KEY MESSAGES:

- The adolescent fertility rate in Burkina Faso is 115.4 births per 1,000 women 15-19 years old, slightly below Sub-Saharan Africa’s regional average of 117.4 births per 1,000 women 15-19 years old and well above the global average of 45 births.
- Female genital cutting is common in Burkina Faso; even though, it has no health benefits and is a human rights violation.
- Policy-makers in Burkina Faso need to raise the legal age of marriage to 18 years and enforce this, as early marriage is common.
- Promoting female completion of primary and secondary school and increasing labour force participation; strengthening adolescent girls and young women’s knowledge, awareness, and access to quality sexual and reproductive health (SRH) services (including family planning); and increasing the availability of these services will result in better health outcomes for not only adolescent girls and young women but their families and societies overall.

Introduction

Today’s adolescents and youth face substantial physical, social, legal, and economic barriers to meeting their SRH potential. Key factors underlying these issues are a lack of adolescent SRH (ASRH) policies and access to accessible, affordable, and appropriate health services. The impact that these factors have on adolescent health and development is clearly seen in Burkina Faso. Burkinabé adolescent girls face high adolescent fertility rates, early and forced marriage, an increased risk of maternal mortality, and a high unmet need for contraception, among others. Adding to this issue is a lack of access to education, basic health information, and SRH services, contributing to a lack of awareness and knowledge about SRH and traditional and harmful gender stereotypes.

The adolescent fertility rate is 115.4 births per 1,000 girls 15-19 years of age (World Bank, 2014). In 2010, almost a quarter (23.6 percent) of 15-19 year olds had a child or were currently pregnant, and 14-29 year olds represented 60 percent of Burkina Faso’s total fertility rate (INSD, 2012; Soulary, 2011). These rates are highest in rural areas. Contributing to this is low contraceptive use (6 percent of 15-19 year olds and 17 percent of 20-24 year olds use modern contraception) with over 20 percent of 15-19 year olds reporting an unmet need for contraception (INSD, 2012).

Maternal and infant mortality and morbidity are twice as high among young women and their children as that of older women. In 2010, 14 percent of all deaths due to maternal complications were among 15-19 year olds and 29 percent among 20-24 year olds, greatly diminishing a woman’s chance of continuing her education and limiting employment opportunities. Meanwhile, the average age at first marriage was 17.9 years with 29 percent of girls married between 15-19 years and two thirds married by the time they turned 24 years (INSD, 2012). Also, female genital cutting (FGC) is widespread with 58 percent of 15-19 year olds and 70 percent of those between 20-24 years subjected to it. This is more prominent in rural areas.
Given the paucity of research on ASRH in Burkina Faso, the World Bank conducted a three-part research project that included: (i) a quantitative analysis using Burkina Faso’s Demographic and Health Survey (DHS) data from 2003 and 2010 among female respondents 15-19 and 20-24 years of age; (ii) a literature review on the structural and proximal determinants of ASRH; and (iii) a mapping of the most recent ASRH policies and programs. The objectives of the study were to understand the impact that structural and proximal determinants have on access to ASRH services and health outcomes; and the impact that recently implemented policies and programs have on ASRH.

Study Findings

WEALTH, EDUCATION, AND EMPLOYMENT

The results found that 20-24 year olds showed greater improvements in wealth than 15-19 year olds between 2003 and 2010. The percentage of 20-24 year olds in the poorer category slightly decreased from 18.8 percent to 17.4 percent while there was a slight increase in poverty among 15-19 year olds from 15.2 percent to 16.4 percent. Adolescents increased their level of education during the same time period (figure 1).

Figure 1. Education among adolescent girls (15-19 years of age) and young women (20-24 years of age) by education level and year (2003 and 2010) (percent)


Indeed, Burkina Faso has been successful at ensuring that females attend school; the country is projected to achieve gender parity in primary school by 2014. However, the gender gap in primary school completion remains wide, with 34 percent of adolescent boys and 24 percent of girls in 2010 completing primary education. Also, literacy rates among females remain low: the country ranks as one of 5 countries with the lowest female (15-24 years) literacy rates (currently at 33 percent) globally. Additionally, 90 percent of poor children do not complete primary education in comparison to 54 percent of rich children (UNESCO, 2014).

In fact, Burkina Faso faces high out-of-school rates with over 1 million children estimated to be out-of-school (UNESCO, 2011). Adolescent girls enrolled in school are less likely to engage in sexual activity, while lower educational achievement and lower school attendance are associated with: younger age at first marriage; higher fertility rates; greater age differences between adolescent girls and their partners; negative gender norms and domestic violence; increased prevalence of HIV among adolescent girls; decreased contraceptive use; and decreased use of antenatal care.

MARITAL STATUS

Between 2003 and 2010, marriage increased among adolescent girls and young women, regardless of age. Early and forced marriage is prevalent (especially in rural areas) in Burkina Faso, contributing to higher fertility rates, unplanned pregnancies, and STIs including HIV/AIDS (Guiella, 2004).

SEXUAL ACTIVITY

Adolescents engage in sexual activity at a young age. One study found that 12-14 year olds were engaging in sexual activity, with adolescent boys more likely to be sexually experienced than girls (5.8 and 2 percent respectively) (Bankole, 2007).

CULTURAL AND GENDER NORMS AND VIOLENCE

The percentage of females circumcised decreased between 2003 and 2010, and more females were against the practice in 2010 (figure 2).

Figure 2. Cultural norms among adolescent girls (15-19 years of age) and young women (20-24 years of age) by norm and year (2003 and 2010) (percent)


Burkinabè women face rejection, rape, sexual violence, early and forced marriage, domestic violence, FGC, intimate partner violence, sexual harassment, and gender stereotypes and prejudices (Bigauette, 2007). Several articles have documented the prevalence and severity of
gender-based violence (GBV), its high prevalence among young women, and its association with poorer health outcomes and reduced wellbeing (JICA, 2013; Ministère de la Promotion de la Femme, 2009).

SRH KNOWLEDGE, ATTITUDES, AND PRACTICES

There is a high unmet need for family planning (FP) among adolescent girls, particularly in terms of spacing of births. Among 15-19 year olds, unmet need for spacing slightly increased from 8.2 percent in 2003 to 8.4 percent in 2010. Although knowledge of modern contraception increased between 2003 and 2010, most females stated that they were not currently using a contraceptive method while over 20 percent stated that they would never use a contraceptive method (figure 3). Importantly, a lack of contraceptive use puts the female at higher risk for STIs including HIV/AIDS and unplanned pregnancies (Guiella, 2007).

Figure 3. Current use of any contraceptive method among 15-19 year olds and 20-24 year olds by year (2003 and 2010) (percent)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Modern Method</td>
<td>30%</td>
<td>40%</td>
<td>25%</td>
<td>35%</td>
</tr>
<tr>
<td>Traditional Method</td>
<td>20%</td>
<td>25%</td>
<td>15%</td>
<td>20%</td>
</tr>
<tr>
<td>Not currently using</td>
<td>40%</td>
<td>35%</td>
<td>50%</td>
<td>45%</td>
</tr>
<tr>
<td>Will not use contraception</td>
<td>10%</td>
<td>5%</td>
<td>15%</td>
<td>10%</td>
</tr>
</tbody>
</table>


It also leads to higher abortion rates. Although it’s legal for therapeutic reasons, abortions range from 65 percent among 15-24 year olds to a rate of 60 induced abortions per 1,000 15-19 year olds in Ouagadougou; with rates higher among younger women than older age groups (Rossier, 2006; Bankole, 2013). Illegal abortions contribute to high adolescent maternal mortality and morbidity (MJJFPE, 2008), and a number of socioeconomic costs including: direct economic costs; health care costs arising from complications; and social costs associated with missing school, stigma and discrimination, and potential mental health issues (Thomas, 2013).

SRH knowledge is limited as well. One study found that 5 percent of adolescent girls and 9 percent of boys stated that they were well informed about pregnancy prevention (Bankole, 2007). This may be attributed to a lack of family and sexual education courses. A reported 10 percent of adolescent girls and 14 percent of boys stated that they received family or sexual education in school (Bankole, 2007).

ASRH HEALTH SERVICES AND USE

The percentage of 15-19 year olds who visited a health facility decreased from 42.7 percent in 2003 to 32 percent in 2010. There was an increase among 20-24 year olds seeking health care from 40.6 percent in 2003 to 60.4 percent in 2010. Delay in seeking healthcare among women could be attributed to: (i) Abusive and disrespectful conditions when seeking health care services, especially during pregnancy and childbirth (Amnesty International, 2009); and (ii) Some national programs that provide maternity care have not reduced out of pocket or poverty as much as was anticipated.

To address these barriers, the government has been working with organizations to subsidize emergency obstetrical and neonatal care, implement community based health insurance, and ensure skilled birth attendance (Ridde, 2011).

Overall, the DHS analysis found that among 15-21 year olds a higher level of education, a higher wealth index, living in an urban area, and regions outside of the Sahel predicted a lower level of unmet need for FP, increased use of health facilities, and a desire to have fewer children. These results were higher among 20-21 year olds than among 15-19 year olds. Married women were more likely to have a higher level of unmet need, increased hospital visits, and a desire to have more children.

Government Efforts

The government has implemented 5 Plans and Strategies that address young people’s SRH needs in various capacities. These are:

(i) The National Health Development Plan 2011-2020 (PNDS), prioritizes improving young people’s health and access to health care by strengthening the quality and accessibility of maternal and obstetric care; accelerating support for FP services; building human resource capacity for cancer and FGC; promoting clinical and community interventions; and integrating nutrition and primary health care strategies. However, financial constraints have limited the implementation of the PNDS and quality of services provided has been poor (UNFPA, 2012).


(iv) The National Policy on Education and Technical and Vocational Training involves various governmental agencies to improve access to vocational training for those 15 to 24 years of age.

(v) The National Gender Policy (PNG) was developed
in 2009 to promote: (i) equal rights; (ii) economic development and equitable access; (iii) equal participation in decision-making processes; (iv) dynamic partnerships for gender development; and (v) equity and equality information and awareness. Financial constraints undermine its current implementation.

**Challenges**

In addressing the influence of health and non-health policies and access to ASRH services on health outcomes, there are several challenges:

- **ASRH outcomes are not often measured in Burkina Faso**. Data on adolescent fertility rates may be collected and analyzed, however data on maternal morbidity and mortality, GBV, and domestic violence is not collected.
- **The lack of monitoring and evaluation of policies and programs makes it difficult to accurately estimate impact.**
- **Current social norms support withholding information from adolescents and youth.**
- **A lack of adequate and transparent funding** has been a key challenge to the implementation of ASRH policies and programs as the demand for health services and supplies has rapidly increased over the past few decades.
- **Government expenditure remains insufficient.** In 2009, only 6 percent of the total health budget was allocated to reproductive health, of which 5 percent was spent on maternal health and FP (Amnesty International, 2009).

Addressing each of these issues through policies and programs improves ASRH, contributes to the social and economic development of the country and results in reduced fertility rates; delayed voluntary and forced marriages; and reduced rates of FGC and physical abuse, leading to improved status for women in society, healthier communities, and economic growth and development (UNFPA, 2010).

**Conclusion**

The study findings confirm what is known about ASRH in many parts of the world: adolescents and youth lack access to basic SRH information and services. Traditional gender norms and stigma and discrimination associated with SRH are prevalent and contribute to low levels of knowledge, poor access to accurate and quality information and services, as well as harmful practices and norms. Early marriage and high adolescent fertility rates are the norm among adolescent girls. Promoting and enforcing ASRH policies using a gender approach while implementing ASRH programs and services, particularly in rural areas, can help prevent early/unplanned pregnancies, early marriages, FGC, high rates of STIs including HIV/AIDS, and the promotion of gender equality.

**References**


UNFPA. 2010. Investing in Young People as a part of the Poverty Reduction Strategy New York:UNFPA.


---

This HNP Knowledge Brief highlights key findings from a World Bank study on “Adolescent Sexual and Reproductive Health in Burkina Faso” prepared by a World Bank team including, Diana Bowser (Researcher, Brandeis University), Valeria Gemello and Jini Etoule (Consultants) and Rafael Cortez (World Bank’s Team lead). This report is part of the World Bank’s Economic Sector “Paving the Path to Adolescent Sexual and Reproductive Health” conducted by the Health, Nutrition and Population Global Practice and financed by The World Bank-Netherlands Partnership Program (BNPP).