

Assessing Implementation Fidelity Of A Results-based Financing Intervention In Burkina Faso

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Background

Low utilization of healthcare and high mortality levels pressured the Burkinabe government to implement a results-based financing (RBF) intervention combined 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 subsidies to health facilities and health workers according to the quantity and quality of services delivered. Indicators are used to measure the levels of performance.

Rationale

Why assess implementation fidelity?

To date, RBF mechanisms suffer from a lack of scientific evidence (Ireland et al., 2011). By comparing the activities initially programmed with those that were implemented, the evaluation of fidelity helps to better understand the success or the lack of success of the RBF intervention.

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. 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

The intervention's implementation was relatively faithful to the plan (65,5%) although it encountered **certain obstacles**. On the whole, 13 activities were added to the plan. There was **no striking fidelity difference between** the three districts. However, the second district demonstrated a higher proportion of activities modified. A **difference existed between levels of care**: Regional hospital reported low implementation fidelity (44,0%) in comparison with district hospitals (58,3%) and primary healthcare centres (68,2%). Moreover, operationalization activities (**performance verification** and **subsidies payment**) (65,3%) seemed to have experienced some **implementation difficulties**. The fidelity of verification processes was mixed. Qualitative and quantitative assessments showed high implementation (95,2% and 100% respectively) while patients satisfaction survey and community verification, and cross-check faced poor realization. Regarding performance payment, 57,7% of expected subsidies payment were made despite a high fidelity of payment determination (86,9%). 0% providers pro-poor patient care bonus was delivered to targeted facilities as planned.

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. These results will support the forthcoming analysis of the intervention results

Conclusion

Carroll C, Patterson M, Wood S, Booth A, Rick J, et al. (2007) A conceptual framework for implementation fidelity. *Implement Sci* 2: 40

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