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Policy, paperwork and 'postographs': Global indicators and maternity care documentation in rural Burkina Faso

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ABSTRACT

Targets and indicators set at the global level are powerful tools that govern health systems in low-income countries. Skilled birth attendance at a health facility is an important indicator for monitoring maternal mortality reduction worldwide. This paper examines how health workers negotiate policy implementation through the translation of clinical care into registries and reports. It does so by analysing the links between the global policy of institutional births and the role of documentation in the provision of birth care in primary health centres in Burkina Faso. Observations of health workers' practices in four primary maternity units (one urban, one semi-urban and two rural) conducted over a 12-week period in 2011–2012 are analysed alongside 14 in-depth interviews with midwives and other health workers. The findings uncover the magnitude of reporting demands that health workers experience and the pressure placed on them to provide the 'right' results, in line with global policy objectives. The paper describes the way in which they document inaccurate accounts, for example by completing the labour surveillance tool partograph after birth, thus transforming it into a 'postograph', to adhere to the expectations of health district officers. We argue that the drive for the 'right' numbers might encourage inaccurate reporting practices and it can feed into policies that are incapable of addressing the realities experienced by frontline health workers and patients. The focus on producing indicators of good care can divert attention from actual care, with profound implications for accountability at the health centre level.

1. Introduction

Despite decades of international attention, maternal mortality remains a major problem, especially in Sub-Saharan Africa. More than 300,000 women died from pregnancy-related complications in 2015, most of them living in low-income settings (Alkema et al., 2016). The majority of maternal deaths are avoidable because the direct causes of maternal deaths, and the medical interventions to prevent and treat these are well known (Ronsmans and Graham, 2006). Ensuring that all women have access to safe abortions as well as quality care at and around the time they give birth are essential for reducing maternal morbidity and mortality (Campbell et al., 2016). Because maternal mortality is inherently difficult to estimate in countries without reliable civil registration systems, skilled birth attendance has become an important proxy indicator for maternal mortality (Storeng and Béhague, 2017; Wendland, 2016). Skilled birth attendance is assured by a healthcare provider with midwifery skills who is trained in the management of normal deliveries and the detection and management of complications during birth, and who has the ability to refer to a higher level of care when needed (World Health Organisation, 2004). In most countries, women giving birth in healthcare institutions are considered to be provided with skilled attendance, although this is based on the sometimes questionable assumption of sufficiently trainined health workers and well-functioning referral systems (Campbell et al., 2016).

Since the launch of the Safe Motherhood Initiative in 1987, the global community has fostered a number of initiatives, policies and goals. Over the past decades, global efforts to reduce maternal mortality have been channelled through the Millennium Development Goal

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(MDG) 5 (2000–2015) and, after 2015, through the Sustainable Development Goal (SDG) 3.1, targeting maternal mortality reduction. These global initiatives have mobilised attention and funds. At the same time, they have narrowed the field of reproductive health and influenced national health system through a myopic focus on averting maternal *mortality* – rather than improving maternal *health* – in policies and interventions (Austveg, 2011; Roalkvam and McNeill, 2016; Storeng and Béhague, 2014).

Policies promoted in the field of maternal healthcare are often highly standardised, and they constitute what Olivier de Sardan et al. (2017) refer to as travelling models to be realised in the same format in many countries. The policy texts are presented as culturally neutral and they are expected to be implemented by frontline workers in healthcare institutions with great geographical, economic, political and cultural diversity (Blystad et al., 2010; Olivier de Sardan et al., 2017; Smith, 2001).

Global policy targets are powerful, and they can alter and incentivise nation states, health systems and women giving birth in several ways (Danielsen, 2017; Oni-Orisan, 2016; Roalkvam and McNeill, 2016; Storeng and Béhague, 2014). The global policy level is multifaceted with possible policy dynamics between various actors at different levels; it is far from being a permanent entity with well-defined actors, beneficiaries, mandates and ways of working (Ferguson and Gupta, 2002). The way in which policies formulated in the so-called global sphere are translated into country-level programmes is determined by the power of global actors and national governments. A country's degree of discretionary power over policy adoption is reliant upon its level of donor dependency, the functioning of its civil society and the availability of healthcare expertise (Sandberg and Justice, 2013).

In many settings, the successful implementation of policies addressing maternal mortality becomes a prerequisite for the nature of external financing and governance of weak health systems (Oni-Orisan, 2016; Storeng and Béhague, 2014). Development assistance partners tend to influence priority setting at all stages of the policy process including in the development of national and lower level policies, and in the monitoring and evaluation of their implementation where key indicators are used to measure the success or failure of policies and programmes (Khan et al., 2018). In a context where maternal mortality constitutes an important measure of social development and women's status, skilled attendance at birth also becomes an indicator of the success of the state vis-à-vis the international community, and it is often used to compare the performance of countries and regions (Oni-Orisan, 2016). These measurements can be helpful in monitoring progress, and policymakers and governments alike view them as a tool to stimulate improvements in maternal healthcare and, thereby, justify donors' investments (Storeng and Béhague, 2017).

The attention to targets might influence health workers' practices and sense of accountability within health systems (Coutinho et al., 2000). Strong performance accountability, which Brinkerhoff (2004, p. 374) defines as 'demonstrating and accounting for performance in view of agreed-upon performance targets', can modify the internal accountability between health workers and their superiors (George, 2009). Performance accountability can also modify the external accountability between health workers and women in need of birth care (Roalkvam and McNeill, 2016).

Health centres, as primary health care units constitute the interface between global technical norms around birth care, patients' practices and understandings, and health workers' actions influenced by professional and organisational factors (Jaffré and Suh, 2016). Frontline health workers provide services to the population within the framework of government policy, but with the ability to mould these policies through their discretion over which services are offered, how they are offered and the benefits and sanctions allocated to patients (Lipsky, 1980; Suh, 2014). As civil servants at the lowest level of government, and in direct contact with the general population, Lipsky (1980) refers to them as 'street-level bureaucrats'. Implementation and adherence to policy by front line health workers is negotiated through written registries and reports (Hull, 2012). One example of this is how Burkinabè health workers complete the partograph intended for labour surveillance after birth, thus transforming it into a 'postograph', to demonstrate bureaucratic compliance (Ridde et al., 2017). Therefore, an analysis of health workers' actions and inaction with regard to documentation practices is key to understanding policy implementation, especially in resource-deprived areas (Erasmus, 2014; Kaler and Watkins, 2001; Walker and Gilson, 2004).

The articulations between standardised policies, local healthcare systems and local health workers at the point of service delivery remain poorly understood (Olivier de Sardan et al., 2017). By examining the interfaces between policy and practice (Jaffré and Suh, 2016), this study aims to shed light on the links between the global policy of skilled birth attendance and the provision of birth care in health care facilities. The study is set in primary health centres in rural Burkina Faso, which struggle with high levels of maternal mortality and a donor-dependent healthcare system. We argue that the magnitude of reporting linked with global policies is burdensome and time consuming for health workers, and can compromise quality of care. In addition, the pressure to achieve measurable progress at the health centre level encourages inaccurate reporting practices among health workers. On an aggregate level this produces incorrect statistics on skilled attendance, which in turn feeds into inaccurate policies that do not serve the interests of women in need of pregnancy and birth care.

2. Methods

2.1. Study setting

Burkina Faso, a former French colony situated landlocked in West Africa, is among the world's poorest countries. It was ranked 183 out of 187 on the 2012 Human Development Index with over 40% of its population living below the poverty line (United Nations Development Programme, 2011). Maternal mortality remains high; in 2013 the estimated maternal mortality ratio was 400 per 100 000 live births (Kassebaum et al., 2013). In 2014, the health expenditure per capita was 82 international USD, which corresponds to 5% of the gross domestic product (GDP) (Word Health Organization, 2018). About one-fourth of the country's national health budget in 2009 was financed by external donors and channelled through the Programme d'Appui du Développement Sanitaire (Ministère de la Santé).

The Burkinabè healthcare system consists of four levels of health facilities in which the health centre (Centre de Santé et de Promotion Sociale) is the most basic unit responsible for the provision of preventive and curative primary healthcare services (Ministère de la Santé, 2011). Other facilities include district, regional and university hospitals. At the time of the current study 13 regional health directorates, divided into 67 health districts organised the country's 1443 primary health centres. Official health data is compiled in monthly reports developed at the health facilities consolidated into tri-annual reports by health districts and regional health directorates (Direction Générale de l'Informaion et des Statistiques Sanitaires, 2012). In accordance with the decentralised structure of the Burkinabè healthcare system, annual action plans are developed at every level (facility, district, region) based on the data reported. National level policies, such as the ten-year National Sanitary Development Plan and the Plan to Accelerate the Reduction of Maternal and Neonatal Mortality, are integrated into these action plans.

Facility-based or institutional delivery care has been the core national strategy to reduce maternal mortality in line with the MDG 5 target. To achieve this aim, the Ministry of Health set an ambitious goal of increasing the proportion of women giving birth with skilled attendance from 50% to 80% between 2006 and 2015 and to provide Basic Emergency Obstetric and Neonatal Care (BEmONC) in 80% of the