COVERAGE MONITORING NETWORK

# Addressing barriers to access in Fada N'Gourma, Burkina Faso

## Case study

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### Justification

Health district of Fada N'Gourma in Burkina Faso bears a number of signs of a "privileged" health district in terms of provision of CMAM services: health authorities are extremely engaged and maintain regular contact with a plethora of non-governmental organisations which support the implementation of activities directly or indirectly linked with CMAM, the district is regularly chosen to pilot new regulations or innovative approaches and knows little of supply chain glitches.

The first SQUEAC investigation in Fada N'Gourma in February 2012 identified a weak coverage rate of **19.9%.** The following investigation in January 2014 showed a spectacular improvement by 28.1%, reaching a moderate coverage rate of **48%** and falling short of achieving SPHERE standards for rural settings by mere 2 percentage points. The latest coverage assessment using the SLEAC methodology carried out in the East region of Burkina Faso in November 2014, which covered the health district of Fada N'Gourma, classified the coverage in the district as "**moderate**", i.e. above 25% but below 50%.

The present case study aims to explore what combination of factors drove this remarkable increase in coverage and what areas might still need improvement to push the coverage rate in the health district above the **50%** benchmark.

### Summary of main reasons why coverage changed

- New and improved CMAM protocol in Burkina Faso, allowing for the introduction of new approaches, such as an engagement of traditional healers in screening/referral of SAM cases
- Change of a supporting partner with a narrowed focus on quality of care
- Availability of more NGO staff to train and support health centre personnel in the provision of CMAM services
- Better coordination among partners and outsourcing of CMAM components to other stakeholders (if beyond supporting partner's capacity)
- Engagement of community actors, namely community-based organisations
- Parallel NGO activities aiming at prevention of malnutrition and/or fighting its underlying causes

### Enabling environment

Despite its obvious negative effect on the well-being of concerned populations, the humanitarian crisis of 2012 drew a number of international partners to the health district of Fada N'Gourma to support national authorities in difficult times. Their arrival was accompanied by generous financial envelopes, which accelerated the implementation of a national scale-up plan of CMAM services in the region. A transition from a vertical to a horizontal approach based on the integration of CMAM services in public health facilities was initiated in January 2013 with the support of ACF.

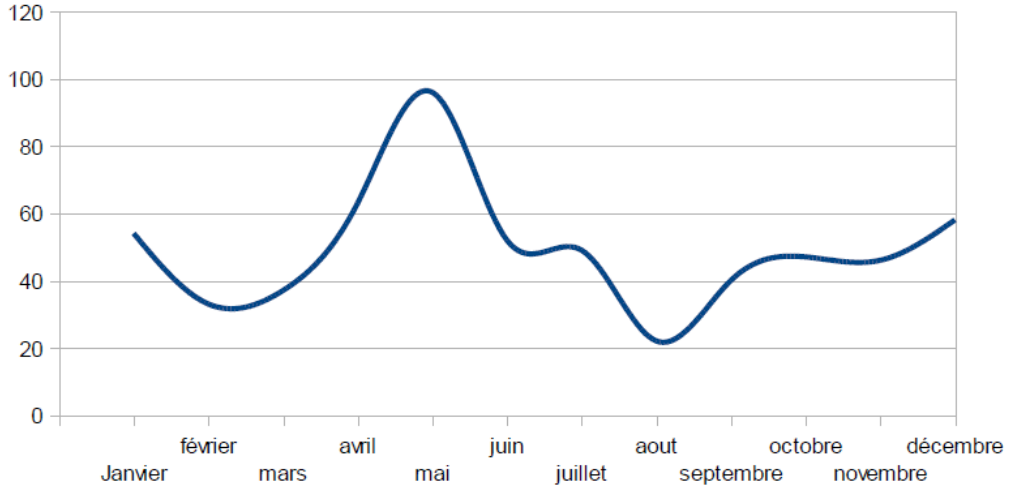
### Analysis of quantitative data

The analysis of quantitative data from two SQUEAC investigations shows considerable differences in multiple indicators. Rather low admission rates varying independently of a seasonal calendar in 2011 increase substantially in 2012 and 2013, copying the seasonality of linked factors while responding adequately to mass screening campaigns. Performance indicators stabilise above or below respective benchmarks and median MUAC at admission increases from critical 104mm in 2011 to acceptable 111mm in 2013.

- Admissions

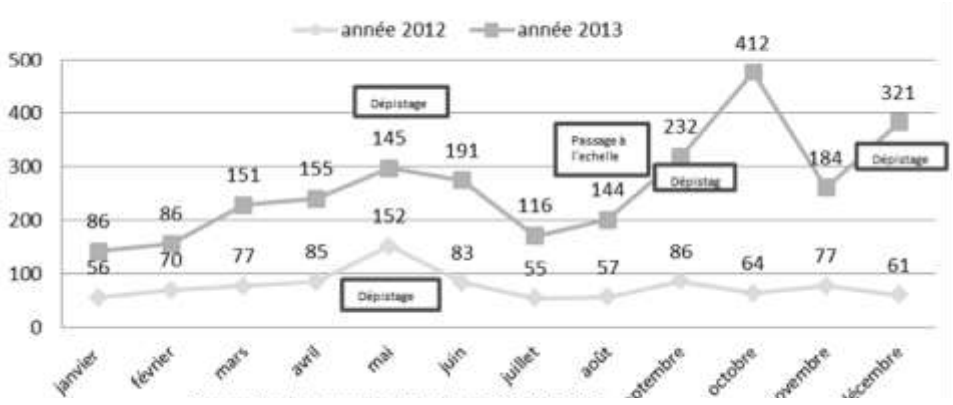
The evolution of admissions in 2011 did not correspond to the seasonal calendar with a peak in May (before the onset of the lean season) and very low numbers in August/September when SAM prevalence rises. Despite problematic accessibility at that time, screening activities in the last trimester did not seem to have a major impact on the increase of admissions during that period.

Figure 1: Evolution in admissions in 2011




The evolution of admission in 2012 and 2013 are more aligned with the seasonal calendar with peaks being accompanied by mass screenings during sensitive periods. While numbers are rather low for 2012, they double in 2013 and show predictable variation rhythms.

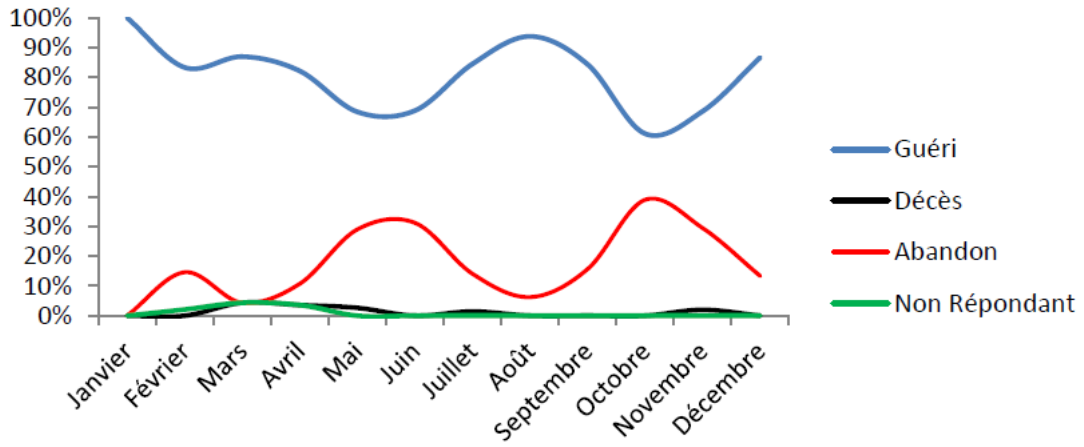
Figure 2: Evolution in admissions in 2012 - 2013



- Performance indicators

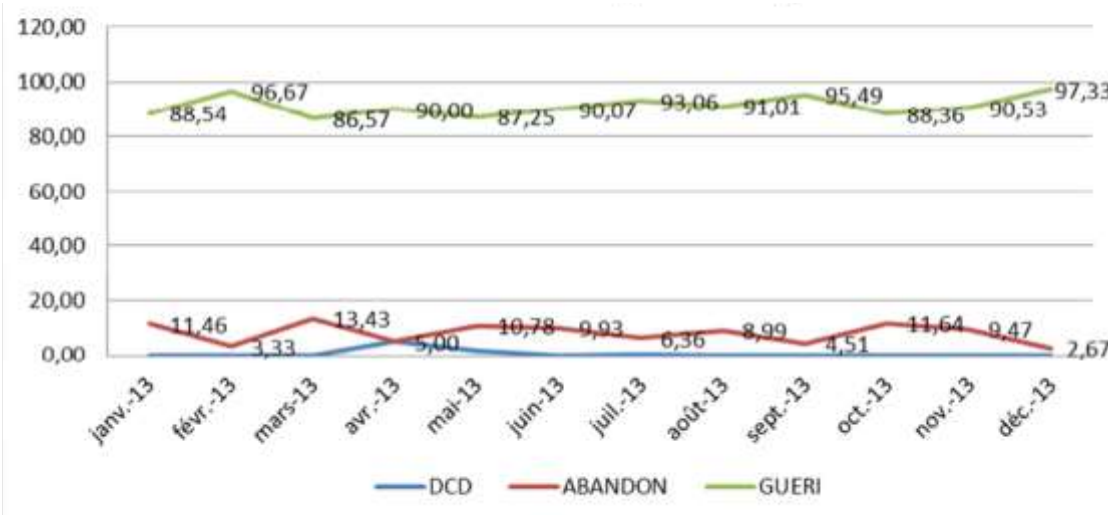
In 2011 performance indicators show great variations in discharged cured rates, which drop below 70% and 60% between May and June and October and November, respectively. This roughly corresponds with peaks in defaulting, which go above 30% and 40% in respective periods. Both sets of rates fail to achieve SPHERE standards for recovered and defaulting cases during above-mentioned periods.

Figure 3: Performance indicators in 2011




In 2013 all indicators are smoothed out with discharged cured changing slightly around 90% and defaulters between 3 to 14%. None of monthly recorded values fails to achieve SPHERE standards for recovered, defaulting or deceased cases – which besides a slight increase in April 2013 stabilises at 0.

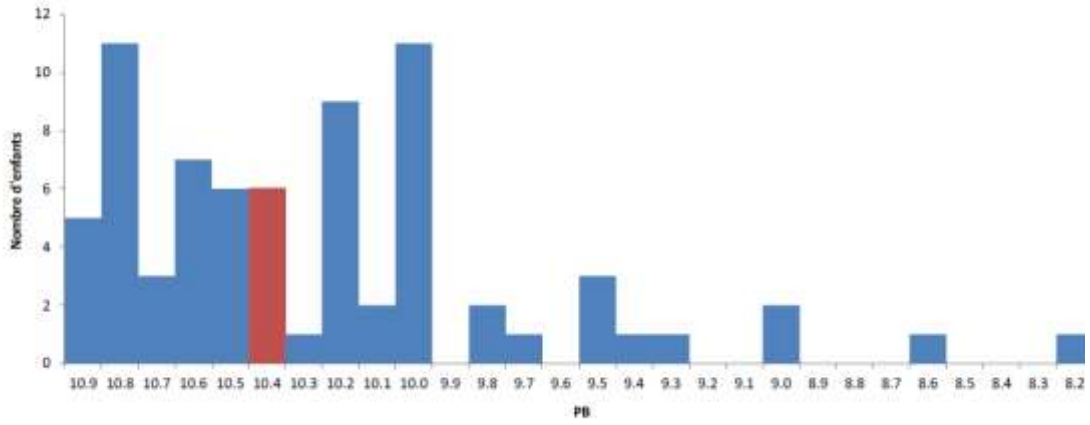
Figure 4: Performance indicators in 2013



- MUAC at admission

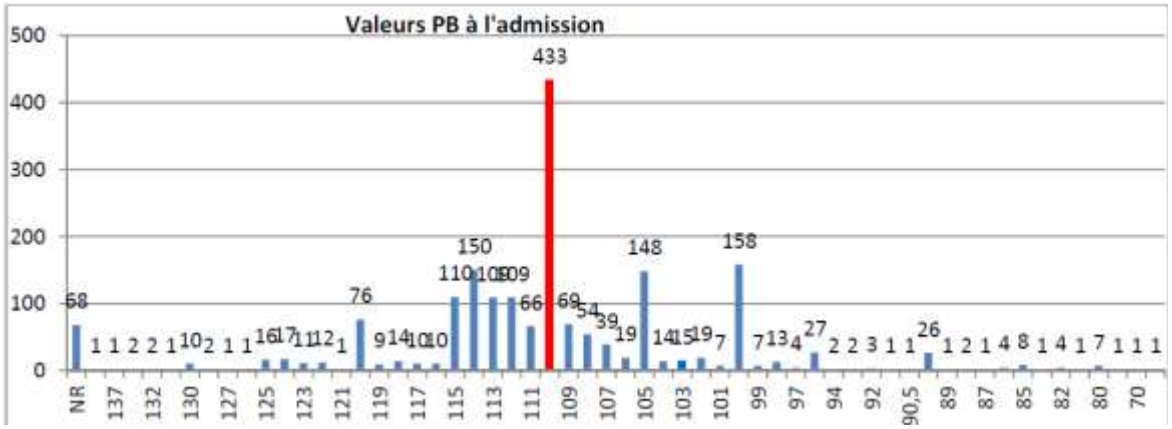
Median value for MUAC at admission in 2011 was calculated at 104mm with maximum recorded value at 109mm, which presents higher risk of health complications and mortality for admitted children.

Figure 5: MUAC at admission in 2011




In 2013 a significant improvement can be observed with median value for MUAC at admission calculated at 111mm and children being admitted as early as 115mm.

Figure 6: MUAC at admission in 2013




Analysis of barriers and boosters

A comparison of BBQ tools developed during SQUEAC investigations in 2012 and 2014 does not show a major development either on the barrier or the booster side. The lists are more populated in the 2014 report, which generally appears to be more detailed than its predecessor. None of the barriers cited in 2012 disappeared, yet few others appeared, for example wrong understanding of RUTF/RUTF sharing, low quality of service or long waiting times, which were linked to heavy workload of health personnel and the lack of sensitisation (in health facilities as well as in communities).

On the booster side, the programme maintained the good collaboration among partners and the appreciation of services by local populations. Their awareness about the availability of the programme at no cost increased sufficiently to add this factor on the booster list in 2014 along with mass screenings and use of health facilities in case of illness.

Table 1: Lists of barriers and boosters developed during SQUEAC investigations in early 2012 and 2014

| Date of Assessment | Main Barriers Identified | Main Boosters Identified |
|---|---|---|
| February 2012 | - Weak community outreach (screening & follow-up)<br>- Limited usage of MUAC as admission | - Good collaboration among partners<br>- Better understanding of malnutrition and CMAM programme in areas |

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| | criterion<br>- Lack of awareness of the malnutrition<br>- Preferred use of traditional health practitioners<br>- Lack of awareness that the service is free<br>- Stigmatisation<br>- Distance & accessibility | supported by HKI<br>- Appreciation of CMAM programme<br>- Integration of CMAM programme into existing health system |
| January 2014 | - Lack of awareness of the malnutrition<br>- Preferred use of traditional health practitioners<br>- Wrong understanding of RUTF / RUTF sharing<br>- Long waiting times<br>- Bad reception in health facilities<br>- Lack of sensitisation in health facilities<br>- Weak community outreach (screening & follow-up)<br>- Seasonal & geographical barriers<br>- Lack of awareness that the service is free<br>- Stigmatisation<br>- Lack of family support | - Good collaboration among partners<br>- Some knowledge about the malnutrition<br>- Use of health facilities in case of illness<br>- Awareness of CMAM programme<br>- Awareness that the service is free<br>- Appreciation of CMAM programme<br>- Mass screenings |

General reflections

Between two SQUEAC investigations in the early 2012 and 2014, the CMAM programme in Fada N'Gourma went through a series of important changes, which collectively contributed to the increase of coverage in the health district. While in 2011 and 2012 the CMAM programme was supported by Hellen Keller International (HKI), the whole province was gradually absorbed by Action Against Hunger (ACF), which commenced its activities in Fada N'Gourma in 2012. At the beginning of its engagement, ACF supported the CMAM programming only in two communes of the province, extending its support to all communes in the course of 2013 – which coincided with the national scale-up plan for the province. HKI's retreat of support for CMAM programming in Fada N'Gourma was driven by an unavailability of financial resources as well as a prioritisation of health districts in the north of the country, which did not benefit from such an intense NGO support as the eastern region. However, HKI maintained its operations in the province, focusing on agriculture for nutrition activities and school health, which target the underlying causes of malnutrition. Owing to its global community-based strategies, HKI contributed to community screening and sensitisation activities in their zones of intervention though local partners.

Apart from HKI, Fada N'Gourma benefited from the support of yet another partner, GRET, which paired up with ACF to lead on community engagement activities. Except for rare occasions of increased workload where ACF staff backing were necessary, GRET assumed complete responsibility for the training of community health workers/volunteers and community leaders, community screenings and sensitisation activities via a variety of communication channels. As a result, an increased awareness about the malnutrition and CMAM among targeted population could be observed. In addition, an important shift in health district ownership occurred in 2013 when community screenings activities (which until then were NGO-managed) were integrated into a health district action plan.

Having outsourced a very demanding CMAM component to its partner, ACF could concentrate on improvements in the domain of quality of care. In the spirit of capacity building and skills strengthening, ACF put the emphasis on the training and supervision of health centre personnel which led to their greater engagement in CMAM programming and consequently resulted in noticeable improvements of all performance indicators. A revision of national CMAM protocol following a detailed context analysis of a local health system was of a considerable advantage during the process.

As to the actual handover of CMAM support between two NGOs, compiled evidence does not confirm an existence of coordination efforts between HKI, ACF, GRET and district authorities during HKI phase-out/ACF scale-up process. However, there is sufficient evidence that ACF had an access to 2012 SQUEAC report and used its recommendations to tailor its strategies to identified challenges.

## Future improvements

The documented evolution of CMAM programme in Fada N'Gourma and analyses of qualitative data from SQUEAC investigations in 2012 and 2014 highlight continuous shortcomings in community engagement activities, which translate into misconceptions about malnutrition/CMAM programming, and without which certain structural and sociocultural barriers outside the scope of influence of a local health system cannot be resolved. It is recommended to initiate a series of community initiatives aiming at traditional healers or other alternative medicine providers, influent figures, parents of children suffering from SAM, women's groups or village solidarity mechanisms to tackle access-to-health-care obstacles revolving around stigmatisation, lack of family support, distance and accessibility of preferred use of traditional health practitioners. It is important to note that these initiatives should aim to motivate local, sustainable solutions with NGO in the role of a facilitator of change, rather than its driving force.