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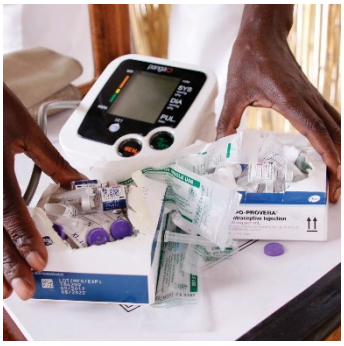

TECHNICAL REPORT | AUGUST 2021

# Burkina Faso: In-depth analysis of family planning task sharing and self-care policies, and alignment with WHO guidelines

# Contents



**ACKNOWLEDGEMENTS**

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# Acronyms

| | |
|---|---|
| APL | Agents de Premier Ligne |
| BLT | Bilateral tubal ligation |
| CHW | Community Health Workers |
| DMPA | Depot medroxyprogesterone acetate |
| DMPA-IM | Intramuscular depot modroxyprogesterone acetate |
| DMPA-SC | Subcutaneous depot modroxyprogesterone acetate |
| ECP | Emergency Contraceptive Pills |
| FIGO | International Federation of Gynecology and Obstetrics |
| FP | Family Planning |
| HRH | Human Resource for Health |
| IUD | Intrauterine Device |
| KII | Key Informant Interview |
| LARC | Long-Acting Reversible Contraception |
| MOH | Ministry of Health |
| NSV | No Scalpel Vasectomy |
| OCP | Oral Contraceptive Pill |
| OTC | Over the Counter |
| PNP | Policies, Norms and Protocols |
| RH | Reproductive Health |
| WHO | World Health Organization |

# Overview

In 2020, the Human Resources for Health in 2030 Program (HRH2030) published a technical report, National Family Planning Guidelines in 10 Countries: How they align with current evidence and WHO recommendations on task sharing and self-care. That publication explores the extent to which 10 countries have adopted policies, service delivery guidelines, or other government documents in-line with current scientific evidence and World Health Organization (WHO) guidelines on task sharing[1] (the provision of methods to mid- and lower-level cadres) and promotion of self-care[2] through self-injection of DMPA-SC[3] and/or over-the-counter provision of hormonal oral contraceptive pills (OCPs).

From this first phase of analysis, we noted Burkina Faso has made some interesting advancements from the policy perspective on task sharing and self-care. As such, USAID and the Ministry of Health supported a more detailed case study of Burkina Faso's current policy environment. This report presents the findings from the second phase of HRH2030's analysis, a more in-depth look at Burkina Faso, which was implemented through in-country data collection initiated in March 2021.

Below are some common terms used in this report.

## Definition of Terms

**Medical barriers** are any contraindications, eligibility requirements (e.g., age, parity, spousal consent), process hurdles (like irrelevant laboratory tests or pelvic exams), the provider of contraception (e.g., limiting FP provision to specialized cadres), provider bias, and regulation that may have had some medical rationale but are scientifically unjustified.[4] Reducing medical barriers to contraception can include undertaking legal, regulatory, or service delivery change that removes barriers to accessing contraception and enables self-care. It seeks to improve contraceptive access or "contraceptive convenience."[5] In the area of family planning, it can include new task sharing policies to increase the number and type of (less-specialized) providers able to offer certain methods, it can include changes in drug regulations to allow hormonal pills to be offered over-the-counter by pharmacists and drug shops, or it may include advance provision of pills or DMPA-SC to allow women to have a year's supply at home for her added convenience and self- administration.

**Task shifting** refers to moving the responsibility for simple health tasks from a more highly qualified health provider to health workers with shorter training and fewer qualifications in order to streamline health services and make more efficient use of human resources for health. **Task sharing** means expanding what cadres can perform which tasks, where the tasks are not taken away from one cadre, but rather additional cadres are capacitated to take on new tasks (WHO, 2017). The FP/RH community has adopted task sharing as their standard term, which is used in this document, but this analysis included literature and policies that use either term or concept.

Self-care refers to "the ability of individuals, families and communities to promote health, prevent disease, maintain health, and cope with illness and disability with or without the support of a health care provider."[6] It is meant to complement a provider-client model and to be promoted within an enabling environment, such as investment in health literacy, strong quality control of contraceptives available in the market place, and continued access to trained health care workers should the client need them. The focus on self-care in this review was for DMPA-SC and oral contraceptives as that is what is addressed in the 2019 WHO guidance as it relates to contraceptive methods.

# Methodology

For this phase, analysis included a second, more in-depth effort to identify, obtain, and analyze additional policies, regulations, guidelines, scopes of work, etc., that may support or detract from full implementation of the family planning (FP) task sharing and self-care policies outlined in the three key documents reviewed previously: the 2019 Politique et *Normes en Matière de Santé de la Reproduction, the 2019 Protocoles de la santé de la reproduction; Composantes communes, and the 2019 Document national d'orientation sur la délégation des taches en SR/PR/VIH/ Nutrition.* A local consultant was hired to identify, obtain, and review additional government documents, given that many are not available online. An inventory of documents sourced and consulted for this analysis is included in Annex I. The primary documents referred to throughout the report are listed in Table 1 below. Key stakeholders were then identified and interviewed by the country consultant through key informant interviews (KII) to supplement missing information or clarify interpretation of the policy analysis.

[1] *WHO. 2017. Task sharing to improve access to Family Planning/Contraception.*
[2] *WHO. 2019. WHO Consolidated Guideline on Self-Care Interventions for Health.*
[3] *Depot medroxyprogesterone acetate – Subcutaneous; an alternative form is injected intramuscularly (IM)*
[4] *Shelton. J, and R.A. Jacobstein, and M.A. Angle. 1992. "Medical Barriers to Access to Family Planning". Lancet 340(8831):1334-5*
[5] *Barot. S. 2008. Making the Case for a 'Contraceptive Convenience' Agenda. Guttmacher Policy Review. Vol 11, No 4.*
[6] *WHO. 2019. WHO Consolidated Guideline on Self-Care Interventions for Health. Page 3*

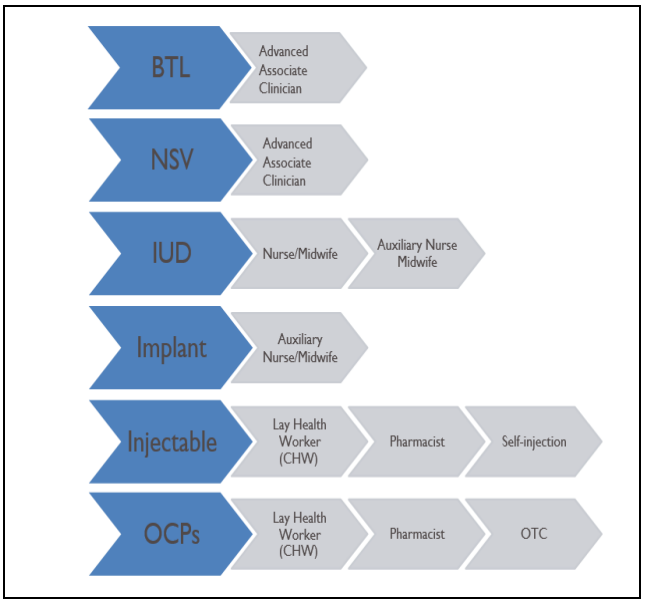
**Table 1: Primary Burkina Faso Policy Documents Referenced**

| Burkina Faso Document Name (Year) | English Reference Name |
|---|---|
| *Politique et Normes en Matière de Santé de la Reproduction (2019)* | Reproductive Health (RH) Policy, Norms, Protocols (PNP) |
| *Protocoles de la santé de la reproduction; Composantes communes (2019)* | RH protocols |
| *Document national d'orientation sur la délégation des taches en SR/PR/VIH/Nutrition (2019)* | Task sharing policy |
| *Plan de passage à grande échelle de la délégation des taches au Burkina Faso (2020)* | Task sharing scale-up strategic plan |
| *Directives nationales pour l'auto prise en charge en santé reproductive, maternelle, néonatale, infantile et de l'adolescent (2020)* | Self-care directives |
| *Guide d'opérationnalisation des directives d'auto prise en charge en santé reproductive, maternelle, néonatale, infantile et de l'adolescent (2020)* | Self-care operational guidelines |

## Benchmark

This analysis used guidance from the WHO's *Task sharing to improve access to Family Planning/Contraception* (WHO, 2017), and its *Consolidated Guideline on Self-Care Interventions for Health* (WHO, 2019) as the international benchmarks on which cadres can provide which family planning methods, including self-administration/over-the counter (OTC) injectables and oral contraceptive pills (OCPs). A summary of this is visually represented below in Figure 1.

**Figure 1. Benchmarks for lowest level of service delivery for select FP methods**




## Research Questions

The primary questions the HRH2030 team explored during this phase was:

*What other policies, such as health worker scopes of practice, protocols, pharmaceutical (or other) regulations support or hamper the implementation of the FP guidelines as they relate to task sharing, over-the-counter access to contraceptives, and self-care? Which policies, regulations, etc. take precedent over others? Is there any further policy development or advocacy that is needed?* In addition, the team sought to understand:

*What is the status of implementation of task sharing and self-care? What has been rolled out on a pilot basis? What has been taken to scale? What are some barriers to full implementation of the guidelines? If these changes have been implemented, is there any local documentation of the impact on service delivery?*

# Context

In October 2016, the Burkina Faso Ministry of Health (MOH), explored the feasibility and acceptance of task sharing for a period of two years in the health districts of Dandé (Hauts Bassins region) and Tougan (Boucle du Mouhoun region) with the support of civil society organizations and implementing partners.[7] Based on the initial experience, Burkina Faso developed a national task sharing policy that was validated on July 05, 2019, and revised in July 2020 to incorporate self-care guidelines. Earlier in 2019, the country revised its reproductive health policies, norms, and protocols (RH PNP, RH Protocols) to align with WHO guidelines on family planning task sharing. The RH protocols describe the activities permitted by different health worker cadres. In 2020, the national task sharing policy was further revised to incorporate task sharing and self-injection of DMPA-SC. This policy document was accompanied by a strategic plan for scaling up task sharing that was validated in 2020. With the arrival of the COVID-19 pandemic in 2020, two additional policies were issued: the self-care directives and operational guidelines.

For the past several years, the MOH, along with professional associations and health unions, has undertaken an effort to revise their health worker cadre structure to be more in line with regional bodies such as the West African Health Organization and WHO. The impetus for this is to have more mid-level clinicians, such as the *health advisor* and *attaché*, and midwives that can be deployed throughout the country, particularly in the regions at lower-level facilities. The health advisors and attaché cadres were established several years ago to respond to a critical health worker shortage[8] and other cadres, such as the *infirmiers brevetés* or *accoucheuses auxiliaires,* will be phased out as part of the

[7] *In the Burkina Faso context, "implementing partners" is used to refer to implementing partners along with multilaterals such as UNFPA, WHO, and donors (e.g., USAID, foundations)*

[8] *Annuaire statistique 2019 du Ministère de la santé*

staffing structure revision and retrained for more mid-level cadres. These cadres listed below will be discontinued or renamed to be replaced by the following cadres:

1. *Infirmiers brevetés* (Registered Nurses) will be retrained to become *Infirmiers d'Etat* (State Nurses)
2. *Agent itinèrent de santé* (Mobile Health Worker) will have a new title of *Agents de santé communautaire* (while the title translates to community health worker the cadre is in line with an auxiliary nurse by training)
3. *Accoucheuses auxiliaires* (Auxiliary Birth Attendants) will be retrained to become Midwives
4. *Accoucheuses brevetées* (Registered Birth Attendants) will also be retrained to become Midwives.

The ultimate goal is to build a more resilient health system and enable the MOH to deploy health workers more efficiently at decentralized levels and to increase access to quality services.

The existence of numerous mid- to lower-level cadres made the analysis across policies and comparison with WHO guidelines complex at times. To understand the analysis findings and the degree of Burkina Faso's alignment with WHO guidelines, Table 2 shows a comparison of the WHO classification to Burkina Faso's cadres and their required training. It is important to note that in Burkina Faso, frontline health workers (or "APL" *"agents de premier ligne")* refers to all health workers with at least two years of training in a professional health school, who often have the first contact with the population. As shown in Table 2, these include registered nurses, mobile health workers, registered and auxiliary birth attendants.

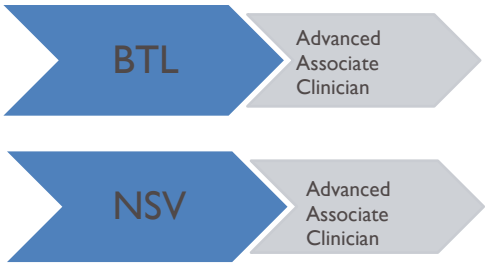
**Table 2: Burkina Faso Cadres names and training vs WHO classification**

| WHO Classification | Burkina Faso cadre | English title | Training |
|---|---|---|---|
| **Associate/Advanced Associate Clinicians** | *Conseiller de santé* | Health Advisors | Masters-2 (2 years additional training after Health Attaché) and training as Midwife or State Nurse |
| | *Attaché de santé* | Health Attaché | Masters-1 or Masters-2 (2 years additional training beyond base of Midwife or State Nurse) |
| **Midwife** | *Sages-femme* | Midwife | Baccalaureate + 3 years professional school |
| **Nurse** | *Infirmiers d'Etat* | State Nurse | Baccalaureate + 3 years professional school |
| | *Infirmier brevetés** ^ | Registered nurse | Secondary school + 2 years professional school |
| **Auxiliary Nurse Midwife and Auxiliary Nurse** | *Agent itinèrent de santé*^ | Mobile Health Workers | Secondary school + 2 years professional school |
| | *Accoucheuse brevetée*^ | Registered Birth Attendant | |
| | *Accoucheuse auxiliaire*^ | Auxiliary Birth Attendant | |
| **Community Health Worker** | *Agent de santé de base communautaire* | Community Health Worker (CHW) | Primary school + 2-week training |

*These cadres will be discontinued as per the narrative above the able.
^Frontline health workers or APL.

# Findings

## Voluntary Surgical Contraception (Tubal Ligation and Vasectomy)




Burkina Faso's policies on voluntary surgical contraception relating to task sharing are in line with WHO guidelines; however, implementation does not match the policies and there are some client-specific requirements that are not evidence based and are unnecessary medical barriers.

In Burkina Faso, the 2019 RH protocols authorize sterilization to be performed in facilities with an operating theatre (e.g., university hospitals, regional hospitals, maternity wards) equipped with the required surgical equipment and infection prevention supplies. Within these protocols there are several internal inconsistencies and phrasing of cadres authorized to perform sterilization. For bilateral tubal ligations (BTL) (2019 RH protocols, p. 128), trained doctors and health attachés can perform the procedure, while for vasectomy (p. 133), the cadres are slightly different: general practitioners and specialist doctors (such as gynecologists and surgeons), and health attachés. These cadres are in line with WHO guidelines even if referenced slightly differently for each procedure.

In addition to addressing cadres and facility level, the 2019 RH protocols outline several conditions to be met by the woman before she can receive a tubal ligation. The protocols state on page 129-130 that the client must be at least 35 years old, have at least three living children, that the client must sign a voluntary consent card before the procedure, and that while the husband's consent is desired and must be sought, it is not required. There are no specific criteria for men before they can receive a vasectomy. The conditions imposed by the 2019 RH protocols for women requesting tubal ligation raise concerns about free and informed choice by putting unnecessary age and parity restrictions as well as directing partner/husband's consent. Further, the counseling guidance for sterilizations in the protocols could have an unanticipated effect of biasing providers against offering this method, particularly since time is required to complete the necessary consent form. While requiring spousal consent for sterilization procedures is not an international best practice, documented client consent is, and as such, vasectomy procedures should include a signed voluntary consent card as well.
Additional factors compromising full optimization of task sharing for sterilization services in Burkina Faso were raised by several KII respondents. According to them, the country has opted for these consent precautions given the strong socio-cultural beliefs about FP. The permanent and irreversible nature of sterilization has led the MOH to require more approvals during the decision-making and consent to service process for clients interested in this method. KIIs also shared their opinions that, given the very technical procedure for BTL, only well-trained health workers (doctors or health attachés) at the right level, and under the correct conditions should perform the procedure. These conditions are important for quality service delivery as long as the health personnel are well deployed throughout the country; if not, limited facility access along with age and parity requirements present unnecessary medical barriers for women seeking a sterilization.

Other KIIs shared different perspectives, with one representative from an international NGO indicating, "*We need to bring care closer to people. Therefore, we must allow attachés* and health counsellors closer to the population to offer these methods." A respondent from a technical directorate of the Ministry of Health said, "I think we need to revise the PNPs to allow midwives who are closer to the population to do voluntary surgical contraception. Also, the [spousal] written consent form and the conditions regarding number of children must be removed."[9]

> "*Surgical contraception is very delicate and it is an irreversible method. The precautions taken by Burkina Faso are likely to protect clients who are generally illiterate and very religious. I also think that this method is not too socially accepted, so the legislators must take precautions so as not to offend popular sensibilities,*" advises an implementing partner.

## Intrauterine device (IUD)


For the IUD, Burkina Faso has successfully shown it is safe and effective to go beyond WHO recommendations. WHO recommends that auxiliary nurse midwives be able to provide IUDs, but that for auxiliary nurses, IUD insertion and removal should be done in the context of rigorous research, meaning important uncertainties about an intervention remain and need to be evaluated.[10] Auxiliary nurses and auxiliary nurse midwives in Burkina Faso have demonstrated, through research/evaluation, that they can safely offer the IUD when work environment conditions are appropriate, and supervision occurs regularly. These cadres have effectively integrated this method into their FP services provision when training is done well, equipment and commodities are available, and regular supportive supervision is conducted.

Burkina Faso's 2019 RH Protocols allow auxiliary nurses and auxiliary nurse-midwives to insert/remove IUDs, along with

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*[9] Note that in its 2017 guidance, WHO only recommends midwives perform sterilization procedures within the context of rigorous research to determine its safety and effectiveness.*

*[10] WHO, 2012. Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting.*

doctors, midwives, and nurses. To introduce task sharing, Burkina Faso piloted this approach with support from Marie Stopes Burkina Faso and *Association Burkinabé pour le Bien-être Familial*, and in collaboration with Equipop and WHO and the West Africa Health Office (WAHO). These frontline health workers were trained to insert and remove IUDs. The pilot introduction was evaluated by FHI360,[11] which did not document any adverse events with IUDs or implants offered by these cadres, demonstrating it was possible for these cadres to safely offer IUDs.

Following the pilot project evaluation, the MOH was satisfied that this cadre could offer IUDs provided they continued to receive close supervision, along with having the appropriate equipment. To date, the MOH continues to support these cadres, with assistance from implementing partners. Evidence from a recent supervision report[12] in the Nanoro health district in the Center-West region shows that for 16 auxiliary nurse midwives and auxiliary nurses trained in 2020, 13 were still at post in this district in 2021. These 13 auxiliary nurse midwives and auxiliary nurses inserted 346 IUDs in 2020.

Authorization for this cadre group is mentioned on page 24 of the 2019 national task sharing policy, page 9 in the 2020 task sharing scale up plan, and on page 77 and in Table IX of the 2019 RH protocols. Furthermore, the curricula for auxiliary nurse midwives and auxiliary nurses have been revised to incorporate task sharing; thus, all new auxiliary nurse midwives and auxiliary nurses receive training in insertion/removal of IUDs. The MOH is upgrading existing auxiliary nurse midwives and auxiliary nurses' skills as described earlier in this report.

To date, Burkina Faso's experience with task-sharing IUD services to auxiliary nurse midwives and auxiliary nurses has been considered successful (per WHO/WAHO, and the MOH[13]), in part because of the cadre's proximity to clients particularly in rural areas. While the policy environment for IUD task sharing is favorable, implementation is challenged by the availability of insertion and withdrawal equipment, which is often lacking in rural health facilities. The implementing partners purchase commodities to support the MOH, thus, scale up of task sharing for IUD is progressing slowly and depends significantly on implementing partner resources.

## Implants


For implants, Burkina Faso is in line with WHO guidelines, with the policy/regulatory texts allowing task sharing to auxiliary nurse midwives and auxiliary nurses. However, to date, implementation of task sharing of this method as authorized in the 2019 RH Protocol and 2019 task sharing policy is not yet at scale.

Auxiliary nurse midwives and auxiliary nurses are allowed to offer implants in all levels of Burkina Faso's health facilities, which can include community health posts and private health facilities (as is the case for IUDs as well). This authorization is mentioned in the 2019 task sharing policy (page 19), in the 2020 task sharing scale up plan (page 9), and on page 61 of the 2019 RH protocols. These cadres are monitored closely (see above under IUDs) through regular supervision as is recommended by WHO.[14] The challenge with task sharing implants, according to KIIs, is that implant insertion and withdrawal kits are often lacking in the rural health facilities where the lower-level cadres provide services. Similar to the situation with IUDs, this shortage is due to insufficient funding from the government. Often, implementing partners finance the equipment but at the discretion of their project budgets, which do not often provide for purchase of sufficient quantities of kits. In addition to the kits, overall hygiene and sanitation equipment and commodities are lacking. As such, while implant insertion and removal have been task shared to auxiliary nurse midwives and auxiliary nurses from a policy perspective, commodity and supply shortages continue to limit access, and funding limits the overall scaling of task sharing.

## Injectables (DMPA-IM and SC)


To be more in line with WHO guidelines, Burkina Faso will need to revise several policy documents allowing for full task sharing of injectables to pharmacists and CHWs. Alignment for self-care of injectables is strong, however, provision of DMPA-SC over-the-counter requires clarification.

Per the 2019 RH protocols, doctors, midwives, nurses, and auxiliary nurses and nurse midwives at all levels/facility types are allowed to provide both forms of injectables – IM and SC. Pharmacists are authorized to administer DMPA-SC per the 2019 task sharing policy (whereas WHO also allows pharmacists to provide IM in specific circumstances). With the movement to introduce DMPA-SC, Burkina Faso authorized task sharing for this injectable at the community level by CHWs as referenced in several policies[15] and as such is in line with WHO guidelines for DMPA-SC; however, it is still not in line for IM. CHWs are trained to counsel and provide the subcutaneous injection and refer women to a facility who want to learn to self-inject. However, clients preferring DMPA-IM must still go to a health facility to receive the intramuscular injection from a higher-level cadre, which is not in line with WHO guidelines.

CHWs were part of the initial pilot to introduce task sharing in country. As such, a stand-alone CHW training module on DMPA-SC injections already exists. Currently, CHWs in 17 of

*[11] Chin-Quee, Dawn S. September 2018. Rapport final: Accroître l'accès des femmes aux méthodes contraceptives à courte et à longue durée d'action au Burkina Faso grâce au partage des tâches : évaluation d'une intervention pilote dans les districts de Dandé et de Tougan.*

*[12] Consultant personal communication*

*[13] Consultant personal communication*

*[14] Terminology used by WHO in their 2017 guidance, page 8.*

*[15] 2019 Task sharing policy; 2020 Task sharing scale up plan; 2019 RH Protocols (page 52); 2020 Self-care directives and operational guidelines.*

70 districts[16] are trained on provision of DMPA-SC, meaning there is a long way before Burkina Faso reaches scale. Findings from the KIIs explain part of this challenge: they noted that the general CHW training curriculum has not been revised to include the specific module on providing sub-cutaneous injections, due to lack of funding. Instead, CHW training on DMPA-SC is conducted by the MOH with implementing partners only when there is funding from partners to extend the geographical coverage of the task sharing scale up strategy. "*There are currently no plans to revise the CHW training module to include the delegation of tasks [sic]. This training is done by district and according to the funding of the partners,*" according to one key informant working in a technical directorate of the Ministry of Health. The RH protocols and CHW training also require revision to authorize trained CHWs to provide DMPA-IM as other countries have already done.

There are some policy/regulatory contradictions concerning task sharing of DMPA to pharmacists. Pharmacists are not officially trained during their pre-service education to offer any injections; however, some learn independently[17] to perform them and do assist clients with other types of injections like insulin, and now also know how to offer DMPA-SC injections. In the task sharing policy, (p. 25), pharmacists became authorized to administer DMPA-SC injections, which is not supported by their pre-service training or the public health code (see below). Also, in contrast with the task sharing policy, there is a restriction in the essential medicines list that precludes selling of DMPA-SC in pharmacies, which presents another challenge to fully implementing task sharing and self-care through pharmacies. KIIs also noted the need for a system for monitoring and collecting biomedical waste from pharmacies as part of task sharing and self-care. Thus, revisions to pharmacy-related policies and training curricula are needed to render task sharing of injectables to this level fully legal.

Key informants noted that the ongoing revision of the public health code which outlines the organization and application of the medical and auxiliary professions, and pharmacy technicians, may likely resolve this situation with pharmacists. The public health code is currently with the National Assembly for review, and adoption by December 2021 is expected. The revised public health code (which takes precedent over protocols, policies, and plans) includes modifications to authorize pharmacies and pharmaceutical depots to offer DMPA-SC. KIIs mentioned an important overall next step for task sharing and self-care in Burkina will be for the Ministry of Health to establish effective communication with the pharmacies/depots to address biomedical waste reporting and management systems and ensure competency of pharmacy staff offering DMPA-SC injections.

Administration of DMPA-SC from a self-care lens is accomplished through referral to a facility to support clients to master the self-injection technique. After the self-injection orientation, which includes the client self-injecting the first dose, the woman is given one dose to take home with an appointment to return in 13 weeks. At that follow up visit, the provider verifies that client is tolerating the injectable and correctly performing self-injection and if the response is positive, she can obtain advance provision of as many doses as requested for home administration. This advance provision can be up to one year, per the consultant; the 2020 self-care operational guidelines did not provide more specifics. Women are also permitted to obtain a resupply from a pharmacy. CHWs are not allowed to train clients to do DMPA-SC self-injection but must refer them to a facility for this training.

## Oral Contraceptive Pills (including emergency contraception pills)


In line with WHO guidelines for oral contraceptive pills, Burkina Faso's legislation and regulations allow task sharing the initiation and dispensing of OCPs to CHWs and pharmacists, and they is offered over-the-counter without a prescription. Doctors, midwives, nurses, auxiliary nurses, and midwives, CHWs, and pharmacists are authorized to offer pills. In agreement with the WHO guidelines, the 2019 task sharing policy and the 2020 self-care guidelines authorize OCPs to be sold in all drug depots and over-the-counter dispensaries, without a prescription.

The situation with the emergency contraception pill (ECP) in Burkina Faso is complicated, given socio-cultural/religious beliefs and lack of alignment between the 2005 reproductive health law (*loi n° 049-2005/AN du 21 décembre 2005 portant santé de la reproduction*), the 2019 RH protocols, and what is actually practiced in facilities and pharmacies. The 2005 RH law is vague about specific contraceptive methods (Article 20[18]), indicating that "All family planning techniques and methods, except induced abortion or voluntary termination of pregnancy are authorized in public and private health facilities which meet the required conditions." However, ECP are interpreted by health workers and MOH, per KIIs, as an abortifacient, an interpretation not grounded in evidence. Operationally, the 2019 RH Protocols, Section VII addresses responses to clients' needs for emergency contraception, and in the section on OCPs (page 44), ECPs are referenced as well. Section VII presents both emergency contraception in the form of post-coital IUD insertion or hormonal oral contraceptive pills, with specific ECP formulations as dedicated products. ECPs are included in providers' basic training on contraception and are provided as part of routine FP service delivery when necessary and requested, as outlined in the 2019 RH protocols. Thus, there is an operational discrepancy between what the policies indicate and how health workers interpret service protocols based on socio-cultural beliefs and practices.

[16] *Consultant communication*
[17] *Consultant communication and KIIs*
[18] *Per the local consultant – While this law does not clearly state "morning-after pill", it is interpreted as such. In addition, the law gives only two cases when a woman can terminate a pregnancy: in case of rape or incest and in case of congenital malformation. The specifics must be attested to by a doctor. He further notes that the Penal Code has been revised because in the past, the finding of rape, incest and malformation had to be certified by a doctor and confirmed by another doctor, but this provision has been relaxed to include only one doctor.*

# COVID-19 and its effect on Task Sharing and Self-Care Policies

With the emergence of COVID-19, the international family planning community raised alarms on how this global pandemic would impact women and couples worldwide and issued numerous calls to government and development partners to mitigate it.[19] Many of the solutions proposed to ease COVID-19's impacts on contraceptive use are not new or untested, in fact, they squarely align with standard WHO guidance on task sharing and self-care. For instance, the International Federation of Gynecology and Obstetrics (FIGO) urged provision of a one-year supply of OCPs, operationalizing task sharing/self-care recommendations to improve access to DMPA-SC for self-injection, lifting rules that hinder pharmacies from selling products directly to consumers, and implementing task sharing FP with lower-level cadres.[20] There were also calls for advance provision of emergency contraception, increased counseling on fertility awareness methods and condoms, and changing health insurance plan restrictions on refills,[21] which can all empower self-care and help maintain FP access and use during the pandemic.

> The Guttmacher Institute has estimated that just a 10% decline in essential sexual and reproductive health care would lead to over 48 million women with an unmet need for contraception, an additional 15 million unintended pregnancies, an additional 28,000 maternal deaths, an additional 168,000 newborn deaths.

While COVID-19 has stressed all health systems, including Burkina Faso's, the country has taken the crisis as an opportunity to dramatically push forward implementation of its FP task sharing and self-care vision. In December 2020, Burkina Faso issued the "*Directives nationales pour l'auto prise en charge en santé reproductive, maternelle, néonatale, infantile et de l'adolescent*" (self-care directives) and "*Guide d'opérationnalisation des directives d'auto prise en charge en santé reproductive, maternelle, néonatale, infantile et de l'adolescent*" (self-care operational guidelines). These directives advance task sharing and self-care even further than the 2019 RH PNPs and, given that they are more recent, are considered by the MOH to supersede them. These new directives address more service provision towards self-care, rather than task sharing. For example, the operational guidelines indicate that OCPs can be dispensed in "sufficient quantity" according to the woman's interest and need. Thus, a provider can interpret this to mean that if a client has experience with OCPs and would like a 12-month supply, that is to be granted, provided the facility has that quantity in stock. In addition, pharmacies and CHWs can now resupply clients without a prescription (Self-care operational guidelines, p.10), and ECPs are to be available (no additional detail is provided regarding quantity, price, location).[22] These directives call for an accelerated scale up process for DMPA-SC self-injection and instruct providers to counsel women on use and disposal of DMPA-SC, as they have previously been authorized to do; these guidelines further emphasize the importance of this scale-up. Adolescents and youth also benefit, as these new directives eliminate the requirement for parental consent (Self-care directives, Directive 14, page 13). COVID-19, along with ongoing insecurity in Burkina Faso, is listed as the rationale for these changes. There is also a reference to the benefit of telemedicine to assist with task sharing and self-care, a delivery channel not referenced in other policy environment documents previously.

According to communication with the director of the Ministry of Health's Pharmaceutical Supply Coordination Directorate, the COVID-19 pandemic has had an impact on the supply of contraceptive products in Burkina Faso. Suppliers were unable to meet delivery deadlines and some manufacturers were unable to meet demand (i.e., Implanon NXT). These delays were due to freight disruption and new international priorities. At the facility level, the pandemic affected the use of FP services in the first months of the pandemic (March-April 2020) during which health workers and clients had little information about the pandemic and hesitated to offer or use services, per the consultant and Health Policy Plus staff. After May 2020, according to MOH routine FP service data, clients availed themselves of FP health services at similar pre-pandemic levels, so there seems to be limited longer-term effects on service delivery levels/statistics.

Equally important as COVID, the growing insecurity situation in the Boucle du Mouhoun, North, Center-North, East and Sahel regions of Burkina Faso has facilitated implementation of and support for task sharing and self-care, according to KIIs from the MOH, routine service data, and supervision visits. The observation from MOH contacts and KIIs is that both self-care and task sharing are well appreciated in areas where safety is reduced. In these areas, getting to a health facility is a risk for clients, as is talking publicly about FP. In these situations, clients prefer to stay at home and self-administer DMPA-SC or use a CHW to administer DMPA-SC or provide pills.

# Discussion and Recommendations

Since 2016, Burkina Faso has focused on introducing and scaling-up task sharing and self-care strategies, recognizing the potential high-impact these strategies could have for its FP program and clients. Implementation of these strategies is closely monitored; however, they are not at national scale in all health districts across the country due to insufficient funding. Progress is significantly dependent on financial support from implementing partners.

[19] *https://www.unfpa.org/resources/impact-covid-19-pandemic-family-planning-and-ending-gender-based-violence-female-genital*

[20] *FIGO Statement 13 April 2020 Available: https://www.figo.org/sites/default/files/2020-05/COVID%20contraception.pdf*

[21] *Ibid*

[22] *While ECPs are available, they are not officially considered a method according to the Burkina RH law, Article 20. See section IV, 5 for further discussion of this issue.*

Overall, the FP policy and regulatory environment in Burkina Faso is in line with WHO guidelines, as was noted in the phase 1 report. The second phase, as detailed within this report, revealed key opportunities to further improve alignment with WHO guidelines and harmonization across Burkina's policy environment of laws, policies, strategies, plans, and curricula. Burkina Faso should also be recognized for advancing tasking sharing for LARCs.

The key findings relating to task sharing and self-care for the different methods are described in detail below. A summary of key recommendations from Phase 2 is listed here:

- **Sterilization:** Burkina Faso needs to implement its PNPs as written, but also give further consider to revising them to remove language that could compromise rights-based principles and unnecessary medical barriers.
- **IUD:** Burkina Faso allows auxiliaries (auxiliary nurses and auxiliary midwives) who are being routinely supervised to insert/remove IUDs. Task sharing to these additional cadres could be an example for other countries.
- **Injectables:** Adoption of the revised public health code and revisions to pharmacist pre-service curriculum are needed to permit this important cadre to officially offer DMPA-SC, and the PNPs should be revised to allow CHWs to provide DMPA-IM and counsel/train women on self-injection of DMPA-SC.
- **OCPs:** Particularly for emergency contraception, there are internal conflicts between the RH law, PNPs, and common practices that, if resolved, would allow more couples to access this method if needed.

Table 3 summarizes the WHO guidelines and the situation in Burkina Faso for the "lowest" level of cadre that might provide each method—omitting medical doctors and obstetricians-gynecologists.

**Table 3: Task Sharing of FP Methods, WHO and Burkina Faso**

| | WHO | Burkina Faso* policies |
|---|---|---|
| **Sterilization (BTL & NSV)** | Clinical Officer | Associate clinician |
| **IUD** | Auxiliary Nurse Midwife | Auxiliary Nurse Midwife<br>Auxiliary Nurse |
| **Implant** | Auxiliary Nurse Midwife<br>Auxiliary Nurse | Auxiliary Nurse Midwife<br>Auxiliary Nurse |
| **Injectable (IM and SC)** | CHW<br>Pharmacist<br>Self-injection (DMPA-SC) | CHW (trained only for DMPA-SC) ^<br>Pharmacist (DMPA-SC)<br>Self-injection (DMPA-SC) |
| **Oral Contraceptive Pills (OCPs) (including ECPs)** | CHW<br>Pharmacist<br>Over-the-Counter – no prescription | CHW<br>Pharmacist<br>Over-the-Counter (OCPs and ECPs) – no prescription |

*Burkina Faso PNPs emphasize personnel trained in FP. The national Task Sharing Policy and the Self-Care Operationalization Guidelines are also referenced here (See Table 1 for complete names of the policy documents).
^Not in line with WHO guidelines.

## Discussion

### *The importance of involvement of multiple actors in the process of task sharing and self-care*

The KIIs revealed that the introduction, piloting, implementation, and scale-up of task sharing and self-care in Burkina Faso has involved the mobilization of several actors, led by the Ministry of Health, with engagement from implementing partners and civil society organizations. Several key partners that were not as well engaged from the outset include the professional associations and training institutions. When the results of the pilot phase were available and the MOH decided to pursue task sharing (and later self-care), they recognized this omission and held an orientation meeting with all implementing partners, which included key groups such as the Pharmacist Association, a critical cadre for the future of task sharing and self-care coaching in Burkina Faso. Broad stakeholder engagement is important for successful task sharing and self-care, as there are many parts of the health system that need to be involved to introduce, validate, and scale-up these strategies. This expanded engagement has contributed to strong support for the revision of the public health code, for example, to enable pharmacists to offer more services and drugs through their facilities. That said, KIIs also emphasized the importance and need for ongoing and transparent consultation with the professional associations, particularly pharmacists, along with the private sector to ensure strong implementation and scale up of the policies.

In the current environment, key informants felt that there is strong political will to implement task sharing and self-care, while also recognizing that there are still revisions needed to some policies, laws, and regulations to further facilitate scale up of the practice as have been noted above. They also acknowledged the need to more carefully articulate cadres' specific roles and responsibilities for task sharing and self-care and include as needed facility management and administration cadres to enable task sharing and self-care to be fully scaled up. In addition, the revised specific job guidance texts (in French, *textes d'orientation des emplois spécifiques* or TOES) for health cadres do not currently reference responsibilities relating to task sharing and self-care. As several KIIs noted, *"No, the TOES*

*[sic] have been revised but do not to take into account the delegation of tasks [sic] and self-care."*

The consultant and KIIs also noted that task sharing and self-care are not well considered or referenced in the updating process of traditional pharmacopoeia and medicine. KIIs indicated that, the "*policy does not list this component because the level of collaboration is still low,*" and "*Yes, traditional pharmacopoeia and medicine have been taken into account in self-care but not specifically in the field of FP.*" Thus, there is additional effort that the MOH and partners can make to be more comprehensive across the policy and regulatory environment to ensure strong scale-up and implementation of task sharing and self-care.

### *Resources required for implementation and scale-up of policies*

The policy environment is favorable for task sharing and self-care as described above, with some areas for improvement, but a major challenge to full implementation and scaling up is the resource gap. This may reflect on the political will to some degree, but the ongoing COVID-19 pandemic and insecurity present serious challenges for the government, and thus the MOH, to mobilize and sustain funding. Key informants highlighted this funding gap in two key areas:

**Commodities and Supplies**
For LARCs, key informants emphasized the importance of planning for financing as part of policy implementation. Currently, the MOH relies on implementing partners to provide insertion/removal kits for implants and IUDs, which means women do not always have access to the method of their choice. Despite MOH budgeting for the supplies, government funding is not available/released, or often redirected for other health priorities thereby negatively affecting the FP program. In addition, key informants expressed particular concern regarding funding for skills building for providers, particularly at the community level, and waste management for pharmacies and clients self-injecting DMPA-SC. "*The delegation of tasks works well in Burkina Faso, only the lack of resources inhibits national scale. The districts where resources exist have good results,*" notes an implementing partner. Several other key informants raised the issue of updating data collection processes and tools to accommodate task sharing and self-care approaches, to ensure the MOH and partners have good data with which to make informed decisions going forward.

In addition, funding is needed for commodities and associated equipment for the CHWs to deliver OCPs, condoms, DMPA-SC to their clients.

**Training**
Another resource gap relates to updating and rolling out training curricula. The national task sharing policy includes DMPA-SC injectable provision by CHWs; however, as noted under section IV, 4 above, the training curriculum has not been fully updated to include these new task sharing/self-care competencies. CHWs are initially trained in a 14-day program; however, the current curriculum does not incorporate all aspects of community-based task sharing. There are approximately 17,700 CHWs and the MOH lacks resources for funding to update the curriculum and to roll out training nationwide. As such, Burkina Faso is scaling up only at the pace of implementing partners' available funding.

### *Harmonizing prices across all sectors and methods*

Across francophone West Africa, stakeholders have advocated for free FP services and methods. Burkina Faso has adopted this policy, but this in-depth analysis revealed pricing differences that could affect clients' access to contraceptives; accessing services was not addressed. Pharmacies are allowed to sell brand name OCPs versus generics, which creates some access barriers for women choosing to obtain their OCPs in pharmacies. Under Burkina Faso's policy on free FP services, OCPs are provided free of charge in public health facilities. In contrast, they are not free in pharmacies and private depots. Pharmacies/depots sell a packet of OCPs for 500 FCFA in contrast to what the OCPs would cost at a public facility (200 FCFA) without the free services policy. The country could benefit from a total market approach analysis to determine suitable outlets for different products and the price thresholds that allow different service delivery channels to earn a profit/recover their costs and be affordable to the client.

## Recommendations

### *Recommended policy and regulatory revisions*

As stated earlier in the Findings section (see page 7), in general, Burkina Faso's FP policy and regulatory environment has incorporated task sharing and self-care in line with WHO guidelines. There remain some specific revisions that would result in a more favorable environment and contribute to scale up. These include.

**Revise the 2005 Reproductive Health Law**
Based on the document analysis and KIIs, Burkina Faso should revise the 2005 RH Law (loi n°049-2005/AN du December 21, 2005[23]) to include clarity around contraceptives and remove the interpreted association between ECPs and abortifacients. This update would bring the law in agreement with the PNPs, and the decree *n°2019-0040/PRES/PM/MS/MFSNF/MFPTPS/MATD/ MINEFID* from 23 January 2019, which addresses free FP services. With the revision, policy contradictions with MOH directives would be eliminated, thus allowing health workers to deliver this dosage of oral contraceptive pills without fear. ECPs could then be included and covered free of charge if they are classified as a contraceptive. Such a revision would also remove the fear that some providers may have (including those working in pharmacies/depots) given the conflict between policy and law.

**Adoption by the National Assembly of the revised Public Health code**
The law, or code, n°233/94/ADP of 19 May 1994,[24] which outlines public health in Burkina Faso has been revised to allow

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[23] http://www.ilo.org/dyn/natlex/docs/ELECTRONIC/110853/138026/F874500029/BFA-110853.pdf.

24 *https://sherloc.unodc.org/cld/uploads/res/document/bfa/loi-n-23-94-adp-portant-code-de-la-sante-publique_html/Burkina_Faso_Loi_N_2394ADP_portant_Code_de_la_Sante_Publique.pdf.*

pharmacies to conduct clinical activities in pharmaceutical dispensaries and depots, which would then also legally permit pharmacists to offer the DMPA-SC injections. The law is currently with the national assembly, with expected adoption by December 2021. Once the law is formally adopted, the central directorates governing pharmacists, the National Pharmaceutical Regulatory Agency and the Directorate responsible for pharmaceutical procurement, will need to work with the MOH to update guidelines and protocols about FP services and commodities, as they are responsible for monitoring the use of products in general and contraceptive products in particular (including OCPs, DMPA-SC).

**Remove unnecessary medical barriers to female sterilization in the 2019 RH Protocols**

Although the social and religious context might add complexities to sterilization services, Burkina Faso should ensure its medical guidance and protocols are harmonized with international norms and standards, which include documented voluntary consent for clients (both male and female), removal of spousal consent, and eradication of any parity or age requirements. The 2019 RH Protocols should be revised to remove these restrictions which are not in line with the 2018 USAID-Johns Hopkins-WHO family planning guidebook for providers (pages 213, 220) to respect human rights. There should also be more attention to gender equity during counseling.

**Pharmacist curricula**

Related to the adoption of the revised public health code, updating of the pharmacist curriculum is necessary to fully engage this important cadre. In Burkina Faso, two public universities and a private university train pharmacists. Currently, there is no clinical skills component; thus, they do not learn to do injections. However, some motivated students take the initiative to learn how to provide injections. As they are trained on how medications are used, along with their side effects and ways to manage them, including contraceptives, pharmacists can provide valuable advice to clients, particularly those who want to receive the DMPA-SC injection or receive counseling to practice self-care. Pharmacists, particularly pharmaceutical depots (staffed by any health worker who applies for a license from the MOH) are present in regions and health districts, where they provide drug management and advice to users/ clients regarding medicines and can be the first contact a woman has with the health system, given their proximity to many clients, and thus they can contribute to FP uptake if authorized. As feasible until the public health code is adopted and the curriculum revised, it is important that the MOH build capacity of pharmacists to provide DMPA-SC in accordance with the 2019 task sharing policy.

**Cadres job guidance texts or "*TOES*"**

To further ensure that task sharing/self-care are formalized for each cadre, Burkina Faso should consider articulating each cadres' specific roles and responsibilities in their scopes of practice.

### *Advancing task sharing practices for Implants and IUDs*

The in-depth policy analysis and KIIs served to provide additional insights into the context surrounding task sharing of insertion and removal of implants and IUDs by auxiliary nurse and auxiliary nurse midwives level cadres. As described above, these cadres were included in the task sharing pilot project in 2016 and continue to be closely supervised to ensure quality services. The outcome of the pilot was for the MOH to include them in the 2019 RH protocols, 2019 RH PNPs, 2019 task sharing policy and 2020 task sharing scale up plan. WHO has been involved throughout the process of developing and validating these policies. This experience could serve as a model for other countries in the region that are striving to address human resource shortages at lower levels of their health pyramids and increase access for women/couples in more rural areas where these cadres tend to be more present. The Burkina Faso experience may also serve as evidence for WHO when it next updates its task sharing guidance.

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*A midwife provides prenatal care to one of her patients. Photo Credit: Ibrahima Kamaté, HRH2030 (2019).*

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