

# Why do women pay more than they should? A mixed methods study of the implementation gap in a policy to subsidize the costs of deliveries in Burkina Faso

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## ABSTRACT

In 2007, Burkina Faso launched a public policy to subsidize 80% of the cost of normal deliveries. Although women are required to pay only the remaining 20%, i.e., 900 F CFA (1.4 Euros), some qualitative evidence suggests they actually pay more.

The aim of this study is to test and then (if confirmed) to understand the hypothesis that the amounts paid by women are more than the official fee, i.e., their 20% portion.

A mixed method sequential explanatory design giving equal priority to both quantitative ( $n = 883$ ) and qualitative ( $n = 50$ ) methods was used in a rural health district of Ouargaye.

Half (50%, median) of the women reported paying more than the official fee for a delivery. Health workers questioned the methodology of the study and the veracity of the women's reports. The three most plausible explanations for this payment disparity are: (i) the payments were for products used that were not part of the delivery kit covered by the official fee; (ii) the implementers had difficulty in understanding the policy; and (iii) there was improper conduct on the part of some health workers.

Institutional design and organizational practices, as well as weak rule enforcement and organizational capacity, need to be considered more carefully to avoid an implementation gap in this public policy.

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## 1. Introduction

UNICEF (2009) has stated that 80% of maternal deaths could be avoided if known interventions were implemented. Thus, in the fight against maternal mortality, many voices have been raised deploring the fact that strategies known to be effective a priori are not being implemented, particularly in Africa (De Brouwere & Van Lerberghe, 2001; United Nations Secretary-General, 2010). One recommended intervention is to encourage women to use qualified personnel for deliveries. Proper care at deliveries could reduce the risks of maternal mortality and morbidity by 95% (Graham, Bell, & Bullough, 2001; World Health Organization, 2010a). Studies have shown that the financial barrier is one of several reasons for women's low recourse to qualified personnel for assisted deliveries (Nanda, 2002). Therefore it is now recommended that user fees for deliveries be eliminated (African Union, 2010; Richard, Witter, & de Brouwere, 2010; World Health Organization, 2010b).

However, it is not enough to follow internationally recognized recommendations by formulating public policies; these policies must also be effectively implemented, since, "if implementation fails, everything fails" (Chen, 2004). Indeed, other authors have asserted that "many evidence-based innovations fail to produce results when transferred to communities in the global south, largely because their implementation is untested, unsuitable or incomplete" (Madon, Hofman, Kupfer, & Glass, 2007). Moreover, meta-analyses have shown that the efficacy of interventions is generally subject to multiple distortion factors related to implementation, often in excess of 50% (Durlak & DuPre, 2008). Unfortunately, only 4% of publications on public policy implementation between 1933 and 2003 concern Africa (Saetren, 2005), and few of those were concerned with issues of equity in health (Gilson & Raphaely, 2008). In addition, scarcely any studies on health promotion or health policies in low-income countries refer directly to concepts and theories used in the study of public policies (Breton & De Leeuw, 2011; Gilson & Raphaely, 2008).

## 2. Context and intervention

In Burkina Faso, 46% of the population is considered to live below the poverty threshold, which is 0.41 Euros per day. It has

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been estimated that 4000 women die each year of maternity-related causes (World Health Organization (WHO), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), & World Bank, 2010) and the implementation of interventions that are a priori effective in reducing maternal mortality is still very limited (World Health Organization, 2010a). For example, in 2006 only 43% of women delivered in a public health facility (*Direction des études et de la planification, 2007*). In 2007, to address this problem, Burkina Faso decided to launch a public policy of subsidizing the cost of deliveries. The policy is entirely funded by the State's budget (*Ministère de la Santé, 2006b*). Since January 2007, the cost of a normal delivery, estimated by the Ministry to be 4500 F CFA (6.86 Euros), has been subsidized at the level of 80% in the maternity units of primary care health centers (CSPS). Women are required to pay only the remaining 20%, i.e., an official fee of 900 F CFA (1.4 Euros). This amount is considered to be a flat rate covering all medical expenses related to a delivery carried out in a maternity unit. The policy's execution specifies that this payment is for "acts, medicines and consumables, and observation" (*Ministère de la Santé, 2006a*). That document also recommends what items should be in the "delivery kit" and details the clinical protocol that health personnel are expected to follow for deliveries.

Several qualitative studies have shown that the process used to define this policy was not sufficiently inclusive. They also showed that many women, and even health workers, were not entirely aware of the dispositions of the policy. In these studies, some of the qualitative interviews also indicated that women were paying more than the official fee of 900 F CFA (*Amnesty International, 2009; Ridde, Richard, Bicaba, Queuille, & Conombo, 2011; Sombié et al., 2007*). While some studies have examined the implementation of this policy, no study had systematically quantified this payment disparity at the time we started this research, nor, if need be, attempted to explain it.

Thus, the objectives of this study were (1) to test the hypothesis that the amounts paid by women in cases of normal deliveries in primary care maternity units in Burkina Faso were more than the official fee, i.e., their 20% portion of the total cost, and (2) if confirmed, to understand these results by means of a qualitative approach. Our study was thus specifically focused on the implementation gap in the payment of the delivery fee, and not on the overall implementation of the policy.

### 3. Methodology

Our methodology was that of a descriptive and analytical implementation evaluation using a mixed sequential design (*Creswell & Plano Clark, 2007*). We describe and discuss the methodology here in accordance with recommendations for enhancing the quality of mixed-methods reporting (*Pluye et al., 2011*).

#### 3.1. Study setting

The study was conducted in the Ouargaye health district, a mostly rural area with 260 000 inhabitants engaged primarily in subsistence agriculture. In the Center-East region, where this district is located, 55.2% of inhabitants were living below the poverty threshold in 2003. Both the society and the healthcare system are organized very pyramidally, with attachment to the status quo outweighing any drive toward organizing reforms, particularly any aimed at creating equity. Health workers wield significant power over the population, and community involvement is most often limited to financial contributions.

#### 3.2. Implementation evaluation

There are many approaches, but little consensus, on how to analyze the gap between what is planned and what is implemented (*Durlak & DuPre, 2008; Patton, 2008; Saetren, 2005; Walt et al., 2008*), i.e., the implementation gap (*Pressman & Wildavsky, 1984*). Rather than a process evaluation exploring the dynamics among the actors in an implementation, our study was an implementation evaluation focused on measuring and then analyzing the gaps. The case we studied was the public policy of subsidizing deliveries. Unlike the approach based on analysis frameworks that are often slanted toward concepts and determinants of fidelity (*Carroll et al., 2007*) our study used an explicative approach based on four research proposals, described below.

#### 3.3. Mixed method design

We used a mixed method sequential explanatory design, giving equal priority to both quantitative and qualitative methods (*Creswell & Plano Clark, 2007*). The design was sequential, in that the quantitative methods preceded and informed the subsequent qualitative methods, and explanatory, in that qualitative methods were used to understand the quantitative findings. Earlier published qualitative studies (*Amnesty International, 2009; Ridde et al., 2011; Sombié et al., 2007*) provided indications that women reported paying more than the official fee. However, these scattered reports needed to be objectivized by means of a quantitative survey. Thus, based on that earlier qualitative evidence, the aim of the quantitative strand was to test the hypothesis that the amounts paid by women in cases of normal deliveries in primary care maternity units were more than the official fee. Then, if this hypothesis was confirmed, a qualitative survey would be used to better understand the reasons for this gap from the standpoint of those implementing the policy.

#### 3.4. Quantitative process

A cross-sectional household survey was conducted in February 2010. From the registers of the maternity units, the surveyors collected the names of all women ( $n = 1019$ ) who had delivered in the 25 health centers (CSPSs) in the previous six weeks. With the help of key informants in the villages, 905 of these women were located. In all, 883 women were surveyed. The questionnaire, adapted from a previous study (IMMPACT), collected information on the demographic and socio-economic characteristics of the households and on medical expenses incurred at the time of delivery. Double data entry was done using EpiData<sup>®</sup>, and SPSS<sup>®</sup> and Excel<sup>®</sup> were used for the descriptive analyses.

#### 3.5. Qualitative process

A qualitative approach was implemented between December 2010 and January 2011. The qualitative data were combined with the quantitative data when the researchers interpreted the results. The qualitative data were collected using a conceptual framework approach (*Ritchie & Spenser, 1994*) which considered four potential explanations for the observed gap. After analysis of the quantitative data, and based on their knowledge of the context, the policy implemented and the scientific literature on the subject, the researchers formulated four potential explanations for the observed gap between the official fee and the payments reported by the women: (i) the excess payments were for products used that were not part of the delivery kit covered by the official fee; (ii) the excess payments were for products not available in the health centre's pharmacy; (iii) the implementers had difficulty in understanding the policy; and (iv) there was improper conduct

on the part of health workers. These four possibilities were the main focus of the interviews, but the researchers remained open to other explanations that might be suggested by the actors encountered during the data collection.

First, a focus group was organized with 33 persons (only one of whom was a woman, as most maternity units and health centers are managed by men), plus three members of the health district management team. The researchers presented the quantitative results and the group examined and discussed the four potential explanations and provided other explanations. For ethical reasons, the health centers were not named. These discussions provided the researchers with a first level of reflective analysis. Then, to supplement and enhance these data, and to take into account biases inherent in group discussions (social control), particularly in Africa (Olivier de Sardan, 2008) we organized individual in-depth interviews. These were carried out in the maternity units considered to be the extreme cases, to better understand the phenomenon under study (Yin & Ridde, 2012). Following the principle of sequential design, in which the quantitative results guide the selection of qualitative data sources (Creswell & Plano Clark, 2007), we selected these cases based on the results of the quantitative survey. Thus, the interviews were conducted in four of the five maternity units (three rural and one urban) that had the highest average payments (>2300 F CFA) reported by women. This number of cases was chosen based on our resource constraints. We did not visit the fifth maternity unit because the manager had been transferred since the quantitative survey. We interviewed the main implementers of the policy. From our knowledge of the context and from previous studies in Africa (Agyepong & Nagai, 2011; Olivier de Sardan, 2009; Walker & Gilson, 2004), we felt that only street-level bureaucrats would have a detailed understanding of the policy's implementation. Indeed, the women could tell us *how much* they had to pay (which they did in the quantitative survey), but they could not explain *why* they had to pay. We therefore met with four nurse managers of health centers, four maternity unit managers, two basic health workers, one traditional birth attendant, and four managers of community pharmacies. In addition, we conducted two individual interviews with district-level managers: one with the current chief of reproductive health who coordinates interventions in this sector, and the other with the former district chief medical officer who had been there at the time of the quantitative survey. All these interviews were aimed at getting information on the four potential explanations, as well as alternative ones.

The focus group and the interviews were recorded and transcribed into a word processing program. Data analysis was done manually using a framework analysis approach (Ritchie & Spenser, 1994) based on the four potential explanations and any other alternative explanations suggested by the implementers.

## 4. Results

In this section, we first present the quantitative results, followed by the qualitative results.

**Table 1**

Characteristics of the women in the quantitative survey.

	N	%
Mean age	26	
<b>Matrimonial status</b>		
Single	19	2.15%
Married, monogamous	463	52.43%
Married, polygamous	365	41.34%
Common-law	32	3.62%
Widow/divorced	4	0.45%
<b>Education</b>		
None	829	93.88%
Primary school	37	4.19%
Secondary and more	17	1.93%
<b>Distance from a CSPS</b>		
<5 km	506	57.30%
5–10	244	27.63%
>10 km	133	15.06%

### 4.1. Half the women reported paying more than the official fee

Table 1 describes the sample for the quantitative survey, and Table 2 presents the expenses reported by the women for each of the various categories. Thus, three years after the launch of the national policy, 50% of the women in the district reported paying more than the official fee of 900 F CFA usually charged for a normal pregnancy. The average payment reported was twice as much as the official fee and represented seven days of living expenses for 46% of the population that lives under the poverty threshold. There was no maternity unit in the district in which the average medical expenses were below the official fee. This average ranged from a minimum of 1075 F CFA (1.64 Euros) to a maximum of 4232 F CFA (6.45 Euros) (Fig. 1); we did not, at that time, attempt to understand this heterogeneity. Of the women interviewed, 30% reported buying medicines from the community pharmacy and 6%, from health workers.

### 4.2. Understanding the observed gap

Aside from the health workers' calling into question of the quantitative results, four factors may be associated with the implementation gap in the fees paid, since, as one health worker said, "it's not normal."

#### 4.2.1. Denying the gap

When the quantitative results were presented, the spontaneous and immediate reaction was sometimes surprise ("Frankly, we find that number truly astonishing," one nurse said), but mostly it was formal denial. The researchers had to contend with a two-pronged questioning of the results—"Do you have confidence in your surveys?" one nurse asked.

First, they criticized the women's capacity to respond to questions about expenses: "Really, that gap, there, it surprises me. I wonder if, on the day of the questioning, the women really understood," one nurse ventured.

Others suggested that the women we surveyed had not understood the questions properly and so had been confused.

**Table 2**

Medical expenses (F CFA) reported for normal deliveries in Ouargaye district (2010).

	N	Median	Mean	Standard deviation	Minimum	Maximum
Delivery fees	883	700	819	290	0	17 400
Hospitalisation fees	883	200	108	122	0	1400
Drug expenses – care provider	49	1100	1786	1552	200	6600
Drug expenses – community depot	255	1500	2917	4399	100	50 000
Total	883	900	1863	2814	0	50 900

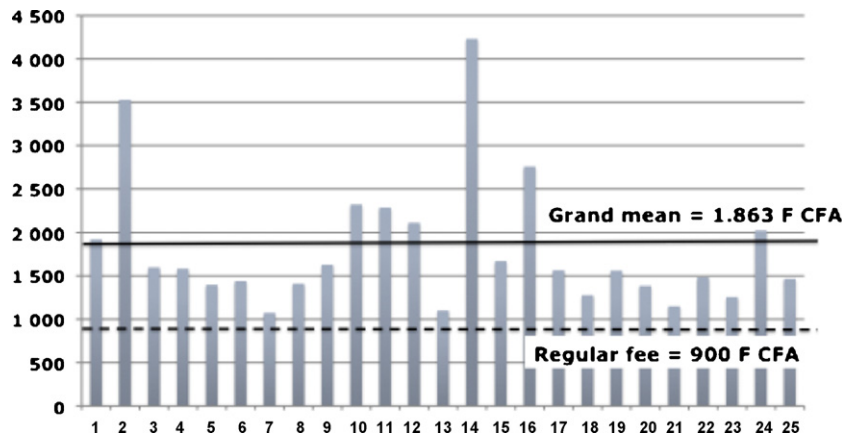


Fig. 1. Mean Medical expenses (F CFA) for normal delivery by health center in Ouargaye District, Burkina Faso.

*“There’s the case of false labour. The woman comes, for example, thinking it’s for a delivery, but we find other pathologies; and after she receives treatment, the woman delivers. She’ll think that [the policy] covers all those things,”* said a nurse.

Some workers also accused the women of knowingly reporting that they had paid more than was required because they thought, according to the workers, that they would be reimbursed: *“...and our parents, there, they think when they tell you this, you’ll reimburse them,”* asserted a midwife.

Then it was the methodology that was called into question, and especially the validity of the data:

*“Did you require them to show you the receipt? Didn’t the people questioned, at the time of the survey, really only say what they wanted to say?”* asked a nurse.

Even though the quantitative analyses were based only on women who had a normal delivery, some health workers wondered whether the researchers had included dystocic deliveries in the results on reported expenses, because the fee for those is four times greater (see below).

#### 4.2.2. Open or closed kits?

To help us understand the situation at the time of the qualitative survey (as well as the difficulties of implementing this policy), the health workers explained to us in detail how inputs for deliveries were managed. When the policy was launched in 2007, the district managers adopted a way of functioning they termed “open kit”. This meant health workers were not obliged to stock all the products officially specified in the manual for the delivery kit (Ministère de la Santé, 2006a), but only had to make note of those they actually used. Since the health centers received a fixed-rate reimbursement (3600 F CFA) from the Ministry, in addition to the women’s payment (900 F CFA), the fewer products they used, the greater the savings. One nurse recalled, *“We noted that there were women who could deliver with just one pair of gloves that cost 50 F CFA.”* A bonus system had been instituted in this district, in which the monetary difference (on average 1000 F CFA = 1.52 Euros) between the Ministry reimbursement and the real expenses was divided, with 80% going to the community management committee and 20% to the health workers. All the actors (women, health workers, committee) affected by this policy were thus “happy”, in the words of the manager who had organized this win-win system. This arrangement functioned for one year. Then, the central level at the Ministry ordered that the national policy was to be strictly respected, with a return to “closed kits” and no more bonuses. However, two years later, when this same central level came to realize that resources were being wasted as reimbursement

exceeded actual expenses, it ordered a return to “open kits”. From then on, health centers were reimbursed based on their actual expenses. However, at the time of the quantitative survey, the “closed kit” formula was still in operation.

#### 4.2.3. Payment for products not included in the official kit

In all the maternity units, aside from the cleaning product used to wash the delivery room, for which women had to pay, the health workers confirmed they had prescribed products that the women needed but that were not part of the kit, and for which they could be charged a fee. These included antimalarials and antibiotics for the women and eye drops for the newborns.

*“For me, if there’s malaria, it’s outside [the policy], I’ll prescribe it for you. If I see it requires an intravenous injection, I’ll prescribe the intravenous injection. Honestly, the cost will change,”* explained a health worker.

However, not everyone had the same understanding (see below), since one nurse asserted quite the opposite, that antimalarials during delivery were included in the policy.

In only one maternity unit, the health workers also insisted that this additional payment was due to prescriptions requested by the women, for example: *“There are some women who ask us to buy them products to help them deliver more easily,”* one midwife said.

Finally, we should add that, in one health center, women were systematically charged an additional amount of 300 F CFA (0.46 Euros) for registering the child’s birth certificate. In the other centers, parents had to go to the town halls of their rural communes to pay for this, if they wanted it.

#### 4.2.4. Payment for products not available at the health centre’s pharmacy

It appeared that stock shortages in health center pharmacies were very rarely involved in the additional expenses incurred by the women. This specific and occasional situation was mentioned only in one rural maternity unit. There, to explain how such payments might have occurred, the workers recalled that the manager of the community pharmacy was often absent and that there was a private pharmacy in the village: *“If the manager wasn’t there, they had to go to the private depot for that,”* one health worker said.

#### 4.2.5. Problems in understanding the dispositions of the policy

*“Here, we have a serious problem with understanding [the policy],”* a nurse told us. Three examples illustrate this lack of information.



First, in all the maternity units, normal deliveries in which episiotomies were performed were considered by the health workers to be dystocic deliveries. These women were then required to pay the fee for a dystocic delivery, which was 3600 F CFA rather than 900 F CFA. Thus, one nurse recalled that “...in the beginning, an episiotomy was considered dystocic and in that case the woman paid 3600 F CFA.”

Then, in all the maternity units, the understanding of the time period for which the fee was to be applied also affected the purchase of supplementary products. For example, the fee was assumed to apply only from the moment when the woman's labor began, and to end after the infant was delivered, except in cases of hemorrhage that were treated over the following week. Thus, all inputs used before or after this temporal window were billable to the patient, such as examination gloves (used to verify whether labor had started), antispasmodics, or drugs to treat an episode of fever in a woman who had delivered and was still in the maternity unit.

Finally, this poor understanding the policy also extended to the composition of delivery kits. As one nurse recalled, “...people didn't all have the same understanding about the kits.” Also, the health workers did not know what to do with the kits' leftover products that had not been used in a delivery.

Three main explanations were proffered for these problems of understanding. The first had to do with either lack of support to the implementers from those in charge of the policy (“...at the national level, no directives were provided to say what was dystocic and what was normal,” one physician told us), or their inconsistent advice (“...it was not reliable, sometimes they would say it was like this, then they would say it was like that,” said a midwife in a rural area). The second explanation was related to inadequate information. Although training sessions were held at the time of the policy's launch, no ongoing training or information document was organized. So, health workers hired subsequently were not informed, such as this midwife in her first position: “I don't know anything about this, since I'm new here, but it's been ten months now.” Another health worker who had been there a long time observed, “...we still haven't gotten any documents to guide us.” The third explanation referred to an intentional strategy, which we discuss below; thus, a manager asserted that “...it's a loophole that the health workers use, for example, when the woman says she already paid for amoxicillin at one time or another, the workers say, no, that wasn't related to her pregnancy.”

#### 4.2.6. Improper conduct on the part of health workers

Obviously, it is difficult to obtain from the health workers' statements explicit empirical data on their own possibly improper conduct, although one physician told us, “...if women are paying more than the 900F, it's due to the behaviors of individuals, it's not official.” However, the quantitative survey showed that only 56% of the women had a receipt for the payments they made to the health center, which is an objective indicator of the situation.

Normative discourse is often present, as we saw in the focus group. However, it is possible, from implicit discourses, to surmise the existence of unscrupulous behaviors in relation to the official fee.

This is particularly true when it comes to products in the closed kits that are not used during deliveries. What happens to them? “You do the delivery ... and the leftovers from the kit, now, that's a problem,” explained one health worker. This question is all the more compelling, in that ending health workers' bonuses and reverting to closed kits could clearly have driven the actors to engage in coping strategies to recuperate lost income. When the authorities at the central level told nurses at a meeting that the 20% bonus would no longer be provided and that they would go back to using closed kits, the nurses said nothing. Their acceptance of this

change was very likely due to their anticipation of the potential for using the leftovers from the kits. The district manager had warned of “...improper use of the kit, which we will be unable to control.”

As well, the health workers began to reconsider: “We've just found out about these numbers. We want to understand them so that we can review and better define these responsibilities. Also, personally, we want to catch these people.” A physician added: “The problem is that there is no supervision, and as long as it stays that way, they'll keep on taking advantage of the population.” Moreover, the efforts by the district manager at that time to contain these types of phenomena show that this hypothesis of inputs being resold was not far-fetched. In fact, he started by calculating the real expenses incurred by maternity units for deliveries. In so doing, he became aware of the waste of public resources, given the disparity between expenses and the amount of the State reimbursement. He changed the way kits were used. One nurse recalled that this manager “...wanted a clearer picture of how the leftovers from the kits were managed, and we were asked to switch from closed kits to open kits.” This manager must have had some suspicions, because, “...when I told them a team was coming to question the women about what they had paid, there were some who trembled.”

## 5. Discussion

### 5.1. On the methodology

The strength of the quantitative method, even if the analysis was basic, was that it allowed us to confirm and measure with a household survey the payment gap that some qualitative studies had already suggested (Amnesty International, 2009; Ridde et al., 2011). The external validity of our quantitative results was reinforced by the fact that two studies conducted after the present study was done, in two districts far removed from Ouargaye, obtained similar results for the average amount paid for a normal delivery: 1400 F CFA in Nouna (De Allegri et al., 2012) and 1300 F CFA in Djibo (Ben Ameer, Yameogo, Bado, Ingabire, & Ridde, 2010). The weaknesses of the quantitative method, which is more useful for measuring than for understanding, were largely offset by the subsequent qualitative approach. This demonstrates the value of having used a sequential design to achieve the objectives of this study. Clearly, the qualitative approach did not allow us to establish a quantified causal relationship, which has been demonstrated elsewhere (Ridde, Kouanda, Bado, Bado, & Haddad, 2012), but the data collected and the triangulation of information sources provided a better understanding of a significant number of factors associated with the implementation gap.

### 5.2. Formal discourse and practice standards

The health workers' spontaneous, defensive and normative reactions regarding the implementation gap in the fees were not surprising. First, these reactions arose out of the method used initially (focus group), in which social controls and the presence of their direct hierarchical supervisor made it difficult for them to express any lack of respect for the policy's content. However, such normative reactions are also common in public administrations and in the regions' health systems, where studies (Booth, 2011; Olivier de Sardan, 2010) have already brought to light the logics of complicity and avoidance in reaction to these issues being raised, as well as the gap between official professional standards and actual practices. A study on the implementation of facility-based medical audits in a maternity unit in Burkina Faso showed the staff had difficulty practising self-criticism, and moreover, 40% of them affirmed to researchers that “women are lying” (Richard et al., 2009). It would therefore be interesting to document in depth the midwives' professional culture, to understand whether their

common practice standards—far removed from professional standards and from the culturalist interpretation of State functioning in Africa (Olivier de Sardan, 2010)—might not explain, to some extent, the health workers' coping strategies and the implementation gap observed.

### 5.3. A perfectible implementation

The present study, conducted in a single district, confirmed, measured and explained the implementation gap regarding the flat fee that was not respected. Because this situation has been shown to exist in other districts of the country, it is reasonable to believe this is a national problem. The role of drug stock shortages was not really confirmed, but the other three factors combined help to explain the phenomenon, although none stands out from the others.

In contrast to other countries that organized similar measures for subsidizing services (Meessen et al., 2011; Ridde & Morestin, 2011), the formulation of the policy was relatively participatory and without any populist political considerations (Booth, 2011). However, this participation was often limited to central and peripheral administrators in the health system, as well as gynecologists, with little room for input from street-level workers, as was also the case in South Africa (Walker & Gilson, 2004). Neither the delivery kits' contents nor the amount of the reimbursement sufficiently reflected the local realities of the primary care system. Moreover, in disregard to recommendations on implementing public policies (Brinkerhoff & Crosby, 2002), decision-makers in Burkina Faso often refuse to conduct pilot projects that would allow errors to be detected and corrected before scaling up nationally. What happened in 2007 with deliveries happened again in 2010 in the national program against malaria when decision-makers did not wait for the results of pilot studies before expanding the activities to the national level.

Very often in West Africa the central administrators of health ministries serve in those positions for only a short while. They are often discovered and then recruited by other organizations (e.g. WHO, UNICEF) that can offer them better working conditions, creating disruptions in administrative continuity before and after their departure. This was the case for this policy, with very frequent turnover occurring in the highest positions. Between 2005, when the policy was first being planned, and 2010, the Ministry department in charge of this policy went through three directors. The fees abolition experience in Ghana (Witter & Adjei, 2007; Witter, Adjei, Armar-Klimesu, & Graham, 2009) and the achievement of universal coverage (Mathauer & Carrin, 2011) showed the importance of having institutional ownership and support for implementation from the central level. Yet, in the case of this policy, what was observed instead was "policy-driven institutional incoherence" (Booth, 2011). In 2011, the Ministry changed its organizational structure, and responsibility for this policy was incorporated into another new department, which will most certainly produce new institutional repercussions. In addition, the messages conveyed by these administrators, when visiting the field, have not always been consistent, often changing depending on the person. The unit supervising this policy has remained too small, does not have enough experts and finds it difficult (or is unwilling?) to take any evidence into account to modify the policy, as happened in the calculation of the delivery fee. This low utilization of evidence by health policy-makers seems to be the case in other countries in Africa as well (Wone & Tal-Dia, 2012). Thus, the impacts of moving from a flat-rate reimbursement to reimbursement of the actual costs of deliveries remain to be studied. This is a subject about which there is desperately little knowledge in Africa (Ridde & Morestin, 2011).

Too little effort was made to provide ongoing information on the policy's dispositions, whether to the public or to health personnel. New workers did not know the details, and health workers' level of information in general was uneven, such as had happened, for example, in Burkina Faso's fight against HIV (Ouattara, Gruénais, Zongo, & Ouedraogo, 2011) or in Senegal, in the involvement of community-based health workers in the fight against malaria (Faye, 2012). The maternity units did not have any simple document explaining how the policy worked, as was also the case in Ghana for the fees exemption for children under five years of age (Agyepong & Nagai, 2011). The policy's execution manual (Ministère de la Santé, 2006a) remained only in the hands of district authorities, who received it in 2007 when the policy was inaugurated. That manual was never subsequently corrected or distributed. Yet, it is essential, in designing healthcare financing, that rules be defined (Mathauer & Carrin, 2011). Otherwise, if a system's governance is relatively weak, unscrupulous health workers can exploit certain openings created by lack of information or clarity about certain functions to turn the system to their advantage. This situation has also been seen in Senegal, Ghana and Niger (Agyepong & Nagai, 2011; Faye, 2012; Ridde & Diarra, 2009; Witter et al., 2009; Witter, Dieng, Mbengue, Moreira, & de Brouwere, 2010). In Burkina Faso, if the health workers had been given the manual ("*recommended clinical protocols*", p. 32), they would have learned, for example, that a delivery can be considered normal even if an episiotomy is done, and that therefore they should not charge these women 3600 F CFA, but rather 900 F CFA. Posting the rates of the fees in maternity units, two years after the inauguration of the policy, was not enough to ensure the policy was respected. Aside from the problems related to the content of the kits, it should be mentioned that the posters were in French, a language that most of the population do not understand, and that women's actual expenses were never monitored. As of this writing, the Ministry had only conducted one survey in 2009, whose results had not yet been disseminated in 2011, on the expenses reported by health workers in the registers. However, no population survey had been carried out. As is the case elsewhere for this type of policy (Meessen et al., 2011; Witter et al., 2009), the evaluation function is still too limited.

### 5.4. Lessons learned

Beyond lessons that were specific to this policy's national context, this study enabled us to draw up a list of several lessons for narrowing the implementation gap in policies that are a priori equity-promoting (Box 1).

#### Box 1. Some lessons learned for improving the implementation of fees subsidization policies

- Involve street-level workers in defining the policy's content;
- Test the policy's implementation and instruments before scaling up nationally;
- Regularly update the policy's operating manual to correct any errors and ambiguities;
- Make the manual's contents accessible and adapted to all levels of the health system and for all the health workers involved;
- Keep the population informed about the policy's content and procedures;
- Carry out regular population surveys to find out whether the policy is actually benefiting its target population.

## 6. Conclusion

This aim of this article was to respond to the call of Gilson and Raphaely (2008) for “more work on implementation, and specifically, the challenges of implementing equity-oriented policies.” To this end, we used a mixed method research approach that allowed us to benefit from the dual strength of both qualitative and quantitative approaches and thereby to better measure and understand the gap between what women report paying for a delivery and what they should be paying officially. Even if there has been a progressive distribution of this policy’s benefits (Ridde et al., 2012), a more rigorous implementation would certainly help to make it even more equitable. Clearly, institutional design and organizational practices are at the core of the explanation, since the absence or lack of clarity regarding certain rules, as well as weak rule enforcement and organizational capacity, are factors that impede the achievement of universal coverage (Mathauer & Carrin, 2011).

## Competing interests

The authors declare they have no competing interests.

## Authors’ contributions

VR and SK wrote the research protocol. VR, MY and KK coordinate the qualitative data collection with SK. SK, VR and AB organize the quantitative survey and do the primary analysis. MY, KK and VR analyze the qualitative data. VR wrote the first draft. All authors read, improved and approved the final manuscript.

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