



**An Evaluation of Reproductive Health Service Provision
for Malian Refugees in the Sahel Administrative Region,
Burkina Faso**

November 18-27, 2013

Inter-agency Working Group on Reproductive Health in Crises

An Evaluation of Reproductive Health Service Provision for Malian Refugees in the Sahel Administrative Region, Burkina Faso

November 18-27, 2013

This report was written by Philippe Cavailler, Mark Beesley, Sarah Chynoweth, and Maya Guttman-Slater for the 2012-2014 IAWG Global Review on Reproductive Health in Crises. It was reviewed by Sara Casey of Columbia University.

With funding provided by the:

US Department of State, Bureau of Population, Refugees and Migration and John D. and Catherine T. MacArthur Foundation

Acknowledgements:

We are deeply grateful to UNHCR, Marie Stopes International (MSI), and the Ministry of Health for their support. We whole-heartedly thank the following individuals, without whom this assessment would not have been possible: *from the assessment team:* Ms Fadimata Aibana, Mr Boubakar Ba, Mr Moustapha Banda, Mr Martin Dayana, Mr Oumarou Cissé, Mr Ousmane Gansoré, Dr Benoit Kayembe, Mr Noel Konkobo, Dr Nicolas Maiga, Mme Michelle, Ms Agathe Mandou, Ms Michelle Nakoulouma, Mr Abdoulaye Nassouri, Mr Ismael Ouédraogo, Dr Théophile Ouédraogo, Mr Sidi Mohamed Oulo, Mr Hamadou Savadogo, Dr Arnaud Toé, and Mme Sabine Zoungrana; *from UNHCR offices staff from Ouagadougou, Dori and Djibo:* Ly Alhousseyni, Karim Anisse Benamar, Mr Blaise, Mr Oumarou Cissé, Annie Dumont, Mme Eliane, Mme Evelyne, Stephane Jaquemet, Marie Louise Kabre, Dr Benoit Kayembe, Mr Kone (Dori), Ali Mahamat, Gislaine Ada Ngaska, Ephrasie Oubda, Hugo Reichenberger, Mr Theophylle, Mr Vincent; *from the Ministry of Health:* Dr Denis Yelbeogo; *from MSI:* Mr Dramane Semde.

Contact: IAWG at info@iawg.net

Contents

| | |
|--|----|
| List of tables | 5 |
| List of acronyms | 5 |
| Executive summary | 8 |
| 1. Introduction | 12 |
| 2. Background | 12 |
| 2.1 Introduction to Burkina Faso | 12 |
| 2.2 Health sector | 14 |
| 2.3 Reproductive health in Burkina Faso | 16 |
| 2.4 Malian refugee crisis | 17 |
| 2.4.1 Humanitarian response | 19 |
| 2.5 Comprehensive RH care | 20 |
| 3. Objectives | 21 |
| 4. Methods | 21 |
| 4.1 Methods and tools | 22 |
| 4.2 Analysis, ethics, and limitations | 28 |
| 5. Findings | 29 |
| 5.1 Overview of humanitarian response | 29 |
| 5.2 Health facility assessments | 31 |
| 5.2.1 Summary of facilities | 31 |
| 5.2.2 UN/NGO support | 32 |
| 5.2.3 General infrastructure | 33 |
| 5.2.4 Infection prevention | 34 |
| 5.2.5 Human resources | 34 |
| 5.3 Family planning | 36 |
| 5.3.1 Overview | 36 |
| 5.3.2 Service delivery | 37 |
| 5.3.3 Provider knowledge and attitudes | 39 |
| 5.3.4 Focus group discussions | 40 |
| 5.4 Emergency obstetric and newborn care | 41 |
| 5.4.1 Overview | 41 |
| 5.4.2 Service delivery | 43 |
| 5.4.3 Provider knowledge and attitudes | 49 |
| 5.4.4 Focus group discussions | 50 |
| 5.5 Comprehensive abortion care | 51 |
| 5.5.1 Overview | 51 |

| | |
|--|----|
| 5.5.2 Service delivery | 51 |
| 5.5.3 Provider knowledge and attitudes..... | 53 |
| 5.5.4 Focus group discussions | 53 |
| 5.6 HIV and other sexually transmitted infections | 53 |
| 5.6.1 Overview..... | 53 |
| 5.6.2 Service delivery | 54 |
| 5.6.3 Provider knowledge and attitudes..... | 57 |
| 5.6.4 Focus group discussions | 57 |
| 5.7 Sexual violence | 58 |
| 5.7.1 Overview..... | 58 |
| 5.7.2 Service delivery | 59 |
| 5.7.3 Provider knowledge and attitudes..... | 61 |
| 5.7.4 Focus group discussions | 61 |
| 6. Discussion..... | 62 |
| 6.1 General..... | 62 |
| 6.1.1 Health coverage..... | 62 |
| 6.1.2 UN/NGO support | 63 |
| 6.1.3 General infrastructure and infection prevention | 63 |
| 6.2 Family planning..... | 64 |
| 6.3 Emergency obstetric and newborn care..... | 65 |
| 6.4 Comprehensive abortion care | 66 |
| 6.5 HIV and other sexually transmitted infections | 67 |
| 6.6 Clinical management of rape | 68 |
| 7. Summary and recommendations..... | 69 |
| References..... | 72 |
| Appendix A: Detailed tables of RH service availability | 77 |
| Appendix B: Provider knowledge and attitudes questionnaire results | 85 |
| Appendix C: Full sampling matrix..... | 91 |

List of tables

| | |
|--|----|
| Table 1. Key health statistics in Burkina Faso..... | 16 |
| Table 2. Key health statistics in Mali | 18 |
| Table 3. Assessed facilities in ranked order by estimated catchment population | 25 |
| Table 4. Summary of facilities | 31 |
| Table 5. Facilities that receive NGO/UN support for RH by topic..... | 32 |
| Table 6. General infrastructure..... | 33 |
| Table 7. Facilities with essential infection prevention supplies available..... | 34 |
| Table 8. Human resources | 35 |
| Table 9. Provision of family planning services to an acceptable standard..... | 37 |
| Table 10. Short-acting family planning services provided & reasons not provided..... | 38 |
| Table 11. Long-acting and permanent family planning services provided & reasons not provided | 39 |
| Table 12. Provision of EmONC to an acceptable standard | 44 |
| Table 13a. EmONC Signal functions provided and main reasons for not providing function..... | 45 |
| Table 13b. EmONC Signal functions provided and main reasons for not providing function..... | 46 |
| Table 13c. EmONC Signal functions provided and main reasons for not providing function..... | 46 |
| Table 14. Provision of EmONC across facilities | 47 |
| Table 15. Facilities with essential elements of newborn care..... | 48 |
| Table 16. Provision of PAC to an acceptable standard | 52 |
| Table 17. Comprehensive abortion care provided & reasons not provided | 52 |
| Table 18. HIV and other STI services (self-reported) | 55 |
| Table 19a. HIV and other STI services provided & reasons for not providing | 55 |
| Table 19b. HIV and other services provided & reasons not providing | 56 |
| Table 20. Facilities with essential drugs to provide PMTCT | 56 |
| Table 21. Selected elements of CMoR..... | 60 |
| Table 22. Essential drugs for CMoR provided & reasons not provided | 61 |

List of acronyms

| | |
|---------|---|
| ABBEF | <i>Association Burkinabé pour le Bien-Etre Familial</i> |
| ART | Antiretroviral therapy |
| ARV | Antiretroviral drugs |
| BEmONC | Basic emergency obstetric and newborn care |
| CAMEG | <i>Centrale d'Achat des Medicaments Essentiels Generiques</i> |
| CARMMA | Campaign to Reduce Adult and Maternal Mortality in Africa |
| CEmONC | Comprehensive emergency obstetric and newborn care |
| CFA | <i>Communauté Financière Africaine franc</i> |
| CHR | <i>Centre Hospitalier Régional</i> |
| CM | <i>Centre Médical</i> |
| CMA | <i>Centre Medical avec Antenne Chirurgicale</i> |
| CMoR | Clinical management of rape |
| CONAREF | <i>Commission Nationale pour les Réfugiés</i> |
| CSPS | <i>Centre de Santé et Promotion Social</i> |
| DRD | <i>Depots Repartiteurs de Districts</i> |
| EC | Emergency contraception |
| EmONC | Emergency obstetric and newborn care |
| FGD | Focus group discussion |
| FP | Family planning |
| GBV | Gender-based violence |
| IASC | Inter-Agency Standing Committee |
| IAWG | Inter-Agency Working Group on Reproductive Health in Crises |
| IUD | Intrauterine device |
| KII | Key informant interviews |
| MCA | Men community leaders Arab |
| MdM | <i>Médecins du Monde</i> |
| MMB | Married men Bela |
| MMT | Married men Tuareg |

| | |
|--------|--|
| MNLA | <i>Mouvement National de Libération de l'Azawad</i> |
| MoH | Ministry of Health |
| MSF | <i>Médecins Sans Frontières</i> |
| MSI | Marie Stopes International |
| MVA | Manual vacuum aspiration |
| MWB | Married women Bela |
| MWT | Married women Tuareg |
| ND | No data |
| NGO | Non-governmental organization |
| OCP | Oral contraceptive pills |
| PAC | Post-abortion care |
| PEP | Post-exposure prophylaxis |
| PI | Principal investigator |
| PLHIV | People living with HIV |
| PMTCT | Prevention of mother-to-child transmission of HIV |
| RH | Reproductive health |
| STI | Sexually transmitted infection |
| UMB | Unmarried men Bela |
| UMT | Unmarried men Tuareg |
| UNFPA | United Nations Populations Fund |
| UNHCR | United Nations High Commissioner for Refugees |
| UNICEF | United Nations International Children's Emergency Fund |
| USAID | United States Agency for International Development |
| UWA | Unmarried women Arab |
| UWB | Unmarried women Bela |
| UWT | Unmarried women Tuareg |
| VCT | Voluntary counseling and testing for HIV |
| WCT | Women community leaders Tuareg |
| WHO | World Health Organization |

Executive summary

Introduction

As of September 2013, almost 50,000 Malian refugees have fled fighting in their home country and have been granted refugee status by the Government of Burkina Faso.¹ An estimated 60% live in three consolidated refugee camps—Goudebo, Mentao and Sag-Nioniogo—and up to 20% reside in host villages.² This report documents the main findings of an assessment of reproductive health (RH) services among Malian refugees in Goudebo and Mentao camps as well as the surrounding host communities in the Sahel Administrative Region of Burkina Faso.

Purpose

As part of a global review on RH in humanitarian settings, the Inter-agency Working Group on Reproductive Health in Crises (IAWG) has undertaken assessments in three humanitarian settings to document the availability, quality, and utilization of comprehensive RH services available for conflict-afflicted communities. This report describes one component of the three-country study: a mixed methods assessment of RH services for Malian refugees in Burkina Faso. The purpose of this study is to inform policy and programming to help meet the RH needs of the refugees and surrounding communities.

Methods

The study team used a mixed methods approach involving both quantitative and qualitative components including health facility assessments, provider questionnaires, focus group discussions (FGDs), and key informant interviews (KIs). From 18 to 27 November 2013, 28 health facilities in Burkina Faso's northern Sahel Administrative Region were assessed. All accessible health facilities providing RH services were evaluated; health posts were excluded. One regional referral hospital and two provincial referral hospitals were assessed as well as four health centers located in the two refugee camps. Twenty-one health centers, managed by the Ministry of Health (MoH) and primarily serving the host population, were also assessed. Eleven providers completed questionnaires to assess knowledge and attitudes towards RH service provision. A total of 11 FGDs were held with eight community leaders and 69 refugees to assess knowledge of and attitudes towards RH and identify barriers to access. KIs were held with 15 representatives of the MoH, United Nations High Commissioner for

¹ UNHCR, *Burkina Faso Fact Sheet: 30 September 2013*, (Geneva: UNHCR, 2013). <http://www.unhcr.org/4d919f369.pdf>.

² UNHCR, *Burkina Faso: 2014 UNHCR country operations profile*, 2014, <http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e483de6>.

Refugees (UNHCR), United Nations International Children’s Emergency Fund (UNICEF), United Nations Populations Fund (UNFPA), international nongovernmental organizations (NGOs), and the national Red Cross to examine the integration of RH into the humanitarian health response.

Key findings

- The three hospitals assessed—the Sahel regional referral hospital, Soum provincial capital referral hospital, and Oudalan provincial capital referral hospital—provided a range of good quality RH services, including family planning (FP) services, post-abortion care (PAC), and services for HIV and other sexually transmitted infections (STIs). However, only one hospital qualified as a comprehensive emergency obstetric and newborn care (CEmONC) service delivery point and one qualified as a basic emergency obstetric and newborn care (BEmONC) service delivery point.
- RH service availability among the four refugee camp health centers was variable. One facility met the criteria as a functioning FP service delivery point, one qualified as a functioning PAC service delivery point, one adequately provided STI services, one provided prevention of mother-to-child transmission of HIV (PMTCT), and one provided antiretroviral therapy (ART). None qualified as BEmONC delivery points.
- RH service availability among the 21 non-refugee health centers was very limited for FP services and non-existent for emergency obstetric and newborn care (EmONC) and PAC.
- Remarkably, almost all MoH facilities—the hospitals and the non-camp health centers—provided PMTCT, diagnosis and treatment of STIs, and voluntary counseling and testing for HIV (VCT).
- Clinical management of rape (CMoR) was not adequately available at any health facilities assessed. None of the hospitals had emergency contraception (EC) for CMoR and none of the health centers—neither camp nor MoH—had post-exposure prophylaxis (PEP) for HIV.
- Health facility assessments found that safe abortion was not available, although one provider at the regional hospital reported that he provided induced abortion during a key informant interview.
- ART was available at the hospitals but at few camp and non-camp health centers.
- Across all facilities, only two hospitals provided assisted vaginal delivery.
- Short-acting FP methods, particularly injectables, were more available than long-acting. Permanent methods (vasectomy) were available at one hospital.
- Condoms were available at the hospitals and the majority of the health centers, but FGDs reported few refugees used them.

- Drug shortages were a key barrier to service provision in all RH areas.
- The majority of health centers reported that they were not authorized to provide assisted vaginal delivery, ART, PAC with misoprostol, and induced abortion. Half reported that they were not authorized to provide EC as part of FP.
- Training gaps regarding permanent FP methods, induced abortion, CMoR, and adolescent-friendly services were identified.
- FGDs with refugees revealed significant socio-cultural barriers to accessing services, and many were not aware of the RH services available.
- Refugees also reported that pregnant women now sought facility-based delivery services whereas they previously gave birth at home, reflecting significant positive changes in health-seeking behavior. They reported high satisfaction with maternal health services in the camps and found care better than in their country of origin.
- Young, unmarried people, particularly young, unmarried women and girls, had low knowledge of RH and faced additional barriers to accessing care.

Key recommendations

Health and RH actors should:

- Prioritize implementation of comprehensive, confidential, good quality CMoR. Develop and/or implement a referral pathway, including for psychosocial care and legal services. Train/re-train staff in CMoR including quality of care. Engage refugee/host-community women in CMoR programming.
- Engage and raise awareness among refugees and host communities about all components of RH. Ground efforts in an evidence-informed, locally contextualized, rights-based approach. Involve women, men, adolescents, and community leaders in designing outreach strategies. Make locally-adapted information, education, and communication material on all RH areas available at health facilities.
- Expand BEmONC service delivery points and address policy barriers to provision of assisted vaginal delivery. Ensure adequate CEmONC is available at all hospitals.
- Address policy barriers to ART to establish additional treatment points, including for children.
- Scale up provision of long-acting FP methods at health centers and provide both vasectomy and tubal ligation at hospitals. Address authorization barriers to provision of EC as part of FP. Conduct outreach on FP to dispel myths, raise-awareness, and educate communities (with specific outreach to men adolescents) about the benefits of FP.
- Implement safe abortion services to the extent of the law and expand PAC service delivery points.

- Expand strategically-situated condom distribution points to increase accessibility including by at-risk populations.
- Undertake logistical audits to review protocols, forecast accuracy, budgetary constraints, storage conditions, and staff capacity. Establish or strengthen contingency stocks of RH supplies to prevent supply shortages.
- Strengthen staff capacity through competency-based training and refresher courses on RH and provide consistent coaching. Address negative provider attitudes and prioritize staff supervision. Consider the deployment of additional trained staff to the Sahel region.
- Train staff in adolescent-friendly services and develop strategies to engage adolescents and facilitate access to care.
- In addition, donors should fund implementing agencies to expand good quality RH service provision and address infrastructure gaps.

See section 7 for additional recommendations.

1. Introduction

Since its formation in 1995, the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises has worked to address reproductive health (RH) needs of communities displaced by conflict and natural disasters. IAWG is comprised of 1,500 members from 450 agencies, including UN agencies, governmental agencies, international and national NGOs, universities, and donors.³ From 2002 to 2004, IAWG undertook a global evaluation on the state of RH service provision in humanitarian emergencies. Now, ten years later, IAWG has conducted a second global review in an effort to document progress and gaps as well as identify ways to improve RH care for communities affected by crises.

This assessment evaluated the availability, quality, and utilization of comprehensive RH service provision for Malian refugees and the surrounding host population in the Sahel Administrative Region of Burkina Faso. Reproductive health components assessed included provision of family planning (FP) services, emergency obstetric and newborn care (EmONC), comprehensive abortion care, services for HIV and other sexually transmitted infections (STIs), as well as clinical management of rape (CMoR). In addition, the study identified key barriers to service delivery and utilization. This report documents these findings and offers recommendations to help inform RH planning and implementation to meet the health needs of the conflict-affected communities.

2. Background

2.1 Introduction to Burkina Faso

Burkina Faso is a land-locked country in West Africa bordered by six countries: Niger, Benin, Togo, Ghana, Ivory Coast, and Mali. According to 2011 estimates, Burkina Faso's population is approximately 16 million people.⁴ Residents are known as Burkinabé, and French is the official language.⁵ Human development indicators for the country are poor. Out of 187 countries, Burkina Faso ranks 183rd on the Human Development Index;⁶ on the Gender Inequality Index, it ranks 131 out of 148 countries

³ Inter-Agency Working Group on Reproductive Health in Crisis. About IAWG (2013). <http://iawg.net/about-iawg/>.

⁴ United Nations, *UNdata: Burkina Faso*, 2014, <http://data.un.org/CountryProfile.aspx?crName=Burkina+Faso>.

⁵ Central Intelligence Agency, *The World Factbook: Burkina Faso*, 2014, <https://www.cia.gov/library/publications/the-world-factbook/geos/uv.html>.

⁶ Khalid Malik and United Nations Development Programme, *Human development report 2013: the rise of the South: human progress in a diverse world* (New York: UNDP, 2013). http://hdr.undp.org/sites/default/files/reports/14/hdr2013_en_complete.pdf.

assessed.⁷ Only 37% of men and 22% of women over the age of 15 years are literate.⁸ Almost half of Burkina Faso's population (44.6%) lives below the USD 1.25 per day poverty line, making the country one of the poorest in the world.⁹ Compared to the African region as whole, Burkina Faso has a lower than average life expectancy—at 56 years of age—and higher under-five mortality rates.¹⁰ Food insecurity and malnutrition rates are also chronically high: Burkina Faso is among the top 15 countries with the worst hunger situations globally.¹¹ The government has been criticized for human rights abuses, including excessive force against civilians, arbitrary arrest and detention, and trafficking.¹²

Despite significant challenges, progress is evident. The government and international partners have launched a number of initiatives to enhance access to education, healthcare, and economic opportunities. As a result, maternal and infant mortality rates have decreased in the past twenty years,¹³ and, between 2008 and 2012, the primary school completion rate rose from 39% to 55%.¹⁴ During that same period, the gender parity index for primary school completion increased from 0.76 to 0.95.¹⁵ In an effort to promote transparency and accountability between the government and the public, the Burkina Open Data Initiative was launched in 2014 and makes key data—such as vaccination rates and deaths due to malaria—open to the public.¹⁶ Despite mounting political tension in 2013, the country has remained stable.¹⁷

⁷ UNDP, *Table 4: Gender Inequality Index*, 2012, <https://data.undp.org/dataset/Table-4-Gender-Inequality-Index/pq34-nwq7>.

⁸ UNFPA, *Burkina Faso: The State of the World's Midwifery* (New York: UNFPA, 2011).

⁹ http://www.unfpa.org/sowmy/resources/docs/country_info/profile/en_BurkinaFaso_SoWMy_Profile.pdf.

¹⁰ World Bank, *Poverty and Equity: Burkina Faso*, 2014, <http://povertydata.worldbank.org/poverty/country/BFA>.

¹¹ World Health Organization, *Burkina Faso: Fact Sheets of Health Statistics 2010* (Geneva: WHO, 2010).

¹² Klaus von Grebmer et al., *2013 Global Hunger Index: The Challenge of Hunger: Building Resilience to Achieve Food and Nutrition Security*, (Washington, DC: International Food Policy Research Institute, 2013). <http://www.ifpri.org/sites/default/files/publications/ib79.pdf>.

¹³ US Department of State, *2010 Human Rights Report: Burkina Faso*, 2010, <http://www.state.gov/j/drl/rls/hrrpt/2010/af/154333.htm>

¹⁴ World Bank, *Burkina Faso Overview*, 2014, <http://www.worldbank.org/en/country/burkinafaso/overview>.

¹⁵ Global Partnership for Education, *Burkina Faso*, 2014, <http://www.globalpartnership.org/country/burkina-faso>

¹⁶ Ibid.

¹⁷ Ese Erheriene, "Struggling Burkina Faso Opens Up Its Government Data," *WSJ Blogs – Digits*, June 9, 2014, <http://blogs.wsj.com/digits/2014/06/09/struggling-burkina-faso-opens-up-its-government-data/>.

¹⁸ UNHCR, *Burkina Faso: 2014 UNHCR country operations profile*, 2014, <http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e483de6>.

Map 1: Burkina Faso and neighboring countries (2004)



Source: United Nations, 2004

2.2 Health sector

Health care coverage in Burkina Faso is limited as a result of poor infrastructure, sporadic service provision, supply shortages, a dearth of trained providers, and remuneration challenges. The health workforce density (composed of midwives, nurses, and doctors) is approximately 8 per 10,000 people,¹⁸ well below the critical threshold defined by the World Health Organization (WHO) of 23 or more midwives, nurses, and doctors per 10,000.¹⁹

¹⁸ UNFPA, *Burkina Faso: The State of the World's Midwifery* (New York: UNFPA, 2011).

http://www.unfpa.org/sowmy/resources/docs/country_info/profile/en_BurkinaFaso_SoWMy_Profile.pdf.

¹⁹ World Health Organization, *Density of doctors, nurses and midwives in the 49 priority countries* (Geneva: WHO, 2010), http://www.who.int/hrh/fig_density.pdf.

The government of Burkina Faso spends approximately 6.2% of its gross domestic product on healthcare, and 11.9% of the total government expenditures are spent on health sector.²⁰ In US dollars, this translates to \$37.8 spent annually per person on healthcare. Financing of the healthcare system is split relatively evenly between public and private funding.²¹ Of the 45.7% private spending, 79.6% is through out-of-pocket payments by patients upon use of service.²²

In 1987 African ministers of health adopted the Bamako Initiative, an agreement aimed at increasing access to and efficiency of primary healthcare services.²³ In 1992, as a result of the Initiative, the government of Burkina Faso began a period of reform of the health system.²⁴ Focusing on decentralization and the provision of essential generic drugs, management of health facilities became more autonomous and the cost of drugs more affordable.²⁵ The health reform included specific targets aimed at improving the RH status of populations.²⁶

Government health facilities are organized into three classes:

- The “CMA,” the *Centre Medical avec Antenne Chirurgicale* (roughly, Medical-Surgical Center). This corresponds to a tertiary hospital with an operating theater, laboratory, and in-patient wards. Health staff, including at least one surgeon, should be on duty or on call at all times.
- The “CSPS,” the *Centre de Santé et Promotion Social*, or health center. This is the first level facility—there being no health posts in Burkina Faso—offering both primary and secondary care. CSPS should have up to a dozen in-patient beds, but no laboratory.
- The “CM,” the *Centre Médical*, or Medical Center, lies between the two above categories. It is a large health center with a generalist doctor in residence.²⁷

All health centers, or CSPS, are staffed with a Baccalaureate-holder with an additional three years’ health training. A state nurse is the first mid-level provider available.

²⁰ World Health Organization, *WHO African Region: Burkina Faso statistics summary*, 2013, <http://apps.who.int/gho/data/?theme=country&vid=5500>.

²¹ Ibid.

²² Ibid.

²³ UNICEF, *The State of the World’s Children 2008* (New York: UNICEF, 2007). <http://www.unicef.org/sowc08/docs/sowc08.pdf>.

²⁴ S. Haddad et al., “Learning from health system reforms: lessons from Burkina Faso,” *Tropical Medicine & International Health* (2006): pp. 1889–1897.

²⁵ Ibid.

²⁶ Olivier Weil et al., *Addressing the Reproductive Health Needs and Rights of Young People since ICPD: Burkina Faso Country Evaluation Report* (Washington, DC: OECD, 2003), <http://www.oecd.org/countries/burkinafaso/36747493.pdf>.

²⁷ LAAFI, *Burkina Faso*, n.d., http://www.laafi.at/eng/burkina_faso/index.html.

Maternity services are provided by an auxiliary midwife, a provider with three years' health training but with no Baccalaureate pre-requisite, with the state nurse on call. If a second mid-level provider is available, it is a midwife, also Baccalaureate-holders with an additional three years' health training. She or he delivers RH services, sometimes with an auxiliary midwife to assist, with the state nurse also in support. While only 60% of the CSPS health facilities meet their staffing requirements, CMAs and CMs in urban areas are generally overstaffed. However, even with the surplus of staff, quality standards are often not met within the CMAs and CMs.²⁸

2.3 Reproductive health in Burkina Faso

As outlined in Table 1 below, RH indicators in Burkina Faso are extremely poor. According to the 2011 *State of the World's Midwifery*, RH in Burkina Faso has a total fertility rate of 5.9 and a modern contraceptive rate of 17%. Twenty-nine percent of the population has an unmet need for family planning. Maternal mortality is high with 400 maternal deaths per 100,000 live births. Only 54% of births are attended by skilled health personnel and coverage is even poorer in rural areas where the majority of births are unattended and mothers often deliver alone. Approximately 169 of every 1,000 children die before the age of five.²⁹

Table 1. Key health statistics in Burkina Faso³⁰

| Indicator | |
|--|------------|
| Total population | 16,460,141 |
| Life expectancy at birth, total (years) | 55.9 |
| Maternal mortality ratio (modeled estimate, per 100,000 live births) | 400 |
| Under-five mortality rate (per 1,000 live births) | 169 |
| Birth rate, crude (per 1,000 people) | 41.4 |
| Fertility rate, total (births per woman) | 5.9 |
| HIV prevalence (% of population ages 15-49) | 1.0 |
| Contraceptive prevalence (% of women ages 15-49) | 16.2 |

Burkina Faso has adopted several policies regarding RH. In 2005, the Reproductive Health Law was passed, overturning a ban from 1920 on providing FP services. This pivotal law outlined universal access to RH services and articulated RH rights for individuals, especially women and girls.³¹ Family planning in particular has become a

²⁸ Dayitaba Compaore, "La mise en oeuvre de l'approche syndromique des infections sexuellement transmissibles: les leçons d'une intervention," *Institut de Médecine Tropicale d'Anvers* (2003) http://www.memoireonline.com/09/10/3878/m_La-mise-en-oeuvre-de-lapproche-syndromique-des-infections-sexuellement-transmissibles-les-leon2.html.

²⁹ UNFPA, *Burkina Faso: The State of the World's Midwifery* (New York: UNFPA, 2011), http://www.unfpa.org/sowmy/resources/docs/country_info/profile/en_BurkinaFaso_SoWMy_Profile.pdf.

³⁰ All data from the World Bank. *Indicators*, 2014, <http://data.worldbank.org/indicator>.

³¹ Modibo Maiga and Lo Asissatou, *Repositioning Family Planning in Burkina Faso* (Washington, DC: Futures Group, 2013). http://www.healthpolicyproject.com/ns/docs/Burkina_Faso_WestAfricaBriefs_Final.pdf.

priority in recent years, as reflected in a number of policies and initiatives. The National Family Planning Revival Plan (2013-2015) aims to increase modern contraceptive utilization by 25% in 2015.³² Reproductive health commodity security is also on the national agenda and has received additional funding. In 2008, the budget for contraceptives was six times higher than the 2006 budget.³³ In 2010 the Strategic Plan to Secure Access to Reproductive Health Commodities was developed, focusing on consistent distribution throughout the country.³⁴ Reproductive health commodity security has also been integrated into the national public health program and it was included in Burkina Faso's Poverty Reduction Strategy Paper.³⁵

In 2012, in an effort to address the country's high maternal mortality and fertility rates, the Campaign to Reduce Adult and Maternal Mortality in Africa (CARMMA) was launched. It focuses on enhancing national political and community leadership, raising awareness of existing global campaigns, and promoting the recognition of maternal mortality as a key indicator of a well-functioning health system and society.³⁶

The *Association Burkinabé pour le Bien-Etre Familial* (ABBEF) and UNFPA have been leaders in RH policy reform, focusing on increased involvement and mobilization of the community.³⁷

2.4 Malian refugee crisis

Mali borders Burkina Faso to the north and west, and is the largest country in West Africa. Mali's health indicators place it in similarly poor condition as Burkina Faso. Both countries have low life expectancy around 55 years and an estimated HIV prevalence of 1%.³⁸ Several important indicators, however, contribute to Mali's poorer health conditions. Contraceptive coverage using modern methods is only 10%, and maternal mortality rates are significantly higher at 550 deaths per 100,000 population compared to 400 in

³² Burkina Faso Ministry of Health, *Plan national de relance de la Plantification Familiale 2013-2015* (2013). http://advancefamilyplanning.org/sites/default/files/resources/Plan%20de%20relance%20PF%202013-2015_final.pdf

³³ UNFPA, *Progress Profile: Global Programme to Enhance Reproductive Health Commodity Security* (New York: UNFPA, 2011). http://www.unfpa.org/webdav/site/global/shared/documents/gprhcs/GPRHCS_Burkina_Faso.pdf.

³⁴ Modibo Maiga and Lo Asissatou, *Repositioning Family Planning in Burkina Faso* (Washington, DC: Futures Group, 2013). http://www.healthpolicyproject.com/ns/docs/Burkina_Faso_WestAfricaBriefs_Final.pdf.

³⁵ UNFPA, *Progress Profile: Global Programme to Enhance Reproductive Health Commodity Security* (New York: UNFPA, 2011). http://www.unfpa.org/webdav/site/global/shared/documents/gprhcs/GPRHCS_Burkina_Faso.pdf.

³⁶ UNFPA, *Maternal Health Thematic Fund: Annual Report 2012* (New York: UNFPA, 2012) <http://www.unfpa.org/webdav/site/global/shared/documents/publications/2013/MHTF%202012%20Annual%20Report-final.pdf>.

³⁷ Olivier Weil et al., *Addressing the Reproductive Health Needs and Rights of Young People since ICPD: Burkina Faso Country Evaluation Report* (Washington, DC: OECD, 2003), <http://www.oecd.org/countries/burkinafaso/36747493.pdf>.

³⁸ World Bank. *Indicators*, 2014, <http://data.worldbank.org/indicator>.

Burkina Faso.³⁹ The fertility rate is also higher at 7 births per woman.⁴⁰ A survey conducted by Doctors of the World in the region of Mopti suggested that out of the 2,000 villages in the region, half have at least one woman living with fistula.⁴¹

Table 2. Key health statistics in Mali⁴²

| Indicator | |
|--|------------|
| Total population | 14,853,572 |
| Life expectancy at birth, total (years) | 55 |
| Maternal mortality ratio (modeled estimate, per 100,000 live births) | 550 |
| Under-five mortality rate (per 1,000 live births) | 128 |
| Birth rate, crude (per 1,000 people) | 47 |
| Fertility rate, total (births per woman) | 7 |
| HIV prevalence (% of population ages 15-49) | 1.0 |
| Contraceptive prevalence (% of women ages 15-49) | 10 |

In early 2012, conflict between armed rebels and government forces broke out in northern Mali forcing hundreds of thousands of people to flee their homes. The situation worsened in March 2012, when the Malian armed forces successfully carried out a coup against the Malian government. The *Mouvement National de Libération de l'Azawad* (MNLA), a rebel group led by the Tuareg ethnic group, leveraged chaos of the coup and attempted to declare the secession of northern Mali. However, the MNLA was soon taken over by militant Islamist groups who were able to occupy most of the north, including major cities such as Timbuktu. Since then, the situation has continued to deteriorate. As of 2013, violations of human rights, including torture and abuse, have been reported and many basic services have been discontinued. Northern Mali is mostly inaccessible to relief agencies due to the presence of armed groups and violence.⁴³

The violence in Mali resulted in the internal displacement of approximately 204,000 people, and over 200,000 Malians have found refuge in neighboring countries of Mauritania, Niger, and Burkina Faso.⁴⁴ According to UNHCR estimates from September 2013, a total of 49,975 Malian refugees have fled to Burkina Faso since February 2012.⁴⁵ Approximately 60% live in three consolidated refugee camps: Goudebo (10,363), Mentao (16,546), and Sag-Nioniogo (2,830). Nearly 20% reside among the host communities in the Sahel Region, and the remaining live in spontaneous sites and

³⁹ Ibid.

⁴⁰ Ibid.

⁴¹ Medecins du Monde, *Annual Report 2012*. 2012, http://issuu.com/doctorsoftheworld/docs/annual_report_2012.

⁴² All data from The World Bank. *Indicators*, 2014, <http://data.worldbank.org/indicator>.

⁴³ UNHCR, *UNHCR Global Appeal 2013 Update* (Geneva: UNHCR, 2013), <http://www.unhcr.org/50a9f82316.pdf>.

⁴⁴ Ibid.

⁴⁵ UNHCR, *Burkina Faso Fact Sheet: 30 September 2013* (Geneva: UNHCR, 2013). <http://www.unhcr.org/4d919f369.pdf>.

urban settings.⁴⁶ Malian refugees in the Goudebo and Mentao camps are mainly from the Tuareg ethnic group, although some are Peuhl, Songhaï, or Bella.

2.4.1 Humanitarian response

The Sahel Administrative Region of Burkina Faso hosts two of the three major official UNHCR-administered camps (Goudebo Camp in Seno Province and Mentao Camp in Soum Province). In a rough boomerang shape, the region's internal borders describe the Burkinabé homeland of the trans-national Fulani ethnic group with a Tuareg enclave in the extreme northeast (Map 2).

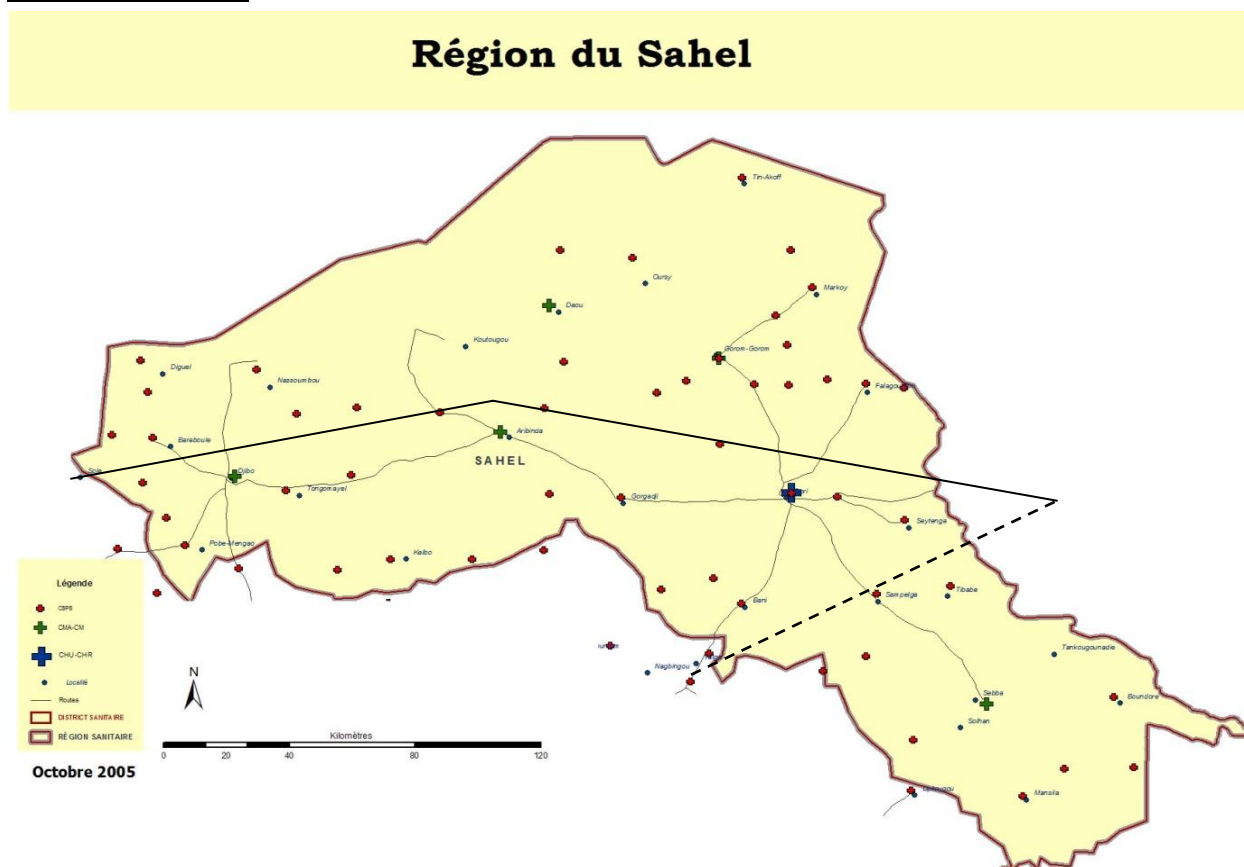
The Government of Burkina Faso provides land and water as well as access to public health clinics and primary and secondary schools for refugees.⁴⁷ However, refugees and the surrounding host communities live in a challenging environment, affected by successive famine and droughts, extreme heat, violent winds and rain.

Many parts of Burkina Faso are formally considered off-limits to international staff and to national staff working for or collaborating with international agencies. In the map of the Sahel Region below (Map 2), official visits to all sites north of the upper solid line require a military escort.

⁴⁶ UNHCR, *Burkina Faso: 2014 UNHCR country operations profile*, 2014, <http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e483de6>.

⁴⁷ UNHCR, *Burkina Faso Fact Sheet: 31 October 2013* (Geneva: UNHCR, 2013). <http://data.unhcr.org/SahelSituation/download.php?id=818>

Map 2: Burkina Faso's Sahel Region, showing health centers and referral hospitals (2005)



In 2013, at the height of the crisis, the budget for the UNHCR's Burkina Faso program was USD 32.8 million. In 2014, approximately 5,000 Malians are expected to return, and UNHCR's budget has decreased to USD 25.7.⁴⁸ The 2014 budget included RH and HIV services with a commitment of roughly USD 1.2 million. This is the third largest amount, following shelter and infrastructure and services for people with specific needs.⁴⁹

2.5 Comprehensive RH care

Reproductive health is a minimum standard in humanitarian health care provision.⁵⁰ Comprehensive RH is organized into five broad areas: FP, maternal and newborn health, HIV and other STIs, gender-based violence (GBV), and general RH.⁵¹ RH

⁴⁸ UNHCR, *Burkina Faso: 2014 UNHCR country operations profile*, 2014, <http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e483de6>.

⁴⁹ Ibid.

⁵⁰ Inter-Agency Standing Committee (IASC) Global Health Cluster, *Health Cluster Guide* (Geneva: World Health Organization, 2009). http://www.who.int/hac/network/global_health_cluster/health_cluster_guide_6apr2010_en_web.pdf

⁵¹ Inter-Agency Working Group on Reproductive Health in Crises, *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2010. <http://www.iawg.net/IAFM%202010.pdf>.

should be integrated into primary health care with referrals for specialized needs. A multi-sectoral approach is essential to ensuring comprehensive RH services are successfully implemented.

3. Objectives

The study's objectives were to:

- assess the availability, quality, and utilization of RH services of Malian refugees and surrounding communities in the Sahel Administrative Region
- identify access and implementation barriers
- propose recommendations to inform the humanitarian RH response.

4. Methods

The assessment took place in the capital of Ouagadougou and the Sahel Administrative Region of Burkina Faso from November 16 to 30, 2013. Two of the three camps hosting refugees from Mali were included in the assessment: Goudebo Camp in Seno Province and Mentao Camp in Soum Province.

Country and site selection

Burkina Faso was chosen as one of the three sites for the by the IAWG Global Review Steering Committee because it met four of the five selection criteria:

1. Defined as low income by the World Bank classification in 2012;
2. Classified as “Warning” in the Failed States Index;
3. Has experienced conflict from 2010 to 2012 (Uppsala University Conflict Database);
4. Is defined as being on Stressed, Crisis or Emergency on the Famine Early Warning System;
5. Has experienced a major disaster during 2011 or 2012. “Major” is defined as launch of a flash appeal for international assistance.

The three northernmost provinces (Seno, Soum, and Oudalan) of the Sahel Region were defined as the assessment's general setting as most Malian refugees remain in this region. Yagha Province—the area south of the dashed line in Map 2—is outside the survey setting as it does not include refugee camps or settlements.

Quantitative and qualitative assessments

This cross-sectional, mixed methods study was comprised of two components:

1. A quantitative approach that included assessments of health facilities purposively selected from those providing services to crisis-affected populations as well as an assessment of a convenience sample of providers' knowledge and attitudes; and
2. A qualitative approach using and key informant interview (KIIs), focus group discussions (FGDs).

Assessment team

The assessment team was comprised of three core members:

1. Dr. Philippe Cavailler, Principal Investigator (PI)
2. Mark Beesley, Study Coordinator
3. Abdoulaye Nassouri, Data Manager

UNHCR hosted the assessment team, and UNHCR and MSI provided logistical support.

Training and participation of facilitators and data collectors

Eight facilitators conducted the FGDs and participated in the KIIs. They were identified by UNHCR and participated in a one-day training on facilitation of the FGDs at UNHCR offices in Dori. A total of nine data collectors conducted the health facility assessments. During a two-hour afternoon orientation session, copies of the health facility assessment questionnaire were distributed for familiarization and role plays of introduction, consent-seeking, and debriefing were enacted. Two teams comprising four members each conducted the first facility assessment of one health center, from start to finish, with guidance, while the other team watched. The study coordinator accompanied the untested team to a second site, while the first team assessed a third site. Seven data collectors working in two teams conducted assessments the first week, while two teams of two conducted the assessments in the second week.

4.1 Methods and tools

Methods used included desk research, health facility assessments, KIIs, FGDs, and questionnaires.

The tools used included:

- Four-part quantitative facility assessment tool that covered:
 - Basic facility information (Method: interview)
 - Staffing and services (Method: interview)
 - Inventory equipment and supplies (Method: observation)
 - Service statistics (Method: record review)
- Key informant interview guides
- In-depth interview guides for community leaders

- FGD question guides for male and female community members and male and female unmarried young adults (ages 18-25)
- Questionnaires to assess provider knowledge and attitudes.

The four-part quantitative health facility assessment tool was used to assess RH service availability. The introduction collected basic facility information including the size, catchment population, services available, and existence of NGO support for RH. The staffing and services section gathered data on human resources and specific RH service provision. The inventory of equipment and supplies collected information on basic equipment and RH commodities for each RH service. Service statistics were collected through clinical register review over a 12-month time frame. However, many of these data were missing due to poor registers or lack of availability of key data points; therefore, utilization could not be adequately assessed. All tools were translated into French.

Desk research

Background information on Burkina Faso and the Malian refugee crisis was reviewed, including information on RH policies, disaster preparedness, humanitarian response, and treatment protocols. Existing studies were also reviewed.

Health facility assessments

In accordance with the protocol, a sampling frame of all health facilities (of health center-level or above) mandated to provide RH services was generated with information from the MoH Regional Office in Dori. Care was taken to ensure that the facilities from the private and not-for-profit sub-sectors were included.⁵²

The full sampling frame recorded all 85 known facilities in the three provinces (n=85). (See Appendix C for the full sampling frame.) Following the study protocol, further criteria were applied:

- Forty facilities (all north of the solid line in Map 2, above) were deleted for reasons of insecurity (n=45)
- Four sites (three provincial military garrisons and a dental clinic) were removed since they did not provide RH services (n=41)
- One facility, Taouremba CSPA, was deleted due to physical inaccessibility (n=40)

⁵² There were just four known non-MoH sites: two private clinics in Djibo, one not-for-profit facility in Gorom-Gorom, and one MSF-supported site at Dibissi; see sampling matrix.

- Four facilities (three health centers plus a referral hospital) were then reintroduced when an opportunity arose for a one-day military escort to the restricted zone (n=44)
- Fifteen facilities were health post-level, and were excluded from the data set because they did not provide RH services (n=29)
- An additional health facility at an accessible larger town was omitted due to time and resource constraints, resulting in the final data set of n=28 as outlined in Table 3 below.

Of the 28 facilities assessed, seven were utilized by refugees: the three referral hospitals and the four facilities within the two official refugee camps.⁵³ The remaining 21 facilities were operated by the MoH (with one managed by a faith-based organization) and utilized primarily by the host community, although some non-camp refugees may have accessed them as well. Within the assessment setting, all accessible health facilities serving refugees and all but one serving the host population were assessed.

Six facilities (three referral facilities and three large secondary health care facilities) were assessed in greater detail, which included additional questions about service provisions and discussions with a variety of providers:

1. Centre Hospitalier Regional (CHR) de Dori, the principal referral structure for the Sahel Region
2. CMA of Djibo, intermediate level facility for Sahel Region
3. CMA of Gorom Gorom, intermediate level facility for the Sahel Region
4. CSPA Urbain in Dori, primarily served the host population
5. CSPA of Mentao Sud, the biggest of the three CSPA located in the Mentao Camp
6. CSPA of Pobe Mengao, located not far from Djibo and primarily served the host population.

⁵³ In fact, the three separate health facilities at different locations within the large Mentao camp largely shared the same services and personnel and recorded combined data. Arguably they represent one sole facility at Mentao South, with two satellite physical spaces. Nevertheless, since they are officially reported as separate facilities, they were investigated as such.

| Table 3. Assessed facilities in ranked order by estimated catchment population (n=28) | | | | | |
|--|-------------------------------|--|---|---|-------------------|
| Rank by catchment population | Facility name | Observation | Estimated catchment area pop (to nearest 100) | Number of health facility staff interviewed | Assessed in-depth |
| 1 | Dori Regional Hospital | Sahel Regional capital referral hospital; referral hospital for refugees | 1,158,100 | 8 | Yes |
| 2 | Djibo Medical-Surgical Centre | Soum Provincial capital referral hospital; referral hospital for refugees | 429,800 | 6 | Yes |
| 3 | Gorom-Gorom Med-Surg Centre | Oudalan Provincial capital referral hospital; referral hospital for refugees | 237,100 | 3 | Yes |
| 4 | Dori Town, Seno Province | | 49,900 | 3 | Yes |
| 5 | Gorgadji, Seno | | 34,700 | 2 | |
| 6 | Gorom-Gorom Town, Oudalan | Under armed escort | 33,600 | 2 | |
| 7 | Orphelinat, Oudalan Province | FBO-run; under armed escort | 33,600 | 2 | |
| 8 | Arbinda, Soum Province | Doctor in residence | 27,200 | 3 | |
| 9 | Bani, Seno | Site used for assessment team training | 23,000 | 3 | |
| 10 | Seytenga, Seno | | 22,900 | 3 | |
| 11 | Silgadji, Soum | | 18,500 | 2 | |
| 12 | Tongomayel, Soum | No maternity staff. State Nurse only | 18,300 | 1 | |
| 13 | Katchirga, Seno | | 18,100 | 2 | |
| 14 | Sampelga, Seno | | 17,400 | 1 | |
| 15 | Oulo, Seno | | 15,500 | 1 | |
| 16 | Béléhédé, Soum | | 15,300 | 2 | |
| 17 | Pobe-Mengao, Soum | | 14,800 | 3 | Yes |
| 18 | Saouga, Oudalan | Under armed escort | 14,200 | 1 | |
| 19 | Bambofa, Seno | | 14,000 | 2 | |
| 20 | Selbo, Seno | | 12,500 | 1 | |
| 21 | Mentao South, Soum | In refugee camp; run by MdM-F. The only maternity unit in the Mentao camp; the other | 12,300 | 2 | Yes |

| | | | | | |
|--------------|-----------------------------|--|-----------|----|--|
| | | two smaller facilities referred there | | | |
| 22 | Bougué, Soum | | 10,900 | 1 | |
| 23 | Kobaoua, Soum | Most physically isolated facility assessed | 10,400 | 1 | |
| 24 | Goudebo, Seno | Refugee camp. Managed by MdM-Spain | 10,400 | 2 | |
| 25 | Pougouzaibao go, Soum | | 9,200 | 1 | |
| 26 | Gaïk-Goata, Soum | No maternity staff—State Nurse only | 7,100 | 1 | |
| 27 | Mentao Central, Soum | Refugee camp. Health facility in camp sub-division | 2,300 | 1 | |
| 28 | Mentao North, Soum | Refugee camp. Health facility in camp sub-division | 2,150 | 1 | |
| Total | | | 2,273,250 | 61 | |

**All bold facilities served the refugee camps*

Whenever feasible at the end of each facility assessment, quick debriefings on the findings were held to triangulate findings. Each evening the teams reviewed data sheets for accuracy, clarity, and completeness.

The existence of stock was not consistently verified on site. In the smaller facilities, where items were likely to be within reach or sight, the assessors were shown individual items. In larger facilities, including all hospitals, the response of the person-in-charge was accepted.

Key informant interviews

A total of 15 key informants were interviewed in Ouagadougou, Dori, and Djibo. Key informants were identified through discussions with the UNHCR focal point and the staff from the UNHCR office in Ouagadougou. The interviewees included representatives from UN agencies (UNHCR, UNICEF, and UNFPA), international NGOs—Médecins du Monde (MdM) and Médecins Sans Frontières (MSF)—the national Red Cross, and the MoH including officials from the Regional and District Offices of Dori and Djibo. The objective of the KIIs was to explore integration of RH into humanitarian health response, challenges and successes in service delivery, and planning for or expansion of comprehensive RH services.

Interviews were conducted in French, in a private room, by the leading PI. All interviews were typed in Word and then analyzed using a thematic analysis in order to identify the

main themes that emerged from the discussion. The PI translated the findings into English.

Focus group discussion with community leaders and refugees

A total of 11 FGDs were held with eight community leaders and 69 refugees. Focus group participants were identified through purposive sampling through discussion with camp leaders and partners operating in the camps (UNHCR and MdM). The objective of the FGDs was to obtain in-depth information on the participants' perceptions regarding accessibility, utilization of, and satisfaction with the RH services provided.

FGDs were conducted by a team of three facilitators: the main facilitator asked the questions in French, the second facilitator was a member of the local community and translated the questions and responses, and the third facilitator took notes in French. At the end of the FGDs, the notes were reviewed and discussed with the group of facilitators and the PI, who typed these notes in French before leaving the camp. Notes were translated into English by the PI.

Two FGDs were held with eight community leaders: one in Goudebo Camp with four female leaders from the Tuareg community; the second in Mentao Camp with four male leaders from the Arab community.

Nine FGDs were held with refugee community members. In Goudebo camp, the first four FGDs were conducted with the Bela community members (married men, married women, unmarried men aged 18 to 20, and unmarried women aged 18 to 20). Four additional FGDs were conducted in Goudebo with the Tuareg community (also married men, married women, unmarried men aged 18 to 20, and unmarried women aged 18 to 20). Due to time constraints, only one FGD was conducted in Mentao camp with a group of unmarried women aged 18 to 20 from the Arab community. In Goudebo, each of the FGD sessions included eight participants, while the last FGD conducted in Mentao included five participants (due to logistic constraints).

At the end of the assessment, preliminary findings were presented and discussed with UNHCR managers in Ouagadougou.

Provider questionnaires

A convenience sample of 11 health providers at assessed facilities completed questionnaires to assess RH knowledge and attitudes. The majority of the providers were midwives (7) followed by medical assistants (2), and a nurse and a doctor. (See Appendix B.)

4.2 Analysis, ethics, and limitations

Analysis

Facility assessment data were entered into CS Pro version 5.0 and analyzed using SPSS version 21 (IBM Corp., Armonk, NY, USA); qualitative data were analyzed using thematic analysis.⁵⁴

Ethics

Ethical approval was obtained through the Columbia University Institutional Review Board and also through Burkina Faso institutions.

UNHCR-Burkina Faso, the focal partner for this investigation, informed the relevant MoH official in advance (verbally and in writing) about the study, its purpose and context, and the imminent arrival of the expatriate investigators. The study coordinator sought and received authorization with the MoH regional health authorities in Dori, Djibo, and Gorom-Gorom.

At each facility, courtesy meetings, conducted by the leader of the assessment team, were held with the senior member of staff on duty. Verbal consent was obtained from each interviewee. In order to preserve confidentiality, names were not recorded on the interview tools of participants during FGDs.

Limitations

Security restrictions imposed by partner organizations and local governmental authorities rendered inaccessible almost half the known health facilities in the sampling frame. Although no refugee camps were located in the restricted zone, some undocumented refugees reside with the host population and may be more vulnerable in the insecure environment with less access to RH services.

Many of the utilization data were missing due to poor registers or lack of availability of key data points; therefore, utilization could not be adequately assessed.

The method used in the qualitative assessment (interviews conducted within a non-representative sample of community members) made it difficult to extrapolate the results for the full community. However, we tried to minimize the occurrence of bias by using a stratified approach: we conducted separate investigations within the main cultural groups (Tuareg, Bela, and Arab) and interviewed separately the unmarried men, unmarried women, married men, and married women.

⁵⁴ G. Guest et al., *Applied thematic analysis* (Thousand Oaks: Sage; 2011).

Many topics covered in the FGDs, such as sex, GBV, contraception, and abortion, were sensitive issues; some of the participants may have been reluctant to share their views and experiences in a group format.

Ethical concerns about keeping to a minimum the disruption to service delivery (out of consideration to the many waiting patients) represented a self-imposed limit to the time available to conduct each facility assessment. Data collectors were particularly sensitive to this at sites where there was but a solitary provider.

Translation error was a possibility, particularly with the FGDs, because the responses had to be translated twice: from the local language to French, and then French into English.

5. Findings

5.1 Overview of humanitarian response

Humanitarian coordination

Since February 2012, bi-weekly general coordination meetings have been organized in Ouagadougou under the leadership of UNHCR and the National Commission for Refugees / CONAREF. Participating agencies included government counterparts, UN agencies, NGOs, donors, and the International Red Cross and Red Crescent Movement. Weekly coordination meetings were established in Dori and Djibo. The regular interaction helped identify gaps by sector and prevent the duplication of activities. The topics addressed included some RH services, such as gender-based violence (GBV) and HIV management, but not family planning (FP) or emergency obstetric and newborn care (EmONC). Regarding RH coordination specifically, UNFPA established an RH working group with a focal point for GBV.

RH service provision

Officially, the RH services provided to refugees in camps were expected to be aligned with national policies. In practice, key informants reported that the RH package for refugees was better than the one provided to the local communities. The Sahel Province is big and some remote villages have very limited access to the nearest health center.

In the Djibo area, MdM-France had implemented a mobile system covering 30 villages. Aside from the management of malnutrition, the mobile clinics provided basic RH services (FP and antenatal and postnatal care). MSF-France oversaw the management

of rural refugees residing in spontaneous sites near Dibissi, close to the Malian border. It had also established a mobile clinic, which provided basic RH services. These mobile clinics and spontaneous settlements were not included in the assessment.

A major challenge identified by the key informants was the sustainability of funding for RH services. They also desired better transparency in the allocation of resources.

RH supplies

RH supplies were distributed through the *Depots Repartiteurs de Districts* (DRD), which were sourced by the *Centrale d'Achat des Medicaments Essentiels Génériques* (CAMEG) at the national level. NGOs also had their own RH supply chains. Informants reported occasional short-term stock-outs of RH drugs and equipment.

Access

Key informants reported that the refugee population in the camps had access to free health services, which were within walking distance (15 to 20 min). Focus group participants also mentioned that the health centers located inside the camps were accessible for both men and women. For the surrounding communities, under the national system, basic health care was not entirely free but significantly subsidized. For example, a health center patient generally paid a minimal amount (around CFA 200 or USD .50 on average) for a consultation and treatment. The government subsidized EmONC for the local communities, and patients bore 20% of the expense. In some settings, the local municipalities or NGOs covered the residual costs.

Most of the key informants highlighted that access was hindered by cultural barriers and emphasized the need to enhance RH sensitization campaigns.

General health concerns

According to FGDs with refugees, the main health problems included malaria, diarrhea and gastroenteritis, respiratory infections, joint pains, syphilis, mental health problems, abdominal pain, and fatigue due to the change of dietary habits. Some men reported a reduction in the libido and lethargy due to limited food. Women reporting frequent post-partum bleeding, abdominal discomfort, and gynecological infections.

Quality of care according to FGDs

Refugees reported satisfaction with the quality and range of RH care provided by the camp health centers and respondents praised the skills of the health professionals. They were grateful for free access to the health centers and were treated well by staff. A

few refugees voiced complaints about waiting times at some clinics, being treated with generic drugs, and that some staff served people whom they knew first.

Host community attitudes toward refugees

Two key informants reported that the surrounding host communities had expressed compassion towards refugees during the initial period of displacement. However, now they now observed growing resentment towards the refugees who were considered to have a “privileged” status with access to free food and services. Local villagers were also not pleased with the camps occupying agricultural lands.

5.2 Health facility assessments

The following section presents data collected on the health facilities assessed, including NGO/UN support for RH, general infrastructure, infection prevention, available human resources, and RH service provision.

5.2.1 Summary of facilities

Table 4 provides an overview of the health facilities’ operating agencies and catchment population. Of the 28 health facilities assessed, the MoH was the sole operating agency for the three referral hospitals and twenty health centers. While UNHCR managed both refugee camps, a consortium of collaborating NGOs delivered specific services, of which MdM oversaw health provision for the four camp facilities assessed: MdM-France in Mentao camp and MdM-Spain in Goudebo camp. The Catholic Church was operating agency for one health center: Orphelinat in Oudalan Province.

| Table 4. Summary of facilities (n=28) | | | |
|--|------------------------|----------------------------------|---------------------------------------|
| | Hospitals (n=3) | Camp health centers (n=4) | Non-camp health centers (n=21) |
| Facility type (s) | 3 | 4 | 21 |
| Operating agency (ies) | MoH | NGO | 20 MoH 1 faith-based org |
| Mean catchment population | 608,320 | 18,452 | 6,782 |
| Mean number of beds | 89 | 6 | 10 |

The three hospitals had the greatest mean catchment population of 608,320 and averaged 89 beds. The camp health centers had a mean catchment population of 18,452 and an average of six beds. Comparatively, the non-camp health centers served a much smaller mean catchment population—6,782—and averaged more beds (10).



Members of the surrounding host community accessing RH services at Tongomayel CSPS
© Beesley/IAWG/2013

5.2.2 UN/NGO support

UN/NGO financial support was assessed per RH area as outlined in Table 5. The four camp health centers, operated by NGOs, were supported in all RH topics assessed. Of the three hospitals, two received UN/NGO support for FP and EmONC. Only one of the 21 non-camp health centers received UN/NGO funding, which was earmarked for FP and EMoNC services. None of the MoH-run facilities received support for PAC, services for HIV or STIs, or care for GBV.

| Table 5. Facilities that receive NGO/UN support for RH by topic (n=28) | | | |
|---|----------------------------|--------------------------------------|---|
| | Hospitals (n=3) | Camp health centers (n=4) | Non-camp health centers (n=21) |
| Family planning | 2 (66.7%) | 4 (100%) | 1 (4.8%) |
| Emergency obstetric and neonatal care | 2 (66.7%) | 4 (100%) | 1 (4.8%) |
| Post-abortion care | 0 | 4 (100%) | 0 |
| STIs/HIV | 0 | 4 (100%) | 0 |
| Gender-based violence | 0 | 4 (100%) | 0 |

5.2.3 General infrastructure

As Table 6 demonstrates, the general infrastructure of the three hospitals was robust and included functioning power and water supplies provided by power lines and indoor plumbing. Two of three camp health centers and 13 (76.5%) non-camp health centers assessed had a functioning power supply; both of the camp health centers had generators, and most of the non-camp facilities were powered by solar energy. One camp and four non-camp health centers had no functioning electricity supply. All four of the camp health centers had functioning water supplies and three received their water through indoor plumbing. Twenty percent of the non-camp health facilities did not have functioning water supplies; of those that did, a water pump was the most common.

| Table 6. General infrastructure (n=28) | | | |
|---|------------------------|----------------------------------|---------------------------------------|
| | Hospitals (n=3) | Camp health centers (n=4) | Non-camp health centers (n=21) |
| Functioning power supply | 3 (100%) | 2 (66.7%) ND* (1) | 13 (76.5%) ND* (4) |
| Source of power | Power lines | Solar (1), generator (2) | Power lines (6), solar (11) |
| Functioning water supply | 3 (100%) | 4 (100%) | 16 (80%) ND* (1) |
| Source of water | Inside plumbing | Inside plumbing (3) | Inside plumbing (5), water pump (12) |

*No data



The water supply for Silgadji village. The health center is in the background.

© Beesley/IAWG/2014

5.2.4 Infection prevention

The assessment evaluated the facilities' infection prevention environment (Table 7). The three hospitals had most minimum infection prevention supplies available, although only one had the full package of supplies; data for one hospital was incomplete and one lacked plastic sheeting. None of the three camp health centers assessed and five of the non-camp health centers had all of the necessary supplies for infection prevention. Plastic sheeting was the most common gap across facilities; health centers also lacked aprons. Other supplies, such as gloves and antiseptics, were available at all health facilities. Supplies for sterilization and adequate waste management were variable among health centers with only one camp and 11 non-camp facilities equipped with an incinerator.

Amongst those without minimum infection prevention practices, providers at three facilities admitted to re-using their full sharps boxes. In one, the assessment team observed used sharps strewn about the health center grounds.

| Table 7. Facilities with essential infection prevention supplies available (n=28) | | | |
|--|----------------------------|----------------------------------|---------------------------------------|
| Infection prevention supplies | Hospitals (n=3) | Camp health centers (n=4) | Non-camp health centers (n=21) |
| Washing station with soap | 3 (100%) | 3 (100%) ND* (1) | 21 (100%) |
| Plastic sheeting | 1 (50%) ND* (1) | 0 ND* (1) | 8 (38.1%) |
| Non-sterile gloves | 3 (100%) | 4 (100%) | 21 (100%) |
| Sterile gloves | 3 (100%) | 4 (100%) | 21 (100%) |
| Antiseptics | 3 (100%) | 4 (100%) | 21 (100%) |
| Apron | 3 (100%) | 2 (50%) | 11 (52.4%) |
| Autoclave (or other appropriate equipment for sterilization) | 3 (100%) | 2 (66.7%) ND* (1) | 15 (71.4%) |
| Incinerator | 2 (100%) ND* (1) | 1 (33.3%) ND* (1) | 11 (52.4%) |
| Sharps are separated from other waste and disposed of properly. | 3 (100%) | 3 (75%) | 16 (80%) ND* (1) |
| % of facilities with minimum infection prevention supplies available | 1 (50%) ND* (1) | 0 ND* (1) | 5 (23.8%) |

*No data

5.2.5 Human resources

Every facility assessed at least one mid-level provider. A quarter of health centers had either three or four mid-level providers, one or two of whom were qualified midwives. The Dori Regional Hospital had ten medical doctors: six generalist doctors, two obstetrician/gynecologists, one pediatrician and one full-time surgeon. Both provincial

hospitals had four generalist doctors each, at least one with some surgical background. There were also six degree-level pharmacists: four in the Dori hospital and one each in the provincial hospitals. In the refugee camps, three generalist doctors covered the four facilities.

| Table 8. Human resources (n=28) | | | |
|---|----------------------------|--------------------------------------|---|
| | Hospitals (n=3) | Camp health centers (n=4) | Non-camp health centers (n=21) |
| At least one qualified provider on site during the night and on weekends | 2 (66.7%) | 3 (100%) ND* (1) | 13 (61.9%) |
| At least one qualified provider on site or on call during the night and on weekends | 2 (66.7%) | 3 (100%) ND* (1) | 13 (61.9%) |
| At least 1 provider trained to provide short-acting FP methods | 3 (100%) | 3 (100%) ND* (1) | 20 (95.2%) |
| At least 1 provider trained to provide long-acting FP methods | 3 (100%) | 3 (100%) ND* (1) | 17 (85%) ND* (1) |
| At least 1 provider trained to provide permanent FP methods (at least one of tubal ligation and/or vasectomy) | 0 ND* (1) | 0 ND* (2) | 1 (5%) ND* (1) |
| At least 1 provider trained to provide basic EmONC services | 3 (100%) | 3 (100%) ND* (1) | 18 (85.7%) |
| At least 1 provider trained to provide comprehensive EmONC cesarean sections | 2 (100%) ND* (1) | 0 ND* (1) | 0 ND* (1) |
| At least 1 provider trained to provide post-abortion care | 3 (100%) | 2 (100%) ND* (2) | 16 (80%) ND* (1) |
| At least 1 provider trained to provide induced abortions | 0 | 1 (33.3%) ND* (1) | 0 ND* (1) |
| At least 1 provider trained to provide adolescent-friendly services | 0 | 2 (66.7%) ND* (1) | 8 (40%) |
| At least 1 provider able to provide care for clinical management of rape | 2 (66.7%) | 1 (33.3%) ND* (1) | 10 (47.6%) |

*No data

As outlined in Table 8 above, the three camp facilities assessed had at least one qualified provider available at all times. KII's found that at least one mid-level provider slept on site at all camp health centers. However, one hospital and eight non-camp health centers only had providers available during the day. All hospitals and camp facilities and the majority of non-camp health centers had at least one provider trained in short-acting and long-acting FP methods, but none of the hospitals had staff trained in provision of either tubal ligation or vasectomy. Across facilities, most had at least one provider trained in BEmONC and PAC, but training gaps were documented in induced abortion, adolescent-friendly services, and CMoR.

5.3 Family planning

5.3.1 Overview

The use of modern FP methods in Burkina Faso and Mali is low with only 16.2% contraceptive prevalence in Burkina Faso and 10% in Mali.⁵⁵ The unmet need for contraception is high in both countries. In Burkina Faso, 29% of women and girls aged 15 to 49 want access to FP methods to space (22%) and limit (7%) births.⁵⁶ Similarly, in Mali the unmet need for FP is also 29%, with 21% of women and girls wanting FP for birth-spacing and 8% to limit births.⁵⁷

According to UNFPA, married or partnered women in Burkina Faso avoid using modern contraceptive methods due to a desire for more children (18%); personal, partner, or religious opposition (17%); fear of health effects (10%); and not knowing a method or a source (10%).⁵⁸ The most commonly used modern contraceptive methods, in order of popularity, are injectables, implants, and oral contraceptive pills.⁵⁹

In Mali, 8.1% of married women use FP methods. This rate has continued to rise over the past few years as access and cost have improved. The most commonly used contraceptive methods are hormonal, including oral contraceptive pills and injectables.⁶⁰

In the past decade, the government of Burkina Faso has prioritized FP, with a focus on commodity security. The Strategic Plan to Secure Access to Reproductive Health Commodities was developed in 2010,⁶¹ and, with funding from the Global Programme to Enhance Reproductive Health Commodity Security, Burkina Faso has made significant efforts to improve supply chain management and enhance access to FP methods.⁶² In 2013, the National Family Planning Revival Plan 2013-2015 was launched to

⁵⁵ The World Bank, *Indicators*, 2014, <http://data.worldbank.org/indicator>.

⁵⁶ James Gribble, "Family Planning in Ghana, Burkina Faso, and Mali," *Population Reference Bureau*, April 2008, <http://www.prb.org/Publications/Articles/2008/westafricafamilyplanning2.aspx>

⁵⁷ Ibid.

⁵⁸ UNFPA, *Maternal Health Thematic Fund: Annual Report 2012* (New York: UNFPA, 2012) <http://www.unfpa.org/webdav/site/global/shared/documents/publications/2013/MHTF%202012%20Annual%20Report-final.pdf>.

⁵⁹ UNFPA, *Quiz on Family Planning in Burkina Faso*, 2013, http://countryoffice.unfpa.org/burkinafaso/2013/10/02/8106/quizz_pf_in_english/.

⁶⁰ James Gribble, "Family Planning in Ghana, Burkina Faso, and Mali," *Population Reference Bureau*, April 2008, <http://www.prb.org/Publications/Articles/2008/westafricafamilyplanning2.aspx>

⁶¹ Modibo Maiga and Lo Asissatou, *Repositioning Family Planning in Burkina Faso* (Washington, DC: Futures Group, 2013). http://www.healthpolicyproject.com/ns/docs/Burkina_Faso_WestAfricaBriefs_Final.pdf.

⁶² UNFPA, *Progress Profile: Global Programme to Enhance Reproductive Health Commodity Security* (New York: UNFPA, 2011). http://www.unfpa.org/webdav/site/global/shared/documents/gprhcs/GPRHCS_Burkina_Faso.pdf.

systematically scale up FP use.⁶³ These efforts have made an impact: contraceptive utilization has increased from 8.6% in 2006⁶⁴ to 16.2% in 2014.⁶⁵

5.3.2 Service delivery

A facility was designated as a functioning FP service delivery point if the following criteria were met: self-reported provision of the service in the previous three months, at least one provider trained in FP service provision, and the presence of minimum essential supplies and equipment on the day of the assessment. All hospitals and one camp and one non-camp health center met the criteria as functioning FP service delivery points (see Table 9). The facility run by the Catholic Church had no modern FP methods available.

| Table 9. Provision of family planning services to an acceptable standard (n=28) | | | |
|--|------------------------|----------------------------------|---------------------------------------|
| | Hospitals (n=3) | Camp health centers (n=4) | Non-camp health centers (n=21) |
| IUD | 3 (100%) | 1 (25%) | 1 (4.8%) |
| Implant | 3 (100%) | 1 (25%) | 8 (40%) ND* (1) |
| Oral contraceptive pill | 3 (100%) | 3 (100%) ND* (1) | 17 (81%) |
| Injectable contraceptive | 3 (100%) | 3 (100%) ND* (1) | 17 (81%) |
| Functioning FP service delivery point | 3 (100%) | 1 (25%) | 1 (4.8%) |

*No data

Short-acting methods included oral contraceptive pills (OCPs), injectable contraceptives, EC, and male and female condoms. Short-acting methods were more available than long-acting: all hospitals, three camp health centers, and 81% of non-camp health centers were able to adequately provide OCPs and injectables. Although injectables and OCPs were provided at all but one health facility—the faith-based organization—in the previous three months (Table 10), some lacked key equipment, such as a blood pressure cuff, and methods, including OCPs and injectables, on the day of the assessment. (See Appendix A: Tables A1 to A3 for more detailed tables.)

⁶³ Burkina Faso Ministry of Health, *Plan national de relance de la Plantification Familiale 2013-2015* (2013). http://advancefamilyplanning.org/sites/default/files/resources/Plan%20de%20relance%20PF_2013-2015_final.pdf.

⁶⁴ UNFPA, *Progress Profile: Global Programme to Enhance Reproductive Health Commodity Security* (New York: UNFPA, 2011). http://www.unfpa.org/webdav/site/global/shared/documents/gprhcs/GPRHCS_Burkina_Faso.pdf.

⁶⁵ The World Bank, *Indicators*, 2014, <http://data.worldbank.org/indicator>.

Providers at 24 of the 28 facilities reported that they had provided male condoms in the three months prior to the assessment; female condoms were not available. Ten health facilities reported having recently provided EC. Of those that did not offer EC, most facilities reported that they were not authorized to do so.

| Table 10. Short-acting family planning services provided & reasons not provided (n=28) | | | | |
|---|---------------------------------|---------------------------------|--------------------------------|---------------------------------|
| Function | Oral contraceptive pills | Injectable contraceptive | Emergency contraception | Condoms (male or female) |
| Provided in the past 3 months (self-report) | 27 (96.4%) | 27 (96.4%) | 10 (35.7%) | 24 (85.7%) |
| Provided in the past 3 months (clients noted in registers) | 22 (95.7%) ND* (5) | 23 (100%) ND* (5) | 0 ND* (5) | 11 (47.8%) ND* (5) |
| Main reason service not provided | | | | |
| Lack of skilled staff/training | 0 | 0 | 2 | 0 |
| Lack of supplies / equipment | 0 | 0 | 5 | 0 |
| Not authorized to provide | 0 | 0 | 12 | 1 |

*No data

Long-acting methods include intrauterine devices (IUDs) and implants; permanent methods include tubal ligation and vasectomy. One camp and eight non-camp health centers adequately provided implants, and one camp and one non-camp health center adequately provided IUD. Almost all facilities (26) reported providing implants (mainly Jadelle) in the previous three months (Table 11), but only eight facilities met the minimum criteria for implant provision due to lack of supplies such as sponge forceps (Appendix A: Table A5.)

The hospitals and one camp health met the minimum criteria for providing IUDs (Table 9). However, among non-camp health facilities, four reported providing IUDs in the previous three months, but only one met the criteria to adequately do so. Although most of the non-camp health centers had staff trained in provision of long-acting methods, they lacked supplies for IUDs (Appendix A: Table A4.) Of those that did not provide IUDs, seven reported they were unauthorized.

| Table 11. Long-acting and permanent family planning services provided & reasons not provided (n=28) | | | | |
|--|----------------------|-----------------------|-----------------------|------------------|
| Function | IUD | Implant | Tubal Ligation | Vasectomy |
| Provided in the past 3 months (self-report) | 8 (28.6%) | 26 (92.8%) | 0 | 1 (3.6%) |
| Provided in the past 3 months (clients noted in registers) | 3 (12.5%) ND* (4) | 19 (82.6%) ND* (5) | 0 ND* (5) | 0 ND* (5) |
| Main reason service not provided | | | | |
| Lack of skilled staff/training | 4 | 1 | 7 | 5 |
| Lack of supplies / equipment | 7 | 1 | 6 | 4 |
| Not authorized to provide | 6 | 1 | 25 | 25 |

*No data

5.3.3 Provider knowledge and attitudes

Eleven providers completed questionnaires regarding knowledge of and attitudes toward RH (see full results in Appendix B). All providers had been trained in counseling for FP methods and 90% had provided counseling in the past three months. All providers had been trained to insert implant and nine of the 11 providers had been trained to insert IUDs. However, only one of the eleven providers had inserted an IUD in the past three months.

Providers were asked about what they discussed when they counseled a woman for FP. All providers said they would discuss all FP methods, but only two said they would tell her about dual protection. When asked about what methods women can use immediately post-partum, the participants mainly cited the lactational amenorrhea method; only three mentioned IUD and condoms, and none suggested tubal ligation. When asked about what FP methods a woman who is breast-feeding can use six weeks after delivery, all cited progestin-only pills; six mentioned IUD and condoms and two reported tubal ligation.

All providers strongly agreed that FP services should be available to every woman who wants to use a method. All also strongly agreed that young unmarried women and men need to know how to prevent pregnancies and should be educated about sex and reproduction.

The questionnaires also revealed some negative attitudes that can undermine quality of care. Two providers agreed that “men should be responsible for choosing how many children their wife/wives have.” While nine of the eleven providers disagreed that young women need parental consent in order to receive FP methods, two providers agreed

that parental consent was necessary. One respondent did not support the statement that “a woman should be able to obtain a FP method without her husband presence.” One agreed that “the more children a mother a mother has, the more respected she is in the community.”

5.3.4 Focus group discussions

Focus group discussions were held with married men, married women, unmarried men, and unmarried women to understand attitudes towards to FP and barriers to accessing services. (Codes: *UMB = Unmarried Men Bela, UWB = Unmarried Women Bela, MMB = Married Men Bela, MWB = Married Women Bela, UMT = Unmarried Men Tuareg, UWT = Unmarried Women Tuareg, MMT = Married Men Tuareg, MWT = Married Women Tuareg, WCT = Women Community Leaders Tuareg, MCA = Men Community Leaders Arab, UWA = Unmarried Women Arab*)

A majority of the respondents mentioned that the best timing to have a first child was one year after marriage and also highlighted that those who marry early should wait to reach the “majority” (16 to 18 years old) before becoming pregnant. All men mentioned the importance of having a lot of children; this was a matter of prestige and also a way to ensure financial security for the future. Benefits from birth spacing were only raised in two groups of women (MWT and UWT). However, they also highlighted the fact that birth spacing was not always possible because it is “the man who decides” when his wife should become pregnant.

All focus group participants had heard about contraceptive methods and knew that some couples used them. When asked about ways to prevent pregnancy, the majority suggested abstinence and one group (MWT) mentioned injections, OCPs, and traditional medicines. Some of the groups (MWB, UWB, MMT) had very limited knowledge about FP methods. Most of the interviewees knew that FP methods were available for free at the health centers inside the camps, and that access was simple and no paperwork was required. However, they mentioned that some of the community members preferred to consult a traditional doctor and buy condoms at a pharmacy to ensure confidentiality. Some women went to the camp health centers to access FP methods, but said they first needed the approval of their husband. Focus groups reported that some women went to the health centers “in secret” because they did not want neighbors or relatives to know that they were seeking FP. One group (UWB) mentioned that access to FP was more difficult for young women.



Health facility managed by MdM-France at Mentao South, the largest facility in the camp of 12,300 © Beesley/IAWG/2013

5.4 Emergency obstetric and newborn care

5.4.1 Overview

Burkina Faso has high maternal and infant mortality ratios: 400 per 100,000⁶⁶ and 66 per 1,000 live births, respectively.⁶⁷ However, the maternal mortality rate has steadily declined since the early 1990s the maternal mortality rate was recorded at 770 women per 100,000 live births.⁶⁸ Despite progress, the country is not on track to meet its maternal health Millennium Development Goal (Figure 1). In Mali, maternal and infant mortality ratios are worse than Burkina Faso at 550 per 100,000⁶⁹ and 79.6 per 1,000 live births, respectively.⁷⁰

⁶⁶ The World Bank, *Maternal mortality ratio (modeled estimate, per 100,000 live births)*, 2014, <http://data.worldbank.org/indicator/SH.STA.MMRT>.

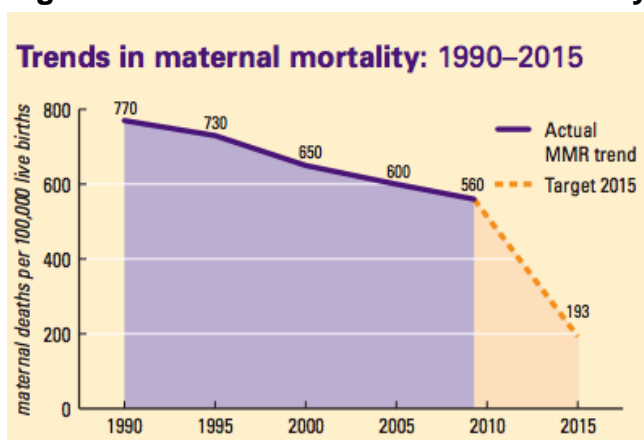
⁶⁷ The World Bank, *Mortality rate, infant (per 1,000 live births)*, 2014, <http://data.worldbank.org/indicator/SP.DYN.IMRT.IN>.

⁶⁸ UNFPA, *Burkina Faso: The State of the World's Midwifery* (New York: UNFPA, 2011). http://www.unfpa.org/sowmy/resources/docs/country_info/profile/en_BurkinaFaso_SoWMy_Profile.pdf.

⁶⁹ The World Bank, *Maternal mortality ratio (modeled estimate, per 100,000 live births)*, 2014, <http://data.worldbank.org/indicator/SH.STA.MMRT>.

⁷⁰ The World Bank, *Mortality rate, infant (per 1,000 live births)*, 2014, <http://data.worldbank.org/indicator/SP.DYN.IMRT.IN>.

Figure 1: Burkina Faso: Maternal mortality ratio, 1990-2015



Source: UNFPA 2011

On average, women in Burkina Faso have about 6 children in their lifetime.⁷¹ About half of births are accompanied by skilled health personnel.⁷² Pregnancy-related complications account for as many as 2,000 deaths each year,⁷³ and many are due to delays in referral to a skilled birth attendant.⁷⁴ The adolescent birth rate is also high at 131 per 1,000 births by women of reproductive age.⁷⁵

In 2012 the government of Burkina Faso created the Midwifery Council, a national body designed to improve training for midwives and other skilled birth attendants.⁷⁶ Since its inception, the knowledge and basic practices of midwives and skilled birth attendants has improved, which has been hailed as a successful step towards comprehensive RH rights.⁷⁷ A national maternal and newborn health plan is also in place that includes enhancing the midwifery workforce.⁷⁸

⁷¹ UNFPA, *Burkina Faso: The State of the World's Midwifery* (New York: UNFPA, 2011).

http://www.unfpa.org/sowmy/resources/docs/country_info/profile/en_BurkinaFaso_SoWMy_Profile.pdf.

⁷² Ibid.

⁷³ Catherine Lalonde, "Burkina Faso: Expanding Access to Misoprostol for Postpartum Hemorrhage," *The FCI Blog* (October 23, 2013). <http://familycareintl.org/blog/2013/10/23/burkina-faso-expanding-access-to-misoprostol-for-postpartum-hemorrhage-in/>.

⁷⁴ UNFPA, *Maternal Health Thematic Fund: Annual Report 2012* (New York: UNFPA, 2012).

<http://www.unfpa.org/webdav/site/global/shared/documents/publications/2013/MHTF%202012%20Annual%20Report-final.pdf>.

⁷⁵ UNFPA, *Burkina Faso: The State of the World's Midwifery* (New York: UNFPA, 2011).

http://www.unfpa.org/sowmy/resources/docs/country_info/profile/en_BurkinaFaso_SoWMy_Profile.pdf.

⁷⁶ UNFPA, *Maternal Health Thematic Fund: Annual Report 2012* (New York: UNFPA, 2012).

<http://www.unfpa.org/webdav/site/global/shared/documents/publications/2013/MHTF%202012%20Annual%20Report-final.pdf>.

⁷⁷ Ibid.

⁷⁸ UNFPA, *Burkina Faso: The State of the World's Midwifery* (New York: UNFPA, 2011).

http://www.unfpa.org/sowmy/resources/docs/country_info/profile/en_BurkinaFaso_SoWMy_Profile.pdf.

In 2012 the MoH, with support from UNFPA, launched a Maternal Death Surveillance and Response initiative, which aims to generate quality data on maternal and newborn deaths and availability of contraceptives and life-saving medicines; track the evolution of maternal deaths over time; and develop a response and monitoring policy.⁷⁹ UNFPA also created 462 village-based EmONC committees to decrease the referral times and improve the overall referral process.⁸⁰ EmONC trainings have been implemented by UNFPA in facilities with high case fatality rates.⁸¹

5.4.2 Service delivery

A functioning EmONC delivery point was defined as being able to adequately provide the following signal functions, or life-saving obstetric interventions, as recommended by WHO:⁸²

For BEmONC

- Administration of parenteral antibiotics
- Administration of uterotonic drugs
- Administration of parenteral anticonvulsants
- Manual removal of placenta
- Removal of retained products
- Assisted vaginal delivery
- Neonatal resuscitation with bag and mask

For CEmONC

All of the above plus:

- Blood transfusion
- Caesarean section

Hospitals should be able to provide CEmONC and health centers should be able to provide BEmONC. In order to qualify as a functioning service delivery point, facilities must have provided the appropriate signal functions in the previous months, trained staff must have been in place, and equipment and supplies to provide the respective signal functions in evidence at the time of the assessment. Availability of partographs, blood pressure cuff, and stethoscope, which are essential to provide good delivery care, were also required. This assessment found that one hospital met the criteria for a

⁷⁹ UNFPA, *Maternal Health Thematic Fund: Annual Report 2012* (New York: UNFPA, 2012).
<http://www.unfpa.org/webdav/site/global/shared/documents/publications/2013/MHTF%202012%20Annual%20Report-final.pdf>.

⁸⁰ Ibid.

⁸¹ Ibid.

⁸² World Health Organization et al., *Monitoring emergency obstetric care: a handbook* (Geneva:WHO, 2009).
http://www.unfpa.org/webdav/site/global/shared/documents/publications/2009/obstetric_monitoring.pdf

functioning CEmONC delivery point and one qualified as a functioning BEmONC service delivery point (Table 12). None of the health centers met the criteria as functioning BEmONC service delivery points.

| Table 12. Provision of EmONC to an acceptable standard (n=28) | | | |
|--|----------------------------|--------------------------------------|---|
| | Hospitals (n=3) | Camp health centers (n=4) | Non-camp health centers (n=21) |
| At least one staff trained to provide BEmONC | 3 (100%) | 3 (100%) ND (1) | 18 (85.7%) |
| Parenteral antibiotics | 3 (100%) | 1 (25%) | 21 (100%) |
| Parenteral uterotonics | 3 (100%) | 1 (25%) | 11 (52.4%) |
| Parenteral anticonvulsants | 3 (100%) | 1 (25%) | 7 (33.3%) |
| Manual removal of placenta | 3 (100%) | 2 (50%) | 10 (47.6%) |
| Removal of retained products | 3 (100%) | 1 (25%) | 1 (4.8%) |
| Assisted vaginal delivery | 2 (66.7%) | 0 | 0 |
| Neonatal resuscitation with appropriate bag and mask | 3 (100%) | 1 (25%) | 10 (47.6%) |
| Partograph | 3 (100%) | 3 (75%) | 21 (100%) |
| Blood pressure cuff | 3 (100%) | 4 (100%) | 19 (90.5%) |
| Stethoscope | 3 (100%) | 4 (100%) | 21 (100%) |
| Functioning BEmONC service delivery point | 1 (33.3%)* | 0 | 0 |
| At least one staff trained to conduct blood transfusion | 3 (100%) | N/A | N/A |
| Blood transfusion | 3 (100%) | N/A | N/A |
| At least one staff trained to perform caesarean section | 2 (1 ND) | N/A | N/A |
| Caesarean section | 1 (33.3%) | N/A | N/A |
| Functioning CEmOC service delivery point | 1 (33.3%)* | N/A | N/A |

*1 hospital provides CEmOC (and is not included as a BEmOC facility); 1 provides BEmOC (but not CEmOC)

All facilities had provided some elements of EmONC in the previous three months (Tables 13a,13b, 13c.) Yet, of the 28 facilities, only one hospital adequately provided the appropriate level of care given that all hospitals should be able to provide CEmONC. (See Appendix A: Tables A6 to A15 for details on each signal function.) Assisted vaginal delivery was a key gap across facilities, with half of the facilities reporting that they were unauthorized to provide this signal function.

The camp health centers struggled to provide BEmONC mainly due to a dearth of essential supplies. For example, although all had provided parenteral anticonvulsants in the previous three months, only one had magnesium sulfate at the time of the assessment. Three out of four had performed neonatal resuscitation in the three months prior, but only one had a resuscitation bag and infant face mask when assessed.

Similarly, non-camp health centers lacked equipment and drugs as well. Although all were able to adequately provide parenteral antibiotics, only one-third had magnesium sulfate as a parenteral anticonvulsant. Lack of aprons and vacuum extractor were also gaps.

Other essential obstetric services were assessed, including the use of partograph to manage labor, the active management of the third stage of labor, and PMTCT (Appendix A: Table A6). All hospitals and non-camp facilities used partographs as well as had provided active management of the third stage of labor whereas two camp facilities did not have partographs and one had not provided active management of the third stage of labor. These facilities cited lack of supplies as the main reason the service was not provided. (PMTCT is discussed in the HIV section.)

In addition to stock-outs and supply chain challenges, policy barriers undercut adequate provision of EmONC. Many health centers reported being unauthorized to provide parenteral uterotonics, removal of retained products, and, as noted above, assisted vaginal delivery. Training was not a significant gap: all hospitals and majority of health centers had at least one appropriately trained staff.

| Table 13a. EmONC Signal functions provided and main reasons for not providing function (n=28) | | | | | | | | | |
|--|------------------------|----------|-----------|------------------------|---------|------------|----------------------------|----------|----------|
| Function | Parenteral antibiotics | | | Parenteral uterotonics | | | Parenteral anticonvulsants | | |
| | Hosp | Camp | Non-camp | Hosp | Camp | Non-camp | Hosp | Camp | Non-camp |
| Provided in the last 3 months (self-reported) | 3 (100%) | 4 (100%) | 21 (100%) | 3 (100%) | 1 (25%) | 11 (52.4%) | 3 (100%) | 4 (100%) | 17 (81%) |
| Main reason service not provided | | | | | | | | | |
| Lack of skilled staff/training | | | | 4 (30.8%) | | | 0 | | |
| Lack of supplies / equipment | | | | 6 (46.2%) | | | 0 | | |
| Not authorized to provide | | | | 10 (76.9%) | | | 0 | | |

| Table 13b. EmONC Signal functions provided and main reasons for not providing function (n=28) | | | | | | | | | |
|--|----------------------------|---------|------------|------------------------------|---------|----------|---------------------------|------|----------|
| Function | Manual Removal of Placenta | | | Removal of retained products | | | Assisted Vaginal Delivery | | |
| | Hosp | Camp | Non-camp | Hosp | Camp | Non-camp | Hosp | Camp | Non-camp |
| Provided in the last 3 months (self-reported) | 3 (100%) | 2 (50%) | 16 (75.2%) | 3 (100%) | 1 (25%) | 4 (19%) | 2 (66.7%) | 0 | 0 |
| Main reason service not provided | | | | | | | | | |
| Lack of skilled staff/training | 0 | | | 3 (15%) | | | 6 (23.1%) | | |
| Lack of supplies/equipment | 2 (33.3%) | | | 11 (55%) | | | 16 (61.5%) | | |
| Not authorized to provide | 1 (16.7%) | | | 10 (50%) | | | 14 (53.8%) | | |

| Table 13c. EmONC Signal functions provided and main reasons for not providing function (n=28) | | | | | | | | | |
|--|--|---------|------------|-------------------|------|----------|-------------------|------|----------|
| Function | Neonatal resuscitation with bag and mask | | | Blood Transfusion | | | Caesarean Section | | |
| | Hosp | Camp | Non-camp | Hosp | Camp | Non-camp | Hosp | Camp | Non-camp |
| Provided in the last 3 months (self-reported) | 3 (100%) | 3 (75%) | 11 (52.4%) | 3 (100%) | 0 | 0 | 3 (100%) | 0 | 0 |
| Main reason service not provided | | | | | | | | | |
| Lack of skilled staff/training | 0 | | | 1 (4.2%) | | | 7 (29.2%) | | |
| Lack of supplies / equipment | 10 (90.9%) | | | 9 (37.5%) | | | 8 (33.3%) | | |
| Not authorized to provide | 0 | | | 22 (91.7%) | | | 23 (95.8%) | | |

Data were collected from health facilities on delivery and EmONC services in the previous six months (Table 14). None of the camp health centers and only one of the non-camp health centers reported a maternal death. The hospital reported 26 maternal deaths, accounting for an estimated 3.9% of complications.

Over 1,000 (16%) of the 6,656 deliveries reported across the setting in six months involved complications. Among health centers, complications accounted for 5% to 6% of deliveries. These figures neatly correspond with the standard estimate of up to 15% of pregnant women who experience a complication during childbirth, suggesting that women who experience complications may be reaching facilities.⁸³ Among hospitals—to which women with complications were referred—88% of deliveries involved complications and 19% required caesarean sections.

| Table 14. Provision of EmONC across facilities (n=25) | | | | |
|--|----------------------------|--------------------------------------|---|-----------------------|
| | Hospitals (n=2) | Camp health centers (n=2) | Non-camp health centers (n=21) | Total (25) |
| Total number of deliveries | 743 | 304 | 5,609 | 6,656 |
| No. of obstetric complications treated at health facility | 655 | 14 | 365 | 1,034 |
| Complications per total deliveries (%) | 88% | 5% | 6% | 16% |
| Caesarean sections | 141 | n/a | n/a | 141 |
| Maternal deaths at the facility | 26 | 0 | 1 | 27 |
| Obstetric case fatality rate (maternal deaths/complications) | 3.9% | 0% | 0% | 2.6% |
| Number of stillbirths | 136 | 4 | 86 | 226 |
| Number of stillbirths/deliveries | 18% | 1% | 2% | 3% |

*No data

According to key informants, the referral system for refugees was functioning well. For delivery, women first went to the camp health center. At Goudebo camp, EmONC cases were referred directly to the regional referral hospital in Dori. When indicated, emergencies were then transferred to a national referral hospital in Ouagadougou. The French Red Cross was managing and supporting the transportation (a three hour drive) and the medical management of all the refugees transferred to the capital city. In Mentao camp, complicated cases and emergencies were referred to the Djibo provincial hospital. If further referral was needed, patients were transferred directly to Ouagadougou rather than Dori regional hospital. (The road Djibo to Dori was very poor, especially during the rainy season).

Newborn care: Data on additional essential elements of newborn care were collected, including having provided neonatal resuscitation in the previous three months, the availability of skilled staff trained to provide breastfeeding support, newborn infection management, thermal care, cord care, kangaroo care, delivery practices for PMTCT as well as drugs for infection management. Availability of adequate newborn care was

⁸³ Inter-Agency Working Group on Reproductive Health in Crises, *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2010. <http://www.iawg.net/IAFM%202010.pdf>.

limited across health facilities (Table 15). Two of the three hospitals, one camp health center, and two non-camp health centers had all assessed elements of newborn care.

The hospitals had all elements in place, although one did not have a provider trained in early and exclusive breastfeeding support. Among camp health centers, some lacked trained staff and drugs, but resuscitation bag and infant mask were available at only one facility although three had performed neonatal resuscitation in the three months prior. Among non-camp health centers, corticosteroids were available in just four facilities. Lack of resuscitation bag and infant mask and providers trained in newborn infection management were also gaps in non-camp health centers.

| Table 15. Facilities with essential elements of newborn care (n=28) | | | |
|---|----------------------------|--------------------------------------|---|
| | Hospitals (n=3) | Camp health centers (n=4) | Non-camp health centers (n=21) |
| Neonatal resuscitation with appropriate bag and mask performed in last 3 months | 3 (100%) | 3 (75%) | 11 (52.4%) |
| At least one provider trained to provide | | | |
| Breastfeeding (early and exclusive) | 2 (66.7%) | 3 (75%) | 15 (71.4%) |
| Newborn infection management (including injectable antibiotics) | 3 (100%) | 3 (75%) | 12 (57.1%) |
| Thermal care (including immediate drying and skin-to-skin care) | 3 (100%) | 3 (75%) | 17 (81%) |
| Sterile cord cutting and appropriate cord care | 3 (100%) | 4 (100%) | 17 (81%) |
| Kangaroo care for low birth weight babies | 3 (100%) | 4 (100%) | 18 (85.7%) |
| Special delivery care practices to prevent mother-to-child transmission of HIV | 3 (100%) | 4 (100%) | 20 (95.2%) |
| Partograph | 3 (100%) | 3 (75%) | 21 (100%) |
| Resuscitation bag and infant face mask | 3 (100%) | 1 (25%) | 12 (57.1%) |
| Infant scale | 3 (100%) | 3 (75%) | 21 (100%) |
| Fetoscope | 3 (100%) | 4 (100%) | 21 (100%) |
| Corticosteroids (dexamethasone) | 3 (100%) | 3 (75%) | 4 (20%) ND* (1) |
| Ampicillin injectable | 3 (100%) | 4 (100%) | 21 (100%) |
| Gentamycin injectable | 3 (100%) | 3 (75%) | 21 (100%) |
| Ceftriaxone injectable | 3 (100%) | 4 (100%) | 21 (100%) |
| Facilities with all essential elements of newborn care | 2 (66.7%) | 1 (25%) | 2 (9.5%) |

*No data



Rural MoH-run health center delivery room © Beesley/IAWG/2013

5.4.3 Provider knowledge and attitudes

Provider questionnaires revealed that knowledge of EmONC services varied (Appendix B). In regards to monitoring during labor, all eleven respondents quoted the importance of monitoring the maternal vital signs and dilation of the cervix. Ten providers mentioned the importance of monitoring the fetal heartbeat. However, only two respondents mentioned observing the color of the amniotic fluid and degree of molding.

In the event of heavy bleeding after delivery, most participants (nine out of 11) confirmed that they would assess for signs of shock. About half (6) of the providers mentioned checking for a damaged genital tract and signs of anemia, and seven mentioned looking for retention of the placenta. Only three respondents mentioned the importance of assessing whether the uterus is contracted. To treat heavy bleeding, most participants (8) would begin IV fluids and manually remove the retained product. Less than half said that they would take blood for hemoglobin and cross-matching.

The most frequent responses to post-delivery retention of the placenta were the administration of IV fluid and oxytocin, the manual removal of placenta, and referral. Only three providers mentioned preparing the operating theater or checking blood type, and only one respondent mentioned monitoring the vitals signs.

When asked about immediate care to the last newborn the provider had delivered, all respondents highlighted the importance of cleaning the baby's mouth, face, and nose, and weighing the newborn. Nine respondents said they cared for the umbilical cord and ensured the baby was kept warm. Only four respondents evaluated or examined the newborn within the first hour, and only five respondents initiated breastfeeding within the first 30 minutes.

Most respondents (10) mentioned hypothermia and hyperthermia as signs or symptoms of infection or sepsis in the newborn. Difficulty breathing was mentioned by a majority of RH providers, but only five respondents spoke about poor breastfeeding, restlessness, and irritability, and only one mentioned deep jaundice.

Regarding care provided to low-weight newborns, ten highlighted the importance of keeping the baby warm, but only four providers mentioned supporting the mother to establish breastfeeding and monitoring the baby for the first 24 hours. Three providers mentioned ensuring prevention of infection and only two mentioned monitoring the ability of the mother to breastfeed.

Questions regarding provider attitudes and opinions revealed that all strongly agreed that visiting a health facility to check on a pregnancy's progress was a good idea for a pregnant woman. All also strongly agreed that delivery a baby at a health facility was safer than delivering a baby at home.

5.4.4 *Focus group discussions*

Focus groups discussions found that refugees were very satisfied with the maternal care services at the camp health facilities and also revealed significant positive changes in delivery practices. Refugees reported that the services provided were better than in their country of origin. All married and unmarried women mentioned that they were able to access free, good quality services, and the staff was competent and welcoming. They were treated in the same way independently of their age and origin.

Regarding delivery practices, all respondents acknowledged the great value of delivering at a health facility, where both pregnancy and delivery were monitored by competent staff. Respondents remarked that this was a big improvement in comparison with practices observed in their village of origin in Mali, where most of the deliveries occurred at home with the assistance of traditional birth attendants. Focus groups knew that complicated deliveries were transferred to the hospital. They said that access to the health center maternity ward was easy, even during nights and weekends (with an average of 15 to 20 minutes walking distance). In general women usually walked or

were transported by motorcycles or donkey carts to the maternity ward. Some negative practices were cited, including the husband or mother of the pregnant woman deciding where she should deliver. However, generally, men and women were supportive of facility-based deliveries.

5.5 Comprehensive abortion care

5.5.1 Overview

According to the Burkina Faso penal code, induced abortion is legal under three conditions: 1) fetal impairment, 2) incest, and 3) rape.⁸⁴ A 2013 report found that a third of all pregnancies in Burkina Faso are unintended.⁸⁵ Of these unintended pregnancies, a third were terminated through abortion.⁸⁶ While the proportion of maternal deaths from unsafe abortions has not yet been established, about one in seven maternal deaths in Sub-Saharan Africa is a result of unsafe abortion.⁸⁷ Throughout Burkina Faso, approximately 40% of women who experience abortion-related complications do not receive care.⁸⁸

Across Burkina Faso, urban settings tend to have higher rates of unsafe abortions than rural areas. This has been attributed to the differences in desired family size in urban and rural areas, at 2.8 and 5.9 children respectively.⁸⁹

5.5.2 Service delivery

Comprehensive abortion care includes both PAC and induced abortion. A functional PAC service delivery point was defined as having provided PAC services in the previous three months, having at least one skilled staff providing the service, and having equipment and supplies to provide PAC with manual vacuum aspiration (MVA) or misoprostol. Table 16 demonstrates that while all three hospitals met the criteria as functioning PAC service delivery points, only one camp and none of the non-camp health centers qualified.

⁸⁴ Burkina Faso Penal Code, Law No. 043/96/ADP of November 13, 1996, Chapter II, Section 3, Articles 383-390
Law No. 049-2005/Year Concerning Reproductive Health, Jo No. 06 of February 9, 2006, Chapter III, Article 21

⁸⁵ Akinrinola Bankole et al., *Grossesse non désirée et avortement provoqué au Burkina Faso: causes et conséquences* (New York: Guttmacher Institute, 2013). <http://www.guttmacher.org/pubs/grossesse-non-desiree-Burkina.pdf>.

⁸⁶ Ibid.

⁸⁷ Ibid.

⁸⁸ Ibid.

⁸⁹ Ibid.

Although none of the non-camp health centers met the criteria for a functioning PAC service delivery point, four reported having provided PAC with MVA in the previous three months (Appendix A: Tables A17, A18.) Many lacked supplies such as MVA syringe, adapters and cannulae (Table 17). Camp health centers also lacked supplies such as sponge forceps and tenaculum. About half of the health centers reported that they were unauthorized to provide PAC. Almost all facilities had at least one provider trained in providing PAC.

Most PAC was provided with MVA; eighteen facilities reported not being authorized to provide PAC with misoprostol. According to health facility assessment findings, induced abortion was not available at any facility, with 26 facilities reporting that they were unauthorized to provide the service, despite legal indications for its use. Table 8 demonstrates that, across all 28 facilities, only one camp health center had at least one provider trained to perform induced abortion.

| Table 16. Provision of PAC to an acceptable standard (n=28) | | | |
|--|----------------------------|--------------------------------------|---|
| | Hospitals (n=3) | Camp health centers (n=4) | Non-camp health centers (n=21) |
| FP is offered to all PAC clients | 3 (100%) | 4 (100%) | 21 (100%) |
| PAC with MVA | 3 (100%) | 1 (25%) | 0 |
| PAC with misoprostol (<i>optional</i>) | 0 | 0 | 0 |
| Functioning PAC service delivery point | 3 (100%) | 1 (25%) | 0 (0%) |

| Table 17. Comprehensive abortion care provided & reasons not provided (n=28) | | | | | | | | | |
|---|---------------------|---------|----------|-----------------------------|---------|----------|-------------------------|------|----------|
| <i>Function</i> | PAC with MVA | | | PAC with misoprostol | | | Induced abortion | | |
| | Hosp | Camp | Non-camp | Hosp | Camp | Non-camp | Hosp | Camp | Non-camp |
| Post-abortion care (PAC) provided in last 3 months (self-reported) | 3 (100%) | 1 (25%) | 4 (19%) | 2 (66.7%) | 1 (25%) | 0 | 0 | 0 | 0 |
| Main reason service not provided | | | | | | | | | |
| Lack of skilled staff/training | 3 | | | 6 | | | 4 | | |
| Lack of supplies / equipment | 11 | | | 13 | | | 4 | | |
| Not authorized to provide | 10 | | | 18 | | | 26 | | |

5.5.3 Provider knowledge and attitudes

Questionnaires found that only one of the eleven providers had been trained to provide an induced abortion, and seven had been trained to provide PAC with MVA (Appendix B). When asked about the immediate complications of an unsafe abortion, all providers identified bleeding. About half mentioned shock and genital injuries. None cited abdominal injuries. Questionnaires asked about what actions the provider takes when a woman presents with complications from an unsafe or incomplete abortion; most indicated that they would conduct a vaginal exam, assess vital signs, provide counseling, initiate IV fluid and antibiotics, and conduct manual/vacuum aspiration. Only one mentioned dilation with curettage or provision of misoprostol.

When asked about information provided to patients treated for incomplete or unsafe abortion, all providers mentioned giving counseling on FP and services and information about consequences of unsafe abortion. Only three providers mentioned supplying information to prevent STI/HIV or social support resources.

5.5.4 Focus group discussions

Most of the respondents said that they had no options when an unwanted pregnancy occurred, and women reported that they did not know how to avoid pregnancy after unprotected sex. Focus groups participants said that a pregnancy was “God’s will” and that the couple “needs to assume its responsibilities.” There are “rare” and “shameful” situations in which the husband agrees to proceed with an unsafe abortion. One group (MWT) said that a primary health concern was repeated unsafe abortion. Focus groups said that, in general, women secretly consult a *marabout* (an Islamic religious leader common in West Africa) who prescribes traditional medicine to induce abortion, usually as powder to be added to milk, but this was considered a “crime” according to their religious beliefs. They reported that the prevailing attitudes towards unwanted pregnancies were part of the Malian tradition.

5.6 HIV and other sexually transmitted infections

5.6.1 Overview

Both Burkina Faso and Mali have a generalized HIV epidemic with an estimated adult HIV prevalence of around 1%.⁹⁰ Approximately 70% of people in Burkina Faso and 52%

⁹⁰ The World Bank, *Prevalence of HIV, total (% of population ages 15-49)*, 2012, <http://data.worldbank.org/indicator/SH.DYN.AIDS.ZS>.

of people in Mali with advanced HIV infection are on ART.⁹¹ Burkina Faso's government has made significant efforts to strengthen its HIV/AIDS response. A commitment was made in 2001 to increase funding for prevention, surveillance, care and treatment of people living with HIV and AIDS, and the government has continued to increase resources over the years.⁹² Since 2001, it has developed three national strategic frameworks to address HIV and AIDS. The third—the National Strategic Framework for the Fight against AIDS (2011-2015)—focuses on a multi-sectoral response with specific attention to at-risk populations.⁹³

While over 1,000 health workers and 14,000 community supporters have been trained to deliver HIV/AIDS services, human resources for HIV/AIDS care are still limited.⁹⁴ In addition to creating incentives to encourage health workers in the public sector to become trained in the delivery of HIV/AIDS care, mechanisms of procurement and delivery of medications still require strengthening.⁹⁵ In addition, a pillar of the Global Programme to Enhance Reproductive Health Commodity Security, mentioned previously, is the education of adolescents on the prevention of HIV and other STIs.⁹⁶

According to the United States Agency for International Development (USAID), in Mali, STI rates are relatively low; emphasis has been placed on syndromic rather than generalized testing.⁹⁷ Burkina Faso's STI rates are also relatively low with the greatest STI prevalence among sex worker and mine worker populations.⁹⁸

5.6.2 Service delivery

Adequate provision of STI services (syndromic or laboratory testing and treatment) and PMTCT included self-reported provision of the service in the preceding three months and the availability of essential drugs on the day of the assessment. Data were

⁹¹ The World Bank, *Antiretroviral therapy coverage (% of people with advanced HIV infection)*, 2012, <http://data.worldbank.org/indicator/SH.HIV.ARTC.ZS>

⁹² World Health Organization, *Summary Country Profile for HIV/AIDS Scale-Up: Burkina Faso* (Geneva: WHO, 2005) http://www.who.int/hiv/HIVCP_BFA.pdf.

⁹³ Molly Fitzgerald and Sharon Stash, *The Changing Face of HIV Prevention Programs in Burkina Faso and Togo: Opportunities and Challenges of Providing HIV Prevention and Services for Most-at-Risk Populations in Burkina Faso and Togo* (Arlington, VA: USAID's AIDSTAR, 2013). http://www.aidstar-one.com/sites/default/files/AIDSTAR-One_TogoBF_Review_web.pdf.

⁹⁴ Ibid.

⁹⁵ Ibid.

⁹⁶ UNFPA, *Progress Profile: Global Programme to Enhance Reproductive Health Commodity Security* (New York: UNFPA, 2011). http://www.unfpa.org/webdav/site/global/shared/documents/gprhcs/GPRHCS_Burkina_Faso.pdf.

⁹⁷ USAID, *Country Profile: Mali* (Washington, DC: USAID, 2002). http://pdf.usaid.gov/pdf_docs/Pnac685.pdf.

⁹⁸ Robert Soudre, *Grant proposal form round 8: HIV* (Ouagadougou: L'Unité de Formation et de Recherche en Sciences de la Santé (UFR/SDS), 2009). http://www.theglobalfund.org/documents/rounds/8/notapproved/8BURH_1638_0_full/.

collected on self-reported provision of ART for people living with HIV (PLHIV), VCT, and condoms in the previous three months.

Among the hospitals and non-camp health centers, STI and HIV services were robust, with the exception of ART (Table 18). Although all camp health facilities provided VCT and condoms in the three months prior, only one met the criteria to provide STI care and provision of PMTCT. Lack of supplies was the primary barrier to adequate STI provision: all four camp facilities had provided STI care in the previous three months, yet only one had the requisite antibiotics at the time of the assessment (Appendix A: Table A19.)

| Table 18. HIV and other STI services (self-reported) (n=28) | | | |
|--|------------------------|----------------------------------|---------------------------------------|
| | Hospitals (n=3) | Camp health centers (n=4) | Non-camp health centers (n=21) |
| STIs* | 2 (67%) | 1 (25%) | 21 (100%) |
| Administered ARVs to HIV+ mothers and newborns in maternity (see Table 20) | 3 (100%) | 1 (25%) | 18 (90%) ND (1) |
| ART for PLHIV | 3 (100%) | 1 (25%) | 3 (14.3%) |
| Voluntary HIV counseling and testing | 3 (100%) | 4 (100%) | 19 (90.5%) |
| Condom provision | 3 (100%) | 3 (75%) | 18 (85.7%) |

*Drugs available and self-reported provided in the previous three months

ART was a significant gap with only the hospitals and one camp health center providing this care in the previous three months (Table 19a). The majority of health centers reported that they were unauthorized to provide ART. VCT was available at all but two non-camp health centers, which reported they were unauthorized to do so. Condoms were available at the most of the health facilities, although one camp health center had not provided condoms in the previous three months (Table 19b).

| Table 19a. HIV and other STI services provided & reasons for not providing (n=28) | | | |
|--|--|---|------------------------------|
| <i>Function</i> | Perform syndromic or laboratory diagnosis and treatment of STIs | Provide voluntary HIV counseling and testing | Provide ART for PLHIV |

| | Hosp (n=3) | Camp (n=4) | Non- camp | Hosp (n=3) | Camp (n=4) | Non- camp (n=21) | Hosp (n=3) | Camp (n=4) | Non- camp (n=21) |
|---|---------------|---------------|--------------|---------------|---------------|------------------------|---------------|---------------|------------------------|
| Provided in last 3 months (self-reported) | 3 (100%) | 4 (100%) | 21 (100%) | 3 (100%) | 4 (100%) | 19 (90.5%) | 3 (100%) | 1 (25%) | 3 (14.3%) |
| Main reason service not provided | | | | | | | | | |
| Lack of skilled staff/training | | | | 0 | | | 3 | | |
| Lack of supplies / equipment | | | | 0 | | | 6 | | |
| Not authorized to provide | | | | 2 | | | 18 | | |

| Table 19b. HIV and other services provided & reasons not providing | | | | | | |
|---|--|-----------------|--------------------|-------------------------|---------------|--------------------|
| <i>Function</i> | Administer ARVs to HIV+ mothers and newborns in maternity | | | Condom provision | | |
| | Hosp (n=3) | Camp (n=4) | Non-camp (n=21) | Hosp (n=3) | Camp (n=4) | Non-camp (n=21) |
| Provided in last 3 months (self-reported) | 3 (100%) | 1 (25%) | 21 (100%) | 3 (100%) | 3 (75%) | 18 (85.7%) |
| Provided in the past 3 months (clients noted in registers) | | 0 ND* (1) | 0 | 1 (50%) ND* (1) | 0 ND* (3) | 2 ND* (2) |
| Main reason service not provided | | | | | | |
| Lack of skilled staff/training | 0 | | | 0 | | |
| Lack of supplies / equipment | 3 | | | 0 | | |
| Not authorized to provide | 0 | | | 1 | | |

*No data

Antiretroviral drug (ARV) administration to HIV positive mothers and newborns was well established in hospitals and non-camp health centers (Table 20). Outside of the camps, all health facilities had provided PMTCT in the previous three months, although two health centers did not have adequate drugs at the time of the assessment. Only one camp health center adequately met the criteria to provide PMTCT. The most common barrier was lack of ARVs.

| Table 20. Facilities with essential drugs to provide PMTCT (n=28) | | | |
|--|----------------------------|--------------------------------|------------------------------------|
| PMTCT | Hospitals (n=3) | Camp health centers | Non-camp health centers |

| | | (n=4) | (n=21) |
|--|-----------------|----------------------|-----------------------------------|
| Administered ARVs to HIV+ mothers in maternity in the last 3 months (self-reported) | 3 (100%) | 1 (33.3%) ND* (1) | 21 (100%) |
| Administered ARVs to newborns born to HIV+ mothers in maternity in the last 3 months (self-reported) | 3 (100%) | 1 (25%) | 21 (100%) |
| ARVs for the mother available | 3 (100%) | 3 (75%) | 19 (90.5%) |
| ARVs for the infant available | 3 (100%) | 3 (75%) | 18 (90%) ND* (1) |
| Facilities adequately provide PMTCT | 3 (100%) | 1 (25%) | 18 (90%) ND* (1) |

*No data

5.6.3 Provider knowledge and attitudes

All eleven providers who filled out the questionnaire reported having been trained in the provision of PMTCT; eight reported having administered PMTCT in the previous three months (Appendix B). When asked what they do when someone presents with symptoms of an STI, all said that they focus on the diagnosis and provide antibiotics. Only five of the providers mentioned that they would also counsel on contact tracing and four would counsel on HIV and offer VCT. Only two said they would explain how to use and provide condoms.

5.6.4 Focus group discussions

All focus groups were aware of HIV and AIDS, and mentioned that this was a concern at the community level. When asked about other STIs, several groups mentioned syphilis, urethral discharge/gonorrhea, chancroid, vaginal discharge, although others mentioned measles and chickenpox (MWB), typhoid (UWB), and leprosy and smallpox (MWT). One group of unmarried women could not name any STIs (UWT).

FGD participants were questioned about how to avoid getting infected, and who was most at risk of infection. One group of young unmarried women (UWT) could not answer these questions. The responses provided by the other groups included fidelity, abstinence, condom utilization, monogamy, avoiding contact with commercial sex workers, and avoiding contact with objects contaminated with the blood of HIV-positive individuals. Other responses provided by the group included protecting kitchen utensils (from contact with PLHIV), avoiding contact with flies, and believing in God.

Unmarried women were not able to provide any information on condom availability. Most other FGD participants were aware of the availability of condoms at the health center, but that many did not access them. Participants expressed that condoms should be used by those with multiple partners, commercial sex workers, young people, and unfaithful married men.

Most FGD participants indicated that people who think they might have contracted HIV should go to the health center to get tested for HIV. Most participants were aware of the need to visit a health facility in order to get treatment. One group (MWB) mentioned that “there is nothing to be done” after a positive diagnosis, and another group (UWT) was unaware of the existence of test and treatments for HIV and STIs. In regards VCT, one group (UMT) mentioned the importance of having confirmation of the diagnosis, and receiving counseling and treatment. In regards to the reasons for not being tested, FGD participants expressed concerns about lack of confidentiality and also mentioned shame, the fear of discovering that they could be sick, and the fear of social consequences (stigmatization or banishment from the community).

5.7 Sexual violence

5.7.1 Overview

The three most common forms of violence against women in Burkina Faso are intimate partner violence, early and forced marriages, and rape. Sexual violence has been documented throughout the country, including against young girls. Marital rape is believed to be commonplace. Few survivors come forward to report rape or seek health services, and usually do so only when they have suffered significant bodily injury requiring medical attention. Forced marriage of adolescent—and sometimes prepubescent—girls to adult men is prevalent in rural areas, especially in the Sahel region.^{99,100}

In Mali, sexual violence increased after fighting erupted in the North. GBV was prevalent before the conflict, including forced marriage and intimate partner violence. In April 2012, a senior UN official in Mali condemned sexual violence including public rape and abductions.¹⁰¹

⁹⁹ Wendyam Kabore Zare et al., *Background study of the inter-agency joint programme on violence against women: Burkina Faso* (New York: The Inter-Agency Network on Women and Gender Equality Task Force on Violence Against Women, 2008).

http://www.un.org/womenwatch/ianwge/taskforces/vaw/Version_anglaise_de_l_etude_de_base_VEF_2009-ud.pdf.

¹⁰⁰ African Centre for Gender and Social Development, *Violence Against Women in Africa: A Situational Analysis* (Addis Ababa: United Nations Economic Commission for Africa, 2011).

<http://www1.uneca.org/Portals/awro/Publications/21VAW%20in%20Africa-A%20situational%20analysis.pdf>.

¹⁰¹ International Medical Corps, *Gender-Based Violence Assessment: Conflict-Affected Communities in Gourma Rharous District, Timbuktu Region-Mali 15-20 July 2013*, (Los Angeles: International Medical Corps, 2013). https://mali.humanitarianresponse.info/sites/mali.humanitarianresponse.info/files/assessments/GBV_Assessment_IMC_OCHA.pdf.

The government of Burkina Faso has taken some steps to address violence against women, although more efforts are needed. One initiative is the National Policy for Women's Empowerment launched in 2004 that focuses on improving women's social and legal status.¹⁰² Many government sectors have also promised to mainstream gender into their programs.¹⁰³

The UNHCR Burkina Faso country office has worked to address GBV in the Malian refugee crisis. It has developed a standard operating procedure for GBV, and a GBV focal point in place. In 2013, it undertook an analysis of GBV, including sexual violence, among the refugee populations.¹⁰⁴

5.7.2 Service delivery

Selected key elements of CMoR were assessed, including the availability of EC, PEP, and antibiotics for STI prevention, the provision of these drugs in the previous three months, as well as at least one staff trained to provide CMoR. None of the facilities assessed adequately provided these selected elements (Table 21).

¹⁰² Wendyam Kabore Zare et al., *Background study of the inter-agency joint programme on violence against women: Burkina Faso* (New York: The Inter-Agency Network on Women and Gender Equality Task Force on Violence Against Women, 2008).

http://www.un.org/womenwatch/ianwge/taskforces/vaw/Version_anglaise_de_l_etude_de_base_VEF_2009-ud.pdf.

¹⁰³ Ibid.

¹⁰⁴ Personal communication, Chynoweth SK, UNHCR-Burkina Faso

| Table 21. Selected elements of CMoR (n=28) | | | |
|--|----------------------------|--|---|
| | Hospitals (n=3) | Camp health centers (n=4) | Non-camp health centers (n=21) |
| At least 1 provider able to provide CMoR | 2 (66.7%) | 1 (33.3%) ND* (1) | 10 (47.6%) |
| Post-exposure prophylaxis (PEP) (supplies available and provided in the previous 3 months) | 2 (66.7%) | 0 | 0 |
| Emergency contraception (EC) (supplies available and provided in the previous 3 months) | 0 | 2 (66.7%) ND* (1) | 6 (28.6%) |
| Antibiotics to prevent sexually transmitted infections (STIs) (supplies available and provided in the previous 3 months) | 2 (66.7%) | 2 (50%) | 9 (42.9%) |
| Facilities with essential drugs available and ≥1 qualified staff for CMoR | 0 | 0 | 0 |

*No data

Although none of the facilities met the criteria to adequately provide these elements of CMoR, a number had provided some CMoR care in the previous three months (Table 22). All of the camp facilities had provided EC and antibiotics for STIs as part of CMoR in the three months prior; three had provided PEP. Yet many lacked essential drugs at the time of the assessment. None had PEP available, two had EC, and two had antibiotics for CMoR at the time of the assessment (Appendix A: Table 20). Among the hospitals, two had provided EC, but neither had EC available when assessed. Among non-camp health centers, five had provided PEP, yet all failed to have PEP in evidence at the time of the assessment. Further, half of the health centers reported not being able to provide PEP due to lack of authorization. Nine facilities also reported not being authorized to provide EC for CMoR, and five reported lack of authorization to provide antibiotics as part of presumptive treatment for STIs. Further, training gaps were identified: only one of three camp health centers and about half of non-camp health centers had at least one provider trained to provide CMoR. One of the hospitals also lacked a provider trained in CMoR care.

| Table 22. Essential drugs for CMoR provided & reasons not provided (n=28) | | | | | | | | | |
|---|---------------------------------|-----------------|-----------------|------------------------------|------------|-----------------|----------------------|------------|-----------------|
| Function | Post-exposure prophylaxis (PEP) | | | Emergency contraception (EC) | | | Antibiotics for STIs | | |
| | Hosp (n=3) | Camp (n=4) | Non-camp (n=21) | Hosp (n=3) | Camp (n=4) | Non-camp (n=21) | Hosp (n=3) | Camp (n=4) | Non-camp (n=21) |
| Provided in last 3 months (self-reported) | 2 (66.7%) | 3 (75%) | 5 (23.8%) | 2 (66.7%) | 4 (100%) | 7 (33.3%) | 2 (66.7%) | 4 (100%) | 9 (42.9%) |
| Provided in the past 3 months (clients noted in registers) | 0 ND* (1) | 1 (25%) ND* (2) | 0 ND* (1) | 0 ND* (1) | 0 ND* (2) | 0 ND* (1) | | | |
| Main reason service not provided | | | | | | | | | |
| Lack of skilled staff/training | 6 | | | 3 | | | 2 | | |
| Lack of supplies / equipment | 7 | | | 5 | | | 3 | | |
| Not authorized to provide | 12 | | | 9 | | | 7 | | |

*No data

5.7.3 Provider knowledge and attitudes

Seven of the eleven providers reported through a questionnaire that they had been trained to conduct a post-rape exam; three providers reported having performed a post-rape exam in the past three months. Nine had been trained to provide EC following sexual violence, and seven had supplied EC as part of CMoR in the three months prior to the assessment.

When asked what they do when a woman presents after rape, the majority (7) said they would refer. About half (6) said that they would take history, do an examination, provide EC, and counsel about pregnancy prevention. Five reported that they would provide PEP and collect blood and genital smears. Three providers indicated that they would encourage the victim to report to the police, counsel for pre- and post-HIV testing, or take forensic evidence. Only one said they would provide antibiotics for presumptive treatment of STIs.

5.7.4 Focus group discussions

Refugees said that sexual violence and other forms of GBV were very sensitive issues in their community. Domestic violence was reported as common by focus groups, who said that men may abuse their wives if they refuse sexual intercourse. Some may force their wives into sex. Focus groups reported that sexual violence outside of the home

was rare, although had occurred. They specifically mentioned the report of one young woman who had been raped by a member of the community. Focus groups reported that some women had sex in exchange for food or money. In addition, a number of key informants expressed concerns that rape and other forms of GBV were under-reported.

According to participants, women most at risk of sexual violence were those who were “dressing badly,” women who go out at night, single-headed households, and single women. All groups highlighted the increased risk of sexual assault when women walk into the bush for firewood collection or when frequenting latrines by night. Follow up with UNHCR found that, since mid-2012, UNHCR has provided approximately 30 kg of firewood per month to both refugees and local communities; solar cookers and fuel efficient stoves were also distributed and groups of women were trained to build fuel efficient stoves for personal use or sale. However, some refugees continue to gather firewood for resale as a source of income.¹⁰⁵

Focus groups reported that perpetrators were generally young men from the same community. They had never heard about sexual violence against men.

All FGD participants were aware of the reporting process and said that survivors were expected to present themselves at the security post. However, they said survivors were reluctant to come forward because of feelings of shame, confidentiality concerns, and the absence of any female security guards. In addition to security posts, health centers, CONAREF and religious representatives were mentioned by focus groups as available services for survivors of sexual violence. Only two groups (UMB and UWA) mentioned health centers specifically.

6. Discussion

6.1 General

6.1.1 Health coverage

The hospitals and the camp health facilities struggled to adequately meet the needs of the population. The WHO recommends at least one health center per 50,000 people and one district or rural hospital per 250,000 people.¹⁰⁶ Ten inpatient and maternity beds should be available for every 10,000 people.¹⁰⁷ Although three hospitals served

¹⁰⁵ Personal communication, Chynoweth SK, UNHCR-Burkina Faso

¹⁰⁶ WHO, *Health Cluster Guide: A Practical Guide for Country-Level Implementation of the Health Cluster*, 2009. http://www.who.int/hac/global_health_cluster/guide/en/.

¹⁰⁷ Ibid.

the area, the mean catchment population was over 600,000, more than twice the WHO benchmark, and they averaged only 1.5 beds per 10,000 people. Camp health centers averaged 3.3 beds per 10,000 people. Non-camp health centers surpassed the benchmark with an average of 15 beds per 10,000 people. Although the MoH health facilities—primarily the hospitals—have been burdened by the influx of refugees, facilities have also benefited from the international humanitarian response, which has helped scale up services and decentralize care.

6.1.2 UN/NGO support

All camp health facilities received UN/NGO funding for all RH areas assessed, including FP, EmONC, PAC, services for HIV and other STIs, and care for GBV. Few MoH health facilities received international financial support; of those that did, funding did not cover all RH areas: two hospitals and one health center received funding for FP and EmONC services only.

Cross-tabulation of service availability with funding received demonstrated that even if a health facility obtained support for a specific RH area, this did not always translate to good quality service availability. For example, although all four camp health facilities received funding for all RH areas, only one met the criteria for functioning FP and PAC service delivery points. One adequately provided STI and PMTCT care; none met the criteria for adequately provided selected elements of CmOR or for a functioning EmONC service delivery point, despite receiving funding. Among hospitals, although two received funding for EmONC, neither of these qualified as a functioning CEmONC service delivery point; the third hospital that did adequately provide all CEmONC signal functions had not received UN/NGO funding. The two hospitals that received funding for FP, however, did qualify as functioning FP service delivery points. These findings suggest that facilities require additional funding for service implementation as well as other types of support, such as training and capacity building.

6.1.3 General infrastructure and infection prevention

Adequate infrastructure, including functioning water and power supplies, are crucial to effective quality healthcare delivery. The three hospitals were generally well equipped with functioning electricity and water supplies. Camp health centers were well established with functioning water supplies, although one lacked an adequate power source. Infrastructure was variable among non-camp health centers: one out of five did not have a functioning water supply and three-quarters did not have access to adequate power. Interviews with key informants also found that health agencies needed funding to scale up infrastructure and address gaps.

Infection prevention and control was a serious concern, particularly among health centers. Although the hospitals fared well, camp health centers lacked some essential supplies and waste management in particular requires attention. Non-camp health centers had some basic supplies in place, but gaps were documented in availability of other essential supplies, equipment for sterilization, and waste management systems. Adequate supplies, protocols, and systems for infection prevention and control are essential for good quality RH care, particularly for prevention of sepsis, a leading cause of maternal death globally.

6.2 Family planning

Family planning is a key component of comprehensive RH services. In Burkina Faso, and Mali FP is especially important due to high fertility rates and rapid population growth. Unstable population growth can contribute to slow development and poor health outcomes.¹⁰⁸

This study found that while the three hospitals assessed met the criteria as functioning FP service delivery points, just one camp and one non-camp center were able to adequately provide a minimum method mix. However, the large majority of facilities were adequately providing *some* FP methods, primarily short-acting (injectables). All facilities servicing refugees—namely the camp facilities and the three hospitals—adequately provided OCPs and injectables. Most of the non-camp, MoH-run facilities were also providing these methods, perhaps reflecting the government’s commitment to expanding FP.

However, long-acting methods were less available at health centers for both refugees and host community alike, in particular IUDs. All hospitals and camp health centers and the large majority of non-camp centers had at least one staff trained in short- and long-acting methods, yet they were in need of supplies for long-acting methods. It is not clear whether this unavailability was due to supply chain failures and inadequate distribution or if there were other reasons at play. Some facilities were not authorized to provide IUDs, indicating another barrier to the delivery of RH services. EC was less available at MoH facilities and tubal ligation was not available at any facilities, including the Dori Regional Hospital, although one hospital reported providing vasectomy. The majority of facilities had provided condoms in the previous three months, although refugees reported not accessing them. No modern FP methods were available at the Catholic-run facility utilized by the host community. It is important to make available the entire range

¹⁰⁸ John G. Cleland et al., “Family planning in sub-Saharan Africa: progress or stagnation?” *Bulletin of the World Health Organization* (November 4, 2010). <http://www.who.int/bulletin/volumes/89/2/10-077925/en/>.

of FP services to women in order to ensure that they can choose an option that is most appropriate for their individual situation.

While the majority of providers were trained and had provided FP counseling in the previous three months, some maintained negative attitudes including toward provision of FP to unmarried young people and women without their husbands' consent. These attitudes and corresponding behaviors (such as not offering FP to unmarried people) can undermine access and utilization. Although most health facilities had trained providers, these findings reflect the need to address provider attitudes and beliefs specifically.

Focus groups revealed that while most refugees were aware that FP services were offered for free inside the camps, the majority recommended abstinence. They also reported preferring to consult a traditional doctor or purchasing condoms than accessing them at the health center. All were concerned about confidentiality, and few understood the benefits of FP. Deeply ingrained beliefs about the importance of a large family and gendered power dynamics—such as men deciding when and how many children to have—also prevented uptake in services. Key informants confirmed that socio-cultural norms were leading barriers to utilization of RH services, particularly FP. They stressed the importance of engaging community leaders and men in FP sensitization efforts. These findings indicate the need for community engagement beyond awareness-raising of service availability.

6.3 Emergency obstetric and newborn care

Good quality EmONC saves lives, prevents disability, and is a critical component of RH care. The assessment found that only one hospital qualified as a CEmONC delivery point and none of the health centers—including the two facilities with maternal units serving refugees or any of those providing care to the host communities—met the criteria as a BEmONC service delivery point. The primary gap was provision of assisted vaginal delivery, with half of the facilities reporting that they were not authorized to provide this signal function. Indeed, assisted vaginal delivery is allowed only at referral facilities, yet remains an important obstetrical procedure. In remote settings, where access to referral structure is challenging, it may be crucial to perform the procedure in the case a complicated labor (such as prolonged labor and suspicion of fetal compromise). Lack of supplies and lack of trained staff were also reported as barriers. Only one of the hospitals met the criteria to perform caesarean section although two regularly provided this signal function

Neonatal resuscitation was routinely performed at the hospitals and most health centers, but only one camp center had a resuscitation bag and infant face mask at the time of the assessment. Non-camp facilities lacked key drugs and trained staff, including providers trained in newborn infection management. Proper resuscitation supplies and infection prevention are crucial components for the prevention of complications and in the reduction of the neonatal mortality.

The number EmONC cases treated at the hospitals as well as feedback from key informants and FGDs suggests a robust referral system for complications during pregnancy. However, a number of MoH facilities lacked 24-hour care—including one hospital—which is essential for life-saving EmONC. The four camp facilities had at least one provider available at all times.

Provider knowledge regarding EmONC was variable, and some knowledge gaps were evident, including key aspects of newborn care. Focus groups revealed notable positive norms and behaviors regarding maternal care. Refugees reported high satisfaction and trust in the maternal care received. When compared to the refugees' countries of origin, the maternal care at the camps was considered superior. They also reported easy access to the health facilities. Further, remarkable changes were reported in childbirth practices. Respondents knew the benefits of delivery at a health facility with qualified staff and routinely sought care. They reported this was a large improvement compared with their home country where most deliveries occurred at home. These significant improvements in health-seeking behavior are a marked success.

6.4 Comprehensive abortion care

In Burkina Faso, induced abortion is permitted under certain circumstances.¹⁰⁹ Yet unsafe abortion is widespread: only 3% of abortions are carried out by doctors and an additional 12% are carried out by trained health assistants; four in 10 women who resort to unsafe abortions experience life-threatening complications.¹¹⁰ An estimated one in seven maternal deaths is caused by unsafe abortion.¹¹¹ Comprehensive abortion services are essential, life-saving components of RH care.

For this study, the health facility assessment found that safe abortion was not available in any facility and only one provider at a camp health center had been trained to provide induced abortion. Yet a key informant reported providing abortion at one of the

¹⁰⁹ Center for Reproductive Rights, *The World's Abortion Laws 2013*, 2013, <http://worldabortionlaws.com/map/>.

¹¹⁰ Akinrinola Bankole et al., *Grossesse non désirée et avortement provoqué au Burkina Faso: causes et conséquences* (New York: Guttmacher Institute, 2013). <http://www.guttmacher.org/pubs/grossesse-non-desiree-Burkina.pdf>.

¹¹¹ Ibid.

hospitals; this warrants further exploration to determine whether some safe abortion is indeed available.

The three hospitals qualified as functioning PAC delivery points, yet only one of the camp facilities and none of the non-camp facilities met the criteria for this quality standard. Availability of trained staff was robust, with almost all facilities reporting at least one provider trained in PAC. Most PAC was performed with MVA; misoprostol was available at just one facility, a non-camp health center. Indeed, more than half of the health centers reported that they were not authorized to provide PAC with misoprostol. A few facilities had provided PAC with MVA in the previous months, but did not have sufficient supplies available at the time of the assessment.

Although almost all facilities had staff trained in PAC, knowledge of key PAC activities was variable. Focus groups viewed abortion negatively and believed that pregnancy is “God’s will.” Some respondents acknowledged that some women and girls resorted to unsafe abortion, with one group of women even citing it as a primary health concern, suggesting unsafe abortion is not uncommon. In settings where abortion is “culturally” rejected or access to services is limited, women with unwanted pregnancies may resort to unsafe abortions and subsequently require urgent medical attention. Suboptimal management of abortion can put women at high risk of infections, hemorrhaging, long-term complications (e.g., ectopic pregnancies, infertility, psychological problems), and death.

6.5 HIV and other sexually transmitted infections (STIs)

Burkina Faso and Mali both have a generalized HIV epidemic, and the MoH, with the assistance of international partners, has made significant strides in addressing HIV and AIDS through national strategic frameworks, policies, and programs, and independent initiatives. Jhpiego, UNICEF, and WHO have worked with the MoH to scale up PMTCT services across the country.^{112,113} The findings reflect success in efforts to address HIV to date. Provision of PMTCT among MoH (non-camp) facilities was remarkable, with the three hospitals and 90% of health centers adequately providing PMTCT. In contrast, one camp facility adequately provided PMTCT. The wide availability of this care—including a sustainable supply of ARVs—is noteworthy in such a remote, inaccessible area as the Sahel Region.

¹¹² Jhpiego, *Burkina Faso*, 2011, <http://www.jhpiego.org/content/burkina-faso>.

¹¹³ UNICEF, *Burkina Faso: HIV/AIDS Unicef in Action*, 2007, http://www.unicef.org/bfa/english/hiv_aids_870.html

Services for STIs were similarly robust with two hospitals and all non-camp health centers adequately providing diagnosis and treatment for STIs, although laboratory testing was only available at the hospitals. Only one camp center adequately provided this care. Camp facilities lacked supplies—ARVs and antibiotics—at the time of the assessment.

In contrast to PMTCT, coverage of ART is a clear gap. Among MoH facilities, ART was available at the hospitals yet at only three of the health centers, with the majority reporting they were not authorized to provide care (despite being authorized to provide ARVs for PMTCT). One camp health center provided ART for PLHIV.

Among refugees, there remains a lack of knowledge about HIV and STIs and the risks of transmission. While condoms were available at most health centers, they were rarely accessed because of fear of being seen. Stigma and discrimination surrounding HIV and STIs are suspected barriers to utilization of services, including VCT.

6.6 Clinical management of rape (CMoR)

Globally, sexual violence is underreported.¹¹⁴ Yet sexual violence is perpetrated in all communities, and reporting rates are not an accurate reflection of occurrence. Good quality, confidential care for survivors of rape is a minimum standard in humanitarian service delivery and essential for health and RH actors to implement. This study assessed selected key clinical components of CMoR, including availability of essential drugs and trained staff, yet a full package of CMoR should be available to refugees and the host population. This includes additional activities, drugs, and supplies.¹¹⁵

Health facility assessments found that none of the facilities adequately provided these selected elements of CMoR, reflecting a worrying gap. None of the hospitals had EC and none of the health centers—both camp and non-camp—had PEP for CMoR. Dearth of trained staff and ad hoc availability of antibiotics for STIs undermined service provision. Provider questionnaires also revealed gaps in knowledge of CMoR provision, even among those trained.

UNHCR has made some important efforts to address GBV, including provision of firewood and fuel-efficient stoves. Yet the lack of reports of sexual violence does not necessarily indicate it is not happening. While refugees reported that rape outside of

¹¹⁴ Charlotte Watts and Cathy Zimmerman, “Violence against women: global scope and magnitude,” *The Lancet*, vol.359, issue 9313 (April 6, 2002) pp. 1232-1237.

<http://www.sciencedirect.com/science/article/pii/S0140673602082211>.

¹¹⁵ Inter-Agency Working Group on Reproductive Health in Crises, *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2010. <http://www.iawg.net/IAFM%202010.pdf>.

marriage was rare, it is unclear if this is a true reflection of incidence. Further, rape within marriage was reportedly not uncommon. Refugees revealed reluctance to report sexual violence and seek services because of confidentiality concerns, self-blame, and fear of social repercussions. Key informants also reported that GBV was a sensitive issue among the communities and outreach was needed.

In addition, the first point of the reporting process was the security post, which was staffed by men and thus instilled further distrust and discomfort in the reporting process. Concerns regarding the safety and security of women in the refugee camps were voiced repeatedly by the focus groups and interviewees. The lack of patients presenting for post-rape care highlights the need to implement good quality, confidential services—which may motivate survivors to come forward—as well as engage with and raise-awareness among the refugee community on the availability and importance of these services.

7. Summary and recommendations

The assessment found that, while some RH services were provided at all facilities, services were inconsistent and quality was variable, particularly among health centers (both camp and non-camp). Striking gaps were found in provision of CMoR, basic EmONC, and safe abortion care with no facility adequately providing CMoR and none of the health centers—both camp and non-camp—adequately providing basic EmONC. Health facility assessments also found that, despite legal indications for its use, safe abortion was not available, although KIIs suggested that some abortion may be available at the regional hospital.

The three hospitals assessed generally provided a range of good quality RH services, including FP services, PAC, and services for HIV and STIs. Yet supplies for CEmONC were lacking at two hospitals. Among camp health centers, the two larger facilities provided a relatively broad range of RH care, but they also struggled to meet the minimum criteria for good quality service delivery. Facilities serving the host community fared poorly with regards to FP, BEmONC, and PAC. However, almost all MoH facilities—the hospitals and the non-camp health centers—provided PMTCT, diagnosis and treatment of STIs, and VCT.

Stock-outs of drugs were a key barrier to service provision in all RH areas, and the majority of health centers reported that they were not authorized to provide assisted vaginal delivery, ART, PAC with misoprostol, and induced abortion. Half reported they were not authorized to provide EC as part of FP. Training gaps were also identified in

permanent FP methods, induced abortion, CMoR, and adolescent-friendly services. Further, FGDs with refugees revealed significant socio-cultural barriers to accessing services, and many were not aware of the few RH services available. Simultaneously, refugees reported that pregnant women now sought facility-based delivery services whereas they previously gave birth at home, reflecting significant positive changes in health-seeking behavior. Refugees praised the health service provision in the camps and reported services were free, accessible, and patients were treated well by the staff. Adolescents, particularly young women and girls, had low knowledge of RH and faced additional barriers to accessing care.

General recommendations for health and RH actors

- Prioritize implementation of comprehensive, confidential, good quality CMoR. Develop and/or implement a referral pathway, including for psychosocial care and legal services. Train/re-train staff in CMoR including quality of care. Engage refugee/host-community women in CMoR programming.
- Engage and raise-awareness among refugees and host communities about all components of RH. Ground efforts in an evidence-informed, locally contextualized, rights-based approach. Involve women, men, adolescents, and community leaders in designing outreach strategies. Make locally-adapted information, education, and communication material on all RH areas available at health facilities.
- Expand BEmONC service delivery points and address policy barriers to provision of assisted vaginal delivery. Ensure adequate CEmONC is available at all hospitals.
- Address policy barriers to ART to establish additional treatment points, including for children.
- Scale up provision of long-acting FP methods and provide both vasectomy and tubal ligation at hospitals. Address authorization barriers to provision of EC as part of FP. Conduct outreach on FP to dispel myths, raise-awareness, and educate communities (with specific outreach to men adolescents) about the benefits of FP.
- Implement safe abortion services to the extent of the law and expand PAC service delivery points.
- Expand strategically-situated condom distribution points to increase accessibility including by at-risk populations.
- Undertake logistical audits to review protocols, forecast accuracy, budgetary constraints, storage conditions, and staff capacity. Establish or strengthen contingency stocks of RH supplies to prevent supply shortages.
- Strengthen staff capacity through competency-based training and refresher courses on RH and provide consistent coaching. Address negative provider

attitudes and prioritize staff supervision. Consider the deployment of additional trained staff to the Sahel region.

- Train staff in adolescent-friendly services and develop strategies to engage adolescents and facilitate access to care.
- In addition, donors should fund implementing agencies to expand good quality RH service provision and address infrastructure gaps.

References

- African Centre for Gender and Social Development, *Violence Against Women in Africa: A Situational Analysis* (Addis Ababa: United Nations Economic Commission for Africa, 2011). <http://www1.uneca.org/Portals/awro/Publications/21VAW%20in%20Africa-A%20situational%20analysis.pdf>.
- Bankole, Akinrinola, et al., *Grossesse non désirée et avortement provoqué au Burkina Faso: causes et conséquences*. (New York: Guttmacher Institute, 2013). <http://www.guttmacher.org/pubs/grossesse-non-desiree-Burkina.pdf>.
- Burkina Faso Ministry of Health, *Plan national de relance de la Plantification Familiale 2013-2015* (2013). http://advancefamilyplanning.org/sites/default/files/resources/Plan%20de%20relance%20PF_2013-2015_final.pdf
- Burkina Faso Penal Code, Law No. 043/96/ADP of November 13, 1996, Chapter II, Section 3, Articles 383-390 Law No. 049-2005/Year Concerning Reproductive Health, Jo No. 06 of February 9, 2006, Chapter III, Article 21
- Central Intelligence Agency, *The World Fact Book: Burkina Faso*, 2014, <https://www.cia.gov/library/publications/the-world-factbook/geos/uv.html>.
- Cleland, John G. et al., "Family planning in sub-Saharan Africa: progress or stagnation?" *Bulletin of the World Health Organization* (November 4, 2010). <http://www.who.int/bulletin/volumes/89/2/10-077925/en/>.
- Compaore, Dayitaba, "La mise en oeuvre de l'approche syndromique des infections sexuellement transmissibles: les leçons d'une intervention," *Institut de Médecine Tropicale d'Anvers* (2003) http://www.memoireonline.com/09/10/3878/m_La-mise-en-oeuvre-de-lapproche-syndromique-des-infections-sexuellement-transmissibles-les-leon2.html.
- Erheriene, Ese, "Struggling Burkina Faso Opens Up Its Government Data," *WSJ Blogs – Digits*, June 9, 2014, <http://blogs.wsj.com/digits/2014/06/09/struggling-burkina-faso-opens-up-its-government-data/>.
- Fitzgerald, Molly and Stash, Sharon, *The Changing Face of HIV Prevention Programs in Burkina Faso and Togo: Opportunities and Challenges of Providing HIV Prevention and Services for Most-at-Risk Populations in Burkina Faso and Togo* (Arlington, VA: USAID's AIDSTAR, 2013). http://www.aidstar-one.com/sites/default/files/AIDSTAR-One_TogoBF_Review_web.pdf.

- Global Partnership for Education, *Burkina Faso*, 2014, <http://www.globalpartnership.org/country/burkina-faso>
- Grebmer, K. et al., *2013 Global Hunger Index: The Challenge of Hunger: Building Resilience to Achieve Food and Nutrition Security*, (Washington, DC: International Food Policy Research Institute, 2013).
<http://www.ifpri.org/sites/default/files/publications/ib79.pdf>.
- Gribble, James, "Family Planning in Ghana, Burkina Faso, and Mali," *Population Reference Bureau*, April 2008,
<http://www.prb.org/Publications/Articles/2008/westafricafamilyplanning2.aspx>
- Guest, G. et al., *Applied thematic analysis* (Thousand Oaks: Sage; 2011).
- Haddad, S. et al., "Learning from health system reforms: lessons from Burkina Faso," *Tropical Medicine & International Health* (2006): pp. 1889–1897.
- Inter-Agency Standing Committee (IASC) Global Health Cluster. *Health Cluster Guide*. (Geneva: World Health Organization, 2009).
http://www.who.int/hac/network/global_health_cluster/health_cluster_guide_6apr2010_en_web.pdf
- Inter-Agency Working Group on Reproductive Health in Crises, *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. 2010.
<http://www.iawg.net/IAFM%202010.pdf>.
- _____, *Inter-agency global evaluation of reproductive health services for refugees and internally displaced persons*. Geneva: UNHCR, 2004.
http://iawg.net/resources/2004_global_eval/documents/REPORT/report-toc.pdf
- International Medical Corps, *Gender-Based Violence Assessment: Conflict-Affected Communities in Gourma Rharous District, Timbuktu Region-Mali 15-20 July 2013*, (Los Angeles: International Medical Corps, 2013).
https://mali.humanitarianresponse.info/sites/mali.humanitarianresponse.info/files/assessments/GBV_Assessment_IMC_OCHA.pdf.
- Jhpiego, *Burkina Faso*, 2011, <http://www.jhpiego.org/content/burkina-faso>.
- Kabore Zare, Wendyam et al., *Background study of the inter-agency joint programme on violence against women: Burkina Faso* (New York: The Inter-Agency Network on Women and Gender Equality, 2008).
http://www.un.org/womenwatch/ianwge/taskforces/vaw/Version_anglaise_de_l_etude_d_e_base_VEF_2009-ud.pdf.
- LAAFI, *Burkina Faso*, n.d., http://www.laafi.at/eng/burkina_faso/index.html.

Lalonde, Catherine, "Burkina Faso: Expanding Access to Misoprostol for Postpartum Hemorrhage," *The FCI Blog* (October 23, 2013).

<http://familycareintl.org/blog/2013/10/23/burkina-faso-expanding-access-to-misoprostol-for-postpartum-hemorrhage-in/>.

Maiga, Modibo and Asissatou, Lo, *Repositioning Family Planning in Burkina Faso* (Washington, DC: Futures Group, 2013).

http://www.healthpolicyproject.com/ns/docs/Burkina_Faso_WestAfricaBriefs_Final.pdf.

Malik, K., & United Nations Development Programme. *Human development report 2013: the rise of the South: human progress in a diverse world* (New York: UNDP, 2013). http://hdr.undp.org/sites/default/files/reports/14/hdr2013_en_complete.pdf.

Medecins du Monde, *Annual Report 2012*, 2012,

http://issuu.com/doctorsoftheworld/docs/annual_report_2012.

Soudre, Robert, *Grant proposal form round 8: HIV* (Ouagadougou: L'Unité de Formation et de Recherche en Sciences de la Santé (UFR/SDS), 2009).

http://www.theglobalfund.org/documents/rounds/8/notapproved/8BURH_1638_0_full/.

UNDP, *Table 4: Gender Inequality Index*, 2012, <https://data.undp.org/dataset/Table-4-Gender-Inequality-Index/pq34-nwq7>.

UNFPA, *Burkina Faso: The State of the World's Midwifery* (New York: UNFPA, 2011), http://www.unfpa.org/sowmy/resources/docs/country_info/profile/en_BurkinaFaso_SoW_My_Profile.pdf.

_____, *Maternal Health Thematic Fund: Annual Report 2012* (New York: UNFPA, 2012), <http://www.unfpa.org/webdav/site/global/shared/documents/publications/2013/MHTF%202012%20Annual%20Report-final.pdf>.

_____, *Progress Profile: Global Programme to Enhance Reproductive Health Commodity Security* (New York: UNFPA, 2011),

http://www.unfpa.org/webdav/site/global/shared/documents/gprhcs/GPRHCS_Burkina_Faso.pdf.

_____, *Quiz on Family Planning in Burkina Faso*, 2013,

http://countryoffice.unfpa.org/burkinafaso/2013/10/02/8106/quizz_pf_in_english/.

UNHCR, *Burkina Faso: 2014 UNHCR country operations profile*, 2014,

<http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e483de6>.

_____, *Burkina Faso Fact Sheet: 30 September 2013*, (Geneva: UNHCR, 2013).

<http://www.unhcr.org/4d919f369.pdf>.

_____, *Burkina Faso Fact Sheet: 31 October 2013*, (Geneva: UNHCR, 2013).

<http://data.unhcr.org/SahelSituation/download.php?id=818>

_____, *UNHCR Global Appeal 2013 Update*, (Geneva: UNHCR, 2013),
<http://www.unhcr.org/50a9f82316.pdf>.

UNICEF, *Burkina Faso: HIV/AIDS Unicef in Action*, 2007,
http://www.unicef.org/bfa/english/hiv_aids_870.html.

_____, *The State of the World's Children 2008* (New York: UNICEF, 2007).
<http://www.unicef.org/sowc08/docs/sowc08.pdf>.

United Nations, *UNdata: Burkain Faso*, 2014,
<http://data.un.org/CountryProfile.aspx?crName=Burkina+Faso>.

US Department of State, *2010 Human Rights Report: Burkina Faso*, 2010,
<http://www.state.gov/j/drl/rls/hrrpt/2010/af/154333.htm>

USAID, *Country Profile: Mali* (Washington, DC: USAID, 2002).
http://pdf.usaid.gov/pdf_docs/Pnacr685.pdf.

Watts, Charlotte and Zimmerman, Cathy, "Violence against women: global scope and magnitude," *The Lancet*, vol.359, issue 9313 (April 6, 2002) pp. 1232-1237.
<http://www.sciencedirect.com/science/article/pii/S0140673602082211>.

Weil, O. et al., *Addressing the Reproductive Health Needs and Rights of Young People since ICPD: Burkina Faso Country Evaluation Report* (Washington, DC: OECD, 2003),
<http://www.oecd.org/countries/burkinafaso/36747493.pdf>.

The World Bank, *Antiretroviral therapy coverage (% of people with advanced HIV infection)*, 2012, <http://data.worldbank.org/indicator/SH.HIV.ARTC.ZS>

_____, *Burkina Faso Overview*, 2014,
<http://www.worldbank.org/en/country/burkinafaso/overview>.

_____, *Indicators*, 2014, <http://data.worldbank.org/indicator>.

_____, *Maternal mortality ratio (modeled estimate, per 100,000 live births)*, 2014,
<http://data.worldbank.org/indicator/SH.STA.MMRT>.

_____, *Mortality rate, infant (per 1,000 live births)*, 2014,
<http://data.worldbank.org/indicator/SP.DYN.IMRT.IN>.

_____, *Poverty and Equity: Burkina Faso*, 2014,
<http://povertydata.worldbank.org/poverty/country/BFA>.

_____, *Prevalence of HIV, total (% of population ages 15-49)*, 2012,
<http://data.worldbank.org/indicator/SH.DYN.AIDS.ZS>.

World Health Organization, *Burkina Faso: Factsheets of Health Statistics 2010* (Geneva: WHO, 2010).

_____, *Density of doctors, nurses and midwives in the 49 priority countries* (Geneva: WHO, 2010), http://www.who.int/hrh/fig_density.pdf.

_____, *Summary Country Profile for HIV/AIDS Scale-Up: Burkina Faso*, (Geneva: WHO, 2005), http://www.who.int/hiv/HIVCP_BFA.pdf.

_____, *WHO African Region: Burkina Faso statistics summary*, 2013, <http://apps.who.int/gho/data/?theme=country&vid=5500>.

World Health Organization et al., *Monitoring emergency obstetric care: a handbook* (Geneva: WHO, 2009).
http://www.unfpa.org/webdav/site/global/shared/documents/publications/2009/obstetric_monitoring.pdf

Appendix A: Detailed tables of RH service availability

1. Family planning

| Table A 1. Facilities with at least one package of family planning methods available (n=28) | | | |
|--|----------------------------|--------------------------------------|---|
| Method | Hospitals (n=3) | Camp health centers (n=4) | Non-camp health centers (n=21) |
| OCPs | 3 (100%) | 4 (100%) | 20 (95.2%) |
| Injectable contraceptives | 3(100%) | 4 (100%) | 20 (95.2%) |
| IUDs | 3(100%) | 1 (25%) | 10 (47.6%) |
| Implants | 3 (100%) | 4 (100%) | 20 (95.2%) |
| Emergency contraception | 0 | 2 (66.7%) ND* (1) | 7 (33.3%) |

*No data

| Table A 2. Facilities with staff and supplies to provide daily oral contraceptive pills (OCPs) (n=28) | | | |
|--|----------------------------|--------------------------------------|---|
| | Hospitals (n=3) | Camp health centers (n=4) | Non-camp health centers (n=21) |
| OCPs provided in last 3 months (self-report) | 3 (100%) | 4 (100%) | 20 (95.2%) |
| Staff trained provide short-acting methods | 3 (100%) | 3 (100%) ND (1) | 20 (95.2%) |
| FP counseling available | 3 (100%) | 4 (100%) | 20 (95.2%) |
| BP cuff | 3 (100%) | 4 (100%) | 19 (90.5%) |
| Stethoscope | 3 (100%) | 4 (100%) | 21 (100%) |
| Daily oral contraceptive pills | 3 (100%) | 4 (100%) | 20 (95.2%) |
| Facilities with minimum essential supplies and staff to provide OCPs | 3 (100%) | 3 (100%) ND* (1) | 17 (81%) |

*No data

| Table A 3. Facilities with staff and supplies to provide injectables (n=28) | | | |
|--|----------------------------|--------------------------------------|---|
| | Hospitals (n=3) | Camp health centers (n=4) | Non-camp health centers (n=21) |
| Injectables provided in last 3 months (self-report) | 3 (100%) | 4 (100%) | 20 (95.2%) |
| Staff trained to provide short-acting methods | 3 (100%) | 3 (100%) ND (1) | 20 (95.2%) |
| FP counseling available | 3 (100%) | 4 (100%) | 20 (95.2%) |
| BP cuff | 3 (100%) | 4 (100%) | 19 (90.5%) |
| Stethoscope | 3 (100%) | 4 (100%) | 21 (100%) |

| | | | |
|--|-----------------|----------------------------|-----------------|
| Needles and syringes | 3 (100%) | 4 (100%) | 21 (100%) |
| Injectable contraceptives | 3 (100%) | 4 (100%) | 20 (95.2%) |
| Facilities with minimum essential supplies and staff to provide injectables | 3 (100%) | 3 (100%) ND (1) | 17 (81%) |

*No data

| Table A 4. Facilities with staff and supplies to provide IUDs (n=28) | | | |
|---|----------------------------|--------------------------------------|---|
| | Hospitals (n=3) | Camp health centers (n=4) | Non-camp health centers (n=21) |
| IUD insertion performed in last 3 months (self-report) | 3 (100%) | 1 (25%) | 4 (19%) |
| Staff trained to provide long-acting methods | 3 (100%) | 3 (100%) ND (1) | 17 (85%) ND (1) |
| FP counseling available | 3 (100%) | 4 (100%) | 20 (95.2%) |
| Sterile gloves | 3 (100%) | 4 (100%) | 21 (100%) |
| Speculum | 3 (100%) | 4 (100%) | 20 (95.2%) |
| Uterine sound | 3 (100%) | 3 (75%) | 5 (23.8%) |
| Uterine tenaculum | 3 (100%) | 1 (25%) | 6 ND (1) |
| Sponge forceps | 3 (100%) | 2 (50%) | 13 (61.9%) |
| Antiseptics | 3 (100%) | 4 (100%) | 21 (100%) |
| IUDs | 3 (100%) | 1 (25%) | 10 (47.6%) |
| Facilities with minimum essential supplies and staff to provide IUDs | 3 (100%) | 1 (25%) | 1 (4.8%) |

*No data

| Table A 5. Facilities with staff and supplies to provide implant (n=28) | | | |
|---|----------------------------|--------------------------------------|---|
| | Hospitals (n=3) | Camp health centers (n=4) | Non-camp health centers (n=21) |
| Implant insertion performed in last 3 months (self-report) | 3 (100%) | 4 (100%) | 19 (90.5%) |
| Staff trained to provide long-acting methods | 3 (100%) | 3 (100%) ND (1) | 17 (85%) ND (1) |
| FP counseling available | 3 (100%) | 4 (100%) | 20 (95.2%) |
| Sponge forceps | 3 (100%) | 2 (50%) | 13 (61.9%) |
| Scalpel handle (No. 3) and blade | 3 (100%) | 3 (75%) | 16 (76.2%) |
| Needles and syringes | 3 (100%) | 4 (100%) | 21 (100%) |
| Antiseptics | 3 (100%) | 4 (100%) | 21 (100%) |
| Implants | 3 (100%) | 4 (100%) | 20 (95.2%) |
| Facilities with minimum essential staff and supplies to provide Implants | 3 (100%) | 1 (25%) | 8 (40%) ND (1) |

*No data

2. Obstetric services, including EmONC

| Table A 6. Providing other essential obstetric services and main reasons for not providing (n=28) | | | | | | | | | |
|--|---------------------------------------|------------|-----------------|--|------------|-----------------|--|-----------------|-------------------|
| <i>Function</i> | Use partograph to manage labor | | | Active management of third stage of labor | | | Administer ARVs to HIV+ mothers and newborns in maternity | | |
| | Hosp (n=3) | Camp (n=4) | Non-camp (n=21) | Hosp (n=3) | Camp (n=4) | Non-camp (n=21) | Hosp (n=3) | Camp (n=4) | Non-camp (n=21) |
| Provided in last 3 months (self-reported) | 3 (100%) | 2 (50%) | 21 (100%) | 3 (100%) | 3 (75%) | 21 (100%) | 3 (100%) | 1 (25%) | 21 (100%) |
| Provided in the past 3 months (clients noted in registers) | | | | | | | 0 ND (1) | 1 (25%) ND* (2) | 3 (14.3%) ND* (1) |
| Main reason service not provided | | | | | | | | | |
| Lack of skilled staff/training | 0 | | | 0 | | | 0 | | |
| Lack of supplies / equipment | 1 (100%) | | | 1 (100%) | | | Mothers=1 (100%) Newborns=2 (100%) | | |
| Not authorized to provide | 0 | | | 0 | | | 0 | | |

*No data

| Table A 7. Parenteral antibiotics (n=28) | | | |
|--|------------------------|----------------------------------|---------------------------------------|
| | Hospitals (n=3) | Camp health centers (n=4) | Non-camp health centers (n=21) |
| Parenteral antibiotics administered in last 3 months (self-report) | 3 (100%) | 4 (100%) | 21 (100%) |
| Needles and syringes | 3 (100%) | 4 (100%) | 21 (100%) |
| Ampicillin | 3 (100%) | 4 (100%) | 21 (100%) |
| Gentamycin | 3 (100%) | 3 (75%) | 21 (100%) |
| Injectable Metronidazole | 3 (100%) | 2 (50%) | 21 (100%) |
| Facility able to provide parenteral antibiotics | 3 (100%) | 1 (25%) | 21 (100%) |

| Table A 8. Parenteral uterotonics (n=28) | | | |
|--|------------------------|----------------------------------|---------------------------------------|
| | Hospitals (n=3) | Camp health centers (n=4) | Non-camp health centers (n=21) |
| Parenteral uterotonics administered in last 3 months (self-report) | 3 (100%) | 1 (25%) | 11 (52.4%) |

| | | | |
|--|-----------------|----------------|-------------------|
| Needles and syringes | 3 (100%) | 4 (100%) | 21 (100%) |
| Oxytocin | 3 (100%) | 4 (100%) | 21 (100%) |
| Facility able to provide parenteral uterotonics | 3 (100%) | 1 (25%) | 11 (52.4%) |

| Table A 9. Parenteral anticonvulsants (n=28) | | | |
|--|------------------------|----------------------------------|---------------------------------------|
| | Hospitals (n=3) | Camp health centers (n=4) | Non-camp health centers (n=21) |
| Parenteral anticonvulsants administered in last 3 months (self-report) | 3 (100%) | 4 (100%) | 17 (81%) |
| Needles and syringes | 3 (100%) | 4 (100%) | 21 (100%) |
| Magnesium sulfate | 3 (100%) | 1 (25%) | 7 (33.3%) |
| Facility able to provide parenteral anticonvulsants | 3 (100%) | 1 (25%) | 7 (33.3%) |

| Table A 10. Manual removal of placenta (n=28) | | | |
|---|------------------------|----------------------------------|---------------------------------------|
| | Hospitals (n=3) | Camp health centers (n=4) | Non-camp health centers (n=21) |
| Manual removal of placenta performed in last 3 months (self-report) | 3 (100%) | 2 (50%) | 16 (75.2%) |
| Needles and syringes | 3 (100%) | 4 (100%) | 21 (100%) |
| Non-sterile gloves | 3 (100%) | 4 (100%) | 21 (100%) |
| Antiseptic solution | 3 (100%) | 4 (100%) | 21 (100%) |
| Apron | 3 (100%) | 2 (50%) | 11 (52.4%) |
| Oxytocin | 3 (100%) | 4 (100%) | 21 (100%) |
| Facility able to provide parenteral antibiotics | 3 (100%) | 2 (50%) | 10 (47.6%) |

| Table A 11. Assisted vaginal delivery (n=28) | | | |
|--|------------------------|----------------------------------|---------------------------------------|
| | Hospitals (n=3) | Camp health centers (n=4) | Non-camp health centers (n=21) |
| Assisted vaginal delivery performed in last 3 months (self-report) | 2 (66.7%) | 0 | 0 |
| Vacuum extractor | 2 (66.7%) | 0 | 2 (9.5%) |
| Non-sterile gloves | 3 (100%) | 4 (100%) | 21 (100%) |
| Apron | 3 (100%) | 2 (50%) | 11 (52.4%) |
| Facility able to provide assisted vaginal delivery | 2 (66.7%) | 0 | 0 |

| Table A 12. Neonatal resuscitation with appropriate bag and mask (n=28) | | | |
|---|------------------------|----------------------------------|---------------------------------------|
| | Hospitals (n=3) | Camp health centers (n=4) | Non-camp health centers (n=21) |
| Neonatal resuscitation with appropriate bag and mask performed in last 3 months (self-report) | 3 (100%) | 3 (75%) | 11 (52.4%) |
| Resuscitation bag and infant face mask | 3 (100%) | 1 (25%) | 12 (57.1%) |
| Facility able to provide neonatal resuscitation | 3 (100%) | 1 (25%) | 10 (47.6%) |

| Table A 13. Blood transfusion (n=3) | |
|---|------------------------|
| | Hospitals (n=3) |
| Blood transfusion provided in last 3 months (self-report) | 3 |
| Staff able to conduct blood transfusion | 3 |
| Airway needle for collecting/giving blood | 3 |
| Blood typing and cross-matching reagents | 3 |
| Blood collection bags | 3 |
| Hepatitis B Test | 3 |
| Hepatitis C Test | 3 |
| HIV Test | 3 |
| Syphilis Test | 3 |
| Canula/catheter for IV line (16-18) | 3 |
| Non-sterile gloves | 3 |
| Facility able to provide blood transfusion | 3 |

| Table A 14. Caesarean section (n=3) | |
|--|----------------------------------|
| | Hospitals (n=3) |
| Caesarean section performed in last 3 months (self-report) | 2 |
| Staff able to perform caesarean section | 2 (1 ND) |
| Type of anesthesia used (<i>write in</i>) | <i>Ketamine, general, spinal</i> |
| Sponge forceps | 3 |
| Straight artery forceps with teeth | 3 |
| Uterine haemostasis forceps | 3 |
| Needle holder | 3 |
| Scalpel blades | 2 |
| Round-bodied needles/No 12/size 6 | 1 |
| Triangular point suture needles/7.3 cm/size 6 | 1 |
| Abdominal retractor or double ended | 2 |
| Curved or straight operating scissors/blunt | 3 |

| | |
|--|----------|
| Straight scissors, pointed | 3 |
| Dressing (non-toothed tissue) forceps | 3 |
| Sutures | 1 |
| Gauze swabs (sterile) | 2 |
| Suction nozzle | 2 |
| Ampicillin OR Cefazolin | 3 |
| Oxytocin | 3 |
| Ringer's Lactate OR Normal Saline | 3 |
| Needles and syringes | 2 |
| Apron | 3 |
| Boots | 3 |
| Mask | 3 |
| Gown | 3 |
| Able to provide surgery for caesarean section | 1 |

| Table A 15. Facilities with supplies for at least one type of anesthesia (n=3) | |
|---|------------------------|
| Anesthesia | Hospitals (n=3) |
| Spinal | |
| Ringer's Lactate OR Normal Saline | 3 |
| Lidocaine 2% or 1% | 3 |
| Adrenaline (Epinephrine) | 3 |
| Spinal needles (18-gauge to 25-gauge) | 2 |
| Ketamine | |
| Ketamine | 3 |
| Atropine sulfate | 3 |
| Diazepam | 3 |
| Oxygen | 3 |
| Dextrose OR Glucose | 3 |

3. Comprehensive abortion care

| Table A 17. Post-abortion care (n=28) | | | |
|---|----------------------------|--|---|
| | Hospitals (n=3) | Camp health centers (n=4) | Non-camp health centers (n=21) |
| PAC counseling is available | 3 (100%) | 4 (100%) | 21 (100%) |
| Family planning is offered to all clients who receive abortion services before they are discharged from the facility | 3 (100%) | 4 (100%) | 21 (100%) |
| If no, why? | N/A | N/A | N/A |
| Facilities with minimum essential elements to provide counseling and family planning for clients who receive abortion services | 3 (100%) | 4 (100%) | 21 (100%) |

| Table A 18. Removal of retained products of conception using MVA or misoprostol (n=28) | | | |
|---|----------------------------|--|---|
| | Hospitals (n=3) | Camp health centers (n=4) | Non-camp health centers (n=21) |
| PAC performed in last 3 months using MVA (self-report) | 3 (100%) | 1 (25%) | 4 (19%) |
| At least 1 trained staff to provide PAC | 3 (100%) | 2 (100%) ND* (2) | 16 (94.12%) ND* (4) |
| Vaginal speculum | 3 (100%) | 4 (100%) | 20 (95.2%) |
| Sponge forceps | 3 (100%) | 2 (50%) | 13 (61.9%) |
| Uterine tenaculum | 3 (100%) | 1 (25%) | 6 ND (1) |
| MVA syringe, adapters and cannulae | 3 (100%) | 1 (33.3%) ND (1) | 4 (19%) |
| Antiseptic solution | 3 (100%) | 4 (100%) | 21 (100%) |
| Non-sterile Gloves | 3 (100%) | 4 (100%) | 21 (100%) |
| Oxytocin | 3 (100%) | 4 (100%) | 21 (100%) |
| Needles and syringes | 3 (100%) | 4 (100%) | 21 (100%) |
| Facilities with minimum essential supplies to provide PAC with MVA | 3 (100%) | 1 (25%) | 0 (0%) |
| PAC performed in last 3 months using misoprostol (self-report) | 2 (66.7%) | 1 (25%) | 0 |
| Misoprostol | 0 | 0 | 1 (4.8%) |
| Facilities with minimum essential supplies to provide PAC using misoprostol | 0 | 0 | 0 |

4. HIV and other STIs

| Table A 19. STI services (n=28) | | | |
|--|---------------------------|-------------------------------------|--|
| | Hospital (n=3) | Camp health center (n=4) | Non-camp health center (n=21) |
| DIAGNOSIS & TREATMENT OF STIs | | | |
| Performed syndromic or laboratory diagnosis and treatment of STIs in last 3 months (self-report) | 2 (67%) | 4 (100%) | 21 (100%) |
| Gentamycin | 3 (100%) | 3 (75%) | 21 (100%) |
| Ceftriaxone | 3 (100%) | 4 (100%) | 21 (100%) |
| Injectable metronidazole | 3 (100%) | 2 (50%) | 21 (100%) |
| Facilities with essential supplies for diagnosis and treatment of STIs | 2 (67%) | 1 (25%) | 21 (100%) |

5. Sexual violence

| Table A 20. Facilities able to provide selected elements of clinical management of rape (n=28) | | | |
|---|---------------------------|-------------------------------------|--|
| | Hospital (n=3) | Camp health center (n=4) | Non-camp health center (n=21) |
| POST-EXPOSURE PROPHYLAXIS (PEP) | | | |
| Provision of PEP for CMoR in last 3 months (self-report) | 2 (66.7%) | 3 (75%) | 5 (23.8%) |
| PEP | 3 (100%) | 0 | 0 |
| Facilities with minimum elements to provide PEP | 2 (66.7%) | 0 | 0 |
| EMERGENCY CONTRACEPTION | | | |
| Provision of EC for CMoR in last 3 months (self-report) | 2 (66.7%) | 4 (100%) | 7 (33.3%) |
| EC | 0 | 2 (66.7%) ND* (1) | 7 (33.3%) |
| Facilities with minimum elements to provide EC | 0 | 2 (66.7%) ND* (1) | 6 (28.6%) |
| ANTIBIOTICS FOR SEXUALLY TRANSMITTED INFECTIONS (STIs) | | | |
| Provision of antibiotics for presumptive treatment of STIs for CMoR | 2 (66.7%) | 4 (100%) | 9 (42.9%) |
| Gentamycin | 3 (100%) | 3 (75%) | 21 (100%) |
| Ceftriaxone | 3 (100%) | 4 (100%) | 21 (100%) |
| Injectable metronidazole | 3 (100%) | 2 (50%) | 21 (100%) |
| Facilities with minimum elements to antibiotics for STIs | 2 (66.7%) | 2 (50%) | 9 (42.9%) |

*No data

Appendix B: Provider knowledge and attitudes questionnaire results

| Table B 1. Professional classification and years of experience | | % (n) |
|--|-------------------|--------|
| What is your professional classification? | Medical Doctor | 9 (1) |
| | Health Officer | 0 |
| | Midwife | 63 (7) |
| | Nurse | 9 (1) |
| | Medical Assistant | 18 (2) |

| Table B 2. Provider practice and training | | |
|--|---|---|
| Service | a. Have you provided (read service) in the past 3 months? | b. Have you ever received instruction on how to provide this service? |
| | %(n) | %(n) |
| 1. Counsel women and girls about family planning and contraception | 90 (10) | 100 (11) |
| 2. Insert an IUD | 9 (1) | 81 (9) |
| 3. Insert an implant (e.g. Implanon, Jadelle) | 81 (9) | 100 (11) |
| 4. Perform manual vacuum aspiration (MVA) for post-abortion care | 45 (5) | 81 (9) |
| 5. Provide post-abortion care using misoprostol | 36 (4) | 63 (7) |
| 6. Perform an induced abortion using MVA | 9 (1) | 9 (1) |
| 7. Perform an induced abortion using misoprostol | 9 (1) | 9 (1) |
| 8. Provide post-abortion family planning counselling | 90 (10) | 100 (11) |
| 9. Use the partograph | 100 (11) | 100 (11) |
| 10. Do active management of the thirdstage of labor | 100 (11) | 100 (11) |
| 11. Insert a post-partum IUD | 9 (1) | 72 (8) |
| 12. Perform manual removal of the placenta | 100 (11) | 100 (11) |
| 13. Administer IM or IV magnesium sulfate for the treatment of severe pre-eclampsia or eclampsia | 36 (4) | 90 |
| 14. Use the vacuum extractor for assisted vaginal delivery | 27 (3) | 54 (6) |
| 15. Resuscitate a newborn with bag and mask | 90 (10) | 100 (11) |
| 16. Administer corticosteroids to a mother with preterm labour | 27 (3) | 81 (9) |

| Table B 2. Provider practice and training | | |
|---|--|--|
| Service | a. Have you provided (read service) in the past 3 months? | b. Have you ever received instruction on how to provide this service? |
| | %(n) | %(n) |
| 17. Manage newborn infections, including use of injectable antibiotics | 63 (7) | 72 (8) |
| 18. Administer antiretrovirals to prevent mother-to-child transmission of HIV | 72 (8) | 100 (11) |
| 19. Conduct a post-rape exam | 27 (3) | 63 (7) |
| 20. Provide emergency contraception following sexual violence | 63 (7) | 81 (9) |

| Table B 3. Staff knowledge of key RH actions and services | | | |
|--|---|---|---|
| No. | Question | | Response |
| | | | %(n) |
| 1. | For a woman in labor, what observations do you make as you monitor her progress? | a. Fetal heartbeat b. Color of amniotic fluid c. Degree of molding d. Dilatation of the cervix e. Descent of the head f. Uterine contractions g. Maternal blood pressure h. Maternal temperature i. Maternal pulse | 90 (10) 18 (2) 18 (2) 100 (11) 63 (7) 63 (7) 100 (11) 100 (11) 100 (11) |
| 2. | Where do you write down these observations? | a. On a partograph b. In the patient's clinical record c. On the partograph in the prenatal card d. In the delivery (or other) register e. On a piece of paper | 90 (10) 54 (6) 18 (2) 9 (1) 9 (1) |
| 3. | When has heavy bleeding or develops severe bleeding after giving birth, what do you look for? | a. Signs of shock (dizziness, low blood pressure) b. Amount of external blood c. Signs of anemia d. Damage to the genital tract e. Whether the uterus is contracted f. Retained products or retained placenta g. Full bladder | 81 (9) 36 (4) 54 (6) 54 (6) 27 (3) 63 (7) 18 (2) |

| Table B 3. Staff knowledge of key RH actions and services | | | |
|--|---|---|--|
| No. | Question | | Response |
| | | | %(n) |
| 4. | When a woman develops heavy bleeding after delivery, what do you do? | a. Massage the fundus b. Give ergometrine or oxytocin (IV or IM) c. Begin IV fluids d. Empty full bladder e. Take blood for hemoglobin and cross-matching f. Examine woman for lacerations g. Manually remove retained products h. Refer | 54 (6) 54 (6) 72 (8) 36 (4) 45 (5) 63 (7) 72 (8) 18 (2) |
| 5. | When a woman who just gave birth has not delivered the placenta, what do you do? | a. Empty the bladder b. Check signs placenta separation before cord traction c. Give or repeat oxytocin d. Do manual removal of the placenta e. Administer IV fluids f. Monitor vital signs for shock and act g. Check that uterus is well contracted h. Determine blood type and cross-match i. Prepare operating theater j. Refer | 18 (2) 54 (6) 72 (8) 81 (9) 63 (7) 9 (1) 9 (1) 27 (3) 27 (3) 45 (5) |
| 6. | The last time you delivered a baby, what immediate care did you give the newborn? | a. Clean baby's mouth before shoulder comes out b. Clean the baby's mouth, face, and nose c. Ensure the baby is breathing d. Ensure the baby is dry e. Observe for color f. Ensure baby is kept warm (skin-to-skin) g. Administer prophylaxis for the eyes h. Weigh the baby i. Care for the umbilical cord j. Initiate breastfeeding within the first 30 minutes k. Evaluate/examine the newborn within the first hour | 54 (6) 100 (11) 72 (8) 45 (5) 45 (5) 81 (9) 54 (6) 100 (11) 81 (9) 45 (5) 36 (4) |
| 7. | What are the signs and symptoms of infection, or sepsis, in the newborn? | a. Less movement (poor muscle tone) b. Poor or no breastfeeding c. Hypothermia or hyperthermia d. Restlessness or irritability e. Difficulty breathing or fast breathing f. Deep jaundice g. Severe abdominal distention | 36 (4) 45 (5) 90 (10) 45 (5) 63 (7) 27 (3) 9 (1) |

| Table B 3. Staff knowledge of key RH actions and services | | | |
|---|--|--|--|
| No. | Question | | Response |
| | | | %(n) |
| 8. | When a newborn weighs less than 2.5kgs, what special care do you provide? | a. Make sure baby is warm (skin-to-skin...) b. Provide support to mother to establish breastfeeding c. Monitor ability to breastfeed d. Monitor baby for the first 24 hours e. Ensure infection prevention | 90 (10) 36 (4) 18 (2) 36 (4) 27 (3) |
| 9. | Which FP can a woman use immediately post-partum? | a. IUD b. Tubal ligation c. Condoms d. Lactational Amenorrhea Method (LAM) | 27 (3) 0 27 (3) 54 (6) |
| 10. | Which FP methods can a woman who is breastfeeding use 6 weeks after delivery? | a. IUD b. Tubal ligation c. Condoms d. Progestin only pills | 54 (6) 18 (2) 54 (6) 100 (11) |
| 11. | When you counsel a woman for family planning, what do you do/discuss? | a. Ask whether she has used FP before b. Ask about her reproductive goals c. Check for medical complications d. Tell her about dual protection e. Tell her about all FP methods | 36 (4) 36 (4) 36 (4) 18 (2) 100 (11) |
| 12. | What are the immediate complications of an unsafe abortion? | a. Sepsis b. Bleeding c. Genital injuries d. Abdominal injuries e. Shock | 72 (8) 100 (11) 45 (5) 0 54 (6) |
| 13. | When you see a woman with complications from an unsafe or incomplete abortion, what do you do? | a. Do a vaginal exam b. Assess vaginal bleeding c. Assess vital signs d. Begin IV fluids e. Begin antibiotics f. Do (manual/electric) vacuum aspiration g. Do dilatation with curettage or evacuation h. Provide misoprostol i. Provide counseling j. Refer | 72 (8) 45 (5) 63 (7) 72 (8) 63 (7) 63 (7) 9 (1) 9 (1) 63 (7) 36 (4) |

| Table B 3. Staff knowledge of key RH actions and services | | | |
|--|--|---|--|
| No. | Question | | Response |
| | | | %(n) |
| 14. | What information do you give patients treated for incomplete or unsafe abortion? | a. Information prevent RTI/HIV b. Information when a woman can conceive again c. Counseling on family planning and services d. Refer for family planning or provide FP methods e. Information on social support f. Information consequences unsafe abortion | 27 (3) 45 (5) 100 (11) 54 (6) 27 (3) 100 (11) |
| 15. | What do you do when someone presents with signs of a RTI? | a. Diagnose and provide antibiotics b. Counsel on contact tracing c. Explain how to use / provide condoms d. Counsel on HIV and offer VCT e. Refer | 100 (11) 45 (5) 18 (2) 36 (4) 9 (1) |
| 16. | When a woman presents after a rape, what do you do? | a. Encourage her to report to police b. Facilitate filling out the police report c. Take history and do an examination d. Take forensic evidence e. Counsel for pre and post HIV testing f. Counsel about pregnancy prevention g. Provide emergency contraception h. Provide post-exposure prophylaxis for HIV i. Provide antibiotics to prevent STIs j. Request urine, vaginal smear/swabs, blood exams k. Refer | 27 (3) 9 (1) 54 (6) 27 (3) 27 (3) 54 (6) 54 (6) 45 (5) 9 (1) 45 (5) 63 (7) |

| Table B 4. Provider attitudes and opinions | | | | | |
|---|--|------------------------------|---------------------|------------------|---------------------------|
| | | Strongly Disagree (n) | Disagree (n) | Agree (n) | Strongly Agree (n) |
| 1. | Visiting a health facility to check on a pregnancy's progress is a good idea for a pregnant woman. | 0 | 0 | 0 | 11 |
| 2. | Delivering a baby at a health facility is safer than delivering a baby at home. | 0 | 0 | 0 | 11 |
| 3. | Within the couple, both the wife and the husband should have equal say in important decisions. | 0 | 0 | 7 | 4 |
| 4. | The more children a mother has, the more respected she is in the community. | 1 | 9 | 1 | 0 |

| Table B 4. Provider attitudes and opinions | | | | | |
|---|--|------------------------------|---------------------|------------------|---------------------------|
| | | Strongly Disagree (n) | Disagree (n) | Agree (n) | Strongly Agree (n) |
| 5. | Men should be responsible for choosing how many children their wife/wives will have. | 1 | 8 | 2 | 0 |
| 6. | Family planning should be available to every woman who wants to use a method. | 0 | 0 | 0 | 11 |
| 7. | A woman should be able to obtain a family planning method without her husband's presence. | 0 | 1 | 5 | 5 |
| 8. | IUDs can be a good method for women who have no children. | 2 | 4 | 3 | 2 |
| 9. | Adolescent, unmarried girls should be allowed to obtain family planning if they want. | 0 | 0 | 1 | 10 |
| 10. | Young unmarried men and women need to know how to prevent pregnancies. | 0 | 0 | 0 | 11 |
| 11. | Young unmarried women should be required to get their parents' consent in order to receive a family planning method. | 4 | 5 | 2 | 0 |
| 12. | Young unmarried men and women should be educated about sex and reproduction | 0 | 0 | 0 | 11 |

Appendix C: Full sampling matrix

| Table C 1. Mapping of all health facilities in the three northernmost provinces of the Sahel Administrative Region | | | | | |
|--|-----------------------|----------------------------|----------------------------|------------------------|--|
| Name of Facility | Provides RH services? | Accessible without escort? | Accessible Larger village/ | Non- MoH run facility? | Observation |
| Seno Province | | | | | |
| Bani | ✓ | ✓ | ✓ | | |
| Bouna | ✓ | ✓ | | | |
| Bombofa | ✓ | ✓ | | | |
| CHR Dori | ✓ | ✓ | ✓ | | Regional Referral Hospital |
| Falangotou | ✓ | | | | |
| | | | | | |
| Gangaol | ✓ | ✓ | | | |
| Garnison (Garrison) | | | | ✓ | Ministry of Defense |
| Gorgadji | ✓ | ✓ | ✓ | | |
| Gotougou | ✓ | | | | |
| Goulgoutou | ✓ | | | | |
| | | | | | |
| Goudebo | ✓ | ✓ | ✓ | ✓ | Official refugee camp. Served by MdM-E |
| Kodjola | ✓ | ✓ | | | |
| Katchirga | ✓ | ✓ | | | |
| Lamdamaol | ✓ | ✓ | | | |
| Oulo | ✓ | ✓ | | | |
| | | | | | |
| Sampelga | ✓ | ✓ | ✓ | | |
| Selbo | ✓ | ✓ | | | |
| Sellu | ✓ | | | | |
| Seytenga | ✓ | ✓ | ✓ | | |
| Sidibebe | ✓ | ✓ | | | |
| | | | | | |
| Soffekel | ✓ | | | | |
| Toukabayel | ✓ | | | | |
| Urbain | ✓ | ✓ | ✓ | | |
| | | | | | |
| <i>Sub-total</i> 23 | 22 | 16 | 7 | 2 | |
| Soum Province | | | | | |
| Arbinda | ✓ | ✓ | ✓ | | |
| Croix Rouge | ✓ | ✓ | ✓ | | Red Cross-supported but MoH-run facility |
| Badnego | ✓ | ✓ | | | |
| Baraboule | ✓ | | | | |
| Belehédé | ✓ | ✓ | | | |
| | | | | | |
| Bossey –T | ✓ | | | | |

| | | | | | |
|-------------------------|----|----|----|---|--|
| Bougue | ✓ | ✓ | | | |
| Bouro | ✓ | | | | |
| Clinique Dentaire | | ✓ | | ✓ | Private |
| Clinique Eliot | ✓ | ✓ | ✓ | ✓ | Private |
| | | | | | |
| CMA Djibo | ✓ | ✓ | ✓ | | Provincial Referral Hospital |
| Dankamao | ✓ | | | | |
| Diguel | ✓ | | ✓ | | |
| Djao-Djao | ✓ | ✓ | ✓ | | |
| Djika | ✓ | ✓ | | | |
| | | | | | |
| Gaïk-Goata | ✓ | ✓ | | | |
| Gargaboule | ✓ | | | | |
| Garnison (Garrison) | | | | ✓ | Ministry of Defense |
| Gasseltapoua | ✓ | | | | |
| Gasseliki | ✓ | ✓ | | | |
| | | | | | |
| Gomdé | ✓ | | | | |
| Kelbo | ✓ | ✓ | ✓ | | |
| Kobaoua | ✓ | ✓ | | | |
| Kouefadji | ✓ | | | | |
| Koutougou | ✓ | | | | |
| | | | | | |
| Mentao South | ✓ | ✓ | ✓ | ✓ | Main camp health facility. Served by MdM-F |
| Mentao Centre | ✓ | ✓ | ✓ | ✓ | A subsidiary of the above |
| Mentao North | ✓ | ✓ | ✓ | ✓ | Ditto |
| Nassoumbou | ✓ | | | | |
| Ouindopoli | ✓ | | | | |
| | | | | | |
| Petegoli | ✓ | | | | Border post with Mali |
| Pobe-Mengao | ✓ | ✓ | ✓ | | |
| Pougouzaibaogo | ✓ | ✓ | | | |
| Sikiré | ✓ | | | | |
| Silgadji | ✓ | ✓ | | | |
| | | | | | |
| Sona | ✓ | ✓ | | | |
| Taouremba | ✓ | ✓ | | | Accessible only with great difficulty |
| Tondiata | ✓ | | | | |
| Tongomayel | ✓ | ✓ | ✓ | | |
| Yalanga | ✓ | | | | |
| | | | | | |
| <i>Sub-total</i> | | | | | |
| 40 | 38 | 23 | 12 | 6 | |
| Oudalan Province | | | | | |
| Bossey-Dogabé | ✓ | | | | |
| Boukessi | ✓ | | | | |
| CMA GoromGorom | ✓ | | | | Regional Referral Hospital |
| Deou | ✓ | | | | |
| Dibissi | ✓ | | | ✓ | Unofficial refugee camp. Served by MSF-F |
| | | | | | |
| Essakane | ✓ | | | | Site of open-cast gold mines |

| | | | | | |
|---------------------|----|----|----|----|---|
| Fadae-Fadae | ✓ | | | | |
| Gandafabou | ✓ | | | | Once also an unofficial refugee camp – now closed |
| Gangani | ✓ | | | | |
| Garrison (Garrison) | | | | | Ministry of Defense. |
| | | | | | |
| Katcham-Katcham | ✓ | | | | |
| Korezena | ✓ | | | | |
| Markoye | ✓ | | | | |
| Oursi | ✓ | | | | |
| Orphelinat | ✓ | | | ✓ | Health Unit within Roman Catholic premises |
| | | | | | |
| Salmossi | ✓ | | | | |
| Saouga | ✓ | | | | |
| Tasmakat | ✓ | | | | |
| Tinagadel | ✓ | | | | |
| Tin-Akoff | ✓ | | | | Border post with Mali |
| | | | | | |
| Tocabangou | ✓ | | | | |
| Urbain | ✓ | | | | |
| | | | | | |
| <i>Sub-total</i> | | | | | |
| 22 | 21 | 0 | 0 | 2 | |
| Total | | | | | |
| 85 | 81 | 39 | 19 | 10 | |

Source for CSPS locations and ownership: Pharmacy Directorate, Regional Ministry of Health, Dori (Nov 2013)

Source for accessibility: Area Field Security Office, UNHCR, Dori (Nov 2013)