ASSESSMENT REPORT

BURKINA FASO: EXPANSION

Sectors: Economic Recovery and Development; Health (including Nutrition and Environmental Health); Violence Prevention and Response
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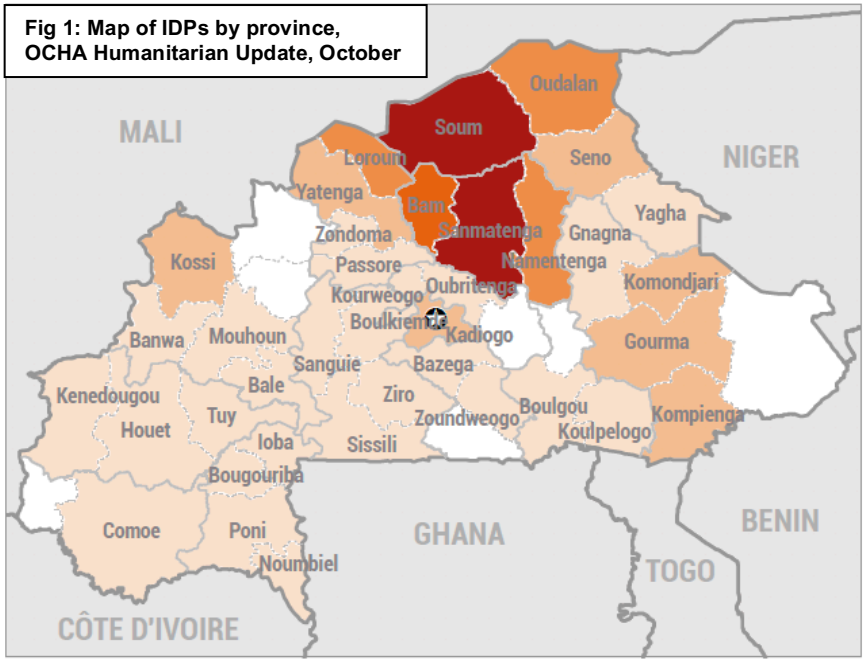
Location in Burkina Faso: Sahel, Boucle du Mouhoun, Nord and Centre Nord Regions
Data Collection: September 19 - 23, 2019

Fig 1: Map of IDPs by province, OCHA Humanitarian Update, October



INTRODUCTION AND JUSTIFICATION

Since July 2018, Burkina Faso has started to see an increase in violent incidents involving militant groups causing internal displacement in the North, Sahel, Central-North and East regions. After conducting a needs assessment in April, the IRC began responding in April 2019 to immediate needs related to water, hygiene and sanitation in the municipality of Djibo, Soum province in Sahel.

In July 2019, an increase in violence involving non-state armed groups caused further displacement in the regions of Nord, Sahel, Centre Nord and Est regions of Burkina Faso. Since then, displacement reached other regions, particularly Boucle du Mouhoun and Centre Sud. According to the latest report on displacement of populations within Burkina Faso, published on September 6, OCHA recorded 288,994 displaced people in Burkina Faso; with 130,535 (45%) of whom are living in Sahel,119,798 (41%) in Centre Nord, 14,356 (5%) in Nord and 8,577 (3%) in Boucle du Mouhoun1 regions.2 With these ongoing displacements in new regions, the IRC elected to conduct a second needs assessment to determine scope and scale to address additional needs.

STATEMENT OF INTENT

Objectives

1. Assess the needs of the crisis affected population to design appropriate interventions.
2. Examine threats to safety to the population of concern, especially as related to access to health care, protection services and markets
3. Understand needs across all sectors and how these have evolved in the past six months.
4. Identify which services are available and accessible to the population of concern.

[1] OCHA, Humanitarian Update, 6 September, 2019 (weblink)
[2] At the time of releasing this report, OCHA updated their numbers: 486,360 IDPs within Burkina Faso; including 56% in Centre Nord; 33% in Sahel; 7% in Nord; and 2% in Est and Boucle de Mouhoun, respectively. (weblink)

5. Identify gaps that IRC is well-placed to address.

Core Questions

6. What barriers do people face to meet their basic needs? How does this vary by age/sex/demographic group?
7. What are the needs across all sectors? Which services are available and accessible to the population of concern? What gaps can the IRC cover?
8. Are there any specific threats to safety for the affected population?
9. Who, specifically, is our target population?

METHODOLOGY

To prepare for the assessment, the team conducted seven interviews in Ouagoudougou with stakeholders. These interviews helped the team to narrow the locations to conduct the assessment.

Location

This assessment focused in the Sahel regions (Soum province, Djibo communes, and Kelbo and Yatenga province in Tongomayel commune) and Boucle de Mouhoun (Koussi province, Barani, Nuna and Djibasso communes). In addition, data collected remotely via phone, through Key Informant Interviews (KII) in the Nord regions (Loroum province, Titao Commune) and the Centre Nord (Bam province, Bourzanga and Kongossi communes).

Methods

The assessment included a total of 622 household (HH) surveys; 73 Key Informant Interviews (KIIs); and 53 focus groups (FGDs). The KIIs included mayors, local leaders, teachers, health facility workers, and market actors, such as vendors. In the FGDs, there were no more than 10 participants each, to allow for appropriate contribution. In addition, all participants were adults – ages 18 and above. All FGDs and HH survey respondents were IDPs residing either with host families or in informal, collective shelter arrangements such as schools and municipal buildings.

Limitations

This assessment used a convenience sample, increased from 500 (standard in multi-sector emergency needs assessments to be considered representative) to 622 HH. The 622 was to account for multiple locations, and if any errors were made during data collection, that the number of surveys would still be sufficient. The main limitation was that HH surveys were targeted to only IDPs, which is one population of interest. Including host families would have meant an additional HH survey of 500 people to be confident that this was an appropriate representation. Due to the fluid security context, last minute changes were required (population movement caused certain locations to be difficult to access or void of residents and resulted in some areas targeted for the needs assessment to be changed), which reduced the assessment timeline. Additionally, in Nord and Centre Nord regions the data was collected remotely by phone via KIIs only, due to lack of access and/or time constraints.

KEY FINDINGS

Three quarters (73.2%, or 385/526) of respondents in the HH surveys were displaced for the first time from Koussi Province in Boucle du Mouhoun and Kelbo Commune in Soum Province. In Tongomayel, 50.6% (42/83) of the respondents to the HH survey reported being displaced for the first time and 22.9% (19/83) displaced three times, which was less common than Kelbo commune.

Health and Nutrition

Almost all HHs (98%, or 609 HHs) know where to access a health facility (HF) when they or a family member is sick. In most of the communes across both regions surveyed, over 90% of the respondents were accessing this care through a HF, the outlier being Tongomayel, where 25% of respondents noted that their primary source of health care is a traditional healer.

In KIIs, health care providers were asked to list the greatest needs to improve the health of the community. The most common response was malaria (n=9), followed by diarrhea (n=7), respiratory infections (n=6), and malnutrition (n=6).

When asked about walking distance to the nearest health facilities FGDs noted: 31/53 (59%) travel time is less than 30 minutes, 11 groups (21%) reported between 30 minutes and 1 hour, 4 groups said the travel time is between 1-2 hours and 7 mentioned a travel time of over two hours.

When asked during FGDs about the top two obstacles that impede access to health facilities, groups answered: Paying fees for services: n=30, transportation costs: n=21, security concerns: n=11, and availability of transport: n=8. Two of the most cited barriers note financial obstacles as the main factor.

When asked during HH surveys if they are their feeding their children differently since the start of the crisis, half said yes. Out of a total of 622 HH, an average of 70% are feeding their children twice a day from an average of 3-4 meals per day. This could be linked to an increased risk of malnutrition, particularly in children under five.

There is a general need for health and nutrition services in the assessed communities. Examining the distance from home to the HF (on foot) for example, FGDs noted: 31/53 (59%) travel time is less than 30 minutes, 11 groups (21%) reported between 30 minutes and 1 hour, 4 groups said the travel time is between 1-2 hours and 7 mentioned a travel time of over two hours. These distances could be related to the recent closures of health facilities due to the crisis. At the time of reporting, 27% (11/41) of HF in Sahel,78.5% (11/14) of HF in Centre Nord, and in Boucle de Mouhoun 12.8% (5/39) have closed and many HFs which remain open are operating with reduced services. These closures are likely to continue to increase the distances for the population of concern to accessing care which is likely to increase risks due to the dynamic security context.

The gaps and needs underlined by respondents are similar for the population of Djibo, Kelbo and Tongomayel as well as for Boucle de Mouhoun (Djibasso, Nouna and Bomborokuy).

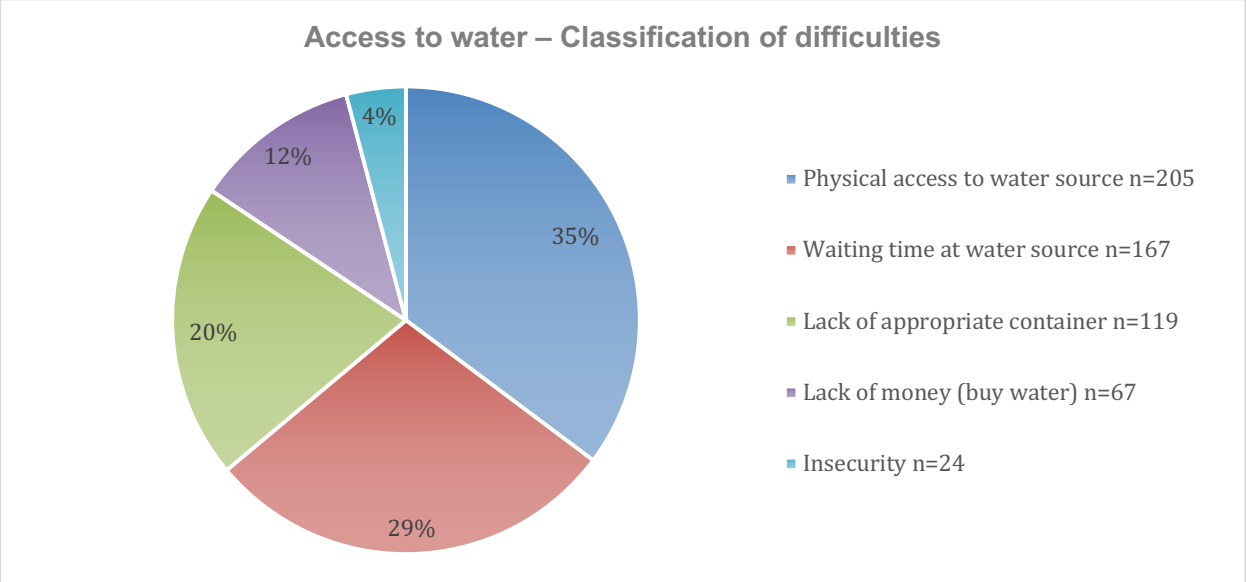
Environmental Health

The average amount of time displaced ranged from 2.5 months in the communes of Nouna, Bomborukuy and Djibasso to 5 months for displaced persons living in Tongomayel and Kelbo.

Drinking water, bathing and cooking is accessed through taps, open wells and hand pumps. Responses recorded during the FGDs reported boreholes as the main source of water (n=21), followed by unprotected wells (n=11).

The most common equipment use for water transport by households is the jerry can, as confirmed by HH survey. A total of 508 respondents in the HH survey noted that a ‘’bidon of 20-liter/jerry can with lid’’ is the most commonly used container for water transportation (n=304) followed by open buckets without lid (n=126).

Below are the main barriers cited to accessing water for 582 HHs.



The same concerns affecting water access was confirmed in the FGDs. Fourteen groups noted the lack of an appropriate container in order to safely transport and store water, 8 noted lack of money to purchase water and 7 mentioned the distance to water points as their main concerns. From the HH surveys, waiting times was another main issue cited, highlighting the need for increased water points.

In total, 577 HHs were surveyed on hygiene and sanitation. In terms of hygiene practices, some key findings include: 48% use unhygienic latrines (while 12% use hygienic latrines); 30% practice open defecation; and 10% have and use showers (10%). Further study should be done to understand how these key sanitation concerns might result in serious public health impacts.

Thirty-six FGDs discussed the difficulties related to the construction and use of latrines. The results gathered during these interviews highlighted the following reasons:

- Lack of available materials in the markets, e.g. cement, iron, etc. (n=19)
- Lack of ways to construct the latrines (n=13)
- Latrines collapsing or unstable soil (n=11)
- Not a priority for the HH, even if the HH knows the importance (n=6)

In terms of hand washing practice, 622 HH answered the question: *Over the course of the day yesterday, at what points did you wash your hands?* Over 91% (n=570) said they washed before eating, followed by 74% (n=462) who washed when doing ablutions or after eating. 54% (n=333) mentioned washing their hands after using the latrines. 8% (n=54) people answered washing hand after their return to the fields.

Child protection

Focus group discussions explored the risks of different child protection concerns on different age groups: 0-5 years, 6-11 years, 12-17 years, and 18-25 years (youth).

Girls were reported overall as being the most affected and exposed to child protection risks across the board, with adolescents (12-17 years) being the most vulnerable age group for either gender. FGDs cited the biggest risks for adolescent girls included barriers for accessing education (n=38), harmful traditional practices such as forced marriage (n=37), gender-based violence (n=34), and family and household

violence (n=30). Further assessment and analysis would be useful to explore the level of risk that preexisted the crisis, whether the risks worsened as a result of the crisis.

For adolescent boys, the biggest risks reported included lack of access to education (n=32), recruitment and use by armed groups (n= 28), economic security (n=24), and risks and dangers in the physical environment, including dangerous working conditions and risks while living and working on the street (n=24).

Both boys and girls aged 6-11 were cited as being at highest risk of lack of access to education (girls n=38, boys n=38), risks related to living with extended family (when children are placed with extended family there is typically a higher risk of physical and emotional/verbal abuse, sexual violence and often child labor) (girls n=36, boys n=32), and danger in the physical environment (girls n=30, boys n=28). Younger boys and girls were reported as being at high risk due to health and nutrition concerns, notably children aged 0-5 years (girls n=43, boys (n=42) and aged 6-11 years (girls n=25, boys n=25).
Protection concerns related to children's care environment were the following: adolescent girls (n=30) and boys (n=21) were most at risk due to family and household violence (which often increases due to household level stress during a crisis); 6-11 year old girls (n=36) and boys (n=35) were most exposed to risks while living with extended family; and younger girls aged 0-5 (n=25), aged 6-11 (n=25) and boys aged 0-5 (n=25), aged 6-11 (n=20) were reported to be at highest risk of inadequate care and supervision.

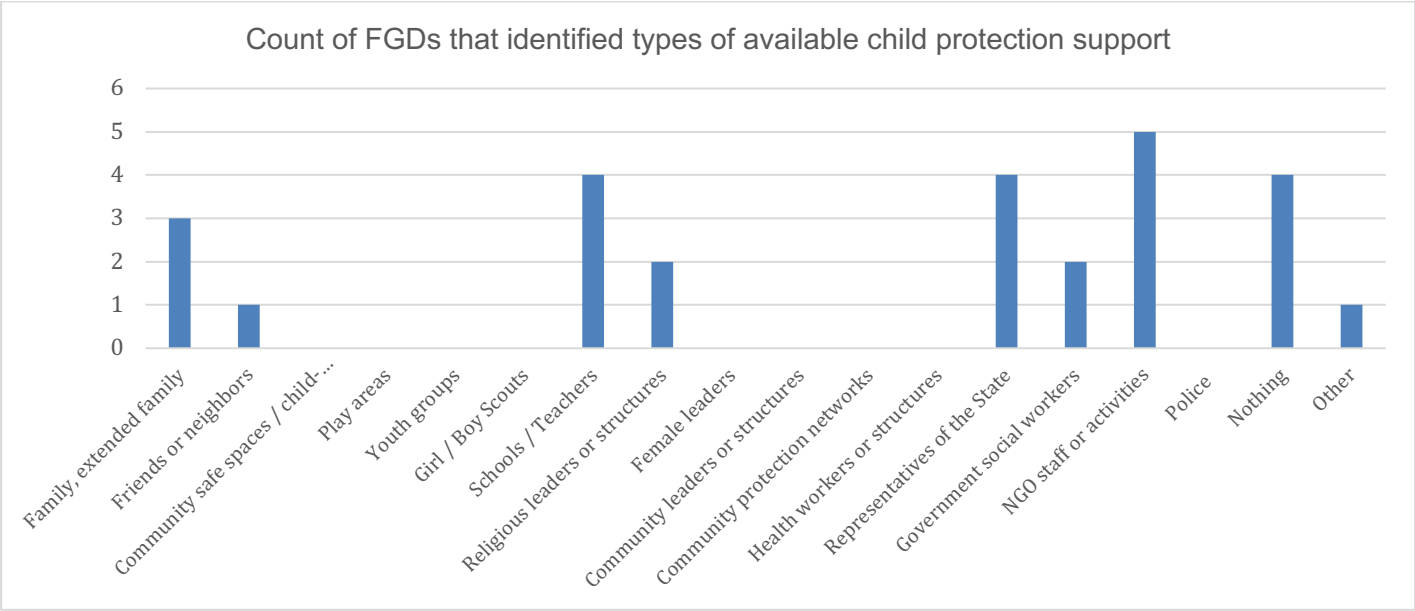
Family separation

In FGDs that identified unaccompanied and separated children (UASC) as a priority protection concern in their communities (n=19), FGD participants reported that UASC primarily stayed with extended families, informal foster families, or with neighbors or other communities. This suggests a preference for family-based placements in local communities. However, a significant population of UASC are reported to be placed in institutions, living alone, or in child-headed households, putting them at heightened risk for abuse, neglect, and other forms of maltreatment, and deserves further assessment to better understand the specific risks and vulnerabilities experienced by these children. The age groups most affected by separations were reported to be adolescent girls and boys, aged 12-17, followed by primary school aged children, also both boys and girls, aged 6-11.

Child protection services and supports

In 17/18 focus groups that were asked about available child protection services and supports, participants overwhelmingly reported that parents had the primary responsibility for children's protection and wellbeing. One FGD highlighted the role of community leaders, and in another, the role of State representatives.

Of the 18 FGDs that were asked about available services or supports, participants stated there were no services available (n=4) or did not indicate the presence of any supports at all (n=2). In communities where participants were aware of child protection services, supports included NGO staff or activities (n=5) or schools (n=4), though in three FGDs, participants reported that families would turn to other relatives or extended family for support.



Gender Based Violence

Risks that were highlighted by the participants in male and female FGDs include sexual violence (n=32), emotional violence (n=27), forced marriage (n=16), limited access to services (n=11), domestic violence (n=9), denial of resources (n=5), and sexual exploitation (n=5).

Access to services

In the 26 female FGDs, half reported that when they experience violence they turn to women's groups (n=13), followed by NGOs (n=4) and women centers (n=3). Many women reported that they can reach out to social action for support, but could not provide details on how. Social action refers to the decentralized structure of the Ministry of Social Action in charge of women issues. However, with the current security situation, some have closed and some staff moved to safer regions.

Markets and Economic Programming:

The assessment explored access to markets, experience with cash programming, societal norms and protection concerns when providing cash at HH level, as well as preferences to receive assistance.

In 44 of 53 FGDs, men in the household make the financial decisions, and that this has not changed since before the crisis. In the instances where FGDs noted women are in charge of financial decision making since the crisis, respondents cited reasons such as their husbands had left or been killed as a result of the conflict. Nine FGDs said that there were challenges for communities to access markets. Of these nine groups, when asked if it was specific to age or sex, they noted it is a problem for: men (n=7), women (n=4), boys (n=1), girls (n=2). When asked if there were any challenges between men and women when it came to receiving cash transfers, 7 FGDs said yes, while 37 said no, and 9 did not know.

KIIs were asked if markets were physically accessible to the population of concern, and whether the population can access these markets without threats to their safety. Most noted that markets are accessible and safe, including 6/10 mayors, 11/12 women's group representatives, and 9/12 vendors. This is consistent with the HH surveys. Of the three vendors who said that markets were not accessible, when

prompted, all noted that it is dangerous to access the markets; and one added that prices are too expensive.

When asked about preference for assistance to receive food aid, of 618 HHs, 39% (n=240) preferred food distribution, followed closely by cash at 35% of HHs (n=213), with 11% (n=65) selected vouchers.

Across the provinces and communes surveyed, most respondents (569/621) felt that markets or stores with food/NFIs are within a reasonable distance (by foot or public transport) from where they are living. Additionally, 558/620 respondents reported that they are able to find reasonable quality and quantity of food and non-food items in these markets, while 529/621 respondents reported that they are able to physically and safely access markets, and 30 respondents were not sure. The percentage of respondents who felt they could access markets physically and without threats to their safety was fairly consistent at around 85-90% of those surveyed across all communes except for Tongomayel, where only 65% of the respondents felt that they could safely access the markets.

Access to information

FGD respondents noted that the top two ways that people found out about services were via friends and family (n=37) and via radio/television (n=30).

RECOMMENDATIONS

- → Address the high percentages of lack of access to hygienic latrines and open defecation by building appropriate latrine structures.
- → Create access to safe water to address concerns about lack of physical proximity to water points as well as waiting times at water points.
- → Address the low percentage of respondents who noted that they have access to shower, by designing appropriate bathing facilities.
- → Review how many health facilities are open and functioning, to determine how to support and possibly re-open these structures.
- → Address the concern from FGDs that sexual violence is a primary risk.
- → As the population noted overall that they have access to markets, and the preference for cash over vouchers, cash distribution could be a viable approach – possibly through mobile money. Cash distribution could also support access to health facilities or other services.
- → Engage communities about access to services via word of mouth and possibly via radio.