Maternal Health Financing Profile: Burkina Faso

November 2002

Prepared by:

Janet Edmond
Development Associates, Inc.

Alison Comfort
University Research Corporation, LLC

Charlotte Leighton
Abt Associates Inc.

Abt Associates Inc. ■ 4800 Montgomery Lane, Suite 600
Bethesda, Maryland 20814 ■ Tel: 301/913-0500 ■ Fax: 301/652-3916

In collaboration with:
Development Associates, Inc. ■ Emory University Rollins School of Public Health ■ Philoxenia International Travel, Inc. ■ Program for Appropriate Technology in Health ■ Social Sectors Development Strategies, Inc. ■ Training Resource Group ■ Tulane University School of Public Health and Tropical Medicine ■ University Research Co., LLC.

Funded by:
U.S. Agency for International Development

Order No. WP 002

PHR*plus*

Mission

Partners for Health Reformplus is USAID's flagship project for health policy and health system strengthening in developing and transitional countries. The five-year project (2000-2005) builds on the predecessor Partnerships for Health Reform Project, continuing PHR's focus on health policy, financing, and organization, with new emphasis on community participation, infectious disease surveillance, and information systems that support the management and delivery of appropriate health services. PHRplus will focus on the following results:

- *Implementation of appropriate health system reform.*
- *Generation of new financing for health care, as well as more effective use of existing funds.*
- *Design and implementation of health information systems for disease surveillance.*
- *Delivery of quality services by health workers.*
- *Availability and appropriate use of health commodities.*

November 2002

Recommended Citation

Edmond, Janet, Alison Comfort, and Charlotte Leighton. November 2002. *Maternal Health Financing Profile: Burkina Faso.* Bethesda, MD: The Partners for Health Reform*plus* Project, Abt Associates Inc.

For additional copies of this report, contact the PHR*plus* Resource Center at PHR-InfoCenter@abtassoc.com or visit our website at www.PHRplus.org.

Contract/Project No.: HRN-C-00-00-00019-00

Submitted to: Karen Cavanaugh, CTO
Policy and Sector Reform Division
Office of Health and Nutrition
Center for Population, Health and Nutrition
Bureau for Global Programs, Field Support and Research
United States Agency for International Development

The opinions stated in this document are solely those of the authors and do not necessarily reflect the views of USAID.

Table of Contents

List of Tables

Acronyms

COGES	*Comité de Gestion de la Santé* (Health Management Committee)
DHS	Demographic and Health Survey
EOC	Essential Obstetric Care
FCFA	*Franc de la Communauté Francophone d'Afrique* (West African currency)
GDP	Gross National Product
HIPC	Highly Indebted Poor Countries
IDA	International Development Association
ILO	International Labour Organization
IMF	International Monetary Fund
INSD	*Institut National de la Statistique et de la Demographie* (National Institute of Statistics and Demographics
MHO	Mutual Health Organization
NGO	Non-governmental Organization
PSRP	Poverty Reduction Strategy Paper
RH	Reproductive Health
SMI	*Santé Maternelle et Infantile* (Safe Motherhood Initiative)
SWAp	Sector-wide Approach
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

1. Introduction

The purpose of this paper is to provide an overview of the maternal health situation in Burkina Faso and to examine current trends and activities with respect to financing of maternal health services, specifically deliveries assisted by skilled birth attendants. The paper begins by giving a picture of the current status of women's health and factors relating to poor maternal health outcomes, then examines historical information of how women in Burkina Faso pay for maternal health services, such as antenatal care, deliveries with skilled birth attendants, and consultations. The paper offers policy recommendations on the financing of these services.

2. Overview of Economic Development and Health

2.1 The Economy and Health

Since independence from France in 1960, Burkina Faso has remained one of the poorest countries in the world. According to the 2002 United Nations Development Program Human Development Index, Burkina Faso ranks 169th out of 173 countries in the world in terms of development (United Nations Development Program 2002). Of Burkino Faso's total population of 11.3 million, 18.5 percent lives in urban areas, and the country is experiencing a rapid population growth rate of 2.8 percent per year. The most recent government survey of household living conditions, conducted in 1998, found that 45.3 percent of the population lives below the poverty line (Ministry of Economy and Finance 2000), a slightly higher percentage than in 1994 (44.5 percent). The same survey found that 27.5 percent of the population lives in extreme poverty.

According to the country's Poverty Reduction Strategy Paper's (PRSP) annual progress report in 2001 (Ministry of Economy and Finance 2001), the economy of Burkina Faso remains fragile, with economic growth significantly lower than expected or hoped; for example, a 2001 World Bank study found the real gross domestic product (GDP) growth rate to be 2.2 percent, compared to a projected rate of 5.7 percent. Nearly 95 percent of the poor live in rural areas and agriculture plays a dominant role in the national economy, employing almost 80 percent of the working population (Ministry of Economy and Finance 2000). These factors mean that Burkina Faso has a significant handicap in overcoming poverty and achieving sustainable development in the short and long term.

Despite significant efforts to reduce poverty and develop social services, there is still great need. In terms of health, Burkina Faso is plagued with very high morbidity and mortality rates, attributable to low rates of access to and utilization of health services and the persistently high incidence of infectious and parasite-borne diseases (Ministry of Economy and Finance 2000). The health system is faced with multiple, complex challenges to improving health outcomes across the population. Nevertheless, in the PRSP 2001 annual report, the government states that improving health is the first step in Burkina Faso's larger effort to combat poverty.

2.2 Maternal and Child Health Status

Not surprisingly, maternal and child mortality rates in Burkina Faso are among the highest in the world. According to the Demographic and Health Survey (DHS) 1998-99, which analyzed data from the five-year period 1995-99, the maternal mortality rate was 484 deaths per 100,000 live births during that period (*Institut National de la Statistique et de la Demographie* [INSD] and Macro International 2000). Maternity-related factors account for 22 percent of deaths for women ages 15-49. The leading causes of maternal mortality are, in order, for the period 1988-95: hemorrhage (18.8 percent), infection (15.9 percent), placenta retention (11.40 percent), uterine rupture (10 percent), abortion complications (7.6 percent), and anemia (Family Care International, November 2000). At

least 24 percent of pregnant women were anemic in 1999. The infant mortality rate has fallen from 134 deaths per 1,000 live births in 1980, to 111 deaths per 1,000 live births in 1990, and to 104.4 deaths per 1,000 live births in 2000 (INSD and Macro International 2000.) The under 5 mortality rate is currently 205.8 deaths per 1,000 live births (World Bank April 2002). The United Nations Population Fund (UNFPA) estimates that close to two-thirds of the population suffer from recurrent malaria, which contributes to the toll of infant and child death (UNFPA 2002).

Based on the DHS 1998/99, 39 percent of women had no prenatal care visits, 5 percent of women received one visit, 32 percent received two to three visits and 23 percent received three visits. In terms of attendance at birth, 42.1 percent of women were attended by a traditional birth attendant, 31 percent by trained personnel (30.2 percent by a trained nurse or midwife and 0.8 percent by a doctor), and 19.8 percent of women were attended by a relative; 7.1 percent of births were unattended. Broken down by urban–rural births, the DHS data show that 91.7 percent of births in urban areas were attended by trained personnel (doctors, nurses, midwives, and matrons) whereas only 25.5 percent of births in rural areas were attended. Nearly 67 percent of births took place in the home versus 32 percent in health facilities. Only a small percentage of births occur in private facilities (INSD and Macro International 2000).

As Table 1 shows, health status indicators for the population of Burkina Faso have improved little over the past 10 years.

Table 1. Select Indicators of Health Status in Burkina Faso

Indicator of Health Status	DHS 1992/93	DHS 1998/99
Infant mortality rate	107.6 per 1,000	105 per 1,000
Maternal mortality rate	556 per 100,000	484 per 100,000
Deliveries in facilities (assisted by trained medical personnel)	N/A	32
Contraceptive: ever use, any modern method	9.9%	13.1%
Childhood vaccination coverage (infants ages 12-23 months receiving all the recommended immunizations)	35 %	28 %
Fertility rate (women ages 15-49)	6.9	6.8
Life expectancy at birth (years)	N/A	54

Sources: INSD and Macro International 1993 and 2000.
NOTE: World Health Organization estimate for maternal mortality rate in 1990 is 930, significantly higher than the DHS estimate.

3. Health Care Sector: Structural Reform

In the years since independence, the government of Burkina Faso has attempted to provide primary health care services to local populations despite barriers such as limited access to health care facilities, lack of consumer confidence in the public health care system, and limited resources for staff, materials, and drug supplies.

In 1988, the Ministry of Public Health and Social/Family Action introduced a program of community care in response to local health care needs and calls for health sector reforms. The government reaffirmed its commitment to providing basic health services to vulnerable groups such as women and children through the World Health Organization (WHO)-recommended health facility structure, including a five-tiered system of health facilities. It moved resources to the lowest level of the system, primary health posts staffed by a community health worker and a traditional birth attendant, in order to reach people on the community level. The second level of facility is a center for health and social development, with a maternity and dispensary (with nurse and a trained midwife), which serves a population of 15,000 to 20,000. The third level is the medical center, staffed by at least one doctor. At the fourth level are provincial hospitals. The fifth level comprises national hospitals, of which there are only two in Burkina Faso: one in Ouagadougou and one in Bobo-Dioulasso. According to a study by Develay and colleagues, about 90 percent of this health care system had been implemented by 1989 (Develay et al. 1996).

In the early 1990s, the government of Burkina Faso began to decentralize its administration and finance systems. This restructuring included the decentralization of health care services and implementation of several initiatives designed to empower local communities to take responsibility for the health and welfare of their populations. (See Section 4.3 for further discussion of the decentralization of the health sector.)

Despite these changes to the health sector, the 2000 PSRP points out that Burkina Faso still faces overwhelming challenges to improve health status throughout the country, especially in rural areas. “Although much has been done to promote essential basic social services (basic education, basic health services, including reproductive health, drinking water, nutrition, hygiene and sanitation), Burkina Faso still suffers from a huge gap in social services” (Ministry of Economy and Finance 2000). According to the report, health services are particularly underutilized by the poor and vulnerable groups, with the poorest 20 percent of the population using services half as much as the 20 percent who are the most well off. In general, the poor use public health services less than the rich, both for immunizations and for curative services for children or childbirth. Approximately 72 percent of the group comprising the poorest 20 percent give birth at home.

A health sector reform study by Bodart et al. in 2001 echoes the PSRP report, finding very little evidence that Burkina Faso’s health policy reforms over the past 12 years have had any positive effect on health service utilization rates.

4. Health Care Sector: Financing Reform

As noted above, Burkina Faso is an extremely poor country that for 30 years has had slow economic growth. Nevertheless, in recent years the government has dedicated increasing resources to the establishment and operation of a viable public health system.[1] The Ministry of Economy and Finance in 2000 reported that public health expenditures, expressed in percentages of the government budget, increased from 7 percent in 1993 to 12 percent in 1998 (Table 2).[2] In comparison to neighboring countries with comparable gross national product levels, Burkina Faso shows a total health expenditure figure (government and transfers by external donors) of approximately US $7 per capita, significantly higher than in Mali and Ghana, countries in which standards of living are relatively similar (Ministry of Economy and Finance 2000).

However, in real terms the resources dedicated to the health sector are inadequate and there are large gaps in health service needs and existing provision of services. Therefore, the country is exploring and implementing a number of administrative reforms and payment mechanisms to increase financial resources and thus expand availability and access to health care.

Table 2. Government and Health Expenditures in Burkina Faso

Health Expenditures	Data
GDP per capita in 1999	US$240.0
Percent of GDP on health	1.6%
Health budget as a percent of total public expenditures (1998)	12.0%
Annual household health expenditures per capita per year	US$10.0
Percent of health expenditures spent on drugs*	88%
Per capita public and private spending in the public sector	US$7.0

Source: Ministry of Economy and Finance 2000.
* Bodart et al. 2001.

4.1 User Fees

After the international adoption of the Bamako Initiative principles in 1988, the government of Burkina Faso attempted to implement in all public health facilities a system of fees for primary health care services in order to achieve a degree of cost recovery. The effort was sporadic and largely unsuccessful.

[1] Donor support represents a large proportion of the government's health budget.
[2] According to Bodart et al. (2001), despite the increases in MOH budget from 1996 to 1998 (up FCFA 2.6 billion) the health budget as a percent of the total public budget decreased from 11 to 9 percent.

Despite this lack of success, user fees are still official policy. According to a survey of primary health care patients conducted by the INSD in 2001, prices of primary health care services had generally increased over the preceding year. The price increases varied by province and by service. For example, significant increases were found for many frequently used procedures, such as Caesarean sections (2.3 percent) and treatment of hernias (4.5 percent). The price of certain other services declined, for example, treatment of dystocia in childbirth, by 11.2 percent, and intestinal occlusions, by 19.5 percent (Ministry of Economy and Finance 2000).

Evidence from the literature also shows that the introduction of user fees under the rubric of the Bamako Initiative discouraged health service utilization, particularly among the poor and children, who are the populations targeted by initiatives to increase utilization (Mugisha et al. 2002). Two quality of care studies, conducted by German Technical Cooperation (GTZ) in Tougan district in 1996-97, show that communities were highly dissatisfied with quality of care at health care facilities, a major component of which was the high cost of care.[3] Bodart et al. (2001) also found that utilization rates have not increased and people report less confidence in quality of care.

4.2 Willingness to Pay for Health Care

A household survey in three regions of Burkina conducted in 1994 by the USAID-funded Health Financing and Sustainability project found that one-third of births were assisted by a member of the medical profession, with the youngest women most likely to arrange for medical assistance. Eighty-five percent of women who attended modern school used medical personnel for delivery. There was a significant urban-rural difference: 83 percent of mothers in urban areas were attended by medical personnel, compared with only 22 percent of rural women (Sow 1994). Virtually all households in the survey were prepared to pay for improvements in equipment and maintenance, as well as for drug supplies to treat diarrhea, respiratory infections, malaria, and intestinal infections. Willingness to pay for contraceptives was much lower (Sow 1994).

The Ministry of Economy and Finance reported in the 2000 PRSP that the rich were more likely to seek maternal health care services than the poorest 20 percent of the population. Table 3 shows select information from the PRSP (Annex 8).

[3] Respondents also cited the poor performance of health staff as a major reason for dissatisfaction.

Table 3. Utilization of Maternal Health Services in 1993, by Socioeconomic Group (in percent)

Health Indicator	Poor	Average Poor	Average	Average Rich	Rich	Population Average
Prenatal care visits to:						
Medical professional	42.9	46.5	48.7	68.1	92.7	58.5
doctor	0.2	1.0	1.2	1.2	5.5	1.7
nurse op\midwife	42.7	45.5	47.4	67.0	87.2	56.8
At least two visits	36.3	40.1	42.1	62.1	85.4	52.0
Birth assisted by:						
Medical professional	25.8	25.8	30.7	47.1	86.2	41.4
doctor	0.6	0.3	0.8	1.0	4.6	1.3
nurse op\midwife	25.2	25.6	29.9	46.1	81.6	40.1
In public health facility	27.5	28.3	30.3	49.8	83.1	42.3
In private health facility	0.1	0.1	0.0	0.3	3.3	0.7
At home	72.0	70.9	68.6	49.3	12.6	56.3

Source: Ministry of Economy and Finance 2000

4.3 Decentralization

The government of Burkina Faso has introduced a series of legislative reforms to create the legal, financial, and judicial structure needed to decentralize financial and administrative systems. In August 1998, a decentralization law was passed, including written guidelines for the decentralization process, to help facilitate implementation of participatory governance. The International Development Association (IDA) provided the major source of financing for the health sector decentralization model advocated by the WHO. The 1998 law requires adequate financing provision designed to provide communities with adequate resources to be able to fulfill tasks devolved to the local level, such as basic health and education services. Successful decentralization measures include the formal introduction of health districts and the implementation of a generic drug delivery system (World Bank June 2000).

Complementing the national and local efforts for decentralization, the Highly Indebted Poor Countries (HIPC) Initiative took hold in Burkina Faso in the late 1990s. In HIPC preparation plans, the government is reported to be reorganizing basic health care services based on a decentralized model, with more than 700 centers for health and social development organized into 53 districts. Full autonomy at the local level is a long-term objective. The HIPC goal was to introduce district health budgets in 1998 within the framework of a defined benefits package of services, with financial management accompanying rollout of funds. Districts should be moving toward formulating action plans (International Monetary Fund 2000).

A recent International Monetary Fund (IMF)/IDA loan is supporting the decentralization strategy focused on increasing the quality and supply of health services in newly formed health districts, and formulation of district-level action plans and appropriate indicators. In order to decrease the volume of patients at higher-level facilities and decrease geographic distance from communities to health facilities, the government erected more than 100 new health facilities, including 18 maternities and 56

new health and social development centers across the country. However, the existence of facilities does not translate into increased service utilization by the population.

"Unfortunately, the country has had more trouble introducing decentralized finance and administration in health services than in other sectors" (World Bank June 2000). Several reasons were cited for the transition problems, including lack of consultation with district-level health service leaders; too rapid deployment of health personnel from central to peripheral provincial health postings; and the highly centralized financial system which hamstrung operations of the newly created health districts.

4.4 Community-based Health Financing Mechanisms

Like many countries in West and Central Africa, Burkina Faso has a tradition of labor solidarity, and in the past few years grassroots concern for gaps in existing health care services has spawned a movement of *mutuelles*, or mutual health organizations (MHOs). These mechanisms vary widely across the region in terms of composition, and management arrangement and style, but generally MHOs include members who contribute premiums for a defined set of health care services, health care providers with established links to the MHO, and a committee or managing body for the MHO fund.

In Burkina Faso, MHOs have grown over the past 10 years with external technical and financial assistance of donors such as the French Cooperation and the International Labour Organization (ILO/STEP) and non-governmental organizations (NGOs). Among communities interested in MHOs, there is increasing attention being paid to the ability of the MHO to cover primary health care services and other services relevant to maternal health, such as deliveries.

A study by Sondo et al. investigated 12 out of 17 primary referral maternity facilities in Burkina Faso from April 15 to June 15, 1995. Recognizing the lack of information and data on the increasing effect of community-level financing efforts or the mechanisms for pooling local funds for referral and transfer to higher-level facilities, the study looked at the health care costs for woman in labor being transferred to a high-level care facility for an at-risk birth. It also explored the ability of these women and their partners to save money to pay for transport to the referral facility.

Interviews conducted by medical students for 15 consecutive days with all women transferred to all 12 referral facilities in anticipation of a risky delivery found that, when a decision for the transfer was made, couples had funds to pay for the expenses in only slightly more than 50 percent of cases. Mechanisms such as group savings committees, annuity schemes, or banks were available to several of the women, but they had not taken advantage of these programs. The study suggested that a policy targeting the involvement of at-risk populations could facilitate the transfer and treatment of women during their pregnancy and delivery (Sondo et al. 1997).

According to the PRSP progress report, the health management committees (*comités de gestion*, COGES) are key players in the development and management of community-based health services. In recent years, committee functions have been expanded to include participatory planning and monitoring of priority health activities (Ministry of Economy and Finance 2000). These committees therefore are tasked with implementing creative and alternative mechanism for providing health services to the population, such as critical maternal health services. Simple interventions such as safe births kits and emergency obstetric kits are within the scope of work of COGES.

An example of a community-driven health activity is described in a 1998 study by Farba Sall, of a United Nations Children's Fund (UNICEF) project to reduce maternal mortality by improving capacity and systems to provide emergency obstetric care to women with complications. The project helped to supply emergency safe birth kits for surgeries. There was a 15,000 FCFA charge per kit, with a view to achieving partial cost recovery. The project succeeded in the pilot area to reduce maternal mortality rates and to recover costs. (More than 50 percent of costs were recovered.) Based on success with this project, UNICEF plans to assist in the development of MHOs for health care, targeting needy populations for risk sharing and cost sharing for basic services (Sall 1998).

4.5 Donor and NGO Health Activities

There are a large number of donors and donor-supported NGOs in Burkina Faso, especially in the health sector. Donor nations and organizations include the Netherlands, Belgium, Norway, Japan, the European Union, France, Germany, Denmark, Taiwan, the African Development Bank, the Islamic Development Bank and the UNICEF. Donor coordination is weak in a country where the annual average overseas development assistance contribution from 1990-96 was 19 percent of GDP, compared to 10.6 percent for other West and Central African countries (World Bank June 2000).

A Safe Motherhood Initiative (*Santé Maternelle et Infantile*, or SMI) has been in place since 1971. A regional health analysis by Maclure found that before the 1970s, almost all women in Namentenga province had given birth at home. After 10 years of SMI and other NGO health assistance programs, this trend began to reverse in the mid-1980s. Clearly the extension of SMI and NGO-based assistance in Nmentenga had contributed to a marked change in the pattern of child delivery (Maclure 1995). By 1991, 14 villages were affiliated with SMI. In those sites, SMI financed construction and equipment of clinics, and education and training of midwives, a very multi-focused program.

In describing the findings of the impact of the SMI initiative on health care utilization, Maclure found that in Namentanega province, NGOs sponsored primary health care programs through financial assistance and support with the long-term goal of rural development. Where NGOs worked, there were increased births with skilled birth attendants, decreased number of births at home, and increased childhood illness visits. While this is encouraging, the study also found that these efforts increased dependency on the donor support, especially among women who are the primary targets of basic health care assistance (Maclure 1995).

UNFPA provides the government of Burkina Faso with technical assistance and institutional support for safe motherhood initiatives and the prevention of maternal mortality. Key activities include training personnel in infection prevention and cervical cancer screening; basic gynecological services; reproductive health services; family health services; and procurement of contraceptives and medical equipment for health units, primarily maternity units and mother–child health centers (UNFPA 2002).

As part of this “RH Bridging project,” UNFPA helped to establish five model RH centers and provided support for the preparation and publication of a national strategy on safe motherhood and the strategic plan for RH. In addition, the organization supported the management of antenatal and postnatal consultations and helped foster the development of community-based services to strengthen women’s access to RH services, including a range of family planning, sexually transmitted diseases, and HIV/AIDS services.

The World Bank and IMF are supporting the development and implementation of a national population policy aimed at improving the living standards for the people through controlled demographic growth. This includes a project on strengthening the role of family planning in health facilities in 100 new family planning centers (Government of Burkina Faso 1999).

4.6 Poverty Reduction

Burkina Faso qualified for HIPC assistance in 2000, and received US $11.4 million in debt service relief in 2000. In 2001, HIPC proceeds reached $35.4 million (IMF/IDA 2002). With the HIPC having taken hold in 2000, the government made significant progress in increasing immunization coverage rates, ensuring a good supply of essential drugs, and improving staffing of primary health facilities. Two important steps taken by the government include the removal of fees for preventive services and encouragement of greater involvement of the COGES in determining health care priorities, formulating strategies, and overseeing resources from cost recovery (World Bank 2001).

Objective 2 of the Poverty Reduction Strategy is to guarantee that the poor have access to basic social services, including health services. Although maternal health indicators were discussed in the PRSP preparation documents, none of the strategy's final health indicators – vaccination coverage ratios, rate of use of health facilities in first-level health centers, essential drug breakdown rate, and cost of medical interventions in first-level health centers – are specific to maternal health. However, the PRSP includes maternal health medium- and long-term health objectives, such as reducing maternal mortality from 484 per 100,000 in 2000 to 200 per 100,000 in 2014 (Ministry of Economy and Finance 2000). In addition, the strategy entails a program to combat disease by offering a health care package tailored to priority programs, including promotion of women's health (by offering RH care and combating cancer) and promotion of child health (by combating all childhood diseases and nutritional deficiencies) (Ministry of Economy and Finance 2000). Also, part of the strategy involves increasing the number of personnel trained in emergency care at regional hospitals, including gyneocologists.

5. Implications for Maternal Health Policies

Given the lack of information and data on overall health care expenditures on maternal health, determining the extent of the role of financing in maternal mortality prevention activities is complicated. Overall, the existing literature suggests that financing is insufficient. Additional resources will be required to make progress on combating maternal mortality and increasing skilled birth attendants through national and local governments, private health sector facilities, communities, donors, NGOs and associations " (Family Care International November 2000).

Several themes or trends emerge from the analysis of maternal health financing. While government resources for health care improvements are reported to have increased, no tangible or significant improvements in utilization have resulted, as is evidenced by stable or decreasing service utilization rates at public health care facilities. Therefore, in order to increase service utilization, particularly among pregnant women who might use skilled birth attendants, the government of Burkina Faso could consider the following policy recommendations concerning financing of maternal health services.

1. Increase visibility and acceptability of alternative health financing mechanisms.

As mentioned above, there is a growing movement within West Africa, including Burkina Faso, for alternative financing mechanisms in order to provide people with accessible, affordable health care. These mechanisms include community-based health insurance, mutual health organizations, prepayment schemes, and cooperative social health funds.

Several diverse voices have called for the further development of these mechanisms on Burkina Faso, and these mechanisms could hold promise for increasing access to maternal health services, for example, by providing emergency transport to referral facilities for complicated deliveries. The Burkina Faso Structural Adjustment Facility Policy Framework Paper 2000-2002 calls for the introduction of sustainable alternatives for financing health care by developing a third-party payment system (mutual insurance companies, health insurance, etc.)

One of the recommendations of the Bodart study of the health reforms was that community-based prepayment and health insurance schemes need to be supported, especially in rural areas where agriculture dominates the economy and cash crops are grown (south and southwest) as a means to alleviate the financial burden of disease. These themes suggest that the government and the Ministry of Public Health should investigate the potential for community-based health insurance or MHOs to address critical maternal health service needs.

2. Disseminate lessons learned from least-risk maternity home program and examine financing aspects.

The government is currently carrying out a program designed to enhance women's reproductive health by implementing experimental least-risk maternity program, carried out in 12 health districts (Ministry of Economy and Finance 2000). If the program is successful, policies and procedures will

be disseminated for use in other districts. Program management and accessibility to clients should be looked at and investigate financing mechanisms.

3. Increase the importance of the community change groups, such as the COGES, and empower these groups to advocate and implement policy change at the local level to increase maternal health financing issues.

These committees should examine the feasibility of emergency transport funds and equipment, and they should recognize importance of maternal health services finances through insurance or other alternative mechanisms. In light of the need for strengthening the ongoing systems and human resource development component of the national decentralization process, COGES should work closely with local health staff to design targeted health strategy plans for the district or region. These COGES should empower health staff to advocate for increased funding for equipment, training, and supplies for essential medical services such as maternal health services.

4. Improve availability and use of Essential Obstetric Care

One implication of increased resources for decentralized health services involves changing slightly the service delivery for Essential Obstetric Care (EOC). Increasing resources for maternal health services could improve training and facility access for women with complicated births. According to joint WHO, UNICEF, and UNFPA guidelines released in 1997, countries should have four facilities that offer EOC for every 500,000 people. Basic EOC provided in health centers and small maternity homes may include "administration of antibiotics, oxytocics, anticonvulsants, manual removal of the placenta, removal of retained products and assisted vaginal delivery with forceps or vacuum aspirator" (Donnay 2000). Some portion or subset of existing facilities could be renovated or new facilities could be constructed designed to provide EOC, and cost-sharing mechanisms should be investigated.

Bibliography

Barrère, Bernard, Gora Mboup and Mohamed Ayad. June 1999. *Enquêtes Démographiques et de Santé en Afrique de l'Ouest: Résultats des Enquêtes Démographiques et de Santé Realisées au Burkina Faso, au Cameroun, en Côte d'Ivoire et au Togo*. Calverton, Maryland: Macro International Inc.

Bodart, Claude, Gerard Servais, Yansane L. Mohamed and Bergis Schmidt-Ehry. 2001. The Influence of Health Sector Reform and External Assistance in Burkina Faso. *Health Policy and Planning* 16(1): 74-86.

Develay, A., R. Sauerborn, and H.J. Diesfeld. 1996. Utilization of Health Care in an African Urban Area: Results from a Household Survey in Ouagadougou, Burkina Faso. *Social Science and Medicine* 43 (11): 1611-1619.

Donnay, F. 2000. Maternal Survival in Developing Countries: What has been done, what can be done, what can be achieved in the next decade? *International Journal of Gynecology & Obstetrics* 70: 89-97.

Family Care International. November 2000. Sauver des Vies: Assistance Qualifiée lors de l'Accouchement. Unpublished.

Findley, Sally, Ahmed Zayan, Maria Kere, Youssof Kone and Gaston Sogbo. April 1997. Stretching the Limits of Health Interventions in Burkina Faso. *Health Transition Review* 1(1): 95-107.

Government of Burkina Faso, in collaboration with the International Monetary Fund and World Bank. August 2, 1999. Burkina Faso: Enhanced Structural Adjustment Facility Policy Framework Paper, 2000-2002. http;//www.imf.org/external/np/pfp/1999/Burkina/

Institut National de la Statistique et de la Démographie (INSD) and Macro International. May 2000. *Enquête Démographique et de Santé, Burkina Faso, 1998-99.* Calverton, MD: Macro International.

——. 1993. *Enquête Demographique et de Santé, Burkina Faso, 1993.* Calverton, MD: Macro International.

International Monetary Fund and the International Development Association. March 28, 2002. *Burkina Faso: Enhanced Heavily Indebted Poor Countries (HIPC) Initiative Completion Point Document.* Washington, DC: IMF and IDA.

——. October 31, 2001. *Burkina Faso: Joint Staff Assessment of the Poverty Reduction Strategy Paper, Annual Progress Report.* Washington, DC: IMF and IDA.

——. August 13, 1997. *Burkina Faso: Final Document on the Initiative for the Heavily Indebted Poor Countries (HIPC).* Washington, DC: IMF and IDA.

Maclure, Richard. 1995. Primary Health Care and Donor Dependency: A Case Study of Nongovernment Assistance in Burkina Faso. *International Journal of Health Services* 25(3): 539-558.

McLees, Suzzane. August 1994. *A Survey of Costs, Revenues, and Staffing at PHC Health Facilities in Three Provinces of Burkina Faso.* Technical Note 30. Bethesda, MD: Health Financing and Sustainability Project, Abt Associates Inc.

Ministry of Economy and Finance. September 2001. *Poverty Reduction Strategy Paper Progress Report, July 2000–June 2001*. Ouagadougou, Burkina Faso: Ministry of Economy and Finance.

——. May 25, 2000. *Poverty Reduction Strategy Paper*. Ouagadougou, Burkina Faso: Ministry of Economy and Finance.

Mugisha, Frederick, Bocar Kouyate, Adjima Gbangou and Raniner Sauerborn. February 2002. Examining Out-of-pocket Expenditure on Health Care in Nouna, Burkina Faso: Implications for Health Policy. *Tropical Medicine and International Health* 7(2): 187-196.

Population Council. 2002.

Sall, Farba Lamine. November 1998. *La Prise en Charge des Urgences Obstetricales au Burkina Faso: au CHF de Fada Ngourma et a l'Hôpital Yalgado Ouedraogo*. Bethesda, MD: Partnerships for Health Reform Project, Abt Associates Inc.

Sauerborn, R., I. Ibrango, A. Nougtara, M. Borchert, M. Hien, J. Benzler, E. Koob, and H.J. Diesfeld. November 1994. The Economic Costs of Illness for Rural Households in Burkina Faso. *Tropical Medicine Parasitol* 46(1995): 54-60.

Sauerborn, R., A. Adams and M. Hien. 1996. Household Strategies to Cope with the Economic Costs of Illness. *Social Science Medicine* 43(3): 291-301.

Sauerborn, R., P. Berman, and A. Nougtara. 1996. Age Bias, But No Gender Bias, in the Intra-household Resource Allocation for Health Care in Rural Burkina Faso. *Health Transition Review* 6: 131-145.

Sondo, Blaise, Jean Testa, Bibiane Kone. 1997. Le Côut Financier des Soins de Santé: Enquête auprés de Femmes ayant en un Accouchement a Risque. *Cahiers Santé* 1997(7): 33-7.

Sow, Boubacar. August 1994. *Survey on Willingness and Ability of Households to Pay for Health Care in Three Provinces of Burkina Faso*. Technical Note No. 34. Bethesda, MD: Health Financing and Sustainability Project, Abt Associates Inc.

United Nations Development Program. 2002. *Human Development Report 2002*. New York, NY: UNDP.

United Nations Population Fund. 2002. *Maternal Mortality Update 1998-1999*. UNFPA: New York, NY. http:/www.unfpa.org/tpd/mmupdate/countries/Burkina.htm

World Bank. April 2002. *World Development Indicators Database*. http://devdata.worldbank.org/external/CPProfile

——. April 15, 2002. *Burkina Faso Reaches HIPC Completion Point*. Washington, DC: The World Bank.

——. October 31, 2001. *Burkina Faso Joint IDA-IMF Staff Assessment of the Poverty Reduction Strategy Paper: Annual Progress Report.* Washington, DC: The World Bank.

——. July 11, 2000. *Burkina Faso Qualifies for HIPC Debt Relief Totaling $700 Million: West Africa Country Completes Original HIPC Initiative and Qualifies for Additional Relief Under Enhanced Framework.* Washington, DC: The World Bank.

——. June 30, 2000. *Burkina Faso Country Assistance Evaluation. Report Number 20704*. Washington, DC: The World Bank.

——. March 11, 1994. *Burkina Faso Health and Nutrition Project Staff Appraisal Report. Report Number 12416-BUR.* Washington, DC: The World Bank.