Assessing implementation fidelity of a results-based financing intervention in Burkina Faso

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Background
Burkina Faso still faces low utilization of healthcare and high maternal and child mortality. After launching a pilot results-based financing (RBF) intervention in 2011 with some “encouraging” results, the government decided in 2014 to expand RBF to 12 districts in six regions and to combine it with pro-poor targeting (bonuses for services provided to the poor and user-fee exemption of the poor) and community-based insurance. The intervention is based on the payment of performance subsidies to health facilities in order to motivate health workers according to the quantity and quality of services delivered tracked by performance indicators.

Method
We compared implementation fidelity in three districts and between primary healthcare facilities and hospitals using a framework analysis process one year after the intervention’s start up. Our data collection tools were documentary analysis and interviews (n=21) with stakeholders. The data were analysed through the three dimensions of fidelity: the intervention’s content, its coverage and its temporality. The activities carried out were classified under one of the four components (planning, operationalization, tools, action research). We quantified the proportion of activities implemented, not implemented, modified or added. We also added a fifth modality ‘blank’ to stress a data gap.

Results
Content
The study showed moderate content fidelity (65.5%), although better for planning activities (91.2%) (training and recruitment). Action research (14.3%) and operationalization (65.3%) activities (performance verification and subsidies payment) seemed to have experienced some implementation difficulties. On the whole, 13 activities were added.

Performance verification

- Qualitative assessment: 95.2%
- Quantitative assessment: 100%
- Patients satisfaction survey and community verification: 6.8%
- Cross-check: 9.5%

Subsidies payment
57.7% of expected subsidies payment were made despite a high fidelity of payment determination (86.9%). Providers pro-poor patient care bonus was delivered to targeted facilities as planned.

Coverage
There was no striking difference between the three districts. However, the second district demonstrated a higher proportion of activities modified. A difference existed between levels of care:

- Primary healthcare centers: 68.2%
- District hospital: 58.3%
- Regional hospital: 44.0%

Temporality
63.4% of the activities followed the planned schedule. The most delayed components were performance verification and subsidies payment. These delays are mainly a consequence of delayed setting up.

Conclusion
The activities were mostly implemented with good fidelity. However, some barriers to implementation and delays were noticed, mainly linked to performance verification and subsidies payment. The situation may lead to delays of expected beneficial effects and potential perverse effects.

References

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