

# The national subsidy for deliveries and emergency obstetric care in Burkina Faso

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**Introduction** To reduce financial barriers to health care services presented by user fees, Burkina Faso adopted a policy to subsidize deliveries and emergency obstetric care for the period 2006–2015. Deliveries and caesarean sections are subsidized at 80%; women must pay the remainder. The worst-off are fully exempted.

**Methods** The aim of this article is to document this policy's entire process using a health policy analytical framework. Qualitative data are drawn from individual interviews ( $n=113$  persons) and focus groups conducted with 344 persons in central government, three rural districts and one urban district. Quantitative data are taken from the national health information system in eight districts.

**Results** The policy was initiated in all districts concurrently, before all the technical instruments were ready. The subsidy is paid by the national budget (US\$60 million, including US\$10 million for the worst-off). Information activities, implementation and evaluation support have been minimal because of insufficient funding. Health workers and lay people have not always had the same information, such that the policy has not been uniformly applied. Coping strategies have been noted among health workers and the population, but there has been no attempt to impede the policy's implementation. At the time of the study, fixed-rate reimbursement for delivery (output-based) and overestimation of input costs were financially advantageous to health workers (bonuses) and management committees (hoarding). Very few of the worst-off have been exempted from payment because selection processes and criteria have not yet been defined and most health workers are unaware of this possibility. The upward trend in assisted deliveries since 2004 continued after the policy's introduction.

**Conclusions** This ambitious policy expresses a strong political commitment but has not been adequately supported by international partners. Despite relatively tight administrative controls, health workers have figured out how to take advantage of the system. Some of the policy's instruments should be reviewed and clarified to improve its effectiveness.

**Keywords** User fees, abolition, obstetric care, Burkina Faso, health policy, implementation

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**KEY MESSAGES**

- Burkina Faso has demonstrated a political commitment to improving access to emergency obstetric and neonatal care by funding, in the national budget, a policy of subsidizing direct costs between 2006 and 2015.
- The country's technicians did not receive all the support required in formulating the policy, and the newness of this type of policy in West Africa meant those in charge had to learn by doing.
- Technical ambiguities in the policy's content led to implementation problems and coping strategies by various actors, but did not impede implementation.
- Except for those indigent women who were unable to pay the fee, all actors appear to have benefited from this policy.

**Introduction**

While many health policy evaluations focus on demonstrating impacts, few study implementation, especially in Africa. Only 4% of articles describing public policy implementation deal with Africa (Saetren 2005). Yet the conditions under which a policy is implemented can determine its impacts, because 'if implementation fails, everything fails' (Chen 2004). This has also been identified as a problem in the domain of maternal health policies aimed at improving access to obstetric services (Witter *et al.* 2008).

Many West African countries have invested in maternal health through policies for fees exemptions in obstetric care. Financial barriers for pregnant women are specifically targeted because three-quarters of maternal deaths could be prevented if women had access to high-quality primary care (Campbell and Graham 2006; Ronsmans and Graham 2006). Many obstetric complications are unforeseen and rapidly fatal, and families have difficulty mobilizing the financial resources in time. The relatively high cost of emergency obstetric interventions puts families in debt, pushes them into poverty and excludes those without means from the health care system (Borghi *et al.* 2006).

With 484 maternal deaths per 100 000 live births (MED and INSD 1999), improving access to emergency obstetric services represents a major challenge for Burkina Faso. The Ministry of Health (MOH) has striven for 10 years to make basic obstetric care accessible in primary health care centres (Centres de Santé et de Promotion Sociale, CSPS) and complete obstetric services in district hospitals (medical centres with surgical units, CMA) thanks to the implementation of the National Health Development Plan (PNDS 2001–2010) and the Strategic Plan for reduced-risk pregnancy. Thus, assisted deliveries by qualified staff have increased steadily since 2004, most especially in 2007, the year in which the subsidy programme studied here was launched (Table 1).

The financial barrier is one of the greatest obstacles to access in Burkina Faso, where 46.4% of the population lives below the poverty line (MED and INSD 2003). The worst-off have no choice but to delay or not use health care services, the official exemption system for the poor being rarely applied in practice

(Ridde 2008). It is in this context that the national subsidy for deliveries and emergency obstetric and neonatal care (EmONC) has been operating since 2006. Unlike other countries in the region such as Mali, Senegal or Ghana, Burkina did not opt for total fees abolition, but for a subsidy covering 80% of the costs of deliveries, obstetric complications and caesarean sections. The aim of this article is to document this policy's process using a health policy analytical framework.

**Methods****Analytical framework**

This study fits within an analytical framework for the study of public policies in health (Walt *et al.* 2008; Hercot *et al.* 2011, in this issue) that has already been used in Burkina Faso (Ridde 2008; Ridde 2009). It arose partly out of a series of studies in six African countries commissioned by UNICEF and managed by the Institute of Tropical Medicine in Antwerp (Belgium) (Meessen *et al.* 2009). This analytical framework defines public policy as a process for regulating situations presenting resource distribution problems (Lemieux 2002). In our case, this situation was the funding and utilization of obstetric services. Conceptually, a public policy consists of three subprocesses (emergence, formulation, implementation) that produce effects. In this article we focus only on the proximal effects on the utilization of delivery services. In keeping with a socio-anthropological and interactionist approach used in Africa (Olivier de Sardan 2005), we analysed particularly the roles of social actors and what leeway they had in implementing the policy (Pressman and Wildavsky 1984; Grindle and Thomas 1991).

**Methodological approach**

Our methodological approach is a single case study with multiple overlapping levels of analysis (Yin 1994). The case is the national subsidy policy for EmONC, analysed at the national level for the emergence and formulation processes and at the district level for the implementation process and effects.

**Table 1** Rates of assisted deliveries in health facilities, Burkina Faso

Year	2003	2004	2005	2006	2007	2008	2009
Rate of assisted deliveries	30.92	33.49	37.67	42.90	54.63	62.72	73.40
Annual rate of increase	–	+8.3	+12.5	+13.9	+27.3	+14.8	+17.0

Source: Statistical Yearbooks (2003–2009), Direction des études et de la planification, Burkina Faso.

**Table 2** Instruments for collecting qualitative data

Instruments	Category & examples of actors			
	Affected <i>NGO member, COGES member, EGD depot manager</i>	Individuals <i>Service users and non-users</i>	Officials <i>Central officials, consultants, advisors</i>	Workers <i>Nurses, midwives, physicians, district/regional managers</i>
Group interviews (# persons)	5 (63)	18 (154)	–	8 (127)
Individual interviews	30	34	8	41

Notes: NGO = non-governmental organization; COGES = community management committee; EGD = essential generic drugs.

The implementation study is focused on one urban district of the capital and three rural districts. We selected these districts based on previous contacts with local actors that gave us access to empirical data, and because of time and resources limitations imposed by several data collections conducted for UNICEF and the non-governmental organization (NGO) HELP (funded by ECHO). These four districts offer a diversity of social and health situations that are representative of the country.

### Materials and methods

The study is based on both qualitative and quantitative data.

Individual and group interviews were conducted with key actors (Table 2) between November 2008 and April 2009. Applying the triangulation principle, we interviewed individuals within the four categories of actors involved in public policies (Kingdon 1995; Lemieux 2002) at the national and local levels of the health system.

We carried out observations in 25 health centres in the four districts to document the policy's implementation and interactions among actors. Notes were taken systematically of all interviews and observations. We also analysed all documents related to the policy under study and key documents on Burkina Faso's health policies.

Quantitative data on service utilization were abstracted from the national health information system at the district level. Given the complexity of factors related to caesareans (Lin and Xirasagar 2004), we focused on assisted deliveries in CSPSs and CMAs, where the policy's impacts are more readily observable. We obtained secondary data from eight health districts, for a total of 211 health facilities. To assess trends, we produced time series of the mean monthly number of deliveries by CSPS between January 2004 and September 2009 (69 months) after calculating fifth-order moving averages.

Qualitative data analysis was based on the analytical framework presented above and used content analysis (Mucchielli 2004) and triangulation of sources. The preliminary report was critiqued by two people at the MOH who had been involved at the beginning in the policy's development and implementation. Two of this article's authors (FR and GC) attended planning meetings for this policy, which was under GC's responsibility at the time it was launched.

## Results

### Emergence of the policy

Since the 1990s, Burkina Faso has tried various initiatives to lower financial barriers to obstetric care. In 1997, the prime minister announced that public hospitals would treat

emergencies without pre-payment and caesareans would be free for the worst-off. However, this policy was never actually implemented (Bicaba *et al.* 2003). Starting in 2001, UNICEF supported setting up cost-sharing among the State, local communities, CSPS management committees, and the population for obstetric emergencies. This initiative, launched in the Eastern region and promoted by the MOH, was then extended to 10 other districts (Richard *et al.* 2007). Within the strategic framework against poverty, the Millennium Development Goals (MDGs) and the Programme national de développement sanitaire (PNDS) objectives (one of which is improving financial accessibility), several decisions were also taken to reduce or eliminate fees for certain acts. For example, preventive care for pregnant women became free in 2002. Then, negotiations were started in 2004 with the World Bank on the 6th Poverty Reduction Support Credit (PRSC6). In fact, one condition for funding the preceding Credit (PRSC5) had been the management of obstetric emergencies, because, as one key informant said, "*Burkina Faso had to meet certain indicators and if we did not, there could have been repercussions on the funding of the ministries of Economy and Finance. The point was to know how to help countries to be able to meet this indicator.*" According to the MOH, this policy was part of the government's commitments to the World Bank and other partners for obtaining funding support (Ministère de la santé 2007). The MOH set up a technical committee to define the policy, reporting to the MOH's Department of Health and Family (DSF). The World Bank provided limited technical support to this committee. It funded three missions of a World Bank expert and a consultation by a national public health physician who had been involved with the cost-sharing system in the Eastern districts. A DSF staff member, a physician trained in health economics, also contributed to the consultation by providing the figures and projections of the different options. This team had to deliver a draft of a policy on very short notice (3 weeks) and with very limited international technical support. Table 3 summarizes the policy's chronology.

### Policy formulation process and content

#### Level of subsidy

At the Health Minister's request, the technicians proposed three subsidy options: 60%, 80% and 100%. The official document indicates that the choice was 'based primarily on the strategy's efficiency and sustainability' (Ministère de la Santé 2006). The 80% subsidy was selected "*by the core group of the director [of the DSF] and the department heads*", said one MOH official from that time. Another MOH staff member said, "*they were prepared to go to free deliveries at the first level*". The decision not to subsidize at 100% appears to have been based on: (1) the negligible difference observed in simulations of the impact on

**Table 3** Chronology of activities related to the national subsidy policy for deliveries and emergency obstetric and neonatal care (EmONC)

<b>Time period</b>	<b>Activity</b>
<b>2004</b>	
November–December	Meetings of technical work group on policy development
<b>2005</b>	
February	Policy development workshops
September	Policy implementation workshops
<b>2006</b>	
March	Adoption by Council of Ministers
April	National validation workshop
May	Application decree
May–August	Regional orientation workshops for the regional health departments and health districts
September	National workshop
September	Memo from Secretary General (SG) of Health requesting that its application become effective on 1 October 2006
October	Pre-positioning of funding in university and regional hospitals and CMAs
November	Workshops to present the information system for the national subsidy
<b>2007</b>	
January	Memo from the SG to extend subsidy to deliveries in CSPSs
May	National workshop to prepare regional orientation workshops for the actors
May–July	Baseline evaluation conducted
July–August	Regional orientation workshops for actors in the 13 regions
October	Review of management tools
November–February 2008	Development of posters and information brochures on the subsidy
January–December	Follow-up visits to 5 health regions, 14 health districts, 1 university hospital and 2 regional hospitals
<b>2008</b>	
March	Collaboration workshop on application problems
March	Memo from the SG to clarify the definitions of acts and of transportation
March–May	Design and broadcast of audio and video public awareness advertisements
March–July	Development of the protocol document for newborn management
May–July	Regional information workshops with more than 900 leaders in the 13 regions
April–September	Design of the EmONC software program (SYGSONU)
November	National information workshop with 150 media professionals
November	National information workshop for members of Parliament
November–December	Development of summary document on the national strategy
November–December	Deployment of EmONC software and training of actors in its use
January–December	Follow-up visits to 10 health regions, 18 health districts and 1 regional hospital
<b>2009</b>	
January	Launch of computerized management system
February	Beginning of evaluation study on costs of subsidized services
June–July	Orientation workshops for actors in the hospitals
June	Beginning of collaboration with the Ministry of the Economy and Finance
October	Joint visits by the Ministries of Health and of the Economy and Finance to 6 health regions, 9 health districts, 5 regional hospitals and 1 university hospital
October–December	Second broadcast of public awareness ads over 50 FM radio stations
November	Information workshop for teachers in the training schools
January–December	Follow-up visits to 1 health region, 15 health districts, 3 regional hospitals and 1 university hospital

Notes: CMA = medical centre with surgical unit (district hospital); CSPS = Centre de Santé et de Promotion Sociale (primary health care centre).

maternal mortality at 100% and 80%; and (2) the desire to maintain a contribution from the population. First, a simple linear function was produced comparing the subsidy percentage (100%, 80%, 60%) and the maternal mortality ratio (MMR) over a period of years. It was assumed that the MMR would necessarily decrease over time according to a linear relationship in which the line representing the MMR would intersect with that representing years in 2018, when the MMR would be 0. When developing this hypothesis, the national consultant relied on a communication from a United Nations Population Fund (UNFPA) agent that, as he informed us, contained no scientific references. At 100%, it was calculated that maternal mortality would drop from 484 per 100 000 live births in 2005 to 105 in 2015; at 80%, the latter number would be 122. According to technicians, these calculations were difficult, and they sought help from several partners, but did not receive all the support required. However, to convince decision-makers, they needed an assessment of the subsidy's impact. Second, there was a fear of undermining the cost-recovery policy begun in 1993 and "habits already ingrained in the population", said one MOH physician. Thus the 80% subsidy was selected (Table 2).

#### *Calculating the costs of reimbursement*

It was decided to use fixed-rate reimbursement (lump sum flat fee). The cost of caesareans was calculated by consensus, based on the average costs of six district hospitals, one university hospital and a 2001 memo from the Secretary General of Health setting fees for certain services. For reimbursement purposes, this cost was set at 55 000 franc de la Communauté Financière Africaine (FCFA) (84 Euros), including 10 000 F for fuel for evacuations. For normal deliveries, no comparison of actual costs was done. Based on the Secretary General's 2001 memo, their cost was set at 4500 F (6.9 Euros) for the normal delivery fees, including the costs of the delivery kit (medicines and consumables). Women thus paid either 11 000 F for caesareans or 900 F for normal deliveries (20%). To encourage women to deliver in CSPSs, hospitals were reimbursed only 60% and women had to pay 1800 F. Because some indigent women could not pay even the 20%, it was decided to subsidize 20% of deliveries at 100%. We were unable to find out how it was determined, in the policy formulation workshops, that 20% of pregnant women were indigent.

#### *Political commitment and national budget*

On the basis of these calculations and the number of deliveries expected for the period 2006–2015, 30 billion F CFA (45.4 million Euros) was planned, of which 5 billion (16.6%) was for the worst-off. This was supposed to be included in the national budget, expressing a real political commitment. As one high-level MOH official said, "the advantage is that it is a Council of Ministers' decision, it runs until 2015, and the Finance Minister is required to put it in his budget." Another MOH staff member said, "there have been other situations where we have advocated without success, and here, we were surprised." A World Bank manager speculated that this political commitment might partly be explained by the attendance of some deputies at a training session on health care financing where this issue was discussed. If we compare the required budget stated in the policy to what was actually in the finance bill to reimburse the cost of services to health facilities, the gap is –17%

in 2006, –35% in 2007, and –27% in 2008. We were unable to find out the amounts actually paid out.

#### *Associated measures*

There was "no specific move to buy equipment", said a regional health director, since it was expected this initiative would be "added to an already-functioning system", said an MOH official. This was because the country had already invested significantly in the PNDS and service quality improvement. Thus, there was no plan for associated measures (operating rooms, ambulances, medical personnel, medical-surgical equipment, etc.) in the subsidy strategy because they were already in the October 2006 Roadmap for the Acceleration of the Reduction of Maternal and Newborn Mortality. It is very difficult to determine whether the Roadmap was funded at 100% because the central level does not have information on the peripheral facilities. The rate of physical production for major activities was around 50%. For drugs, a pharmacist reported that: "decisions to start the policy and subsidize treatment of complications have been taken while certain elements were not available from the central purchasing agency." Such was the case for magnesium sulfate, recommended for treating convulsions in cases of eclampsia, but not available when the subsidy was started.

#### **Implementation processes**

##### *When policies outpace the technicians*

Starting in 2004, many meetings and workshops were organized to define the policy's content (Table 3). The Council of Ministers adopted the caesareans subsidy on 22 March 2006; "we were still in the basic documents phase and were unable to define the operationalization when the government released the funds," one MOH official said. Several documents were prepared by March and April 2006: (1) presentation of the policy and calculation of the financial requirements; (2) policy support activities and monitoring plan; and (3) procedure manual. An official letter went out in September announcing the policy's application in public hospitals beginning on October 1st. Even though some things were not entirely ready, the policy had to be applied: "health care services were not adequately programmed, but because it was a directive..." said one regional officer. Then, despite a call by the work group that had prepared the policy to learn from the caesareans experience before extending the subsidy, it was decided on 16 January 2007, to extend it to CSPSs for deliveries (Table 3). This was applied country-wide because, according to a central official, "there was resistance at that time to pilot projects." One working group member said, "political biases were such that two months after starting with caesareans, people launched the deliveries and things [the decision] became unmanageable. That's also the reality."

##### *Partial funding*

While service subsidies were included in the national budget and well disbursed, funding for policy support activities was not. One former senior official speculated that "the deputies told themselves the Ministry of Health had resources for policy support activities." A former senior MOH official explained that, "the mistake was in presenting two documents for funding: the subsidy strategy and the policy support activities plan." The policy support activities and monitoring plan for 2006–2010 called for

660 million FCFA, less than 6% of the amount destined for the subsidies. This plan was supposed to fund the activities of producing technical documents and materials to inform and raise awareness among stakeholders, as well as to ensure monitoring and follow-up/evaluation. The communication activities were included in this plan. Among the 40 activities proposed, 13 were for communications, representing 26% of the policy support activities budget.

#### **Women not always aware of the policy**

Mass communications activities were organized relatively late in the process. Women in cities were informed through television and radio. Those in rural settings sometimes only learned about the subsidy at the time of delivery. Others remained unaware of the price of deliveries because their husbands paid. One group of women told us that *“the maternity service users passed along the information.”* This poor communication, which is not unique to this particular policy, is due to not implementing the communications plan fully and promptly. Community leaders were met between May and July 2008, yet information posters only appeared in CSPSs at the end of 2008, and only in French (in a country where just 28% of the population is literate). The first media workshop was held in November 2008 (Table 3). These delays are significant; as one MOH senior official said, *“for the communications aspect, we spent a lot of time shining our shoes before entering the room.”* The communications plan was supposed to be entrusted to a private firm, but the Ministry preferred to use its own services. Also, in a context where participants expect a per diem for meeting attendance, the Ministry lacked sufficient resources.

#### **Problems of interpretation and of clarity on certain items**

We observed many problems with interpreting the policy's content, or even just lack of knowledge about certain provisions. *“Everyone went and implemented according to his understanding”*, one regional health director said. Health workers were not given the operations manual, although this was envisioned in the implementation plan. Frontline health workers were not at workshops where the policy's content was defined, except for some midwives from the capital's maternity services who attended initial workshops with district medical officers. Regional and district information workshops in 2006 and 2007 did not reach all the workers. Those who did attend apparently did not share all the information with their colleagues or did not remember the policy's details. For example, workers whom we interviewed did not know the prescribed post-delivery length of stay, nor whether abortions were covered. Pre-eclampsia management was problematic because it required antihypertensive medications not available in generic form in district hospitals; families had to buy them at private pharmacies.

No one knew 20% of the budget was earmarked for free care to the worst-off. Also, certain provisions of the policy were insufficient. For the worst-off, for example, one criterion specified was presentation of an indigence card from the social action committee, whereas it is well-known that few undertake the process of acquiring one (Bicaba *et al.* 2003). A pilot phase intended to define indigence criteria did not occur because, as someone from the DSF said, *“when there are priorities,*

*everything else is set aside”*. It was not clear whether the 10 000 F for transportation was payable to the receiving facility or the referring one. The cost of transportation between the home and the maternity unit was not covered, nor was the cost of the post-caesarean trip home. In one urban district, ambulance drivers still, in November 2008, charged women 1500 F for a transfer from a health centre to a district hospital, even as the poster in the health centre informed women that *“with the subsidy, transportation is now free”*. This payment charged in the urban setting can be considered an informal payment specific to this context, since we did not see it in any of the other districts studied.

#### **Efficient funds transfers but a lagging public accounting system**

The CSPSs received, before the policy started, funds based on an estimated number of deliveries. Thereafter, they were reimbursed for services actually provided, on a fixed-rate reimbursement. The funds were transferred from the central to the peripheral levels along the usual public accounting channels. Then the districts transferred the funds to the managers of the health centres by means of bank drafts. At the time of the study (November 2008–April 2009), there were almost no reimbursement delays in the districts studied.

However, certain districts soon noticed that the rate for normal deliveries was nearly double the actual cost of a delivery without episiotomy in a CSPS. One district management team therefore stopped paying CSPSs the fixed-rate reimbursement and instead reimbursed actual expenses at 2500 FCFA (3.8 Euros), per their own calculations. The MOH's financial department was aware of this situation. After the policy had been in force for some time, it was necessary to explain to health workers, as one official said, that *“it's elusive money”*, and therefore any surplus of the fixed-rate reimbursement over actual cost should be applied to other acts (although there were no clear guidelines) and also, as a high official in the Ministry said, that *“it's not for [their] consumption”*, in other words, any surpluses should not be diverted or misappropriated.

Some workers grasped this potential profitability early, particularly in terms of the 20% bonuses on their delivery fees. The policy did not specify how this was to be applied, leading to different interpretations by health workers, especially because the form they had to complete for each patient included a calculation called *“balance for the health facility”*. Some calculated their bonus as 20% of the surplus, the difference between the fixed-rate reimbursement and real costs, while others based it on total price. One nurse said, *“we understood that the surplus was profit”*. Workers did not appreciate the plan to reimburse only actual costs and became inclined to use more inputs. It was even harder to accept, said one nurse, *“if only we hadn't tasted this money”*. As this article was being written, reimbursement was still at fixed-rate but a shift to real costs was under consideration. However, the organization of the public finance system does not seem to lend itself well to output-based financing operations.

#### **Actors' coping mechanisms**

Despite some of the policy's unclear provisions, it is noteworthy that no one attempted to impede it. On the positive side, one district management team took advantage of the policy to

use some of the district's budget to eliminate the women's payment of 900 FCFA. Elsewhere, they used the surpluses from the fixed-rate reimbursement to update the vaccination outreach motorcycle fleet. Districts that had cost-sharing schemes before the policy used the surpluses to further reduce women's payments. Some districts charged only 5000 F for caesareans and others eliminated fees completely. On the negative side, one regional hospital director used several months' worth of subsidy to pay bonuses to health workers to end their strike. Some midwives decided the subsidy only applied when the woman's labour began, so inputs used beforehand were charged, "from the moment of labour it's 900 F, so if we need gloves to check, they have to pay 100 F". Pregnancy complications also presented problems, since only pre-eclampsia and eclampsia were mentioned in the subsidy's procedure manual, but severe anaemia or infection during pregnancy were not.

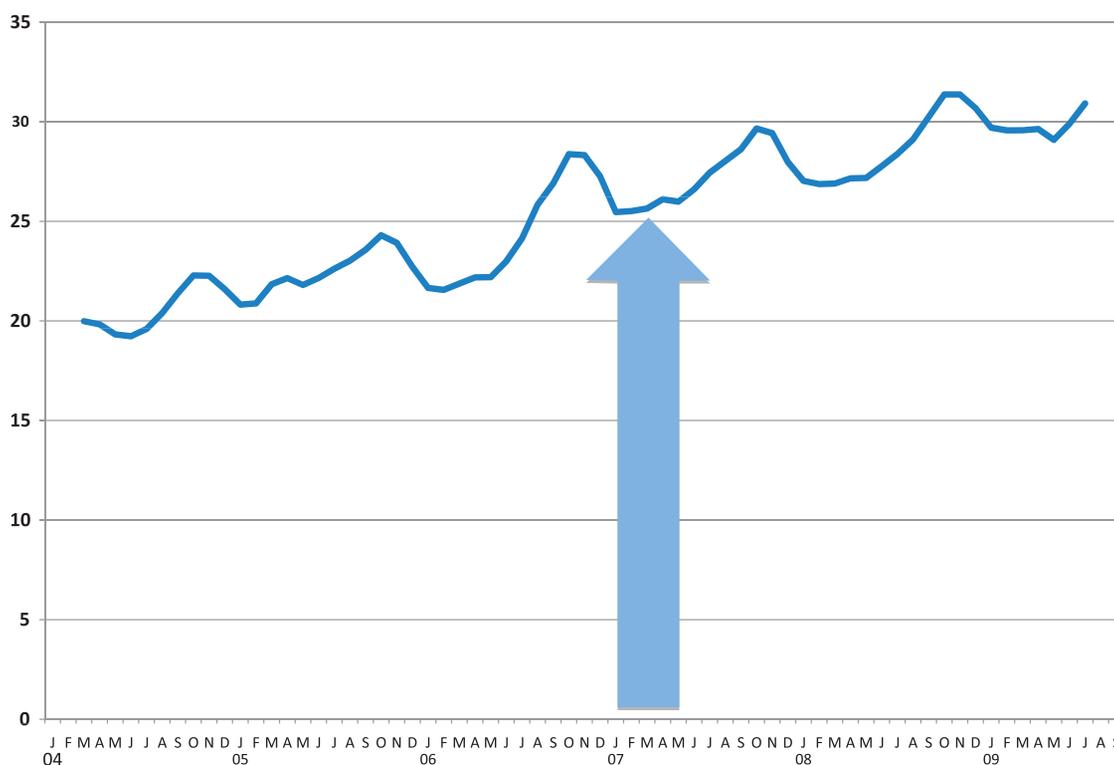
#### System for monitoring, follow-up and evaluation

At the DSF, a small cell of four people oversaw the policy without adequate logistical means. Everyone involved in the policy at the beginning had left. Subsidy-specific management tools were implemented, but late. They were mostly based on documents from an urban district practising cost-sharing. Health workers had to complete two forms (nearly identical for deliveries) per patient receiving the subsidy, in addition to filling in the usual multiple registers. These forms were completed heterogeneously across CSPSs and districts. This was added workload and no associated measure was planned. Software was developed to support districts' data management,

but training and explanations were not always provided, such that several districts went through periods without data entry because of system blockage. In one urban district, the team had "tested" three versions of the software. Each time, because older versions no longer worked, all previous data had to be re-entered. At the time of writing, they were entering data into an Excel file because the software had been blocked for 4 months. There was no policy evaluation plan, but there was a list of indicators to monitor implementation. There was no co-ordination with the MOH department responsible for evaluations. An evaluation was done 6 months post-implementation by a consulting firm (Sombié *et al.* 2007). The implementation plan called for two more evaluations. The three evaluations were expected to cost 20 million FCFA, i.e. 0.02% of the entire implementation cost and 0.07% of the subsidy.

#### Effects on service utilization

Figure 1 shows that the upward trend observed country-wide (Table 1) was confirmed in the 211 health facilities and eight districts studied. This trend preceded the subsidy for deliveries. Three years after the subsidy began, we see no significant change in this overall trend. Some heterogeneity might be observed in trends at the national level, since the rate of increase in 2007 appears to differ from other years. However, in the eight districts for which we were able to obtain data, only one showed a significant increase more than 12 months after the policy's introduction. Thus, a detailed statistical analysis remains to be done at the national level and in other districts in order to understand this heterogeneity hypothesis.



**Figure 1** Average number of assisted deliveries by health facility in eight districts of Burkina Faso from 2004 to 2009. Note: The arrow indicates the policy's launch, which varied from January to April depending on the districts. Source: National health information system in the districts.

## Discussion

### Study limitations

We do not expect our results to be statistically generalizable. These four districts are representative of the country's diversity, and the results have some elements of replication logic that strengthen the 'analytic generalization' (Yin 1994) of the difficulty of implementing the public policy. However, all public policies' contexts and application processes are in constant flux. Thus, this study undertaken approximately 2 years after the policy's launch can tell us only about what happened in that period and offers no assurances about how the policy's application may have changed since our analysis was done. The final methodological limitation is that our approach did not allow us to investigate the policy's impacts on the population.

### A Burkinabè exception?

This study shows that the policy implemented in Burkina Faso resembles many public policies (Saetren 2005), including those abolishing fees in Africa (Witter *et al.* 2008; Ridde and Morestin 2011). The decision was political; the technicians were better prepared than elsewhere, but not for everything, and they received no funding for the policy support activities and monitoring plan. The vagueness in some of the policy's content led actors to use whatever leeway and powers they had (Lemieux 2002; Walker and Gilson 2004; Erasmus and Gilson 2008). The indigence issue still urgently needs to be resolved for greater equity, since this policy did not serve as a window of opportunity, any more than had the Bamako Initiative (launched in 1993 in Burkina Faso), for solving this problem, which is actually more a responsibility of the State in general than of this policy in particular (Ridde 2009).

Setting aside the exemption for the worst-off, no one tried to block the implementation. One success of the policy was that

no major implementation gap (Pressman and Wildavsky 1984) was noted; most of the policy's content was implemented. All the technical documents were ready at launch, although some elements were insufficiently explained or had been omitted. For example, the terms of reimbursement for transport were not very detailed, nor the procedure for calculating staff bonuses on the amounts received by the health centres, which created many problems. Those in charge tried several times to fix the policy (Table 3) as best they could, but the message was not always well communicated and understood. The error was in separating the funding of acts from that of other aspects (policy support activities, evaluation, communications).

On the other hand, in terms of policies to combat maternal mortality, Burkina Faso is an exception in the region because it chose subsidy over fees exemption. In fact, countries in that subregion abolished user fees: free deliveries, management of complications and caesareans in Ghana (April 2005); free caesareans in Mali (June 2005) and Niger (February 2006); free deliveries and caesareans in public facilities in Senegal (January 2006). However, Ghana's experience, which is the longest, shows that abolition does not always equate to free services. Even under the free system, women were paying US\$153 for caesareans and US\$34 for deliveries (Asante *et al.* 2007). None of these policies covers transportation, unlike Burkina Faso.

In Box 1, we present the policy's key strengths and weaknesses as revealed by our analysis. That Burkina Faso opted for subsidy is both consistent and inconsistent with local social practices and representations (Ridde 2006). It is consistent, because this country's decision-makers most often choose subsidy over fees abolition. In 2009, people living with HIV still had to pay a fee for antiretroviral treatments. Children still had to pay for artemisinin combination therapies (ACT) treatment. The principle that user fees will give people a sense of responsibility, advocated by the proponents of the Bamako Initiative, is still deeply embedded in people's thinking. However, it is inconsistent because some services or products

#### Box 1 Key strengths and weaknesses of the policy in Burkina Faso

##### Strengths

- Political will and funding in the national budget.
- Relatively participative process for defining the policy's content.
- Simplicity and efficiency of the service reimbursement system.
- Integration of the subsidy into the health system and community-based management.
- Choice of a subsidy accompanied by full exemption for the worst-off.
- Subsidy covering the direct costs of treatment (acts, hospitalization, surgical kit, drugs) and transportation for obstetric emergencies.

##### Weaknesses

- Direct country-wide implementation.
- Minimal involvement of funding agencies and international technical assistance.
- Technical steering unit too small and under-used.
- Fixed rate of reimbursement for normal deliveries too high.
- Accounting control system not set up for fixed-rate reimbursement.
- Ambiguity regarding certain elements of the policy's content.
- No criteria defined for indigence or indigent selection.
- Lack of resources for communications, implementation and evaluation.

are free, such as drugs against leprosy and tuberculosis (free for a long time), prenatal visits (since 2002) and treatment of severe malaria (since 2005), although our data showed that these were not always respected. The State even allowed two NGOs to subsidize at 100%, in four districts, visits for children under age 5 and deliveries. A fifth district abolished the 900 F payment without any NGO assistance by using its decentralized credits. These variations should be studied in the future to understand the political inconsistency. Sustainability cannot be invoked to justify the women's 20% payment for deliveries. In fact, the 80% government subsidy covers the real costs, as one district team concluded. Abolishing that payment as promised by the Head of State in February 2010 therefore appears feasible, as long as mechanisms are in place to repress and eliminate informal charges.

### From input-based to output-based

The study uncovers a technical mechanism that remains poorly documented in West Africa, that of fixed-rate reimbursement of services. This change is profound for an administrative culture used to providing inputs in kind and expecting accounts of actual expenses. Because of negative input distribution experiences, particularly for free prenatal visits, decision-makers embarked on an innovative operation. While not a miracle solution (Kalk *et al.* 2010), this approach has the potential to simplify public administration and to make actors more responsible and motivated (Meessen *et al.* 2007). However, effective controls are needed, since earlier fee-for-service experiences in vaccination revealed serious limitations in Burkina Faso, where health workers tended to greatly inflate the number of acts carried out (Lim *et al.* 2008). Moreover, accounting rules must be adjusted and the auditing system improved.

This MOH initiative was not aligned with the culture of the national administration in general nor that of the Ministry of Finance in particular. This conflict resulted in fixed-rate reimbursement under an actual-cost accounting system (where thousands of bills must be checked and computerized), a situation that is neither appropriate nor consistent. It is important to maintain the lump-sum, flat-fee rate system to reduce clinical staff workload, but the real number of acts carried out must still be monitored effectively, as in Rwanda (Meessen *et al.* 2007), in addition to cross-checking visits in the community to verify the reality of deliveries reported. Sanctions must be imposed as required—not easily done, either in Rwanda (Kalk *et al.* 2010) or in Burkina Faso. It would be interesting in the future to look at the public decision-makers' choices as well as the results of any potential audits of the service reimbursement situation since the policy's introduction. The DSF carried out a cost analysis of 2009, the results (still not shared) of which could be useful.

### Who are the winners?

From the above, and given the weak evaluation component of the MOH's policy plan, we are unable to assert that women are the real winners. Three years into the policy's application, its impacts are unclear and, with no evaluation system, assessing impacts is difficult. Moreover, decision-makers chose not to introduce the policy progressively in just a few districts,

preferring instead an immediate country-wide implementation. The difficulty of assessment is compounded by the fact that utilization continues to rise. The hypothesis that the increase in assisted deliveries seen in one of the eight districts on this study is heterogeneous across all districts in the country remains to be tested. But, using multilevel statistical models, a recent study was able to isolate and measure the extent of the impacts of the policy in four districts. In all districts, 33 months after the national subsidy the net effect is assessed to be between 4 and 32 deliveries per month (Haddad, *et al.* 2011). However, unlike the experience in Mali (Fournier *et al.* 2010), a population-based study in the Nouna district of Burkina Faso showed that following the subsidy policy, disparities in utilization between rich and poor remain constant, i.e. the subsidy did not exacerbate the inequalities (De Allegri M. *et al.* 2011). Moreover, even though the subsidy does not cover all costs, this study showed that poor households undoubtedly benefited from the reduced expenses more than the less poor (Ridde, V. Kouanda S. *et al.* 2011) although more research is needed on this.

The subsidy also very likely benefited health workers and COGESs (community-based management committees). Surpluses generated by overestimation of the actual costs of normal deliveries provided bonuses to health workers and strengthened the COGESs financially, as long as the reimbursements continued to arrive on time (Sodoré *et al.* 2009). The impacts of these bonuses on the reported numbers of acts should be studied, given previous experiences of workers inflating vaccination counts (Lim *et al.* 2008). Thus, everyone seems to have won from this subsidy, except for the worst-off—even though it has been shown that in Burkina Faso there are no problems with the process for identifying them (Ridde *et al.* 2010).

## Conclusion

This subsidy policy expresses a certain political commitment to improve women's situation in Burkina Faso, even though the World Bank and other donors influenced the decision in a particular direction. The innovation was the introduction of fixed-rate reimbursement, which is not in the administrative culture. No one has tried to impede the process, but there is considerable pressure to revert to actual-cost reimbursement. Still, the actual costs of deliveries have not yet been calculated, nor have the processes and criteria been defined for giving the worst-off free access. The administration does not yet seem to have decided between actual-cost and fixed-rate reimbursement. The national subsidy's impacts cannot be analysed without studying the health care system context and the practices of health professionals. Factors that might constrain the policy's implementation, such as poor service quality or informal supplemental charges, could negate the government's efforts. We might reasonably ask, therefore, whether it would be more advisable to redirect the time and resources currently applied to tedious administrative and ineffective controls toward better verification of the reality of the reported deliveries and monitoring in the field of service quality and worker practices, to ensure women actually receive services of high quality and do not pay more than they should.

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## Conflict of interest

The authors declare they have no competing interests.

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