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REPRODUCTIVE HEALTH *at a* GLANCE

BURKINA FASO

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Country Context

Burkina Faso is a landlocked country with an economy based largely on cotton exports.[1] More than half of the population still subsists on less than US $1.25 per day.[2] According to the 2003 DHS, the average annual population growth rate is very high at 2.4 percent, potentially doubling the population every 29 years.[3]

Burkina Faso's large share of youth population (46 percent of the country population is younger than 15 years old[2]) provides a window of opportunity for high growth and poverty reduction—the demographic dividend. But for this opportunity to result in accelerated growth, the government needs to invest in the human capital formation of its youth. This is especially important in a context of the country's exposure to high volatility in commodity prices.

Gender equality and women's empowerment are important for improving reproductive health. Higher levels of women's autonomy, education, wages, and labor market participation are associated with improved reproductive health outcomes.[4] In Burkina Faso, the literacy rate among females ages 15 and above is 22 percent.[2] Fewer girls are enrolled in secondary schools compared to boys with a 74 percent ratio of female to male secondary enrollment.[2] Further, 80 percent of adult women participate in the labor force[2] that mostly involves work in agriculture. Gender inequalities are reflected in the country's human development ranking; Burkina Faso ranks 154 of 157 countries in the Gender-related Development Index.[5]

Economic progress and greater investment in human capital of women will not necessarily translate into better reproductive outcomes if women lack access to reproductive health services. It is thus important to ensure that health systems provide a basic package of reproductive health services, including family planning.[4]

Burkina Faso: MDG 5 Status

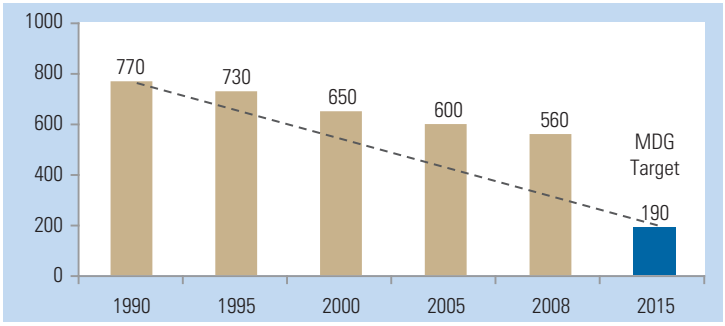
MDG 5A indicators	
Maternal Mortality Ratio (maternal deaths per 100,000 live births) *UN estimate*[a]	558
Births attended by skilled health personnel (percent)	53.5
MDG 5B indicators	
Contraceptive Prevalence Rate (percent)	17.4
Adolescent Fertility Rate (births per 1,000 women ages 15–19)	129
Antenatal care with health personnel (percent)	85
Unmet need for family planning (percent)	31.1

Source: Table compiled from multiple sources.
[a] *The 2006 DHS estimated maternal mortality ratio at 435*

MDG Target 5A: Reduce by Three-quarters, between 1990 and 2015, the Maternal Mortality Ratio

Burkina Faso has made insufficient progress over the past two decades on maternal health and is not on track to achieve its 2015 targets.[6]

Figure 1 ▪ Maternal mortality ratio 1990–2008 and 2015 target



Source: 2010 WHO/UNICEF/UNFPA/World Bank MMR report.

World Bank support for Health in Burkina Faso

The Bank's current ***Country Assistance Strategy*** is for fiscal years 2010 to 2012.

Current Projects:
P110815 BF-Health Sect Sup & MAP – Add Fin (FY08) ($15m)
P116645 BF-JSDF Fight against FGM/C (FY09) ($2.73m)

Spanish program for Africa ($3m)

Pipeline Project:
P119917 BF-Reproductive Health (FY11) Appraisal date 06/06/2011 ($42 m)
(P125285) Health Sector Support and Multi-Sectoral Aids Project – Additional Financing Approval date 07/05/2011 ($30 m)

Previous Health Projects:
P071433 BF-HIV/AIDS Disaster Response APL (FY02)
P093987 BF-Health Sector Sup. & AIDS Proj (FY06)

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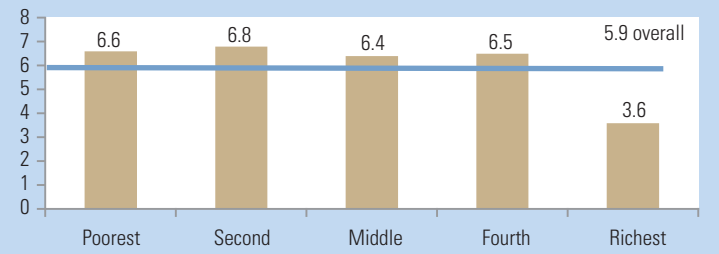
Key Challenges

High fertility

Fertility has been declining but remains high among the poorest. Total fertility rate (TFR) dropped slightly from 6.8 births per woman in 1998 to 6.2 births per woman in 2003.[7] Wide disparities exist between the fertility of women in the lowest four wealth quintiles (6.4 and above births per woman) at nearly twice those in the highest wealth quintile (3.6 births per woman) (Figure 2). Similarly, TFR is 2.8 among women with secondary education or higher compared to 6.7 among women with no formal education. It is also higher among rural women than urban women (6.9 and 3.1 respectively).[7]

Figure 2 ▪ Total fertility rate by wealth quintile



Source: DHS Final Report, Burkina Faso 2003.

Adolescent fertility adversely affects not only young women's health, education and employment prospects but also that of their children. Births to women aged 15–19 years old have the highest risk of infant and child mortality as well as a higher risk of morbidity and mortality for the young mother.[4, 8] In Burkina Faso, adolescent fertility rate is high at 129 reported births per 1,000 women aged 15–19 years.

Early childbearing is more prevalent among the poor. While 57 percent of the poorest 20–24 years old women have had a child before reaching 18, only 23 percent of their richer counterparts did (Figure 3). Furthermore, comparing across cohorts, the rich-poor gap in prevalence of early child bearing appears to have widened over time.

Use of contraception is increasing. Current use of contraception among married women has been slowly increasing from 4 percent in 1993 to 9 percent in 2003 to 13 percent in 2006.[3, 7] More married women use modern contraceptive methods than traditional methods (13 percent and 4 percent).[3] Injectables are the most commonly used method (5.0 percent), followed by the pill (4.6 percent). Use of long-term methods such as intrauterine device and implants are negligible. There are socioeconomic differences in the use of modern contraception among women: modern contraceptive use is 36 percent among women in the wealthiest quintile and 6 percent among those in the poorest quintile (Figure 4).[3] Similarly, just 10 percent of women with no education use modern contraception as compared to 38 percent of women with secondary education

Figure 3 ▪ Percent women who have had a child before age 18 years by age group and wealth quintile

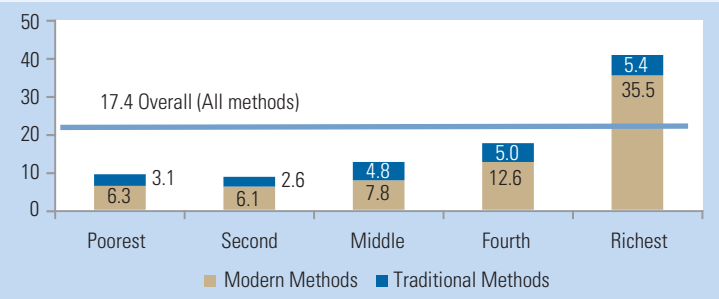
Source: Burkina Faso DHS 2003 (author's calculation).

or higher, and 8 percent for rural women versus 32 percent for urban women.

Unmet need for contraception is high at 31 percent[3] indicating that women may not be achieving their desired family size.[9]

Opposition to use and health concerns are the predominant reasons women do not intend to use modern contraceptives in future. Seventeen percent of women not intending to use contraception expressed opposition to use, primarily by themselves, their husband, or due to their religion while 10 percent cited health concerns or fear of side effects as the main reason.[3] Cost and access are lesser concerns, indicating further need to strengthen demand for family planning services.

Figure 4 ▪ Use of contraceptives among married women by wealth quintile



Source: MICS3 Final Report, Burkina Faso 2006.

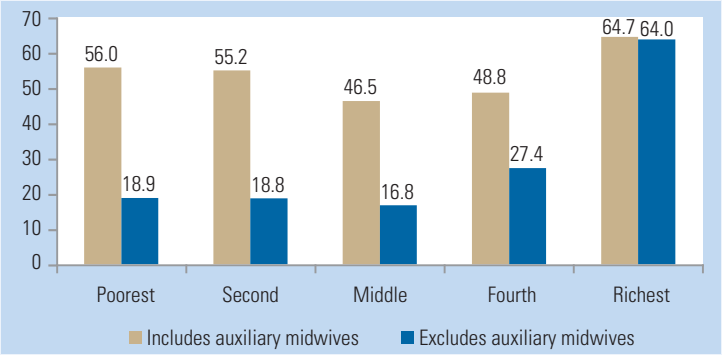
Poor Pregnancy Outcomes

Over four-fifths of pregnant women receive antenatal care from health personnel (doctor, midwife, nurse, or auxiliary midwives). Still, 68 percent of pregnant women are anaemic (defined as haemoglobin < 110g/L) increasing their risk of preterm delivery, low birth weight babies, stillbirth and newborn death, a figure that suggest that there is scope to strengthen the quality of the antenatal services being offered.[10]

Over half (53 percent) of women deliver with the assistance of health personnel as reported in the 2006 MICS. However, only 27 percent delivered with the assistance of skilled health personnel (doctor, nurse, or midwife). While disparity by wealth quintile regarding use of health personnel is not marked, it is so for

use of skilled health personnel (Figure 5). Further, wide urban-rural disparities exist: 66 percent of women in urban areas delivered with the assistance of skilled health personnel as opposed to only 18 percent in rural areas. Further, of the total of 1,628 health facilities, only 25 offer EmONC services.[11]

Figure 5 ▪ Birth assisted by skilled health personnel (percentage) by wealth quintile



Source: MICS3 Final Report, Burkina Faso 2006.

Of those women who did not give birth in a health facility, 74.1 percent never received postnatal care, and only 12 percent got a postnatal check-up within two days.[3]

Over three-fifths of women who indicated problems in accessing health care cited concerns regarding inability to afford the services while two-fifths cited difficulty getting transport or long distance to a health facility as barriers to access (Table 1).[7]

Human resources for maternal health are limited with only 0.064 physicians per 1,000 population but nurses and midwives are slightly more common, at 0.729 per 1,000 population.[2]

The high maternal mortality ratio at 560 maternal deaths per 100,000 live births indicates that access to and quality of emergency obstetric and neonatal care (EmONC) remains a challenge.[6]

HIV prevalence is low

HIV prevalence relatively low with 1.8 percent of women and 1.9 percent of men ages 15–45 years are HIV positive.[3] While knowledge of HIV/AIDS is high, only 47 percent of 15–24 year olds know where to access condoms

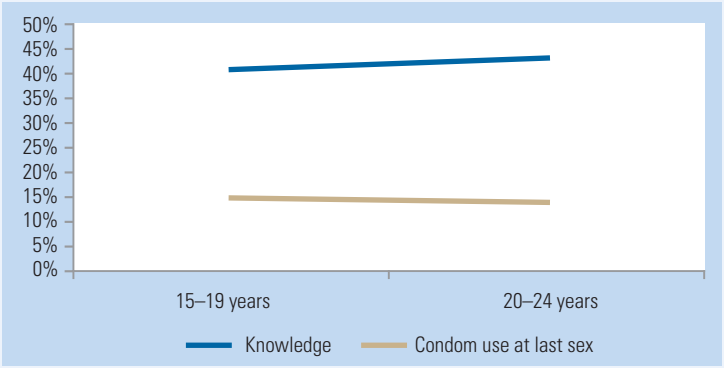
There is a large knowledge-behavior gap regarding condom use for HIV prevention. Overall awareness among young women that using a condom prevents HIV is quite low at about 40 percent. Reported use of condoms is even lower with 14 percent reporting use of condoms at last intercourse (Figure 6).

Table 1 ▪ Barriers in accessing health care (women age 15–49)

Reason	%
Any one of the specified problems	79.2
Having money for treatment	63.0
Distance to health facility	46.4
Having to take transport	40.4
Not wanting to go alone	27.4
Knowing where to go for treatment	18.8
Concern not having a female caregiver	17.4
Having permission to go for treatment	15.8

Source: DHS final report, Burkina Faso 2003.

Figure 6 ▪ Knowledge behavior gap in HIV prevention among young women



Source: Burkina Faso DHS 2003, (author's calculation).

Technical Notes:

Improving Reproductive Health (RH) outcomes, as outlined in the RHAP, includes addressing high fertility, reducing unmet demand for contraception, improving pregnancy outcomes, and reducing STIs.

The RHAP has identified 57 focus countries based on poor reproductive health outcomes, high maternal mortality, high fertility and weak health systems. Specifically, the RHAP identifies high priority countries as those where the MMR is higher than 220/100,000 live births and TFR is greater than 3.These countries are also a sub-group of the Countdown to 2015 countries. Details of the RHAP are available at *www.worldbank.org/population*.

The Gender-related Development Index is a composite index developed by the UNDP that measures human development in the same dimensions as the HDI while adjusting for gender inequality. Its coverage is limited to 157 countries and areas for which the HDI rank was recalculated.

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Key Actions to Improve RH Outcomes

Strengthen gender equality

- Support women and girls' economic and social empowerment. Increase school enrollment of girls. Strengthen employment prospects for girls and women. Educate and raise awareness on the impact of early marriage and child-bearing.
- Educate and empower women and girls to make reproductive health choices. Build on advocacy and community participation, and involve men in supporting women's health and wellbeing.

Reducing high fertility

- Address the issue of opposition to use of contraception and promote the benefits of small family sizes. Increase family planning awareness and utilization through outreach campaigns and messages in the media. Enlist community leaders and women's groups.
- Provide quality family planning services that include counseling and advice, focusing on rural areas. Highlight the effectiveness of modern contraceptive methods and properly educate women on the health risks and benefits of such methods.
- Promote the use of ALL modern contraceptive methods, including longterm methods, through proper counseling which may entail training/re-training health care personnel.
- Secure reproductive health commodities and strengthen supply chain management to further increase contraceptive use as demand is generated.

Reducing maternal mortality

- During antenatal care, educate pregnant women about the importance of delivery with a skilled health personnel and getting postnatal check. Encourage and promote community participation in the care for pregnant women and their children.
- Promote institutional delivery through provider incentives and possibly, implement risk-pooling schemes. Provide vouchers to women in hard-to-reach areas for transport and/or to cover cost of delivery services.
- Strengthen the referral system by instituting emergency transport, training health personnel in appropriate referral procedures (referral protocols and recording of transfers) and establishing maternity waiting huts/homes at hospitals to accommodate women from remote communities who wish to stay close to the hospital prior to delivery.
- Address the inadequate human resources for health by training more midwives and deploying them to the poorest or hard-to-reach districts.
- Target the poor and women in hard-to-reach rural areas in the provision of basic and comprehensive emergency obstetric care (renovate and equip health facilities).

Reducing STIs/HIV/AIDS

- Integrate HIV/AIDS/STIs and family planning services in routine antenatal and postnatal care.
- Reduce the HIV prevalence rate further by strengthening Behavior Change Communication (BCC) programs via mass media and community outreach to raise HIV/AIDS awareness and knowledge. Make available voluntary testing and counseling through the antenatal care.

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BURKINA FASO REPRODUCTIVE HEALTH ACTION PLAN INDICATORS

Indicator	Year	Level	Indicator	Year	Level
Total fertility rate (births per woman ages 15–49)	2008	5.9	Population, total (million)	2008	15.2
Adolescent fertility rate (births per 1,000 women ages 15–19)	2008	129	Population growth (annual %)	2008	3.4
Contraceptive prevalence (% of married women ages 15–49)	2006	17.4	Population ages 0–14 (% of total)	2008	46.2
Unmet need for contraceptives (%)	2006	31.1	Population ages 15–64 (% of total)	2008	51.8
Median age at first birth (years) from DHS	—	—	Population ages 65 and above (% of total)	2008	2
Median age at marriage (years)	—	—	Age dependency ratio (% of working-age population)	2008	93
Mean ideal number of children for all women	2003	5.6	Urban population (% of total)	2008	19.6
Antenatal care with health personnel (%)	2006	85	Mean size of households	—	—
Births attended by skilled health personnel (%)	2006	53.5	GNI per capita, Atlas method (current US$)	2008	480
Proportion of pregnant women with hemoglobin <110 g/L	2008	68.3	GDP per capita (current US$)	2008	522
Maternal mortality ratio (maternal deaths/100,000 live births)	1990	770	GDP growth (annual %)	2008	4.5
Maternal mortality ratio (maternal deaths/100,000 live births)	1995	730	Population living below US$1.25 per day	2003	56.5
Maternal mortality ratio (maternal deaths/100,000 live births)	2000	650	Labor force participation rate, female (% of female population ages 15–64)	2008	79.7
Maternal mortality ratio (maternal deaths/100,000 live births)	2005	600	Literacy rate, adult female (% of females ages 15 and above)	2008	21.6
Maternal mortality ratio (maternal deaths/100,000 live births)	2008	560	Total enrollment, primary (% net)	2009	64.4
Maternal mortality ratio (maternal deaths/100,000 live births) target	2015	190	Ratio of female to male primary enrollment (%)	2009	88.1
Infant mortality rate (per 1,000 live births)	2008	92	Ratio of female to male secondary enrollment (%)	2009	74.4
Newborns protected against tetanus (%)	2008	79	Gender Development Index (GDI)	2008	154
DPT3 immunization coverage (% by age 1)	2008	79	Health expenditure, total (% of GDP)	2007	60.7
Pregnant women living with HIV who received antiretroviral drugs (%)	2005	6.2	Health expenditure, public (% of GDP)	2007	3.4
Prevalence of HIV, total (% of population ages 15–49)	2007	1.6	Health expenditure per capita (current US$)	2007	29.3
Female adults with HIV (% of population ages 15+ with HIV)	2007	50.8	Physicians (per 1,000 population)	2008	0.064
Prevalence of HIV, female (% ages 15–24)	2007	0.9	Nurses and midwives (per 1,000 population)	2008	0.729

Indicator	Survey	Year	Poorest	Second	Middle	Fourth	Richest	Total	Poorest-Richest Difference	Poorest/Richest Ratio
Total fertility rate	DHS	2003	6.6	6.8	6.4	6.5	3.6	5.9	3.0	1.8
Current use of contraception (Modern method)	MICS3	2006	6.3	6.1	7.8	12.6	35.5	13.3	–29.2	0.2
Current use of contraception (Any method)	MICS3	2006	9.4	8.7	12.6	17.6	40.9	17.4	–31.5	0.2
Unmet need for family planning (Total)	MICS3	2006	32.4	33.7	35.3	33.5	19.6	31.1	12.8	1.7
Births attended by skilled health personnel (percent)	MICS3	2006	56.0	54.9	46.5	48.8	64.7	53.5	–8.7	0.9