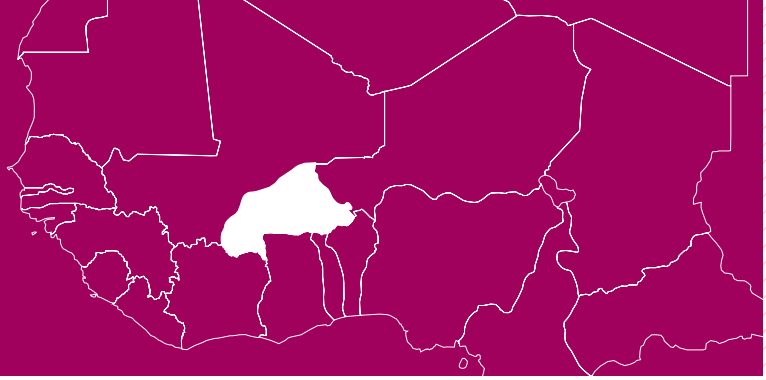
BURKINA FASO

PAC-FP COUNTRY BRIEF



Postabortion care (PAC) provides a comprehensive approach to preventing morbidity and mortality caused by abortion complications (PAC Consortium, 2014). As per the U.S. Agency for International Development (USAID) PAC model, a critical component of PAC is providing access to family planning (FP) counseling and services. Providing these services helps meet the reproductive intentions of women who most clearly demonstrate an unmet need for FP, reduces unintended pregnancies, and prevents repeat abortions, thus reducing maternal deaths (Curtis, Huber, and Moss-Knight, 2010). The information below highlights Burkina Faso's investment in providing PAC and FP services to women in need.

POLICIES, LEADERSHIP, AND GOVERNANCE

Burkina Faso's national policy on family planning (FP) and reproductive health (RH) is outlined in a number of documents, including the Policies and Standards for Reproductive Health (2010), the National Health Development Program 2011–2020 (2011), the National Family Planning Stimulus Plan 2013–2015 (2013), and the Reproductive Health Law (2005). The Reproductive Health Law guarantees the right of individuals and couples to RH, equitable access to RH care, and respect for the physical integrity of women and girls. However, this has yet to be fully applied, and many—even some healthcare providers—are unaware of its provisions (Futures Group, 2013). The country's latest plan, the National Family Planning Stimulus Plan 2013–2015 (2013), highlights eight priority actions to extend and improve FP services and education (Futures Group, 2013). Through this policy, Burkina Faso aimed to increase contraceptive prevalence among married women to 25% in 2015 (Ministry of Health, [no date]).

Postabortion care (PAC) was established in Burkina Faso in 1998. Between 1998 and 2005, PAC was included in national policy documents, standards, and protocols that are revised every one to three years. Burkina Faso's Ministry of Health (MOH) Directorate for Maternal and Child Health oversees FP programs and provides direction and coordination for both public and private sector organizations engaged in FP activities. By strengthening of PAC to include FP, the country adopts a centralized approach to scale up services, with guidance flowing from the national to subnational levels (RamaRao et al., 2011) and with support from partners including Jhpiego, the United Nations Population Fund (UNFPA), and EngenderHealth's *Agir pour la Planification Familiale* program (Dieng et al, 2008). The national PAC protocol specifies the use of manual vacuum aspiration for PAC through 12 weeks following the last menstrual period (Turner, Senderowicz, and Marlow, 2016).

Legal status of abortion

Article 21 of the Penal Code (1920, revised in 1996) authorizes abortion in the case of rape and incest, to save the life of the woman, to preserve a woman's physical health, or in cases of fetal impairment (Turner, Senderowicz, and Marlow, 2016).

PAC TRAINING AND STANDARDS

PAC services in Burkina Faso were previously limited to the country's primary teaching hospital, 13 regional hospitals, and some district facilities. Starting in 2008, PAC services were included in annual district planning, specific national PAC registers were created, and PAC activities were integrated with the training curricula of the National School of Public Health (*École National de Santé Publique*) and other health services (Fikree, Mugore, and Forrester, 2014). International organizations such as UNFPA, Jhpiego, and Ipas additionally strengthened PAC health provider training and provided manual vacuum aspiration kits for PAC and related health services.

PAC·FP THE POSTABORTION CARE FAMILY PLANNING PROJECT
Expanding contraceptive methods and informed choice to PAC clients

USAID FROM THE AMERICAN PEOPLE

EngenderHealth for a better life

In 2010, EngenderHealth's Responding to the Need for Family Planning through Expanded Contraceptive Choices and Program Services (RESPOND) project further strengthened the provision of PAC services in Burkina Faso by training doctors and midwives on the use of manual vacuum aspiration for PAC, FP counseling and service delivery, and infection prevention (Fikree, Mugore, and Forrester, 2014).

Burkina Faso has also made substantial progress in the quality of PAC service provision by strengthening preservice and in-service training programs for midwives, and including PAC in its national standards and protocols (Fikree, Mugore, and Forrester, 2014).

STRENGTHENING SERVICE DELIVERY

To strengthen PAC service delivery, Burkina Faso's MOH pushed for the decentralization of PAC to the district level and incorporated PAC in the emergency obstetric and neonatal care component of their Safe Motherhood program (Sedgh et al., 2011). As a result of this expansion, voluntary FP is now being offered at all community health centers, supported by civil society organizations and some private clinics (Futures Group, 2013).

Burkina Faso also strengthened the presence of midwives that provide critical services, including PAC, by increasing the number of annually recruited midwives, opening national health schools in four regions, and training and recruiting midwives specializing in obstetric and gynecologic care (Sedgh et al., 2011).

Lastly, as part of the implementation plan for the safety of RH products and FP recovery, Burkina Faso has, since 2012, institutionalized weekly stock surveillance for vital health products, including contraceptive commodities. Since then, no stock-outs for essential products have been reported to the Central of Purchasing Essential and Generic Drugs. To further strengthen this initiative, Burkina Faso installed in 2016 Contraceptive Management Software at the district level to enable multisite management of service delivery points and improve the availability of products where stock-outs occur (FP 2020, 2016).

BARRIERS TO PAC

Women in Burkina Faso face multiple barriers to accessing PAC and FP services. The high cost of FP services is one of the major barriers to accessing this critical care. In public health clinics, women are charged—albeit at a subsidized price—for contraceptive supplies (Bankole et al., 2013). Women in Burkina Faso also face stigmatization by providers and fear of prosecution when accessing PAC (Turner, Senderowicz, and Marlow, 2016).

FINANCING MECHANISMS

In 2015, Burkina Faso adopted universal health coverage to support equitable access of quality healthcare services. However, the national health insurance plan does not presently provide reimbursement or coverage for PAC. There are currently no other financing mechanisms to ensure that PAC remains affordable to clients. While donor agencies provide free contraceptives, the cost of commodities remains high due to the government's cost-recovery system (Fikree, Mugore, and Forrester, 2014).

Since 2008, Burkina Faso has included a line item in its national budget for the purchase of contraceptives. This line item reached approximately $1 million in 2013 (500 million FCFA) (Turner, Senderowicz, and Marlow, 2016). Yet, with the political instability unfolding in 2015 and the establishment of a new government, the budget line for FP has decreased; advocacy groups are now working to restore funding and pursue budget support to reinstate FP services and commodities at its previous level (FP2020, 2016).

BURKINA FASO		Year	Source
Demographic/background indicators			
Country population	18,106,000	2017	United Nations (UN)
Total fertility rate	5.2	2015–2020	UN Data World Population Prospects
Age at first birth	19.5	2010	Demographic and Health Survey, 2010
Maternal mortality per 100,000 live births	341		
Newborn mortality per 1,000 live births	28		
Infant mortality per 1,000 live births	65		
Under-five child mortality per 1,000 live births	129		
Facility-based delivery	86.2%		
At least one antenatal visit during previous pregnancy	95%		
At least one postnatal visit during previous pregnancy	36.8%		
Abortion and FP-related indicators			
Number of abortions	105,000	2012	Guttmacher Institute, 2013
Abortions per 1,000 women	25	2008	Guttmacher Institute, 2013
Number of unintended pregnancies	600,000	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Proportion of unintended pregnancies that end in abortion (2014)	1/3	2014	Guttmacher Institute, 2013
Number of unintended pregnancies averted due to use of modern contraceptive methods	397,000	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Number of unsafe abortions averted due to use of modern contraceptive methods	142,000	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Number of maternal deaths averted due to use of modern contraceptive methods	960	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Modern method contraceptive prevalence rate, all women of reproductive age (WRA)	31.7 %	2017–2018	PMA2020, R5
Modern method contraceptive prevalence rate, all WRA	30.1		
Knowledge of FP, all WRA	97.6%	2010	Demographic and Health Survey, 2010
Contraceptive use by type		2017–2018	PMA2020, R5
Long-acting and permanent methods			
Sterilization (female)	See other modern methods		
Sterilization (male)	See other modern methods		
Intrauterine device	4.2%		
Implant	50.3%		
Short-acting methods		2017–2018	
Injection (intramuscular and subcutaneous)	28.6%		
Pill	11.7%		
Condom (male)	3.7%		
Condom (female)	0.0%		
Other modern methods (e.g., female condom, cycle beads, and lactational amenorrhea method)	1.5%		
Unmet need for FP[1] *(2018)*	20.2%	2017–2018	PMA2020, R5
Unmet need for spacing	16.2%		
Unmet need for limiting	4.0%		
Percentage of all women who received FP information during their last visit with a health service provider	38.0%	2017–2018	PMA2020, R5

[1] Women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report either not wanting any more children or wanting to delay the next child. The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behavior.

REFERENCES

Bankole, A. et al. 2013. *Unintended Pregnancy and Induced Abortion in Burkina Faso: Causes and Consequences*. New York: Guttmacher Institute. https://www.guttmacher.org/sites/default/files/report_pdf/unintended-pregnancy-burkina-eng.pdf.

Curtis, C., Huber, D., and Moss-Knight, T. 2010. "Postabortion Family Planning: Addressing the Cycle of Repeat Unintended Pregnancy and Abortion." *International Perspectives on Sexual and Reproductive Health* 36(1):44–48. doi: 10.1363/ipsrh.36.044.10.

Dieng, T., Diadhiou, M., Diop J. N., and Faye, Y. 2008. *Assessment of Progress of the Postabortion Care Initiative in Francophone Africa*.

Centre de Formation et de Recherche en Santé de la Reproduction (CEFOREP) and Frontiers in Reproductive Health. http://pdf.usaid.gov/pdf_docs/Pnadl826.pdf.

Family Planning 2020 (FP 2020). 2016. *Burkina Faso: Commitment Maker Since 2012*. Washington, DC. www.familyplanning2020.org/entities/91.

Fikree, F. F., Mugore, S., and Forrester, H. 2014. *Strengthening Postabortion Family Planning in Burkina Faso: Preservice and In-Service Training on Postabortion Care*. Washington, DC. Evidence to Action Project. www.e2aproject.org/publications-tools/pdfs/strengthening-pac-fp-burkina.pdf.

Futures Group. 2013. *Repositioning Family Planning in Burkina Faso: Status of Family Planning Programs in Burkina Faso*. Policy Brief. Washington, DC. www.healthpolicyproject.com/ns/docs/Burkina_Faso_WestAfricaBriefs_Final.pdf.

Ministry of Health. [no date]. *National Family Planning Stimulus Plan*, 2013–2015. Ouagadougou. http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2015/04/Burkina_Faso_National_FP_Plan_ENGLISH1.pdf.

Postabortion Care (PAC) Consortium. 2014. *Misoprostol for Postabortion Care: Expanding PAC Service Delivery and Access with a Highly Effective Treatment for Incomplete Abortion*. PAC Consortium. RamaRao, S., Townsend, J. W., Diop, N., and Raifman, S. 2011. "Postabortion Care: Going to Scale." *International Perspectives on Sexual and Reproductive Health*, 37(1):40–44.

Sedgh, G., Rossier, C., Kaboré, I., Bankole, A., and Mikulich, M. 2011. "Estimating Abortion Incidence in Burkina Faso Using Two Methodologies." *Studies in Family Planning* 42(3):147–154.

Turner, K. L., Senderowicz, L., and Marlow, H. M. 2016. Comprehensive *Abortion Care Needs and Opportunities in Francophone West Africa: Situational Assessment Results*. Chapel Hill, NC: Ipas.

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