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Local initiatives to access emergency obstetric and neonatal care in Burkina Faso

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ABSTRACT

Objective: To describe the various local initiatives to access emergency obstetric and neonatal care in Burkina Faso. *Methods:* An existing framework was used to review the three processes for local initiatives: emergence, formulation, and implementation. Multiple case studies were conducted, followed by literature review and semi-structured interviews with key informants. *Results:* Sixteen districts had implemented local initiatives, including cost sharing, free care for women and children, and free care for delivery and cesareans. Most districts (n = 10) had implemented the cost-sharing intervention. These initiatives were initiated by local actors as well as nongovernmental organizations. The profile of those involved led to different ways of handling the emergence and formulation processes. At implementation, these initiatives faced many issues including late payment of contributions, low involvement of local governments, and equity in participation. *Conclusion:* There are some issues in the implementation and sustainability of the local initiatives. Although many initiatives exist, these are unable to fully address the financial barriers to care. However, these initiatives highlight context-based financial barriers that must be taken into account to accelerate universal access to health care.

1. Introduction

Following the economic challenges of financing health care in the early 1980s, most African countries introduced user fees. The Bamako Initiative launched in 1987 at a meeting of African Ministers of Health, supported by WHO and UNICEF, legitimated user fees as a major health financing source [1,2].

Twenty years later, the inefficiency of this direct payment for health service delivery has led to a series of measures aimed at ending the system [2]. These measures were supported by studies that showed that ending direct payment has the advantage of increasing the use of health services [3–4].

To meet the Millennium Development Goals (MDGs), in the 2000s several governments decided to reduce and even end direct payment for health care at the point of service delivery. Such initiatives targeted either specific diseases or treatments, for example HIV and antiretroviral therapy, or particular groups including pregnant women, children under 5 years, and elderly people [5–7].

In October 2006 and January 2007, Burkina Faso set up initiatives aimed at reducing the costs of deliveries and cesareans, respectively. These initiatives consisted of subsidizing medical interventions by 60%–80%. Consequently, women would pay 11 000 XOF (CFA Francs; US $18.3) for a cesarean delivery; while transfer of patients from a primary health center to a hospital became free [7–9].

Before and after implementation of this national initiative, other local initiatives (at district level) were developed to reduce the financial barriers for pregnant women and children under 5 years. Some of these initiatives have been documented in the literature [7–12].

The aim of the present article is to describe the initiatives undertaken at district level. In particular, we review the conditions under which these local initiatives emerged, and were formulated and implemented.

2. Material and methods

The study used the framework described by Lemieux [13] to review the three processes of local initiatives: emergence, formulation, and implementation. The emergence of the policy, also called "agenda setting" refers to the process through which an issue becomes visible and subject to debate. At this stage, individuals or groups identify the issue and engage to influence decision makers to intervene.

At the formulation stage, different policy options were evaluated and discussed by stakeholders. This process led to the choice of one policy option in response to the identified issue.

At the implementation stage, analysis must focus on how the policy is implemented in the field. At this stage, the process of implementation

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is analyzed with attention to the factors (internal and external) that can influence the implementation process of the policy [14].

Multiple case studies were conducted to understand the emergence, formulation, and implementation processes of the local initiatives [14].

2.1. Selection of cases

Cases were identified at the Ministry of Health, especially from the Child and Mother Health Unit (DSF). The cases selected were those concerning local initiatives that were implemented at the health district level that aimed to reduce or end direct payment for mother and child care. In addition, initiatives that had been implemented for at least two years were considered. For every case selected, a grey literature review was performed and semi-structured interviews were conducted with key informants.

2.2. Literature review and interviews

To document the initiatives, we compiled and analyzed various documents containing information on interventions. These documents included reports of meetings, action plans of districts, reports of associations involved in the implementation, and evaluation and progress reports of the initiatives.

The documents were collected at districts with representatives of the Center for Health Information and Epidemiological Surveillance (CISSE)—representatives of associations in charge of implementation of interventions. Data were extracted from the documents using a lecturer grid built around themes: emergence of the issue, design and adoption, and implementation.

Semi-structured interviews were carried out with 27 stakeholders involved in the processes of the initiatives and included the head of the district or his/her deputy, local association leaders, the Steering Committee of the cost-sharing system (COPISPAC), and nongovernmental organizations (NGOs) involved in local initiatives. A topic guide for semi-structured interviews was developed to collect data and was built around three key themes: emergence of the issue, design and adoption, and implementation.

2.3. Data analysis

We performed a framework analysis to review the three processes associated with the initiatives [15]. The processes were considered as individual categories, and subcategories were further assigned for each category. The data were coded manually and analyzed according to these categories and subcategories.

2.4. Ethical considerations

The protocol received the approval of the national ethics committee for health research. All participants received the information leaflet and informed consent was provided before each interview.

3. Results

The analysis identified sixteen districts that had implemented initiatives aligning with the inclusion criteria. The initiatives identified included cost sharing, free care for women and children, and free care for delivery and cesareans (Table 1). Most districts (n = 10) had implemented the cost-sharing system for emergency obstetric and surgical care. Some interventions (n = 6) were implemented prior to the 2006 national policy promoting subsidies for emergency obstetric and neonatal care.

These local initiatives were applied throughout Burkina Faso and particularly in the Eastern and Central East regions (Fig. 1). In these two regions, 7 of the 10 health districts used the cost-sharing approach.

3.1. Cost sharing

This was the main strategy implemented in 10 of the 16 districts. Costs were shared between the stakeholders involved in the process of medical evacuation and referral of patients to minimize the transport fees and also reduce costs related to care borne by the patient and their family.

The cost-sharing system covered the following services: major obstetric interventions for absolute maternal indications; ambulance to carry the patient to the district or regional hospital; additional medical tests; hospital admission fees; dressings until healing of the surgical wound; and fuel to operate the generator in districts with no permanent source of energy. The major obstetric interventions include cesarean delivery, laparotomy for uterine rupture, internal version, and embryotomy (craniotomy, cranioclasty, thoracotomy).

Stakeholders involved in the cost-sharing approach were the government represented by the Ministry of Health and district management team, the health center management committees (COGES), beneficiaries, and local governments. A review of these stakeholders showed the diversity of profiles and number of payers. For the cost-sharing system, the government—through the district management team—was the main contributor.

The government contributed by providing an ambulance, a driver, maintenance of the ambulance, anesthetic products, sutures, and oxygen, while patients as the key contributors paid by cash.

Patients' contributions ranged from 30%–40% of the costs for major obstetric interventions for absolute maternal indications. This financial contribution was 19 130 XOF (US $32) in Diapaga, 19 850 XOF (US $33) in Koupèla, 17 600 XOF (US $29) in Ouargaye, and 25 000 XOF (US $42) in Bogodogo health district.

COGES contributed directly through revenues generated by the health centers. In Bogodogo and Pô health districts, this amount was 8000 XOF (US $12.31) and 9000 XOF (US $13.85), respectively.

In some health districts, communities used a prepaid system where each household contributed. This system was managed by COGES. Regardless of age, each household member contributes an annual flat amount. This contribution also varied between districts: 25 XOF (US $0.04) in the districts of Koupèla, Ouargaye, and Zabré, but 200 XOF (US $0.31) in Bogandé, Diapaga, and Pama.

3.2. Exemption from payment/free care

There were two categories of payment exemptions depending on the medical intervention and on the promoters.

The first category was applied in the health districts of Dori and Sebba by an NGO called HELP, and in Seguenega and Tougan by Terre des Hommes (TDH), another NGO. This initiative covered the medical intervention fees, admissions to hospital, drugs, medical consumables as well as the biomedical tests available in these districts and essential for the health of the target communities. In Dori and Sebba districts, this initiative covered women in both the health centers and the regional hospital in Dori. In Seguenega and Tougan, the exemption was applied exclusively to the primary health centers. In a case of referral to the regional hospital, referral costs and those of the first medical prescription were supported.

The second category was applied more to local stakeholders. Here, the health center allowed free delivery and cesareans.

Exemption from direct payment for delivery (900 XOF, US $1.5) has been applied in the health district of Kaya since 2007. The health district contributed 80% (720 XOF, US $ 1.2) and the principle was to bear the cost of the remaining 20%, which would otherwise have been borne by the patient. The COGES subsidized this amount (180 XOF, US $0.3). The district management team contributed through provision of delivery kits using part of the budget for buying drugs; COGESs contributed with cash.

Free cesarean delivery was implemented in Zorgho health district. The health district used the government's annual budget allocated to