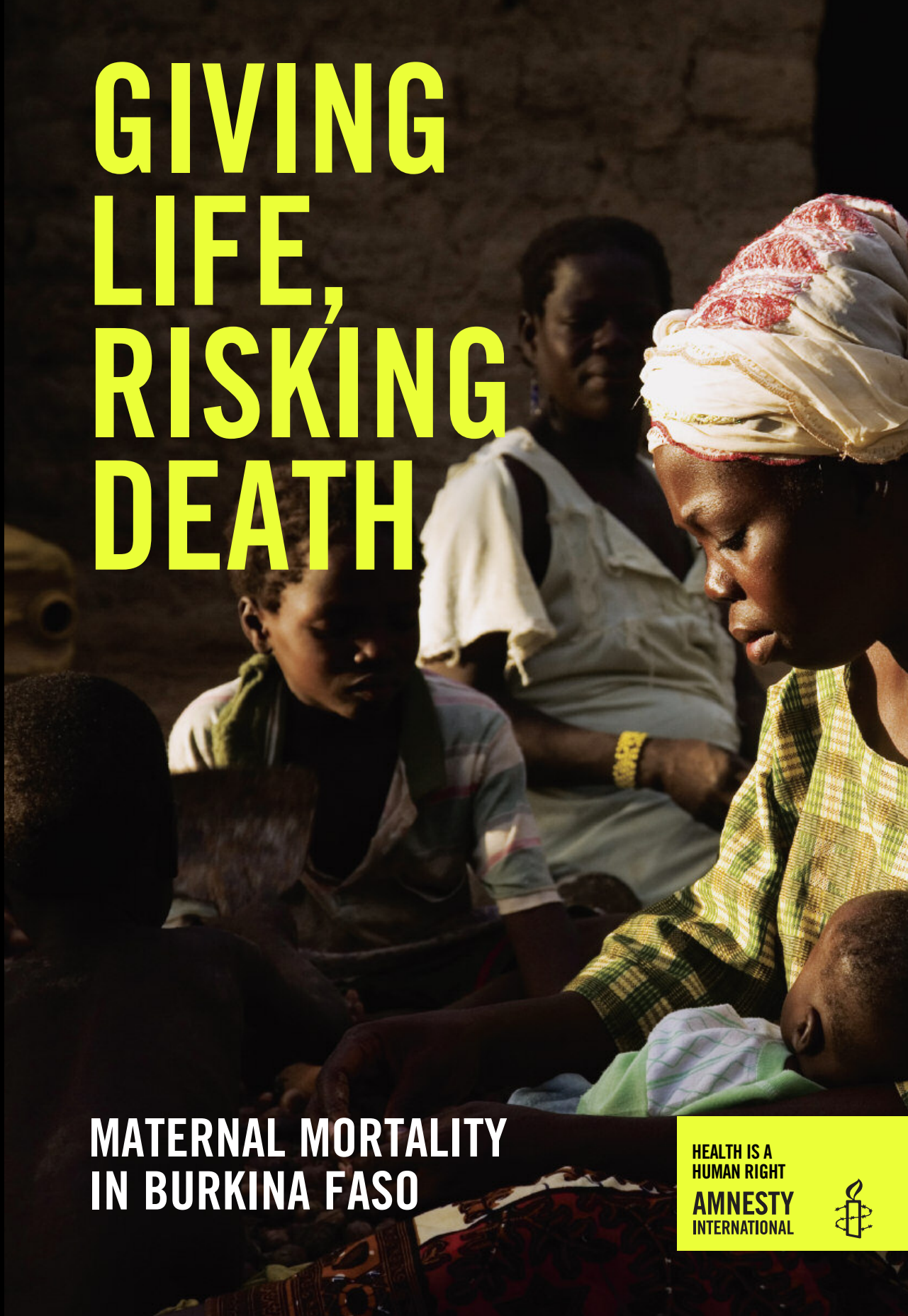
GIVING LIFE, RISKING DEATH



MATERNAL MORTALITY IN BURKINA FASO

HEALTH IS A HUMAN RIGHT

AMNESTY INTERNATIONAL

GIVING LIFE, RISKING DEATH

MATERNAL MORTALITY IN BURKINA FASO

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Cover photo, front:
Women crack nuts surrounded by their children. Despite equal status in law, many women are subordinate to the men in their lives and are unable to make decisions about their own health. © Anna Kari
Cover photo, back:
Ramatoulaye and her baby daughter by the Nakambe river close to Wonko, Burkina Faso.
Four months earlier she was forced to give birth on the river bank because there was no boat available to take her across. © Anna Kari

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GIVING LIFE, RISKING DEATH

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Amnesty International Publications

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ABBREVIATIONS USED IN THIS REPORT

ABBEF	Association burkinabè pour le bien-être familial, Burkinabè Association for Family Welfare
ACHPR	African Charter on Human and Peoples' Rights
AfDB	African Development Bank
AIDS	Acquired Immune Deficiency Syndrome
AQUASOU	Amélioration de la qualité et de l'accès aux soins obstétricaux d'urgence, Improvement of the quality of and access to emergency obstetric care
ASCE	Autorité supérieure de contrôle de l'État, Superior Authority of State Control
ASMADE	Association Songui Manégré / Aide au développement endogène, Songui Manégré Association / Aid to Endogenous Development
ASSOG	Attaché(e) Soins Santé en Obstétrique et Gynécologie, Obstetric and Gynecological Health Care Attaché
AU	African Union
CAMEG	Centrale d'achats des médicaments essentiels génériques et des consommables médicaux, Purchasing centre for essential generic drugs and medical goods
CCG	Cadre de concertation genre, Gender consultation framework
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CEDAW Committee	UN Committee on the Elimination of Discrimination against Women
CEPE	Certificat d'études primaires élémentaires, Elementary school-leaving qualification
CESCR	UN Committee on Economic, Social and Cultural Rights
CFA francs	Common currency of 14 countries in West and Central Africa linked to the Euro. CFA stands for Communauté financière d'Afrique (Financial Community of Africa)
CHR	Centre hospitalier régional, regional hospital
CHU	Centre hospitalier universitaire, university hospital
CMA	Centre médical avec antenne chirurgicale, medical centre with surgical services, district hospital
COGES	Comité de gestion des services de santé, health management committee
CRC	Convention on the Rights of the Child
CRCHUM	Centre de recherche du Centre hospitalier de l'Université de Montréal, Research Centre, Montreal University Hospital
CSPS	Centre de santé et de promotion sociale, community health centre

DHS	Demographic and Health Survey
ECHO	European Commission Humanitarian Office
ECOWAS	Economic Community of West African States
EmONC	Emergency Obstetric and Neonatal Care
EU	European Union
FASFACO	Fédération des Associations de Sages-Femmes de l'Afrique du Centre et de l'Ouest, Federation of Associations of Midwives from Central and West Africa
FGM	Female Genital Mutilation
FIGO	International Federation of Gynaecology and Obstetrics
GAVI	Global Alliance for Vaccines and Immunisation
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit, German agency for technical assistance
HACLC	Haute autorité de coordination de la lutte contre la corruption, High Commission for the Coordination of Anti-Corruption Activities
HIV	Human Immunodeficiency Virus
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICM	International Confederation of Midwives
MDG	Millennium Development Goals
NCBT	National blood transfusion centres
NGO	Non-governmental organization
NHRC	National Human Rights Commission
PADS	Programme d'appui au Développement Sanitaire, Support programme for the development of the health sector
PNDS	Plan national de développement sanitaire, National Health Development Plan
REN-LAC	Réseau National de Lutte Anti-Corruption, National Network to Fight Against Corruption
RGPH	Recensement général de la population et de l'habitat, General Population and Housing Census
STI	Sexually transmitted infections
TDH	Terre des Hommes, an NGO working for the rights of children
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNCAC	United Nations Convention against Corruption
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Mothers and their newborn babies in Kiembara clinic. Many women in Burkina Faso cannot access the health services they need.

1/INTRODUCTION

'A PREGNANT WOMAN HAS A FOOT IN THE GRAVE AND A FOOT ON THE EARTH'[1]

African saying

Every year, more than 2,000 women die in Burkina Faso from complications of pregnancy and childbirth.[2] Most of these deaths could have been prevented.

Many women die because they need blood but none is available. Others die from obstructed labour, infections or hypertension because they are unable to reach a health facility capable of treating them, or because they arrive too late. Many lose their lives because their relatives cannot pay the fees being asked for by medical personnel. Many more do not even reach health facilities because of geographical, financial or cultural barriers.

There are many reasons why women in Burkina Faso do not receive the health care they need. These include: lack of information on sexual and reproductive health and rights; women's low status, which undermines their right to decide whether, when and how many children to have; social and economic barriers, notably the cost of medical treatment; geographic barriers obstructing access to health facilities; and poor quality of treatment due to shortages of medical supplies and qualified personnel.

Maternal mortality[3] takes its major toll on the poorest and the least educated women and those who live in rural areas, home to 80 per cent of the population.

The maternal mortality ratio[4] is high, although according to official statistics it has decreased from 566 per 100,000 live births in 1993 to 484 in 1999,[5] and to 307 in 2008.[6]

The direct medical causes of maternal deaths in Burkina Faso have been consistently identified as haemorrhage, infection, uterine rupture, post-abortion complications, eclampsia (seizures or coma in a patient with pregnancy-induced hypertension) and placenta retention.[7] These complications are treatable if women have timely access to the means to prevent unwanted pregnancy and safe abortion services, to a skilled attendant at delivery, to a functioning referral system and to adequate emergency obstetric care.

The authorities in Burkina Faso have not ignored this tragedy, a tragedy that deprives thousands of families of their wives, mothers, daughters and sisters. During the last decade the authorities, with the help of the donor community, have devoted effort and resources to reducing maternal mortality.

Ambitious strategies have been developed and partially implemented. In 2006 the government adopted a subsidy policy based on the principle that 80 per cent of the cost of deliveries and emergency obstetric and neonatal care would be met by the government.

Efforts have also been made to increase the number of trained medical personnel, including midwives and nurses, and to enhance their skills. In an effort to encourage more women to give birth in health facilities, rather than at home, the role of traditional birth attendants[8] has been changed from assisting women in deliveries to promoting medically assisted delivery and helping women gain access to these services. Primary health care centres have been built throughout the country. The government has also adopted a national strategy for family planning.

However well elaborated on paper, the policies to combat maternal mortality suffer from major flaws in their implementation. Although the cost of deliveries has been reduced since 2006, access to adequate medical services continues to be a problem and many women remain reluctant to go to health facilities to give birth. This is particularly the case among poor and rural women who face treatment in health facilities which are often unhygienic and understaffed, with medical personnel who are underpaid and sometimes treat them disrespectfully.

The situation is particularly acute in the area of family planning. Although figures vary, it is clear that contraceptive use remains low. Despite passing a Law on Reproductive Health in 2005 that entitles couples and individuals to decide freely whether and when to have children, the government still does too little to ensure that women and girls have safe and confidential access to information and to modern contraceptive methods. The result is a large number of early, unwanted or life-threatening pregnancies, as well as unsafe abortions. Family planning is severely underfunded, partly because, until recently, international donors and the government have concentrated on other public health priorities, notably the AIDS pandemic, polio and malaria.

Several structural factors continue to prevent women from enjoying their right to health care that is available, accessible, acceptable and of good quality.

- Availability of care is undermined by a lack of adequate health facilities as well as shortages in medical supplies and personnel.

- Accessibility is hampered both by geographical and financial barriers and by women's lack of information and decision-making power.

- Acceptability of care is compromised by the disrespectful or even cruel attitudes and conduct of some medical personnel.

- Quality of care is often inadequate, with medical staff not properly monitored or held accountable, and poor pay and conditions for staff.

Aïcha's story is one of many which illustrate the obstacles women face on the journey through pregnancy to childbirth, the suffering they may endure, and in many cases, the tragic and preventable loss of life.

Aïcha died in April 2008 in Ouagadougou, aged 21.

Aïcha was the only daughter in a family of five children. She met her husband, Abdou, in Ouagadougou and they were engaged for two years before getting married. Neither Aïcha or Abdou went to school. Abdou, who was 25 years old in 2008, works irregularly as an assistant carpenter, but has been without steady employment for the past year.

Aïcha used to sell benga, a mix of beans and rice, and worked until the very last day of her pregnancy. She had to fetch wood several kilometres away from their home, and would wake up at 5am every day to cook the benga. She then went to sell it on the road near her home, returning at 4pm to prepare the evening meal. "She worked every day, unless she had something else to do like the laundry", her husband said.

This was her first pregnancy, and she attended the three recommended prenatal visits at the CSPS (community health centre). Her husband Abdou told Amnesty International: "I never accompanied her on these visits but I thought that it was a good thing that she was treated there." During her pregnancy, Aïcha was prescribed iron for her anaemia and maloxine to prevent malaria.

A male nurse at the CSPS where Aïcha was treated told Amnesty International: "She could not pay for a single prescription. We even found some of them in her health record which had not been used."

In April 2008, at around 8pm, Aïcha had labour pains. A friend took her to the health centre 1km from her home on a small motorcycle and her husband followed on a bicycle. She gave birth to a boy at 2am. After the delivery, the medical personnel asked the family to buy bleach to clean up her blood.

Ten minutes after the delivery, the midwife told the family that Aïcha had to be transferred to a district hospital because she was suffering from a haemorrhage. The head of the community health centre told Amnesty International: "We transferred her to a district hospital nearby for transfusion because we don't have blood here."

Although transfers between health centres should be free under the government's subsidy policy, the family had to pay for transport. Abdou said: "An ambulance had already been called to transfer her to the hospital. The ambulance driver insisted on receiving 1,500 CFA francs (around US$3.50) before he would start his vehicle. He did not give us a receipt."

Abdou told Amnesty International: "When we arrived at the hospital, Aïcha was still bleeding. Her clothing was soaked with blood and so was the stretcher. The driver helped us carry her to the treatment room. We were given a prescription. We had to pay for the gloves and bleach. I went to buy them with a friend. When we came back, a health worker gave us a new prescription and I bought medicine and pills for a total of 4,500 CFA francs (around US$10). Ten minutes later, a third prescription was given to us for other pills and bottles for 3,500 CFA francs (around US$8)."

Aïcha's husband was then told to get his wife's blood tested: "I first went to the hospital lab where I was told that they could not do the blood test. I was sent to the lab at a nearby health centre specializing in blood tests. It was almost 3am and I had no transport, so I went on foot. It took me an hour to get there. When I reached the health centre, the watchman was asleep. So I woke him up and spent 2,000 CFA francs (around US$4.50) on the test. I quickly went by taxi to the district hospital: the first one broke down and I had to find another, which charged 1,000 CFA francs (around US$2) – the normal fare is less than 200 (around US$0.50) but when taxis see that people are in a hurry, they charge higher prices. It was past 5am when I arrived at the hospital and delivered the blood test results. When I arrived, I didn't find my mother and friends. I was told that they had already left. I thought that Aïcha had felt better and was cured. Then a doctor came. He spoke French to me but once he saw that I did not understand, he addressed me in Mooré.[9] He told me that my wife was very weak and that 'her blood was all gone'. I learnt that she died at 5:18am."

Abdou returned on foot to his home with his newborn baby. Abdou's mother, who used to live in a village, came to live with her son in order to take care of the baby.

As this story shows, even when a woman lives in Ouagadougou, close to a health facility, her access to vital treatment can be undermined by lack of essential medical services, including blood, and by unofficial and arbitrary costs. Families are in practice being charged significant sums for medicines and other medical services that should be subsidized under the 2006 subsidy policy.

All the barriers met by pregnant women in Burkina Faso increase the three critical delays[10] that add to the risk of maternal death: the delay in making the decision to seek care, the delay in reaching the health facility and the delay in receiving treatment at the health facility.

- **Delay in the decision to seek care:** in Burkina Faso, women usually depend on their husbands or their in-laws to take the decision to go to a health centre.

- **Delay in reaching care in time:** the barriers of distance and cost prevent many women from reaching the health facility in time. In rural areas, distances between communities and health centres can be very long and roads are poor. Bicycles and donkey carts are often the only available means of transport.

- **Delay in receiving adequate treatment:** inadequate provision of health services and a frequently poor and slow referral system combine to delay life-saving treatment. The barrier of cost is often critical as in many emergency cases women and their families are asked to pay large sums for medicines and supplies that are officially free of charge or subsidized.

While the government has made efforts to reduce these delays, the high rate of maternal deaths in Burkina Faso shows that women are being denied their right to health, a right enshrined in international and national law, a right that every state is obliged to respect, protect and fulfil. When women die in pregnancy or childbirth because the government fails to address preventable causes of maternal death, the government violates women's right to life.

Poverty is a key factor in maternal mortality. Burkina Faso is ranked as one of the poorest countries in the world,[11] with 46.4 per cent of its population living below the national poverty line[12] and 80 per cent living in rural areas where the infrastructure is often inadequate.

However, this cannot justify the government's failure to meet its obligation to take steps to the maximum of its resources to realize the right to health (including sexual and reproductive health) for all its population, notably those living in poverty. In its 2008 report to the Human Rights Council's Working Group on the Universal Periodic Review, the government of Burkina Faso recognized its responsibility to respect and realize fundamental economic, social and cultural rights, while stressing the economic constraints it faces. It stated, "While underdevelopment should not be considered an

excuse for a State not fulfilling its responsibility to realize human rights, it must be acknowledged as a real brake and genuine constraint on the realization of many rights."[13]

In its fight against maternal mortality, the government of Burkina Faso is supported by the donor community which contributes to the health budget and also supports specific projects aimed at improving access to health care. This report acknowledges the efforts to address maternal mortality undertaken by the government with the help of the donor community, as well as projects led by international and national NGOs.

OBJECTIVES OF THIS REPORT

This report examines preventable maternal mortality as a violation of the right to health and ultimately of the right to life. It focuses on:

- The need to respect and ensure women's right to gain access to sexual and reproductive services;

- The need to dismantle the barriers that obstruct women's access to adequate health care, including barriers of cost that continue to deter or prevent the poorest women from benefiting from skilled assistance at the time of delivery and emergency obstetric care when necessary;

- The need to improve the quality of care by ensuring skilled attendance at deliveries, within an environment capable of providing care for normal deliveries and emergency obstetric care when complications arise;

- The need to ensure accountability of the government in respect of its obligation to devote the maximum possible resources to ensure the highest attainable standard of health for all pregnant women, in particular ensuring that emergency obstetric care and skilled birth attendance are available, accessible, acceptable and of good quality throughout the country, including in rural and poor areas.

In conclusion, the report presents recommendations to the government, the international community and donors to entrench progress and tackle maternal mortality with greater consistency and, more generally, to enhance respect for women's rights. Amnesty International calls for improvements in access to and information about sexual and reproductive services and health; the removal of financial barriers to health services, especially for the poorest; and improvements in the quality of care and training of medical personnel so that the right to health for women is fully respected.

METHODOLOGY

This report is based on four fact-finding missions to Burkina Faso since July 2008 and on the work of a consultant who carried out research for three months in the country. Amnesty International visited health facilities and met medical personnel in several cities including the capital, Ouagadougou, as well as Bobo-Dioulasso, Ouahigouya and Kaya. Amnesty International also visited a dozen rural areas throughout the country.

In the course of its research Amnesty International investigated more than 50 cases of women who died during pregnancy and childbirth. Its delegates interviewed family members, health care staff, and members of the community, and collected hospital and health care records on the cases where available. Amnesty International also spoke to ministers and staff from the Ministries of Health, of Human Rights, of Promotion of Women and of Finance, staff from UN agencies, national and international NGOs, bilateral and multilateral donors, as well as researchers and public health specialists.

This study focuses only on public health facilities – there are also private health structures operating in the country.[14]

Statistics mentioned in this report are drawn mainly from official data sources, notably the Demographic and Health Survey (DHS), published every five years.[15] Every year the government publishes detailed statistics on the health sector,[16] but these figures have to be treated with caution since many people, especially in rural areas, do not use the formal health system when they are sick and do not declare births and deaths. Therefore the official statistics (including those based on hospital figures) only give a partial picture of the real situation in the country. This report uses UN statistics only when national figures are not available.[17]

Several independent specialists have read and commented on this text on a voluntary basis, including scholars Véronique Filippi from the London School of Hygiene and Tropical Medicine, Fabienne Richard from the Institute of Tropical Medicine in Antwerp and Valéry Ridde from the University of Montreal (CRCHUM).

For the sake of confidentiality and to protect witnesses and contacts, all names and locations have been changed or omitted.

2/WOMEN'S STATUS IN BURKINA FASO

'FOR MEN, A WOMAN IS ONLY A TOOL FOR REPRODUCTION'

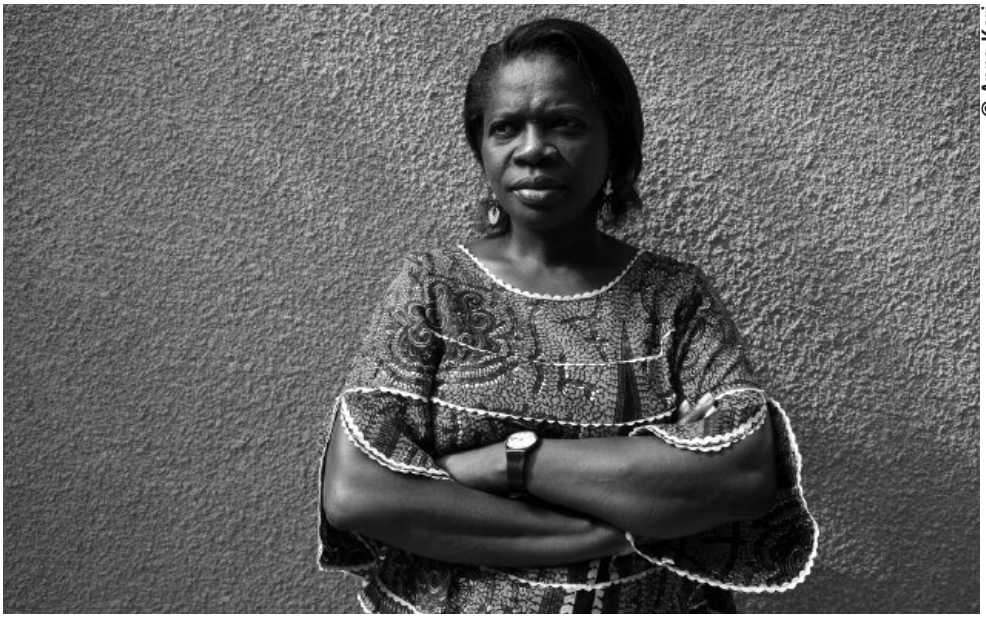
A woman from the village of Gorgaré, June 2009

The government has adopted many laws aimed at improving the status of women and has ratified the relevant international treaties. However, women in Burkina Faso continue to suffer from discrimination in every area of their lives. Particularly in rural areas, women have little or no say in key domestic decisions.

Burkina Faso's Constitution and laws prohibit all forms of discrimination, including on grounds of gender. However, there is no specific legislation that defines what constitutes discrimination against women and the legal provisions assuring women's equality have had limited impact, due notably to the continuing influence of religious and customary laws.[18] Religious and customary laws have officially had no legal effect in family relations since the adoption of the 1990 Individual and Family Code (Code des personnes et de la famille). However, the government has acknowledged: "the persistence of certain traditional and religious practices that put women at a disadvantage, including the levirate [the practice of marrying a widow to her deceased husband's brother], under age and/or forced marriage, excision [female genital mutilation] and the reluctance to send girls to school."[19]

The 2005 Concluding Comments of the UN Committee on the Elimination of Discrimination against Women (CEDAW Committee) stressed the Committee's concerns about: "the continuing strong prevalence of patriarchal attitudes and deep-rooted stereotypes and of customs and traditions that discriminate against women, particularly women in rural areas, and constitute violations of their human rights."[20]

Women are marginalized in many areas of society and have unequal access to education, health care and employment. In 2007, the literacy rate for women and girls was only 21 per cent, compared to 36.7 per cent for men and boys.[21]



Ini Damien, who founded an organization that works to improve women's quality of life in the region of Gaoua, Burkina Faso. This NGO promotes knowledge of reproductive and health rights, addressing both men and women, using the medium of theatre.

WOMEN'S STATUS IN THE FAMILY

Women are primarily valued as wives and mothers, especially in rural areas. Unmarried women are seen as ill-fated and of little worth. Married women without children face discrimination and are at risk of being abandoned or rejected by their husbands and in-laws.

There are heavy cultural pressures from the community on women to have many children, seen as a sign of wealth. This is especially true in rural areas where the fertility rate is 6.9 children per woman, as compared with 3.7 in urban areas. The national average is 6.2.[22]

Ramatoulaye and her baby daughter by the Nakambe river close to Wonko, Burkina Faso. Four months earlier she was forced to give birth on the river bank because there was no boat available to take her across.

Fatou was subjected to domestic violence because all her children were girls.

Fatou, a housewife and petty trader living not far from Bobo-Dioulasso, had a very difficult life with her husband because he was unhappy with her for only giving birth to girls. She had seven pregnancies and gave birth to five girls. At the birth of one of her daughters some years ago, Fatou asked the medical personnel and the women accompanying her not to reveal the baby's sex until her husband had paid the bills. When he learned that it was a girl, he left, very angry. Later on, her husband took a second wife who gave him a son. While under customary rules the first wife retains a prominent place, Fatou was forced to play a secondary role in the family.

In 2007, at the age of 41, Fatou again became pregnant. After a sonogram revealed that she was expecting another girl, her life became even more difficult. A friend told Amnesty International in March 2009: "Her husband continuously yelled at her. Life was not bearable anymore and she decided to flee her home and found refuge at my home in Ouagadougou. The journey took six hours by bus and she arrived exhausted and afraid in the evening." Fatou eventually died in childbirth at the university hospital in Ouagadougou.

'THE FIRST TO GET UP IN THE MORNING AND THE LAST TO GO TO SLEEP'

Amnesty International collected many testimonies describing the hard daily lives of women, especially in rural areas where they are generally expected to bear their normal workload while pregnant or just recovering from childbirth.

Sarata died in childbirth, having worked until the last day of her pregnancy.

Sarata lived in a rural area not far from Ouagadougou, and was married at the age of 17. None of her first four children survived for more than six months. She became pregnant again at the age of 26 in 2006 – her fifth pregnancy in nine years.

Her friend told Amnesty International: "She worked until the very last day of her pregnancy helping her husband with the farming, which normally begins around 7am. But beforehand, she prepared the meal, at around 6am. When she got back from the fields around 2pm, she had her meal and then rested for a moment before returning to work in the field until 6pm. Outside of the rainy season, she used to sell pancakes at the market. During her pregnancy, I asked her to rest, but she responded that she could not, because she would be teased for not having any children."

She worked until the very last day before delivering and had no time to go to the CSPS. One night she had pains and a while later, around 4am, she gave birth in her home. She was taken by motorcycle to the CSPS and then to the university hospital in Ouagadougou where she was diagnosed with puerperal infection (an infection that occurs after childbirth, due to poor sanitary conditions), severe malaria and eclampsia. She died on arrival at the hospital, before receiving any treatment.

FEMALE GENITAL MUTILATION

The practice of female genital mutilation (FGM, or excision) has been prohibited by law in Burkina Faso since 1996 (under Articles 380 to 382 of the Penal Code) and women accused of practising FGM are from time to time prosecuted and sentenced to prison terms. However, due to the persistence of traditional practices and customs, it is still practised clandestinely in insanitary conditions, and is a major cause of death and disability.[23]

Fatimata cycles to get water at the end of the day. Women, especially in rural areas, are expected to continue their normal work regardless of pregnancy and childbirth.

Some studies indicate that the practice of FGM can lead to difficulties in labour and other complications of pregnancy. For example, the WHO study group on female genital mutilation and obstetric outcome found that: "deliveries to women who have undergone FGM are significantly more likely to be complicated by caesarean section, postpartum haemorrhage, episiotomy, extended maternal hospital stay, resuscitation of the infant, and inpatient perinatal death, than deliveries to women who have not had FGM."[24]

EARLY MARRIAGES AND PREGNANCIES

Early marriages have serious consequences for girls; they lessen the chance of girls attending school while increasing the risk of early and life-threatening pregnancies.

Since 1990, marriage and family matters have been governed by the Individual and Family Code. Article 238 sets the minimum age of marriage at 17 for girls and 20 for boys, which may be reduced to 15 for girls and 18 for boys.[25] In its 2004 report, the

CEDAW Committee stressed its concerns "about the persistence of several discriminatory provisions in the [Individual and Family] Code, particularly in relation to the minimum age of marriage."[26]

This provision only applies to civil marriages. In rural areas, many people marry according to traditional rules with no minimum age, and girls as young as 10 are often married. An official study recently found that the age of marriage was most often between 10 and 19, although the majority of teenagers living as a household were married when they were between 14 and 19.[27] In addition, young women in rural areas are more likely to bear children, with 157 per thousand rural adolescents becoming mothers, compared with 64 per thousand in urban areas.[28]

Early pregnancies entail a number of risks. Young girls who bear children before their pelvises are fully developed often suffer complications, including obstructed labour. Where these complications do not result in death, they may cause chronic injury such as fistula – perforations in the birth canal that permit leakage from the bladder or rectum into the vagina.[29]

POLYGAMY AND FORCED MARRIAGE

Polygamy is legal and widespread in Burkina Faso. Article 232 of the Individual and Family Code provides that monogamy is the common law form of marriage and permits polygamy only when the spouses agree to that option before the wedding ceremony. But when women cannot in reality take any important decision within the couple, it is the man who chooses whether a marriage will be monogamous or polygamous.

Forced marriages are forbidden by law: Article 16 of the Individual and Family Code enshrines the right of men and women to choose their spouse. However, as acknowledged by the government in 2004, "In reality forced marriages are common owing to ignorance of the relevant rules by victims and the constraints of customs, religion and other factors."[30]

The custom of the levirate, under which a widow has to marry a relative (usually the brother) of her late husband, is prohibited by the Individual and Family Code and the Penal Code. Despite this, it is still practised in Burkina Faso, especially in rural areas.

WOMEN'S LACK OF POWER

Although women have equal status under the law,[31] in practice most are subordinate to the men in their lives and are unable to make key decisions, including the timing and spacing of their pregnancies. Women are embedded in a vicious circle with little access to education or to information on sexual and reproductive rights, and are subject to early marriages, female genital mutilation and polygamy as well as being expected to work long hours while pregnant or after childbirth.

Women are well aware of the dangers of pregnancy, as nearly everyone knows a relative or friend who died or suffered complications in pregnancy and childbirth. Several women told Amnesty International that young girls in rural areas used to wish each other "not to have the misfortune of being pregnant". However, their access to information on reproductive rights and services is extremely restricted.

Women's lack of power, linked to economic dependence and subordinate status, means that women who need their husband's permission and funds to obtain health care have to adopt bargaining strategies. In a qualitative study published in 2007, three researchers identified the techniques adopted by women in Burkina Faso: "Typically, the process is gradual. First, they will adopt strategies that respect the husband's authority; only when these have been exhausted would they resort to defiance."[32] These bargaining strategies include offering to make a contribution (if the wife has savings), turning to mediation through in-laws, and confrontation, where the woman reminds her husband of his responsibilities towards her or threatens to return to her parents. As a last resort, the woman can return to her family's home, but as the authors of the study stressed: "Confrontation occurs from time to time. Returning to the paternal home is rare."[33]

In order to make pregnancy and childbirth safer, the government of Burkina Faso has to move beyond formal equality before the law and make greater efforts to give women access to information and education in order to empower them to claim their rights and the public services they are entitled to.

In the absence of government leadership, a growing number of women in Burkina Faso have created NGOs in the last two decades to inform women of their rights, especially their sexual and reproductive rights. These NGOs include professional organizations of nurses and midwives as well as associations of women activists.

Examples of NGOs raising awareness of sexual and reproductive rights

The Women's Promotion Association (Association pour la promotion féminine), founded in 1992 by Ini Damien, a schoolteacher, has more than 400 members working to improve women's quality of life. This NGO promotes knowledge of reproductive and health rights, addressing both men and women, using the medium of theatre. Ini Damien told Amnesty International in June 2009: "The government's messages of awareness have not gone through in a population which remains deeply illiterate."

Juliette Compaoré, who also created an NGO for the defence of women rights, had herself been confronted by traditional rules which restrict women's freedom. "My uncle wanted to impose a husband on me but I refused because he was not the man of my choice. Then problems started because I was 'the peasant who refuses the prince' as my uncle said. It drove me to create a NGO for the promotion of women's rights because I realized that the Ministry of Health does not have the means to lead a communication policy among the population." Juliette Compaoré created in 1994 the organization ASMADE,[34] which has campaigned to raise awareness on sexuality among young people and to promote the adoption of the Law on Reproductive Health. "We fight now so this law is made a reality so all women have their say on matters of reproductive health."

3/GOVERNMENT POLICIES

'THE REDUCTION OF MATERNAL MORTALITY IS A PRIORITY'

Ministry of Health of Burkina Faso, 2006 "Roadmap"[35]

The authorities have given special attention to combating maternal mortality. Their policies, strategies and actions were developed and implemented in the context of Millennium Development Goal 5 (MDG-5) adopted by the UN in 2000.[36] This stipulates a reduction in maternal mortality of 75 per cent by 2015, which for Burkina Faso would mean achieving a maternal mortality ratio of 142 deaths per 100,000 live births.[37] However, in its 2003 report on progress towards the MDGs, the government stressed that "this international goal seems very ambitious for Burkina Faso which, considering the strategies it wishes to develop, aspires to reach a ratio of 209 deaths per 100,000 live births by 2015."[38]

INCREASING BUDGET ALLOCATION

For the past decade the authorities in Burkina Faso have devoted increased financial resources to the health sector. In 2001, the authorities committed themselves to "increase the portion of the health budget in the total budget by 10 per cent per year until it reaches 12 per cent."[39] The proportion of the budget allocated to health grew from 6.3 per cent in 2001 to 8.42 per cent in 2008.[40]

Budget figures for 2006[41]

■ Health budget	7.8 per cent of the total budget
■ Reproductive health budget[42]	5.99 per cent of the health budget, 0.47 per cent of the total budget
■ Maternal health and family planning budget	4.67 per cent of the reproductive health budget, 0.02 per cent of the total budget
■ EmONC budget	11.44 per cent of the reproductive health budget, 0.05 per cent of the total budget

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An 18-year-old woman in severe pain is calmed by a medical student while she waits for a caesarean. During the operation, in which her daughter was safely delivered, the birth cord was found to be tightly wound around the baby's neck. Yalgado Hospital, Ouagadougou, Burkina Faso.

However, the authorities have recognized that the percentage of the health budget "remains under the WHO standard (10 per cent)."[43] Moreover, it remains far behind the 15 per cent goal set by the African Heads of State at the AU Summit in Abuja in 2001.[44]

POLICY FRAMEWORK

The government's current health policy stems from the National Health Policy adopted in September 2000[45] and its implementation plan, adopted in July 2001, the National Health Development Plan (PNDS, Plan national de développement sanitaire 2001-2010). The aim of the Plan is to reduce morbidity and mortality through eight global objectives such as increasing the coverage of national health services, improving the quality, financial accessibility and use of health services, and improving the management of human resources in the health sector.[46]

Official goals and results according to governmental statistics

The National Health Development Plan (PNDS) set up the following goals to reduce maternal mortality. In 2008, some of them had been met, according to official statistics.

Goal: 40 per cent reduction in maternal mortality.

Result: The maternal mortality ratio went from 484 per 100 000 live births in 2001 (DHS 2003) to 307 per 100,000 live births in 2008 (RGPH 2006), a 36.5 per cent reduction.

Goal: Increase in women undertaking prenatal visits from 65 to 90 per cent.

Result: By 2008 75.25 per cent of pregnant women undertook at least one prenatal visit.

Goal: An increase in assisted births from 34 to 60 per cent.

Result: In 2008, the level of assisted deliveries was 65.19 per cent.

Goal: An increased prevalence of contraceptive use from 6 to 17 per cent.

Result: Although showing an increase, figures differ on contraceptive prevalence (see Chapter 5).

It should be noted that these official statistics are incomplete, in particular because of gaps in information on rural areas and the failure to record births and deaths that take place outside medical facilities.

In order to increase the coverage of national health services, the National Health Development Plan provides that in rural areas there should be one CSPS (Centre de santé et de promotion sociale, community health centre) per 10km radius, and in highly populated areas, one per 10,000 inhabitants. The Plan also contains provisions to improve the quality of health personnel, through the redeployment of personnel, the implementation of incentives, punishing misconduct, the development of training programmes and the creation of an ethics committee. Lastly, the Plan provides that generic drugs should be made more available through better supervision of the supply and distribution of medicines in all districts.[47]

In a landmark move to reduce the economic obstacles to women's access to health care, the government adopted in 2006 a subsidy policy for childbirth and emergency

obstetric care, including caesarean sections. This subsidy strategy – the National strategy of subsidy for deliveries and emergency obstetric and neonatal care[48] – was fostered and facilitated by the World Bank and is one of the priority actions of the Poverty Reduction Strategy Framework adopted by the government in 2000.[49] Its main purpose is to limit the impact of payments for medical care on the incomes of poor households.

Under the subsidy strategy, women are entitles to have the costs of delivery subsidized by 80 per cent, indigent women (women living in extreme poverty) should receive free care in childbirth, and transport between different health facilities should be free for all women in labour (see Chapter 7).

Within the framework of its health care policy, the government of Burkina Faso prioritized the extension of geographical coverage by increasing the number of CSPS from 798 in 2000 to 1,352 in 2008.[50] This reduced the average distance to a health facility from 9.4km in 2000 to 7.5km in 2008.[51]

However, there are still enormous disparities between urban and rural areas (see Chapter 6).

The government of Burkina Faso is resolutely in favour of using exclusively generic medicines. In 1992, a central drug procurement and distribution agency, CAMEG,[52] was created with the aim of generalizing the use of generic medicines and improving the supply of drugs in rural areas. The quality of these medicines is regularly checked and their use plays a key role in the government's efforts to control health costs.

Under this policy, all public health facilities receive generic medicines distributed by the CAMEG and cannot sell non-generic branded medicines.

ORGANIZATION OF THE HEALTH SYSTEM

The health care system in Burkina Faso is divided along administrative borders into 13 regions and 63 health districts. Each district covers a population of 150,000 - 200,000 people.

There are three levels of health care: primary, secondary and tertiary.

- Primary health care is provided by the Centre de santé et de promotion sociale (CSPS, Health and Social Promotion Centre) at the community level and by the Centre médical avec antenne chirurgicale (CMA, Medical Centre with Surgical Services - hereafter district hospital) at the district level. The CSPS provides maternal and child health care as well as running prevention and promotion activities. The district hospital

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The delivery room at Kiembara health centre, Burkina Faso. More than a third of all births still take place without medical assistance.

is the first reference level for pregnant women with complications. In 2008, there were 1,352 CSPS and 42 district hospitals.[53]

- Secondary health care is provided by nine Centres hospitaliers régionaux (CHR, hereafter regional hospitals) which are referral hospitals.

- Tertiary health care is provided by three Centres hospitaliers universitaires (CHU, hereafter university hospitals) – two of which have maternity units, one in Ouagadougou and one in Bobo-Dioulasso, the country's second largest city.[54]

There are also some private clinics and treatment institutions, especially in the cities.

The three-level health system was facilitated by a policy of decentralization implemented by the government since the early 1990s. National and regional hospitals have progressively been given greater autonomy in terms of financial and personnel management. In 1994, hospitals and health centres were allowed to retain funds collected from fees and the sale of drugs. Elected local Health Service Management Committees,[55] COGES, were set up. These committees are composed of members of the community, including women,[56] with medical personnel as

advisers, and are responsible for the management of the retained funds. Twice a year these Committees have to account to the community and are audited by a District Management Team including an account supervisor and a chemist.

TRADITIONAL BIRTH ATTENDANTS AND AUXILIARY MIDWIVES

The government has developed in recent years a new policy towards traditional birth attendants ("matrons" or *accoucheuses villageoises*), who assist women giving birth within the community. In December 2007, the Ministry of Health stated that it intended to "refocus" their role from carrying out deliveries to preparing women for childbirth by identifying the place of delivery, namely the nearest CSPS, and by making sure that reliable transport is available to take the woman to the health centre for the birth or in case of complications.[57]

In order to improve the quality of care at the local level, the authorities also decided to deploy auxiliary midwifes (*accoucheuses auxiliaires*) in every CSPS. Auxiliary midwives require a basic elementary school-leaving qualification[58] and receive two years' training at the national school of public health.[59] The auxiliary midwifes carry out prenatal check-ups, in the course of which they identify and treat symptoms of maternal problems such as high blood pressure, anaemia and malaria, and they are responsible for normal deliveries[60] in the CSPS. They have to be capable of recognizing the signs of complications during childbirth, so that they can refer the woman to a higher level health facility as quickly as possible.

In December 2007, the government also published a plan to set up village-level management teams for obstetric and neonatal emergencies in some pilot zones. These teams of two or three community members would be responsible for raising awareness of danger signs and enhancing preparations for childbirth by families and the community. They would also work to improve the referral system by developing communications and transport to reduce delays in transfers.[61]

These efforts succeeded in increasing the number of medically assisted deliveries – the official proportion of assisted deliveries rose from 37.7 per cent in 2005 to 65.19 per cent in 2008, according to official figures.[62] While this is positive, more than a third of all deliveries still take place without medical assistance, with a much lower proportion of medically assisted deliveries in rural areas.[63]

4/THE HUMAN RIGHTS FRAMEWORK

'HEALTH IS A FUNDAMENTAL HUMAN RIGHT INDISPENSABLE FOR THE EXERCISE OF OTHER HUMAN RIGHTS. EVERY HUMAN BEING IS ENTITLED TO THE ENJOYMENT OF THE HIGHEST ATTAINABLE STANDARD OF HEALTH CONDUCIVE TO LIVING A LIFE IN DIGNITY.'

UN Committee on Economic, Social and Cultural Rights, General Comment 14, para 1

The obligation on states to progressively realize the right to the highest attainable standard of health is enshrined in various international and regional instruments to which Burkina Faso is a party. The treaties ratified by Burkina Faso that guarantee the right to health include the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Convention on the Rights of the Child and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol).

The preamble to the Constitution of Burkina Faso refers to the Universal Declaration of Human Rights (UDHR) and reasserts the country's commitment to international treaties and to the African Charter on Human and Peoples' Rights (ACHPR). Articles 1 and 26 of the Constitution of Burkina Faso confer on every person the right to life and the right to health.

THE RIGHT TO HEALTH

The Committee on Economic, Social and Cultural Rights (CESCR) has stated that the right to health requires that health and health care facilities, goods and services be available, accessible, acceptable and of good quality.[64] This means that:

- A sufficient quantity of health facilities, trained professionals and essential medicines must be available.

- Health facilities, goods, services and information on health must be physically and economically accessible (within easy reach and affordable) to everyone without discrimination.

- Health facilities, goods, services and information must be acceptable, that is respect medical ethics, be culturally appropriate and sensitive to gender requirements.

- Health facilities, goods, services and information must also be scientifically and medically appropriate and of good quality. This requires, among other things, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment and adequate sanitation.

PREVENTABLE MATERNAL MORTALITY IS A VIOLATION OF THE RIGHT TO LIFE

Preventable maternal mortality is also recognized as a violation of the right to life as enshrined in the International Covenant on Civil and Political Rights (ICCPR). The Human Rights Committee urges states to take positive measures to safeguard individuals from arbitrary and preventable losses of life.[65] This includes steps to protect women against the unnecessary loss of life related to pregnancy and childbirth[66] by ensuring that health services are accessible.[67] In addition the CEDAW Committee has issued a number of General Recommendations that further develop this right. In its General Recommendation on Health, it states that women's access to health care services, "particularly in the areas of family planning, pregnancy, confinement and during the post-natal period"[68] is imperative. The Committee's recommendations support the claim that there is a governmental duty to ensure that all women have access to maternal care, pre and postnatal care, emergency obstetric care, and family planning.

MATERNAL HEALTH IS A RIGHT

The right to maternal health is part of the right to health. The UDHR, the ICESCR, the CEDAW, the ACPHR and the Maputo Protocol specifically obligate governments to protect maternal health.[69] Under these agreements, the state has an immediate duty to ensure that the right to health is realized and enjoyed without discrimination of any kind by providing access to "a full range of high quality and affordable health care, including sexual and reproductive services."[70]

The ICESCR contains the most comprehensive provisions regarding this right. In its Article 10(2), it states that "special protection should be accorded to mothers during a reasonable period before and after childbirth."

In November 2008, the African Commission on Human and Peoples' Rights adopted a resolution to address maternal mortality in Africa.[71] The resolution acknowledged that preventable maternal mortality in Africa is a violation of women's right to life, dignity and equality as enshrined in the ACHPR and the Maputo Protocol. It calls on African governments to address, individually and collectively, the issue of maternal mortality.

THE RIGHT TO NON-DISCRIMINATION

Most human rights treaties guarantee women the right to equality and non-discrimination. Pregnancy and childbearing impose "inequitable burdens" on women, particularly in relation to access to education and employment. This perpetuates women's inequality, which is further reinforced by discriminatory practices such as early marriage and stereotyped views on women's role as procreators. The CEDAW states that "the role of women in procreation should not be a basis for discrimination."[72]

Article 12 of the CEDAW requires states to "eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services."[73] Women suffer from both direct and indirect forms of discrimination in attempting to obtain health care. Certain groups of women face not only gender discrimination, but discrimination on such bases as economic status, geographic location and age. Under Article 14 of the CEDAW, governments must make special efforts to ensure that women in rural communities are not disadvantaged, particularly regarding "access to adequate health care facilities, including information, counselling and services in family planning."[74]

In addition, the ACHPR declares that all individuals are "equal before the law" and requires states to "ensure the elimination of every discrimination against women and also ensure the protection of the rights of woman and the child as stipulated in international declarations and conventions."[75] The Maputo Protocol also calls upon states to reform laws and practices that discriminate against women.

Furthermore all children are entitled to enjoy the highest attainable standard of health,[76] just as adults are,[77] and the Convention on the Rights of the Child explicitly guarantees children the right to be free from discrimination.[78] Under the principle of non-discrimination, adolescents should enjoy the same rights to reproductive health services as adult women.

SEXUAL AND REPRODUCTIVE RIGHTS

Sexual rights are human rights and are recognized in international human rights standards.[79] They include the right of all people, free of coercion, discrimination and violence, to the highest attainable standard of sexual health, including access to sexual and reproductive health care services.

Everyone is entitled to:

- seek, receive and impart information related to sexuality
- education related to sexuality
- respect for bodily integrity
- choose their partner
- decide to be sexually active or not
- consensual sexual relations
- consensual marriage
- decide whether or not, and when, to have children
- pursue a satisfying, safe and pleasurable sexual life

Reproductive rights enable all people to decide freely the number, spacing and timing of their children and to have the information and means to do so. They also guarantee all people the right to attain the highest standard of sexual and reproductive health free of discrimination, coercion and violence. These rights relate to access to reproductive health services and information, safe pregnancy and childbirth, prevention and response to unwanted pregnancy, and freedom from forced sterilization, contraception or abortion.

Sexual and reproductive rights are central to the realization of every individual's human rights. Respect for these rights is essential to human dignity and to the enjoyment of physical, emotional, mental and social well-being. Their fulfilment enhances life and personal relationships and helps to achieve gender equality and empowerment. All people must be allowed to enjoy their sexual and reproductive rights free of coercion, discrimination and violence.

5/FAMILY PLANNING

'IF UNMET NEEDS WERE SATISFIED, CONTRACEPTIVE PREVALENCE COULD REACH 43 PER CENT OF WOMEN OF CHILDBEARING AGE; I.E. THREE TIMES HIGHER THAN THE ACTUAL RATE.'

Ministry of Health, January 2009[80]

More than 5,000 women died in Burkina Faso between 1995 and 2000 as a result of pregnancies that were unintended,[81] according to a statistical analysis published in 2002.[82] Such a large number of deaths is strongly correlated throughout the world with inadequate access to family planning information and services as well as early and forced marriages. Early, mistimed and unwanted[83] pregnancies contribute greatly to the health risks for both the woman and the baby. Faced with an unwanted pregnancy, many women, especially unmarried girls, resort to unsafe and life-threatening abortions.

Ensuring access to voluntary, safe and effective family planning and contraceptive methods is therefore a vital part of any strategy for reducing maternal mortality. The CEDAW guarantees the right of women, on the basis of equality with men, to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.[84] The CEDAW Committee has emphasized the obligation of states to "prioritise the prevention of unwanted pregnancy through family planning and sex education and reduce maternal mortality rates through safe motherhood services and prenatal assistance."[85]

The government of Burkina Faso has acknowledged the importance to every human being of enjoying her or his sexual and reproductive rights. In December 2005, it adopted a Law on Reproductive Health[86] that enshrines these rights. This law states that "The right to reproductive health is a fundamental right guaranteed to each human being during her or his entire life, in all situations and in all places" (Article 8) and that "couples and individuals decide freely and responsibly the number of children they have as well as the spacing of their births" (Article 9). Four years after the adoption of this law, the government passed two decrees on the creation of private reproductive health structures and on the production and import of contraceptive products.[87]

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A 45-year-old mother of five in the recovery ward after a caesarean to remove her twins who had died due to complications at seven months. Yalgado Hospital, Ouagadougou, Burkina Faso.

In practice, although modern contraception was introduced in Burkina Faso in the late 1980s, its use remains very limited, especially in rural areas. The inadequacy of sexual and reproductive health services in Burkina Faso was noted by the CEDAW Committee in 2005, when it called on the government "to improve the availability of sexual and reproductive health services, including family planning… [and to] enhance availability of contraceptive services."[88]

In December 2005, the government adopted a Contraceptive Security Strategic Plan (2006-2015). Its main objectives include the state gaining independence from donors in the purchase of contraceptives, guaranteeing that contraceptives are available to all women and that family planning services are of good quality.[89] A broader plan for all products related to reproductive health, the Reproductive Health Products Security Strategic Plan (2009-2015), was adopted in June 2009 and assessed the achievements to date and the remaining gaps in this area (see Chapter 10). It emphasized the use of female condoms as a way to improve reproductive health.[90] As a result, training programmes on this method of contraception have started in some regions, with dummies purchased in order to demonstrate their use.[91]

USE OF CONTRACEPTIVES REMAINS LOW

While there is great variability and uncertainty in the statistics on contraceptive use, all available figures indicate that the proportion of women who use contraception has at least doubled in the last 15 years. The DHS 2003 found that the rate had risen from 8 per cent in 1993 to 14 per cent in 2003. This survey stated that only 14 per cent of women in a relationship (one in seven) were using some method of contraception at the time of the survey: 9 per cent were using a modern method, primarily injections (3 per cent) and the contraceptive pill (2 per cent) and 5 per cent were using a traditional method, primarily periods of abstinence (3 per cent).[92]

Figures published recently by the UN indicate that the contraceptive prevalence rate is 17 per cent for women aged between 15 and 49.[93]

This low rate means that the contraceptive needs of many women remain unmet. In its report to the CEDAW Committee submitted in February 2004, the Burkina Faso government estimated that 42.4 per cent of married women had an unmet need for contraception.[94]

BARRIERS TO THE USE OF CONTRACEPTIVE SERVICES

An auxiliary midwife working at a rural CSPS told Amnesty International in March 2009 that:

"The attendance rate for family planning consultations is low compared to the population. In rural areas, women of childbearing age often don't know the methods of modern contraception or they don't trust them as they are afraid of becoming sterile or of being affected by other side effects. In fact, many women in rural areas want a high number of children as this is beneficial in the traditional social and economic organization but they want the pregnancies to be spaced; so instead of modern contraception, they prefer post partum abstinence and use notably a natural method called *"le collier"* [the necklace – a string of plastic beads of different colours representing the fertile and infertile days of the menstrual cycle]. Cost can be another obstacle. Some women attend the initial consultation but don't return after that because they have to pay for the products and they don't dare ask their husband. Husbands are often an obstacle because some men believe contraception leads to infidelity. Fertility is one means of monitoring women's fidelity."

This testimony highlights some of the overlapping barriers to women's access to contraception in Burkina Faso. As well as lack of information, often giving rise to misplaced fears, there are cultural barriers, notably the opposition of husbands and

the social condemnation of extramarital sexuality. In focus groups organized by Amnesty International, both married and adolescent unmarried women described women suspected of having sexual relations before marriage as *"dévergondées"* (loose or debauched). There are other structural barriers: the inadequate quality of family planning services, the lack of availability and cost of contraceptive products and, at least until recently, a lack of funding by the government and the donors who had other priorities.

INADEQUATE INFORMATION ON SEXUAL AND REPRODUCTIVE RIGHTS

Official statistics indicate that knowledge of modern contraception has increased. According to the DHS 2003, in 1993, 63 per cent of married women said they knew about modern contraceptive methods, rising to 89.4 per cent in 2003, and 91.1 per cent among men.[95] However, this stated knowledge does not mean that women are able to use these methods, especially in rural areas. This is confirmed by the DHS 2003: "Contraceptive prevalence for all the methods is 3.4 times higher in urban zones (34 per cent) than in rural areas (10 per cent) and more than 5 times higher as regards the modern methods (28 per cent against 5 per cent)."[96] The DHS also shows that women with a higher level of education are more likely to use contraception.[97]

However, information collected by Amnesty International indicates that many women still suffer both from a lack of general information on sexual and reproductive rights and on specific medical information related to contraception methods. A large number of women interviewed by Amnesty International, especially in rural areas, had not heard of the Law on Reproductive Health or were unfamiliar with its main provisions, notably the right "to decide freely and responsibly the number of children they have as well as the spacing of their births."[98] Moreover, some people told Amnesty International that they were finding it difficult to get information about contraception from medical personnel or family planning services.

Although the right to information about family planning is enshrined in the 2005 Law on Reproductive Health,[99] the government has not launched the nationwide, comprehensive awareness raising campaign needed to make this a reality. The Contraceptive Security Strategic Plan for 2006-2015 called for a Communication Plan to raise awareness on family planning, especially among men,[100] which started in 2007. A campaign was carried out to encourage people to use family planning services and to rally civil society actors on this issue, but it does not seem to have covered the whole country.

The lack of information on sexual and reproductive rights and contraception is especially key for young people, many of whom told Amnesty International that they did not have the information they needed about family planning. Several girls who

participated in a focus group discussion in Pissy (a neighbourhood of Ouagadougou) said that the classes offered in school were insufficient and overly abstract. The inadequacy of information for young people was stressed by the CEDAW Committee which recommended to the government of Burkina Faso in 2005 "that sex education be widely promoted and targeted at girls and boys, with special attention to the prevention of early pregnancies and sexually transmitted diseases."[101] The UN Special Rapporteur on the right to health has also emphasized that "women should have equal access, in law and fact, to information on sexual and reproductive health issues."[102]

In order to improve the education of the general public, notably young people, local NGOs such as the Association burkinabè pour le bien-être familial (ABBEF, Burkinabè Association for Family Welfare) carry out awareness-raising programmes in communities.

ABBEF: raising awareness among young people

Within the framework of its campaign to promote sexual and reproductive health, ABBEF offers advice on family planning, gynaecological consultations and confidential consultations in the 13 regions of the country.

This NGO has set up Centres d'écoute pour jeunes (Listening centres for young people). In Koupela, 140 km east of Ouagadougou, for example, teenagers and young people are welcomed to the listening centre and are given advice in confidence. In 2008, the number of people who benefited from this service increased by 27 per cent from 1,397 to 1,783. Of the 1,007 adults, 826 were women and of the 776 young people, 680 were girls.

QUALITY CONCERNS IN FAMILY PLANNING SERVICES

Women who want information and contraceptive products have to go to local health facilities. A male nurse working in a rural CSPS told Amnesty International in June 2009:

"Women can come every day, we receive them and present them the different methods of contraception and, if needed, we make some gynaecological exams to see what methods suit them better. At our community level, we can prescribe them pills or condoms and we can carry out injections and implants. But we cannot place an intra-uterine device so we refer them to the nearby district hospital."

However, family planning services are often inadequate both in terms of quality of information and confidentiality. Amnesty International gathered evidence from several local NGOs and women indicating that the personnel in charge of informing women about contraceptive methods often fail to give sufficient information about the different methods and do not tailor their advice to women's individual needs. In a focus group in Ouagadougou in July 2009, several women said that the public family planning services were often run by men who tried to deter them from using contraceptives. They also complained about a lack of confidentiality.

In some cases, medical personnel refused to give information to adolescents because they were "too young". An auxiliary midwife working in a rural CSPS told Amnesty International in March 2009 that "sometimes medical personnel tell adolescents who come for a consultation about contraception that it is not for girls their age and that they should go home."

During a focus group discussion in Pissy, several young female students said that they were reluctant to seek information about family planning in health centres as they were "likely to meet their parents or neighbours". This is of particular concern for the young and unmarried women, and for women who do not want their husbands to know they are seeking contraception.

This lack of privacy is a strong deterrent against seeking contraceptive advice. The issue of discretion is even more sensitive in rural areas where it is impossible for an adolescent girl to visit a health centre for advice without that fact being known. Married women with children can seize the opportunity of child consultations to ask questions discreetly.

By failing to ensure that women are able to receive health care services in a manner that respects their confidentiality, the government inhibits women's access to contraceptives.

CONTRACEPTIVE PRODUCTS NOT ALWAYS AVAILABLE

Since the launch of the Contraceptive Security Strategic Plan (2006-2015), the government has made a concerted effort to improve the availability of contraceptives by contributing a significant part of the budget to the purchase of contraceptive products.[103] It has also sought to provide health centres with better teaching and technical materials in order to reinforce the skills of health providers.[104]

In the CSPSs visited by Amnesty International, contraceptive products were apparently available and staff said that when there were shortfalls the products were immediately ordered and quite quickly provided. But Amnesty International also heard that in some locations, notably in remote areas, contraceptives are sometimes not

available for long periods. Amnesty International learned, for example, that in Koupela a shortage of male condoms during 2008 seriously undermined family planning campaigns. These temporary shortages have serious consequences, increasing the risk of sexually transmitted infections, including HIV, as well as unwanted pregnancies. These supply shortages have been acknowledged in the Reproductive Health Products Security Strategic Plan, which points to failures in logistics and information management leading to "risks of disruption in the supply chain, expiration [of contraceptive products due to delays], damage in transit or overstocking of contraceptives." The Plan explains that "there is no national plan for the supply of products."[105]

COSTS ARE AN OBSTACLE TO CONTRACEPTIVE USE

The cost of contraceptives is a barrier to women without independent sources of income. Although consultations at public health centres are free, contraceptives must be purchased at a subsidized price of 25 per cent of the cost. Male condoms cost 10 CFA francs each (around US$0.02), female condoms cost 100 CFA francs (around US$0.20), the pill costs 100 CFA francs per monthly pack, injectable contraceptives[106] cost 500 CFA francs (around US$1, four per year), a contraceptive implant[107] costs about 1,000 CFA francs (around US$2, renewable every three or five years) and an intra-uterine device costs 800 CFA francs (around US$1.60, renewable every 10 years).

The information gathered by Amnesty International indicates that the cost of buying contraceptives dissuades many women from using them, especially in rural areas, where women do not have money. A male nurse from a rural CSPS told Amnesty International:

"For the poorer populations, the cost of contraceptive products is a real obstacle. Some women who chose the injections [that need a shot every three months] don't come back for the second shot as they couldn't collect the money. Others choose the pills as it's the least expensive method but it's risky as they can be lost, forgotten or found by the husband."

Cost is an often insuperable barrier for young girls who depend entirely on their families. One adolescent in a town 100km north of Ouagadougou said: "I often have to manage to find the money to buy contraceptives and I have to hide them because we [women who use contraceptives] are considered loose."

RESISTANCE FROM HUSBANDS OR OTHER RELATIVES

In many cases documented by Amnesty International, husbands or other male family members were opposed to contraceptive use. During a focus group discussion with women in Pissy, a 26-year-old mother of four said that she hid her birth control pills in her kitchen because she knew that her husband never went in there. The choice of contraceptive product can be determined by the necessity to hide it. A male nurse in a rural district said that "many women prefer to choose injectable contraceptive products or contraceptive implant even if it's more expensive as with the pills there are daily constraints and it may be very difficult to hide them from their husband."[108] Amnesty International heard of cases where husbands denounced medical personnel for providing contraceptive products and advice to their wives. During their visit to a rural area in March 2009, Amnesty International's delegates were informed by an auxiliary midwife that the week before a man had come to the CSPS to admonish staff for prescribing a contraceptive for his wife.

Opposition to contraception is often rooted in the traditional role assigned to women and the value placed on children as a source of wealth. It is therefore very difficult for a married woman to choose when to have a child. The husband of a woman who died in April 2008 two weeks after giving birth told Amnesty International:

"At the beginning of our relationship, my wife wanted to use condoms, but I refused because I wanted to have a baby while I was still young. I also desired a child because I told myself that if I was married, I would take good care of my wife. I wanted to give my wife a place within my family: when a woman has a child, she can have this place. This is our tradition."

A woman living in Ouagadougou told Amnesty International in March 2009 that:

"after seven pregnancies and five live children, I told my husband that I wanted to use contraceptive methods but my husband refused and told me that if I did this, I should return to my mother's home. I therefore had to obey him."

These two testimonies show how difficult it is for women to negotiate contraceptive use, which is essential to the realization of their sexual and reproductive rights.

INADEQUATE FINANCING OF FAMILY PLANNING

For many years, family planning programmes in Burkina Faso have been suffering from a lack of financial resources. In its Contraceptive Security Strategic Plan (2006-2015), the Ministry of Health stated: "the financial partners and the government who usually provided the contraceptives considerably decreased and even interrupted their assistance in favour of other areas which they consider a priority such as malaria, tuberculosis and AIDS."[109]

However, both governmental officials and donors told Amnesty International that in the past few years, family planning has again become a priority, with the state willing to become financially independent from donors for the purchase of contraceptives. For example, the government spent 359 million CFA francs in 2006, 410 million CFA francs in 2007 and 450 million CFA francs in 2008 (around US$820,000, 940,000 and 1 million).[110] However, the cost of contraceptive products is still currently 70 per cent financed by international partners (with UNFPA contributing 80 per cent of the total provided by donors) and 30 per cent by the national budget.[111]

CLANDESTINE AND UNSAFE ABORTIONS

The lack of information and gaps in access to contraceptive methods partially explain the high number of clandestine abortions in Burkina Faso. These abortions are carried out outside public health centres, often in unhygienic conditions and by untrained practitioners.

Although exact statistics are impossible to determine, the number of clandestine abortions is high. UN statistics published in 2002 indicate "that five per cent of all women admitted to maternity wards in hospitals in Burkina Faso had serious complications resulting from illegally induced abortions. Of these, 70 per cent were between the ages of 16 and 24 and 80 per cent were students or unemployed."[112]

According to more recent official statistics for the year 2008, complications arising from clandestine abortions represented 6.3 per cent of maternity cases treated at the district level (1,214 out of 19,400 cases) and 11.6 per cent of the cases treated in regional and university hospitals (277 out of 2,381 cases).[113] These figures only cover women who had access to treatment in health facilities for post-abortion complications.

The real figure of clandestine abortions leading to serious health problems is certainly much higher. Official statistics do not take into account the women who do not go to health facilities after an unsafe abortion. Moreover, women do not admit to clandestine abortions and it can be difficult to differentiate an induced abortion from a spontaneous miscarriage.

Augustine suffered serious complications after an unsafe abortion.

Augustine, aged 25, lived during her childhood in Abidjan, Côte d'Ivoire, and returned to Burkina Faso with her family when she was 12. Living in the streets with no resources, she became pregnant and tried to obtain an abortion. Amnesty International met her in February 2009 after she had three sessions with an "illegal abortionist", followed by three dilations and curettages (D and Cs) at a hospital in Ouagadougou. Her life was in serious danger.

Augustine told Amnesty International: "I did not want to keep the baby. I went to see a man so that he would help me get rid of my pregnancy. He took an iron bar and tried to get rid of the baby. But it didn't work. I returned again and he started over again with the iron bar on the inside. I returned a third time but after that it was too painful. I paid him a total of 15,000 CFA francs (around US$34). I did not go back. I was losing a lot of blood. I had a lot of pain on my right side. Finally, I went to a hospital in Ouagadougou. I was suctioned, but everything didn't come out. So I had to start over, and there was still debris inside after the second time. I also had two sonograms. Yesterday morning [February 2009], I again had a lot of pain on my right side. But I did not have any way to get to the hospital, so I had to go get my brother so that he could take me there on his motorcycle. The nurse told me to take 'cytotec' (a product used to open the cervix of the uterus in order to permit the evacuation of debris)."

When Amnesty International met her, Augustine was still suffering from persistent pains in her lower abdomen.

ABORTION: THE LEGAL FRAMEWORK

The government modified its legislation on abortion in 1996 to reduce the number of associated maternal deaths.[114]

Under the 1996 amended Penal Code, abortion is classified as a crime, and a person who carries out an abortion is liable to between one and five years' imprisonment and a fine of 300,000 to 1,500,000 CFA francs (around US$685 to 3,430). However, abortion is allowed if the life of the pregnant women or of the unborn child is in danger and in cases of rape and incest.

Article 387 of the Penal Code states: "Voluntary interruption of pregnancy is allowed at all times during pregnancy if two physicians attest that the continuance of the pregnancy endangers the health of the woman or that a strong possibility exists that the unborn child will be afflicted with a condition of exceptional seriousness recognized as incurable at the time of diagnosis. Moreover, in a case of rape or incest established by the State prosecutor, a woman is authorized to request a physician to perform an abortion during the first 10 weeks of pregnancy."

The provisions allowing women to terminate a pregnancy in these circumstances are complex and difficult to meet.

For therapeutic abortions, two doctors have to attest to the danger of continuing the pregnancy. This can be an insuperable obstacle for women living in rural areas, since CSPSs are not staffed by doctors, so women have to travel to a hospital, which can be difficult and costly.

In cases of rape or incest, the requirement that the public prosecutor establishes that the crime has been committed appears to be a particularly intimidating and deterrent condition in a context where women victims face serious risks of stigmatization.[115]

The government appears to have done very little to inform the general population of the legal provisions allowing abortion under certain circumstances and most of the women met by Amnesty International in rural areas were not aware of these provisions.

The Special Rapporteur on the right to health has emphasized that: "The right to health, including sexual and reproductive health, encompasses both freedoms, such as freedom from discrimination, and entitlements. In the context of sexual and reproductive health, freedoms include a right to control one's health and body."[116]

The Special Rapporteur on the right to health has also stated that: "Women with unwanted pregnancies should be offered reliable information and compassionate counselling, including information on where and when a pregnancy may be terminated legally. Where abortions are legal, they must be safe: public health systems should train and equip health service providers and take other measures to ensure that such abortions are not only safe but accessible. In all cases, women should have access to quality services for the management of complications arising from abortion. Punitive provisions against women who undergo abortions must be removed."[117]

During an Extraordinary Assembly in Nigeria in October 2009, Health Ministers of the Economic Community of West African States (ECOWAS) called for the passage of safe abortion laws as part of efforts to reduce the high maternal mortality rate in the sub-region.[118]

AMNESTY INTERNATIONAL'S POSITION ON ABORTION

Amnesty International believes that where women's access to safe and legal abortion services and information is restricted, their fundamental human rights may be at grave risk. Amnesty International therefore calls on states to prevent and end grave abuses of women's human rights in accordance with state obligations under international human rights standards and to:

- repeal all laws which permit the imprisonment or any other criminal sanction on women who seek or have an abortion, and all other laws which provide for imprisonment or other criminal penalties solely for those providing information about or carrying out abortions;

- provide access to medical services for complications arising from abortion to all women in need in any circumstance, regardless of the legal status of abortion;

- take all necessary measures to ensure that safe and legal abortion services are available, accessible, acceptable and of good quality for all women who require them in cases of pregnancy as a result of rape, sexual assault or incest and pregnancy which poses a risk to the life or grave risk to the health of the woman.

Amnesty International does not take a position on any other aspects of abortion.

6/HEALTH FACILITIES HARD TO REACH

'HEALTH FACILITIES, GOODS AND SERVICES MUST BE WITHIN SAFE PHYSICAL REACH FOR ALL SECTIONS OF THE POPULATION'

UN Committee on Economic, Social and Cultural Rights, General Comment 14, para 12(b)

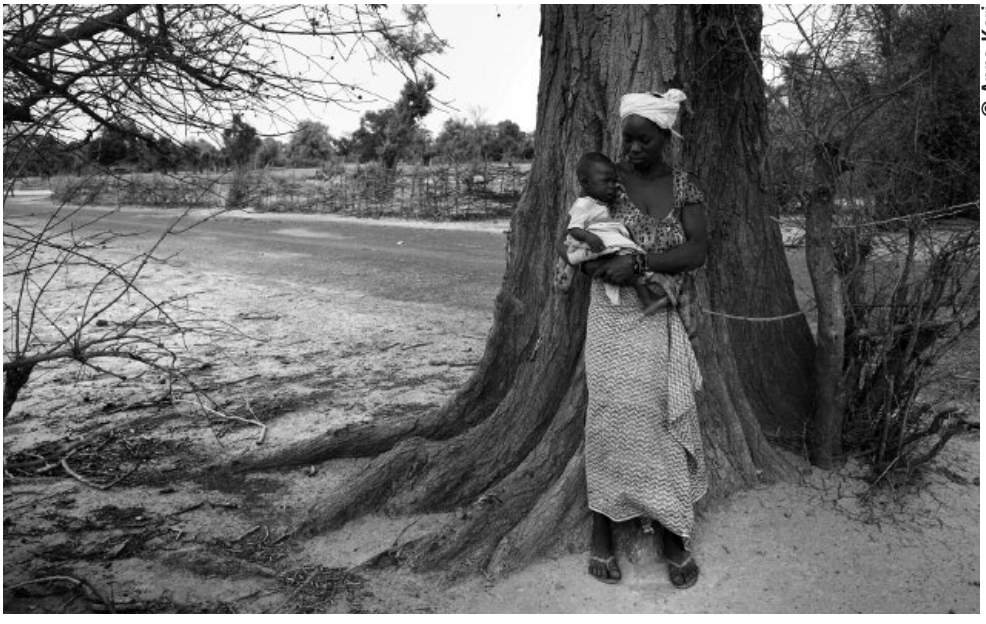
Health care facilities are often far from people's homes, especially in rural areas, and transport is unreliable and expensive. Although the government has increased the number of CSPSs in recent years, enormous disparities continue to exist between urban and rural areas. In the Central Region, which includes the capital Ouagadougou, 98 per cent of the population live less than 10km from a health centre, while in the Sahel Region only 50 per cent live within 10km.[119]

An official map of health facilities for 2007 showed that the districts containing the three largest cities (Ouagadougou, Bobo-Dioulasso and Ouahigouya) had far shorter average distances than remote areas in the east and the north.[120] Moreover, by 2008, 11 districts across Burkina Faso still had no district or regional hospital.[121] Two regions around the capital (Central South and Central Plateau) have no regional or university hospital, but depend on the university hospital in Ouagadougou.

The combination of the inequitable distribution of health facilities, especially the CSPSs, the poor road conditions and the absence of a transport network means that many women face significant barriers if they seek access to health services and facilities.

DIFFICULT JOURNEYS

Amnesty International investigated a number of cases where pregnant women had difficulties in reaching health facilities in time because of long distances, weather conditions (notably during the rainy season[122]), geographical obstacles such as rivers, and the lack of reliable and affordable transport. The government's stated policy is to refocus the role of traditional birth attendants towards identifying the place of delivery and ensuring reliable transport to take the woman to the health centre for the birth or in case of complications. However, so far no transport system has been put into place, and women's families have to organize their own transport reach the health



A woman and her seven-month-old son, pictured by the tree where she gave birth. Women in rural areas often cannot reach a health facility in time.

facility. There is no ambulance system to help transport women to a CSPS, even in an emergency. The ambulance system, where it exists, only operates between the CSPS and other health facilities.

Few roads are paved beyond the cities and major arteries, and they are not well maintained. In rural areas, women rarely have access to any means of transport and have to rely on husbands and relatives, or on the generosity and solidarity of villagers. In general, women usually walk or are transported by bicycles, motorcycles or donkey carts to the health centres. This can be dangerously slow, especially during the rainy season when roads are muddy.

Maternity ward, Ouahigouya regional hospital, Burkina Faso.

Ramatoulaye had to give birth on her own on the bank of a river.

Ramatoulaye, a 25-year-old housewife, lives in a rural village in the district of Séguénéga. She had her first child at the age of 12, giving birth at home assisted by a traditional birth attendant. She told Amnesty International that during her later pregnancies, she had been encouraged to go to the CSPS in Ramsa, 12km from her village, for prenatal visits and to give birth. To reach Ramsa she had to take a boat to cross a deep river.

She told Amnesty International that during her fourth pregnancy, in March 2009, "I started to have my first pains. My husband's brother drove me with his motorcycle, my husband followed us on another motorcycle. Once arrived on the bank of the river, we looked for the boatman but he was not there because he also has another job. But without him, no other person can help you to cross the river because it's deep and it is impossible to cross it by foot. Thus I gave birth alone on the banks of the river. It was very difficult. After my delivery, the boatman came back and I was able to get on the boat to go for treatment in the CSPS in Ramsa."

Safiatou died while trying to reach a health centre after delivering at home.

Safiatou, 26, married her cousin Hamidou when she was 14 years old. They lived in a village about 100km south of Ouagadougou, where they farmed livestock. She already had four children when she became pregnant again in 2007.

According to the nurse who saw her some days before her delivery, in May 2008, Safiatou had not attended prenatal visits. She only went to the CSPS (some 12km from her home) at the end of her pregnancy and she stayed there for 48 hours because she was very weak and was suffering from anaemia. The nurse said that he impressed upon her and her husband the importance of taking iron (provided free of charge) and that Safiatou should deliver her baby in the health centre.

Safiatou's husband told Amnesty International: "The day of her delivery, she was in good health and worked all afternoon as usual without any problem. She prepared tô [a local dish made from maize flour] for her children and went to get the hay for the animals. In the evening, when her labour began, she left for her mother's home. Her mother came to warn me that she was not well, that we had to take her to the clinic. I do not have a motorcycle, so I had to go and get one. That made us lose time." The husband added that he "did not know that she should have delivered at the clinic. When I came to fetch her at her mother's house, she had lost consciousness."

The husband borrowed a small motorcycle from his neighbour, but it did not have any fuel and the closest gas station was 10km away. They had to first push the motorcycle for 10 km… Safiatou ended up delivering at home, but there was placenta retention and serious haemorrhaging.

Her husband asked a friend to help him take Safiatou to the CSPS but she died on the motorcycle 4km away from the health centre. The friend told Amnesty International: "When I arrived, Safiatou was delirious; she could no longer stand on her feet. Her husband was afraid of driving her on my motorcycle. So we put her on the motorcycle between us. It was 2am when we left. There are three small ravines before you reach the CSPS. Each time, we had to get off the motorcycle and then get back on, and with Safiatou, it was not easy… At some point, Safiatou wasn't moving anymore, we understood that she had died. We did not go to the CSPS. We decided to take an easier road, to return to the village with the body."

Safiatou left five boys, aged 11, nine, seven and four, and the newborn baby. Since her death, the children spend their days with their maternal grandparents and sleep at their paternal family's home. Safiatou's father was devastated by the death of his daughter. The Amnesty International delegates were told that since then he "no longer gets up, he does not sleep and he almost doesn't eat any more."

The geographical and other barriers encountered by pregnant women explain the low number of assisted deliveries in rural areas. For example, in the area covered by a rural CSPS in the district of Tougan, official figures indicate that in 2007 the average rate of assisted deliveries was 11.22 per cent for communities within 5km of the health centre but only 4.05 per cent for communities more than 10km away.[123]

Faced with these difficulties, many women resort to the services of traditional birth attendants even though officially they are no longer supposed to deliver babies. A traditional birth attendant in a village some 30km west of Ouagadougou told Amnesty International:

"The authorities asked me to stop carrying out the deliveries but if there is nobody, I have to do it. Last Tuesday [8 July 2008], a woman had pains, it was bucketing down and because of the big rains, roads were impracticable and as the family had only a cycle it was impossible to bring her to the health centre. I was called at midnight by the husband. I went with my scarf but I had no tools. The woman was shouting. I asked to switch on a light, they brought me a kerosene lamp, I examined her, her water had just broken and the amniotic liquid had gone out. I asked them to put her on a tablecloth. I delivered her with my hands, without gloves. It went well, it was a girl."

Under the CEDAW, Burkina Faso is under an obligation to ensure access for rural women to adequate health care facilities, including information, counselling and services in family planning.[124] Both the CESCR and the CEDAW Committee have clarified that the realization of women's right to health requires the removal of all barriers interfering with access to health services.[125] The CEDAW Committee has stated that "barriers include… distance from health facilities and absence of convenient and affordable public transport."[126]

The CESCR has also emphasized that states are under a core obligation to ensure the equitable distribution of all health facilities, goods and services and also the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups.[127] The government is therefore under a duty to prioritize those groups, who face the greatest barriers realizing their rights, when allocating resources.

OTHER BARRIERS

Pregnant women also have to overcome another obstacle. Women in labour are generally accompanied by members of the family or by friends. Being alone during childbirth is seen as socially unacceptable, and a woman's companions have a number of tasks to perform, such as washing clothes and feeding her.[128] However, if the pregnant women arrives "too early" at the health facility, she may be asked to return later, which may annoy her companions and make them reluctant to accompany her again.

A housewife who sells mil (a small-seeded cereal) in a rural village told Amnesty International:

"Two years ago, during my fourth pregnancy, I was at the market very early in the morning when I started to feel pain. Friends working in the market agreed to accompany me in a cart to the CSPS, 7km from there. It took more than two hours to reach the CSPS. But the [auxiliary] midwife said to me that it was much too early. On returning to the village, my friends made me understand that they had wasted time to accompany me pointlessly. I continued to have pain but I did not dare to ask them any more to come along. Finally, one evening, the pain was unbearable and I had to deliver at home with a traditional birth attendant."

7/COSTS AS A BARRIER TO HEALTH CARE

'HEALTH FACILITIES, GOODS AND SERVICES MUST BE AFFORDABLE FOR ALL'

Committee on Economic, Social and Cultural Rights, General Comment 14, para 12(b)

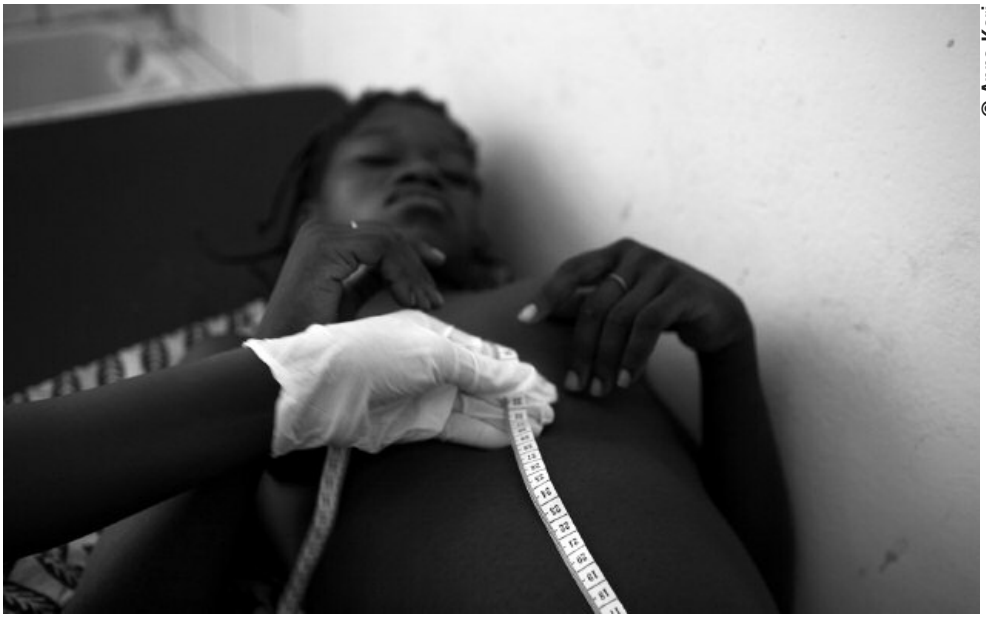
"It cost too much for a poor man like me"

Albertine, a 25-year-old mother of two children, died in January 2007 at a regional hospital 200km north of Ouagadougou.

Albertine's brother-in-law, who farms during the rainy seasons and also works in the mines, told Amnesty International in July 2008: "Her husband was not in the village when her labour pains started and I took her by motorcycle to the CSPS, 15km from our village. I paid at least 5,000 CFA francs (around US$11.50) for medicines but the medical personnel told me that they could not do anything, that she needed to be hospitalized at the regional hospital. As I had given them all the money I had, I brought back Albertine to our village. But the next day, she was still having labour pains and after borrowing some money I took her to the hospital."

"I was told that Albertine needed a blood transfusion and I was given a prescription costing around 20,000 CFA francs (around US$46). I don't know whether this money was to buy blood or medicines. After the transfusion, Albertine seemed to be doing better. The next day she gave birth to a stillborn baby."

"On the third day, she was suddenly very cold. She was given a prescription and I paid 15,000 CFA francs (around US$34) to buy her injections and medicine. On the fourth day, she had a relapse; I was given a new prescription for new medicines costing 12,000 CFA francs (around US$27.50) but I didn't have any more money. So I had to go to the village and back. On the fifth day, I came back with the money and paid for the medicines but Albertine had died in the meantime. I did what I could to save my sister-in-law but it cost too much for a poor man like me."



An 18-year-old woman in labour in a new clinic in Gorgare. This is her first child and she is accompanied by her aunts who wait outside. Health centre (CSPS) in Gorgare, Burkina Faso.

In many parts of world – especially, but not solely, in developing countries – cost has been identified as a significant barrier to people's access to health care. The case of Albertine clearly shows how costs can deter or delay medical treatment, endangering the life of a pregnant woman.

People have paid directly for medical care in Burkina Faso since the 1980s. The Bamako Initiative,[129] a policy adopted by African health ministers designed to raise revenue for health care and increase efficiency in the use of health services by, among other things, imposing and decentralizing control of user fees, stimulated the government to put in place a uniform pricing system throughout the country in 1993. At the same time, however, conscious of the fact that this system of direct payments creates an impassable barrier to people living in poverty, the government adopted several policies to allow waivers or subsidies in some cases.[130] Prenatal visits were made free for all women in 2003.[131] The government also announced a policy to waive all payments from those unable to pay (so-called "indigents") in accordance with one of the principles of the Bamako Initiative aimed at "ensuring that the poorest have access to primary health care".

THE 2006 SUBSIDY POLICY

The decision made in 2006 to subsidize emergency obstetric and neonatal care (EmONC) was taken in a context of general willingness to reduce financial barriers to health care. This policy was prepared with the support of the World Bank, which played a key role.[132] The subsidy policy is funded by the national budget with a planned budget close to 30 billion CFA francs (around US$68.5 million) for the period from 2006 to 2015, of which 5 billion CFA francs (around US$11.5 million) was to be devoted to giving free care to pregnant women deemed indigent.[133] The policy began to be implemented in October 2006 for caesarean sections and in January 2007 for other deliveries.

The main components of the subsidy policy

- 80 per cent of the cost of deliveries and caesarean sections is covered by government subsidy, with women paying the remaining 20 per cent. The subsidized payments from patients are meant to cover parts of the costs of medical services, drugs and supplies needed for the delivery. Complications and postnatal care during the first week after the delivery are also covered by this policy.
- Transport between a CSPS and a referral hospital is free for all pregnant women.
- The subsidy covers the entire health costs for indigent pregnant women.

Under this policy, deliveries are subsidized by 80 per cent.[134] Patients have to pay 900 CFA francs (around US$2) for normal deliveries, 3,600 CFA francs (around US$8) for complex deliveries and up to 11,000 CFA francs (around US$25) for caesarean sections or for treatment of a complication during the delivery. This sum covers the cost of medical services and a kit containing the drugs and supplies (such as sterile gloves and syringes) needed for a normal delivery or for a caesarean section.[135]

The subsidy policy only comes into effect when the pregnant woman arrives at the health care centre. Transport costs between home and the care centre can be a real barrier for women in poverty, but are not taken into consideration in this policy.

However well elaborated on paper, this policy subsidy suffers from several severe shortcomings. In every case studied by Amnesty International since the policy was implemented, the families said that they had paid more than the amount outlined in the policy. Many families said that they had to pay for gloves because the medical staff did not have any more, as well as other products or medicines. Moreover, almost all had to buy bleach to clean the delivery room.

Some midwives and doctors continue to prescribe branded medicines, rather than generic drugs as required by national policy. An expert told Amnesty International:

"The whole system of subsidized kits that contain the drugs and supplies for the deliveries relies upon the use of generics. However, some doctors continue to prescribe patented drugs that are available in a generic form which means that the families have to go to private pharmacies outside the health facilities and spend much more."

Women's families are therefore forced either to pay for branded medicines or to forgo potentially life-saving treatment, although equivalent generic medicines are usually available free of cost.

The main problems undermining the implementation of the subsidy policy are:

- absence of clear communications to women and health staff about the policy and, notably, lack of clarity on what is subsidized and what is exempted;

- in some districts, failure to implement an effective free referral service between health facilities due to factors such as shortages of ambulances and fuel;

- absence of criteria enabling indigent women to be identified.

In practice, the subsidy policy is also undermined by the fact that health care staff often demand unofficial payments for treatment, supplies or transport.

LACK OF INFORMATION ON THE SUBSIDY POLICY

Many people[136] told Amnesty International that they were not entirely sure which treatments or medical products were free, which were subsidized and which had to be paid for in full.

This has given rise to confusion and suspicion. A midwife told Amnesty International:

"Since the launch of the subsidy policy, there is still an endless conflict between the medical staff and the patients because the masses think that everything is now free whilst several treatments, including blood tests and scans, must still be paid for."

"I don't know why I paid so much money, I was told health care is now free."

In March 2009, Amnesty International investigated the case of a woman who had nearly died two days earlier in a district hospital near Bobo-Dioulasso.

The doctor who treated this woman told Amnesty International: "This woman suffered from high blood pressure, pre-eclampsia, anaemia and malaria. When she arrived at the district hospital, she was feeling dizzy. During her delivery, she was suffering from a haemorrhage due to a cervical rupture. We can consider her to be a near-miss."[137]

Her husband, who sells textiles, told Amnesty International: "I paid a total of 22,500 CFA francs (around US$51.50). My wife followed the three prenatal visits and each time I was asked to pay. I had to pay successively 2,000, 1,000 and 1,000 CFA francs (around US$4.50 and US$2.25) for medicines but I didn't receive any receipt and I don't know whether I should have paid for them."

"I was then given two prescriptions for medicines I bought at the pharmacy, which cost me 3,875 CFA francs and 1,750 CFA francs (around US$9 and US$4). When we reached the hospital, I was told I had to buy gloves and serum for which I paid 650 CFA francs (around US$1.50). I was then asked to pay for bleach in order to clean the delivery room. I then bought a kit for the delivery that cost 3,600 CFA francs (around US$8) and then after the delivery I was given another prescription and I had to pay 2,250 CFA francs (around US$5). I've still got to pay the hospital bills which are likely to be expensive because my wife has been hospitalized for a whole week. I don't know why I paid so much money, I was told health care is now free."

According to the subsidy policy, this man should only have had to pay 3,600 CFA francs (around US$8) for the delivery. The prenatal visits and some of the medicines given during those visits should have been free. The remaining costs linked directly to the delivery, including gloves, medicines and hospitalization costs during the first week after the delivery, are normally covered under the subsidy policy. Amnesty International was not able to find out whether these payments stemmed from real stock shortages or not.

The widespread confusion over what the subsidy policy covers allows extortion of money by medical staff.

A recent study found that "only 2 per cent of the budget allocated for the implementation plan was devoted to the communication of the policy to the general public."[138] That money was largely spent on radio programmes and local meetings. Two years after the beginning of the policy, notices were put up in French in many health facilities showing what is subsidized and the prices to be paid by patients. However, the notices do not include several treatments which patients still have to pay for, and in any event a large proportion of the population cannot read.

NO FREE TRANSPORT BETWEEN HEALTH FACILITIES

One important aspect of the subsidy strategy is that transport between the primary health care centre and the referral hospital is provided free of charge. However, Amnesty International has collected information on a number of cases where families had to pay for this transfer. In some cases, ambulance drivers or medical personnel appear to have taken advantage of the urgency of the situation to demand money. In others, the family had to pay for fuel for the ambulance.

These costs, added to the price of drugs, can lead to delays in transferring women to hospital for emergency care.

Awa, aged 26, died in September 2007.

Awa, who married when she was 17, became pregnant for the fifth time and gave birth at a CSPS in September 2007. She then had severe pains in her stomach. Another wife of Awa's husband told Amnesty International: "She was seen by a midwife's assistant, who prescribed her medicines, for which we paid the sum of 11,250 CFA francs (around US$26). I don't know what medicines we had to buy."

A nurse told Amnesty International that "after delivering a stillborn baby, she was swimming in her own blood. An uterine revision was done and she was kept under observation. Her husband opposed this observation because he said that he didn't have enough money to buy any medicines." She was taken home in the afternoon at around 4pm.

Early the next morning, her family brought her back to the CSPS. She was given a prescription but the medicines were not available at the health centre store and the family had to pay 5,750 CFA francs (around US$13) to get them.

That afternoon, at around 2pm, the nurse said that they could not do anything more for Awa and that she had to be evacuated by ambulance to the university hospital in Ouagadougou. As there was apparently no fuel for the ambulance, Awa's husband was asked to pay for it. He said he could not afford this, and the nurse had to negotiate with him for quite a long time until he agreed to pay 5,000 CFA francs (around US$11.50) for the fuel. They left the CSPS at around 4.30pm and arrived at the hospital in Ouagadougou an hour later.

At the hospital, there were no free beds, so she had to lie down on a mat on the floor. One became free at 7.30pm, but Awa died a few minutes later.

The hospital medical records note puerperal infection (an infection that occurs after childbirth), serious malaria and eclampsia.

NO CRITERIA TO IDENTIFY WOMEN ENTITLED TO FREE CARE

According to the subsidy policy, about 17 per cent of the available funds – close to 5 billion CFA francs (around US$11.5 million between 2006 and 2015) – would be used to provide free care to indigent women. However, this part of the policy has yet to be implemented, largely because the government has established no criteria to identify who qualifies as indigent.[139]

In interviews with Amnesty International, the authorities asserted that it was very difficult to determine criteria of poverty and that it was necessary at all costs to avoid abuse of the system. Their fear was that some people would falsely claim to be indigent in order to take advantage of the system.

However, an experiment led by researchers with health workers and community representatives in the Ouargaye district demonstrates that identifying people who should qualify under such schemes is possible. In 124 villages, selection committees were put in place and they were able, without pre-established criteria, to select people that the villagers considered should benefit from free health care.[140]

The lack of political will in implementing this key aspect of the subsidy policy is corroborated by the fact that very little, if any, information on this part of the subsidy policy has been disseminated by the authorities. According to a study carried out in 2008, "Although the state provided that there would be 5 billion CFA francs for indigent people until 2015 under the subsidy policy, the majority of people met in the field as well as some of those at a central level were absolutely not aware of this possibility."[141]

In a country where according to official figures nearly half of the population lives below the national poverty line,[142] the fact that the government has done nothing to identify and address the emergency obstetric needs of the most marginalized women, who would otherwise be unable to afford essential health care, undermines the entire subsidy policy. It also contravenes Burkina Faso's obligation under international human rights law to ensure the affordability of health care and, when allocating resources, to prioritize the most vulnerable and marginalized groups who face the greatest barriers realizing their rights.

UNOFFICIAL PAYMENTS

In the course of its research, Amnesty International collected many testimonies from the families and friends of pregnant women who paid unofficial and illegal sums to medical personnel while seeking medical care.

"If you are poor, you are 'left'; if you can pay, you are treated."

Mariam was 23 when she died in a hospital in Ouagadougou in April 2008, 13 days after delivering a stillborn baby. Mariam lived with her husband, Ali, a motorcycle mechanic, in Ouagadougou. Their first child died at six or seven months. During Mariam's second prenatal visit at a nearby CSPS, they learned that Mariam was expecting twins.

A few days later, they were told that Mariam needed blood tests which cost 3,200 CFA francs (around US$7). Ali told Amnesty International: "Actually, the personnel told us that the ones who did the exams were not there and I understood that we had to pay. I really wanted the exams to be done. As soon as I paid, my wife was able to do the tests."

There were problems during the delivery. One baby was born (he survived), but the second didn't come out. Mariam was then transferred to a hospital where she spent three days.

One week later, Mariam became dizzy and experienced severe headaches. Ali took her back to the hospital. He told Amnesty International: "Mariam was moaning and shaking a lot and several medical personnel told me I had to pay for products, I don't know which ones. I paid several sums amounting to more than 30,000 CFA francs (around US$68.50)."

The following day, Mariam was told that she could go home. Her husband said: "We were getting ready to leave, but Mariam said that she wanted to sleep: she slept from 7am to 7pm at the hospital. But once Mariam was awake, she was not well. She began to shake again and had to be taken back to the emergency ward." Her husband was again given a prescription and had to pay 4,500 CFA francs (around US$10) for a box of gloves.

"They opened them and gave me some. I was not given the other gloves. After waiting for two hours, I went to ask why the treatments had still not begun. I was told that there were sicker patients to treat first. I kept waiting and then asked why they were not taking care of my wife. I was told: 'You must first take care of your patient'. I then realized that I had to pay so that they would take care of my wife: I handed over 5,000 CFA francs (around US$11.50) and then my wife was taken care of."

Ali was given another prescription but he could not find the product. "I asked a nurse for help. She offered to sell me the product that she herself had bought for her mother.

She told me that the product cost 7,000 CFA francs (around US$16) from a pharmacy and that she would sell me it for 4,720 CFA francs (around US$11). I gave her 10,000 CFA francs (around US$23) and she gave me back my change but it was too late, my wife did not use this product, as she had already died."

In total, the delivery and the trips to the hospital cost Ali around 90,000 CFA francs (around US$206).

Mariam's eldest brother said, "my sister died due to a lack of means and adequate treatment. The hospital, it is like a chamber of commerce. If you are poor, you are 'left'; if you can pay, you are treated."

It is clearly forbidden for medical staff to sell medicines, which can only be bought from pharmacies, where receipts should be given, but often are not.

The information collected by Amnesty International shows that two types of corruption are widespread: people are asked to pay to have access to a medical facility or treatment; and people are charged for medical supplies which should be covered under the subsidy policy and which have been misappropriated.

These corrupt unofficial payments take several forms, notably:

- ambulance drivers demanding large sums to transport a woman from a health centre to a hospital although this transfer is officially free under the subsidy policy;[143]

- staff selling medicines and supplies that should be covered under the subsidy policy, citing shortages;

- doctors prescribing branded medicines instead of generic drugs;

- staff demanding money so that a patient will be treated more quickly or diligently, or will be given a hospital bed.

Each of these forms of payment was described to Amnesty International by several different witnesses. For example, the husband of a woman who died in August 2007 of a haemorrhage in a city 200km north of Ouagadougou told Amnesty International:

"The nurse of the CSPS decided that my wife had to be referred to the regional hospital. At that time, our area was not covered by the cell phone network, so I went by bicycle to fetch an ambulance from the regional hospital. The ambulance driver demanded that I pay him 12,000 CFA francs (around US$27.50)

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A woman sits with her daughter and newborn son outside the maternity ward in Kiembara, Burkina Faso.

before he would start the vehicle. I didn't have the money and had to ask a friend which delayed our departure."

Anxiety and uncertainty when complications arise during childbirth make families vulnerable to extortion. In addition, as a researcher who investigated the issue of corruption in Burkina Faso has stressed, "the asymmetry of information that puts sick, illiterate patients face-to-face with more knowledgeable doctors leads to an informational imbalance that encourages … corruption."[144]

Local NGOs and journalists have consistently monitored and exposed cases of extortion by medical personnel. According to REN-LAC, the National Network to Fight Against Corruption (Réseau National de Lutte Anti-Corruption), the health sector has been for many years seen by the population as one of the sectors most tainted by corruption. In its most recent annual report, published in December 2007, REN-LAC found that the health sector was perceived by the people it surveyed to be the fourth most corrupt sector, after customs, taxes and the justice system.[145]

THE DEBATE AROUND TOTAL FEES EXEMPTION

The issue of providing obstetric care free of charge has been debated in Burkina Faso for several years. Some experts, policy-makers and NGOs have argued for a total fees exemption to ensure greater clarity throughout the system, to allow the most marginalized people living in poverty, especially women, to have access to health care and also to make it more difficult for health staff to demand unofficial payments. Similar debates are also taking place in other countries in Africa and elsewhere.[146]

When elaborating the subsidy policy, in June 2006, the government examined three options: a subsidy of 60 per cent, 80 per cent or 100 per cent of the cost. The government apparently excluded the full fees exemption option not so much on financial grounds, but because of the fear that providing a free service would tend to make the population irresponsible in its use of services. An official document published in June 2007 stated that: "several scenarios were envisioned including one that configured free services. Nevertheless, the idea of subsidy was chosen because according to some findings, free services create less accountability from the recipient."[147]

Several government officials repeated to Amnesty International the view that free health care can be counter-productive because it does not give the public a sense of the value of the services provided.[148]

PILOT PROJECTS PROVIDING FREE CARE

The total fees exemption option is currently being studied in two pilot projects in Burkina Faso, led respectively by the Swiss NGO Terre des Hommes (TDH) and by the German NGO HELP.

The TDH project covers two northern districts. Launched in October 2008, it provides free care for pregnant women, breastfeeding women and children under the age of five. The project, initiated at the request of the European Union, is financed by the European Commission Humanitarian Office (ECHO).

The project provides technical support to all 47 CSPSs and two hospitals in the districts of Tougan (Sahel region) and Séguénéga (Northern region). This support costs close to 25,000 euros per month.

Since the launch of this project, TDH has noted a sizeable growth in the number of people visiting the CSPSs. According to TDH, the increase in Tougan has been 235 per cent, with an 18.6 per cent increase in the number of deliveries in hospital. The population's confidence in the health system has similarly risen.

A representative from TDH told Amnesty International at Ouagadougou in March 2009:

"Our action is operational, it is aimed at developing the pilot experiments in order to demonstrate that total exemption of payment for care for young children and their mothers is possible, in the hope that this experiment will be undertaken again on a larger scale."

TDH sought to increase community mobilization in order to encourage visits to health centres. They have made nurses available to the public, and have assigned a pharmacist to Tougan to manage prescriptions and the reimbursement system linked to the exemption of costs.

TDH have also attempted to resolve transportation problems. One solution (a "health care taxi" pulled by a donkey) has not been successful while another (maternity waiting houses near CSPSs) has worked well.

TDH staff believe that the project has been a success but fear for its future, as a TDH representative explained:

"This project has been designed from the perspective of an A and E (accident and emergency) doctor, it is for the time being financed for 2009 and we hope that this will be continued through 2010 but it is not designed to be followed indefinitely. It is therefore necessary to take lessons from this experiment and see how to perpetuate or even extend it. Otherwise, the enormous expectations that we have created at the heart of the population run the risk of being cruelly disappointed."

The HELP project is running in two districts in Sahel region. After having successfully led a project providing free care for children under the age of five and pregnant and breastfeeding women in Niger, HELP proposed to the Burkina Faso government a similar project in one of the regions where health services are less well used, the Sahel region.[149] This project was launched in September 2007 in the Dori and Sebba districts, with a total of 450,000 inhabitants.

A large information campaign was organized in the villages in order to explain the project. Taking into consideration the lessons learned in Niger, the local health management committees (COGES) were involved from an early stage. The system for reimbursement after consultations provided without charge to patients went through the committees as an integral part of the process. After 10 months of experience, it was established that each consultation for a child cost about 1,200

CFA francs (around US$2.50). For deliveries, HELP met the cost of 900 CFA francs (around US$2) established under the national subsidy policy.

According to an expert who studied the impact of this project:

> **"the first effects are very encouraging. The public's confidence in their health system has recovered and mothers are bringing their ill children a lot earlier than before the launch of this project."**

The use of health services for children under the age of five more than doubled, while deliveries assisted by qualified staff increased by 50 per cent when comparing the 10 months before the project started with the following 10 months.

HELP, in collaboration with TDH and other NGOs, has organized a series of activities aimed at documenting the effects of the fees exemption in order to promote a decision to exempt fees throughout the whole country.

Both TDH and HELP have reported that the projects appear to be reducing the incidence of preventable maternal mortality. While Amnesty International has not verified these results, these models should be investigated and discussed further by the authorities, while reviewing the health policy.

REMOVING FINANCIAL BARRIERS TO MATERNAL HEALTH CARE

The government of Burkina Faso has made real efforts to reduce significantly the cost of maternal health care, but the remaining 20 per cent that has to be paid by the population still poses a barrier for many women needing essential and life-saving treatment. First of all, many women still have to rely on their husbands or other members of their family to pay the subsidized price for heath care. Secondly, this policy is not well understood by the public, leading to confusion and to unofficial payments demanded by medical staff. Thirdly, the most marginalized indigent women do not in practice receive free care as there are no criteria for identifying the women entitled to a total exemption from costs.

A total subsidy for sexual and reproductive health care would therefore greatly contribute to the government's stated goal of ensuring that all pregnant women have access to medically assisted deliveries. As illustrated by the TDH and HELP projects in Burkina Faso, and other projects in Africa, removing costs increases the demand for health services. It also makes the health policy clearer for the population and makes it more difficult for medical personnel to demand unofficial payments.

While in the recent past user fees for health care have been promoted as a means of cost recovery and improving efficiency in service provision, the reality has shown that they are often a significant barrier to access to health services. They often have particularly negative effects on people living in poverty, especially the poorest and most vulnerable, and a have particularly detrimental effect on women living in poverty.[150]

The WHO has also highlighted the negative effects of payments for health care, stating in its World Health Report 2005 that: "Catastrophic payments for health care – which push about 100 million people in the world into poverty every year – occur wherever health services require out-of-pocket payments, there are no mechanisms for financial risk-pooling, and households have a limited capacity to pay."[151]

Even when there are exemptions and waivers to protect those who cannot afford to pay, these have often been found to be unreliable, ineffective, costly and difficult to administer and also open to misuse – with people often not aware that exemptions even exist and that they are entitled to them if they cannot afford to pay for necessary health care.[152]

While fees are still in place in many countries, in recent years a lot of attention has been paid by NGOs, UN agencies and governments to the negative effects of charging fees for essential health services on people living in poverty and the need to provide free health care services where necessary to ensure access.

A report published in June 2009, called *The Global Campaign for the Health Millennium Development Goals 2009 – Leading by Example – Protecting the most vulnerable during the economic crisis*, which was endorsed by a number of countries, UN agencies and institutions, stated that: "Evidence is now mounting for the efficacy of a package of free quality services at the point of care to overcome the inequity that fee-for service inevitably breeds. This is one effective, evidence-based and equitable way to expand access to services to a greater proportion of the population."[153]

Thus there is now an emerging policy consensus that removing fees that present a financial barrier to health services is a key element in achieving universal access to essential health care, with a number of developing countries removing fees and a number of donors committing to support countries to do so with technical and financial assistance. September 2009 saw a donor agreement to support six countries to increase access to free health care: Burundi, Ghana, Liberia, Malawi, Nepal and Sierra Leone.[154] There is also a growing consensus on the vital need to strengthen countries' health care systems in order to prevent avoidable deaths and illness. The removal of user fees therefore needs to be accompanied by additional measures to increase the availability of quality services, which requires an increase in the number of adequately trained and remunerated health professionals and adequate medical facilities and

supplies, in order to respond effectively to increased demand and ensure quality of care.[155]

In Burkina Faso, while the provision of free obstetric care presents evident advantages, many believe that such a policy can only succeed if the management of funds and medical supplies is greatly improved. As a doctor from Burkina Faso told Amnesty International in March 2009:

"Total exemption of costs for EmONC [emergency obstetric and neonatal care] can be the solution, but the problem is knowing how to secure the presence of medical material in the public sector, in other words, how to prevent this material from disappearing and then being sold privately."

A policy for the total exemption of costs for obstetric services, if adopted, should therefore be accompanied by other measures to ensure that it can be implemented effectively and increase access to quality care. To this end, any policy on removing financial barriers to health care needs to be communicated in a timely and effective way to both health facilities and service users, and must be implemented in tandem with the necessary measures to strengthen and improve health care centres, such as increasing the number and ensuring the equitable distribution of adequately trained health care staff, improving staff's working conditions, ensuring the provision of necessary medical supplies and equipment, having an effective referral system and enhancing monitoring and accountability systems in the health care system.

THE RIGHT TO HEALTH AND FINANCIAL BARRIERS

One of the crucial components of the right to health is economic accessibility or affordability. The CESCR has emphasized that under Article 12 of the International Covenant on Economic, Social and Cultural Rights: "health facilities, goods and services must be affordable for all. Payment for health care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households."[156]

The government is also under a duty to prioritize the most vulnerable and marginalized groups, who face the greatest barriers realizing their rights, when allocating resources.

Burkina Faso, as a state party to CEDAW, is under an obligation to take all appropriate measures "to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services" and "to ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation" (Article 12). The CEDAW Committee has interpreted Article 12 of CEDAW to include a requirement on states to eliminate barriers to access to health services such as high fees and to take measures to ensure women timely and affordable access to health services.[157] The Committee has emphasized that it is the duty of states to ensure women's right to safe motherhood and emergency obstetric services and that they should allocate to these services the maximum extent of available resources.[158]

The Special Rapporteur on the right to health has also stated that the right to health entitles women to reproductive health care services, goods and facilities that are accessible physically and economically: "Physical access to, and the cost of, health services often influence women's decisions about whether or not to seek care. In many countries, reducing maternal mortality will depend on making relevant services more accessible, including through expansion of relevant services into underserved areas. It will also often depend on ensuring relevant interventions are affordable."[159]

8/SHORTAGES OF STAFF AND SUPPLIES

'FUNCTIONING PUBLIC HEALTH AND HEALTH CARE FACILITIES, GOODS AND SERVICES, AS WELL AS PROGRAMMES, HAVE TO BE AVAILABLE IN SUFFICIENT QUANTITY WITHIN THE STATE PARTY. THEY WILL INCLUDE, HOWEVER, THE UNDERLYING DETERMINANTS OF HEALTH, SUCH AS SAFE AND POTABLE DRINKING WATER AND ADEQUATE SANITATION FACILITIES, HOSPITALS, CLINICS AND OTHER HEALTH-RELATED BUILDINGS, TRAINED MEDICAL AND PROFESSIONAL PERSONNEL RECEIVING DOMESTICALLY COMPETITIVE SALARIES, AND ESSENTIAL DRUGS.

'… AS WELL AS BEING CULTURALLY ACCEPTABLE, HEALTH FACILITIES, GOODS AND SERVICES MUST ALSO BE SCIENTIFICALLY AND MEDICALLY APPROPRIATE AND OF GOOD QUALITY. THIS REQUIRES, INTER ALIA, SKILLED MEDICAL PERSONNEL, SCIENTIFICALLY APPROVED AND UNEXPIRED DRUGS AND HOSPITAL EQUIPMENT, SAFE AND POTABLE WATER, AND ADEQUATE SANITATION.'

UN Committee on Economic, Social and Cultural Rights, General Comment 14, para 12(a) and (d)

Despite significant efforts by the government to improve health facilities and increase the skills of medical personnel, the quality of emergency obstetric treatment remains largely inadequate and many women do not have access to a skilled attendant at birth. Both factors contribute to the high number of maternal deaths in Burkina Faso.

The health care system suffers from several recurrent problems which have a serious impact on maternal mortality:

- inadequate health infrastructure
- shortages and interruptions of supplies of drugs and medical equipment

A midwife checks a 17-year-old girl who is in the first stages of labour. This is her first child. Lankoué, Burkina Faso.

- recurring blood shortages
- lack of trained medical personnel
- lack of skilled birth attendants

INADEQUATE HEALTH INFRASTRUCTURE

In the 2001 PNDS, the authorities acknowledged that "health facilities and medical supplies have been given until now very little attention in terms of maintenance" and that they should "define a maintenance strategy for infrastructures and supplies."[160] During Amnesty International's four research missions in Burkina Faso, the delegates visited a number of health facilities, nearly all of which were suffering from infrastructural problems.

This 23-year-old woman was referred to a regional hospital for a caesarean three days before this photo was taken. When she failed to recover from the operation she was sent to Yalgado hospital in Ouagadougou, where she was diagnosed with anaemia, hypertension and kidney problems. She was unconscious for most of her stay at Yalgado and was disoriented when awake. She died eight days after this photo was taken on 1 July 2009.

DILAPIDATION AND INSANITARY CONDITIONS IN HEALTH PREMISES

Most of the health facilities visited by Amnesty International had significant infrastructural problems. Some CSPSs visited were very run down, with broken windows and holes in their sheet metal roofs. They suffer flooding when it rains, due to the age of the buildings or a lack of upkeep and maintenance.

Such problems can be found to different degrees at all levels of the health system, from the CSPS to the national university hospitals. During a visit to one of the university hospitals in June 2009, Amnesty International observed that the access roads on the hospital's grounds are not asphalted, and the external corridors leading to the maternity ward are flooded when there is heavy rain.

Health facilities are desperately short of space and Amnesty International saw women in a university hospital who were about to give birth or had just given birth sleeping on the floor in the corridors.

ELECTRICITY SUPPLY

There are recurring and serious problems with the electricity supply for health facilities, especially in rural areas where health centres rely on solar power. In several rural health centres, medical personnel told Amnesty International that the solar panels were damaged and had not been replaced.

An auxiliary midwife working in a rural CSPS said that the solar power batteries only last four hours a day, and that she regularly had to perform deliveries "with a torch held between her neck and her shoulder".

Electricity supply is also a problem in several district hospitals in Ouagadougou. During a research mission in March 2009, Amnesty International delegates learned that a few days earlier the medical personnel of a district hospital in Ouagadougou had to help a woman give birth by candlelight because there was no electricity.[161] This hospital, which has particularly serious infrastructure problems, can barely carry out surgical operations. During a meeting with Amnesty International a few days later, the Minister of Health, Seydou Bouda, acknowledged the problem and said that this district hospital "was undergoing considerable renovation".

WORKING CONDITIONS

Working conditions for staff in surgical units and delivery rooms are extremely difficult because of the lack of basic hygiene and adequate ventilation. Medical personnel complained to Amnesty International about the insanitary conditions, including filthy rooms and toilets that were blocked for weeks at a time.

Amnesty International delegates saw in June 2009 a flooded corridor leading to the surgical unit in one of the university hospitals and they saw cockroaches crawling on the walls of the maternity ward's staff room.

In the country's biggest health facilities, which carry out a large number of caesarean sections, the lack of air conditioning is a major problem. An obstetrician told Amnesty International: "Without air conditioning it is very difficult to operate at such high temperatures since we cannot open the window because of germs."

During meetings with government officials and members of Parliament, Amnesty International raised its concerns regarding the state of the health facilities that it had

visited and echoed the frustrations of medical personnel. All the government officials in charge admitted that they were aware of the situation and a senior member of Parliament said that he had seen some CSPSs "in an unimaginable state of dilapidation with holes in the roof", and explained this was due to budgetary constraints.

Infrastructure and supply issues in 10 community health centres

In July 2009 Amnesty International visited 10 CSPSs on the outskirts of Ouagadougou and spoke with medical staff.

• Each CSPS has at least one delivery table and four beds on average. Although most are in good condition, they are not covered with sheets and it is up to those accompanying the patients to bring cloths.

• Although all of the facilities have electrical equipment, electricity works in only one of the CSPSs. Even this CSPS does not have electricity all the time because of frequent power cuts.

• Among the CSPSs without access to an electrical grid, eight have solar panels and one has no electricity source at all. Medical staff told Amnesty International that solar energy was not reliable and only produced electricity for short periods. Furthermore, the wiring is faulty and does not extend to all the rooms in the health centre. Staff use torches and lamps for deliveries and those accompanying patients are sometimes asked to supply this equipment.

• All the CSPSs are supplied with water by wells which belong either to the health centre or to the village. Where hot water is needed, the people accompanying the patient are asked to heat it.

• One CSPS uses a dry heat sterilizer, while the other nine sterilize their instruments with steam from a pressure cooker or by using High-Level Disinfection (HLD) which is the norm in health centres without electricity.

• Six CSPSs indicated that they regularly suffered shortages of medical products (no pharmaceutical outlet, no iron for pregnant women, worn out blood pressure meters, no weighing scales), as well as shortages of cleaning products (bleach, liquid soap, alcohol, gloves and protective material). Restocking takes a very long time.

SHORTAGES OF DRUGS AND MEDICAL EQUIPMENT

In many of the health facilities visited by Amnesty International, some essential supplies were damaged or missing. In addition, many medical staff complained of interruptions to supplies and delays in restocking drugs and equipment.

SHORTAGES OF EQUIPMENT AND DISREPAIR

At all levels of the maternal health care system, there are shortages of beds and delivery tables. In several CSPSs visited by Amnesty International, the delivery tables were rusty or damaged. A nurse working in a rural CSPS told Amnesty International that "the delivery table is so uncomfortable and dirty that women prefer to deliver on the ground."

Many women interviewed by Amnesty International said that tables were not cleaned between deliveries and that the pregnant woman's companions (sisters, mother, friends) were asked to wipe down the beds and wrap the newborn babies with their own cloths or soiled linens. At least two women living in a rural area near Ouagadougou remembered being placed on a soiled delivery table upon which another woman had just given birth. These unhygienic conditions are placing pregnant women and their newborn at risk of infection.

The lack of delivery tables can be seen right at the top of the health system. In the university hospital in Bobo-Dioulasso, medical personnel told Amnesty International in March 2009 that there were only two functioning delivery tables and a doctor said, "If both tables are occupied, the woman who waits to be delivered has to be lucky."

SHORTAGES AND POOR QUALITY OF MEDICAL SUPPLIES

In many CSPSs visited by Amnesty International, medical staff complained that supplies were of poor quality, especially instruments to measure blood pressure which often lasted no longer than three months. Many stressed that they lacked essential medical supplies such as gloves and syringes, sometimes for months at a time. These two items are essential in preventing the transmission of disease. Several nurses told Amnesty International that they had only one pair of scissors or a small number of clamps that they had to sterilize after each use, causing delays.

SHORTAGES OF DRUGS

Amnesty International visited pharmacies in some CSPSs and district hospitals where staff said that there were frequent shortages of drugs such as iron, used to treat anaemia, and anti-malarials.

A midwife working in Ouagadougou said in March 2009:

"We cannot work like this: products like gloves, alcohol and some essential generic medicines to prevent haemorrhages are missing. There are not any sterile gloves. The midwives have to bring their gloves with them in their handbags. There are often supply breakdowns. We have delivery kits without any sterile gloves, no bleach, no alcohol… We keep on making demands for the stocks to be replenished, but there are no responses to the grievances that are made and the personnel cannot do anything more."

Stock shortages could result from a shortage at the central level or from poor stock management in the health facility itself. As a Burkina Faso health system expert put it, "sometimes people wait until the last vial has been used before they make an order". She went on to say:

"The problem of broken equipment can be due to maintenance problems, poor care or bad usage. For example, concerning rusted delivery packs it's often a case of poor knowledge of disinfection solutions before the sterilization takes place (over-concentrated solution, too long soaking time, poor rinsing, etc… which damages the equipment). All aspects of sterilization are neglected and are rarely subject to quality control. Furthermore, in some health facilities, doctors and those in charge of managing the treatment centre only give medication or medical material sparingly because they know that if material was given all at once there's a chance it could be broken or disappear into thin air to be resold to patients illegally or recycled for a fee in private clinics."

RECURRING BLOOD SHORTAGES

Haemorrhage is a primary cause of maternal mortality in countries worldwide. Urgent access to compatible and safe blood is essential.

The government of Burkina Faso has made real efforts to improve the quality and quantity of available blood. A national policy on blood transfusion[162] was adopted to ensure that blood for transfusion is collected and kept according to WHO standards.[163] Two national blood transfusion centres (NCBTs) were created in Ouagadougou and in Bobo-Dioulasso in 2005 and two more were created in 2008 in Fada and in Koudougou. The government also increased the budget for the NCBTs fivefold, from some 200 million CFA francs in 2005 to 927 million CFA francs in 2009 (from around US$457,000 to US$2.1 million).[164]

These four national blood transfusion centres are responsible for supplying regional and district hospitals with blood. However, they are unable to provide a national service as they cannot supply blood to three health regions (North, Sahel and South-West). Even in the regions covered by the blood transfusion centres, the supply is not always regular. For example, Amnesty International was told by medical staff that the blood transfusion centre in Bobo-Dioulasso can only provide blood "from time to time" to the regional hospital in Banfora, the one in Kodougou can only supply blood "from time to time" to the regional hospital in Dédougou and the blood transfusion centre in Fada can "rarely" supply the regional hospital in Tenkodogo.[165]

Shortage of blood is particularly critical during the rainy season because of the incidence of paludal anaemia (anaemia as a consequence of malaria) and because it coincides with vacations for schools and universities (students are the largest group of blood donors). During this period, the blood transfusion centre in Ouagadougou only manages to obtain 60 units of blood a day, less than half of the needed 150 units a day.

The fact that the four blood transfusion centres cannot supply all the regional hospitals and district hospitals is very serious, as these health facilities often do not have the refrigerators and equipment to collect and preserve blood safely. According to a specialist on blood transfusion in Burkina Faso, the hospitals do what they can to manage without the national supply: "The blood is tested; however they make transfusions with what is at hand, without being able to respect the WHO international standards that stress that the entire blood must not be given. It must be split into various components (red blood cells, plasma, and plaques) and only the component needed should be transfused."

Some health facilities cannot have blood banks because of lack of electricity. For example, a district hospital some 100km west of Ouagadougou visited by Amnesty International in July 2008 had no blood bank as it had not had regular electricity supplies since May 2007. A doctor working there said:

> **"When a pregnant woman needs a transfusion, we ask the relatives to give their blood. There is a problem of compatibility and even if we can find compatible blood, it may not be in sufficient quantity for a particular patient."**

Amnesty International has documented many cases where the relatives of a pregnant woman have been asked to give their own blood.

Maïmouna died in August 2007 of haemorrhage and lack of blood.

Maïmouna lived in a village 5km from the nearest CSPS in a district 200km from Ouagadougou. During her pregnancy, she regularly visited the CSPS. After giving birth at the CSPS, Maïmouna started bleeding and was told that she needed a blood transfusion and had therefore to be transferred to the regional hospital, 30km away.

Maïmouna's husband told Amnesty International in March 2009: "When we reached the regional hospital, the doctor told us that my wife needed a transfusion but they had no blood; I offered to give her my blood but it was incompatible. I went to get my parents, who live in this city, but their blood was also incompatible. The medical personnel offered to help me, but their blood was also incompatible. Despite other searches during the night of Saturday till Sunday, we did not find anything. Around 7pm, my wife died without receiving any blood transfusion."

LACK OF TRAINED MEDICAL PERSONNEL

Although there has been an increase in medical personnel in the last five years, there are still not nearly enough qualified medical staff in Burkina Faso. The number of registered midwives grew from 504 in 2004 to 697 in 2008[166] – one midwife for about 21,000 inhabitants, well short of the standards set by the WHO of one midwife for 5,000 inhabitants. The number of physicians also increased from 359 in 2004 to 473 in 2008 (including around 70 gynaecologists), a ratio of one physician for about 31,000[167] inhabitants whereas the WHO standard calls for one physician per 10,000 inhabitants.

This lack of trained medical personnel is exacerbated by the fact that health care providers are not evenly distributed throughout the country. For example, in 2007, the Central Region with a population of 1,560,049 had 44 doctors and 199 midwives at the district level, while in the Northern Region, with a population of 1,156,207, there were only 10 doctors and 16 midwives.[168] These staffing levels meant that in 2007 in the Central Region there was one midwife for every 3,000 women of child-bearing age, while there was only one for every "20,000 and more" women in the Northern Region.[169]

One of the primary reasons for the uneven distribution in qualified personnel is the difficult conditions for health staff in rural areas, where they work alone, without essential materials and new technologies. Generally speaking, qualified personnel are reluctant to go to rural areas and this is particularly true for female midwives. Most are unwilling to work outside cities because they are usually married to a man who works in a city and the women want to remain with their family. To address this, the government created a new body of male midwives, called *"maïeuticiens d'Etat"*, but they are deployed at the district level, leaving only auxiliary midwives at the community level.

The UN Special Rapporteur on the right to health has stated that the right to health entitles women to reproductive health care services, goods and facilities that are available in adequate numbers: "…this gives rise to an obligation on States to ensure an adequate number of health professionals. Improving human resource strategies, including increasing the number of health professionals and improving terms and conditions, is a vital prerequisite for reducing maternal mortality in many countries."[170]

LACK OF SKILLED BIRTH ATTENDANTS

Skilled care at delivery for all women has been identified as one of the three main components of any strategy to reduce maternal mortality, together with contraceptive services to prevent unwanted pregnancy, and emergency obstetric care for all who need it.

Skilled attendance at birth: a definition[171]

A skilled attendant is an accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns.

Skilled care refers to the care provided to a woman and her newborn during pregnancy, childbirth and immediately after birth by an accredited and competent health care provider who has at her/his disposal the necessary equipment and the support of a functioning health system, including transport and referral facilities for emergency obstetric care.

In order to guarantee skilled care at birth, it is essential that the training level of medical staff, notably midwives and auxiliary midwives, is of sufficient quality and is subject to constant revision and improvement.[172]

However, the training of these key medical personnel suffers from long-running problems. A Burkina Faso health system expert told Amnesty International:

"One of the big problems in midwife training is lack of resources in training schools, underpaid professors, few teaching materials, lack of logistical or financial means enabling instructors to follow their students where they do their professional training."

Auxiliary midwives at the CSPS level constitute the first level of care for nearly all pregnant women, especially in rural areas where midwives are not available. In the absence of the head nurse *(infirmier major)*, it falls upon them to take the decision to refer the pregnant woman in case of a complication.

The level of training of auxiliary midwives is subject to debate in Burkina Faso. Some experts say that they can deal with simple deliveries and are able to refer pregnant

women with complications to the referral centres. Others, including several gynaecologists working in the university hospitals in Ouagadougou and in Bobo-Dioulasso, feel that many auxiliary midwives are not competent to recognize signs of danger. A researcher from the Bobo-Dioulasso MURAZ centre told Amnesty International delegates:

"According to international standards, when we talk about qualified obstetric care, a midwife is the benchmark health professional. In Burkina Faso, 80 to 90 per cent of the health facilities only have auxiliary midwives to carry out the deliveries. This category of health professional is not recognized on an international scale by the WHO as being able to guarantee qualified assistance during delivery. We should carry out a complete evaluation of competencies of this type of medical personnel and increase the required level of training. This is much more worrying as a mistake when making a diagnosis in a CSPS can delay the on-time transfer to an appropriate health care facility."

In addition, it seems that partographs[173] – one of the essential protocols in terms of quality of care – are not always used. For example, Amnesty International was able to see the medical record of a near-miss in March 2009 where the partograph was blank. A nurse in a rural area told Amnesty International, "despite the fact that the use of partographs is taught during our training, some health workers fail to use it. This is worrying as the partograph can be a critical tool to decide when to refer a woman to a higher level health centre." An expert on the Burkina Faso health system told Amnesty International that "some midwives fill the partograph after the delivery when it's useless, in order to insert it in the medical record and avoid any reproach".

Some Ministry of Health officials that Amnesty International met in March 2009 recognized that the training of auxiliary midwives was insufficient, and stated that in order to make up for these shortcomings, the government had just created a new intermediate category of qualified midwives *(accoucheuses brevetées)*. The entry requirement for the two-year training is several years' experience in the role of auxiliary midwife, plus the *Brevet d'étude du premier cycle*, an entry-level diploma.[174] One of the officials told Amnesty International that the first cohort of qualified midwives (around 50 people) was due to qualify in mid-2009 and that they would be appointed to district hospitals. The level of treatment in CSPSs, where the large majority of women give birth, will not therefore benefit directly or immediately from this new training programme.

9/SUB-STANDARD CARE

'IN CHILDBEARING, WOMEN NEED A CONTINUUM OF CARE TO ENSURE THE BEST POSSIBLE HEALTH OUTCOME FOR THEM AND THEIR NEWBORNS… THE SUCCESSFUL PROVISION OF THE CONTINUUM OF CARE REQUIRES A FUNCTIONING HEALTH CARE SYSTEM WITH THE NECESSARY INFRASTRUCTURE IN PLACE, INCLUDING TRANSPORT BETWEEN THE PRIMARY LEVEL OF HEALTH CARE AND REFERRAL CLINICS AND HOSPITALS. IT ALSO NEEDS EFFECTIVE, EFFICIENT AND PROACTIVE COLLABORATION BETWEEN ALL THOSE INVOLVED IN THE PROVISION OF CARE TO PREGNANT WOMEN AND NEWBORNS.'

WHO, International Confederation of Midwives and the International Federation of Gynaecology and Obstetrics[175]

Besides shortages of staff and supplies, two key issues undermine the quality of care received by pregnant women in Burkina Faso: serious failures in the referral system and difficulties in the relationship between patients and medical personnel.

SERIOUS FAILURES IN THE REFERRAL SYSTEM

The referral system is the basis of a functioning health system, allowing complications to be treated at a higher level of care. This system has been adopted in Burkina Faso, where CSPSs can only carry out normal deliveries and have to refer to a higher tier (district, regional and university hospitals) any pregnant women suffering from complications.

This referral network is undermined by several deficiencies, in particular:

- delays in making the decision to refer a patient
- lack of emergency capacity in district and regional hospitals

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A woman in labour with her first child lies in the corridor in the maternity ward. With space for only six births at a time, women have to wait to enter the labour ward until the birth is imminent. Yalgado hospital, Ouagadougou, Burkina Faso.

- blood shortages
- lack of ambulances for transferring pregnant women
- no communication between health facilities

Because of those problems, many women are referred to the two university hospitals in Ouagadougou and Bobo-Dioulasso, which leads to delays that can have fatal consequences. Some doctors working in the two university hospitals told Amnesty International that many women have been referred too late. An obstetrician from the Yalgado hospital in Ouagadougou stated: "Some women arrive in a hopeless state and sometimes they are already dead when they arrive."[176]

DELAYS IN REFERRAL DECISIONS

Delays in making the decision to refer a patient can stem from staff in the CSPS not recognizing the urgency of the woman's situation or from difficulties in finding suitable transport.

Sometimes the member of staff able to take the referral decision is absent. The husband of a woman who died in August 2007 told Amnesty International:

"One night, my wife had pains, so I took her on my motorcycle to the CSPS, 12km from our home. We spent Friday night at the health centre and the next day, Saturday, around 11.30am, my wife gave birth to a boy. The baby was delivered by an auxiliary midwife. Just after the delivery, my wife began to shake and wasn't well. We had to wait until the arrival of the head nurse to take the decision to transfer her. He came back six hours later and as soon as he saw her, he said that she should be immediately transferred to the regional hospital."

This woman finally arrived at the regional hospital at 7pm, where the doctor said that she needed a blood transfusion. As there was no blood bank in this hospital and no compatible blood among members of the family, she should have been transferred immediately to the university hospital of Yalgado but it was too late and she died a few minutes later.

LACK OF EMERGENCY CAPACITY IN DISTRICT AND REGIONAL HOSPITALS

Some district and regional hospitals refer patients to university hospitals because they simply do not have the capacity to operate on pregnant women with complications. Sometimes the surgeon is absent, or the operating room is not functioning because the generator is broken or there is a problem of sterilization. So, in Ouagadougou, out of four urban district hospitals, only one, (the Sector 30 district hospital, CMA), operates day and night. The emergencies which arise in the other district hospitals are partially managed by the Sector 30 district hospital and mostly by the Yalgado university hospital which, because of this, is severely overcrowded.[177]

BLOOD SHORTAGES IN DISTRICT AND REGIONAL HOSPITALS

Problems arise in the referrals system because the university hospitals in Ouagadougou and Bobo-Dioulasso receive many women who cannot be treated in district or even regional hospitals because of a lack of compatible blood (see Chapter 8). A doctor working at a regional hospital told Amnesty International:

"When a pregnant woman needs a transfusion, we ask the relatives to give their blood. If we cannot find compatible blood, we transfer the patient to Ouagadougou, which causes delays that can be life-threatening."

LACK OF AMBULANCES FOR TRANSFERRING PREGNANT WOMEN

The lack of ambulances is another real problem, causing potentially dangerous delays in referrals (see Chapter 6). All the district hospitals visited by Amnesty International had one or two ambulances, but in some of them, one of the ambulances did not function, posing real problems when there were two emergencies at the same time.

Assetou, aged 25, died in January 2008 while trying to reach a health facility.

Assetou was married at 21 when her grandparents organized her marriage to Alassane, born in 1964 and the father of four children born to a first wife. Assetou never went to school. The family lives in a village with a CSPS, about 16km from the regional hospital.

During her pregnancy, Assetou attended prenatal visits at the CSPS. In January 2008, Assetou had pains and went to the health centre but was told to come back later. The next day, she again had contractions, and she was accompanied back there by women from the village. Assetou delivered at around 3am but the baby did not survive. At 9am she went back home with her husband. She went to rest, but two days later, she stopped eating. A woman neighbour who cared for her told Amnesty International, "Assetou said that she felt as if there were cinder in her stomach." The following day, this neighbour accompanied Assetou to the CSPS where she was given a prescription that her husband paid for.

After having spent the night at the CSPS, a nurse said that she had to be evacuated to the regional hospital but the ambulance was broken *("elle était gatée")* and staff told the family that "they had to figure out how to get there." Alassane's youngest brother took Assetou on his small motorcycle. Alassane told Amnesty International: "She was holding onto him and as a precaution, we tied a piece of cloth around her and the motorcyclist. I drove another motorcycle."

The brother said: "At a certain point, I noted a certain imbalance, I felt the release of her hands, and I was no longer carrying the weight of her body. I stopped and then I realized that she had rendered her soul. There was blood on my motorcycle."

NO COMMUNICATIONS BETWEEN HEALTH FACILITIES

Another problem raised by several doctors is the lack of any system of communication between health facilities at different levels. An obstetrician from the university hospital in Yalgado said:

"We are never informed when an urgent case is arriving. That would make our task easier as we could prepare ourselves to cater for them. We should introduce a system of communication to help us to maintain telephone links between the different health facilities."

The aunts of a young woman in labour wait patiently outside the delivery room at a new community health centre (CSPS) in Gorgare, Burkina Faso.

PATIENTS AND MEDICAL PERSONNEL: RELATIONSHIP DIFFICULTIES

During its four research missions, Amnesty International observed the professionalism and commitment of medical personnel both in towns and rural areas. However, the delegates also collected a number of accounts illustrating worrying negative attitudes towards pregnant women and their families. This can be partly explained by the lack of motivation and work overload among many medical personnel.

LOW MORALE AMONG HEALTH STAFF

All the medical staff who met Amnesty International underlined that low public sector salaries were detrimental to the quality of treatment and led to the partial or total departure of competent and trained people to the private sector. A medical professor from Bobo-Dioulasso told Amnesty International that the starting salary for a nurse is 50,000 CFA francs per month (around US$114). "To make ends meet, they stay in the public sector in the morning then do private work in the afternoon." A gynaecologist told Amnesty International that by spending two afternoons in the private sector, doctors could double their wages.

The need to offer competitive salaries to medical staff so that they can stay within the public health service has been stressed by some international bodies. The CESCR has stated: "Functioning public health and health care facilities, goods and services, as well as programmes, have to be available in sufficient quantity… These facilities, goods and services should include hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs."[178]

A midwife met by Amnesty International in July 2008 in a town 100km north of Ouagadougou highlighted another factor which explains why experienced midwives are leaving the profession: "The basic wage for midwives varies between 75,000 and 80,000 CFA francs (around US$171 to 183). To live comfortably, you have to specialize. However there is no specialization in obstetrics. Therefore lots of experienced male and female midwives take exams to specialize in surgery, anaesthesia, ENT [ear, nose and throat] or in paediatrics. Because of this we're losing the most experienced and competent people and we constantly have to train new recruits."

This is about to change as a new programme has just been set up to allow midwives to progress in their careers.[179]

NEGATIVE ATTITUDES TOWARDS PATIENTS AND THEIR FAMILIES

Many of the families that Amnesty International spoke to criticized the attitudes of nurses, midwives and auxiliary midwives who treated them rudely and even sometimes violently. When a woman dies in childbirth, medical staff rarely reveal the cause of death and in certain cases treat the family of the woman brusquely, especially families living in poverty and with a low level of education.

In almost all the maternal mortality cases that Amnesty International investigated, the medical staff did not tell the family the cause of death. Members of families living in poverty often do not dare question medical staff, but many bereaved husbands regretted not knowing how their wives died. A farmer told Amnesty International:

"My wife was being looked after in the CSPS where she went for her prenatal visits. They never told us that there was a problem during the pregnancy. She was taking medication, but I don't know what... I went with her to the health centre for the birth. I was told to wait. Then a nurse came and told me it wasn't going well. He asked me if my wife had an illness. I told him that she was healthy, since she had been coming to this health centre and there hadn't been any problems. He came back some time later and told me simply that my wife had died. I don't know why she died. Nobody told me. I didn't dare ask why but I'd really like to know."

There are also cases where the personnel treat a bereaved family disrespectfully. A mechanic, whose wife was treated in a health facility in Ouagadougou before she died in April 2008, told Amnesty International:

"My wife gave birth to two children, one survived, the other died. A male nurse asked me to buy an empty carton. I returned to the maternity ward with it. A few minutes later, the male nurse came back out with the carton, in it there was the stillborn baby. He told me to bury the child, and then to come back."

NEGLIGENCE AND VIOLENCE DURING LABOUR

Amnesty International collected a number of testimonies from mothers who said that they had been victims of carelessness, neglect and even violence in health facilities. Women reported being insulted and being pinched on the thighs, slapped or beaten into compliance during labour. They also said they were left alone for hours. Other women described rough, painful, and degrading treatment during physical examinations and delivery, as well as verbal abuse from medical staff if they expressed pain or fear.

Aïcha was verbally abused and slapped during labour.

Aïcha sells jewellery in the market. The mother of a two-year-old son, she told Amnesty International how she was treated during her first delivery in May 2005. She eventually had a caesarean section and delivered a stillborn baby:

"It was my first delivery. I arrived at the district hospital at 5pm with my mother-in-law, and I was told that I would deliver at 9pm. On the second day, the baby had still not arrived. We were told to go do a sonogram at the hospital so my husband took me back to the hospital. On the delivery table, the midwife asked me to yell but I said that I couldn't do it because I was too tired. Then all of the maternity personnel left, they told me that they had to go to a baptism. I felt abandoned. There were no more medical personnel that afternoon. So we had to wait for the night shift to come, at midnight. Suddenly, I saw the umbilical cord come out and I thought that it was my internal organs. So I thought that I was going to die. A midwife arrived and said 'You shouldn't cry', 'When you were doing the thing with your husband, you were happy' and she slapped me."

A number of women told Amnesty International that midwives, especially auxiliary midwives, were very impatient and occasionally insulted them when they were in pain and asking for help. During a focus group discussion in Ouagadougou in March 2009, a woman told Amnesty International that when she gave birth at a CSPS in the capital, she was told aggressively by a midwife: "I am a woman, I know what it is to give birth, open up, spread your legs, it is not painful."

Women reported that midwives and auxiliary midwives did not pay attention to them and were doing other things such as knitting while they were suffering on the delivery table.

Several doctors said that they were aware of such practices. One of them witnessed verbal abuse from several midwives. "I saw one midwife say to a woman in labour: 'You're hopeless, you're unbearable, you're dirty, go and wash yourself before you come.' If the woman in labour is accompanied, she is protected." A male nurse admitted to Amnesty International in July 2008 that he "occasionally had to slap or pinch pregnant women because they don't want to push and this can cause the death of the baby."

It is difficult to assess how common such cases are. Staff are working in stressful conditions and may be provoked by the family. A midwife working in Ouagadougou told Amnesty International:

"People who accompany pregnant women are always trying to intervene unduly in our work; they press for their relative or friend to be treated first while the case of other women is more urgent and they often want to attend the delivery which causes a lot of disruption. I was once slapped by a woman because her friend was not immediately treated whereas other women needed more urgent care and there weren't enough personnel to take care of so many pregnant women at the same time."

Whatever the provocation, however, acts of verbal or physical violence by medical staff cannot be justified or condoned.

When Amnesty International raised these cases with the authorities and medical personnel, the response was that these were isolated cases, although there was some recognition that they could occur because of the pressures on staff. Amnesty International remains concerned by the lack of control over staff behaviour and the fact that such practices are not subject to disciplinary sanctions, which can only perpetuate them.

Pilot project to improve quality of care: Sector 30 in Ouagadougou

A pilot project – Amélioration de la qualité et de l'accès aux soins obstétricaux d'urgence (AQUASOU, Improvement of the quality and access to emergency obstetric care) – was launched in 2003 in the district hospital in Sector 30 in Ouagadougou, with support from the French Ministry of Foreign Affairs. One of the objectives of the AQUASOU project was to improve the quality of obstetric care: technical quality and also interpersonal quality, since the analysis of the situation brought up frustrations and lack of understanding from both users and providers. Users complained of a poor reception and sometimes bad treatment and health staff complained about women arriving too late and of a lack of respect for visiting hours from friends and family.

Several initiatives have started to improve the carer-patient relationship:

- Home visits for women who have had a caesarean section so that midwives can see the women's living conditions and ensure they have the information they need;
- Users-providers meetings to improve interpersonal relationships;
- Reinforcement of midwife training, with the aim of "developing health professionals so they pay greater attention to people's personal experiences in order to provide more patient-centered care."[180]

When the project ended in 2006, several key objectives seemed to have been achieved, notably in terms of improving relations between users and health staff. Questionnaires completed at the end of this project showed that the majority of women were very satisfied with their care. Many said that: "We were quickly taken care of", "They respect us". There was also better information for those accompanying the patient and better organization of visits.[181]

Those in charge of Sector 30 highlighted, however, that these successes had financial implications. As one of the Sector 30 district hospital doctors pointed out to Amnesty International in March 2009, "We are victims of our own success. Some pregnant women who aren't originally from our Sector come to give birth here. As we perform a lot of deliveries and caesarean sections, the material quickly gets spoilt and we have to ensure that there is a rapid renewal of equipment. The French government aid ended in 2006 and that of the Italian government in 2007. Without external or state support we could soon be declared insolvent."

10/ACCOUNTABILITY

Accountability is a key factor in any functioning health system. The government has to account for the implementation of its health policies. Patients are also entitled to hold accountable medical personnel who might be responsible for abuses or misconduct, such as unlawful demands for unofficial payments, and must have access to avenues of redress. However, in Burkina Faso, accountability is rare, both at government and individual level.

LACK OF MONITORING OF POLICY IMPLEMENTATION

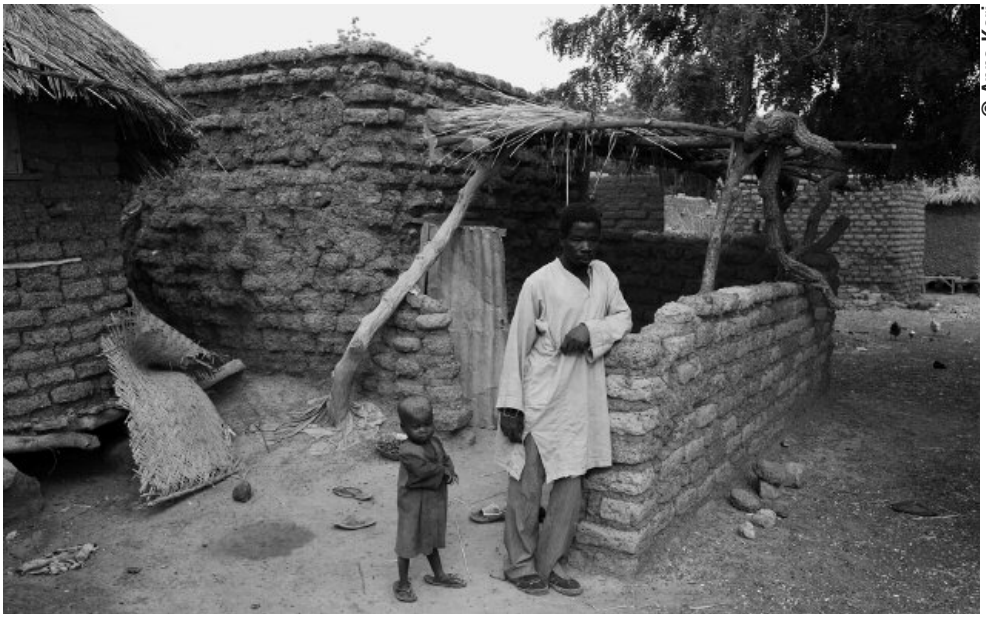
Despite the many strategic plans and policies adopted by the government of Burkina Faso to tackle maternal mortality, and health more generally, some key aspects of these policies still need to be implemented.

During the 10-year period of the PNDS (2001-2010), the government published a series of evaluation reports indicating the progress made and the gaps to be filled. In March 2004, the authorities acknowledged and identified very clearly the following problems in health care for pregnant women:

- limited accessibility and availability of maternal and neonatal care,
- low quality of care,
- insufficient co-ordination and collaboration within and outside the sector,
- and inadequate commitment of stakeholders at all levels.[182]

These problems were again highlighted two years later in a plan adopted by the Ministry of Health in 2006, the Plan d'accélération de la réduction de la mortalité maternelle et néonatale au Burkina Faso (Plan to accelerate the reduction in maternal and neonatal mortality in Burkina Faso), also called the "roadmap" *(feuille de route)*.[183]

Many of these obstacles still need to be addressed.



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The death of a woman in childbirth deprives her family of their daughter, sister, wife and mother. This is the home of Sawadogo Mousa in Wonko, whose wife died in childbirth.

An evaluation of the PNDS (2001-2010) was underway at the time of writing this report. The terms of reference for this evaluation were adopted in June 2009, international and local consultants were hired and the evaluation report was due to be ready by the end of 2009. In a meeting with officials from the Ministry of Health in November 2009, Amnesty International was told that a workshop was planned for January 2010 to consult representatives of civil society, partners and the private sector.

FAMILY PLANNING: THE UNMET NEED FOR CONTRACEPTION

Despite efforts to make contraceptives available to all women since the launch of the Contraceptive Security Strategic Plan (2006-2015), contraceptive use remains low and too many women have unmet needs for contraception. The Reproductive Health Products Security Strategic Plan (2009-2015) acknowledges the existence of weaknesses in the supply and storage of contraceptive products. In this document, the authorities stressed that: "Logistical management shows insufficiencies in terms of availability of reliable and timely information in order to estimate needs at all levels.

Hence risks of stock shortages, expiration, damage or over storage. The information gathering system is... not functional for family planning."[184]

SHORTAGES AND MISAPPROPRIATION OF DRUGS AND MEDICAL SUPPLIES

Stock management of drugs and medical supplies is a very serious problem in many countries, including Burkina Faso. As a doctor from Burkina Faso told Amnesty International in March 2009: "All policies aiming at the exemption of costs must be accompanied by a mechanism of stock control and sanctions for people stealing or misappropriating money or medical goods belonging to the public service." Such mechanisms do not exist or do not function effectively in Burkina Faso.

The issue of stock shortages was acknowledged in the PNDS, which states that in order to make medicines more available, the Ministry of Health would "oversee the supply and distribution of essential generic medicines in all health districts to avoid stock shortages."[185] In practice, throughout the health system, this does not appear to be the reality.

For example, information collected by Amnesty International shows that the kits for deliveries, which are prepared by a person in charge of stock management, are often unavailable or incomplete and no real system of stock management seems to be in place. This allows misappropriation of medical materials, and can lead to alleged shortages of supplies, which means that patients' families have to pay for "missing products".

The government must take more determined and robust action to improve the supply and control of necessary drugs and medical supplies to ensure that they are available and cannot be misappropriated.

ACCOUNTABILITY OF MEDICAL PERSONNEL

In many health facilities, the performance, attendance records and attitudes of medical staff are rarely subject to checks and controls from doctors or managers. All the information gathered by Amnesty International shows that medical personnel responsible for abuses and misconduct against patients are rarely, if ever, held to account.

CHARTER OF PATIENTS' RIGHTS

Amnesty International's research has found that the relationship between medical staff and patients and their families may be strained. Relatives are often not told the cause of death or of serious complications related to childbirth. A patients' Charter was adopted by the Ministry of Health in 2007 and stressed that, "Any health services' user is entitled to be well received and to benefit from quality care".[186] However, this Charter is not displayed in hospitals and other health facilities and is very little known by patients or medical personnel. There is a regional charter concerning the duties and behaviour of midwives,[187] but no such text exists at the national level.

All the testimonies collected by Amnesty International indicate that patients are unaware of their rights, including the right to information and the right to be treated properly and with respect by medical staff.

LACK OF SANCTIONS

The PNDS stressed the necessity to "enforce sanctions for misconduct"[188] committed by medical personnel. Although there is a disciplinary procedure provided by the professional doctors' organization,[189] Amnesty International did not find evidence that medical personnel accused of corruption or inappropriate treatment of patients, including physical and verbal abuse, were effectively punished.

Amnesty International met several doctors who acknowledged that such abuses were committed and that nothing had been done to penalize the person responsible. A doctor working near Bobo-Dioulasso told Amnesty International in March 2009:

"I have heard not long ago that a male nurse charged bribes by saying to the pregnant women: 'Give me some money, I am going to give it to the doctor to motivate him.' When I heard about it, I was furious, I summoned the male nurse. He apologized but there was no penalty."

Another doctor cited the case of a hospital porter who put a patient in the corridor of a hospital in Ouagadougou and told the pregnant woman's family: "if you don't pay 2,500 CFA francs (around US$5.50), I'll leave her here." The doctor added: "Everybody knows cases like this but no one wants to denounce them as this might create problems within the health facility."

Officials working at the Health Ministry acknowledged that there were some "black sheep" *(brebis galeuses)* among the medical staff but stressed that these were isolated cases and that once these cases were known, "everything went back to normal." They also told Amnesty International in November 2009 that if patients feel that their rights are not being respected or they have paid unjustified amounts of money, they can ask for redress through different services, either at the medical or the administrative level. However they acknowledged that "there are in fact very few complaints due to cultural barriers."[190]

INVESTIGATING MATERNAL DEATHS AND NEAR-MISSES

At the national level, every maternal death should be investigated by a team sent by the Ministry of Health, but an official of the Ministry of Health wrote to Amnesty International in November 2009 that audits of maternal deaths are being organized at the referral level and that guidelines were sent to health facilities in 2008.[191] However, this practice is not implemented in every district hospital and no inquiries into maternal deaths are carried out at the community level. In addition, it is unclear how these investigations are to be carried out and what follow-up they entail.

At the level of the health facility, several medical centres organize a monthly audit, either on one case of maternal death (Yalgado university hospital) or on a case of severe maternal complication or a stillborn baby (district hospital Sector 30). A file is chosen at random and all the medical staff concerned (gynaecologists, midwives and nurses) analyse the case. The aim is to learn lessons from past mistakes and to make recommendations while avoiding stigmatization: "No name, no blame, no shame."

These audits are important because they can be used to determine the factors leading to maternal deaths, and establish policy priorities for change. Audits are not meant to assign blame for past maternal deaths, but rather to facilitate prevention of future deaths and learn how to manage severe complications without delays.[192]

Audits: Learning lessons from past mistakes

In March 2009, the head of the maternity department in Yalgado invited the Amnesty International delegation to take part in one of its monthly maternal death audits. For more than three hours, the case of a woman who died a month earlier was examined. The delegates were impressed by how serious and transparent the debates were, as well as by the quality of the report of the discussions which was transcribed on a computer and shown on an overhead projector.

During this audit, all possible failures were scrutinized and discussed, including delays in referral, transport difficulties, and failings in medical care, such as delays, misdiagnosis, lack of blood or insufficient attention. The whole group made recommendations which had to be implemented by one or more of the members of staff within a given time.

Maternal death audits are not always easy to carry out. Without a minimum level of equipment and human resources, audits cannot improve the quality of care. Medical staff must share the desire to change practice and be prepared to reveal mistakes in front of a peer group. Confidentiality cannot be guaranteed in teams which know each other well; members of staff recognize the case even if the patient's name is not revealed. Unless recommendations are implemented, they are of no use and can even demotivate staff.[193]

ABSENCE OF EFFECTIVE REMEDIES

The CESCR has stated that anyone who is a victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels. "All victims of such violations should be entitled to adequate reparation, which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition." It has also stated that "National ombudsmen, human rights commissions, consumer forums, patients' rights associations or similar institutions should address violations of the right to health."[194]

In Burkina Faso, women and their families who are victims of violations of the right to health have extremely limited access to avenues to make complaints and seek effective remedies, either through the courts or by other means.

The right to health is one of the social rights enshrined in Article 18 of the Constitution of Burkina Faso. However, virtually the only way in which victims of violations of their right to health can lodge complaints is to use the normal and very intimidating administrative and justice systems. They cannot bring complaints before the National

Human Rights Commission (NHRC) of Burkina Faso as this body does not have the power to receive and address individual complaints. Moreover the NHRC lacks independence from the state authorities, a failure that was stressed in the conclusion of the Universal Periodic Review of Burkina Faso in January 2009 that asked the government of Burkina Faso to "ensure that the statute of the national human rights commission is in conformity with the Paris Principle, to ensure that it is fully operational … [and] ensure its independence, particularly in adjusting its competences and funding."[195]

There is, formally, a complaints procedure which involves an official known as the Mediator of the Republic, but this procedure is little known, particularly in rural areas, and Amnesty International is unaware of any cases related to maternal mortality taken through this procedure.

LACK OF POLITICAL WILL TO COMBAT CORRUPTION

Corruption by medical personnel, notably unofficial payments, has been identified as a major element undermining the whole health care system and in particular the subsidy policy. It is therefore very worrying that, despite some pledges and the creation of anti-corruption bodies, the government of Burkina Faso seems to be doing very little to tackle this major issue.

The government of Burkina Faso has made statements and undertaken legal duties at the national, regional[196] and international level in order to combat corruption. Under the Penal Code, corruption and influence-peddling in the public sector are criminalized, with penalties including imprisonment with fines and the removal of civic rights.[197]

The government has created several bodies in charge of monitoring and fighting corruption and fraud, and in November 2007 the authorities set up the Superior Authority of State Control (ASCE, Autorité supérieure de contrôle de l'État), whose aim is to rationalize and enhance efforts to combat corruption.[198] The ASCE has the mandate to release annual reports from audited entities and has the authority to receive complaints from the public and investigate and prosecute ethics breaches in the public sector, including by state civil service employees, local and public authorities, state-owned companies, and all national organizations invested with public service.[199]

However, the independence of this new entity is severely undermined by the fact that it comprises only government officials and that it is run by a civil servant named by the government and working under the authority of the Prime Minister. A prominent member of civil society told Amnesty International:

"People have no confidence in this state entity and fear that any denunciation of a civil servant will immediately be transmitted to this person who might resort to retaliation. To be efficient, such a body should comprise members of civil society, of the private sector, of the press as well as state officials and should benefit from state structures such as judges and police officials to carry out investigations and judicial proceedings."

Members of civil society are also worried by the fact that the new ASCE discarded all the corruption cases identified by previous anti-corruption bodies that needed to be referred to the justice system.

The general climate of impunity has been repeatedly denounced by REN-LAC, the National Network to Fight Against Corruption (Réseau National de Lutte Anti-Corruption). In its 2006 report, REN-LAC stated that: "the ongoing absence of political initiative and the reign of impunity make it so that corruption and the corrupt are gaining ground, they are taunting the populations and dangerously compromising development and the democratic process."[200]

The UN Convention against Corruption, which Burkina Faso ratified in October 2006, expresses concern that corruption jeopardizes the rule of law and its Article 34 requires from each state party to "take measures, in accordance with the fundamental principles of its domestic law, to address consequences of corruption."[201]

The government has an obligation to address the problem of unofficial and unlawful charges by medical personnel and others charging for services, transport, drugs and supplies, and to ensure that the limited resources Burkina Faso does have are properly allocated and reach their intended targets. Its failure to take adequate steps to address this problem contributes to serious violations of the right to health, including the persistence of preventable maternal deaths.

11/ROLE OF DONORS

For the last decade, under Burkina Faso's Poverty Reduction Strategy Framework, bilateral and multilateral donors have played a key role in supporting the country's health care policies and delivery.

SOURCES OF DEVELOPMENT ASSISTANCE

Donor support to Burkina Faso for the financing of the national health policy comes from several sources:

- Funding from General Budget Support provided in support of the Poverty Reduction Strategy Framework.

- Funding through the Support program for the development of the health sector 2008-2012 (PADS, Programme d'Appui au Développement Sanitaire), also called "pooled funding" or "basket funding".

- Direct support for specific projects or partners.

GENERAL BUDGET SUPPORT

General Budget Support provides development assistance which is not earmarked for specific projects or items of expenditure, and which is disbursed through the recipient government's own financial system, and in line with the recipient government's own development and poverty reduction strategies. Burkina Faso has received, and continues to receive, General Budget Support from a variety of bilateral and multilateral donors, primarily Denmark, France, Germany, the Netherlands, Sweden, Switzerland, the European Union, the World Bank and the African Development Bank.[202] In terms of the volume of assistance, the World Bank and the EU are the main donors, followed by the Netherlands.

Contributions made through General Budget Support are provided directly to the national Treasury Account and mixed with the country's own revenues. They are thus part of the budgetary allocations to Ministries in accordance with the budgetary priorities

decided by the Burkina Faso government in its Poverty Reduction Strategy Framework, with donors and the government agreeing on minimum allocations to priority sectors, including the health sector.

POOLED DONOR FUNDING FOR THE HEALTH SYSTEM

According to the latest available official figures, in 2006 donor funding contributed 37.69 per cent of health spending on reproductive health, which comprises maternal health and family planning.[203]

The PADS is a pooled funding mechanism for support to the national health development plan. The PADS is defined as "a joint initiative of the Ministry of Health and certain partners in the development of the health sector, for a better coordination and a rational management of the resources mobilized for the implementation of the PNDS."[204] In September 2009, the donors supporting this pooled funding mechanism were the Netherlands (who are acting as lead donor in co-ordinating this funding mechanism), Sweden, France, the World Bank,[205] UNFPA, UNICEF, the Global Alliance for Vaccines and Immunisation (GAVI) and the Global Fund to Fight AIDS, Tuberculosis and Malaria. This "basket funding" is managed by the Ministry of Health.

DIRECT SUPPORT FOR PROJECTS OR SPECIFIC PARTNERS

Donors also provide direct support for certain projects. For example, the African Development Bank (AfDB) is supporting loans at concessionary rates for the development of health infrastructure – hospital buildings, health centres, equipment and also training of health care workers. The AfDB is also supporting the national health action plan in the eastern and northern regions of the country by building two regional hospitals.

UN agencies also finance specific projects. UNICEF provides technical support for safe motherhood and child care interventions and intervenes through the Bill & Melinda Gates Foundation for Maternal, Neonatal and Child Health Programme in two regions. UNFPA supports access to family planning and provides technical assistance for sexual and reproductive health. A spokesperson for UNFPA told Amnesty International in June 2009 that UNFPA contributed to spending linked to family planning to a sum of US$200,000 and financed the subsidy of contraceptive products by up to 80 per cent. The WHO offers technical assistance in many areas including maternal health and HIV/AIDS.

Other donors also finance certain specific projects which have a direct link to reducing maternal mortality. For example, the German agency GTZ focuses particularly on family planning, which it considers crucial in helping to tackle maternal mortality. In a meeting

with Amnesty International in July 2008, GTZ officials said that their action, which is concentrated on the south-west and eastern regions, supports a programme on sexual health and human rights that focuses on family planning, sexual health and HIV/AIDS.[206]

AN APPROACH BASED ON GENDER EQUALITY

Some donors are also supporting the development and implementation of a gender policy to promote gender equality. This represents a priority for many international donors such as Germany, Canada, Denmark, the Netherlands, Sweden and Switzerland. Since 2002, about 20 donors have supported a gender consultation framework aimed at promoting gender equality in Burkina Faso by focusing on themes such as the health and reproductive rights of women, gender and HIV/AIDS and the fight against domestic violence.

FACTORS REDUCING THE EFFECTIVENESS OF INTERNATIONAL AID

In interviews with donor representatives and representatives of the government of Burkina Faso, Amnesty International heard that the effectiveness of development assistance is hampered by insufficient co-ordination between donors and inadequate evaluation of the impact of development assistance for the health sector.

PROBLEMS OF CO-ORDINATION

There are more than 80 different funding sources for health sector activities in Burkina Faso and there is a clear risk that some of these projects either duplicate each other or leave entire geographical areas unaddressed. Amnesty International was told of inadequate co-ordination among donors in relation to support for the Burkina Faso health sector.

During a meeting with Amnesty International in March 2009, the Minister of Finance of Burkina Faso said that "it would be good to rationalize and to improve co-ordination of the donors' interventions, because each donor wants to have their project and certain intervention zones are privileged in relation to others."

A representative of one of the main donors confirmed the existence of this problem and told Amnesty International in July 2009:

"Despite most donors being signatories to the Paris Declaration and Accra plan of action [agreements aimed at improving the delivery and effectiveness of aid],[207] on the ground this is still a dead letter. Too much energy is lost in high transaction activities instead of using the very limited human capacity for concerted actions aiming at the poor."

INADEQUATE OUTCOME EVALUATION

The government of Burkina Faso and donors have set up a series of mechanisms to monitor and control the funds provided by donors. Since 2005 there has been an annual financial audit of funds provided to the PADS.

However, as an expert on the health system in Burkina Faso told Amnesty International:

"Both donors and the government are reluctant to push for a real 'outcome evaluation' that could reveal the real impact of the work done on the ground. The government does regular 'output evaluation' of the activities financed by donors and sends them reports so that aid continues to be provided. But there is no real and general assessment of the situation on the ground that could highlight the needs and gaps."

Amnesty International learned that this issue was to be addressed by the introduction of a Health Sector Review System, a process that will culminate in the first annual review planned for March 2010. The outcome of this review will feed into the annual review of the Poverty Reduction Strategy Framework in April 2010.

Some NGOs have also underlined some of the gaps in the implementation of the PNDS. For example, the GAVI Alliance has noted "insufficient health program monitoring and evaluation" and "insufficient planning and monitoring at the peripheral level."[208]

In this regard, some donors told Amnesty International that the evaluation of the implementation of the PNDS (2001-2010), due to take place in 2010, could be the opportunity for a real assessment of the use of resources allocated to the implementation of the PNDS.

12/CONCLUSION AND RECOMMENDATIONS

Over the past decade, the government of Burkina Faso has devoted significant resources to reducing the level of maternal mortality. With the help of international donors and within a carefully planned framework, the authorities have focused on community-level health care with the stated goal of increasing the number of medically assisted deliveries.

According to official figures, progress has been made, notably in terms of reducing the maternal mortality ratio and increasing the proportion of women who undergo prenatal consultations and have skilled assistance in childbirth.

However, many pregnant women still cannot obtain the health care they need in time. They face many hurdles: women's subordinate status in society; geographical and financial barriers; poor conditions in many health facilities; shortages of staff and of supplies; negatives attitudes from some staff; and demands for unofficial payments by medical personnel. For the most marginalized women living in poverty, especially those in rural areas, pregnancy all too often ends in tragedy.

Family planning is a key component of any strategy for reducing maternal mortality. The authorities of Burkina Faso have to improve the provision of information on sexual and reproductive health, and to ensure that sexual and reproductive health services are more accessible and available. Many women, especially adolescents, find it difficult to have access to family planning services.

The subsidy policy, in place since 2006, represents a step towards dismantling the financial barriers that prevent pregnant women obtaining the health care they need. However, significant problems remain. Women living in the most extreme poverty continue to be confronted by financial barriers which take a heavy toll on their lives and on the lives of their children. The subsidy policy is not clear: few people know exactly what it covers and what treatments still have to be paid for. That confusion allows a situation where medical staff can demand unofficial payments for medicines and services that should be free or subsidized. Amnesty International believes therefore that making obstetric services, including emergency obstetric services, free of charge would have a positive impact on access for all pregnant women, especially the poorest.

Finally, the authorities have to improve the quality of care by addressing shortages of staff and supplies, by improving the training of medical personnel and by putting in place a real system of accountability able to tackle internal failures of the health system such as stock shortages and misconduct by medical personnel.

Donors have a responsibility to sustain the efforts of the authorities of Burkina Faso in their efforts to reduce maternal mortality. International aid has to be co-ordinated so that the government and international and local NGOs can lead their projects in a coherent way. It should be predictable and stable, so that expectations are not raised among the public that cannot be met due to a sudden reduction in funds.

If the government, the donors and all the other actors, including NGOs, can act in a coordinated and accountable way, the progresses already achieved in the fight against maternal mortality will be entrenched and many more preventable deaths of pregnant women will be avoided.

RECOMMENDATIONS

Amnesty International urges the Burkina Faso authorities, and in particular the Ministry of Health, to ensure that the state meets its national and international obligations to respect, protect and promote the right to health, guaranteeing the equitable distribution of health facilities, goods and services, protecting the right of access and eliminating economic and physical barriers. Amnesty International also urges the Burkina Faso authorities to guarantee access to information on sexual and reproductive rights. The organization calls on donors to cooperate closely with the government in a long-term approach, ensuring access for all women to adequate reproductive health services, including emergency obstetric care.

1. ADDRESS DISCRIMINATION AGAINST WOMEN AND HARMFUL PRACTICES

The government has an obligation to take all appropriate measures to end discrimination against women in all its forms, including the elimination of customary practices which are harmful to women, or which are based on stereotyped roles for men and women and reinforce the subordination of women. The government should:

- Review its national legislation to ensure that early marriages are forbidden and that any discrimination between men and women regarding the age of marriage is removed.

- Ensure that harmful customary practices such as FGM – prohibited by law – and early and forced marriages are eliminated.

2. EXPAND AND IMPROVE FAMILY PLANNING SERVICES

Ensuring access to family planning and contraceptive methods is a vital part of any strategy for reducing maternal mortality. The government therefore should:

- Ensure that the 2005 Law on Reproductive Health is made a reality so that all women know their reproductive health rights.

- Undertake information and education campaigns aimed at both women and men to provide accurate, evidence-based, and comprehensive information about contraceptives and to correct commonly held misconceptions. Such efforts should include sexual education aimed specifically at adolescents and publicity for the provisions of the 2005 Law on Reproductive Health.

- Invest in an expansion of family planning services and information for all women, taking steps to ensure confidential access to such services and information for all women, including adolescents.

- Take all necessary measures to ensure that safe and legal abortion services are available, accessible, acceptable and of good quality for all women who require them in the circumstances as set out in national legislation.

- Repeal the provision of the Penal Code permitting the imprisonment of anyone who carries out an abortion.

3. REMOVE FINANCIAL BARRIERS TO ACCESS TO MATERNAL HEALTH CARE

Despite the adoption of the subsidy policy, costs related to health care continue to act as a barrier to women's access to reproductive health services, including emergency obstetric care. The authorities should therefore:

- Implement immediately and in full the subsidy policy in all health facilities and create robust monitoring and accountability systems. Set up a centralized revenue collection system and a mandatory system of providing receipts for any payments collected for services, supplies, transport and drugs.

- Consider introducing a total exemption from fees charged for services, drugs and supplies for reproductive health services, including emergency obstetric care.

- Communicate the policy clearly and in an accessible manner in all parts of the country to create awareness of the exemptions under the policy. Consider setting up information points within health facilities to inform people of their entitlements under the policy.

- As a matter of priority, implement the subsidy policy for women who are entitled to a total exemption from costs related to health care by identifying and publicizing the criteria to qualify for total exemption of costs. Create a transparent, participatory and accessible system for women to claim the exemption.

- Publicize the policy on generic medicines and set up a monitoring system to ensure that patients are not asked to pay for essential drugs.

4. IMPROVE THE AVAILABILITY AND ACCESSIBILITY OF REPRODUCTIVE HEALTH CARE

Most health centres, especially in rural areas, cannot deal with complications linked with pregnancy and do not have functioning ambulances at their disposal to transfer women to referral centres. The lack of proper communications between the primary heath centres, the regional and university hospitals renders the referral system largely dysfunctional. Furthermore, there are wide disparities in the distribution of health facilities between different areas of the country. The authorities should therefore:

- Ensure the equitable distribution of health facilities, goods and services throughout the country. When choosing locations for new health facilities and blood banks, prioritize the most marginalized sections of the population, who face the greatest barriers in accessing health facilities.

- Increase the recruitment of qualified staff and create incentives to encourage qualified staff to work in rural areas and ensure that they receive adequate training and support. Ensure that these incentives promote an equitable distribution of skilled medical personnel throughout the country.

- Set up a system for traditional birth attendants, women and their families to have access to reliable forms of transport to health facilities, particularly in emergencies.

- Establish and strengthen links between health facilities by providing better communications and transport equipment.

- Ensure that hospitals are fully equipped to offer emergency obstetric care and that they have proper ventilation, adequate supplies of electricity or alternative sources of power, drugs, blood and other materials necessary for providing care appropriate to their role within the health infrastructure.

- Ensure that the supplies and equipment necessary to maintain hygienic conditions are available and that hygienic standards are strictly enforced.

5. ENHANCE MONITORING AND EVALUATION AND ENSURE ACCOUNTABILITY

It is the responsibility of the government to address corruption and mismanagement within the health care system by establishing functioning, accountable institutions and systems. Civil society needs to play an active role in monitoring and evaluating the health care system.

- The Ministry of Health should monitor practices in health centres to ensure that informal and inappropriate fees are not levied.

- The Ministry of Health should strengthen norms and procedures aimed at ensuring that health care facilities are welcoming and respectful to all groups of women and young adolescents.

- The implementation of the PNDS should be monitored by mechanisms which provide for the involvement and participation of women who use reproductive and maternal health services, other community members and civil society in planning, monitoring and evaluation processes.

- Monitoring, evaluation and accountability mechanisms should be strengthened, including through systems to combat corruption and mismanagement in procurement, storage and distribution of drugs and supplies. Any complaint mechanisms should be readily accessible to people and well publicized.

- Concerted efforts must be made at the district, regional and national levels to accurately assess the number of women dying and the reason for their death in both communities and in health facilities. The Ministry of Health should take this information into account in devising policies and strategies to reduce maternal death. Relevant health care staff should be trained in data collection and there should be a system to ensure that data are accurately and routinely gathered.

- The government should ensure that medical personnel are trained to behave in a correct manner with patients and that any misconduct is penalized.

- The government should provide effective remedies to all victims, including access to justice and the right to reparations, including restitution, rehabilitation, compensation, satisfaction and guarantees of non-repetition.

- The government should sign and ratify the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights, allowing the right of individual petition.

- The government should encourage the National Human Rights Commission and other monitoring bodies to address violations of the right to health as part of their

work and ensure that systems to submit information about violations are accessible and well publicized.

- The government should work closely with donors and international agencies to strengthen its systems so that they are accountable, transparent and viable. Key priorities include civil service reform, building the leadership and management capacity of the Ministry of Health at the central and district levels, assistance in putting effective drug procurement systems in place and, in the longer term, improved health information systems.

- The government should work with all stakeholders including civil society, national and international NGOs and traditional leaders to carry out a countrywide media campaign to raise awareness of the importance of family planning, prevention of complications, the need for institutional deliveries, timely interventions, and the right to health.

6. IN LINE WITH INTERNATIONAL DEVELOPMENT COMMITMENTS, DONORS SHOULD:

- Support the government of Burkina Faso, with adequate long-term and predictable technical and financial assistance, in its efforts to ensure the removal of financial barriers to maternal health care and the availability and accessibility of reproductive health services, including emergency obstetric care, for all women throughout the country.

- Continue to support the government of Burkina Faso to ensure the availability and accessibility of sexual and reproductive health care for all, including adolescents.

- Work with the government of Burkina Faso to ensure an outcomes-based evaluation of the PNDS which identifies and addresses the continuing barriers faced by women and girls in access to sexual and reproductive health care, including emergency obstetric care.

- Support efforts to improve the training, recruitment, retention and working conditions of health staff, particularly in rural areas.

- Provide international co-operation and assistance to the government of Burkina Faso to help fulfil the right to the highest attainable standard of health in the country, through strengthening the health system and ensuring the prioritization of access to essential health care for the most marginalized and vulnerable.

- Ensure that technical assistance is directed, among other priorities, to improving data collection in the health system, including through maternal death audits, in order to inform sexual and reproductive health planning, policy and practice.

ENDNOTES

1 "Une femme enceinte a un pied dans la tombe et un pied sur la terre".

2 A document published in 2007 by the Burkina Faso Ministry of Health states that "approximately 2,783 women die every year through wanting to give birth, that is 232 maternal deaths a month or 58 maternal deaths a week or another 8 maternal deaths a day." See Ministry of Health, *Projet d'expérimentation de l'utilisation de prestataires communautaires dans la lutte contre la mortalité maternelle et néonatale au Burkina Faso*, November 2007, p1. According to the 2006 General Population and Housing Census (RGPH, Recensement général de la population et de l'habitat) the population of Burkina Faso was 14,017,262, and women formed 51.7 per cent of the population.

3 The WHO defines maternal mortality as the "death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes." See the WHO International statistical classification of diseases and related health problems, 10th Revision, Volume 2, 2nd edition, 2004, p98, available at http://www.who.int/classifications/icd/ICD10_2nd_ed_volume2.pdf (last accessed 5 November 2009).

4 The maternal mortality ratio calculates the number of women who die as a result of pregnancy and childbirth per 100,000 live births. See the International Planned Parenthood Federation website, available at http://www.ippf.org/en/Resources/Glossary.htm?g=M (last accessed 5 November 2009).

5 Ministry of Health, *Annuaire statistique Santé* (Health statistical yearbook) 2005, June 2006, p8. These figures are based on Demographic and Health Surveys (hereafter DHS).

6 The figure of 484 per 100,000 live births was used as the reference by the authorities during meetings with Amnesty International in 2008 and 2009. However, in an official document published in June 2009, the figure of 307.3 was given, but it is based on the 2006 RGPH, which uses a different method than the DHS. See Ministry of Health, *Annuaire statistique Santé 2008*, June 2009, p3.

7 Ministry of Health, *Tableau de bord Santé* (Health reporting schedule) 2008, June 2009, p23.

8 Traditional birth attendants are medically untrained women who assist pregnant women giving birth in the community.

9 Mooré is the language of the Mossi people, the largest ethnic group in Burkina Faso.

10 For the research that identified the three delays, see notably Sereen Thaddeus and Deborah Maine, "Too far to walk: Maternal mortality in context", *Social Science & Medicine*, April 1994, Volume 38(8), pp1091-1110.

11 Burkina Faso is ranked 177 out of 182 countries in the UNDP 2009 Human Development Report, available at http://hdrstats.undp.org/en/countries/data_sheets/cty_ds_BFA.html (last accessed 5 November 2009).

12 See UNDP 2009 Human Development Report.

13 Human Rights Council, National Report: Burkina Faso, 21 August 2008, para 95, A/HRC/WG.6/3/BFA/1, available at http://lib.ohchr.org/HRBodies/UPR/Documents/Session3/BF/A_HRC_WG6_3_BFA_1_BurkinaFaso_E.pdf (last accessed 5 November 2009).

14 The Demographic and Health Survey for the year 2003 indicates that only 0.8 per cent of deliveries were carried out in the private sector. See DHS 2003, p123.

15 The Ministry of Economy and Development in partnership with the National Institute of Statistics and Demography publishes every five years a DHS. This document, which is supported by USAID, UNICEF, UNFPA and the World Bank, is considered the most reliable source of statistics. The most recent

DHS dates from 2003. Amnesty International was told that the results of a survey conducted in 2008 should be published "soon."

16 The Ministry of Health annually publishes an *Annuaire statistique Santé* (Health statistical yearbook) as well as a *Tableau de bord Santé* (Health reporting schedule), the most recent of which, covering 2008, were published in June 2009. In addition a *Carte sanitaire* (Health Map) was published in 2007.

17 UN figures are mostly based on national statistics but use different methods of evaluation, including weighting.

18 Customary law consists of traditional and unwritten rules that regulate issues such as marriage, inheritance, divorce, and property.

19 CEDAW Committee, Combined fourth and fifth periodic reports of States parties: Burkina Faso, 9 February 2004, p29, CEDAW/C/BFA/4-5, available at www.unhcr.org/refworld/pdfid/4117495b4.pdf (last accessed 5 November 2009).

20 CEDAW Committee, Concluding Comments: Burkina Faso, 22 July 2005, para 27, CEDAW/C/BFA/CO/4-5, available at http://www.un.org/womenwatch/daw/cedaw/cedaw33/conclude/burkina_faso/0545036E.pdf (last accessed 5 November 2009).

21 National Institute of Statistics and Demography, *Annuaire statistique* (Statistical yearbook) 2008, April 2009, p57.

22 DHS 2003, p48.

23 The DHS 2003 states that "the practice of excision is very widespread in Burkina Faso as 77 per cent of the women report having undergone this practice." This study also indicates that 65 per cent of girls aged between 15 and 19 had been excised and that the proportion of women who have undergone this form of female genital mutilation is very similar in rural and urban areas (77 and 75 per cent respectively). See DHS 2003, pp204-205.

24 WHO study group on female genital mutilation and obstetric outcome, "Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries", *The Lancet*, 3 June 2006, Volume 367(9525), pp1835-1841.

25 This article states that the marriage age can be reduced for a "serious reason" *(pour motif grave)* by a civil court.

26 CEDAW Committee, Concluding Comments: Burkina Faso, 22 July 2005, para 25.

27 Joelle Palmieri, "Burkina: intensifier la lutte contre les mariages précoces", 5 March 2009, available at http://genre.francophonie.org/spip.php?article519 (last accessed 5 November 2009).

28 DHS 2003, p48.

29 For a link between early pregnancies and the risk of fistula, see for example UNFPA, *Needs Assessment Report: Findings from Nine African Countries*, 2003, available at http://www.unfpa.org/fistula/docs/ (last accessed 5 November 2009).

30 CEDAW Committee, Combined fourth and fifth periodic reports of States parties: Burkina Faso, 9 February 2004, p44.

31 Article 1 of the Constitution of Burkina Faso prohibits discrimination on several grounds including ethnicity, geographic location and gender.

32 Béatrice Nikièma, Slim Haddad, Louise Potvin, "Women bargaining to seek health care: norms, domestic practices, and implications in rural Burkina Faso", *World Development*, April 2008, Volume 36(4), p615.

33 Béatrice Nikièma, Slim Haddad, Louise Potvin, "Women bargaining to seek health care: norms, domestic practices, and implications in rural Burkina Faso", *World Development*, April 2008, Volume 36(4), p615.

34 Association Songui Manégré / Aide au Développement Endogène (Songui Manégré Association / Aid to Endogenous Development).

35 Ministry of Health, *Plan d'accélération de la réduction de la mortalité maternelle et néonatale au Burkina Faso (Feuille de route*), October 2006, p9, available at

http://www.sante.gov.bf/SiteSante/documents/dsf/feuille-route-mmn.pdf (last accessed 5 November 2009).

36 The eight Millennium Development Goals (MDGs) – which range from halving extreme poverty to halting the spread of HIV and providing universal primary education, all by the target date of 2015 – form a blueprint agreed to by all the world's countries and all the world's leading development institutions.

37 This number corresponds to a 75 per cent reduction from the 1993 maternal mortality ratio of 566 deaths per 100 000 live births. In 2004, the government of Burkina Faso recognized that "if the efforts are continued, the rate of decline compared to 1998 could hit the 50 per cent mark in 2015 (283 deaths per 100,000 live births) and draw closer to the millennium development goal set for Burkina Faso, which is 142 deaths per 100,000 live births." See Burkina Faso: Poverty Reduction Strategy Paper, July 2004, p39, available at http://planipolis.iiep.unesco.org/upload/Burkina%20Faso/PRSP/Burkina%20PRSP.pdf (last accessed 5 November 2009).

38 See Burkina Faso and UNDP, *Rapport pays: Suivi des objectifs du millénaire pour le développement*, December 2003, p21, available at http://www.pnud.bf/docs/RAPOMD.PDF (last accessed 5 November 2009). The UNDP considers that the national goal of 209 deaths per 100,000 live births will probably be met, but that the maternal mortality ratio will stay above the goal of 142 deaths set by the international community. See UNDP website, available at http://www.pnud.bf/FR/OMD.HTM (last accessed 5 November 2009).

39 Ministry of Health, *Plan national de développement sanitaire* (2001-2010), p19, available at http://www.cohred.org/HRWeb/CMS/pdf/PlanNationalDeveloppementSanitaire_Burkina_2001_2010.pdf (last accessed 5 November 2009).

40 Ministry of Health, *Annuaire statistique Santé 2008*, June 2009, p4.

41 For the figure concerning the health budget, see Ministry of Health, *Annuaire statistique Santé 2008*, June 2009, p4. For all the other figures in the table, see Ministry of Health, *Comptes nationaux de la santé de la reproduction Burkina Faso* 2005-2006 (National Accounts of Reproductive Health), June 2008, pp25-26.

42 The budget for reproductive health includes health care (deliveries, prenatal visits, counselling, infertility treatment, medical analysis...), drugs, salaries and training of health personnel, equipment, construction of health centres and medical research. See Ministry of Health, *Comptes nationaux de la santé de la reproduction Burkina Faso 2005-2006,* June 2008, pp25-26.

43 Ministry of Health, *Tableau de bord Santé 2008*, June 2009, p54.

44 During a summit in Abuja (Nigeria) in April 2001, African Heads of State pledged "to set a target of allocating at least 15 per cent of [their] annual budget to the improvement of the health sector." See the Abuja Declaration on HIV/AIDS, tuberculosis and other related infectious diseases, para 26, available at http://www.un.org/ga/aids/pdf/abuja_declaration.pdf (last accessed 5 November 2009).

45 Ministry of Health, Politique sanitaire nationale, available at http://www.sante.gov.bf/SiteSante/plans/psn.pdf (last accessed 5 November 2009).

46 Ministry of Health, *Plan national de développement sanitaire (2001-2010)*, p5.

47 Ministry of Health, *Plan national de développement sanitaire (2001-2010)*, pp30, 37-38 and 48-49.

48 Ministry of Health, *Plan de mise en œuvre de la stratégie nationale de subventions des accouchements et des soins obstétricaux et néonatals d'urgence au Burkina Faso*, April 2006.

49 In the late 1990s, the World Bank and the International Monetary Fund fostered the adoption of Poverty Reduction Strategies by many countries in the South. The elaboration of these strategies was clearly spelt out as a "precondition" for "access to debt relief and concessional financing from both institutions." See World Bank website, available at

http://web.worldbank.org/ WBSITE/ EXTERNAL/TOPICS/EXTPOVERTY/EXTPRS/0 ,,contentMDK:22283891~pagePK:210058~ piPK:210062~theSitePK:384201,00.html (last accessed 5 November 2009).

50 Ministry of Health, *Tableau de bord Santé 2005*, November 2006, p27, and *Annuaire statistique Santé 2008*, June 2009, pVII. Prioritizing primary health care in this way was in line with the 1978 Alma-Ata Declaration which underlined for the first time the importance of primary health care on an international level and was accepted by the member states of the WHO as vital to achieve the objective of "health for everyone".

51 Ministry of Health, *Annuaire statistique Santé 2005*, June 2006, p8 and *Annuaire statistique Santé 2008*, June 2009, p28.

52 Centrale d'Achats des Médicaments Essentiels Génériques et des Consommables Médicaux (CAMEG, Purchasing centre for essential generic drugs and medical goods).

53 For all the figures regarding the number of health centres in Burkina Faso, see Ministry of Health, *Annuaire statistique Santé 2008*, June 2009, pp24-25.

54 The CHU Yalgado in Ouagadougou and the CHU of Bobo-Dioulasso.

55 Comités de Gestion des Services de santé (COGES).

56 In the 1995 Decree governing the functioning of the COGES, there are no provisions for the active participation of women. During a mission in November 2009, Amnesty International learned that a new text on the COGES is being elaborated and experts have proposed that it provides that each committee should have at least one woman member. In written correspondence of the same month, an official of the Ministry of Health stated that it is difficult to evaluate women's participation as it varies from one COGES to another, but on average there are two women out of six elected members.

57 Ministry of Health, *Guide d'orientation pour la mise en œuvre du nouveau rôle des accoucheuses villageoises* (Orientation guide for the implementation of the new traditional birth attendant's role), December 2007, pp2 and 10.

58 *Certificat d'études primaires élémentaires* (CEPE).

59 For details of this training, see School of Public Health, *Programme de formation des agents de première ligne* (Training programme for front-line agents), February 1999.

60 Called *"eutociques"*.

61 Ministry of Health, *Guide pour la mise en place et le fonctionnement de cellules de gestion des urgences obstétricales et néonatales au niveau village* (Guide for the implementation and the functioning of management units of obstetric and neonatal emergencies at the village level), December 2007, p8.

62 Ministry of Health, *Tableau de bord Santé 2007*, June 2008, p50, and *Annuaire statistique Santé 2008*, June 2009, p2.

63 For example, in 2007, 68.33 per cent of all deliveries in the Central Region were medically assisted, while only 25.64 per cent were medically assisted in the northern Sahel Region. See Ministry of Health, *Annuaire statistique Santé 2007*, June 2008, pp55-56.

64 CESCR, General Comment 14, para 12, available at http://www.unhchr.ch/tbs/ doc.nsf/(symbol)/E.C.12.2000.4.En (last accessed 5 November 2009).

65 Human Rights Committee, General Comment 6, para 5. General Comments of the Human Rights Committee are available at http://www2.ohchr.org/english/bodies/ hrc/comments.htm (last accessed 5 November 2009).

66 Human Rights Committee, General Comment 28, para 10.

67 Human Rights Committee, Concluding Observations: Mali, 16 April 2003, para 14, CCPR/CO/77/MLI, available at http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/ CCPR.CO.77.MLI.En?Opendocument (last accessed 5 November 2009).

68 CEDAW Committee, General Recommendation 24, para 2. CEDAW

Committee's recommendations are available at http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm (last accessed 5 November 2009).

69 Article 25 of the UDHR provides that "motherhood and childhood are entitled to special care and assistance." See also ICESCR, Article 12, which defines the right to health, and CEDAW, Article 12(2).

70 CESCR, General Comment 14, para 21.

71 African Commission on Human and Peoples' Rights, Resolution 135 on maternal mortality in Africa, 24 November 2008, available at http://www.achpr.org/english/resolutions/resolution135_en.htm (last accessed 5 November 2009).

72 CEDAW, Preamble.

73 CEDAW, Article 12(1).

74 CEDAW, Article 14(2)(b).

75 ACHPR, Article 18(3).

76 CRC, Article 24(1).

77 ICESCR, Article 12.

78 CRC, Article 2.

79 See WHO, "Gender and Human Rights: Sexual Health", available at http://www.who.int/reproductivehealth/topics/gender_rights/sexual_health/en/index.html (last accessed 5 November 2009).

80 Ministry of Health, *Plan stratégique de sécurisation des produits de la santé de la reproduction 2009-2015* (Reproductive Health Products Security Strategic Plan), January 2009, p28.

81 An unintended pregnancy is a pregnancy that is identified by the mother as either unwanted or mistimed (occurring earlier than wanted) at the time of conception.

82 See Nils Daulaire et al., *Promises to Keep: The Toll of Unintended Pregnancies on Women's Lives in the Developing World*, Global Health Council, 2002, p42, available at http://www.globalhealth.org/assets/publications/PromisesToKeep.pdf (last accessed 5 November 2009).
In this study, the expression "unintended pregnancies" comprises unintended births and abortions.

83 An unwanted pregnancy is a pregnancy that the pregnant woman or girl decides, of her own free will, is undesired.

84 CEDAW, Article 16(1)(e).

85 CEDAW Committee, General Recommendation 24, para 31(c).

86 Loi n° *049-2005/AN portant santé de la reproduction* (Law on Reproductive Health), available at http://www.legiburkina.bf/jo/jo2006/no_06/Loi_AN_2005_00049.htm (last accessed 5 November 2009).

87 See Décret n° *2009-676/PRES/PM/MS portant conditions de création et d'ouverture d'une structure privée de santé de la reproduction* (Decree on the creation and opening of a private reproductive health structure) and Décret n° *2009-720/PRES/PM/MS/MEF portant sur les conditions de fabrication et d'importation des produits contraceptifs au Burkina Faso* (Decree on the production and import of contraceptive products in Burkina Faso), October 2009.

88 CEDAW Committee, Concluding Comments: Burkina Faso, 22 July 2005, para 36.

89 Ministry of Health, *Plan stratégique de sécurisation des produits contraceptifs* (2006-2015), p16.

90 Ministry of Health, *Plan stratégique de sécurisation des produits de la santé de la reproduction* (2009-2015), p17.

91 Information provided to Amnesty International by an official of the Ministry of Health.

92 DHS 2003, p69.

93 See Contraceptive prevalence rate by UN Data, based on the UNICEF's State of the World's Children 2009, available at http://data.un.org/Data.aspx?d=SOWC&f=inID%3A34 (last accessed 5 November 2009).

94 CEDAW Committee, Combined fourth and fifth periodic reports of States parties: Burkina Faso, 9 February 2004, p38.

95 DHS 2003, pp64 and 65.

96 DHS 2003, p73.

97 The DHS 2003 states that while only 11 per cent of women with no formal education use contraception (6 per cent modern methods and 5 per cent traditional methods), among women with primary school education, these proportions are 19 per cent (13 per cent modern methods and 5 per cent traditional methods) and for the most educated woman 52 per cent (43 per cent modern methods and 9 per cent traditional methods). See DHS 2003, p74.

98 Loi n° *049-2005/AN portant santé de la reproduction* (Article 9).

99 Article 11 of the Law on Reproductive Health stresses that, "all individuals, including adolescents and children, and all couples have the right to information, to education, concerning the advantages, the risks, and the efficiency of all methods of birth regulation."

100 Ministry of Health, *Plan stratégique de sécurisation des produits contraceptifs* (2006-2015), p18.

101 CEDAW Committee, Concluding Comments: Burkina Faso, 22 July 2005, para 36.

102 Commission on Human Rights, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 16 February 2004, para 28, E/CN.4/2004/49, available at http://www.unhchr.ch/Huridocda/Huridoca.nsf/0/8585ee19e6cf8b99c1256e5a003524d7/$FILE/G0410933.pdf (last accessed 5 November 2009).

103 Ministry of Health, *Plan stratégique de sécurisation des produits de la santé de la reproduction* (2009-2015), p29.

104 In all, 850 health providers in 13 regions and 54 private professionals in family planning were trained. See Ministry of Health, *Plan stratégique de sécurisation des produits de la santé de la reproduction* (2009-2015), pp30-31.

105 Ministry of Health, *Plan stratégique de sécurisation des produits de la santé de la reproduction (2009-2015)*, p36.

106 Injectable contraceptives are administered by a deep intramuscular injection into the muscle of the arm or buttock. They maintain a sufficient level of hormone to ensure contraception for one to three months, depending on the type.

107 A contraceptive implant is a small tube placed below the skin under local anaesthetic. Each implant lasts three or five years.

108 According to official figures, the most widespread modern methods used in Burkina Faso are injectable contraceptives (56.86 per cent), the pill (28.25 per cent), implants (7.27 per cent) and condoms (5.74 per cent). See Ministry of Health, *Annuaire statistique Santé 2008, June 2009*, p52.

109 Ministry of Health, *Plan stratégique de sécurisation des produits contraceptifs* (2006-2015), p14.

110 Ministry of Health, *Plan stratégique de sécurisation des produits de la santé de la reproduction* (2009-2015), p29.

111 Discussions with an official from UNFPA, June 2009.

112 United Nations Population Division, Department of Economic and Social Affairs, *Abortion Policies: A Global Review*, 2002, p76, available at http://www.un.org/esa/population/publications/abortion/profiles.htm (last accessed 5 November 2009).

113 Ministry of Health, *Tableau de bord Santé 2008*, June 2009, p23.

114 According to a 2002 UN document, "[the government's] primary motivation was a concern for maternal health." See United Nations Population Division, Department of Economic and Social Affairs, *Abortion Policies: A Global Review*, 2002, p76.

115 The limitations of this law were stressed by international NGOs in a submission to the Human Rights Council before the 2008 Universal Periodic Review of Burkina Faso. They stated that the legal prohibition of non-therapeutic abortions "increases the rate of illegal abortion. In fact economic difficulties, in early pregnancy and especially parents'

hostility in the face of pregnancy before marriage, plus the fact that sexuality is so often seen as taboo, are all factors that encourage illegal abortion." See Human Rights Council Working Group on the Universal Periodic Review, 15 September 2008, para 32, A/HRC/WG.6/3/BFA/3, available at http://lib.ohchr.org/HRBodies/UPR/Documents/Session3/BF/A_HRC_WG6_3_BFA_3_E.pdf (last accessed 5 November 2009).

116 Commission on Human Rights, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 16 February 2004, paras 24-25.

117 Commission on Human Rights, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 16 February 2004, para 30.

118 See International Planned Parenthood Federation's website, "West African health ministers call for passage of abortion laws", available at http://www.ippf.org/NR/exeres/2B9BBD89-88D4-4940-90CD-950916B1B129.htm (last accessed 5 November 2009).

119 Ministry of Health, *Annuaire statistique Santé 2007*, June 2008, pp19-20.

120 In some of these remote regions, populations are very dispersed and live in desert areas.

121 The health districts without a district or regional hospital are: Mangodara (Cascades region); Bittou, Garango and Pouytenga (Centre East region); Réo and Sapouy (Centre West region); Manni and Gayéri (Eastern region); Kvigué and Léna (Hauts Bassins region); Gourcy (Northern region). See Ministry of Health, *Annuaire statistique Santé 2008*, June 2009, pp24-25.

122 The rainy season in Burkina Faso starts in June and ends in October.

123 This figure was given to Amnesty International by the nurse in charge of this CSPS.

124 CEDAW, Article 14(2)(b).

125 CESCR, General Comment 14, para 21; CEDAW Committee, General Recommendation 24, para 31(b).

126 CEDAW Committee, General Recommendation 24, para 21.

127 CESCR, General Comment 14, para 43.

128 A study of the quality of care carried out in a district hospital in Ouagadougou underlines the importance of being accompanied. "The women who come alone, without someone to accompany them, have been qualified as 'delinquents' or as 'socially disadvantaged persons' … To be alone a priori credibly means that one has no money (it is the accompanying person who pays the material and the prescriptions, and thus a solution has to be found for the deprived woman); it also means that there is a certain number of tasks normally devolved to the accompanying person which have to be 'handled': wash the soiled linen, deal with the placenta, feed the pregnant woman, etc." See Charlemagne Ouédraogo, David Bazié, Marc-Eric Gruénais, Fatoumata Ouattara, Dominique Pobel, Cyril Wissocq, Dominique Dubourg, Vincent De Brouwere, Fabienne Richard, *Programme d'amélioration de la qualité et de l'accès aux soins obstétricaux d'urgence dans les pays en développement, Analyse situationnelle Secteur 30 Ouagadougou*, p66.

129 The Bamako Initiative was adopted in 1987 by Health Ministers of the WHO African Region. According to an expert of the issue of equity and user-fees in West Africa: "the [Bamako] initiative differs from the national policy of user fees, whose main objective is to generate income, in that its introduction should improve the quality of service and ensure equity in access to care... A stock of essential generic drugs is provided by donors to the dispensary management committee (composed of representatives of the population). The drugs must then be sold to users at a profit. This profit, in addition to payments by users for consultations (direct payment = user fees), serves to buy back the initial stock of drugs, and to improve access to care and quality of service (staff incentives, building repairs, etc)." See Valéry Ridde, "Fees-for-services, cost recovery, and equity in a district of Burkina Faso operating the Bamako

Initiative", *Bulletin of the World Health Organization*, 2003, Volume 81(7), p532.

130 The government has withdrawn fees for people suffering from tuberculosis or leprosy (1984), or HIV/AIDS (1991) as well as preventive care for vulnerable groups (consultations for pregnant and breastfeeding women) and for patients with meningitis (2002) and for victims of severe malaria (2005).

131 A circular from the Secretary General of Health in February 2002 asked health centres to make certain preventive treatments free of charge, including medicines against anaemia (iron) and malaria (chloroquine). In March 2003, prenatal visits were made free for all pregnant women.

132 In 2004, World Bank representatives participated with the government when the terms of reference of this policy were elaborated. Later, they took part in sessions in which the strategy was devised. To Amnesty International's knowledge, the decision to set the rate of subsidy at 80 per cent was taken by the government of Burkina Faso; the World Bank played no role in the discussions and decision.

133 This budget was calculated taking into account the estimated number and cost of medical interventions. See Ministry of Health, *Stratégie nationale de subvention des accouchements et des soins obstétricaux et néonataux d'urgence au Burkina Faso*, 2006. For a detailed analysis of the origin and application of this subsidy strategy, see the study financed by UNICEF and co-ordinated by the Institute of Tropical Medicine at Antwerp, Valéry Ridde, Abel Bicaba, *Revue des politiques d'exemption/subvention du paiement au Burkina Faso. La stratégie de subvention des soins obstétricaux et néonataux d'urgence*, 16 January 2009.

134 The subsidy is only 60 per cent when pregnant women go directly to referral centres instead of going first to the CSPS. This is intended to deter bottlenecks at the referral levels.

135 There is an official list of what should be included in kits for normal deliveries and for caesarean sections, but an expert told Amnesty International in August 2009 that "in reality, the contents of these kits vary significantly from one region to another which causes real problems."

136 Amnesty International was given this information by patients and members of their families from both urban and rural areas. This information emerged in individual interviews, and also in focus group discussions.

137 A near-miss in this context refers to a woman who came close to maternal death, but did not die.

138 Valéry Ridde, Abel Bicaba, *Revue des politiques d'exemption/subvention du paiement au Burkina Faso. La stratégie de subvention des soins obstétricaux et néonataux d'urgence*, 16 January 2009, p19.

139 There is a system for acquiring a "certificate of indigence" from the Ministry of Social Action, but people have to ask for it at district offices, which means that most of the rural population do not have access to them. According to an expert on the health system in Burkina Faso, "these certificates are being given in dribs and drabs by officials of the Ministry of Social Action who are only present in towns and who use criteria which are not uniform throughout the country."

140 Village selection committees made lists of people considered to be indigent, using their knowledge of the population combined sometimes with field visits to households. The list was validated by the chief of the village, the mayor, and finally by the COGES which had the final word. The COGES only validated 47.53 per cent of those selected. Half those identified as indigent were women. See Valery Ridde, Maurice Yaogo, Yamba Kafando, Omarou Sanfo, Norbert Coulibaly, Abdouaye Nitiema, Abel Bicaba, "A community-based targeting approach to exempt the worst-off from user fees in Burkina Faso", J. Epidemiol Community Health, 19 August 2009.

141 Valéry Ridde, Abel Bicaba, Revue des politiques d'exemption/subvention du paiement au Burkina Faso. La stratégie de subvention des soins obstétricaux et

néonataux d'urgence, 16 January 2009, p20.

142 The DHS 2003 states that 46.4 per cent of the population lives below the poverty line.

143 Several women at a focus group in Ouagadougou in March 2009 also told Amnesty International that taxi drivers demand higher fares than normal when pregnant women need to reach a health facility fast. One woman said: "some taxi drivers have no pity for us, when they see that we are about to deliver, they take advantage of the situation and ask for higher fares."

144 Boubacar Kaboré, *Etude des déterminants de la corruption passive*, 2005, available at http://www.memoireonline.com/07/08/1194/m_etude-des-determinants-de-la-corruption-passive-chr-ddg.html (last accessed 5 November 2009).

145 REN-LAC, *État de la corruption au Burkina Faso* (State of corruption in Burkina Faso), 2006 Report, December 2007, p29.

146 Certain African countries such as Uganda and South Africa have adopted policies to end user fees. See Valery Ridde, Florence Morestin, *Une recension des écrits scientifiques sur l'abolition des frais aux usagers dans les services de santé en Afrique*, January 2009, available at http://www.medsp.umontreal.ca/vesa-tc/pdf/synthese_abolition_finale.pdf (last accessed 5 November 2009).

147 Ministry of Health, *Rapport de synthèse de la rencontre du Comité national de suivi des programmes et stratégies de réduction de la mortalité maternelle et néonatale* (Report of the meeting with the National Committee following up the programmes and strategies to reduce maternal and neonatal death), 1 June 2007, p3.

148 It seems that the refusal to provide free contraceptive products derives from this same idea. A representative of UNFPA told Amnesty International in June 2009 that "the cost of contraceptive products creates a barrier for the poorest women, but the government has made the choice not to offer free contraception in order not to give them advantage over the rest of the population". For a discussion about user fees in developing countries, see David de Ferranti, *Paying for health services in developing countries: a call for realism*, World Health Forum, 1985, Volume 6.

149 In 2006 in Niger, the German NGO HELP, financed by ECHO, tested the total exemption of payment for children under the age of five and pregnant and breastfeeding women in two districts. The Niger government then decided to make it a national policy, and it was extended to cover the whole territory in 2007. See Valery Ridde, Aissa Diarra, *A process evaluation of user fees abolition for pregnant women and children under five years in two districts in Niger (West Africa)*, BioMed Central Health Services Research, 3 June 2009, available at http://www.reliefweb.int/rw/rwb.nsf/db900sid/MUMA-7SP7XZ?OpenDocument (last accessed 5 November 2009).

150 For example, a study in Nigeria revealed that "the number of deliveries at a main regional hospital plummeted by 46 per cent following the introduction of user fees." See Centre for Reproductive Rights and Federation of Women's Lawyers, *Failure to Deliver: Violations of Women's Human Rights in Kenyan Health Facilities*, 2007, p51, available at http://www.fidakenya.org/publication/failure%20to%20deliver.pdf. See also Overseas Development Institute, *Alternative Social Health Protection in West and Central Africa: Achieving Equitable Access to Health Care and Reducing Child and Maternal Mortality; Save the Children, An Unnecessary Evil? User Fees for Health Care in Low-income Countries*, 2005, available at http://www.savethechildren.org.uk/en/docs/An_Unnecessary_Evil.pdf; and Save the Children, *Freeing up Health Care: A Guide To Removing User Fees*, 2008, available at http://www.savethechildren.org.uk/en/docs/Freeing_up_Healthcare.pdf (last accessed 5 November 2009).

151 WHO, World Health Report 2005, p140, available at http://www.who.int/whr/2005/whr2005_en.pdf (last accessed 5 November 2009).

152 Save the Children, *Paying With Their Lives: The Cost of Illness for Children in Africa*, 2006, available at http://www.savethechildren.org.uk/en/docs/paying_with_their_lives.pdf (last accessed 5 November 2009). See also Centre for Reproductive Rights and Federation of Women's Lawyers, *Failure to Deliver: Violations of Women's Human Rights in Kenyan Health Facilities*, 2007, p54.

153 *Global Campaign for the Health Millennium Development Goals 2009, Leading by Example – Protecting the most vulnerable during the economic crisis*, p53, available at http://www.ausaid.gov.au/publications/pdf/lead_by_example.pdf (last accessed 5 November 2009).

154 See International Health Partnership, "Leaders commit new finance to tackle women's and children's health in the developing world", available at http://www.internationalhealthpartnership.net/en/taskforce (last accessed 5 November 2009).

155 According to the WHO, "By and large, the introduction of user fees is not a viable answer to the underfunding of the health sector: it institutionalizes exclusion of the poor and does not accelerate progress towards universal access and financial coverage. Nevertheless, abolishing user fees where they already exist is not a panacea: it needs to be accompanied, from the very day they are brought to an end, by structural changes and a refinancing of the health services… Without other necessary structural reforms – increased 24-hour availability of services, improved resourcing and referral, enhanced technical capacity, and changed attitudes to patients – gains made by removing financial barriers alone may not be adequate." See WHO, *World Health Report 2005*, p139. See also Save the Children, *Freeing up Health Care: A Guide To Removing User Fees*, 2008.

156 CESCR, General Comment 14, para 12(b).

157 CEDAW Committee, General Recommendation 24, para 21.

158 CEDAW Committee, General Recommendation 24, para 27.

159 UN General Assembly, Report of the Special Rapporteur on the highest attainable standard of physical and mental health, 13 September 2006, para 17(b), A/61/338, available at http://www.atmindex.org/download/10 (last accessed 5 November 2009).

160 Ministry of Health, *Plan national de développement sanitaire* (2001-2010), p32.

161 An obstetrician working in Ouagadougou told Amnesty International in June 2009 that one of the district hospitals "does not have an electricity generator as a back-up in the eventuality of a power cut during operations in the surgical unit".

162 *Décret n° 2000-449/PRES/PM/MS du 6 octobre 2000 portant création du Centre National de Transfusion Sanguine* (Decree on the creation of the National Blood Transfusion Centre). Its missions include "the supply to all health facilities in the country of blood products for which it guarantees the sampling, treatment … conditioning and distribution" as well as "the guarantee of transfusion safety."

163 WHO, *Aide-Mémoire for National Blood Programmes*, 2002, available at http://www.who.int/bloodsafety/transfusion_services/en/Blood_Safety_Eng.pdf (last accessed 5 November 2009).

164 Meeting with an official in charge of the system of blood transfusion on a national level in June 2009.

165 Meeting with an official in charge of the system of blood transfusion on a national level in June 2009.

166 Ministry of Health, *Tableau de bord Santé 2008*, June 2009, p50.

167 Ministry of Health, *Tableau de bord Santé 2008*, June 2009, p6.

168 Ministry of Health, *Annuaire statistique Santé 2007*, June 2008, pp27-29.

169 Ministry of Health, *Carte sanitaire 2007*, p79.

170 UN General Assembly, Report of the Special Rapporteur on the highest attainable standard of physical and mental health, 13 September 2006, para 17(a).

171 WHO, International Confederation of Midwives (ICM) and the International Federation of Gynaecology and Obstetrics (FIGO), *Making pregnancy safer: the critical role of the skilled attendant*, 2004, p1, available at http://whqlibdoc.who.int/publications/2004/9241591692.pdf (last accessed 5 November 2009).

172 In Burkina Faso, midwives have a higher level of entry requirement than auxiliary midwives. Trainee midwives need a school leaving diploma plus a final year certificate. Auxiliary midwives need a basic school leaving qualification. Midwives' training takes three years, while auxiliary midwives' training only takes two years, and midwives study more theory and more courses on normal deliveries and complications. For example, midwives have 30 hours' training on emergency obstetric care, while auxiliary midwives only have 15. For details, see Charlemagne Ouédraogo, David Bazié, Marc-Eric Gruénais, Fatoumata Ouattara, Dominique Pobel, Cyril Wissocq, Dominique Dubourg, Vincent De Brouwere, Fabienne Richard, *Programme d'amélioration de la qualité et de l'accès aux soins obstétricaux d'urgence dans les pays en développement, Analyse situationnelle Secteur 30 Ouagadougou*, pp88-91.

173 A partograph is a tool used to monitor all stages of labour of a pregnant woman. It is essential to the woman's and infant's well-being and allows a timely response in case of a complication. WHO standards require that all deliveries are monitored with a partograph. See WHO, *The Partograph*, 1988, available at http://whqlibdoc.who.int/hq/1988/WHO_MCH_88.4.pdf (last accessed 5 November 2009).

174 For detailed information about the curriculum of this training see the document published by the School of Public Health, *Programme de formation des accoucheuses brevetées*, July 2008.

175 WHO, International Confederation of Midwives (ICM) and the International Federation of Gynaecology and Obstetrics (FIGO), *Making pregnancy safer: the critical role of the skilled attendant*, 2004, pp1-2.

176 Amnesty International learned that quite often pregnant women who die during their transfer are not counted as maternal deaths as both the medical team who referred the woman and the one that received the body refuse to be held accountable for the death. The statistics on maternal mortality are therefore significantly lower than the reality.

177 For example, an obstetrician in Ouagadougou told Amnesty International in June 2009 that since one of the district hospitals in the capital did not have an electricity generator which could guarantee a continued power supply, "the people in charge of the maternity ward do not want to take needless risks with their patients. They prefer simply to transfer them to other facilities." Following the September 2009 floods, several services of the Yalgado university hospital have been transferred to other facilities in Ouagadougou, making the situation even more critical.

178 CESCR, General Comment 14, para 12.

179 This Programme has set up a new category of midwives called *Attaché(e)s Soins Santé en Obstétrique et Gynécologie* (ASSOG, Obstetric and Gynecological Health care attachés). The first recruitment exam took place in 2009 and the training programme lasts two years.

180 Fatoumata Ouattara, *Amélioration de la Qualité et l'Accès aux Soins Obstétricaux d'Urgence dans les pays en développement (AQUASOU)*, available at http://www.ird.bf/activites/ur002.htm (last accessed 5 November 2009).

181 See *Programme d'amélioration de la qualité et de l'accès aux soins obstétricaux d'urgence dans les pays en développement, Composante 2 – Burkina Faso, Rapport final d'activités, 1er janvier 2003 au 31 mars 2006*, p48, available at http://www.uonn.org/uonn/Aquasou/Rapport%20%20Final%20Aquasou%20BF%202006-09-05.pdf (last accessed 5 November 2009).

182 Ministry of Health, *Plan stratégique pour une maternité à moindre risque 2004-2008* (Motherhood at Lesser Risk Strategy), March 2004, p13, available at http://www.sante.gov.bf/SiteSante/documents

/dsf/plan-strategie-mmr.pdf (last accessed 5 November 2009).

183 This document highlighted the low availability of maternal and neonatal care, women's lack of access to maternal and neonatal care, the low level of community investment into maternal and prenatal health care and the lack of stakeholders' engagement at all levels. See Ministry of Health, *Plan d'accélération de la réduction de la mortalité maternelle et néonatale au Burkina Faso (Feuille de route)*, October 2006, p14.

184 Ministry of Health, *Plan stratégique de sécurisation des produits de la santé de la reproduction (2009-2015)*, p36.

185 Ministry of Health, *Plan national de développement sanitaire (2001-2010)*, p38.

186 Arrêté n° *2007-240/MS/CAB Portant Charte de l'Utilisateur des Services de Santé* (Decree on the Charter of Heath Services' User), Article 5.

187 At the regional level, the Federation of Associations of midwives from Centre and West Africa (FASFACO, Fédération des Associations de Sages-Femmes de l'Afrique du Centre et de l'Ouest) adopted in 2005 the African Charter of the midwife.

188 Ministry of Health, *Plan national de développement sanitaire* (2001-2010), p49.

189 Ordre des Médecins, Order of Doctors.

190 Amnesty International learned that in one case, in 2008, administrative sanctions were taken against medical personnel involved in the sales of medicines and vaccinations in a referral hospital and that judicial proceedings are under way.

191 Ministry of Health, *Guide pour les audits de décès maternels, néonatals et des échappées belles* (Guide for audits on maternal and neonatal deaths and near-misses), November 2008.

192 WHO, *Beyond the Numbers: Reviewing maternal deaths and complications to make pregnancy safer, 2004*, pp45-46, available at http://whqlibdoc.who.int/publications/2004/9241591838.pdf (last accessed 5 November 2009).

193 See Fabienne Richard, H. Filali, Vincent De Brouwere, "Les erreurs en médecine : Pourquoi et comment en parler?", *Revue d'Epidémiologie et de Santé Publique*, June 2005, Volume 53(3), pp315-335.

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195 Human Rights Council, Report of the Working Group on the Universal Periodic Review: Burkina Faso, 7 January 2009, para 98, A/HRC/10/80, available at http://lib.ohchr.org/HRBodies/UPR/Documents/Session3/BF/A_HRC_10_80_BurkinaFaso_E.pdf (last accessed 5 November 2009).

196 At the regional level, Burkina Faso ratified the African Union Convention on Preventing and Combating Corruption in November 2005. Article 12 of this instrument requires state parties to "create an enabling environment that will enable civil society and the media to hold governments to the highest levels of transparency and accountability in the management of public affairs." See the AU Convention on Preventing and Combating Corruption, adopted in Maputo, 11 July 2003, available at http://www.africa-union.org/Official_documents/Treaties_%20Conventions_%20Protocols/Convention%20on%20Combating%20Corruption.pdf (last accessed 5 November 2009).

197 Article 156 of the Penal Code defines active corruption as the action by "any agent or employee of the Administration… who accepts offers or promises, who receives donations or presents, to do an act of his or her functions or profession, even legal, but not subjected to salary."

198 This new organ merged three bodies whose mandate was to fight against corruption and fraud, the High Commission for the Coordination of Anti-Corruption Activities (HACLC, Haute Autorité de Coordination de la Lutte Contre la Corruption), the State Inspector General, and the National Commission for the Fight Against Fraud.

199 See ASCE, *Rapport général annuel d'activités 2008 de l'Autorité supérieure de contrôle de l'État*, p6, available at http://www.gouvernement.gov.bf/IMG/pdf_ASCE_Rapport_2008.pdf (last accessed 5 November 2009).

200 REN-LAC, *Etat de la corruption au Burkina Faso*, 2006 Report, December 2007, p10.

201 UN Convention against Corruption, adopted by the General Assembly by resolution 58/4 of 31 October 2003, available at http://www.unodc.org/documents/treaties/UNCAC/Publications/Convention/08-50026_E.pdf (last accessed 5 November 2009).

202 See General Framework for the Organization of Budget Support linked to the Strategic Framework for the Fight Against Poverty (CGAB-CSLP), 2005.

203 Ministry of Health, *Comptes nationaux de la santé de la reproduction Burkina Faso 2005-2006*, June 2008, p19. This document indicates that for the year 2006, out of a total budget of 12 million CFA francs (around US$27,200), the three financial sources for reproductive health were respectively 37.69 per cent from international donors, 30.81 per cent from the state and 28.9 per cent from households.

204 Ministry of Health, *Programme d'Appui au Développement Sanitaire (PADS) 2008-2012*, p10.

205 The World Bank's contribution to the PADS takes the form of a Health Sector Support and Multisectoral HIV/AIDS project that focuses mainly on the fight against HIV/AIDS and malaria. This project is partly providing unearmarked funding through PADS, partly earmarked funding for nutrition activities in six regions as well as supplies of bed nets and drugs for malaria. According to an official of the World Bank, this funding "will give Burkina the necessary flexibility to determine its priorities based on local disease burden while ensuring that key interventions – including for malaria, maternal and child health, nutrition, and HIV/AIDS prevention and treatment – receive the necessary financing." See World Bank press release, 27 April 2006, available at http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:20904900~pagePK:64257043~piPK:437376~theSitePK:4607,00.html (last accessed 5 November 2009).

206 Meeting with a GTZ official in Ouagadougou, July 2008.

207 The Paris Declaration on Aid Effectiveness aims to improve the way that aid is delivered and make it more effective at alleviating poverty. It set out a series of targets to be met by both donors and partner, by 2010, focused on five key principles for improving aid delivery: country ownership, alignment to partner country systems, harmonization and co-ordination of donor efforts, managing for results and mutual accountability for aid commitments. Progress on the implementation of the Paris Declaration was reviewed at the third High Level Forum on Aid Effectiveness in Accra, Ghana, in September 2008. The Accra Agenda for Action, which was endorsed by ministers of developing and donor countries and heads of multilateral and bilateral development institutions, affirmed a set of further commitments to take action to accelerate progress on improving aid effectiveness.

208 GAVI Alliance, Health System Strengthening, May 2009, available at http://www.gavialliance.org/resources/HSS_Burkina_Faso_Round_5_final.pdf (last accessed 5 November 2009).

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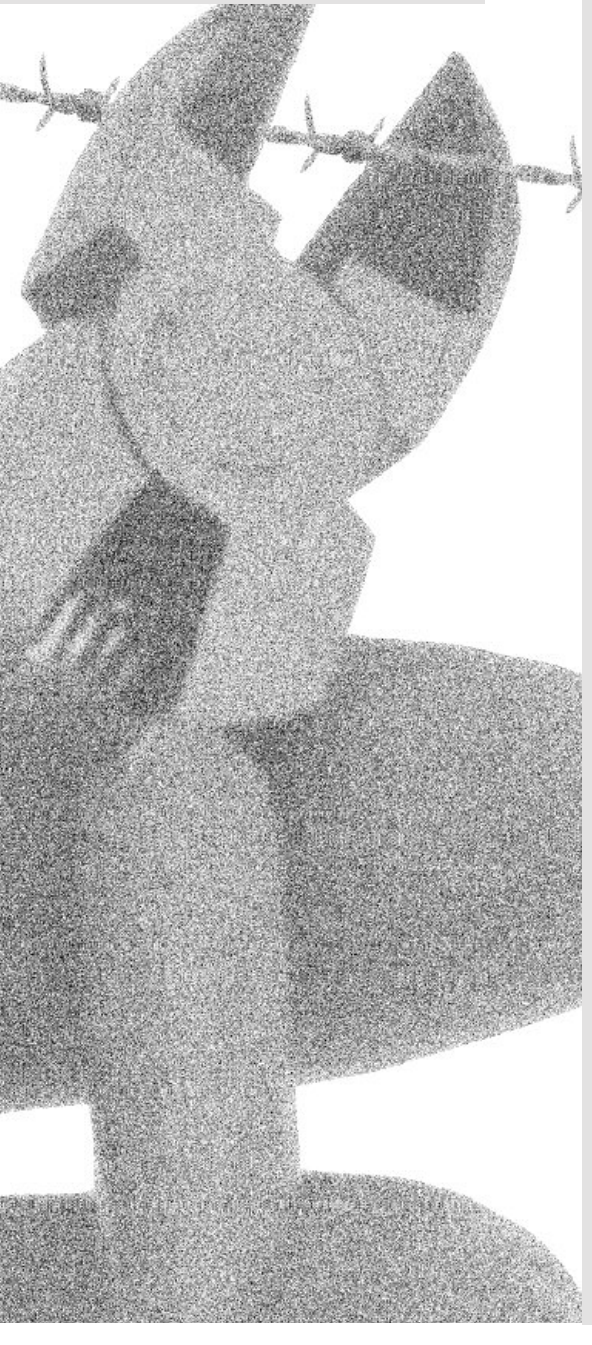

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MATERNAL MORTALITY IN BURKINA FASO

More than 2,000 women die in Burkina Faso every year from complications of pregnancy and childbirth. Most of these deaths could be prevented.

Some women die because they cannot reach a health facility capable of treating them, or because they arrive too late. Many lose their lives because their relatives cannot pay the fees demanded by medical personnel. Others die because of shortages – of blood, drugs, equipment or qualified medical staff. Maternal mortality takes its major toll on the poorest and the least educated women and those who live in rural areas, home to 80 per cent of the population.

The authorities in Burkina Faso have devoted effort and resources to reducing maternal mortality, with the help of the donor community. However, many pregnant women still cannot obtain the health care they need in time, and pregnancy all too often ends in tragedy. Amnesty International calls for better information and services for family planning, for the government to remove financial barriers to maternal health care and for improvements in access to care. To do less is to violate the right to health of the women of Burkina Faso.

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