please also note how the use of the "voucher" could have been used to better reach the more vulnerable groups, and the unintended negative consequence that free supplies through an easily obtained "voucher" might have on other private providers in the same or nearby locality.

[30] Made up of Gitega, Muyinga and Kayanza provinces.

[31] Consists of Bujumbura Marie and Cibitoke provinces.

locations across regions, age, gender, religion and socioeconomic status as illustrated by the graphs below.

Figure 2: Contraceptive availability for young women and young men in PSI Burundi areas of operation



7.5 The program has contributed significantly to SRH knowledge, attitudes and practices among young people

The program carried out a wide range of SBCC and interpersonal communication interventions across the country to reach young people and to improve their SRH knowledge, with the intention that this improved knowledge will result in increased use of FP products and services. Over the life of the program, approximately 43,000 young Burundians received SRH messages and participated in peer counselling.

One out of every two young people interviewed had heard of PSI's Tube Class radio program, and 93% of those who had said it had given them sufficient understanding of reproductive health issues. Forty-five percent of young people said that there were very satisfied with the quality of the show and an additional 44% said they were very satisfied.

As a result, it seems clear that the program has increased SRH knowledge. At the beginning of phase two, only 75% of young people within the PSI area of operation agreed that modern FP methods are safe to use. This had increased to 89% by the writing of this report.. Similarly, the percentage of young people who know that condoms are effective in preventing HIV/AIDS and unintended pregnancies has increased from 57% at the start of the program to 92%..

Fifty-three percent of young people interviewed report having had at least one discussion with a AMT or a ACIP working with PSI Burundi. The penetration is lowest in Lake Region[32] at 36.5%, followed by Mountainous Region at 59.5% and 66% in Plain Region. AMTs and youth peer educators have reached more young people between 19 and 24 years of age, and fewer young people aged 15

[32] Made up of Rumonge, Makamba, Bujumbura Rural provinces.

– 18. Almost 93% of young people who have had a discussion with an AMT or peer educator say it gave them a sufficient understanding of reproductive health issues. 67% of all young people who had a discussion went on to use a service, and 72% went to Tunza for a service. In other words, 48% of all young people who had a discussion went on to a use a service at Tunza.

The household survey evaluation found that 96% of young people in Tunza areas being comfortable to discuss about contraceptives with their partners. This is an marked increased from the baseline, which was at 90.6%. There are slight differences in percentages among regions with the highest being the Lake Region (98%) followed by Plain Region (96%) and Mountainous Region (95%). There are generally higher percentages of respondents agreeing with the statement across all the sociodemographic characteristics as illustrated in the graphs below.

Figure 3: Percentage of young women and men in PSI Burundi areas of operation who agreed with the statement "I can talk to my partner about using modern contraception to prevent unwanted pregnancies"

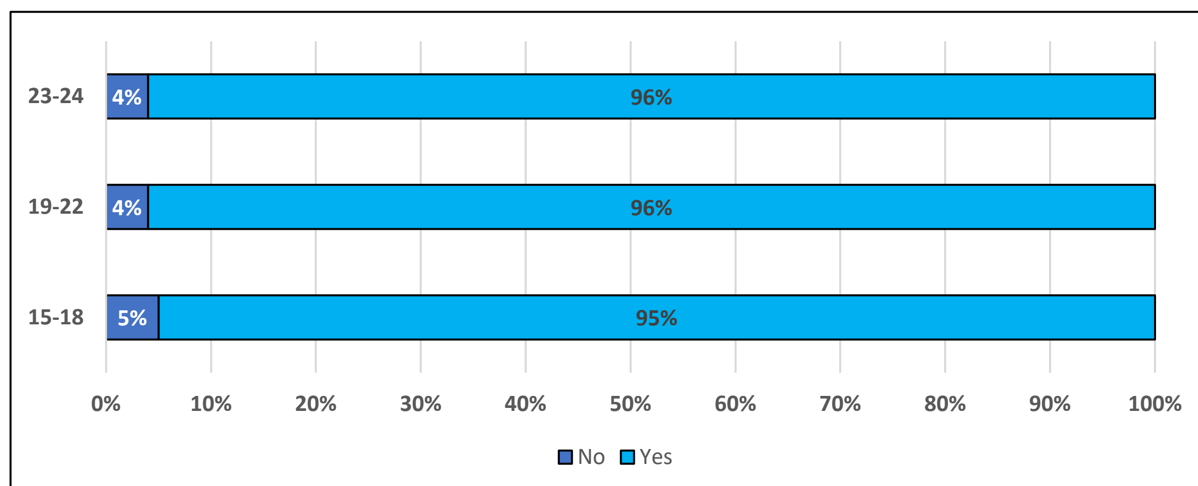
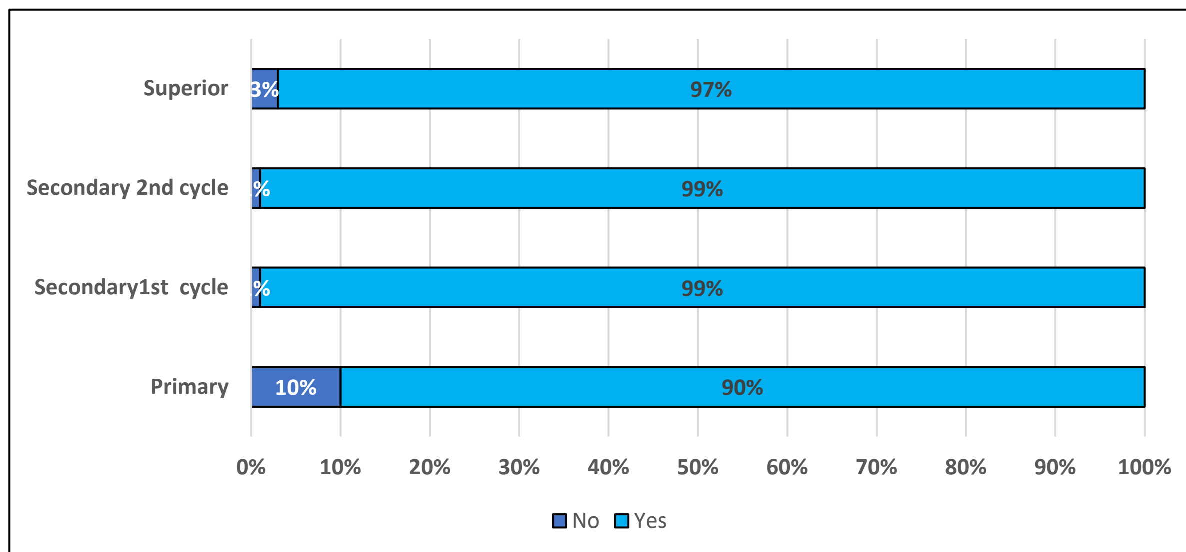


Figure 4: Contraceptive availability for men and young women in PSI Burundi areas of operation who agreed with the statement "I can talk to my partner about using modern contraception to I can talk to my partner about using modern contraception to prevent unwanted pregnancies

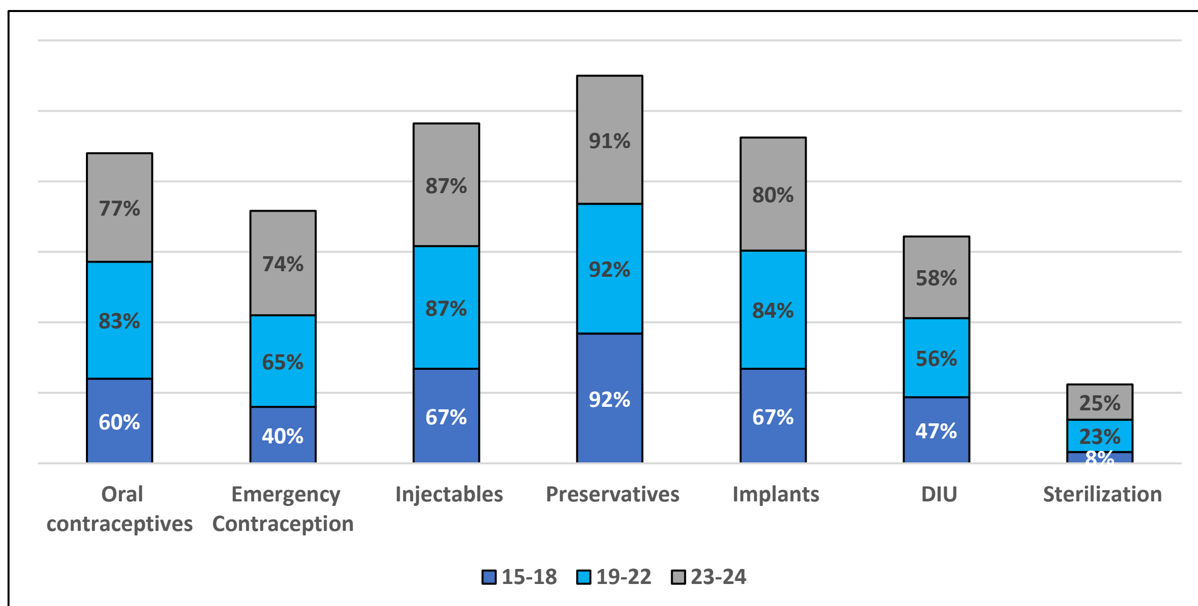


Ninety-two percent of respondents knew that condoms are effective in preventing HIV/STI. This is an improvement of 35% from the baseline (57.1%) taken in 2016; the Mountainous Region had the least knowledge of 89% while both the Plain and Lake regions recorded 93% of respondents agreeing with the statement. This could be attributed to the availability of condoms in the Tunza clinics as well as to SBCC and interpersonal communication interventions conducted by the program. In addition, the use of *Tube Class* to promote SRH knowledge seems to have played a key role.

However, across educational levels, respondents with superior educational level (97%) were more aware that condoms are effective, as compared to primary education level respondents awareness (88%). Within the diverse religious affiliations, Muslims from the three regions were more aware of the effectiveness of condoms at 100%, compared to Jehovah Witness only 75% believe condoms are effective.

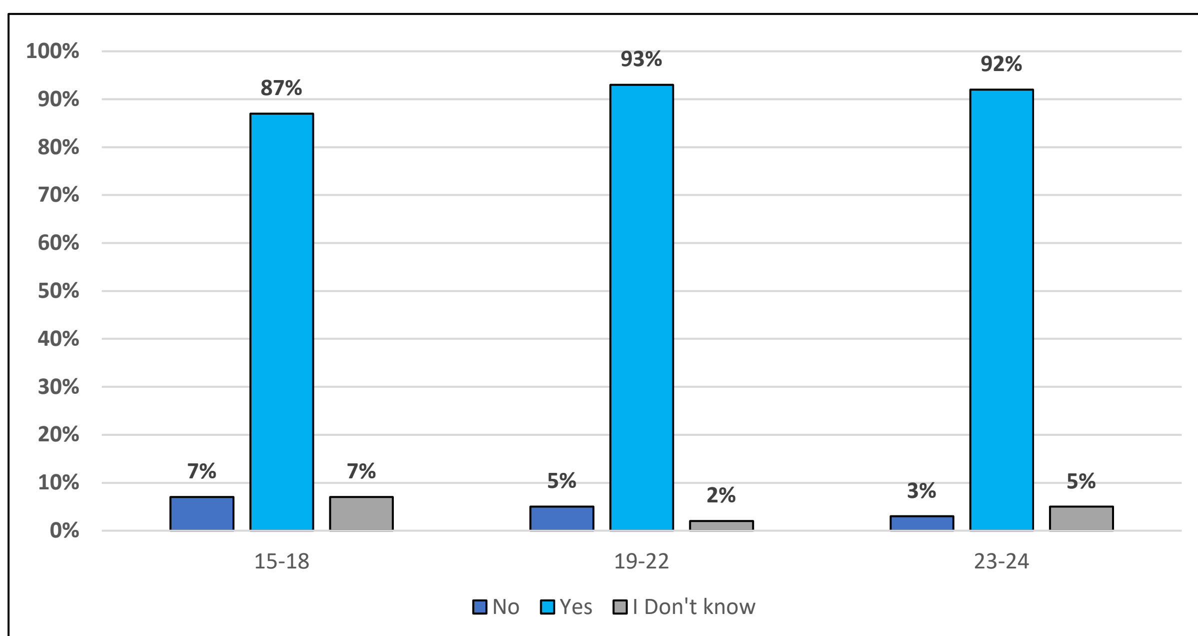
Although the program has made great strides, Tunza providers interviewed reported that there is still high prevalence of STIs despite the decline in unwanted pregnancies. These sentiments were echoed by youth during FGDs who agreed that there still exist a challenge among their peers to use condoms correctly and consistently.

Figure 5: Percentage of young men and young women in PSI Burundi areas of operation that agree with the statement "condoms are effective"



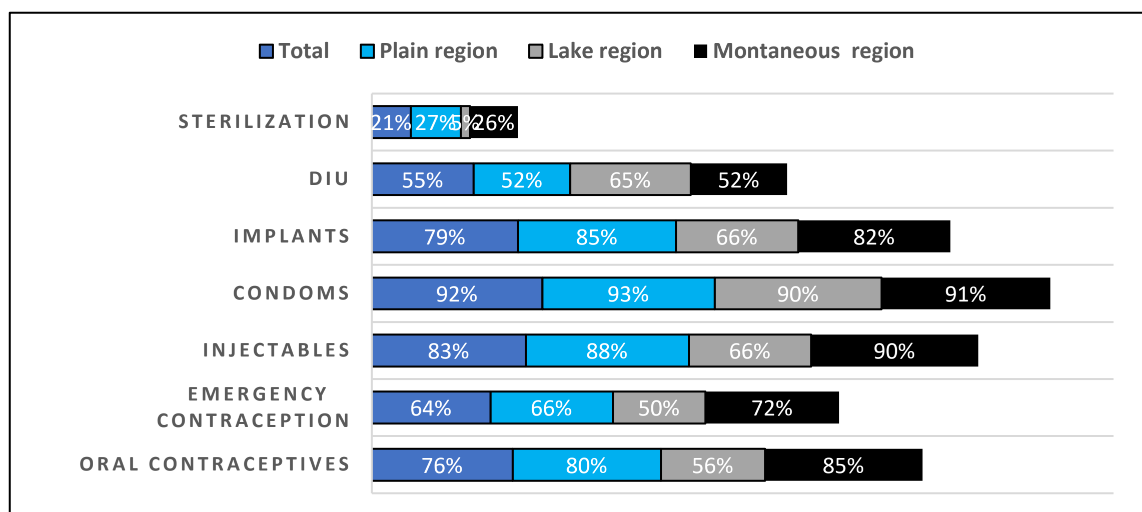
However, only 38% of young people in Mountainous Region could name three or more contraceptive methods without prompting . At 36%, this knowledge is lower in Plain Region and lowest in Lake Region, at 26%.

Figure 6: Knowledge of contraceptive methods among young men and young women in PSI Burundi areas of operation



The top three methods of contraception well known by respondents are condoms (92%), injectables (83%) and implants (79%). The least known method was sterilization with only 21% of respondents having knowledge of it. Condoms remained the most known method across all regions, ages, sexes, religions and education levels.

Figure 7: Contraceptive knowledge among young men and young women in PSI Burundi areas of operation – per region



7.6 The wider environment for SRH rights and service delivery for youth needs strengthening

The SRH environment in Burundi is not straightforward or simple. Young people face a multitude of different challenges and barriers, including those that are determined by the political, social, cultural and religious contexts.

In many ways, the SRH environment has become more difficult. Stakeholder interviews indicate that a few years ago, it was possible to have billboards in Burundi with SRH messages, while these are now banned. Regulations in Burundi still prohibit the sale of contraceptive pills in pharmacies, unlike many other countries in the region, even though young people prefer to use pharmacies due to their anonymity, confidentiality and accessibility. Much of the population still holds traditional views which are influenced by cultural values and religion and which make it more difficult for young people to freely navigate their ways.

To overcome such barriers, the program has increased the number of Tunza clinics that provide youth friendly services, and as described elsewhere in this report, activities have improved young people's KAP and behavior overall. PSI has also worked closely with the MoH to advocate for changes or improvements in the regulation that would make more products and services more available, although restrictive policies and regulations are still in place that prevent the same of some FP methods being sold in. pharmacies, notably OCs and EC. However, experience from other countries indicates that changing such policies and regulations can take several years, and it also requires the concerted efforts of multiple voices and reinforcing pressure points.

The program also carried out some activities that were intended to address social and religious barriers and increase community support (Result 4 and Output 4 in the Results Framework). For example, between 2017 and 2018, some parents and religious leaders attended SRHR workshops and participated in advocacy activities. The impact from these activities is not known, however. According to program data, no such activities were carried out subsequently between 2019 and the end of the program, and so overall the program did not deliver as much on the wider SRHR environment as was expected. PSI indicated that they intended to scale up this work in the latter phases of the program, but were hamstrung by the advent of the COVID-19 crisis and its restrictions on travel and in-person meetings and workshops. Experience from other countries indicates however that tackling systemic barriers such as religious and cultural views does require a long-term approach to work effectively with gatekeepers such as parents and religious leaders and should not have been left to the final year of project activity.

While the work with religious leaders is important to tackle barriers that underpin Burundian society, the evaluation found that religious affiliation may not be as significant a barrier to their FP KAP, and use as expected – as shown in figures 8 and 9 below. The same data collected from households to inform this evaluation similarly did not find that religious affiliation among young people had a negative impact on service delivery uptake either.

Figure 8: Percentage of young people – per religious affiliation - who agree with the statement "I can talk to my partner about using modern contraception to prevent unwanted pregnancies

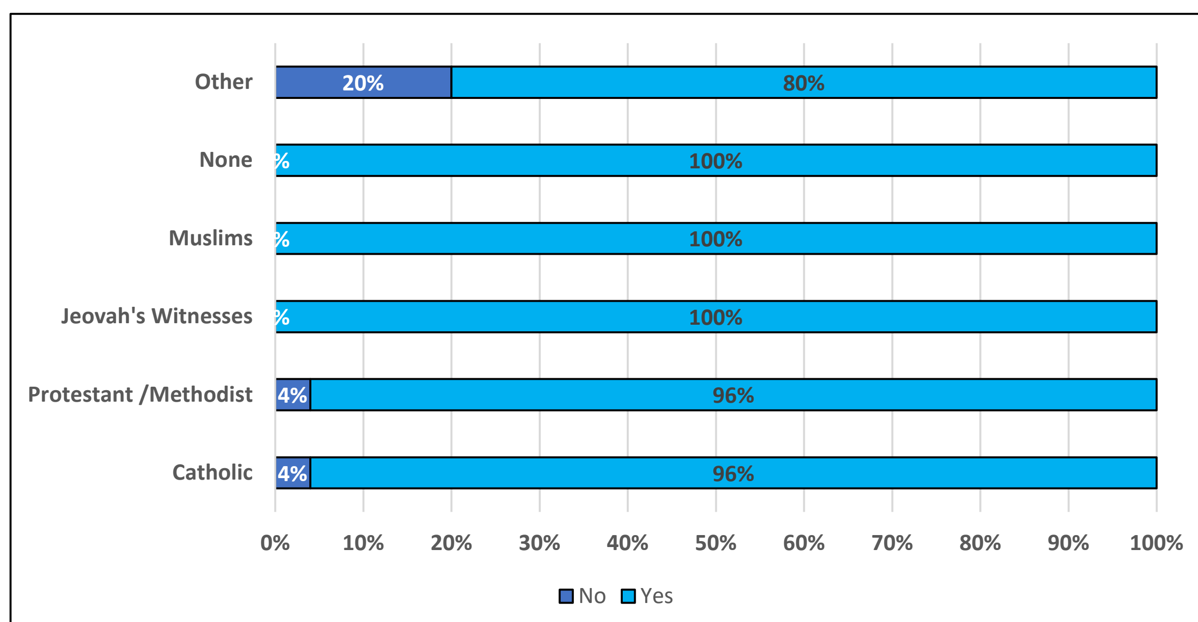
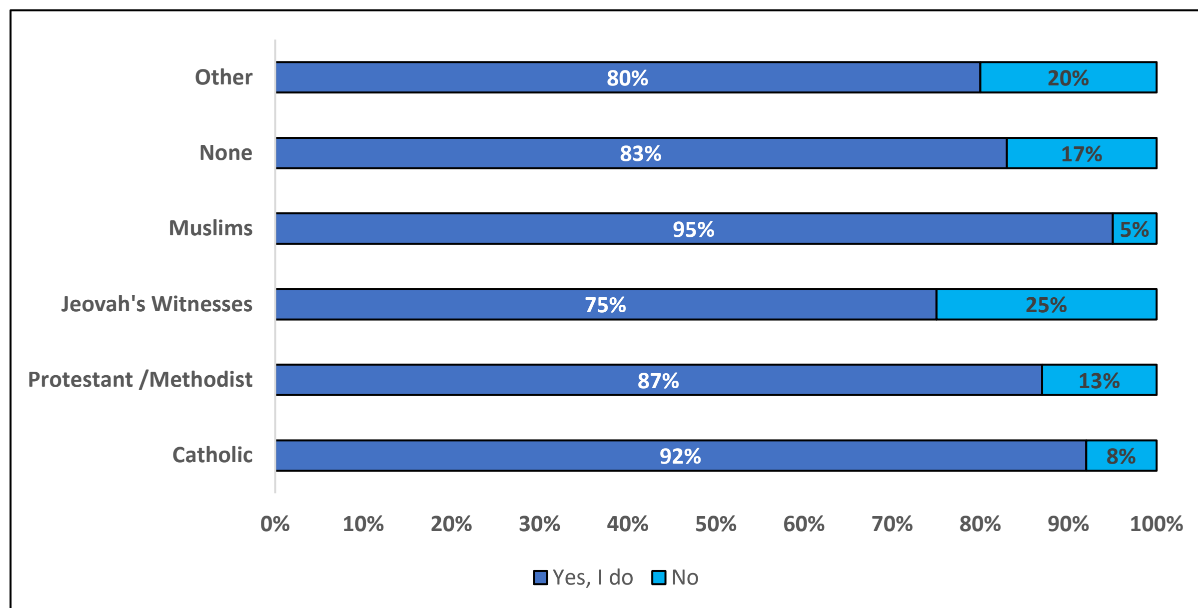


Figure 9: Percentage of young people – per religious affiliation – who agree with the statement "modern family planning methods are safe to use"



7.7 There are some unintended positive and negative impacts of the implementation of the program

While the suspension of international NGO activities by the government of Burundi for three months delayed program activities, it inadvertently offered opportunities for the program, the MoH and other partners to work closely together to resolve the suspension. This helped the program increase its engagement with key stakeholders at the national level.

Quantitative data collected during this evaluation from 15 – 24 years olds across Burundi also indicates an interesting spillover effect from some of the program's demand creation work. 16% of all young people who interacted with a Tunza Mobilizing Agent (AMT) or a peer educator went on to access a RH service from another private provider. The reasons for this could not be explored during the evaluation, but it demonstrates how other private providers inadvertently benefit from the program's demand side work.

There is the potential that the longer PSI continues to provide inputs and ongoing support to Tunza providers that a dependency on such support could develop. While there is no significant evidence of this on the program as far as this evaluation is concerned, similar effects have been experienced on other similar programs in other counties in the region.

While Tunza clinics receive inputs from the program that improve their quality and lead to an increase in their numbers of clients, there is a risk that this could inadvertently undermine other health providers in the same location but who do not have the same inputs and support as Tunza clinics. This could inadvertently destabilize the market. This is especially the case where extensive demand creation events drive clients to Tunza clinics only, and the use of "vouchers" enable clients to receive services for free, but only from Tunza clinics.

WRA participants in FGDs reported that when they experienced side effects from their FP method which they had received from Tunza, they then needed to unexpectedly spend money on additional healthcare to remedy the side effect. While this may be true, side effects cannot be controlled all of the time, but the program effectively mitigates the occurrence of side effects through comprehensive counselling all FP methods.

The switch of condom importer and distributor led to the unintended consequence of a six month condom stock out in 2019. The issue of the stock out is covered below in section 10.5. The issue has been resolved and systems are in place that should mean such a stock out does not occur again.

7.8 The program has contributed to the wider private health sector in Burundi

The program has made some useful contributions to the private health sector in Burundi's urban and peri-urban areas. The number of private clinics that are part of the Tunza network have increased from to 57, and these private clinics have benefitted from a range of inputs that have increased their ability to deliver more high-quality services. The number of clinics being supported by the program equates to around 20% of all private clinics in Burundi.[33]

The program has also worked other private sector players, such as wholesalers and distributors, who are engaged for the importation of FP commodities. *Prudence Class* condom are now sold in more almost 10,000 venues throughout the country. PSI supports these sellers, and has helped to creating a substantial supply chain.

Quantitative data collected during this evaluation from 15 – 24 years old males and female youths across Burundi also indicates an interesting spillover effect from some of the program's demand creation work. 16% of all young people who interacted with a AMT or a peer educator went on to access a RH service from another private provider. The reasons for this could not be explored during the evaluation, but it demonstrates how other private providers benefit from the program's demand side work.

Over the life of the program, the total number of private sector outlets distributing PSI condoms almost doubled from 4,000 in 2016 to 9,779 by 2020.

Insights from FGDs held with WRA and young people throughout Burundi suggests that Tunza clients prefer them to the public sector because they are of high-quality and services are client-centered. While there is no evidence available, it could be suggested that by increasing the overall quality of high quality services in selected locations in Burundi, other private providers could also increase their efforts to improve services and quality of care.

The program also helped strengthen the clinic owners' Association Nationale de Franchise Sociale (National Association of Social Franchises, ANFS) through capacity building. PSI helped the ANFS to develop an annual action plan and to organize regular meetings of its management committee. One of the main objectives of these meetings has been to empower the ANFS to position itself as a key player in improving the quality of private clinics and to become a credible voice for and within the private sector. The ANFS has the potential to become a key player in Burundi's health market.

[33] Sexual and Reproductive Health: A Market Scan in Burundi, Hera, 2019

During the FGD with the wholesalers, one of them stated the following when asked about what they thought of the future of Prudence's social marketing?, "On my part if nothing changes, I see that in the years to come I will be the biggest wholesaler considering the customers I receive on the end." This positive outlook on what the future holds indicates positive impact on the private health care sector.

Given that the program has now worked with the private sector for two phases, there are also additional opportunities for the program to build on its successes in a subsequent phase – as described in the recommendations section.

HALCYON CONSULTING

8. Effectiveness

The program has been effective in much of its delivery – and this has contributed to good results overall. The needs of the main target groups have effectively been met, especially urban and per-urban women and youths, although more could have been done to reach more vulnerable groups.

8.1 The program has achieved the majority of the expected results

The program achieved many key results, as outlined in section 6 above. Overall, the program performance has been impressive. Almost two thirds of of the indicators have either meet exceeded or achieved.

- 27 indicators were achieved or surpassed
- Four indicartors were almost met
- 11 indicators were not met[34]
- Four indicators could not be met due to data not being available at the time of the evaluation

The program has performed best in result area 1: young people are better informed and are thus able to make healthier choices regarding their sexuality; result area 2: a growing number of people have access to anti-retroviral drugs, contraceptives and other commodities required for good SRH (i.e. CYP results) and output 2: increased affordability of a wide range of FP. Indicators here have consistently surpassed the targets in the Results Framework.

8.2 The program effectively met most of the needs of the target group – WRA, men and young women

> *"it is now possible to prevent HIV/AIDS and unwanted pregnancies because we are well received in Tunza clinics and pharmacies."*
> **Young boy, Hakoramagara.**

The program met most of the priority needs of the target group. Clinics have been expanded to reach additional provinces, the range of services has been extended to also include YFS, and quality has been maintained at high levels. Tunza staff and clinic owners during several KIIs said that clients came to Tunza facilities because of confidentiality, the welcoming reception clients receive, the availability of qualified staff and short waiting times. All social franchises have achieved the minimum standards for offering youth-friendly services, and more than 50,000 youths received a contraceptive method in Tunza clinics. As demonstrated throughout this report, the behavior change interventions have highly met the needs of young people and the results have increased dramatically over the life of the program. For example, the percentage of young people within PSI Burundi area of operation who know that condoms are effective in preventing HIV/STI and unintended pregnancy was 57% in 2016 but was 92% by the end of 2020.

8.3 The program has effectively reached peri-urban women and some rural women

Phase one of the program operated in urban and peri-urban areas. By the time phase was commencing the program had five Tunza clinics located in rural areas. In phase two the Tunza

[34] Most of the indicators that were not reached were tied to activities that have not progressed much over the life of the program – and could have either been revised or removed from the Results Framework at key stages of the program, and in agreement between EKN and PSI.

network expanded into new provinces: Muyinga, Bubanza, Cibitoke. These provinces were selected due to their low CPR and their relatively higher concentration of private health facilities compared to other provinces. Here, the focus on urban and peri-urban remained.

> *"We used to have to go to Mabanda nearly 10 km away if we wanted to access FP/SRH services, but now services are near our home".*
> **WRA FGD participant, Ruvugo health facility**

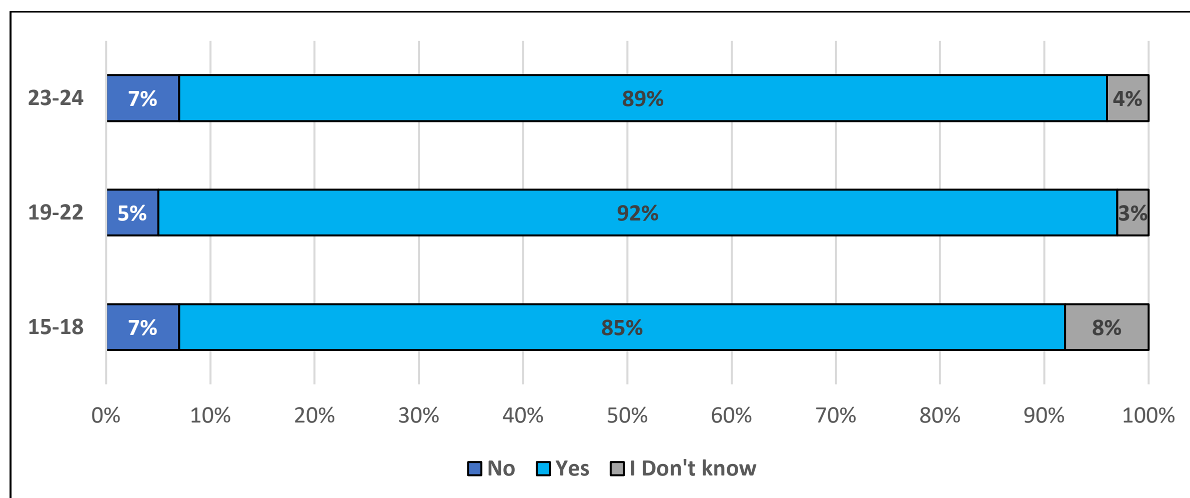
However, as the proposal states: "*to expand access to Burundi's truly rural areas, PSI/Burundi will conduct SRH sensitization activities with the secondary posts and provide information on where Tunza services can be accessed. Condom and OC social marketing will take place at national scale and will cover urban and rural areas. Points of sale, particularly in rural areas, will be equipped with promotional materials about the Tunza franchise and referral cards for SRH services at Tunza clinics… Private clinics will be targeted based on a set of selection criteria, which will favor clinics that are located in rural areas."*

The program effectively reached rural and peri urban women because it had been implemented in urban (75%), peri urban (19%), and rural (6%) areas in nine provinces. Most Tunza clinics are in urban areas because the health private sector is more developed in towns compared to rural areas. A minimal number of Tunza health facilities are in rural areas but their client numbers are typically low, as is typically the case, and as evidence from other countries in the region demonstrate.

> *"Even though our clinic is located in an urban area, most of our clients come from rural areas"*
> **FGD Tunza staff, Rema Mutanga Nord and Sosada Rweza**

This is of course more difficult to do through a private sector approach, but there are ways in which the program might have been able to do more in rural locations – although is it not wholly evident that such a specific expectation was made by the EKN. However, as is common in other such programs even if clinics are located in more urban areas, they can often reach rural populations, especially as women and girls move from rural areas to more urbanized locations for a variety of different reasons.

Figure 9: Percentage of young people living within a PSI Burundi area of operation and who indicate that they have contraceptive availability



8.4 However, the program could have reached more vulnerable groups

There can often be tensions on programs similar to phase two with regards to delivering results through the private sector which require clients to pay and who are typically based in more urbanized areas – and reaching more vulnerable groups, who typically cannot or do not want to pay for services and are often catered for by the public sector.

The original intention of phase two was to target young people in more urban areas, but also to reach some rural populations and sex workers.[35] In 2019, the program intended to scale up its potential to reach more vulnerable groups: "PSI Burundi's demand creation team worked with community mobilizers and Tunza clinic owners to conduct a rapid assessment of low-income clients who were unable to access FP/SRH services because of financial barriers. The assessment was conducted in all nine intervention provinces, and identified that the groups who have least access to FP and SRH services include those without access to land, returnees who had gone into exile in 1972 or 1993, Batwa, polygamous fishermen, SWs, widows, IDPs, people living with a disability, widows, single mothers, and out-of-school youth. During "Tunza Days", members of these vulnerable groups were provided with vouchers which they could exchange for SRH services at Tunza clinics."[36]

The program has managed to expand Tunza to some rural provinces, although the locations of these clinics are within the more urbanized locations of rural provinces. This decision has been made primarily because rural areas being serve as "thin" markets for private sector models such as Tunza.

[35] For example, the proposal states: Private clinics will be targeted based on a set of selection criteria, which will favor clinics that are located in rural areas and are able to provide PAC services and/or already offer youth services [and] particular effort will be made to reach and address the SRH needs of SWs.

[36] Annual Narrative Report 2019, Expanding Sexual and Reproductive Health Services in Burundi, Phase II, 30 March 2020

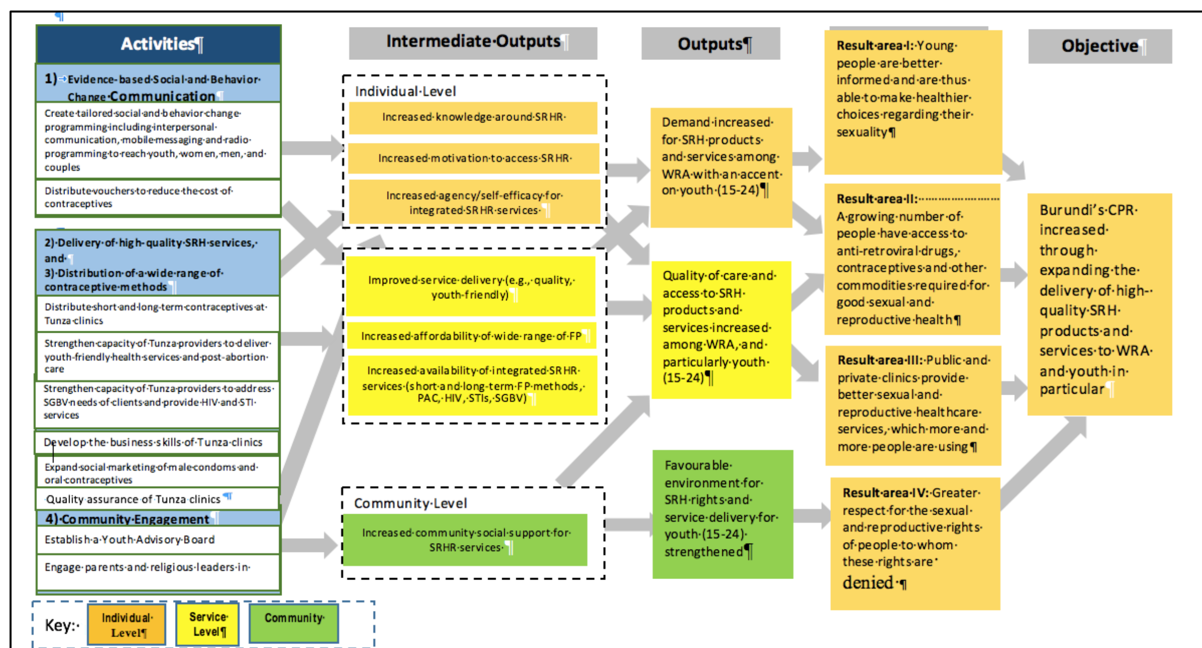
Efforts by the program to reach SWs and other marginalized groups, however, do not appear to have been as effective as was intended. The results of a 2019 rapid assessment into vulnerable groups is not available to this evaluation, although the program does not appear to have reached as many vulnerable groups as intended. Interviews with PSI suggest that the program started working with SWs at the start of phase two, but due to their illegality it was a challenge for the program to do more. Batwa populations are said to have been reached through a campaign once or twice a year, and efforts to work with IDPs were explored but did not materialize.

The voucher program which has been used on "Tunza Days" has also not been used to target and benefit the most vulnerable groups. "Vouchers" are essentially referral slips which are used by AMTs and ACIPs to increase the number of clients already living within the radius of an existing Tunza clinics to access services for free. There is no poverty criteria used to determine if a client is a vulnerable group, and no specific disaggregated program data on which vulnerable groups benefit from the voucher is collected.

8.5 Most of the inputs resulted in the expected outputs

From the program's ToC below, it is evident that the inputs and activities at the community level (sections in green) did not lead to the expected outputs. There were very few activities conducted at the community level on the program, which means that the program only operated at the individual and services level (sections in orange and yellow respectively in the ToC). Tracking how inputs and activities led to community or societal change is longer-term and systemic, but also more difficult to measure and attribute. However, as very small levels of activities took place at this level it can be determined that there was no causality between the inputs and outputs.

Figure 10: The program's Theory of Change



At the individual level, although the activities of the program partners could not be attributed to improved behavior change or uptake in products and services, it appears that the outputs were generally achieved mainly due to the other promotional activities and IPC with young people and potential clients. PSI's own SBCC activities have been demonstrated to lead to the expected results. A more personalized approach to reaching WRA and young people has been effective and led to the outputs being achieved even. Even though the activities at the individual level were achieved in phase two, the longevity of these activities could be stronger with greater, underpinning support at the community level – which has not been effective as intended. Key inputs at the service delivery level have been effective and led to the expected results in the ToC.

While some aspects of the program changed over time, and some activities did not lead to certain inputs, the ToC seems to have remained unchanged over time and has not been modified and updated based on the availability of new evidence and program learnings.

8.6 Some results were not achieved – but there are reasons why

The main results - as detailed in the results framework - that were not achieved are summarized below, along with reasons explaining why the result was not achieved.

Table 2: Program results and activities that were not achieved

Result	Reason for non-achievement
O1.1.6 Nmber of youth who have heard Tube Class amongst youth participating in *Movercado* quiz campaign	There were a series of issues and challenges with the Movercado platform which ultimately did not deliver the anticipated results. Building a complex system using a high-tech platform in a low-tech environment was not appropriate. The system suffered from a few glitches and the partner, Triggerise, was dropped from the program ahead of the program end.
O1.2.2 Number of messages sent via *Movercado*	
O1.3.3 Number of Tunza clients accepting emergency contraceptive (EC) method	Clients in most countries in the region prefer to access EC quickly and confidentially through pharmacies and not through clinics.
O3.2.1 Implant use	Implants are still underutilized in Burundi and are not as popular as they are in some other countries in the region. It is not clear, however, what specific efforts were made on the program to address low implant use.
O3.2.2 Number of pharmacies stocking Confiance in the reporting period	During the program, the government of Burundi prevented pharmacies from supplying OCs. However, it is not clear that efforts were made by the program to advocate for this decision to be revoked so that OCs could be sold through pharmacies
O3.2.8 Number of youth empowered via VSLA model	This component of the program was given to CARE to carry out, although it does not appear to this evaluation to have been carried forwards on the program.
O4.1.1 Number of parents who have attended SRHR workshops during the reporting period	The program carried out some activities that were intended to address social and religious barriers and increase community support. For example, between 2017 and 2018, some parents and religious leaders attended SRHR workshops and participated
O4.1.2 Number of parents who participated in advocacy activities	

O4.1.3 Number of religious leaders who have attended SRHR workshops during the reporting period	in advocacy activities. The activities were not scaled up in subsequent years.
O4.1.4 Number of religious ambassadors who participated in advocacy activities	

9. Efficiency

The program has made some good progress with regards to efficiency. Costs are efficient overall and some good value and cost effectiveness is apparent. Client numbers at Tunza clinics have increased and the overall level of satisfaction at Tunza clinics is high. There was a condom stock out, however, and while program partners offered some good opportunities to innovate and expand the reach to young people, their overall objectives were not fully met.

9.1 Some of the interventions are cost effective

This is covered in further details in section 14 below. Some interventions seem to have offered good cost-effectiveness. For example, some underspend has been experienced for certain program running costs – and savings of $203,490 have been realized, particularly under warehouse and office rent. This suggests that other projects were able to share more of these running costs than originally foreseen.

Program data reports the cost per DALY to be $37.34, which is good compared to other available benchmarks, including for other PSI programs. Program reports also indicate the cost per CYP to be $38.39 which is higher than comparable benchmarks.[37]

9.2 The staffing composition has been appropriate

From both secondary and primary data analyzed, PSI has deployed appropriate staff for supervision and have invested in capacity building. Tunza staff were trained in contraceptive technologies, STIs and post abortion care(PAC). This also includes a recent training on youth SRH.

There has been a high turn-over of ACIPs which can be typical on many similar programs. As young people gain more skills and experience from peer education (or similar roles), they often want to advance their opportunities, and peer education roles can often be good starts for young people to start their careers in public health, or similar fields. While high attrition rates can be disappointing for programs, the flipside that can be considered is that the program has equipped young people with skills and experience which has helped them to advance themselves and their livelihoods.

The Program Director left in October 2019 to take up a new position at PSI globally. There was a gap of a few months until a replacement was found. Sufficient backstopping was provided to fill this gap. Over the second phase of the program there has been a change in Country Representative, and there appears to be satisfaction from EKN regarding the replacement.

9.3 Client numbers at Tunza clinics are increasing

The program proposal for phase two indicates that client numbers at Tunza clinics have been lower than expected. Previous anecdotal evidence suggested that the client numbers were also low. Program data, however, indicates that clint numbers at Tunza clinics have been increasing overall

[37] Typically, on most programs, the cost per DALY is more than the cost per CYP.

throughout phase two – and the expected end of program targets have been surpassed. In total, more than 50,000 young people received their contraceptive method at Tunza[38] and more than 50,000 new FP users have visited Tunza. This evaluation finds that Tunza clinics receive an average of one to three clients per day which translates to an average of 30 - 80 clients per month. Some clinics are performing better than others, and their performance depends on various factors including location, price, provider attitudes and others.

PSI has attempted to address the issue of low Tunza clinic turn up by working with AMTs and ACIPs to increase awareness of available services and products as well as organizing "Tunza Days" where contraceptives are sold at reduced prices. AMTs and ACIPs are important in sensitizing the WRA and youth and consequently improving the number of clients regularly accessing FP services. This however depends on their level of engagement and motivation. PSI worked closely with AMTs and ACIPs to determine and solve the challenges faced. They also recruited additional AMTs and ACIPs where there was need. Also following recommendations during FGDs, the need to recruit more male AMTs to address male client needs.

Increasing the use of implants should be a key driver of CPR in Burundi as in other countries in the region, and so Tunza should be a critical player in the expansion of implant use, which would subsequently increase the program's contribution to national CPR.

Tunza has not been as successful in creating access and use for EC as was expected. A total of 8,547 clients used EC at Tunza compared to a target of 12,000. The EC use each year has steadily been increasing, however. It is important to stress though that EC use in most countries in the region does not typically occur in clinical settings, even in youth corners in clinics; pharmacies are the preferred option due to confidentiality, wide choices of providers available and the ability of young to quickly by EC anonymously. On the flipside, this option is not readily available to young people in Burundi and so Tunza clinics do offer this choice.

Overall, implant use in Tunza clinics has not been as significant as expected. Less than 8,000 implants have been inserted over the program, against a target of 10,000. Numbers were increasing steadily each year, although they have slowed between 2019 and 2020 (only 9% growth compared to 23% the year before).

While the number of young people using Tunza meets expectations, at 35% the overall proportion of clients is below the expected target of 40%. This has not increased since 2016. This can partly be explained by the higher than expected overall number of Tunza clients which has in turn reduced down the proportion of young people using Tunza. It is important to highlight that an average of around 30% of young people using a certain clinical network is on par with other programs where such indicators have been used.[39]

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[38] This includes male condoms too.

[39] The ESHE family planning program in Kenya, which was funded by the UK's FCDO and ran between 2013 and 2018, for example, measured between 25% and 35% of young people using services from its network of clinics.

PSI has increased the number of clients by working with AMT's and ACIPs to increase awareness of available services and products. AMTs had set targets of referring at least 20 women a month to their designated Tunza clinics. However the target was rarely achieved and most AMTs were not satisfied with their motivation packages. PSI addressed their concerns by organizing more supervision and training sessions as well as recruiting more AMTs and ACIPS where they were few.

9.4 Clients provide positive feedback on Tunza

This evaluation found that 53% of all young people that had ever used a clinic said that they used a Tunza. Regarding the satisfaction of clients, 84% of young people interviewed replied that they were satisfied-to-very satisfied with the services that they had receive at either a Tunza or another clinic. While the survey was not specifically designed to measure the attributable satisfaction among young people at Tunza clinics, it is evident that the satisfaction levels for Tunza clinics are high generally.

Women participating in focus group discussion reported that although FP services are generally provided free of charge by public health centres, they prefer to pay for it if they are going to spend a lot of time queuing at public health facilities. Some women reported missing appointments of FP services at public facilities due to lack of time.

FGDs with WRA and young people across Burundi show positive views of Tunza. Clients said that they go to Tunza facilities because of confidentiality, the warm reception the received, the availability of qualified staff and short waiting times. Proximity of the clinic to where client live is also important.

In addition, the household survey carried out to inform this evaluation highlighted that young people aged 15 – 24 visit Tunza also because of the effective communications and referrals made by the program's AMT and ACIP. In addition, satisfied Tunza clients will generally refer their friends to Tunza clinics.

On the flipside, while services are free in the public facilities, the waiting times for FR and SRH services is, for those that cannot afford to pay, most costly that the price of the service. WRA in Plain Region indicated that providers in public facilities are often rude and unmotivated, the availability of services is limited as is the competency of the staff.

It will be important for the program to allocate additional resources to understand the finer reasons at greater scale that determine why WRA and young people use Tunza clinics – more than this evaluation has been able to. Rather than comparing the Tunza experience with that of the public sector, it might be more beneficial to compare Tunza with other private clinics that are located nearby to Tunza clinics.

9. 5 The program experienced a six month condom stock out

The program experienced a stockout of male condoms between March and September 2019. According to program reports and stakeholder interviews carried out to inform this evaluation, the stock out occurred due to the change in the importer and supplier of the condom, as well as changes to the PSI staff that were in charge of supplies and logistics.

During the stock out of PSI's condoms, other condoms were still available in the country, in particular

free condoms which are supplied by the MoH.[40] Tunza facilities were ensured free supplies to ensure that young people could still access condoms. Condoms were still available in the market although not at the same scale of availability. PSI Burundi also worked to ensure a fair and equal distribution of the product throughout the country. PSI also held discussion sessions with other partners engaged in the distribution of free condoms (e.g. Red Cross of Burundi and government departments) to inform them of the situation and to ask them to assist in increasing the availability and accessibility of condoms throughout the country during the stockout.

The wider impact, if any, from the condom shortage has not been quantified. It is not clear if unintended pregnancies increased, or indeed if the use of EC or PAC also increased, or if any young people switched to another method.

However, the overall condom sales in phase two were almost reached by PSI: a total of 25.37m condoms were sold against a target of 25.73m condoms. Sales in 2019 were lower than in other years, but the number of private outlets selling condoms increased significantly between 2019 and 2020.

PSI has remedied the stock out challenge by having a well-organized supply structure from the national to the Tunza facility level. At the provincial level, one Tunza clinic is responsible for supplying the rest with FP products regularly and therefore shortages are low. During interviews recently held with PSI, they are confident that lessons have been learned, their systems are robust and that there should be no stock-outs in the future.

9.6 The partners presented good innovations, but their performance did not meet all program objectives

Much of the program proposal for phase two centers on Triggerise's *Movercado*[41] platform and its intended ability to be able to change behaviours through incentives and increase the number of young people that would use products and services.[42] The Movercado platform and leverages on

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[40] With Global Fund support and through the Red Cross

[41] *Movercado* is based on mobile phone technology that harvests and processes information. PSI/Burundi currently uses the platform to provide better information and services to its target clientele and to acquire better data to make timely, evidence-based decisions. AMTs and youth AMTs use *Movercado* to build a database of beneficiaries and partners. This database is also used by the call centre to conduct quality control of the sessions between AMTs/youth AMTs and beneficiaries. *Movercado* is also used to record comments, reactions and responses from listeners of *Agashi* and *Tube Class*. This creates a usable database that indicates when to send awareness messages.

[42] The proposal for example states: "Phase II will integrate these discrete *Movercado* efforts into a streamlined ecosystem that will not only continue to generate important programmatic data but also improve the clients' access to and uptake of SRH products and services. Other adjustments being made in Phase II to increase uptake of *Tunza* services include working directly with parents and religious leaders to break down barriers that youth, in particular, face; and offering providers additional trainings, supportive materials, and provider BCC to strengthen their capacity to offer high-quality, balanced FP counselling and services. In addition, special emphasis will be placed on building providers' business and management skills so that they may attract and retain additional clients and become more sustainable over time."

the increasing availability and use of mobile phones among young people across most of Burundi.[43] The platform was used in the latter stages of phase one and has been used in several other countries, although with support from the EKN.

Expected results were not delivered by the *Movercado* system and platform. The results in the program's results framework that were tied to the *Movercado* were not achieved, and activities that were partially dependent on the platform also suffered. Respondents from a household survey carried out as part of this evaluation also indicate that *Movercado* had limited reach. 14% of all 15 – 25 year olds interviewed within the proximity of sampled Tunza clinics indicated that they received reproductive health information via the *Movercado* platform. Only 8% of young people in Plain Region had received a message, compared to almost 30% in Mountainous Region. Program data indicates that only about 10% of clients reached the Tunza facility after having interacted with *Movercado*. During FGDs carried out to inform this evaluation, participants reported not having been reached by *Movercado*.

PMC were also a partner on phase one of the program and were continued into phase two to promote SRH messages to young people through their radio *Agashi* program.[44] In total, almost 600 episodes of *Agashi* were produced and aired against a target of slightly under 300, and program data indicates that almost half of Tunza clients listened to *Agashi*. In addition, the final evaluation of PMC's program indicates that 75% of Burundians aged between 15-49 years of age had ever listened to an episode of *Agashi*, and 37% of them listened to it weekly.[45]

However, according to program reports, *Agashi* was not able to directly promote Tunza clinics to young people and so it was determined that the direct linkage between to *Agashi* and the uptake of PSI services and products was not extensive enough. Data from the PMC evaluation indicate that *Agashi* was not appealing to younger audiences (i.e. the program's main target group). In addition, some young male respondents in FGDs carried out to inform this evaluation reported getting more information on SRH from national radio program than from the *Agashi*.[46]

[43] Data from the household survey carried out to inform this evaluation indicates that 78% of all young people have their own mobile phone, and 54% of all phones can connect to the internet.

[44] According to the household survey carried out to inform this evaluation, radio remains the most popular source among young people to access their SRH information.

[45] PMC Burundi Radio Serial Drama Agashi 2 Quantitative Endline Evaluation Responses to Media Access, September 2019

[46] Ibid.

10. Sustainability

Efforts have been made to increase the sustainability of the program over phase two. Numerous inputs have been provided by the program, which have improved the number of clients and supported the clinics to become stronger businesses. However, the sustainability of the program needs to be heightened and strengthened in subsequent phases.

10.1 Expectations on sustainability

Sustaining private sector interventions beyond the life of programs, and within a few years and modest budgets, is typically difficult to achieve. This is especially the case in "thin" markets such as Burundi's where only a small population can afford to pay for private products and services. Despite this, it is important for programs to move along a clear continuum towards improved sustainability, and it was evident in the program proposal that sustainability would be improved and increased in phase two.[47]

10.2 Inputs to improve sustainability have been made

The program has been able to strengthen the management capabilities of the Tunza clinics which in turn have continued to improve their financial sustainability.

"We earn between 200,000 and 250,000 BIF per day, whereas before we used to earn around 150,000 per day, which amounts to an increase of nearly 35%"
La Vie Tunza owner, Bujumbura.

During interviews, Tunza clinic managers reported that their clinics have financially progressed since becoming part of the Tunza program. As a result of the program, the clinics have expanded their services to include FP and SRH. This has therefore increased profits through sales from FP products and procedures with affordable prices for the communities. The expansion of services has also increased the visibility of the Tunza clinics, attracting more clients and contributing to the financial sustainability of the Tunza clinics.

Clinical quality training and business skills capacity building provided on the program has supported the Tunza clinics in understanding and getting insights on franchise costs, introduction of data-tracking systems and leveraging data for decision-making to explore program sustainability. Additionally, as part of improving the skills of human resources and systems a wholesaler model to cut supply chain costs was introduced while simultaneously empowering Tunza "hubs" to act as distributors to smaller facilities in their catchment areas.

The program has created a strong structure around youth friendly services within the Tunza clinics. Most Tunza clinics assessed were observed to have reserved spaces for young people where they

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47 The proposal states: "PSI/Burundi is committed to ensuring that its Tunza clinics provide comprehensive high-quality SRH services and that they will continue to do so in a sustainable fashion once the programme ends…over time (beyond the life of Phase II), the franchise will obtain greater sustainability directly linked to the increased revenues generated by the franchisees and will rely less and less on external donor support to maintain the franchise".

could meet to discuss on matters FP and SRH under the facilitation of AMTs. There was also some awareness of the YFS provided at the Tunza clinic by the national and provincial government entities especially, who got the information from coordination meetings of FP and SRH actors facilitated by PSI. This has helped facilitate the accreditation of Tunza clinics as FP sites, although there is still advocacy work to be done to ensure that Tunza procures FP products from health districts such as public health facilities.

> *"With the training we received in financial management, we have almost doubled our income and we have created other services, including maternity with generates cashflow. We firmly believe that our health center is rooted in this community."*
> **Hope's God Tunza owner, Muyinga**

Additionally, the strong community structures created through the AMT and ACIPs mobilization may enhance continuity of the program and activities long after the program ends. It was however noted that financial incentives and mechanisms in place for the AMTs, no matter how modest, may hinder or weaken the sustainability of the work done by them. These incentives often end when the program ends without any alternative sources or forms of incentives According to interviews with LMOs, the need to be updated regularly and benefit from exchanges of experience with mobilizers in other provinces and other programs in the country was expressed as an additional form of incentive.

The overall sustainability of the socially marketed products has not been an extensive feature of this evaluation, and neither have the sustainability of the other key interventions. There is of course a degree of cost-recovery in the sale of social marketing products and this has resulted in a total of more than $150,000 over the life of the program. This pool of funding is allowed to be reused to support other program activities by the EKN and this therefore can be considered as an important asset that should support future sustainability of some interventions. However, the overall cost-recovery of socially marketed products is not calculated on the program, and so this evaluation has not been able determine how sustainable PSI's products are. Demand creation activities, which are significant on the program, will require external and. continued support as they do not offer any potential for increased sustainability.

10.3 Sustainability requires a long-term approach

However, continuity of the Tunza network is uncertain as it depends on several parameters such as management and resources among many others. Additionally, there is need of continuous capacity building on FP and SRH of the specific target group beyond the duration of the program as they transition through the adolescent stage and the rest of their reproductive lifespan to ensure sustainable FP and SRH.

For advocacy, there is a need for more formalized relations between the AMTs and the community youth structures such as youth associations and networks so as to maintain access of young people and awareness creation platforms for FP and SRH beyond the Tunza program.

From the data gathered in the field from various partners there is uncertainty in the continuation of the approaches and activities done by the Tunza program as they noted that even though structures in place noted above in the duration of the program looked strong they may not be sustainable

beyond the program lifespan. Findings from the government entities did not show any political willingness to incorporate the PSI initiatives within their current work on FP and SRH.

Although the program has been effective in capacity building on matters FP and SRH especially within an underutilized private health sector, long-term impacts can only be felt if the initiatives are incorporated within the government structures. There is therefore a need for PSI to advocate for integration of the Tunza model for FP and SRH services in both the private and public health structures to include diverse choices within the community.

Mapping of private health centers located in the heart of the communities therefore having better reach of the target populations who are in need of family planning and SRH services. However, this is dependent on the continuity of these facilities and its continued provision of FP and SRH services.

Capacity building of Tunza clinics staff and AMTs on service provision which resulted in the improvement and interactions of health care providers with the young people in the communities. This has therefore created a strong synergy between the health facility and the young people through AMTs. Some facilities however noted that some AMTs have not been successful in maintaining close and consistent contact with health facilities despite the systems put in place for regular weekly meetings.

In terms of sustaining the gains beyond the life of the intervention, the program has not been clear on this as it was noted that it did not have an explicit exit strategy. This was supported by reports from some program participants (clinic staff and AMTs) who did not know when the program would be ending and the way forward. Additionally, the government entities have yet to recognize and involve private health facilities in their FP and SRH work. This therefore makes the sustainability of the milestones uncertain after the close of the program.

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11. Gender considerations

Through intentional efforts, the program has made some important gender gains in both clinical and social marketing delivery, behavior change interventions and across the program more broadly. Gender mainstreaming has been effective and the program results demonstrate broadly gender equity.

11. 1 The program has improved gender equity for accessing SRH services

The program effectively contributed to creating favorable conditions for gender equality for SRH access by having a strategy and design that considers gender representation in terms of the number of male and female ACIPs and AMTs that were hired. Gender considerations were also included during their training. Sessions facilitated by the AMTs and ACIPs on SRH had content that covered the issues of girls and boys including mutual respect of sexual rights for both sexes. During the empowerment sessions, girls were trained on how to overcome cultural taboos that impede their sexual rights.

"AMTs have sometimes facilitated sessions only for girls and we have listened and learned that sexuality concerns us, we have learned how to counter some of the tricks from boys, we have learned to say no to non-consensual sex".
Young girl, Bujumbura Kinama.

Although in theory the program put across some strategies for gender consideration, the implementation of it could have been improved especially by addressing the issue of unequal social norms. These includes areas such as the training content by AMTs and ACIPs which heavily focused on risks that girls face such as unwanted pregnancies and rape fueling the social norms that girls and women are vulnerable. This also propagates the notion that girls are victims especially when faced with sexual coercion therefore barring them from being empowered in terms of sexual negotiations and making free and informed choices. The mixed nature of the groups during sensitization sessions conducted by the AMTs sometimes made it difficult for girls or boys to express themselves easily in the presence of participants of the opposite sex.

"In our community, boys discuss sexuality with their girlfriends as we now know that they have sexual rights too."
Young boy, Bujumbura Kinama.

FGDs with parents showed that strong cultural taboos made it very uncomfortable for them to discuss about sex and even harder when it came to sexuality of young people especially young girls. The same sentiments were echoed by mothers who reported that they were afraid of discussing sexuality matters with their adolescent children especially young girls for fear of encouraging early debut of sex. One mother mentioned that she would rather have her daughter give birth than discuss issues of FP use and SRH with the daughter as she believes FP is for adults and also women who have given birth as it may affect the fertility of women who have not given birth yet. Therefore, it will be important for the next phase of the project to focus more on communication with parents as they are influential groups for these young people regarding the adoption of contraceptive methods.

WRA also reported that some of them do not inform their partners if they are using FP. These

sentiments were supported by Tunza clinic staff who mentioned that most women seeking for FP services are almost always not accompanied by their partners.

11.2 The program has largely met the needs of young men and young women

Some aspects of the program did utilize means and resources efficiently in terms of ensuring improved benefits for both women and men case in point AMTs and ACIPs involvement of girls and boys during the various training sessions, which paid attention and considered vulnerabilities faced by girls as compared to the boys. This resulted into active participation of the girls

Some aspects of program design could have been improved. For instance, some advocacy activities did not consider messages tailored to different ages i.e. messages tailored for a 16-year-old girl should be different to the one for a 20-year-old youth. Additionally, some indicators in the logical framework were not disaggregated by sex therefore preventing the monitoring and analysis of the effects of the intervention on boys and girls. An example is the TRAC study that although disaggregated the indicators related to knowledge increase, did not consider the ones on attitude and practices.
It was also noted that in terms of FP products, there was a lack of female condoms among the range of FP products available through the project.

> *"It would be nice to have femidom among the range of products as it is an SRH prevention method that gives girls/women more control ."*
> **Young girl, Bujumbura Town Hall.**

Data collected to inform this evaluation indicates broadly that among young men and women aged 15 to 24 there is no significant difference in the knowledge and use of SRH KAP between them.

Figure 11: Contraceptive availability for men and young women in PSI Burundi areas of operation

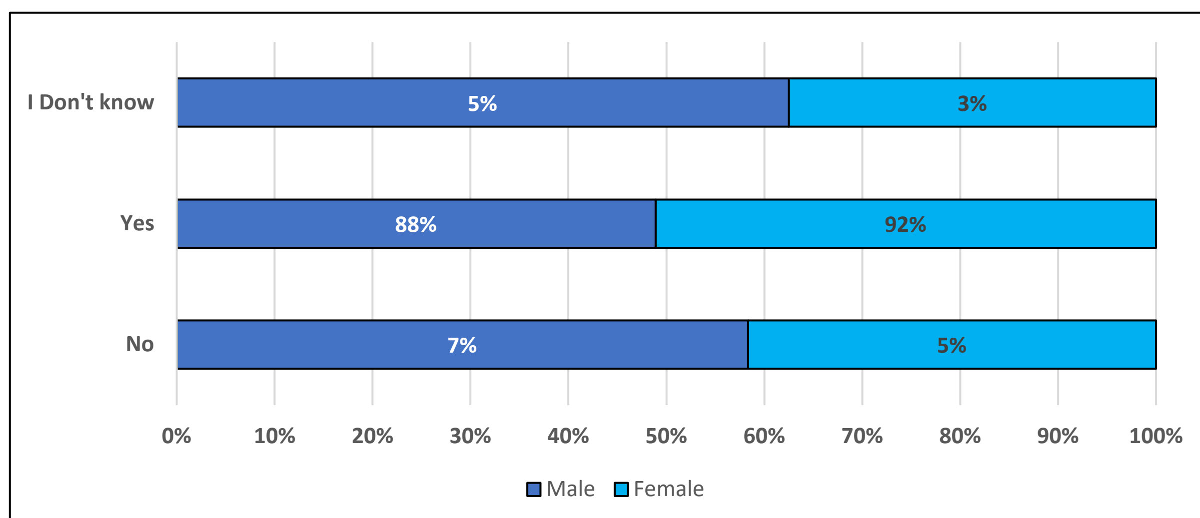
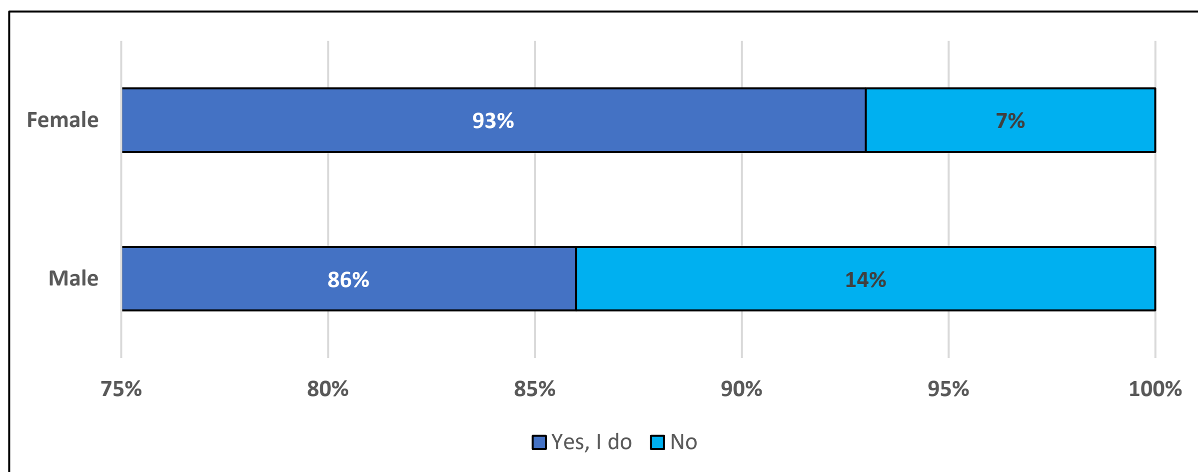


Figure 12: Opinions of young men and young women in PSI Burundi areas of operation who agree with the statement "modern FP methods are safe to use"



11.3 Gender mainstreaming and gender competence among program stakeholders could be improved

Tunza clinic providers reported that the program was able to develop gender competence among their staff as there is now more staff who welcome and serve young people with requested FP services without judgement which was not the case before the project. They however noted that the program missed out on training their staff on aspects of GBV which go hand in hand with FP practice as they sometimes interact with clients who have experienced GBV as a result of using FP services provided by them and therefore do not have the capacity of handling the situation.

> *"Without Tunza, I never thought I would be able to give a young girls her contraceptive method of choice. In my mind I always thought contraceptive methods are reserved for only married women while young girls have to be limited to using condoms"*
> **Tunza provider at the La Charité**

Finally, the agents at the condom sales points also learned not to be judgmental when faced with a girl/ woman coming to buy male condoms. In fact, the sales agents in Bujumbura's city hall experienced high demand for condoms and understood that this was due to the mobilization of AMTs and ACIPs. Additionally the AMTs and ACIPs visited the sale points to sensitize them on the SRHR rights for both girls and boys especially for purchasing condoms.

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12. SWOT analysis

Strengths	Weaknesses
1. Good program delivery in general and effective achievement of most results 2. The program has expanded SRH services through an expanded Tunza clinic network 3. PSI has established an effective network of AMTs to educate clients to seek care in FP and SRH 4. Girls and boys receive messages on FP and SRH through ACIPs 5. Tunza provides quality FP and SRH services to women of childbearing age 6. Many women of childbearing age have access to SRH/FP services in centers of their choice, including the private sector 7. Tunza have effective management and reporting tools to track activities 8. PSI regularly organizes formative supervision to maintain and enhance the quality of care 9. Existence of a decentralized contraceptive and consumables supply system that minimizes stock outages 10. Service providers have been trained to high clinical standards 11. Interactive youth broadcasts raise awareness among young people on various topics including FP/SRH 12. Tunza has expanded the range of products offered, registered new customers and improved revenues for clinics owners 13. Young people are sensitized through the weekly *Tube Class* program through listening clubs in more than 100 municipalities across the country	1. The "voucher" scheme does not intentionally benefit the poor and most vulnerable 2. High turnover of trained Tunza staff and ACIPs 3. Coverage of WRA awareness especially side effects and complications 4. Insufficient attentions on services for men at in Tunza clinics 5. Limited evaluation of the program's media coverage 6. No sustainability plan in place 7. No VfM framework in place 8. Program results framework and ToC have not been proactively used to shape and evolve the program 9. Some clients feel that FP services are expensive in Tunza especially the implant and IUD 10. Lack of youth space and specific services in some Tunza facilities 11. Tunza experiences, especially the quality of services and program reach and delivery is not shared enough with stakeholders at all levels including national, provincial and district 12. Lack of coordination with other projects funded by EKN especially, even SRH programs implemented in the same provinces

14. Behavior change interventions generally are strong and have demonstrable impact 15. The program has contributed to the expansion of health services through the wider private sector, including ANFS, wholesalers and. pharmacies	13. Insufficient coordination of program interventions with other SRH programs and stakeholders in general 14. Provincial and district health staff are not involved in planning and implementing the program
Opportunities	**Threats**
1. Take the program to go to scale and to make a bigger impact nationally 2. The program can reach more rural populations, and more vulnerable groups 3. There is goodwill from the national government PNSR program and the wider MoH generally that supports the program – and which should be leveraged to scale reach and impact 4. Private health centers have welcomed the implementation of SRH/FP services and others are calling for them to be integrated into their service delivery packages 5. The Most Burundians, despite their religious beliefs, accepts FP methods to promote maternal and child health and family well-being, and this should be leveraged by the program 6. Young people with religious affiliations have good SRH KAP and behavior 7. There are opportunities to expand the FP method mix on the program (including DMPA-SC), and opportunities for the private sector to deliver OCs and EC. Scale implants to increase national CPR 8. Opportunities to learn from other PSI programs – and other national SRH and FP programs – in the region 9. The program can take a leadership role on self-care in Burundi 10. Increased role of a stronger ANFS to support more Tunza and other private clinics and to become a key market player 11. Total market approach	1. Socio-cultural, religious and traditional barriers 2. Sustainability of the Tunza model without continuous donor support (and without a clear sustainability plan) 3. Restrictive policy and regulatory environment that limits the role of the private sector and the distribution of certain FP products and services 4. Occasional restrictive environment for INGOs operating in Burundi

14. Budget analysis

14.1 Pace of spend

The total approved budget for the contract is $7,780,071. Based on review of the financial reports, the pace of expenditure was greater in years 1 and 2 (2016-7), with $4,622,466 expenditure reported across the two years (59.4% of total budget). Expenditure then slowed throughout the contract, with 27.1% in year 3 and 13.5% in year 4.

This can be partly attributed to COVID-19 which slowed the rate of delivery and also because 87% of the budget was spent in the first three year, leaving 13% for year four.

14.2 Analysis of performance per budget line

The team predicts to spend the full 100% of the budget by end of 2020. However significant virements to budget lines have been reported, on all lines except subawards/subcontracts.

There is an overall underspend on personnel cost categories, primarily driven by an underspend against budget for all PSI employees in the field, as well as STTA (e.g. in finance, business support, security), and field staff.

Under expense categories, large underspends on consultants, commodities (particularly condoms), communication and education, and 'other direct costs' enabled $502,047 additional budget to be diverted to field staff travel. This increased the travel budget by 149%, suggesting travel was heavily under-budgeted originally (particularly considering that less field personnel time was utilized/billed to the project than planned).

The value for money of the underspend in 'Other Direct Costs' should be noted, as this expense category covers the majority of running costs – and savings of $203,490 were noted, particularly under warehouse and office rent. This suggests that other projects were able to share more of these running costs than originally foreseen.

$230,477 budget was diverted to Promotion and Advertising (an increase to that budget line of 136%), with overspend noted on print media and sales events as well as unbudgeted spend incurred on community events – which suggests a deviation from the original promotional/marketing strategy.

Finally, there is indication that program related trainings and meetings were not adequately covered in the original budget – or more were required than foreseen. This is indicated by the 20% ($75,839) overspend on this budget line. Only security trainings were included in the underlying budget, against which there is a significant underspend, with a number of new budget lines introduced to support staff training, conferences and meetings, as well as a new budget line for a Youth Advisory Board.

14.3 Cost per CYP

Cost per CYP is a standard VFM metric used by FP programs and is noted in the financial report provided to be one of PSI's standard indicators. It reflects variations in length of efficacy and continuation of use of different FP method.

The role of *program size* is important to consider in assessing cost-effectiveness. Larger programs benefit from economies of scale (e.g. in procurement), and the distribution of fixed costs (such as mass media campaigns) across more units; and so unit costs tend to decline as the number of contraceptive users increase.

Additionally, the cost per CYP metric depends heavily on the mode and type of FP services provided. Whilst long-acting methods are more expensive to administer, they tend to offer a lower cost per CYP as they provide protection for longer periods of time. The input costs for different service delivery models also affects the cost per CYP.

Table 3 below shows cost data to demonstrate how the mode of service delivery influences the estimated cost per CYP based on analysis from Sub-Saharan Africa.[48]

Table 3: Comparative cost per CYPs per delivery channel in Sub-Saharan Africa

Mode of service delivery	Cost per CYP (US$)
Social marketing	15.95
Community-based distribution	20.32
Clinics	16.65
Clinics with community-based distribution	8.02

For this phase of the program the cost per CYP has been calculated by PSI as $37.34. In comparison to other industry benchmarks and recent examples:

- PSI's global website states in 2015 that the net cost per CYP was $12.1449 and $39.26 in Burundi[50]
- On the FCDO funded ESHE program in Kenya, PSI reported a cost per CYP of £10.43 (GBP) over the program period (2015-18)
- In 2019, DKT reported a cost per CYP across its target countries in East and West Africa of ~ $7 USD[51]
- The Preventing Maternal Deaths in East and Southern Africa (PreMDESA) which was implemented by UNFPA in 12 countries including Burundi, reported an aggregated cost per CYP of $1.60 USD[52]

48 Levine R, Langer A, Birdsall N. et al. 2006 Contraception. Chapter 57. In: Jamison, D.T. et.al. Disease Control Priorities in Developing Countries. 2nd Edition. The World Bank and Oxford University Press (2006)

49 https://www.psi.org/publication/net-cost-per-cyp-provided-2015/

50 https://www.psi.org/wp-content/uploads/2020/02/Net-Cost-Per-DALY-2015.pdf

51 https://2umya83uy24b2nu5ug2708w5-wpengine.netdna-ssl.com/wp-content/uploads/2020/10/DKT-International-Cost-and-Results-2019.pdf

52 http://iati.dfid.gov.uk/iati_documents/29435864.odt

14.4 Cost per DALY averted

Cost per DALY averted is another metric used to assess the cost effectiveness of healthcare interventions and has been widely used to directly compare cost-effectiveness of interventions in different national settings – including in FP. It is often used to highlight investment in family planning as a "best buy" in global health because of its relative cost-effectiveness.[53] For this phase of the program the cost per DALY averted has been calculated by PSI as $38.39, which is in line, or below other benchmarks:

- Modern contraceptives are estimated by Guttmacher Institute to cost $62 per DALY averted world-wide[54]
- PSI's global website states in 2015 the net cost per DALY averted was $19.48[55] and $40.08 in Burundi[56]
- The FCDO funded Delivering Reproductive Health Results (DRHR) program (which used social franchising and social marketing approaches to increase the supply of high-quality family planning services in underserved areas of Pakistan) reported cost per DALY averted of £20 (GBP)[57]

[53] https://www.guttmacher.org/sites/default/files/report_pdf/AddingItUp2009.pdf

[54] https://www.guttmacher.org/sites/default/files/report_pdf/AddingItUp2009.pdf

[55] https://www.psi.org/publication/net-cost-per-daly-averted-2015/

[56] https://www.psi.org/wp-content/uploads/2020/02/Net-Cost-Per-DALY-2015.pdf

[57] https://link.springer.com/article/10.1186/s41256-018-0089-4

15. Lessons learned

Several lessons have been learned over the life of the program – as identified in program reports, discussions with stakeholders and based on the experiences of this evaluation. Summary lessons learned are outlined below.

15.1 The program's demand side interventions can positively affect the wider market

Evidence from the program demonstrates that mass media, as well as other demand-side intervention including peer educators and AMTs, have unintentionally and positively affected other public and private providers in Burundi. This spillover effect has provided other clinics outside the program with additional clients.

15.2 Young Burundians with religious affiliations in Tunza areas do not appear to have significant barriers to FP

Evidence from this evaluation indicates that young people across Burundi from all religious affiliations do not have significant barriers to FP KAP and use. This should be an important consideration for any future program interventions that aim to tackle traditional and religious barriers among parents and in communities.

15.3 Advocacy remains critical to expanding SRH services and products through the private sector

While the program has successfully expanded services and products through Tunza and private outlets, government restrictions are still in place that inhibit and prevent certain FP products, especially OCs, EC and injectables, from being available through the private sector. The importance of strategic advocacy on programs, including those such as Expanding SRH, is critical to the overall and longer-term advancement of FP.

15.4 Condoms are fairly priced, but consumer behavior indicates the willingness to pay more

The program increased the price of condoms. While this resulted in some decline in sales in the immediate term, sales were not affected overall. Consumers demonstrated that they were generally willing to pay more to continue using their preferred condom choice.

15.5 Changes in supply chain players can have unintended and adverse consequences

The change in the importer and supplier of PSI's condom resulted in a six month stock-out. The program had sufficient stock in hand to ensure that there was not a national shortage of condoms. Working with other players also helped to mitigate the impact of the stock-out.

15.6 Partners' ability to deliver should be aligned with the design of the program and the local context

While both PMC and Triggerise contributed to the program, their performance overall did not meet expectations and, for different reasons, did not deliver the results as expected. While due diligence was carried out on both partners, it is critical to ensure that partners selected to work on programs are the very best fit with the overall design and the specific country contexts.

15.7 Interventions that are the simplest can sometimes have the greatest impact

The innovations that the *Movercado* system offered did not translate into the expected results. Conversely, AMT and peer educators have been shown to have significant impact. Roadshows were changed to focus on IPC interventions instead for the same reasons.

15.8 Active results framework management leads to greater delivery

There are a few indicators in the results framework that should have been removed and/or annual milestones or target modified upwards or downwards. If this had occurred then the overall performance against the results framework would have increased, and the targets for some indicators could have also been increased which arguably would have led to increase program delivery and performance.

16. Recommendations

This evaluation makes a number of recommendations regarding the next phase of the program. Recommendations relate to the scale and reach of the program; expanding the FP method mix; sustainability; SBCC and engaging youths; the private sector and the total SRH market; VfM; the Results Framework and M&E, and routine PSI and EKN engagements.

16.1 Take the program to scale

The first and second program phases put in place key programming foundations. Good results have been achieved and the program has created important momentum that should be capitalized on for greater SRH outcomes. PSI is a major SRH player in Burundi and has an important role to play in positively changing behaviors, creating more access and use of services and contributing the improvements in the health market and the country's CPR growth.

A third phase of the program should therefore be bold, ambitious and more evolutionary in its objectives, scale, delivery and impact. The third phase should be taken to be the game-changing program in Burundi that accelerates SRH across the country in a way that has not been seen before.

16.2 Expand SRH and products services to rural areas

Many of the delivery channels (on both demand and supply sides) are still very focused on urban and peri-urban communities and clients as this is predominately where those who can and are willing to pay for services and products are located. However, there is still a significant need to go beyond the urban and peri-urban areas and to reach rural (and therefore poorer) Burundians will more quality SRH services.

To do this, a combination of modified service delivery side models will likely be required, and these will need to consider various criteria including the need, gaps in the market, service delivery impact, ability of clients to pay (or not) for services and the potential for long-term sustainability.

Based on these factors, the experiences and evidence from other countries in the region, and the costs and benefits below, a combination approach that includes private clinics that are either Tunza "Light" and/or non-branded clinics accredited to a quality network (perhaps ANFS), perhaps combined with some targeted subsidy to reach more vulnerable and poorer groups, would be the best combination. Technical support to increase improved SRH outcomes in selected high volume MoH facilities might also be considered to reach more rural clients.

The mapping of service delivery points that was carried out at the start of phase two should be revisited and refreshed as required. The selection criteria for choosing clinics to deliver services through should be also updated to suit a new program phase and a more ruralized context.

Table 4: Potential service delviery models for the program to consider for expansion to rural areas

Option	Benefits	Costs
Tunza "Light" – private clinics that provide quality services but at lower costs to clients. Such clinics would be accredited to the Tunza network but would perhaps have a smaller and less costly inputs from PSI, thereby enabling greater scale and more potential for graduation after PSI's support for four of five years	• Will enable better quality SRH services to be made available to rural populations, but at lower cost to clients and PSI's donors • Will enable more scale than the typical Tunza model due to lower clinic unit costs/lower support costs per clinic • If designed in such a way, they can be graduated effectively by the end of a program lifecycle	• The quality of many rural private providers is often lower than their urban counterparts – so more technical inputs may be required in the initial phases • Would such a model acceptable to PSI global standards?
Non-branded private and other clinics – expand quality and less expensive services to client through existing private clinics, or FBO clinics. These would not be branded as Tunza, and may not have the same package of inputs, but such clinics would focus on expanding SRH services through existing clinics that are already busy with existing clients and provide a satisfactory level of quality services to local populations	• Same advantages as the Tunza "Light" model • Less expensive than the Tunza "Light" model as less inputs are provided to most clinics • If designed in such a way, they can be graduated effectively by the end of a program lifecycle	• The quality of many rural private of FBO providers is often lower than their urban counterparts – so more technical inputs may be required in the initial phases • The overall strength and capacity of FBO networks in many countries can be varied • Working through centralized FBO network headquarters can be bureaucratic • FP is often not provided in FBO clinics and there is a reluctance to include it
Support to the public sector – technical support is provided to specific clinics (and mobile outreach if available through the public sector) to deliver more quality SRH services	• Can expand SRH service availability to clinics where they are not available • Reaches the poorest • Builds government/MoH capacity	• May not lead to quick results • Trained staff often are not retained for very long and so the impact can be reduced

	• Improves quality in clinics where quality may be typically be lower than in private clinics	

16.3 Expand SRH services and products to urban and peri-urban areas

There remains a significant need for SRH services and products to be taken to greater scale in Burundi's urban and peri-urban locations. Service delivery numbers through Tunza have improved on the program, and the number of private sector outlets stocking PSI products has also increased, and both have contributed to good program results and Burundi's CPR. Both Tunza (or equivalent Tunza "Light" or non-branded clinics – see 16.2 above) and social marketing should be taken to greater scale, while taking on board considerations for greater sustainability.

16.4 If a voucher scheme is justified, then modify and improve it so that it reaches more poor and vulnerable groups

Reviewing the costs, benefits and rationale for having a voucher scheme should carried to inform if one is required for the subsequent program phase, and if it is, clear guidelines and eligibility criteria should be developed and used. Targeted subsidies should be used to benefit the poorest and most vulnerable groups that cannot afford to pay for services, rather than as a way of increasing the overall number of clients using program clinics. Disaggregated data that tracks and measures which client groups benefit from the vouchers should be captured and reviewed routinely to ensure the intended groups benefit appropriately.

16.5 Integrate sustainability into all program interventions meaningfully

Sustainability should be built into the program as a core principle. A sustainability plan should be developed before the start of the next phase and agreed with EKN as part of its contract with PSI. The plan should clearly articulate what is the overall exit strategy of key interventions, and what will be sustained at certain intervals in the program. Meaningful, "SMART" indicators for sustainability should be developed and included in the Results Framework and contractual KPIs. The cost-recovery of socially marketed products should also be included in the sustainability plan, as should other sustainability outcomes such as the use of project income, Tunza owners paying for demand creation support from AMTs and ACIPs – as well as sliding payment scales from Tunza owners for all other future inputs from the program (e.g. training, commodities, materials, branding, equipment) as well as graduating clinics as noted in 16. 6 below.

16.6 "Graduate" sustainable Tunza clinics that are ready to operate independently

The subsequent program phase should put in place clear transition criteria and plans that would support a selected number of Tunza clinics to be strengthened and then "graduated" so that they do not require the same – or any – support from the program. The program can learn and incorporate experiences from PSI countries from within the region.

16.7 Scale up the availability and use of implants

During phase two, it is male condoms and injectables and that have resulted in the most CYPs, while implant use has also increased in Tunza clinics. As part of an overall drive to improve choice and

access to a full method mix, and through an expanded clinic network, the program should focus on increasing the use of implants. Not only will this support users to have more FP protection over the longer-term,[58] it will contribute significantly to national CPR growth, as has been witnessed in other countries in the region.[59] The use of implants will be possible through increased Tunza and other clinics and with a greater emphasis on counselling WRA on the benefits of switching to longer acting methods, the cost benefits to clients of investing in an implant rather than relying on short-acting methods. The cost of implants can be a barrier to use, although if Tunza receives the product for free or at a reduced cost then it will be important for the prices to clients to remain affordable. Targeted subsidies for implants in rural locations may also be explored.

16.8 Consider the introduction of subcutaneous contraceptive injectables

Injectables remain the most popular FP method in Burundi and they are still the key driver of CPR growth.[60] Injectables are also a key engine of CYP growth on the program. Subcutaneous contraceptive injectables (DMPA-SC) are currently available in Burundi through UNFPA but currently for the public sector only. PSI is providing DMPA-SC to clients through its USAID program, and this should be expanded with EKN support into the next program phase. Given the potential for DMPA-SC to be widely used as part of self-care initiatives, it will be important for the product to become available in Burundi through non-clinical outlets, such as pharmacies. This evaluation recognizes the difficulty of this being possible, and so extensive advocacy will be required (please see 16.9 for further details).

16.9 Advocate for greater use of FP products through the private sector

Extensive government restrictions on which FP products can be imported and sold through which categories of health outlets in the country impede Burundi's CPR growth and significantly limit reproductive choices. The program should partner with effective strategic advocacy organizations to improve the policy and regulatory environment so that more quality approved products can be sold through the private sector – especially OCs and EC. Given the restrictions on OCs and EC, DMPA-SC will also require advocacy efforts for it to be made available outside of the public sector, especially if there are intentions for the product to be made available in time outside of clinical settings. Self-care and task-shifting are likely to be key themes for such advocacy efforts.

16.10 Scale up mass media, SBCC and peer education to support the program and grow the total demand in Burundi

Evidence demonstrates that program's demand creation also benefitted other clinics, in both private and public sectors. Increased demand therefore contributed to the overall growth of CYPs and CPR in Burundi. Feedback from young people also indicates that radio programs and peer education are very effective in improving behaviours and increasing the use of services. The current configuration of SBCC interventions on the program should be continued and scaled for urban and peri-urban

[58] One implant typically offers between 2.5 and 3.8 CYPs and therefore offers users much more protection that short-term methods such as injectables (one injectable offers 0.25 CYP).

[59] In Kenya, for example, national CPR growth has increased dramatically over recent years (now 61.4% according to FP2020) and this growth is largely due to the increased use of implants – for both urban and rural clients.

[60] Approximately 50% of Burundi's CPR is accounted for by injectables (Track20).

groups. The program should explore and test the most appropriate interventions to reach rural clients, although evidence indicates that radio and IPC are popular and effective.

Mass communications in the next phase should also focus on growing the total market and the national demand for SRH. Rather than only promoting the program's brands and products only, messages should promote the wider benefits of FP, including the different methods, and tackling myths and rumors. Generic messaging would help to increase the overall use of SRH services and products across a multiplicity of private providers throughout Burundi, including PSI, and others including the public sector

16.11 Increase the focus on tackling socio-cultural, religious and other barriers

If the program is to scale up its work to reach more rural communities, including young girls, then socio-cultural, religious and other such barriers will need to be tackled. Working with faith-based clinics to deliver FP services (as proposed as part of 2021-23 activities) will be a good entry point, but a comprehensive demand-side strategy will be required to support girls to access and use services without socio-cultural and religious backlash.

16.12 Work inclusively with young people as partners

The Youth Advisory Board should be expanded. There is an opportunity for the Youth Advisory Board to provide important perspectives to PSI on the program design and interventions, and for PSI to be more accountable to young Burundians. A Youth Advisory Board representative should occasionally attend program meetings with PSI, EKN and other stakeholders (see 16.18 below).

16.13 Increase the focus on Burundi's total SRH market

The program should continue to expand its focus on supporting, advancing and strengthening Burundi's SRH market. This move would be in line with the EKN's overall Burundi country strategy that places a greater emphasis on market-based approaches across all sectors (and not just health).

Given the limited number of players in Burundi that work with and through the private sector, PSI has an opportunity to demonstrate leadership in this domain. This might require a shift in the approach that PSI typically takes as a direct market player to one that facilitates other parts of the market. It will be important to advocate with the government of Burundi on the increased role of the private sector as part of the overall increased focus on the market. Support to selected private sector players will be important – as outlined in 16.13 below.

16.14 Scale up and strengthen ANFS and expand private sector outlets, including wholesalers and pharmacies

ANFS could become an important new market player in Burundi with specific and time-bound support from the program. It is recommended that the ANFS be provided with a range of technical and managerial support for two years with the aim of them becoming a self-governing and autonomous network. The ANFS could then serve as the main network for Tunza clinics, including those that are graduated, as well as other clinics that may be brought on during the next phase of the program. There are a few various models of different accredited networks that could be explored, and PSI has experience from several other countries which should be used to support Burundi. The

program's work with wholesalers and pharmacies can be expanded in the next phase, especially regarding the expansion of products, such as OCs, EC and potentially DMPA-SC.

16.15 Have a Value for Money framework that is used to develop and maintain cost effectiveness and support sustainability

A comprehensive and meaningful VfM framework should be developed and used on the program – building on the cost effectiveness analysis that resulted in a pricing list for services carried out by PSI in mid-2020. This framework would include key indicators and financial milestones that can be monitored over the life of the program to assess how well the program is functioning vis-à-vis VFM targets. Program sustainability indicators could be added to such a framework. VfM indicators should be included in the Results Framework, and reported against routinely. Compared with the program results, this framework would enable PSI and EKN to better understand which interventions are having the most impact for which costs.

16.16 Actively manage the Results Framework and ToC

The Results Framework and ToC should be managed more actively and routinely at key intervals throughout the program cycle. This would enable the program to work in a more flexible and adaptive way that would be more aligned to the changing program delivery context. It would also enable the Results Framework to be reviewed and potentially updated at the end of each program year to also reflect the situation on the ground – and to be used more as a living document that is more aligned to the program delivery and context. It would serve as a routine moment in the program calendar to test the evidence against the ToC, incorporate key learnings into the ToC, modify program delivery as appropriate and to also review and update the Results Framework and program indicators, milestones and targets as required. Indicators that are not relevant to the program should be adjusted and removed from the Results Framework if required and justified. Indicators with milestones and targets that are easily being met should be reviewed upwards.

16.17 Hold routine, monthly meetings with EKN (and potentially other key stakeholders)

To also support a more active management and engagement of the program, PSI and EKN should consider holding monthly meetings. These would serve as an important opportunity for both parties to check in on the program and its technical and financial delivery, discuss the program strategy, results and other key items. Other key stakeholders, such a program partners, the MoH and youth representatives could also be invited to such meetings on a quarterly or biannual basis for the same reasons and outcomes. The program should also consider having such check-ins with partners and other key stakeholders at a decentralized level on a suitable frequency.