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DECENTRALIZATION OF HEALTH RESOURCES TO LOCAL GOVERNMENTS IN BURKINA FASO

Hilaire Zon

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DECENTRALIZATION OF HEALTH RESOURCES TO LOCAL GOVERNMENTS IN BURKINA FASO

Dissertation

to obtain the degree of Doctor at Maastricht University,
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in accordance with the decision of the Board of Deans,
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CHAPTER 1

General introduction

1.1. SCOPE AND MOTIVATION OF THE DISSERTATION

Decentralization reforms have been pursued throughout Africa over the last 30 years with the aims of improving governance efficiency and making policy more responsive to the needs of local people, particularly the poor (Cabral, 2011). There is not a single country in Africa in which some form of local government is not in operation. The stated objectives of virtually all of these decentralization reforms are to strengthen democratic governance and service provision (Oyugi, 2000). Over the past decades, many Sub-Saharan African countries have undergone decentralization reforms with the overall goal of improving quality, access and equitable delivery of public services provided through or facilitated by local government authorities (Masanyiwa et al., 2012). The decentralization efforts in Sub-Saharan Africa have been mostly driven by political pressure. These reforms were largely supported by international institutions (Litvack et al., 1998) since decentralization is expected to greatly influence economic development and lead to poverty reduction by affecting resource mobilization and allocation, and ultimately macroeconomic stability, service delivery and equity.

It is against this background that since 2009, Burkina Faso has engaged in a process to transfer health resources to local levels through an institutional agreement (Ministry of Decentralization, 2014). The resources transfer is one of the major aspects of the decentralization policy that was set out in the strategic framework for implementing decentralization issued in 2007. The overall goal of the decentralization policy in Burkina Faso is to contribute to poverty reduction through the empowerment of local authorities, and to strengthen their capacities, strengthen the quality of local service delivery and assure affordable public services. The strategic framework for implementing decentralization has identified the following domains, eleven in number, to be transferred to local governments:

- lands;
- planning of land use and city planning;
- environment and natural resources management;
- economic development and planning;
- health and hygiene;
- education, employment, vocational and literacy training;
- culture, sports and leisure;
- civil protection, relief and assistance;
- funerals and cemeteries;
- water, sanitation and electricity;
- markets, trade fair and slaughterhouses.

Although the agreement to transfer health resources to local governments has brought clarity about the areas and functions to be transferred, as well as about the roles of the key stakeholders, there are majors concerns in the management of these resources. Following the resources transfer, a preliminary assessment was conducted and specific weaknesses were uncovered in the management of health resources transferred (Ministry of Decentralization, 2014), including:

- lack of skilled human resources and material resources;
- inadequate monitoring system and lack of accountability mechanism;
- weak stakeholders' ownership over their roles and responsibilities in the management of resources transferred;
- inadequate communication between locally elected officials and health specialists;
- discrepancy between the territorial division of local governments and health sector (health map), including a mismatch between the health sector and decentralization sector organization;
- low budget absorption capacities;
- misunderstanding between health districts and local governments over human resources management.

The health resources transfer is one of the key policies of decentralization reforms. Its aim is to improve healthcare delivery to the population. The situation described above illustrates the main issues that the local governments will face to ensure an adequate provision of public health services during the decentralization. The health resources transfer in Burkina Faso is still underway due to the progressive character of its approach in a context where little is known about the management of primary healthcare delivery by local governments.

This background provides a four-fold motivation for this dissertation. Firstly, many countries in the region have carried out decentralization reforms, while a review of these reforms is absent. Experience and lessons from settings in Sub-Saharan Africa are essential to safeguard the initial level of health service provision and circumventing service deterioration when new decentralization reforms are designed. Secondly, the implications of the decentralization and health resources transfer process in Burkina Faso have not yet been analyzed, and there are also no systematic evaluations of this reform. Research is needed to provide evidence for healthcare decentralization in Burkina Faso, which can be of interest for other Sub-Saharan African countries where such reforms are underway or considered for implementation. Thirdly, the study attempts to explore to what extent these different decentralization reforms have improved the overall health system in terms of better availability of services, a more equitable distribution of resources, increased access to good quality health services, as well as better health outcomes. Finally, despite the decentralization reforms and initiatives undertaken in Burkina

Faso, the population continues to face important challenges in the access and use of health services. The study in this dissertation can help to identify the major bottlenecks that deprive the population of access to healthcare, which must be addressed with decentralization by local governments.

1.2. DECENTRALIZATION: DEFINITION AND RATIONALE

Decentralization is not a monolithic concept (Smoke, 2003). It is often used in a loose way to refer to different forms of local governance, driven either by state or non-state actors. According to the UNDP (1999), decentralization refers to the restructuring or reorganization of authority so that there is a system of co-responsibility between institutions of governance at the central, regional and local levels according to the principle of subsidiarity. For Mawhood (1983) and Bush (1985), decentralization is any act in which a central government formally cedes powers to actors and institutions at lower levels in a political-administrative and territorial hierarchy. Decentralization has different types and can be evaluated according to the four-part classification of delegation, de-concentration, devolution and privatization (Rondinelli, 1983):

- *delegation* transfers responsibilities to a lower organization level;
- *de-concentration* transfers responsibilities to a lower administrative level;
- *devolution* implies transferring authority to a lower political level;
- *privatization* takes place when tasks are transferred from public into private ownership.

These four types of decentralization were used simultaneously or at different times by some governments (Rondinelli, 1983). Some governments began with one approach and later shifted to another after assessing initial results, and other governments have used various combinations of the four. Among the four types of decentralization, de-concentration has been the most frequently used form of decentralization in developing countries since the early 1970s.

Regarding its rationale or motivation, decentralization is often portrayed as a welcome governance reform expected to improve efficiency and equity of resource allocation and to promote participation and empowerment of local people. Decentralization is also frequently advocated as a means of improving public services delivery based on the assumption that in a decentralized system, services are more responsive to local needs and demands of service users because citizens can directly or indirectly influence decisions about resource allocation and service delivery (Ribot, 2002; Junaid et al., 2005; Conyers, 2007; Saltman et al., 2007; Regmi, 2014). The arguments for decentralization vary widely, as presented in Table 1.1.

Table 1.1. Selected arguments in favor of decentralization

Arguments in favor of decentralization
• Local governments have better information about local preferences, needs and the way local systems operate and can therefore allocate resources in a more efficient way
• Quality of service provision can be improved since local governments are likely to be more sensitive to variations in local requirements and open to feedback from service users
• Local governments are more accountable to local communities
• Decentralized governance increases the chances for the poor to access policy processes
• Local action can solve problems of collective action, providing sustainable use of common property resources
• Decentralization makes governments more responsive to the demand of local people by promoting competitiveness between sub-national governments
• Decentralization may lead to more creative, innovative and responsive programs by allowing local experimentation and by improving competitiveness of governments
• Decentralization may make cost recovery less difficult for governments as people may be more willing to pay for services if such services respond to their priorities and particularly if they have been involved in the decision-making process

Source: Bardhan, Azfar, Litvack & Seddon, Smoke, Robinson, cited in Cabral 2011

1.3. DECENTRALIZATION IN BURKINA FASO

Formerly known as the Republic of Upper Volta, Burkina Faso is a low income and landlocked Sub-Saharan African country located in West Africa and covers 270 764 square kilometers. It is bound by Benin, Togo, Ghana, and Côte d'Ivoire in the south, by Mali in the north and in the west, and by Niger in the east. The country accounts for more than sixty local dialects. The main religions are Muslim (52%) Christians (24.3%) and Animists (23.3%). The capital is Ouagadougou and French is the official language. The main health, demographic and socioeconomic indicators are presented in Table 1.2.

Table 1.2. Demographic, socioeconomic and health indicators, Burkina Faso

Indicators	Data	Year & source
Total population	21 510 181	2020 (INSD)
Population growth rate	3.1	2006 (INSD)
Crude birth rate (per thousands)	41	2010 (INSD)
Life Expectancy	56.7	2006 (INSD)
School enrolment (gross rate)	90.7	2017-2018 (INSD)
Human Development Index (HDI) ranking	182/189	2019 (UNDP)
Population under poverty line (%)	40.1	2014 (INSD)
Under 5 years mortality (per 1 000 live births)	76,4	2018 (UNICEF)
Gross National Income (GNI)per capita PPP (Intl $,)	$1,890	2018 (World Bank)
Total Health Expenditure (THE) per capita PPP (Intl $,)	$44,403	2017 (WHO)
Total Expenditure on Health (THE) as % of GDP	6,91	2017 (WHO)
% Total Health Expenditure (THE) as % of General Government Expenditures (GGE)	9,99	2017 (WHO)
Out-of-pocket expenditure (% of current health expenditure)	31,67	2017 (WHO)

The decentralization process in Burkina Faso, initiated in the 1920s, was greatly influenced by the colonial heritage as in most West African countries. At independence, the government in Burkina Faso inherited a system in which local governments were the unit of administrative management. Under this system, so-called "customary" authorities were privileged as the "representatives" of the rural world and the prefects, *commandants des cercles,* and district officers were the appointed supervising managers (Ribot, 2002). The overall objective of decentralization policy in Burkina Faso was to contribute to poverty reduction through the empowerment of local authorities and strengthen their capacities to improve local service quality and assure affordable public services delivery (German Cooperation Agency, 2018). The rationale of decentralization is articulated around two key dimensions. The first dimension is to enhance local development through an increased participation of the grassroot communities in local governance and democracy (Ministère de la Decentralisation, 2014). The second dimension is to promote good governance dictated by the Bretton Woods institutions and other financial institutions based on four key assumptions: responsibility, predictability, participation and transparency (Guiro et al., 2011).

In June 1991, Burkina Faso engaged in democratic renewal with the adoption of a new Constitution. This laid the foundation of decentralization through the organization of the country into local governments and thus, the establishment of local governance (Coulibaly, 2006). The decentralization reforms have been implemented in a progressive and gradual way with the objective of giving time to all stakeholders, including the newly created local governments, to adapt to the new mode of governance in public affairs. This way, the principle of a purposely "slow motion approach" as the foundation of the decentralization policy has been applied (Champagne & Ouedraogo, 2008).

In 2004, the country adopted a new general code of territorial councils (*Code Général des Collectivités Territoriales in French)*, which defines the institutional framework of the implementation of decentralization. This new code defines the decentralization as *"the right of territorial councils to manage themselves freely and handle their own affairs".* This definition confers three main characteristics to decentralization: i) existence of territorial councils, ii) freedom of administration, iii) ownership of powers transferred. This new general code of territorial councils led to the creation of 13 regions, 45 provinces and nearly 351 communes. Regarding the decentralization type in Burkina Faso, it can be categorized as devolution, although devolution and de-concentration components co-exist (Figure 1.1) with a strong presence of central government through the establishment of administrative units whose officials are appointed (Table 1.3).

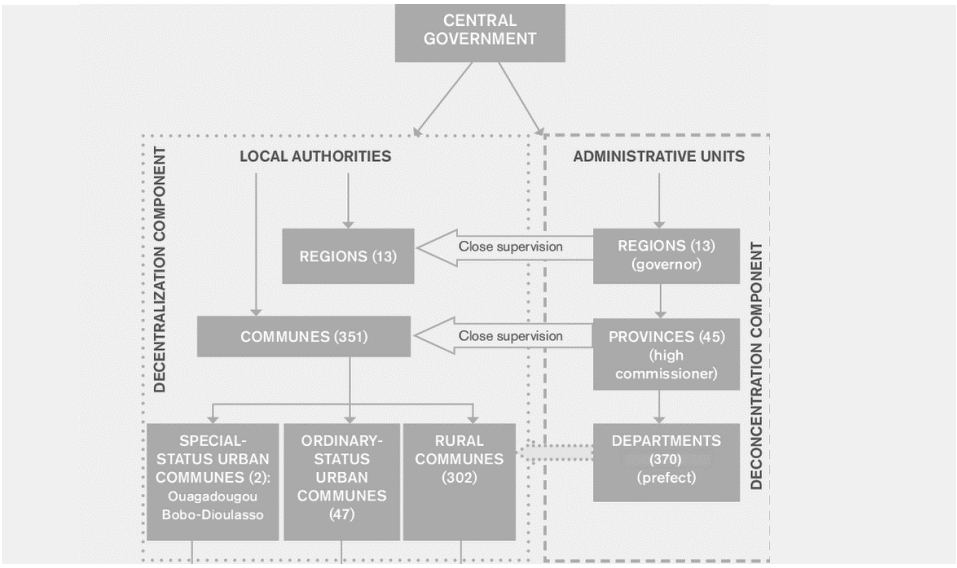

Figure 1.1. Decentralization and de-concentration structures in Burkina Faso in 2020 (adapted from: Diep, Loan & Archer, Diane & Gueye, Cheikh, 2016).

Table 1.3. Different levels of governments in Burkina Faso, whether appointed or elected (2019)

Levels of government, including administrative health structures	Status
Pouvoir central (Central government)	Elected
Gouvernorat (Governorate)	Appointed
Conseil Régional (Regional administrative council)	Elected
Province (Province)	Appointed
Departement (Department)	Appointed
Commune (Local government)	Elected
Région Sanitaitre (Health region)	Appointed
Distrit Sanitaire (Health district)	Appointed

A total of five municipal elections took place in Burkina Faso: the first one in February 1995, the second in May 2000, the third in April 2006, the fourth and fifth in December 2012 and May 2016 respectively. An additional decree was issued in 2007 to provide a strategic framework called CSMOD (*Cadre Stratégique pour la mise en oeuvre de la Décentralisation*) for implementing decentralization policy built upon five strategic orientations, namely:

- political and social ownership of decentralization;
- transfer of resources;
- building of local capacities;
- support to the development and implementation of development plans at grassroot level;
- coordination and steering of decentralization processes.

1.4. DECENTRALIZATION IN WEST AFRICAN REGION

As in Burkina Faso, the vast majority of West African countries have undertaken decentralization reforms. The key features of this policy, including its rationale, are summarized in Table 1.4

Table 1.4. Type and motivations for decentralization in selected West African countries

Countries	Type	Foundations and motivations	Sources
Burkina Faso	Devolution	Pressure from international donors, historical development of the administration, enhancement of local development	*Abraham Ky, 2010; German Cooperation Agency, 2018*
Cote d'Ivoire	Devolution	Improving service delivery	*Shah and Thompson 2004*
Ghana	Devolution	Continuation of colonial heritage, implementation of the constitutional provision, globalization and democratic governance	*Educational Research Network for West and Central Africa, 2011*
Mali	Devolution	Political will, response to conflict (rebellion), citizens' demands, external influence, return to tradition	*Educational Research Network for West and Central Africa, 2011*
Niger	Devolution	Colonial heritage and historical development of the administration	*Ministry of Decentralization, 2015*
Senegal	Devolution	Pressure from international donors, historical development of the administration, claims of local authorities	*Piveteau, 2005*

The type of decentralization is quite the same in all six countries, except Ghana where the devolution is effectively achieved with regard to the transfer of authority to the lower political level. In the other five countries, which are also French speaking countries, two types of decentralization (devolution and de-concentration) co-exist with a strong presence of central government through the establishment of administrative units. A number of factors determine the extent to which a country is decentralized. A study of forty-five countries, undertaken during the mid-1960s by Vieira (1967) indicates that the degree of decentralization (devolution[1]) in both Western and Third World countries was significantly correlated with five factors: (1) the age[2] of the nation; (2) the size of gross national product[3]; (3) the level of development of the mass media[4]; (4) the level of industrialization[5] and (5) the number of local governments. The study revealed that the size and density of the population, the physical size of the country, the level of urbanization, the constitutional structure and etąic composition of the population were not significant factors for the degree of decentralization.

1 Measured by the ratio of local government revenues and expenditures to total government spending and receipts over a ten-year period.
2 Older, well-established national governments having a higher degree of devolution than newer ones.
3 Countries with high levels of GNP tended to have higher degrees of devolution than poorer countries.
4 Countries with a more sophisticated and widespread mass communications system tended to be more decentralized than those with incipient or weak systems.
5 Industrialized countries tended to be more decentralized than those with agricultural economies.

The motivation and rationale for decentralization vary widely across the selected West African countries, and the main foundations remain the colonial heritage that led to the implementation of the historical development of the administration. The findings are similar in other Sub-Saharan African countries. In South Africa, the decentralization was a response to etąic and regional conflicts (Treismann, 2000) and the improvement of service delivery was the basis for decentralization in Uganda (Shah et al., 2004*)*. In Cameroon, decentralization was implemented under the pressure of international donors and the government has seized upon this opportunity to maintain political interest and local powers (Educational Research Network for West and Central Africa, 2011). This is in line with Crook (2003) indicating that decentralization is also often adopted by national elites as a strategy for mobilizing and maintaining regional power bases.

With respect to the decentralization rationale, Conyers (2000) argue that most decentralization efforts have had both explicit and implicit objectives. Specifically, some of those objectives have appealed to the general public, such as local empowerment and administrative efficiency, and have explicitly been stated, while less popular objectives, such as increasing central control and "passing the buck", are unlikely to be voiced. According to the UNDP (1999), decentralization could be expected to contribute to good governance, such as increasing people's opportunities for participation in economic, social and political decisions; assisting in developing people's capacities; and enhancing government responsiveness, transparency and accountability. A review that investigated the impact of decentralization on service delivery and poverty reduction in Africa, i.e. the two most popularized arguments towards decentralization, found the outcomes questionable. The impact of decentralization on service delivery is probably limited, judging by intermediate variables such as access to information, locus of power, administrative performance and accountability relations. There is a lack of systematic analyses of decentralization in Africa and its impact on service delivery and poverty reduction. The limited evidence available suggests, however, that decentralization is yet to deliver its promised results (Cabral, 2011).

1.5. HEALTHCARE DECENTRALIZATION

Decentralization in the health systems can be defined as the transfer of formal responsibility and power to make decisions regarding the management, production, distribution and/or financing of health services, usually from a smaller to a larger number of geographically or organizationally separate actors (Vrangbaek, 2007, p. 46). According to Mills A. (1990), the decentralization in healthcare has four common forms as presented in Table 1.5, which are the same as those presented above for decentralization in general.

Interest in healthcare decentralization received a boost following the 1978 Alma Ata conference on primary healthcare. Decentralization and the primary healthcare approach thus became closely associated as they shared these principles, since decentralization was viewed as a means for achieving the primary healthcare goals (Green, 1992). Decentralization in healthcare was part of the health sector reform policies of many countries with the aim of improving efficiency, effectiveness and equity in the health sector. In Sub-Saharan Africa, health sector reform has been driven by a wider macroeconomic policy and implementation of structural adjustment programs, which require control of public expenditure as well as changes in public and private sector institutional structures (Gilson & Mills, 1995). It may nevertheless be noted that in many settings, the reform has been initiated on the basis of its theoretical benefits rather than concrete evidence of its beneficial impact on health system performance (Kawonga et al., 2005).

Table 1.5. Forms of decentralization of health system

Forms	Description
De-concentration	Administrative responsibilities transferred to locally based office/s of the central Ministry of Health, within the health system
Delegation	Management responsibility transferred to a semiautonomous entity such as a Health Board representing different interest groups. The aim is to free central government from day-to-day management functions
Devolution	Political and administrative authority for health is transferred to local governments (an independent statutory agency, such as a municipality or Local Council). Local levels are able to generate revenue due to their statutory status.
Privatization	Contractual agreements are established between the public and private (profit or not-for-profit) sector for delivery of services. The aim is to improve efficiency and quality by encouraging consumer participation and competition. Government retains regulatory responsibility

Source: Mills, 1990, as cited in Kawonga,2005

1.6. HEALTHCARE DECENTRALIZATION REFORMS IN BURKINA FASO

Burkina Faso inherited a highly centralized country from the French colonial era. Like most West African countries, the organization and the main features of the healthcare system carried out the burden of the colonial past. The healthcare system was strongly hierarchical and centralized.

Since the end of the 1980s, the country has undertaken major reforms towards decentralization, including reform of the health sector (Bodart et al., 2001). Under the push of international donors, these reforms were renewed in 1992 as part of the macroeconomic adjustment programme (Haddad et al., 2006). These reforms mainly

focused on decentralization and the implementation of cost recovery policies, the supply of essential generic drugs, the liberalization of healthcare services and the hospital sector. These reforms were also part of the country's commitment to the Alma Ata declaration aiming to operationalize the declaration's recommendations in order to improve access to healthcare for all citizens. The expectation is that decentralization provides the opportunity for health systems to attain both tecąical and allocative efficiencies, empower local governments, increase accountability, and make gains in many areas, including quality, cost and equity (Sumah et al., 2016).

This reform has resulted in the decentralization of the health system with the establishment of health regions (13 in 2018), divided into health districts (70 in 2018) that are the operational level for implementation of the national health policy. The district health services are organized into two levels, the first of which comprises the primary healthcare centers (1 896 in 2018) that provide communities with basic preventive and curative primary healthcare. The second level consists of district hospitals (45 in 2018) that represent the point of referral for the primary healthcare centers. The overview of health system of Burkina Faso is presented on the Figure 1.2

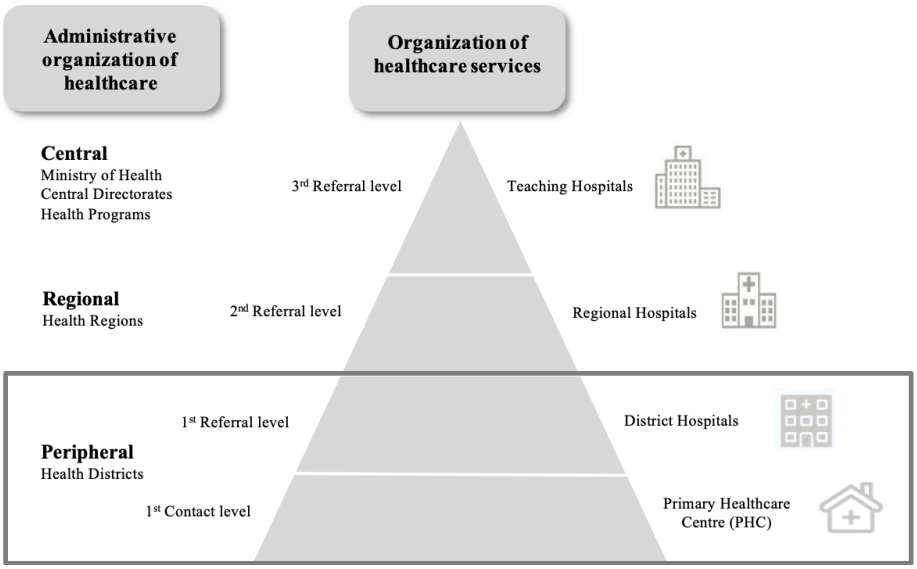

Figure 1.2. Burkina Faso's health system overview, 2019. Adapted by the Author from the description of the health system. Ministère de la Santé, 2019.

The type of health system decentralization in Burkina Faso can be referred to as de-concentration. The central administration (Ministry of Health) has transferred some responsibilities to health regions and health districts. This mainly includes planning and management for providing health services. The health policy formulation and financing are the matter of the central administration. The resources transfer to local governments, which is underway within decentralization focus only on primary healthcare centers. This process will progressively lead to the transfer of political and administrative authority for health to local governments.

1.7. AIMS AND OBJECTIVES OF THE DISSERTATION

The central aims of the dissertation are to explore the process and mechanisms of health resources transfer from the central government to the local governments in Burkina Faso. The dissertation also seeks to analyze the differences in the distribution of health resources and the differences in health outcomes, and to assess the determinants of access to healthcare during the period of healthcare decentralization in Burkina Faso. The different studies reported in this dissertation consider the fact that the progressive transfer of health resources to local governments takes place in an environment where the population lacks access to existing health services. Also, most of the local governments have limited capacities to manage the provision of health services, particularly in rural areas. Therefore, it remains needful to uncover realities and issues involved in the resources transfer process by providing evidence and information on how the central government and local governments can play their role in the provision of health services. This dissertation contributes to a better understanding of the issues and challenges involved, and suggests ways to address them in order to ensure a sustainable provision of health services by local governments in Burkina Faso. The study findings can be of interest to other Sub-Saharan African countries where decentralization reforms are underway or considered for implementation. The findings also contribute to the knowledge on the role of the local governments in the public health services provision, management and financing and generate information to support discussions and actions on pressing communities' health issues. Moreover, the measure of progressive transfer of health infrastructures and equipment, health human and financial capital to local governments in Burkina Faso might well affect the functioning of district and regional hospitals as well. Thus, case studies of basic healthcare facilities, which are the point of entry into the health system will be necessary to learn more about the challenges that the decentralization process presents to hospitals and to their future decision making. It should be noted that the study does not claim to conduct a full impact evaluation of the health resources transfer in Burkina Faso. As noted in the central aim of the dissertation, the purpose here is to provide an overview of the key achievements made against the

stated purpose of decentralization and resources transfer to local governments.

To achieve the aim of the dissertation, the following objectives are defined:

> *Objective 1. To systematically review the experiences of the local governments of Sub-Saharan African countries with the provision of health services during and after decentralization reforms.*

Experience and lessons from settings in Sub-Saharan Africa are essential to safeguard the initial level of health service provision and circumventing service deterioration when new decentralization reforms are designed. An overview of the evidence in this area is however absent. Despite the voluminous literature on decentralization reforms in Sub-Saharan Africa, hitherto, no systematic review on health services provision during and after decentralization has been reported for this region. We conducted a systematic review that combined a systematic literature search and a document analysis. This helps understanding the evidence offered by previous studies to better channel future research and to contribute to the healthcare decentralization process in Sub-Saharan Africa.

> *Objective 2. To assess the decision-makers' knowledge, attitudes and practices (KAP) related to the transfer of health resources and skills to local governments in Burkina Faso.*

The resources transfer from central state to local governments involves a range of stakeholders. This makes the process rather complex as it includes a large number of actors and affects the multi-level system of the state (national, regional and local), thereby inducing a number of challenges for the decentralization. The political decentralization changes the balance of power between national, regional and local levels, disturbing the existing system. Given that health resources and skills transfer in Burkina Faso is in a learning process and there are limited knowledge and insight on the topic, we used a qualitative research method to collect data among decision-makers involved in the health resources and skills transfer process in Burkina Faso. The study aimed to explore the key decision-makers' knowledge, attitudes and practices related to the transfer of health resources and skills to local governments in Burkina Faso and assess to what extent they are familiar with the resources transfer. This qualitative exploration could be of interest to other countries as well, e.g. Sub-Saharan African countries where decentralization in the health sector is being implemented or considered for implementation.

Objective 3. To explore the strengths, weaknesses, opportunities, and threats (SWOT) associated with the health resources transfer from the perspective of decision-makers in Burkina Faso.

Although the institutional agreement to transfer health resources to local governments has brought clarity about the roles and responsibilities of the key players, there are concerns about some major issues such as the adequacy of organizational and operational structures, as well as the match between needs and resources. The implications of the decentralization and health resources transfer process in Burkina Faso have not yet been analyzed and there are also no systematic evaluations of this reform. Given the overall lack of data on the topic, we explore the strengths, weaknesses, opportunities and threats (SWOT) associated with the health resources transfer in Burkina Faso from the perspective of decision-makers. We used a qualitative research approach with interviews with representatives of key decision-making groups. Their opinions were triangulated to determine the degree of consensus about the progress of this reform. The study provides evidence for healthcare decentralization in Burkina Faso as well as in other Sub-Saharan African countries where such reforms are underway or in the pipeline for implementation.

Objective 4. To analyze the differences in health outcomes by health district's demographic and economic status, and the distribution of health resources during the period of healthcare decentralization in Burkina Faso.

Burkina Faso has undertaken decentralization reforms in the health sector to improve the performance of the health system. It is expected that these reforms will help to improve the overall health system performance in terms of better availability and a more equitable distribution of resources, an increased access to good quality health services, as well as better health outcomes across health regions and health districts. A bivariate correlation analysis was conducted using data at the health districts and regions level. These data were derived from the health management information system (HMIS) and national households' surveys. The study aimed to analyze the differences in health outcomes by health districts demographic and economic status, and the distribution of health resources during the period of healthcare decentralization. This analysis is also of interest for other Sub-Saharan African countries that go through a decentralization process to revitalize the public sector while promoting development of the private sector.

Objective 5. To analyze the determinants of households' access to healthcare in Burkina Faso.

Burkina Faso has undertaken major reforms, the cornerstone of which has been the decentralization of the health system with the aim to increase the access to primary healthcare and to increase the effectiveness, efficiency, financial viability and equity of health services. Despite the different reforms and initiatives undertaken in Burkina Faso, the population continues to face major challenges in access and use of health services. The study explored the association of household-level factors with access and utilization of health services in Burkina Faso. We carried out binary logistic and a linear regression analysis using data from a national household survey carried out with the aim of analyzing the determinants of households' access to healthcare in Burkina Faso. The results could be useful for policy-makers in Burkina Faso when assessing the reform progress, as well as for policy-makers in other countries in the region that struggle with problems of healthcare access.

1.8. DISSERTATION OUTLINE

The dissertation includes seven chapters, the first being the general introduction. The following six chapters are devoted to the study's specific objectives described above and the dissertation's discussions and concluding remarks. Chapter 2 focuses on objective 1 regarding the results of the systematic literature review that examines the experiences of local governments of Sub-Saharan African countries with the provision of health services. In Chapter 3, we explore objective 2 and analyze the decision-makers' knowledge, attitudes and practices (KAP) related to the transfer of health resources to local governments. Chapter 4 focuses on objective 3 and assesses the strengths, weaknesses, opportunities, and threats (SWOT) associated with the health resources transfer. Chapter 5 focuses on objective 4 and presents the regional health disparities during the period of healthcare decentralization. Objective 5 on the determinants of households' access to healthcare is the focus of Chapter 6. We conclude the dissertation with Chapter 7 where key findings, discussions and concluding remarks are made.

CHAPTER 2

Municipal health services provision by local governments: A systematic review of experiences in decentralized Sub-Saharan African countries

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ABSTRACT

Background

In the health sector, four types of decentralization are distinguished: de-concentration when the shift in authority is to regional or district offices; devolution when the shift is to state, provincial or municipal governments; delegation when semi-autonomous agencies are granted new powers; and privatization when ownership is granted to private entities.

Objective

This chapter aims to systematically review the experiences of local governments of Sub-Saharan African countries with the provision of health services during and after decentralization reforms.

Methods

A systematic literature search was conducted in November 2016 to identify research publications and policy reports that addressed the issue of decentralization in relation to the health service provision by local governments in Sub-Saharan African countries.

Results

The review shows that most countries have mainly focused on the process by enacting numerous policies, regulations and standards with mixed outcomes for health services delivery. Decentralization, in general, and resources transfer from the central to local governments in particular, are a highly political issue that influences the health reform strategy on decentralization. The literature shows the complexity of implementing decentralization schemes, which strongly impact the health service organization and delivery. The theory of decision space applied in a comparative analysis found that some functions, particularly financing, remain under the control of the central state. Despite the numerous challenges, this review identifies some good practices in resources transfer, key determinants being the type of decentralization and the government's will to make legislative and administrative changes required for the effectiveness of decentralization.

Conclusion

The literature search, even though systematic, resulted in a limited number of relevant publications that show evidence on the link between decentralization and health services delivery. This is a largely unexplored research area, especially the use of financial resources by local governments, the factors that drive local decision-making processes and the effects of decentralization on health sector performance.

2.1. INTRODUCTION

Decentralization is a concept about which there is no common agreement in the literature. It is difficult to define because of the differential meanings it acquires in different contexts (Mawhood, 1983; Rondinelli et al., 1983). Nevertheless, in public planning, management and decision-making, decentralization often refers to the transfer of authority or dispersal of power from the national level to sub-national or local levels of government (Rondinelli, 1981). In this sense, as outlined in Chapter 1, decentralization is about shifting power, resources, function and responsibilities for service delivery from the central government level to the local community or municipality levels within a country.

Another key feature of decentralization is related to the different forms it takes. The transfer of power, functions and resources from central to local authorities takes both political and administrative forms (Ribot et al., 2006). Within the political form, the decision-making authority is delegated to lower levels of government, usually elected bodies or municipalities, and within the administrative form, greater managerial authority is delegated to managers or appointed bodies. A third form of decentralization is fiscal decentralization, which refers to an increased control of revenues by local governments to better meet local needs and increase the efficiency of service provision (Scąeider, 2003). In Chapter 1 where the motivation or rationale of decentralization was outlined it appeared that resource mobilization and allocation by the decentralized levels could enhance efficiency and improve public services delivery.

Beyond the definition and forms of decentralization, questions arise about the motivation and objectives, which may vary from country to country and from region to region. For example, in Uganda, Chile and Cote d'Ivoire, decentralization was carried out to improve service delivery (Shah et al. 2004). In Uganda, a central part of the decentralization policy (Local Government Act 1997) stipulates that most central government powers and responsibilities for public services planning and delivery should be devolved to local governments. In Sri Lanka and South Africa, however, the objectives of decentralization were related to a response to etąic and regional conflicts (Treisman, 2000). Hentic & Bernier (1999) highlight that political decentralization is rarely guided by objectives like improving administrative effectiveness but rather reflects the necessity for consensus to maintain political stability.

The concept of decentralization developed by Rondinelli (1981) was first applied to the health sector by Mills et al. (1990), Mills (1994), Bossert & Beauvais (2002). Decentralization in the health sector can be political, administrative and fiscal (Saltman et al., 2007; Maharani & Tampubolon, 2014). As explained in Chapter 1, four main forms

of decentralization of health system are distinguished: de-concentration, delegation, devolution and privatization. The decentralization can involve the devolution of some political, administrative or fiscal functions to local governments related to health service provision (Hutchinson, 2002). These functions include for example the management of healthcare personnel, hiring of staff, purchasing supplies and equipment, purchasing and delivery of services. However, in addition to devolution (a shift to state, provincial or municipal governments), three other categories of decentralization in the health sector are distinguished: de-concentration when the shift in authority is to regional or district offices; delegation when semi-autonomous agencies are granted new powers; and privatization when ownership is granted to private entities (Bossert & Beauvais, 2002; Saltman et al., 2007). Overall, decentralization in the health sector should take place along with the transfer or assurance of appropriate resources, which will make it possible to adequately respond to local health challenges (Saltman et al., 2007; Regmi, 2014).

This chapter focuses on Sub-Saharan Africa (the 50 African countries located south of the Sahara desert). The reason for doing so is that many countries in the region have carried out decentralization reforms, while a review of these reforms is absent. The recent systematic reviews in this area (e.g. Cobos Munoz et al., 2016; Wickremasinghe et al., 2016) cover low-income countries in general and do not specifically focus on the context of Sub-Saharan Africa. The decentralization reforms in Sub-Saharan Africa were largely supported by international institutions such as the World Bank. In 1998, nearly 30% of the World Bank Projects implemented in the Africa region had a decentralization component (Litvack et al., 1998). A stocktaking survey was conducted by the World Bank in 2002 in 30 out of 50 Sub-Saharan African countries to measure the extent of decentralization (Stephen, 2002). Experience and lessons from settings in Sub-Saharan Africa are essential to safeguard the initial level of health service provision and circumventing service deterioration when new decentralization reforms are designed. An overview of the evidence in this area is however absent. Despite the voluminous literature on decentralization reforms in Sub-Saharan Africa, hitherto, no systematic review on health services provision during and after decentralization has been reported for this region. Thus, a review of the literature is needed to understand the evidence offered by previous studies, to better channel future research and contribute to the health decentralization process in Sub-Saharan Africa. This chapter systematically reviews the experiences of local governments of Sub-Saharan African countries in the provision of municipal health services during and after decentralization reforms.

2.2. MATERIALS AND METHODS

We conducted a systematic literature search in November 2016 (last update) to identify research publications and policy reports that addressed the issue of decentralization in relation to the health service provision by local governments in Sub-Saharan African countries. Publications that addressed decentralization in Sub-Saharan Africa but did not touch upon health services were out of the scope of the review. Three main search concepts were selected for this systematic review, namely DECENTRALIZATION, HEALTHCARE and SUBSAHARAN AFRICA. Synonyms and variations in spelling were considered when selecting the search terms (see Figure 2.1).

SEARCH COMPONENTS	SEARCH TERMS USED IN THE LITERATURE SEARCH
DECENTRALIZATION	("decentralization"[All Fields] OR "decentralisation"[All Fields] OR "decentralize"[All Fields] OR "decentralise"[All Fields] OR "municipal"[All Fields] OR "local government"[All Fields] OR "local governments"[All Fields])
	AND
HEALTHCARE	("healthcare"[All Fields] OR "healthcare"[All Fields] OR "health services"[All Fields] OR "health service"[All Fields] OR "medical care"[All Fields] OR "delivery of healthcare" [All Fields])
	AND
SUB SAHARAN AFRICA	("sub saharan africa"[All Fields] OR "west of africa" [All Fields] OR "west africa" [All Fields] OR "east of africa" [All Fields] OR "east africa" [All Fields] OR "centre of africa" [All Fields] OR "center of africa" [All Fields] OR "central africa" [All Fields] OR "south of africa" [All Fields])
	AND
SEARCH LIMITS	(English[lang] OR French[lang]) AND ("2001/01/01"[PDAT] : "3000/12/31"[PDAT]) AND ("loattrfull text"[sb]

Figure 2.1. Main concepts, search terms and search limits (example PubMed search)

Figure 2.1 presents the exact search terms as well as their relation to the three search concepts mentioned above. We searched with these search terms in PubMed and Sciences Direct. We did not use MeSH terms in PubMed because their inclusion resulted in a very high number of irrelevant articles. In addition, we performed a search per country. As indicated in Figure 2.1, we used three search limits: (1) the language of publication was limited to English and French; (2) we only included publications published after 2001 (the past 15 years); and (3) we included publications for which the full text was available. The initial list of publications that appeared in each database was screened based on the objective of the review described above. Thus, publications that presented broadly or provided only general discussions on decentralization, health services or healthcare were excluded. The reference lists of the selected publications were also reviewed to identify relevant publications on the topic. The same inclusion

and exclusion criteria were applied. Given the limited number of published articles on the experiences in health services provision by local governments in Sub-Saharan Africa during and after decentralization, we also included official policy reports that outline the decentralization and its impact on or relationship with the health sector and the health system (policy and governance, financing, human resources, drugs and health commodities, health management and information). To identify such reports for our review, we searched the websites of the governments in Sub-Saharan Africa as well as the websites of international organizations, namely the Educational Research Network for West and Central Africa, the Netherland Development Organization, the Royal Tropical Institute, the World Health Organization (WHO) and the World Bank. The web-sides of these organizations were screened to identify relevant reports in accordance with the search terms, inclusion and exclusion criteria listed earlier.

To analyze the content of the publications and reports included in the review, we explored the type of publication or report, its objectives, materials and methods, key findings, conclusions and recommendations for future research or exploration. Discussions on reliability and validity of the studies reported in the publications were also reviewed but we did not perform an additional systematic assessment of the quality of the study designs. We also did not exclude publications due to study design problems as the literature on this topic for Sub-Saharan Africa in particular, is scant. Yet, the limitations of the studies reviewed were taken into account in the formulation of our conclusions. The findings on the decentralization reforms and their impact on health service provision were summarized based on the decision space theory as described in Bossert (1998) and applied for example in Bossert et al. (2002), Bossert & Beauvais (2002), and Bossert & Mitchell (2011). This theory is defined as a range of effective choices that are allowed by the central authorities (the principal) to be utilized by local authorities (the agent). The space defines the specific 'rules of the game' of decentralized agents. In particular, we consider the various functions and activities over which local authorities will have increased choices: financing, service organization, human resources and governance. We used both a narrative description and illustration in the form of tables. Given the primarily qualitative nature of the review and the diverse designs of the studies included in the review, no subsequent meta-analysis was conducted. Based on the PRISMA guidelines (Moher et al., 2009), we checked the quality of our systematic review using the PRISMA checklist.

2.3. RESULTS

From an initial list of 49 publications obtained in the systematic literature search, 21 publications that met the relevance criteria, are included in the literature review. Figure 2.2 presents a flow chart of the publication selection process and Appendix A presents a list of the publication included in the review.

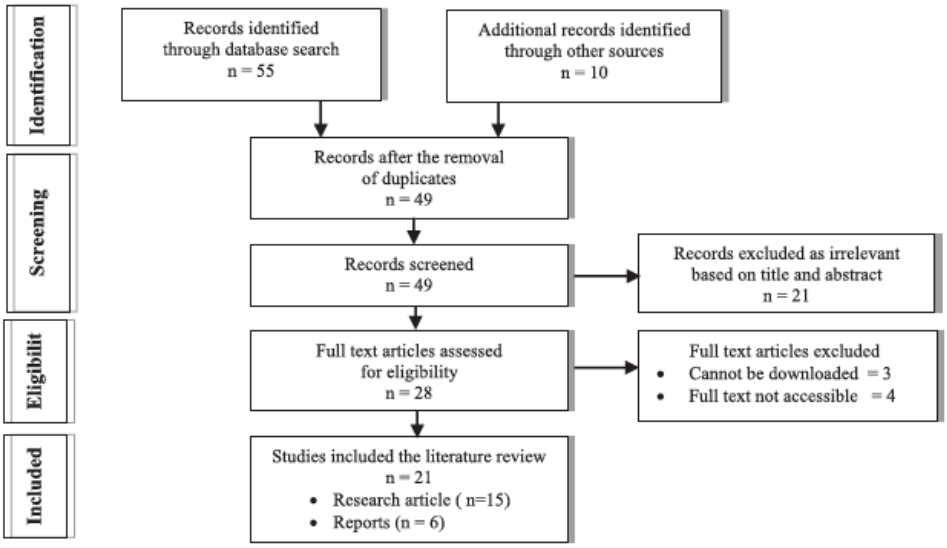

Figure 2.2. Flowchart of the publication selection process

The list of publications reviewed includes 15 research articles and 6 reports. All research articles are published in regional or international scientific journals. From the six reports, one report is a government report on the implementation of the decentralization policy, one report resulted from a national project on health decentralization and four reports resulted from a multicenter study. Overall, the results of the review showed that there is a very limited number of studies in Sub-Saharan Africa that directly or indirectly highlight the link between health services delivery and decentralization processes.

2.3.1. General characteristics of the selected publications

All publications are published since 2002 given our search strategy. Most of the publications report experience from case studies in a single Sub-Saharan African country (namely, Burkina Faso, Côte d'Ivoire, Ghana, Mali, Niger, Nigeria, Senegal, Tanzania, Uganda, Zambia) but two cross-country comparisons are also included

(Appendix A: publication 1, 2), in one of which Benin is also included. The majority of publications show the outcomes of decentralization on health services (services access, services financing, human resources etc.). Data and information provided throughout all publications mainly deal with the decentralization context and process, its effectiveness, the resources transfer and management. The majority of the publications (16/21) use data from qualitative case studies that combine reports, reviews and qualitative field surveys. Other designs used are qualitative field surveys only (3/21) and literature reviews only (2/21). In majority of the publications (15/21), the study population and sampling method are clearly defined. However, in few publications (6/21), the sample size is lacking or is not clearly specified/defined. The key decentralization characteristics and outcomes presented in the publications reviewed include the context, degree, type and process of decentralization; impact of decentralization in terms of effectiveness of resources transfer, equity, quality of care, financing, access and use of services, services organization. They are measured primarily in qualitative terms: description of variations between countries' experiences; description of individual, organizations and countries experiences; insights on relationships. Only in two publications a quantitative approach is applied to measure services availability and utilization, and quality indicators of Expanded Program on Immunization (EPI) services.

Almost half of the publications (9/21) discuss the validity and reliability of their studies. The different methods used to ensure the study validity and reliability are pre-testing and review/validation of data collection tools, triangulation of data/information sources, recoding of data, and the use of statistic tests.

The quality assessment of the publications indicates that all research articles (15/15) and half of reports (3/6) have an appropriate publication title, executive summary, study background and objectives, methodology, as well as results and discussion. However, the main weaknesses identified in the majority of the publications concern the description of the methodology, which is often not very detailed and clearly presented, as well as the frequent absence of discussion on validity and reliability of the findings. Study limitations and areas for future research are also not always included.

The main findings reported in the 21 publications analyze the process and outcomes of decentralization with a focus on the following issues: the context, degree and typology of decentralization, resources and skills transfer to local government, the effects of decentralization on health services delivery, the key issues and challenges encountered, and questions to explore. An overview of these findings is presented below, followed by an overview of good practices based on the publications reviewed.

2.3.2. Context, resources and outcomes of decentralization in healthcare

Four (4/21) articles discuss the context and degree of decentralization. The findings indicate that the health reform strategies towards decentralization took place in a specific political context. It differs greatly from one country to another as countries delegated and employed a mix of policy tools (Bossert & Beauvais 2002). In the health sector, the decentralization process is an essential political and local institutional factor. The power asymmetry among actors has a greater influence on the prioritization process at the local level than expected and intended (Maluka et al., 2011). One report states (Bossert & Beauvais, 2002) that holding core functions such as 'financing', 'services organizations', 'human resources', 'health access rules', 'governance' is influenced by the type and level of decentralization. In Mali, there are constant changes in the decentralization policy, which has undergone many important shifts with successive governments and administrations (Sidibe, 2011). The resources and functions transferred are reviewed by eight publications (8/21). These publications report that the transfer ranges from planning, construction and management of health facilities to enforcement and monitoring of sanitary regulation in Benin, Burkina Faso, Mali and Senegal (Marthe et al., 2010; Guiro et al., 2011; Toure, 2011). In Uganda, the provision, management and maintenance of primary healthcare, primary education, roads and basic urban services are decentralized to districts (Muriisa, 2008). However, the transfer in most of the country is partial or incomplete. For instance, in Mali, there is a partial transfer of infrastructure/equipment and human resources while in Uganda, some functions such as funding remain at central level. The outcomes and effectiveness of decentralization are mixed and its impact also differs from one country to another. The different areas assessed by the different publications include the decision space (9/21), the perceptions and beliefs of stakeholders (3/21), and the outcomes of decentralization on health services (14/21).

Bossert & Beauvais (2002) report a theory of decision space in a comparative analysis of the health systems, including those in Ghana, Uganda and Zambia. The authors use a variety of different types of decentralization and range of choice of functions to be transferred to local governments (Bossert, 1998). This theory was adapted by Frumence et al. (2013) to examine experiences in Tanzania. Soura & Coulibaly (2014) used the same theory to briefly examine the case of Côte d'Ivoire. The findings are summarized in Table 2.1.

Using Table 2.1 on the country decentralization strategy and local decision space, it can be seen that the trends are towards a narrow and moderate choice for financing functions and narrow choice for governance functions. The decision space for allocations of expenditure is moderate and narrow for salaries and for facilities boards. The four (4/21) publications on decision space (Bossert & Beauvais, 2002; Bossert et al., 2003; Maluka et al., 2011; Soura & Coulibaly, 2014), broadly denote an intensive

state intervention with delay in the resources transfer due to political interference in the resources transfer process and the central government's control over resources. Two (2/21) publications report that decentralization has increased autonomy in the mobilization of financial resources from local sources, and the possibility of deciding on how to use them. Local governments' agencies are effectively responsible for delivering basic health services to citizens and health services, and health staff management are assigned to them (Khemani, 2006; Frumence et al., 2013). The key issue that all publications point out is the local government's limited tecąical and financial capacities to deliver health services.

Table 2.1. Comparative decision space of Côte d'Ivoire, Ghana, Tanzania, Uganda and Zambia

Countries	Type of decentralization	Decision space			
		Functions	Range of choice		
			Narrow	*Moderate*	*Wide*
Côte d'Ivoire	De-concentration	Financing	narrow		
		Service organization[a]	narrow		
		Human resources	narrow		
		Governance	narrow		
Ghana	Delegation	Financing		moderate	
		Service organization[b]	narrow	moderate	
		Human resources	narrow		
		Governance	narrow		
Tanzania	Devolution	Financing[c]	narrow	moderate	wide
		Service organization		moderate	
		Human resources[d]	narrow		wide
		Governance	narrow		
Uganda	Devolution	Financing		moderate	
		Service organization[e]	narrow	moderate	wide
		Human resources[f]		moderate	wide
		Governance[g]	narrow	moderate	
Zambia	Deconcentration	Financing[h]	narrow	moderate	
		Service organization[i]	narrow	moderate	wide
		Human resources[j]	narrow	moderate	wide
		Governance[k]	narrow	moderate	

[a] Narrow for Hospital autonomous, Insurance plan and Payment mechanism; Moderate for Contract with private providers

[b] Narrow for Hospital autonomous, Insurance plan and Payment mechanism; Moderate for Contract with private providers

[c] Narrow for Source of revenue; Moderate for Allocation for expenditures; Wide for Allocation of expenditure from locally generated income

[d] Narrow for Permanent staff; Wide for Lower cadre staff

[e] Narrow for Payment mechanism and Insurance plan; Moderate for Hospital autonomous; Wide for Contracts with private providers

[f] Moderate for Civil services; Wide for Contract

[g] Narrow for community participation; Moderate for Health offices

[h] Narrow for Source of revenue; Moderate for Income from fees

[i] Narrow for Hospital autonomous; Moderate for Contracts with private providers; Wide for Payment mechanism

[j] Narrow for Salaries; Moderate for Civil service; Wide for Contract

[k] Narrow for Local government and facility boards; Moderate for Health offices and Community participation

Perceptions and beliefs of stakeholders on the effects of the decentralization are either optimistic or pessimistic. Three publications (3/21) explore this dimension and report that for most of the respondents, decentralization is seen as a reform that increases local participation in identifying needs for healthcare delivery and financing (Anokbonggo et al., 2004a,b; Sakyi et al., 2011; Frumence et al., 2013). The same publications report that other respondents feel that decentralization is also praised for reducing the problem of mismatch between what the districts actually need and what is made available by the central government. Overall, publications agree that decentralization has increased the flexibility in local planning and ownership of health projects at the district level (Munga et al., 2009). At the same time, there is a belief that the central government wants to get rid of costly sectors or areas of interventions such as health-related interventions (Marthe et al., 2010; Guiro et al., 2011; Toure, 2011).

With regard to the outcomes and effectiveness of decentralization on health services delivery, a very limited number of publications is found on the management of the core functions 'financing', 'services organization', 'human resources', 'health access rules' and 'governance' by local governments. Ten (10/19) publications report on the outcomes of decentralization on health in the areas of service management, capacity building, resource allocation and the use of services. Specifically, two (2/21) publications that explore the outcomes in terms of access to services, equity and quality of care, indicate that there is no clear evidence showing the impact of decentralization on health services (Bossert & Beauvais, 2002; Bossert et al., 2003). One (1/21) of the reports also suggests that there are only minor differences between decentralized and non-decentralized districts in terms of health status, process and outcome indicators (Hutchinson 2002). Two (2/21) papers state that an increase in health services attendance and use is associated with decentralization. The key contributing factors are the availability of resources, particularly from international donors, community responsibility and ownership, community participation (Anokbonggo et al., 2004a,b; Hutchinson et al., 2006, Soura & Coulibaly, 2014). The key findings reported earlier are summarized in Table 2.2.

Table 2.2. Outcomes of decentralization in health service delivery

Areas	Outcomes of decentralization	Reference
Financing and resources allocations	Strong impact of government inputs on the use of curative care services by both children under 5 years old and adults. Higher budgeted amounts per capita were associated with the use of curative services. Better coordination with donors, greater ability to attract and retain staff, and higher use of government health services	*Hutchinson et al, 2006*
	Provision of medical care and services has fallen far short of local needs through lack of finances	*Muriisa R.K, 2008.*
	Drug availably is not always adequate and was associated with funding for drug procurement	*Anokbonggo et al, 2004a, 2004b*
Services organization and management	Little evidence on declining attention being paid to primary healthcare in favor of hospitals or unsustainable civil works	*Hutchinson, 2002*
Human resources and capacity building	Greater evidence on the potential benefits of decentralization: improvements in training and capacity building, supervision, and attention to primary health services, availability of district funds.	*Hutchinson, 2002*
	Decentralization reforms have resulted in more effective utilization of local information in the recruitment of health workers, ensuring better planning according to need.	*Munga et al, 2009*
Governance at local level	Established bodies (local government ward and village decentralization bodies) had been very useful in facilitating community participation in the control of infectious diseases	*Semali et al, 2005*
	Provision of the opportunity for the grassroots community to be involved in the planning process	*Frumence G. et al, 2013*
	There is a better community participation in the improvement of healthcare quality	*Soura & Coulibaly, 2014*
Use of services	Use of curative care was associated with the progression of the decentralization process; there was a general increase in patient attendance in hospital	*Anokbonggo et al, 2004a, 2004b*
	EPI coverage decreased to less than 53% compared to the pre-decentralization national average of 80% in the 1990s; decline in the number of EPI supervisory and delivery visits	*Semali et al, 2005*
	There is a significant decline in EPI coverage (DPT3) that cannot be clearly attributed to decentralization	*Bossert et al, 2003*
	There was relatively little impact of decentralization on the utilization of outpatient services	*Bossert et al, 2003*

2.3.3. Issues and challenges of decentralization in healthcare

All publications reviewed discuss the challenges involved in health resource allocation and skills transfer to local governments. The underlying cause of these challenges reported by all publications is related to the central government's stranglehold on the key functions of decentralization. The different issues can be divided into four broad categories or areas as presented in Table 2.3.

In particular, Table 2.3 suggests a highly political nature of the health resource allocation and skills transfer characterized by a continuous state intervention and political interference. In fact, the decision-making of financial resource allocation and transfer remains under the control of the central or regional state. The same applies to the key functions in human resources management (Bossert & Beauvais, 2002). Local governments have limited financial and tecąical capability to manage the health personnel, equipment, and tecąical activities to deliver health services. The distribution of responsibilities, relationships and coordination mechanisms remain insufficient (Marthe et al., 2010; Ministere de la Decentralisation, 2014; Bekale, 2011; Maluka et al., 2011). Specifically, there is a lack of clear delineation of responsibilities and relationships between the levels of local government and health committees and boards, as well as a lack of coordination mechanisms between local governments, district management team and local partners. It has been observed that there is confusion about responsibilities, such as a lack of clarity regarding the local governments' skills and responsibilities for holding certain functions (management of human resources and administrative or legal acts).

A cross-country study conducted in West Africa (Burkina Faso, Ghana, Mali, Niger and Senegal) by the Educational Research Network for West and Central Africa also shows that decentralization is not yet effective (Malam & Ilboudo, 2011). The study calls attention to numerous laws and regulations that are not synonymous with effectiveness in skills and resources transfer, but are considered for adoption. Thus, the main barrier remains, namely the control of the central state over financial and human resources.

These findings are similar to the results from another comparative analysis done by Bekale (2011) in West African countries (Benin, Burkina Faso, Mali and Senegal). Again, the central issue is the attitude of the central governments that experience a relatively high administrative burden, and this is slowing down the skills and resources transfer to local governments.

Table 2.3. Issues and challenges encountered by local governments

Areas	Key issues and challenges	References
Financing	Decision-making to allocate financial resources remain under the control of Central/Regional/District state	*Bossert & Beauvais, 2002*
	Lack of transparency in the allocation of resources and weak budgetary procedures with regard to record-keeping and auditing	*Muriisa, 2008*
	Delay in the transfer of financial resources from the central state to local governments	*Frumence et al., 2013, Marthé et al., 2010*
	Weak financial capacities to support investments costs	*Sidibé N, 2011*
	Most of the local governments have a very limited own financial resources to deliver health services	*Bekale,2011 ; Soura & Coulibaly, 2014*
Services organization	Lack of clear delineation of responsibilities and relationships between the levels of local government and health committees and boards	*Maluka et al., 2011*
	Insufficient monitoring, lack of an accountability mechanism, Inadequacy between the health and the decentralization maps	*Ministère de la Décentralisation, Burkina Faso, 2014*
	Lack of formal coordination mechanism between health centers and local governments	*Guiro et al, 2011*
Human resources	Most of the key functions in health personnel management are centralized	*Bossert & Beauvais, 2002*
	Lack of capacity and personnel at sub-national government level to exercise responsibility for service delivery: qualified people, especially highly skilled workers, were difficult both to recruit and retain because they are in high demand in urban areas and the private sector.	*Muriisa, 2008*
	Weak capacities of local governments to manage the health personnel equipment and tecąical activities	*Ministère de la Décentralisation, Burkina Faso, 2014*
	Limited capacities of health staff and health management committees on decentralization and health resource transfer	*Ministère de la Santé, Mali and the Royal Tropical Institute (KIT) Amsterdam, 2008*
	Slow process of human resource and infrastructural development	*Opare et al., 2011*
Governance	Political interference with the health personnel recruitment process, Intensive state intervention with delays in health resources transfer	*Bekale, 2011*
	Autonomy in health services organization and management by Local governments or boards was very limited, with a continuing centralization of personnel management	*Munga et al., 2009*
	Political harassment of civil servants, increased nepotism	*Anokbonggo et al., 2004a, 2004b*
	Problem of general accountability of local governments	*Khemani, 2006*
	Local governments and decentralized health boards have often a very limit choice (decision space) over their key functions, especially for financing and human resources	*Bossert and Beauvais, 2002 ; Bossert et al., 2003*

2.3.4. Good practices of decentralization in healthcare

Based on the publications reviewed, we outline several aspects of good practices of decentralization in healthcare reported in Sub-Saharan Africa. Despite the challenges reported above, some relatively good practices are reported in Ghana (Opare et al., 2011) and Tanzania (Frumence et al., 2013).

In Tanzania, the effectiveness of decentralization in the health sector is analyzed in terms of financial-related benefits, managerial-related benefits. Findings show that decentralization has increased autonomy in the mobilization of financial resources from local sources and the possibility of deciding on how to use them for the implementation of health services in the district. Furthermore, decentralization provides an opportunity for the grassroots community to be involved in the planning process and identify their local priority needs. Other benefits include enhancement of the accountability of health workers and reduction of bureaucratic procedures in decision making.

In Ghana, the findings show that the decentralization of the health sector has enhanced monitoring and evaluation, the budgetary allocations to the health sector, human and nonhuman resources transfer to the districts. Another key finding is that human resources render satisfactory service; the challenge, however, is that it is difficult to retain them due to frustrations that are characteristic of rural areas. Although these publications have not focused their analysis on the success or relevant factors, it is argued that the satisfactory results achieved in Ghana and Tanzania have to do with the type of decentralization, which greatly influences the resources and skills transfer to local governments. The decentralization structure in these two countries grants a large autonomy and decision space to local governments. In Tanzania, decentralization is one of the most important components of both local government and health sector reforms aimed at transferring key functions, responsibilities, power and resources from the central government to the local authorities, as well as strengthening the capacity of local authorities (Frumence et al., 2013). The country adopted a decentralization by devolution (D by D) strategy, in which local governments are supposed to be largely autonomous institutions, free to make policy and operational decisions consistent with the country's laws, policies and institutions that have the power to possess both human and financial resources. In Ghana, the 1974 Local Government structure described as the 'Single Hierarchy Model' sought to abolish the distinction between local and central government at the local level and to create one common monolithic structure (District Councils) which received the responsibilities of the totality of government at the local level (Opare et al., 2011). When realizing the importance of decentralization in governance, in 1988, the government of Ghana put in place a decentralization program based on governance values such as empowerment, equity, accountability, stability

and checking of the rural-urban. This reform aimed at giving effective meaning to the decentralization by establishing a government system that is the four-tier metropolitan and three-tier municipal/district assemblies' structure. These relatively good practices in health resources transfer to local governments could be useful for other countries. Beyond the frameworks, laws and other regulations governing the decentralization, the countries must lift the barriers to effective implementation of the decentralization policy that are the tendency for the national level holding on to authority, inadequate finances and low capacity of human resource and logistics at the regional and district levels (Opare et al., 2011).

2.4. DISCUSSION

As outlined at the outset of this chapter, decentralization is intended to improve the delivery of public services, including health services. This involves the effective transfer of functions, power and authorities from the central state to local governments. Our review of the evidence on this topic for Sub-Saharan Africa indicates that despite the progress in the countries, decentralization often fails to achieve its end. The different reports and articles show that most of the countries have mainly focused on the process by enacting numerous policies, regulations and standards with mitigating outcomes in health services delivery. This has led to a partial or incomplete transfer of resources and skills due mainly to the intensive state intervention and the political interference. It can be concluded from the review that decentralization in general, and resources transfer from central state to local governments in particular are highly political issues that influence the health reform strategies towards decentralization (Bossert and Beauvais 2002). There are constant changes in the decentralization policy with continuous shifts with successive governments and administrations, leading to an endless and resources consuming process.

The link between the context and degree of decentralization, and the outcomes of decentralization was explored in this review based on the decision space theory presented by Bossert & Beauvais (2002). In their comparative analysis, Bossert & Beauvais (2002) acknowledge that there is limited evidence on the impact of decentralization on the health system performance, specifically in achieving equity, efficiency, quality and financial soundness. We have therefore focused on the relationship between the degree of decentralization and the control of functions transferred to local governments. The findings of our review suggest that a higher degree of decentralization is not always associated with wider ranges of control, as shown by the case of Uganda and Zambia. A deconcentrated health system like in Zambia, where the shift in authority is to regional or district offices, offers the same range of choice over functions as the health system in Uganda where the shift is to autonomous elected district councils (Bossert & Beauvais,

2002). This highlights some issues from the decision space approach, such as the effect of larger decision space on making innovative decisions and making a difference in performance (Bossert, 1998).

Another major finding from the review is the complexity of implementing decentralization schemes, which strongly impact the health service organization and delivery, especially the relationships and responsibilities between local governments and health boards, the coordination and monitoring mechanisms among the stakeholders and decentralization implementation bodies. The differences in perceptions and beliefs of stakeholders concerning decentralization, and the numerous concerns and challenges associated with the decentralization process may result from the misunderstanding of the decentralization objective, the implementing framework and the role of the different stakeholders. However, we also identify some good practices. Good practices in health skills and resources transfer are reported mainly in Anglophone countries, which could indicate the influence of colonial heritage. The key determinants have to do with the type of decentralization, the central government will to make the legislative and administrative changes required for the effectiveness of decentralization. Khemani (2006) indicates that the way in which decentralization is carried out (the sequencing; the choice among different forms of decentralization, and how the politics is managed) can be just as important to service delivery as the decision to decentralize itself.

It should be acknowledged that we base the above conclusions on limited empirical evidence. Specifically, our literature search, even though systematic, resulted in a limited number of relevant publications that show evidence on the link between decentralization and health services. This suggests that despite the growing expansion of decentralization policy and programs, the relation between decentralization and health services provision in Sub-Saharan Africa is a largely unexplored research area. Future research needs to explore the use of financial resources by local government, factors that drive local decision-making processes and the effects of decentralization on health sector performance. Moreover, our review of the discussions on the validity and reliability of the studies presented in the publications, suggest limitations of some study designs and methods, which prevent very specific generalizations based on this review.

2.5. CONCLUSIONS

To enlarge the knowledge base on decentralization in healthcare, which is particularly absent in Sub-Saharan Africa, and to provide evidence useful for policy-making in this region, attention should be paid to a systematic and rigorous evaluation of related policy interventions. Such approach should make use of theoretical conceptualizations,

such as those offered by Mills et al. (1990), Mills (1994) and Bossert (1998), as well as experience with decentralization evaluation in other developing countries (Maharani & Tampubolon, 2014). Nevertheless, we can still conclude that the outcomes of decentralization on health services delivery in Sub-Saharan Africa are mixed. There are some important context-related factors that can facilitate a successful implementation of the decentralization policy. These factors include: the appreciation of the role of all stakeholders by politicians; adequate availability and efficient utilization of resources, reasonably developed infrastructure prior to the policy change, appropriate sensitization and training of those implementing policies, as well as good will and active involvement of the local community. These factors need to be considered when implementing or amending decentralization policies in Sub-Saharan Africa.

CHAPTER 3

Exploring decision-makers' Knowledge, Attitudes and Practices (KAP) related to decentralization and health resources transfer to local governments in Burkina Faso

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ABSTRACT

Background

In the health sector, decentralization mainly consists of the devolution of administrative functions to local governments. Since 2009, Burkina Faso has engaged in a process to transfer health resources to local governments.

Objective

The aim of this chapter is to explore the decision-makers' knowledge, attitudes and practices (KAP) about the decentralization and health resources transfer to local governments in Burkina Faso.

Methods

We used a qualitative research method. In-depth semi-structured interviews were conducted with key decision-makers. The data collected went through a directed qualitative content analysis.

Results

The findings suggest that all respondents are aware and knowledgeable of the rationale of the decentralization and resources transfer to local governments. The vast majority of respondents have a positive opinion towards decentralization and the main elements that appear to be motivating their attitude, are the expected outcomes from decentralization. The respondents' practical experience with health resources transfer was limited to awareness raising, training, supervision, tecąical assistance and resources mobilization. Poor collaboration between health districts and local governments, the control of certain resources by the state and the health districts constrain the implementation of health resources and skills transfer policy at grassroots level.

Conclusion

Careful attention should be given to the country's political context and institutional design.

3.1. INTRODUCTION

Decentralization refers to the dispersal of power in public planning, management and decision-making from the national level to sub-national or local levels, and from higher to lower levels of government (Collins & Green, 1994; Mills, 1994; Rondinelli, 1981). As presented in Chapter 1, decentralization can be evaluated according to the four-part classification of delegation, de-concentration, devolution and privatization: Decentralization is also about shifting authority, resources, functions and service delivery responsibility from the central government to the local level within a country. This transfer of power, functions and resources from central to local level authorities requires political and administrative reforms (Larson & Ribot, 2004). Many Sub-Saharan African countries have undergone major decentralization reforms over the past decades with the overall goal of improving the quality, access and equitable delivery of public services provided through or facilitated by local government authorities (Masanyiwa et al., 2012). Decentralization is frequently advocated as a means to improve public services delivery based on the assumption that in a decentralized system, services are more responsive to local needs and demands of service users because citizens can directly or indirectly influence decisions about resource allocation and service delivery (Junaid et al., 2005; Conyers, 2007; Regmi, 2014; Ribot, 2002; Saltman et al., 2007). In most countries, decentralization reflects a broader process of political and economic reform (World Bank, 1997).

Although there has been a general consensus on the overall goal of decentralization, its motivation and objectives may vary from country to country, from region to region and from service to service, ranging from improving service delivery in Uganda and Cote d'Ivoire (Shah et al., 2004) to responding to etąic and regional conflicts in South Africa (Treisman, 2000). Decentralization is also often adopted by national level elites as a strategy for mobilizing and maintaining regional power bases (Crook, 2003). In the health sector, the expectation is that decentralization provides the opportunity for health systems to attain both tecąical and allocative efficiency, empower local governments, increase accountability and make gains in areas like quality, cost and equity (Sumah et al., 2016).

As outlined in Chapter 1, Burkina Faso engaged in democratic renewal with the adoption of a new Constitution in June 1991. This laid the foundation of decentralization through the organization of the country into local governments and thus, the establishment of local governance. In 2004, the country adopted a new general code of territorial councils (Code Général des Collectivités Territoriales in French), which defined the institutional framework for the implementation of decentralization. In 2007, a decree was issued by the central government to provide a strategic framework for implementing the decentralization policy.

From the different types of decentralization described in Chapter 1, the type of decentralization in Burkina Faso can be categorized as devolution, although devolution and de-concentration components co-exist with a strong presence of central government through the establishment of administrative units (Prefect, High Commissioner, Governors). Since 2006, elected local governments are in place in the 351 communes (municipalities), the lower administrative levels to which the central government is progressively transferring resources.

Regarding the health sector, Burkina Faso has undertaken a reform of its health system since 1992, which has led to the decentralization of the health system. This reform was led by the Alma Ata declaration and was aimed to operationalize the declaration's recommendations to improve access to healthcare for all citizens. The reform was part of a wider macroeconomic policy and implementation of structural adjustment programs, which require control of public expenditure as well as changes in public and private sector institutional structures (Gilson & Mills, 1995). This reform has resulted in the decentralization of the health system with the establishment of health regions (13 in 2018), divided into health districts (70 in 2018) that are the operational level of the national health policy. The district health services are organized into two levels, the first of which comprises the primary healthcare centers (1896 in 2018) that provide communities with basic preventive and curative primary healthcare. The second level consists of district hospitals (45 in 2018) that are the point of referral for the primary healthcare centers. The type of decentralization in the health sector can be categorized as administrative decentralization in the form of de-concentration. The central government (Ministry of Health) has transferred some responsibilities to health regions and health districts, mainly planning and management of health services. The health policy formulation, human resources and financing remain the responsibility of the central government. The resources transfer to local governments focuses only on the primary healthcare centers. Two main objectives underline the resources and skills transfer to local governments in Burkina Faso. The first is to boost the grass-root development by enhancing the local governments' capacities and ownership, and the second is to strengthen democracy and governance. In line with the resources and skills transfer, the central government has set two principles. The first is the principle of subsidiarity, which suggests that a skill must be preferably transferred to the level where it can best be managed. The second is the principle of gradual progress in resources and skills transfer (Ministère de la Decentralization, 2014). The resources transfer is done in consultation with a range of stakeholders involved in the decentralization. This makes the process rather complex as it includes a large number of actors and affects the multi-level system of the state (national, regional and local) (Oluwu & Wunsch, 2004). This also presents a number of challenges for the decentralization. Firstly, political decentralization changes the balance of power between national, regional and local levels, disturbing the existing system. Secondly, decentralization

also tends to change the balance of power between politics, civil society and citizens at the local level because it creates new spaces for the participation of civil society and citizens in local politics (German Development Institute, 2018). Various studies have been conducted on decentralization in Burkina Faso. These have mostly focused on the political decentralization context and processes (Bekale, 2011; Champagne & Ouedraogo, 2008; Guiro et al., 2011; Ky, 2010; UNDP, 1999); resources transfer process and lessons learned (Bekale, 2011; Guiro et al., 2011; Ministère de la Decentralization, 2014); the impact of decentralization on poverty reduction (Roark et al., 2001). None of these studies dwelled specifically on the knowledge, attitudes and practices among health resources transfer decision-makers.

Given that the health resources and skills transfer in Burkina Faso is in a learning process and there is limited knowledge and insight on the topic, this chapter examines whether decision-makers are familiar with the resources transfer. Specifically, the study seeks to gauge their knowledge, attitudes and practices related to the transfer of health resources and skills to local governments in Burkina Faso. This qualitative exploration could be of interest to other countries as well, e.g. Sub-Saharan African countries where decentralization in the health sector is being implemented or considered for implementation. The insights from a KAP study can help to reveal misconceptions or misunderstandings that may represent obstacles to the implementation of decentralization and health resources transfer in Burkina Faso.

3.2. MATERIALS AND METHODS

This study used qualitative research methods to collect data among decision-makers involved in the health resources and skills transfer process in Burkina Faso. For this purpose, in-depth semi-structured interviews were conducted with decision-makers. These decision-makers included mayors of municipalities, health district managers and managers of healthcare center as well as policy decision-makers at a regional and national level, and donors/partners. The research protocol was submitted for ethical approval, and such approval was granted by the ethical committee of the "Institut de Recherche en Sciences de la Santé (IRSS)" of Burkina Faso (clearance number A002-2018/CEIRES).

Three dimensions were explored in this study: knowledge, attitude and practices, which are known as the KAP study framework. This framework is often used by researchers to structure qualitative studies in the field of health policy and management (Muleme et al., 2017; Medecin du Monde, 2011). For the purpose of the study, we used an operational definition based on the WHO's KAP study framework (WHO, 2008). Knowledge refers to the interviewees' awareness and understanding (what is known)

of the study phenomenon, in this case, the decentralization as well as the related transfer of health resources and skills. Attitude refers to the interviewees' perceptions of the health resources transfer, including any preconceived ideas (thoughts or feelings) that they may have towards it. Practices refer to the ways (what is done) in which interviewees demonstrate and apply their knowledge and attitude towards the health resources transfer through their actions or behaviors.

A non-probabilistic sampling method was used for the data collection. The participants were purposefully selected because of their involvement or participation of their organization in the decentralization process in Burkina Faso, as well as due to their management position. These selection criteria were applied to assure that decision-makers with relevant experience were included in the study. An invitation was sent to the selected participants to request their authorization and explain the study objectives, scope and methods. For the interviews, we used a semi-structured interview guide. Giving that the study focus was the respondents' knowledge, attitudes and opinions, a semi-structured interview allowed the respondents the freedom to express their views in their own terms in order to gather information and story behind each participant's experiences with decentralization and resources transfer.

The interview guide (see Appendix B) was developed to collect information on: i) knowledge - awareness and understanding of decentralization, health resources and skills transfer, ii) attitudes - perceptions and feelings of the rationale or intent of the health resources and skills transfer policy, iii) attitudes - support of the policy of decentralization and health resources and skills transfer, iv) practices - their role in the health resources and skills transfer process, v) practices - collaboration between health districts and local governments, vi) practices - effectiveness of the resources and skills transfer process.

To ensure the quality of information, the research tool was pre-tested before commencing data collection. Qualified interviewers were recruited and trained on survey methodology and interview skills, including protection of confidentiality, anonymity and privacy of each participant. The main researcher supervised the data collection and checked the consistency of the data collected. The interviews were transcribed verbatim. The data collection and analysis were carried out in French. The final results were translated in English. Ethical considerations were safeguarded throughout the study process.

All data were analyzed, reported and stored in formats that do not allow identification of the individual participants. A verbal informed consent was obtained from each individual who participated in the study, and was registered by the interviewer. This involved informing the participant about the purpose for which the information is

obtained and about its use in a manner that can be understood by the participant. Participants were informed about the option to not answer questions that they felt unconformable with, and the option to stop the interview if they wanted to do so. The data collected underwent a directed qualitative content analysis (Hsieh & Shannon, 2005; Vaismoradi et al., 2013; Bengtsson, 2016). Data were analyzed in five main steps: reading for content, coding, displaying, data reduction, and interpretation. Information that reflected the reality as expressed by participants, has been retained and reported. The key themes, namely knowledge, attitude and practices, have been used to extract relevant data from the transcripts.

Knowledge: An overall knowledge score was computed by aggregating the variables related to the knowledge that was assessed through two questions. The first question asked whether participants were aware of the health resources transfer to local government, and the second question asked whether they were informed about the health resources transfer policy/bylaw regardless the source of information. Participants who gave a positive response to both questions were considered to have "good knowledge" of the decentralization process. Participants' knowledge was rated as "poor knowledge" when one or both questions were answered negatively.

Attitudes: To assess the participants' attitudes, a question was asked about the intent of the policy/decision to transfer the health resources from the central state to local governments. The participants provided an explanation of their answer in free text from their own respective points of view. The participants' attitudes were considered as "supportive" of the decentralization process when their responses contain at least one relevant rationale/intend of resources transfer. Otherwise, the attitudes were considered as "not supportive".

Practices: Three questions assessed participants' practices. The first question that asked about the collaboration between health districts and local governments was assessed on a 5-points scale (0=not at all satisfied, 5=very satisfied). In the second, the participants were asked to indicate their contribution to the resources transfer process. The participants were considered to have contributed to the decentralization process when they declared to have been involved in any action or activity related to health resources transfer (awareness raising, training, supervision, documents development, tecąical assistance, resources mobilization). The third question was asked in order to gauge the effectiveness of resources transfer. The responses were assessed on a 5-points scale (0=not at all effective, 5=very effective) and participants were invited to provide information or explanation to support their position.

The key results are presented narratively and supported by quotations from the interviews.

3.3. RESULTS

Table 3.1 presents results on the profile of the study respondents. In total, 20 in-depth interviews were carried out with healthcare and decentralization decision-makers. Over half of the respondents (55%) lived in urban settings that are the habitual place of residence of national policy-makers and country donors.

The results of the data analysis are presented below following the KAP framework.

Table 3.1. Profile of study respondents

	Residence		Total
Profile of respondents	*Urban*	*Rural*	
National policy and decision-makers	2	-	**2**
Regional council President	*	1	**1**
Health regional Directors	1	2	**3**
Health district team Managers	2	1	**3**
Mayor of municipalities	2	2	**4**
Primary healthcare center Managers	2	3	**5**
Country Donors	2	-	**2**
Total	**11 (55%)**	**9 (45%)**	**20**

* 1 participant who was not available at the time of the data collection.

3.3.1. Knowledge - awareness of the resources and skills transfer process

As indicated by the respondents, one of the prerequisites for the success of a policy reform is the support of the different stakeholders, which heavily depends on their awareness and knowledge about the objective of the reform. All respondents (20/20) declared that they were informed about the health resources and skills transfer policy through three main channels: information notes or letters (12/20), meetings (5/20) or short trainings (3/20).

According to a healthcare center manager:

> *"We were informed about the health resources transfer to local governments. The health district management team shared with us the documents explaining the objective of this new policy led by the central government."*

Another interviewee, a member of a local government's council, added this:

> *"I have participated in several meetings on resources transfer at local and central level. These meetings were planned to explain the reform and the role of the different stakeholders involved."*

The interviewees were asked whether they have any documents (letters, notes, decree) related to health resources and skills transfer. More than half (12/20) of the respondents said that they had a document at their disposal about resources and skills transfer. Among those who did not have any document (8/20), half (4/8) were healthcare center managers.

On this matter, the head of a healthcare center said:

> *"When I got posted here, I haven't found in the archives a document on health resources transfer."*

3.3.2. Attitude - perceptions of rationale of resources and skills transfer

The interviewees had different perceptions regarding the reasons or rationale for health resources and skills transfer from the central state to local governments, including:

- to increase local stakeholders' involvement and ownership (6/20 respondents)
- to improve local governance and community participation (5/20 respondents)
- to enhance efficiency and effectiveness of resources management (4/20 respondents)
- to bring services closer to beneficiaries (4/20 respondents)
- to implement the decentralization policy (3/20 respondents)
- to provide local governments with adequate resources to boost local development (2/20 respondents)
- to implement the principle of subsidiarity (1/20 respondents)
- to increase local resources mobilization (1/20 respondents)
- to accelerate the decision-making process at local level (1/20 respondents)

On the rationale of resources and skills transfer, a mayor observed the following:

> *"From my understanding, the decision to transfer health resources to local governments is part of the decentralization policy. As such, the resource transfer should be seen as a logical continuation of the decentralization policy implementation."*

From the perspective of some interviewees, namely policy-makers, the health resources and skills transfer to local governments seeks to bring health services to communities through greater empowerment of local authorities. With relation to that, a policy-maker explained:

> *"The elected local governments remain the closest to the population and on that account, the better informed about the citizens' needs. Hence, the resources transfer will strengthen their capacities in order to respond more adequately to population health needs."*

3.3.3. Attitude - opinions on resources and skills transfer

The interviewees were asked about their opinions about resources and skills transfer to local governments. The vast majority of respondents (17/20) had a positive view of the resources and skills transfer policy and the reasons justifying their opinions were based on the expected outcomes of the resources and skills transfer that can be arranged into five broad areas:

- better management of health facilities (8/17);
- improved capacities of local governments to provide services of better quality (5/17);
- better management of resources transferred (3/17;
- increased population's access to health services (2/17);
- increased local governments' accountability towards communities and beneficiaries (1/17).

To support his view, a health district manager said:

> *"I strongly believe that resource transfer to local government is a good decision. It will enhance local decision-making and strengthen the local governments' capacities to offer services adapted to the needs of individuals and communities."*

A few interviewees (2/20) expressed contrasting assessment about the resources and skills transfer policy. To illustrate his disagreement, a mayor said:

> *"I have the feeling that the central government wants one thing and also its opposite. It has transferred one part of the resources and retains one part, making the resources transfer incomplete."*

In the same way, a former mayor added:

> *"My negative opinion is reinforced by the fact that the resource transfer process was not properly planned. Some prerequisites have been not met and some people have the feeling that the country has been put under pressure by country's partners and donors."*

One (1/20) respondent reported a neutral opinion on the resources transfer policy because of its political exploitation.

3.3.4. Practices - contribution to the resources and skills transfer process

To assess their contribution, the respondents were asked about the role they have played in the resources and skills transfer process. Vast majority of respondents (14/20) indicated that they had not directly participated in the design of the decentralization process, either because they were not employed in their current position (5/14*),* or they were not invited or asked to participate in that policy phase (9/14). Among those who declared that they have participated in the process (6/20), the actions undertaken were awareness raising and training of the different actors (2/6), development of documents (manuals, guidelines, standards) for decentralization and resources transfer (2/6), tecąical assistance and resources mobilization (1/6), supervision (1/6). To expand on his contribution to the process, a respondent, a health district manager declared:

> *"I have participated in the development of a manual to guide the management of health resources transferred to local governments. This was an important step because this manual is key to ensure that all the local governments own a harmonized understanding and approach to resources management."*

A country donor expressed support to the process in this way:

> *"We strongly support the country to fully implement the decentralization policy, including the resources and skills transfer process. For this matter, we provide tecąical assistance and funding to design the policy documents and guidelines, as well for capacity building."*

Similarly, a mayor added:

> *"It was necessary to widely inform and raise awareness of the population on the resources transfer process. For this purpose, we have organized*

awareness raising sessions and meetings with communities-based organizations to explain the rationale and the process of resources transfer to local governments."

3.3.5. Practices - collaboration between local governments and health districts

The study sought to gauge the relationship between the local key actors in the resources and skills transfer, namely the local governments' councils and health district management teams. For this purpose, 7 respondents (4 mayors and 3 health district managers) were asked about their mutual relationship. The findings indicated that the collaboration is not satisfactory according to the majority of respondents (5/7). The main issue raised by both groups is the lack of a formal coordination framework between local governments and health districts.

A health district manager illustrated it in this way:

"I think we need to work closely to ensure a proper implementation of this new and important policy. I have the feeling that local governments have a misunderstanding of their role in the resources and skills transfer and which makes our collaboration difficult."

On the collaboration matter, a mayor expressed his concern as follows:

"There is no formal coordination mechanism between health districts and local governments. This gives the impression that everyone is working in isolation."

3.3.6. Practices - effectiveness of the resources and skills transfer process

The interviewees were asked about the current level of resources and skills transfer from the central to local governments. From their response, it can be noted that the vast majority (17/20) found that as of today resources (financial, human, equipment) were transferred to local governments according to the decree issued by the central government. Three out of twenty respondents deemed that there is a delay in the resources and skills transfer.

A question was asked to the interviewees about the extent to which the resources and skills were transferred, and to what extend the local governments had taken over the management of these resources. The responses showed that nearly half (9/20) of the interviewees felt that the health resource management rested with the health district management team and the central state.

To illustrate this point, a mayor said:

> *"The ministry of health and the health districts continue to manage the human resources entirely. For instance, the health personnel are appointed by the health district management teams without involving the local governments whose role is limited to issue authorizations for annual leave."*

In relation to this matter, another respondent, a local government council's member, reiterated by saying that:

> *"Compared to the education's sector where all the resources were transferred and handled by the local governments, the health sector drag their feet."*

This feeling of weak ownership of health resources and skills management by local governments was greater among health services providers at grassroots level, as illustrated by the point of view of a healthcare center manager:

> *"We still don't see the contribution and the accountability of local governments in the management of health facilities. All the issues and concerns that we have reported to the Mayor are not yet resolved. The hierarchical and reporting relationship is unclear."*

Among the respondents who stated that local governments have taken over the management of resources as of today (11/20), some believed that the blame lies with local governments, as pointed out by a respondent, a health district manager:

> *"From my point of view, some stakeholders fail to perform their duties. For instance, some local governments continue to think that health districts management teams must handle certain issues related to health facilities."*

Another respondent, a policy-maker supported this view by noting that:

> *"The management of resources transferred by the central state is not still well-controlled by local governments. For instance, it was reported that some local governments don't even know that funds were transferred by the central government in their bank account.... while they claim a delay in resources transfer"*

3.4. DISCUSSION

The study in this chapter has assessed the decision-makers' knowledge, attitudes and practices related to health resources and skills transfer to local governments in the context of decentralization in Burkina Faso. All respondents in our study expressed awareness and understanding of resources and skills transfer policy to local government, which is crucial for the policy implementation and may ensure its success. In particular, Sakyi et al. (2011) argued that the implementation is likely to suffer whenever there is misunderstanding and uncertainty over the policy objectives due to a communication gap as well as a failure on the part of the central government staff to share information.

According to our results, based on the responses of the decision-makers we interviewed, several factors have led to the decision of the central state to transfer resources to local governments. The main targets include: (i) to increase the local stakeholders' involvement and ownership, (ii) to improve local governance and community participation, (iii) to enhance efficiency and effectiveness in resources management, (iv) to bring services closer to beneficiaries, (v) to implement decentralization policy, (vi) to provide local governments with adequate resources to boost local development, (vii) to implement the principle of subsidiarity, (viii) to increase local resources mobilization and (ix) to boost of the decision-making process at a local level. These reasons, stated by the respondents in our study, correspond to evidence reported elsewhere on the rationale for decentralization (Conyers, 2000; Inman & Rubinfeld, 1997; Kundishora, 2009; Litvack et al., 1998; Musgrave, 1983; Oates, 1972; Ribot, 2002; Saltman et al., 2007; Sumah et al., 2016). According to Conyers (2000), four broad categories outline decentralization objectives: local empowerment, administrative efficiency and effectiveness, national cohesion and central control. In the same way, Ribot (2002) suggests that the underlying developmentalist logic of decentralization is that local institutions can better discern, and are more likely to respond to, local needs and aspirations. Thus, the central state of Burkina Faso must make every effort to ensure an effective implementation of decentralization given that the main objective of a resources and skills transfer policy is to boost the grassroots development through the leadership of local governments. This underpins the principle of subsidiarity adopted by the central state. It suggests that the decentralized government, which is closer to the people, is better able to respond to the preferences of its citizens (Ministère de la Décentralisation, 2014).

Regarding the decision-makers' perceptions, our study found that the majority of the respondents have a positive attitude towards decentralization and the transfer of resources and skills, and there is only little criticism. The main elements that appear to be motivating their attitude are the expected outcomes from decentralization, including:

(i) better management of health facilities, (ii) improved capacities of local governments to provide services of better quality to communities, (iii) better management of resources transferred, (iv) increased population access to health services and (v) increased local governments' accountability towards communities and beneficiaries. The opinions expressed by respondents in our study, are likely to be supportive of the decentralization and health resources transfer with respect to the expected outcomes and their awareness and understanding of the resources transfer policy. It is recognized in previous research that the attitudes of beneficiaries or stakeholders to a given policy, are key to the success of its implementation. In that regard, Makinde (2005) argues that where the implementers of a policy are perceived to be favorable to the policy, their attitude to the implementation is highly positive. The expectations from the decentralization raised by the respondents, have been identified by previous studies on decentralization as well. According to Smoke (2003), the most purported benefits of decentralization are the existence of democratic mechanisms that allow local governments to discern the needs and preferences of their constituents, and the way for these constituents to hold local governments accountable to them. In a review on decentralization in African, Ribot (2002) has highlighted the various expected outcomes from decentralization in selected countries. These are mainly: (i) promoting grassroots democracy and local development, (ii) achieving national solidarity oriented towards development, (iii) sharing of power between central and local levels and (iv) learning process in democracy and people's participation in development.

Regarding the decision-makers' practices regarding resources and skills transfer, the findings revealed that many of the respondents did not directly participate in the process, because they were not employed in their current position at that time or they were not entitled to participate in that policy phase. The role or contribution of those who have participated in the decentralization process, was limited to awareness raising, training, supervision, design of manuals and guidelines, tecąical assistance and resources mobilization. The findings showed that those who have not directly participated in the process, have more positive perceptions and opinions towards resources and skills transfer. From our findings, it could be said that the direct contribution of stakeholders or beneficiaries in the implementation process of a policy, would not make a condition for their support to that policy.

It emerged from the results that stakeholders' knowledge and awareness of the expected outcomes from decentralization and health resources transfer policy made their perceptions and opinions supportive. The study revealed a poor collaboration between health districts and local governments. Two main factors could contribute to this stormy collaboration between health districts and local governments. The first lies in the fact that health manager's expectations about the issue of transfer of resources are mixed, probably driven by their fear or feeling of losing some of

their prerogatives of authority over the primary healthcare centers placed under the responsibility of local governments. In relation to that, a decentralization policy review in Burkina Faso (Champagne & Ouedraogo, 2008) suggested that any social change creates resistance, particularly among the state's officials. Often, the lack of understanding of decentralization policies is used as an excuse to justify the officials' refusal to collaborate with the decentralized bodies and councils. Such hostilities are related to a more general fear of losing their power, in particular financial control, and therefore their influence on people. The second factor has to do with the discrepancy in the decentralization stage between the health sector and the political sector. The progress in the implementation of health resources could be hampered by the fact that the decentralization in the political sector is in a fairly advanced stage (devolution) compared to the health sector (de-concentration). One of the key consequences of this discrepancy is the mismatch between health and administrative territorial breakdown, thus creating confusion in the planning, the implementation of health services delivery and oversight among health managers and local governments.

Challenges in collaboration between the health sector and decentralization sector were reported by several studies (Guiro et al., 2011; Ministère de la Décentralisation, 2014) conducted in Burkina Faso in which the lack of formal coordination mechanisms between health centers and local governments impede the provision of healthcare to communities. On this matter, a study in Ghana (Viglo, 2014) found that the reasons given for the failure of decentralization, often included the unclear definitions of the distribution of functions between central government agencies and local authorities. Smoke (2003) also asserted that one of the greatest deficiencies in decentralization efforts is the lack of coordination of the actors involved and the consequent failure to build linkages among the components of decentralization at the national, intergovernmental and local levels.

Another dimension of the decision-makers' practices was related to the effectiveness of resources and skills transfer. The findings suggested two main positions among respondents: a first group who argued that the resources and skills were entirely transferred and local governments have taken over it, the second group that comprises largely of health managers expressed that they were uncertain about the outcome of the health resources transfer. The main issue raised by this group is the weak ownership of local governments that failed to perform their duties, which is a reason for this group to question the added value of health resources transfer. Further analysis of health manager's position may shed more light on a feeling of losing their prerogative over a field exclusively reserved for them. This could undermine their support to the process and explain the current challenges to collaborating with local governments revealed by our study, which can adversely affect the implementation of health resources transfer. The issue related to the effectiveness of resources transfer

in the context of decentralization was raised in many studies in Burkina Faso and other Sub-Saharan African countries (Bekale, 2011; Guiro et al., 2011; ERNWCA, 2011).

The systematic review on local governments' experiences in health services provision in Sub-Saharan African countries (see Chapter 2) highlighted a partial or incomplete transfer of resources and skills due to the intensive state intervention and political interference. The key functions remain under the control of the central or regional government (decision-making of financial resource allocation, resources transfer, management of human resources). Overall, our results show that the key decisions-makers interviewed have fair knowledge and understanding, as well as a positive attitude towards the resources transfer in Burkina Faso. However, they seem to be divided regarding the effectiveness of the health resources transfer. This appeared to be confirmed by different reports and studies that have highlighted the partiality in the health resources transfer either in Burkina Faso or other West African countries (ERNWCA, 2011). The implementation of decentralization and health resources transfer, likewise any public policy, is heavily determined by the political will and adequate financial resources. According to Rondinelli et al. (1983), in nearly all countries where governments have attempted to decentralize, they have faced serious problems of implementation that arose from insufficient central political and bureaucratic support, and from ingrained centrist attitudes and behavior on the part of political and administrative leaders. Decentralization was weakened by the failure to transfer sufficient financial resources to those organizations to which responsibilities were shifted.

From the study results, an in-depth analysis of different points of view in the interviews, highlights a number of issues. According to Derick & Leighton (2001), these challenges are encountered in implementing a policy of resources or power transfer from central state to local governments:

- *Political and process dimension:* It is well known that decentralization is highly political because
  it changes the balance of power between national, regional and local levels. While there may be strong tecąical arguments in favor of health sector decentralization, without attention to the politics of decentralization, reforms may fail to yield the expected outcomes. The process dimension of decentralization highlights the importance of stakeholder participation, effective communication and political will.
- *Tensions and conflicts among objectives:* In healthcare decentralization, while the objective of responsiveness to local preferences may be met, from the standpoint of the national health system, the result is a sub-optimal allocation of resources. This could be explained by the underfinancing of the vast majority of local governments that heavily depend on central government subsidies and transfers

of resources. These transfers of resources (functions and responsibilities) are not always accompanied by corresponding measures of financial, material resources and particularly human capacities to adequately manage these resources.

- *Roles and responsibilities:* A misunderstanding over the roles and responsibilities of different stakeholders in the decentralization process can heavily impede a policy implementation. A clear definition of stakeholders' roles in addition to a formal collaboration or consultation mechanism among stakeholders, could improve the coordination towards policy implementation.
- *Space for participation:* Attention should be paid to stakeholders' awareness raising as a crucial step in the design and implementation of a given policy. The focus should be on the policy rationale, expected outcomes in order to enhance stakeholders' support and participation to policy implementation.
- *Delay in policy implementation:* The different components or phases of a policy should be implemented as planned or agreed upon with the different stakeholders. This could help to avoid frustration among stakeholders and ensure their commitment and ownership towards decentralization's and health resources transfer's outcomes.

This is a qualitative study that provides an insight into the health resources in Burkina Faso. The sample was limited to 20 participants from the targeted organizations and institutions that are not representative of all organizations and institutions involved in the decentralization process. Therefore, the findings should be seen as indications of the selected key decision-makers' KAP towards health resources and skills transfer, rather than providing a representative picture that can be generalized to the entire country. Future studies are needed to thoroughly evaluate the decentralization process in Burkina Faso.

3.5. CONCLUSIONS

This chapter sought to assess the knowledge, attitudes and practices (KAP) of decision-makers about health resources and skills transfer to local governments in Burkina Faso. The findings indicate that the key factors that determine the decision-makers' positive attitudes and support to decentralization are their good knowledge and understanding of the health resources transfer policy. However, the health managers' support for decentralization could drop if they feel they are losing their power due to the resources transfer process, exacerbating the antagonism between health districts and local governments.

The poor collaboration between the different stakeholders, the control of certain resources by the central state and the health districts could constrain the implementation of health resources transfer policy at a grassroots level.

From the results, it can be concluded that the success of failure of resources transfer in the context of decentralization depends on the country's political and institutional context, as well other associated factors. Decentralization is neither good or bad strategy, but it rather depends on the implementation of the decentralization and the country-specific institutional design (Daflon & Madiès, 2012). The study recommends to Burkina Faso and other countries that have initiated decentralization reforms to pay attention to the key factors that influence the success of decentralization, among others, the country political context and institutional design, the stakeholders' awareness and understanding in order to enhance their accession and support, the establishment of a clear framework for effective collaboration, the transfer of sufficient financial resources. The process must be preceded by an in-depth analysis and careful planning and organization to ensure a successful implementation.

CHAPTER 4

Decentralization and health resources transfer to local governments in Burkina Faso: A SWOT analysis among healthcare decision-makers

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ABSTRACT

Background

In line with the decentralization policy, in 2009, the central government of Burkina Faso issued a decree to transfer health resources to local governments for fulfilling their new responsibilities in healthcare provision. The first stage of this healthcare decentralization process involved the basic healthcare facilities, composed of primary healthcare facilities, maternities, dispensaries, maternal and child health centers, and essential drugs depots.

Objective

This chapter seeks to explore the strengths, weaknesses, opportunities, and threats (SWOT) associated with the health resources transfer in Burkina Faso, from the perspective of decision-makers.

Methods

We carried out a qualitative research approach using semi-structured interviews with representatives of key decision-making groups, in August to December 2017. The participants included mayors of municipalities, health district managers, policy decision-makers, and donors/partners. The data collected were subjected to a directed qualitative content analysis, and the SWOT framework was used to select themes and codes for the analysis.

Results

The most cited strength was the improvement of local governance, which also creates the opportunity for an enhanced partnership and decentralized cooperation. As expected, however, the limited financial capacity of local governments is an important weakness. Furthermore, misuse of financial resources threatens the resources transfer. Recommendations to improve decentralization and health resources transfer included effective enforcement of decentralization laws and policies, strengthening local governments' capacities, adequate funding, and evaluation of the resources transfer process.

Conclusion

An analysis of the preconditions for a successful resources transfer is needed to provide guidance to policy.

4.1. INTRODUCTION

In the health sector, decentralization frequently involves the devolution of some administrative functions to local governments (Hutchinson 2002). These functions include, for example, management of healthcare personnel, hiring of staff, purchasing supplies and equipment, and purchasing and delivery of services. The experience with healthcare decentralization in Sub-Saharan Africa is rather mixed. Systematic reviews, such as the review presented in Chapter 2, show important shortcomings in the decentralization process, the most important of which are the delay in the transfer of financial resources from the central state to local governments, the lack of a formal coordination mechanism between health centers and local governments, the weak capacities of local governments to manage the health personnel, equipment and tecąical activities, the political interference with the health personnel recruitment process, and the intensive state intervention (Cobos et al., 2016; Wickremasinghe et al., 2016). However, good practices are also identified in countries where the government is able to make legislative and administrative changes to facilitate decentralization (see Chapter 2). The resulting achievements were the increased autonomy in the mobilization and allocation of financial resources from local sources, the enhancement of the accountability of health workers and reduction of bureaucratic procedures in decision making, greater involvement of the grassroots community in the planning process, and the identification of their local priority needs. In this chapter, we specifically focus on the experience with healthcare decentralization in Burkina Faso.

4.1.1. Context of healthcare decentralization in Burkina Faso

Burkina Faso is divided into 13 regions, 45 provinces, 370 departments, and 351 local governments (communes). The regions correspond to the territorial breakdown of the health directorates. They are headed by governors, who are appointed by the central government and act as representatives of the Ministerial department in the regions. The governors assure the enforcement of laws at a regional level. The provinces are headed by the High Commissioners, who are also appointed by the central government and are representatives of the respective governor. They ensure the enforcement of laws at the province level. The departments are headed by the centrally appointed Prefects, who are representatives of the High Commissioners at the department level and ensure the enforcement of laws at that level. The communes (local governments) are run by elected mayors who are the head of the communal administration. They perform administrative, civil registrar and police officer functions. The local governments are autonomous in terms of management and financing. Their budget comes mainly from local taxes, revenues from local services grants, subsidies from the central government, and intergovernmental transfers (Nassirou et al., 2004). The local governments have no formal administrative or hierarchical relationship with the health

directorates or their subdivisions, the health districts. The health directorates, health districts, and hospitals have a semiautonomous status in terms of management. They receive annual planning guidelines from the Ministry of Health and decide over their organizational priorities. The financial and human resources are allocated to the health directorates, health districts, and hospitals by the central government on the basis of the needs that they express. The staff salary is also paid by the central government (Ministère de la Santé, 2011).

The health system in Burkina Faso has witnessed significant policy and organizational changes over the past decades. In 1960-1979, the health system in Burkina Faso was strongly centralized. It was based on the "all-state" model, in which the central government managed healthcare provision and funding. However, in 1980-1990, the concept of primary healthcare was introduced to enhance community participation and ownership in healthcare management. One of the cornerstones of the primary healthcare policy was the adoption of the Bamako initiative in 1987, whose aim was the strengthening of the participation of different local stakeholders in the management of healthcare, through an increased decentralization of health resources. Against that background, Burkina Faso undertook, in 1992, a health system reform that reshaped the health system into two main areas (Haddad et al., 2006) described below. The first area is system administration, which is organized into three levels, namely, the central, regional, and peripherical (operational) levels. The central level consists of national and central directorates organized around the Ministry of Health. The role of these directorates is to develop national health policies and guidelines, to ensure their implementation, and to mobilize and allocate health resources. At the regional level, there are the 13 health directorates, and their main role is to ensure the implementation of national health policies and to supervise the 70 health districts. At the peripherical (operational) level, the health districts ensure an effective implementation of the national health policies and oversee the primary healthcare centers (Ministère de la Santé, 2011). The second area is the provision of healthcare according to four levels. The first level is represented by primary healthcare centers, which provide communities with basic preventive and curative primary healthcare (essential package), and referrals to district hospitals. Their number was estimated at 1839 in 2017 (Ministère de la Santé, 2018). They are run by the Chief Nurse, appointed by the District Medical Officer. The second level consists of the district hospitals. Their number was estimated at 45 in 2017 (Ministère de la Santé, 2018). They are headed by the District Medical Officer, appointed by the central government. The third level is represented by regional hospitals, which provide specialized care and represent the point of referral of district hospitals. Their number is estimated at eight in 2017 (Ministère de la Santé, 2018). They are managed by the Directors General, appointed by the central government. The fourth level comprises six teaching hospitals, which provide tertiary care and represent the point of referral of regional hospitals. They are also run by the centrally appointed Directors General.

4.1.2. Content of the healthcare decentralization policy in Burkina Faso

In 2007, a decree was adopted in Burkina Faso that provided a strategic framework for implementing decentralization (in French *"Cadre Strategique pour la mise en oeuvre de la Decentralisation"*). An additional decree was issued in 2009, by the central government to transfer health resources (both human and financial capital) to local governments for fulfilling their new responsibilities in healthcare provision. The first stage of this healthcare decentralization process involved the basic healthcare facilities, composed of primary healthcare facilities, maternities, dispensaries, maternal and child health centers, and essential drugs depots. Through an institutional agreement, local governments have been given responsibility for the management of these healthcare facilities, procurement and supply of medical commodities, disease prevention, and sanitation. The central government has kept its regulatory role, which includes defining the national health policy and orientation, setting norms and standards for the health infrastructure, equipment, health services functioning, and management. The government also oversees health facilities and allocates financial resources through grants and subsidies to local governments. Two main objectives underline the rationale of resources transfer to local governments in Burkina Faso (Ministère de la Décentralisation, 2014). The first is to boost the grass-root development by enhancing the local governments' capacities and ownership, and the second is to strengthen local democracy and governance. The decentralization process is, however, not completed since local governments have not yet taken over the entire management of resources transferred (Ministère de la Décentralisation, 2014). Although the decree of 2009 to transfer health resources to local governments has brought clarity about the roles and responsibilities of the key players, there are concerns about some major issues, such as the adequacy of organizational and operational structures, as well as the match between needs and resources (Ministère de la Décentralisation, 2014).

The implications of the decentralization and health resources transfer process in Burkina Faso have not yet been analyzed, and there are also no systematic evaluations of this reform.

Given the overall lack of data on the topic, this chapter explores the strengths, weaknesses, opportunities, and threats (SWOT) associated with the health resources transfer in Burkina Faso from the perspective of decision-makers. The study follows a qualitative approach. The opinions of key decision-maker groups are triangulated to determine the degree of consensus about the progress of this reform. The study in this chapter provides evidence for healthcare decentralization in Burkina Faso, which can be of interest for other Sub-Saharan African countries where such reforms are underway or considered for implementation.

4.2. MATERIALS AND METHODS

In this study, qualitative research methods were used to collect data among decision-makers involved in the healthcare decentralization process. For this purpose, in-depth semi-structured interviews with representatives of key decision-making groups were conducted from August to December 2017 in Burkina Faso. The targeted decision-making groups included: (a) mayors of municipalities, (b) health district managers, (c) policy decision-makers at a regional and national level, and (d) donors/partners. To structure the data collection and analysis, the SWOT framework (Frost et al., 2014; Çinar et al.,2013) was used. This framework comes from the area of management but has already been successfully applied in studies on health services as well (Frost et al., 2014; Kahveci et al., 2008; Sarter et al., 2010; Shahmoradi et al., 2017; Christiansen, 2002).

The objective of our analysis was to identify the strengths and weaknesses of the healthcare decentralization and health resources transfer in Burkina Faso, in addition to the opportunities and threats to which they are exposed. We also analyzed the degree of consensus between the participants in qualitative terms. The guide (a list of semi-structured questions, see Appendix B) used in the interviews was developed in English and then translated into French to collect information on the following aspects: strengths, weaknesses, opportunities, and threats to decentralization and recommendations for improving the decentralization and process of resources transfer. To assure a common understanding among the participants, an explanation of the SWOT dimensions was given to them during the interviews. The guide was pretested before commencing data collection with five respondents (one district medical officer, one mayor, one policy-maker, one country partner, and one head of primary healthcare center) who were not included in the group surveyed. The guide was slightly adjusted for the different groups (identification section). The guide is provided in Appendix B.

A non-probabilistic sampling method was applied to select participants from each group. Specifically, the participants were purposefully selected because of the involvement or participation of their organization in the decentralization process, as well as because of their management position. These selection criteria were applied to assure that only decision-makers with relevant position or function were included in the study. Also, to assure the inclusion of diverse opinions, participants from both rural and urban areas were selected. Thus, the initial list included 25 potential participants, all from different institutions: five from municipalities (targeting mayors); seven from health districts and health centers (targeting health district managers); seven from health regions and regional councils (targeting policy decision-makers at a regional level); four from national level decision-makers organizations (targeting policy decision-makers at a

national level); and two from donor organizations (targeting donors). An invitation was sent to the selected participants. The invitation explained the study objectives, scope, and methods. All interviews were individual face-to-face interviews and took place at the participants' office. Qualified interviewers were recruited and trained on the study methodology and interview skills, including protection of confidentiality, anonymity, and privacy of each participant. The interviewer made an appointment in advance with a participant to agree on the time and location. The average interview duration was 45 minutes. The main researcher supervised the data collection and checked the consistency of the data. The data were collected using the edited transcription method on printed word sheets. The interviews were not recorded. At the end of each interview, the data collector summarized the key participant's answers and discussed them with the participant to ensure that the participant's views are well recorded. The data analysis started 2 weeks after the end of the data collection in the field.

The data collected underwent a directed qualitative content analysis (Hsieh & Shannon, 2005). Thus, themes and codes were defined in advance on the basis of the SWOT framework. The analysis was performed by the main researcher, who was the single data coder. Intermediate and final results of the data analysis were discussed with the other two researchers involved, and in this way, unclarities were resolved. Data were analyzed manually in five steps: reading the content, coding, displaying, data reduction, and interpretation. Specifically, the main researcher identified the common themes and ideas related to the SWOT dimensions: strengths, weakness, opportunities, and threats of health service decentralization in Burkina Faso. Information that reflected reality, as expressed by participants, was retained and organized in a MS Excel file for each theme. The responses were summarized in two steps: The first step was the aggregation of responses, and the second step consisted of disaggregation of responses according to participant groups. Saturation was achieved within the groups of mayors, health district managers, and policy decision-makers at a regional and national level. For the country donor's group, saturation was not achieved, i.e. while there were similarities between the two interviews with donors, there were also some new findings in the second interview. This suggested the need of an additional interview to confirm the saturation among donors, but we were unable to identify another donor involved in the healthcare decentralization. Nevertheless, we decided to include the results for donors because they offered a different perspective. On the basis of the analysis, a SWOT matrix was designed to summarize the key findings and to identify the level of knowledge and consensus among the participants.

The results are presented narratively and also supported with tables and quotations from the interviews. The subsequent interpretation of the results was used to outline recommendations for strengthening the decentralization implementation and improving the process of health resources transfer. We present quotations from the

interviews to show the level of consistency of data and findings, as well as similarities across the participant groups. The quotations also illustrate and clarify the major themes. We disregarded minor themes not directly related to the aim of this chapter.

Ethical considerations were safeguarded throughout the study process. The research protocol was submitted for ethical approval, and such approval was granted by the ethical committee of a national health research institute, namely, "Institut de Recherches en Sciences de la Santé (IRSS), Centre National de la Recherche Scientifique et Tecąologique (CNRST), University of Ouagadougou (Burkina Faso)." All data were analyzed, reported, and stored in formats that do not allow the identification of the individual participants. Verbal informed consent was obtained from each individual participating in the study and was registered by the interviewer. This involved informing the participant about the purpose for which the information is obtained and its use in a manner that can be understood by the participant.

4.3. RESULTS

In total, among 25 potential interviewees, 17 in-depth interviews were carried out, while eight persons contacted were unavailable (one mayor, two health district managers, three policy decision-makers at a regional level, and two policy decision-makers at a national level did not participate in the study). Thus, the final participant list included the following groups:

- four mayors of municipalities, including two former mayors (two working in urban municipalities and two in a rural municipalities),
- five health district managers (two health district managers working in urban districts, one health district manager in a rural district, and two heads of primary care centers),
- four policy decision-makers at a regional level (three health regional directors and one president of a regional council),
- two decentralization policy-makers at a national level, and
- two representatives of country donors/partners.

The years of experience in their position range from 2 to 7 years, with an average of 4 years (see Appendix C). Various strengths, weaknesses, opportunities, and threats were suggested by the participants. Given the fairly large number of items suggested by the participants for each of these four categories, the five most-often-mentioned items in each category are briefly presented in the text. The full set of items is summarized in Box 4.1 in the form of a SWOT matrix. The responses in each category are presented in decreasing order of frequency.

Box 4.1. Summary of stakeholders' responses on strengths, weaknesses, opportunities and threats (SWOT) of the decentralization and health resources transfer in Burkina Faso.

Strengths	Weaknesses
1. Improvement of local governance (8/17)	1. Limited financial resources allocated to local governments (10/17)
2. Political will of Central government (6/17)	2. Weak capacities of the different stakeholders (9/17)
3. Improvement of communities' participation (5/17)	3. Weak capacities of some local governments for the management of resources transferred (7/17)
4. Enhanced local partnership for resources mobilization (4/17)	4. Resistance from Central government (5/17)
5. Effective establishment of democracy (2/17)	5. Misunderstanding of decentralization by the different stakeholders (3/17)
6. Gradually strengthening of local governments' capacities (1/17)	6. Discrepancy between the territorial division of local governments and health sector (3/17)
7. Strengthening of collaboration with decentralized department's servants (1/17)	7. Weak coordination and communication between local governments and health districts (2/17)
8. Financial support from central government (1/17)	8. Partiality in resources and skills transfer by the central government (1/17)
9. Effective involvement of locally elected officials (1/17)	9. Weak ownership of decentralization process by the stakeholders (1/17)
10. Principle of free and sound administration of local affairs is accepted by communities and central government (1/17)	10. Inconsistency in financial resources transfer from Central government to local governments (1/17)
11. Willingness of local governments to ensure the management of resources and skills transferred (1/17)	11. Misconception of decentralization's laws and policies by the different stakeholders (1/17)
12. Resources availability (1/17)	12. Resources and skills transfer process was not commonly agreed by the different stakeholders (1/17)
13. Provision of staff by central government (1/17)	
14. Building of health infrastructures (1/17)	
15. Existence of local/communal development plan (1/17)	

Opportunities	Threats
1. Enhanced partnership and decentralized cooperation (5/17)	1. Misuse of financial resources (8/17)
2. International/global trends toward decentralization (4/17)	2. Risk of politicization (6/17)
3. Autonomy in local resources mobilization (3/17)	3. Weak application of decentralization laws and policies (5/17)
4. Better functionality of decentralized department/ services (2/17)	4. Social and political crisis (4/17)
5. Country political stability (2/17)	5. Resistance from Central government (3/17)
6. Increased need of transparency and democratic alternation (1/17)	6. Corruption (2/17)
7. Political will (1/17)	7. Resistance form health specialists (2/17)
8. Widespread of freedom in the population and communities Opportunity for health services improvement (1/17)	8. Institutional and political instability (1/17)
9. Good practices from other countries (1/17)	9. Lack of cooperation between some decentralized departments (1/17)
	10. Weak capacities of some local governments (1/17)
	11. Misuse of human resources (1/17)
	12. Terrorism (1/17)

4.3.1. Strengths

The strengths that were suggested by most participants are the improvement of local governance (8/17), the declared political will of the central government (6/17), the improvement of communities' participation (5/17), the local partnership for resources mobilization (4/17), and the effective establishment of democracy (2/17). On the improvement of local governance and the political will as strengths, a regional director

of health (Ki3) declared:

> *"I think that decentralization is a development policy driven by the central government. The transfer of resources to local governments depends heavily on the will to implement the decentralization policies and laws"*

One policy-maker from the Ministry of Decentralization (Ki1) expressed the growing interest of citizens, as follows:

> *"With democracy, there is awareness-raising and citizens are taking an interest in public affairs".*

A mayor (Ki9) highlighted this change, as follows:

> *"Democracy has pushed the decentralization forward, and local elected administrative bodies and councils can play a great role in the in grass-root development".*

4.3.2. Weaknesses

The top five weaknesses that impede the decentralization and health resources transfer process, according to participants, are the limited financial resources allocated to local governments (10/17), the weak capacities of the different stakeholders (9/17), the weak capacities of some local governments (7/17), the resistance from the central government (5/17), and misunderstanding about decentralization by the different stakeholders (3/17). Inadequate funding does not facilitate the management of resources transferred by the central government, including the health resources, as stated by some participants.

A mayor (Ki11) expresses his concern, as follows:

> *"Financial resources are key to sustain the management of resources transferred. We are experiencing delays in funding allocation by the central government, and available funds are often not adequate".*

To emphasize the funding issue, a health district manager (Ki6) stated:

> *"The funding allocated by the central government to support the health resources transfer to local governments is not sufficient to cover the needs of health facilities".*

Regarding local governments' capacities, one health policy-maker (Ki2) noted that:

> *"Obviously, some local governments have limited capacity to manage the resources transferred. The majority of some local governments' council members, particularly in rural area, are illiterate and do not have knowledge about health issues and challenges. This makes the collaboration between the health districts and local governments difficult".*

Some local governments recognize their limits. A member of a local government's council (Ki10) expressed this concern as follows:

> *"Our municipality does not have the required capacity to handle health issues. My background is as a school teacher and I am the focal point for education and health issues within our council. I think it would be advisable to appoint a health specialist to each local government".*

Other weaknesses were identified by the participants, among which was the misunderstanding of decentralization by the different stakeholders. Regarding this point, a decentralization decision-maker said (Ki2):

> *"We noticed that the key actors have no control over their role in the decentralization process, which resulted very often in misunderstanding, crisis, and deadlocks within local government's councils".*

One key weakness that was raised quite frequently by health service providers is the discrepancy between the territorial division of local governments and health sector. Both mayors and health district managers recognized that this creates difficulties for the management of health resources transferred. This lack of harmonization remains one of the biggest concerns. One head of a health center (Ki16) illustrated this point as follows:

> *"Before the resource transfer, we had easy access to the health district office, which was very close to the health center. Now, our health center is under the responsibility of the local government, the offices of which are located very far from the health center. Seeking, for instance, an authorization for an annual leave requires long travel time".*

4.3.3. Opportunities

Participants identified a few opportunities that the decentralization and health resources transfer could create. The opportunities most often identified by the participants are the further enhancement of partnership and decentralized cooperation (5/17), the enabling international environment (4/17), the autonomy in local resources mobilization (3/17), the better functionality of decentralized services (2/17), and the country's political stability (2/17).

On the matter of resource mobilization, a president of a regional council (Ki13) said:

> *"Decentralization allows local governments to collect taxes for generating local revenues to finance their development, given the limited resources and subsidies provided by the central government"*.

A mayor (Ki12) suggested that the current environment enhances partnership and cooperation and noted that:

> *"Decentralization gives an opportunity to establish twinning with other cities at a national and international level"*.

4.3.4. Threats

The top five threats mentioned by participants are the misuse of financial resources (8/17), the risk of politicization (6/17), the weak implementation of decentralization laws and policies (5/17), the social and political crisis (4/17), and the resistance from the central government (3/17). The misuse of funds and the politicization of decentralization are seen to result in political instability and crisis.

One decision-maker from the Ministry of Decentralization (Ki1) put it in this way:

> *"Politicization and corruption with misuse of resources cause frequent crisis, leading to council's dissolution and a renewal of institutions and management team that need to be trained and updated on the management of resources transferred"*.

On the threats related to the decentralization laws and policies, a country partner (Ki14) said:

> *"Most of the crisis that we are observing within local governments' councils are mainly due to a weak implementation of decentralization laws/*

policies, including their inconsistent follow up and misunderstanding among key stakeholders".

About the resistance from the central government, a policy-maker from the Ministry of Decentralization (Ki1) expressed the following opinion:

"There are some key actors from the central government who strongly think that the local governments are unable to manage the resources transferred. This lack of trust could explain the retention of resources at a central level, as well the recurrent delays observed in the implementation of decentralization laws and policies".

On this point, a mayor (Ki11) expressed his disappointment as follows:

"We have the feeling that there is a permanent battle between the local governments and central government. We think it is the same country, and local governments should not be considered as separated entities or institutions".

The resistance among health specialists takes the form of a lack of trust, as expressed by a health district manager (Ki8):

"Health is a very sensitive and specific issue which has to be managed only by health specialists. I do not believe at all in local government capacities and readiness to handle health issues. The future will tell".

4.3.5. Analysis of responses according to participants' affiliation

The disaggregation of the responses according to the participants' affiliation is presented in Table 4.1. The table shows that while there are similar results across the decision-makers in our study, there are also some differences. Specifically, the comparison of the results across the decision-makers groups indicated that the responses seem to be converging to a certain extent. Health services providers and local governments have identified as strengths the improvement of local governance and political will. The weaknesses proposed are related to the limited financial resources allocated to local governments and the weak capacities of some local governments for the management of resources transferred. The opportunity cited is the enhanced partnership and decentralized cooperation, while the threats are related to the risk of politicization and the misuse of financial resources. In addition to the improvement of local governance as a strength, the donors suggested the effective establishment of democracy. The good practices on decentralization from other countries were

identified as opportunities that Burkina Faso could take advantage of, and finally, the political and social crisis was seen as a threat to decentralization and resource transfer.

Further analysis was done on the basis of mayors' political affiliation, which is publicly known. Although the "mayor" group was rather small (two from the opposition and two from the governing party), we did a preliminary analysis to uncover whether their political affiliation could be related to their responses. The findings are presented in Table 4.2. This part of the analysis could only be performed for mayors because the political affiliation of the other participants was unclear since it was not asked for during the study. The comparison of the results in Table 4.3 across the mayors' groups shows that mayors with different affiliations have quite similar opinions on the SWOT aspects related to decentralization and health resources transfer. With regard to the strengths, the improvement of local governance was suggested by both groups, while the weaknesses identified by both groups are the limited financial capacities and weak capacities of some local governments. The opportunities suggested were related to the enhanced partnership and decentralized cooperation, and the threats have to do with the weak implementation of decentralization laws and the misuse of resources. Mayors from the governing emphasized the strengths to the decentralization, while the opposition party often indicated the risk of politicization. Overall, the participants highlighted the highly political nature of the healthcare decentralization.

Table 4.1. Strengths, weaknesses, opportunities and threats (SWOT) of decentralization and health resources transfer in Burkina Faso according to the decision-makers' affiliation.

Participants	Strengths	Weaknesses	Opportunities	Threats
Health services providers	• Political will of Central government • Improvement of local governance • Enhanced local partnership for resources mobilization • Gradually strengthening of local governments' capacities • Improvement of communities' participation • Financial support from central government • Willingness of local governments to ensure the full management of resources and skills transferred	• Weak capacities of some local governments for the management of resources and skills transferred • Limited financial resources allocated to local governments • Discrepancy between the territorial division of local governments and health map • Misunderstanding of decentralization by the different stakeholders • Weak coordination and communication between local governments and health districts • Risk of politicization	• International/global trends toward decentralization • Political will • Enhanced partnership and decentralized cooperation • Increased need of transparency and democratic alternation • Country political stability	• Risk of politicization • Misuse of resources • Social and political crisis • Weak capacities of some local governments for the management of resources transferred • Resistance from health specialists • Terrorism
Local governments	• Improvement of local governance • Political will of central government • Effective involvement of locally elected officials • Strengthening of collaboration with decentralized department's servants • Building of health infrastructure • The provision of staff by central government • Existence of local/communal development plan	• Limited financial resources allocated to local governments • Weak capacities of different stakeholders • Weak capacities of some local governments for the management of resources and skills transferred • Lack of agreement among stakeholders about the resources and skills transfer process • Partiality in resources and skill transfer by the central government	• Enhanced partnership and decentralized cooperation • Enhanced local partnership for resources mobilization • Opportunity for health services improvement • Resources availability	• Weak implementation of decentralization laws and policies • Misuse of financial resources • Lack of cooperation between some decentralized departments • Misuse of human resources • Risk of politicization
Donors	• Improvement of local governance • Effective establishment of democracy	• Weak ownership of decentralization process by the stakeholders • High politicization of the resources transfer process	• Enhanced partnership and decentralized cooperation • Good practices from other countries	• Political and social crisis

Table 4.2. Strengths, weaknesses, opportunities and threats (SWOT) to decentralization and health resources transfer in Burkina Faso according to the political affiliations of Mayors

Political affiliation of mayors	Strengths	Weaknesses	Opportunities	Threats
Governing party	• Improvement of local governance • Existence of local/communal development plan • Effective involvement of locally elected officials • Building of health infrastructure • Appointment of staff by central government • Strengthening of collaboration with decentralized department's servants	• Weak capacities of some local governments for the management of resources and skills transferred • The resources and skills transfer process were not commonly agreed by the different stakeholders • Limited financial resources allocated to local governments	• Enhanced partnership and decentralized cooperation • Resources availability	• Misuse of resources • Weak implementation of decentralization laws and policies • Lack of cooperation between some decentralized departments
Opposition party	• Improvement of local governance • Political will of Central government	• Limited financial resources allocated to local governments • Weak capacities of some local governments for the management of resources and skills transferred • Partiality in resources and skill transfer by the central government	• Enhanced partnership and decentralized cooperation • Opportunity for health services improvement	• Weak implementation of decentralization laws and policies • Misuse of financial resources • Misuse of human resources • Risk of politicization

4.3.6. Ways to address the weaknesses and threats

The participants were also asked to suggest ways to address the weaknesses and threats in order to improve the decentralization and resources transfer. The main results are presented in Table 4.3.

Table 4.3. Suggestions to mitigate the weaknesses and threats to decentralization and health resources transfer in Burkina Faso

Affiliation of participants	Ways to improve decentralization and health resources transfer
Health services providers	• Strengthen the capacities of different stakeholders (training, appointment of skilled personnel) • Ensure an effective enforcement of laws and policies related to health resources transfer • Allocate an adequate financing to primary healthcare facilities • Review the current organization of the health system and appoint health specialist at local government's level • Establish a tecąical coordination mechanism between the health districts and local governments with focus on awareness raising • Set up a program or a budget at district level to support the local government • Conduct a regular annual review on health resources transfer
Local governments	• Ensure an effective enforcement of laws and policies related to decentralization • Increase awareness of the different stakeholders including the political leaders • Train the different stakeholders involved • Strengthen the capacities of local governments by appointing qualified personnel • Allocate an adequate funding • Appoint health specialists at local government level • Ensure the timeliness in health resources transfer • Develop open collaboration between health districts and local governments • Review the current laws and policies to enhance the stability of local governments' board (avoid recurring crisis)
Donors	• Ensure an effective enforcement of laws and policies related to decentralization • Strengthen the capacities of local governments by appointing qualified personnel • Conduct a review of the process of all the resources transfer (education, health, etc.) from the central government to local governments

The results in Table 4.3 show that there are four main areas that would require focus according to the participants: (i) enforcement of decentralization laws and policies, (ii) capacity building with adequate staffing, (iii) adequate funding, and (iv) review of the resources transfer process.

Regarding the decentralization laws and policies, a regional director of health (Ki5) stated:

> *The majority of issues that we experienced resulted from a partial or a lack of proper implementation of the texts governing the health resources*

> *transfer. The different laws adopted have to be properly implemented and monitored.*

Along the same lines, a country partner (Ki15) stated:

> *A proper implementation of laws and policies related to resources transfer, including a consistent follow up, will help to undermine the bottlenecks encountered.*

Other key suggestions made by participants to improve the health resources transfer include the reorganization of the health system through better collaboration between the health districts and local governments. With regard to health system organization, a regional health director (Ki4) noted:

> *The current situation is a little ambiguous and makes the collaboration between health districts and local governments difficult. I think a review and a reorganization of the district health system towards a local government focused will improve the delivery of health services*.

This suggestion seems to be in agreement with the point of view of some local governments claiming an acceleration in the transfer of health resources. On this point, a mayor (Ki9) said:

> *The health resources are not entirely transferred yet to local governments. For instance, the management of human resources remains under the control of the health district. There is a need to ensure a full transfer of health resources to local governments as stated in the decree issued by the central government.*

4.4. DISCUSSION

The aim of the study was to identify the SWOT related to decentralization and health resources transfer in Burkina Faso. The overall results of the study suggest that the participants are fairly knowledgeable of factors that can boost the health resources and skills transfer process, as well as those that could impede this process.

One of the key observations is the difference in participants' understanding of the concepts of strength, weakness, opportunity, and threat. Some strengths are considered as opportunities and vice versa; some weaknesses are seen as threats and vice versa. This difference could be due to participants' misunderstanding of the explanation

given by the data collectors on the concept of strength, weakness, opportunity, and threats. However, it could also be a result of the perspective of the respondent. Strengths and weaknesses relate to factors internal to the health resources transfer, while opportunities and threats relate to the external environment (health sector). Strengths and weaknesses may become opportunities and threats, respectively, when viewed externally.

Other studies have also indicated this aspect of the SWOT analysis (Prakash & Ruhela, 2014). The main strengths that may enhance decentralization and health resources transfer, from the participants' point of view, are the political will and the strengthening of local governance. It is widely admitted that political will and support are key to the successful implementation of a national policy. According to Rondinelli (1982), the political commitment to decentralization is the sine-qua-non of strategy implementation. A systematic review on municipal health services provision by local governments in Sub-Saharan African countries (see Chapter 2) noted the highly political nature of the health resources allocation and skills transfer, characterized by continuous state intervention and political interference. In fact, decision making of financial resource allocation, resources transfer and the management of human resources remain under the control of the central or regional government.

With regard to the weaknesses, the participants pointed out the limited financial resources granted to local governments and the weak capacities of some local governments to manage general resources transferred and, particularly, health resources. These two main weaknesses raised by the participants have been identified in many studies on decentralization in Sub-Saharan African countries (Bekale, 2011; Bossert & Bauvais, 2002; Muriisa, 2008; Sidibé, 2011; Soura & Coulibaly, 2014). These issues were also discussed in a report issued by the Minister of Decentralization of Burkina Faso (Ministère de la Décentralisation, 2014). Financial resources are key to support and sustain the management of resources transferred, as suggested by the participants. A policy review of the decentralization in Burkina Faso (Champagne & Ouedraogo, 2008) suggested that local governments' budgets are extremely limited. For this reason, some decentralization actors in our study state that the central government does not give enough financial resources to local governments. Furthermore, when sufficient financial resources are given, some local governments are unable to spend them because of insufficient financial management capacities and the late disbursement of grants and subsidies by the central government (Ministère de la Décentralisation, 2014). Likewise, local governments have to possess sufficient capacities to properly manage these resources. On this point, the summary of a multicenter study conducted in West Africa on decentralization and resources transfer (ERNWCA, 2011) indicated that the main bottlenecks are the retention of financial resources and human resources at the central level and insufficient training of local

stakeholders. Therefore, local governments do not have the required competencies and experiences to plan, implement, and evaluate development actions or initiatives at the local level. This tends to confirm the point of view of a mayor in our study about the permanent battle between the central government and local governments over the transfer of financial resources. This could be due to the opinions of some decision-makers at the national level, who strongly believe that the local governments do not have the required capacities, and therefore, the resources should be transferred progressively. This situation might be considered as a vicious circle, as "a snake biting its own tail." However, competence cannot be carried out without the required capacities, as confirmed by a study conducted on decentralization and healthcare prioritization process in Tanzania (Maluka et al., 2011). This study suggested that the decentralization process needs to build greater tecąical and management capacity of the oversight institutions.

The main opportunities that were highlighted by the participants are the international/global trends towards decentralization, the increased need of transparency and democracy demanded by the citizens, and the autonomy in local resource mobilization. One key element that made an international context favorable to a country-wide policy is the support by donors and partners' support. The decentralization reforms in Sub-Saharan Africa were largely supported by international institutions, such as the World Bank. In 1998, nearly 30% of the World Bank Projects implemented in the Africa region had a decentralization component (Litvack et al., 1998). As suggested by participants, decentralization could take great advantage of this enabling environment. Regarding transparency and citizens' participation, decentralization provides an opportunity for the grassroots community to be involved in the planning process (Frumence et al., 2013) as well as in the management of resources that were transferred to local governments such as primary healthcare facilities, primary schools, water, and sanitation (Guiro et al., 2011). Also, decentralization plays a great role in resource mobilization, given that one of its outcomes is the increased ownership of citizens for their contribution to local resources mobilization to meet their needs and ensure a sustainable development (Guiro et al., 2011). However, it is observed that apart from the urban local governments, the vast majority of local governments are underfunded (Champagne & Ouedraogo, 2008) and they rely solely on central government grants and subsidies. This might explain why the debate on resources transfer was focused on financial resources.

With regard to threats, the main issues identified by the participants are the risk of politicization and the misuse of financial resources. Given the political nature of decentralization, the risk of politicization and misuse of funds is very likely if adequate control measures and mechanisms are not properly implemented. Various studies on decentralization found that political interference and political harassment of

civilian servants are the factors militating against effective decentralization (Bekale, 2011; Anokbonggo et al., 2004; Sakyi et al., 2001). Regarding financial resources, the findings of previous studies mainly indicate the lack of transparency in the allocation of resources, record-keeping, and auditing (Muriisa, 2008) and lack of accountability of local governments (Khemani, 2006) in the management of resources provided. In Burkina Faso, the risk of misuse and mismanagement of funds by local governments is recognized (Delavallade, 2007) and it is due to the early stage of the communalization process. This situation can be also explained by the weak enforcement of check-and-control mechanisms and the illiteracy rate of the local government councils' members, which can reach up to 90% in some local governments (Champagne & Ouedraogo, 2008). One important weakness or threat to decentralization, according to the view of the participants, is the resistance of the central government and health specialists. A decentralization policy review in Burkina Faso (Champagne & Ouedraogo, 2008) suggested that social change creates resistance, particularly among the State's officials. Often, the lack of understanding of decentralization's policies and laws is stated in order to justify the officials' refusal to collaborate with the decentralized bodies and councils (Champagne & Ouedraogo, 2008). Such hostilities are related to a more general fear for reducing their power mainly over financial control and, therefore, their influence on people.

Finally, the participants suggested some recommendations to improve decentralization and health resources transfer. These suggestions were proposed to address the weaknesses and threats, as well as to reinforce the strengths and opportunities. These included effective enforcement of decentralization laws and policies, strengthening of local governments' capacities, adequate funding and review, and evaluation of the resources transfer process. Some of these recommendations were also provided by studies already conducted on decentralization and resources transfer (Ministère de la Décentralisation, 2014; Cobos et al., 2016; Nassirou et al., 2004) and this raises the question of why the appropriate means to achieve the purpose of decentralization and resources transfer are not implemented. An attempt to answering this question was suggested in a review on preconditions for successful implementation of decentralization in developing countries (Olum, 2010). This study argued that among the preconditions in implementing decentralization, there are two key factors. The first is the nature of the special implementation machinery that is put in place. Any agency that is meant to implement decentralization should have the authority, resources, and motivation. The World Bank suggests that the design of transfer is of critical importance to the success of decentralization (Litvack et al., 1998). When local governments are expected to play a major role in delivering social services, the design of intergovernmental transfers is particularly important because the central government usually retains a strong interest in at least some of the outcomes.

The second factor is the degree of acceptability or opposition it will generate at both the central and local levels. Our study mainly identified factors that impede the decentralization process. These are the weaknesses and threats to the healthcare decentralization highlighted by the participants to this study. However, there are also other barriers to an effective healthcare decentralization suggested in the literature. Using the Walt and Gilson (1994) policy analysis framework, three additional factors, relevant for Burkina Faso, could be found in the literature in addition to the issues raised in the study. The first factor is related to policy content. As explained in Section 1, the healthcare decentralization policy in Burkina Faso is still not finalized, given the frequent political changes. This makes the decentralization implementation inconsistent and blurred for the different stakeholders (Ministère de la Décentralisation, 2014). This also creates uncertainty about the next implementation phase. The second factor is related to the context within which the policy is formulated and executed. The resources transfer to local governments is part of the general decentralization policy, which has undergone several changes and reforms following the shifts of country leaders. This creates the impression that decentralization is just a slogan that can be interpreted more as a desire to seat the government's power on popular support than as a true intent to share political power with the local levels of government (Daflon & Madies, 2008). As a result, the stakeholders' support might be weakened. The third factor refers to the actors involved in policy-making. It is known that policy-making, particularly in the field of decentralization, is still reserved for political elites who profit most of the expansion of their control through developing new local institutions or restructuring existing ones (Smoke, 2003). Thus, a lack of knowledge on decentralization among other stakeholders might be a reason for them to avoid participation in the decentralization process.

This is a qualitative study that aims to give an insight into the decentralization and health resources transfer to local governments in Burkina Faso. The sample was limited to 17 participants from 25 targeted institutions, which may not be representative of all institutions involved in the healthcare decentralization. Although representativeness is not an aspect of a qualitative study, like this one, we need to mention that our findings should only be seen as an indication of the impacts of decentralization and health resources transfer, rather than a representative picture for the entire country. This is especially true for the case of donors since the saturation in this group could not be confirmed. Also, the additional analysis for mayors' political affiliation has no representative character. In addition, for our analysis, we applied the SWOT framework, which helped us to investigate the healthcare decentralization in Burkina Faso from different perspectives. The SWOT framework, however, limits the possibility to study the stakeholders' involvement and their interactions, which necessitates a subsequent study to better understand the decentralization process in Burkina Faso.

4.6. CONCLUSIONS

Based on the results presented in this chapter and their discussion, it can be concluded that the different decision-makers, regardless of their professional affiliation and political affiliation (for mayors), appear to have good knowledge of the decentralization process and are aware of the facilitating factors, as well the bottlenecks to health resources transfer. Although progress has been made in the health resources transfer initiated in 2009, the key decision-makers have identified weaknesses and threats that are impeding the process. These weaknesses and threats have been identified in previous studies in Burkina Faso as well as in some Sub-Saharan countries, as discussed above. To address these weaknesses and threats, it is necessary to ensure the enforcement of decentralization's policies and laws, and the strengthening of local government capacities, as well as their adequate funding and the regular review of the resources transfer process. Furthermore, empirical studies on this topic are needed to provide evidence on the evaluation of the current decentralization phase, and the effective implementation of the subsequent phases.

CHAPTER 5

Regional health disparities in Burkina Faso during the period of healthcare decentralization. Results of a macro-level analysis

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ABSTRACT

Background

Burkina Faso has undertaken decentralization reforms in the health sector to improve the performance of the health system.

Objectives

The objective of this chapter is to analyze the differences in health outcomes by health district's demographic and economic status, and the distribution of health resources during the period of healthcare decentralization.

Methods

A bivariate correlation analysis was conducted using data at the health districts and regions level. Data from the health management information system (HMIS) and national households' surveys were used.

Results

The results indicate a strong correlation between the district's population size and the availability of health resources ($p \leq .05$). The health visits per capita and skilled birth attendance are correlated with the economic status of the health district ($p \leq .05$). Malnutrition among under-five and maternal mortality was associated with the availability of health personnel and health infrastructures ($p \leq .05$). No correlation was found between financial resources and health outcomes. The results indicated disparities in health among the health districts in Burkina Faso.

Conclusion

The ways to address this inequality include more transparent resource allocation, as well as policies to address the socio-economic disparities and financial barriers to health services. Further research is needed to collect relevant data and investigate the effects of decentralization, which was not possible in our study.

5.1. INTRODUCTION

Health inequalities are a major source of social inequity. Several studies and reports have looked at inequality in healthcare in Africa (Makinen et al., 2000; Gwatkin, 2000; Su et al., 2006; Shankar & Kumar, 2009; WHO, 2010; Ataguba et al., 2011; Okolo et al., 2011; Bado et al., 2015; Heaton et al., 2016; Pillay & Bradshaw, 2017; Mwase et al., 2018). Attempts to address health inequalities include initiatives toward universal health coverage. In many developing countries, the aim to establish universal health coverage has led to the revitalization of the public sector and promotion of the private sector through health sector reforms, with the main corollary being the decentralization of healthcare provision and financing.

Regarding healthcare decentralization, it aims to bridge the gap between providers and users in order to increase health coverage and to achieve better health outcomes through a more equitable distribution of resources and an efficiency in health services provision (Rondinelli et al., 1983; Litvack et al., 1998; Saltman et al., 2007). However, the rationale for healthcare decentralization varies across countries. A systematic review of the evidence on the impacts of decentralization on health-related equity found that the main objective for this policy is the improvement of the overall health system performance (Sumah et al., 2016). This objective is based upon three key expectations. The first expectation is that decentralization provides the opportunity for health systems to attain both tecąical and allocative efficiency, empower local governments, increase accountability, and make gains in areas like quality, cost, and equity. The second expectation is imperative to make health services responsive to local population needs and to improve access and quality of healthcare. The third expectation is to minimize government expenditure, reduce the role of the state in the provision of healthcare and to introduce competition and cost-consciousness in the public sector.

In 1992, Burkina Faso undertook a reform of its health system, which has led to the decentralization of healthcare (Haddad et al., 2006). As presented in Chapter 1, this reform resulted in the establishment of health regions, divided into health districts that are the operational level for implementation of the national health policy. The district health services are organized into two levels, the first of which comprises the primary healthcare centers that provide communities with basic preventive and curative primary healthcare. The second level consists of district hospitals that represent the point of referral for primary healthcare centers. District hospitals are managed by a district health management team and are led by a medical officer. The health district funding is largely obtained from the central government. As part of the decentralization process, a decision was taken in 2009 by the central government to transfer the health resources and skills to local governments. These local administrative entities (called

communes) are run by elected mayors that are autonomous in the management and financing of health resources without any formal hierarchical relation with the health districts. This transfer first involved primary healthcare centers. An institutional agreement was made to define the roles and responsibilities of each party (central government, local governments, health districts, and primary healthcare centers). As a result of this agreement, the local governments' roles now include the management of healthcare centers, procurement and supply of drugs and medical commodities, disease prevention, and sanitation. The central government only plays a regulatory role, which includes defining the national health policy and orientation, setting norms and standards for the health infrastructure, equipment, health services functioning, and management. It also oversees health facilities and allocates financial resources through grants and subsidies to local governments (Ministère de la Décentralisation, 2014). It is expected that these reforms will help to improve the overall health system performance in terms of better availability and equitable distribution of resources, increased access to good quality health services, as well as better health outcomes across health regions and health districts. It should be noted that these expectations are not solely decentralization-led as some studies questioned whether decentralization leads to improvement in overall health system performance. A number of these studies report that the outcomes and benefits of decentralization are mixed, the effects of decentralization on healthcare are negative or ambiguous, and inequity is a major concern (Sumah et al., 2016).

The aim of this chapter is to analyze the regional health disparities in Burkina Faso in terms of health districts' demographics, economic status, and distribution of health resources during the period of healthcare decentralization. The effects of decentralization are, however, out of the scope of our study due to the lack of suitable data. We, therefore, limit our investigation to the analysis of correlations between key regional indicators over time.

We apply quantitative analytical methods based on health districts and region level data in order to explore associations between districts' demographics and economic profile, health resources, health outcomes, and health status. The analysis is of interest for policymakers in Burkina Faso who attempt to examine the above expectations. The study helps to gauge whether the healthcare decentralization in Burkina Faso is on a good track to achieve the equality objective and also to provide evidence to the debate surrounding the ultimate aim of healthcare decentralization, namely, the improvement of service quality and coverage. The analysis is also of interest to other Sub-Saharan African countries that go through a decentralization process to revitalize the public sector while promoting the development of the private sector.

5.2. MATERIALS AND METHODS

To assess the relationship between health districts' demographic and economic status, and health outcomes, we created our own database using district and region level data in Burkina Faso. The data sources are the health management information systems and national households' surveys. These two sources provided the main representative, standardized and updated quantitative data on household's health, demographic and economic status in Burkina Faso. The data sources are described below and also in Appendix D.

- Health Management Information System (HMIS) reports

The HMIS reports are published yearly by the Ministry of Health to release key information and data on the health system functioning and services organization, the health services resources available and the distribution, access, utilization and coverage of healthcare, as well as health outcomes and health status. These reports are used to evaluate health system performances and health planning. In this study, HMIS reports were reviewed to gather the secondary data by health districts, namely demographic, health sources, health use, and outcomes data.

- National Household Survey reports

Two reports published by the National Statistics and Demographic Institute were used to gather secondary data on the economic profile of the 13 administrative regions, which also correspond to the territorial breakdown of the 13 health regions covering the 63 health districts. These surveys are representative of the country and they involve large samples of households.

– *The 2010 Demographic and Health Survey (DHS) report.* This survey included 15 000 households and data were collected using a quantitative method. A structured questionnaire was developed to collect data on household members' characteristics, education level, health services availability and access, use of iodized salt, household's welfare indicators.
– *The 2014 Households Living Conditions Survey report.* The sample size of this survey was 10 411 households and data were collected using a quantitative survey method. A structured questionnaire was developed to collect data on household members' characteristics, education level, health, occupation, income, and housing.

The data collection points from all sources were 2010 and 2014 to allow for the changes in the socio-economic status, health services access, and health outcomes in health districts during the decentralization period, which started in 2009. The number

of health districts was 63 during the period covered in the study. Another rationale for selecting the years 2010 and 2014 was the availability of data on economic characteristics collected through the national household surveys during the same periods.

The following main macro indicators were extracted from the sources described above and were used in the study:

- *Demography:* health district population estimated by the National Statistics and Demographic Institute
- *Availability of health resources:*
    - Health personnel per capita: health personnel refers to the sum of the different categories of health personnel used in the HMIS report. These are physicians, pharmacists, midwives, nurses, and skilled birth attendants from the public sector. This ratio was expressed to 10 000 capita;
    - Health infrastructure per capita: health infrastructure refers to district hospitals and primary healthcare centers. This ratio was expressed to 10 000 capita;
- *Financial resources:* these include funds allocated, funds spent, and the difference between these two;
- *Healthcare use and outcomes:* the number of visits to health facilities per capita per year, the percentage of skilled birth attendance, the percentage of malnutrition among under 5, and the maternal mortality ratio.
- *Poverty index and GNI coefficient:* Given that the poverty index and the GNI coefficient were not disaggregated to the district level, the profile of each region applied to all the districts in the respective region.

These indicators were selected because they are suitable for assessing health disparities/inequities. Previous studies have discussed the relevance of these indicators in measuring the geographical difference in health resources, health expenditures, utilization of health services, and health outcomes (Olakunle & David, 2015; Dlouhy, 2018; Hosseinpoor et al., 2018). Specifically, these indicators provide insight into various dimensions of health inequalities. These were also the only data available in Burkina Faso for a comparison across the regions. Data on 1 512 observations were compiled using Excel spreadsheets and analyzed with statistical package SPSS version 25 to assess the correlation between the following variables:

- *Demographic and economic characteristics:* These characteristics refer to the size of the population, the poverty index, and the GNI coefficient.
- *Availability of resources:* The resources refer to the health personnel and health infrastructures.
- *Health outcomes:* The health outcomes refer to the visits to health facilities for

care-seeking, coverage of selected health services, morbidity, and mortality among vulnerable groups (malnutrition among under-five and maternal mortality ratio).

Specifically, we carried out a bivariate correlation analysis to determine, on the one hand, the extent to which health districts' demographic and economic characteristics are associated with the availability of resources, as well as with health outcomes, and, on the other hand, to determine the association between the availability of resources and health outcomes. The Pearson Test was applied and the correlation between the variables investigated was found to be significant when p-value was smaller than .05 (95% CI).

5.3. RESULTS

Table 5.1 presents the general demographic and economic characteristics in the 63 health districts in the 13 health regions of Burkina Faso. The demographic data from Table 5.1 indicate a variation in population size across the regions. The regions with the most inhabitants are the Centre, Centre Nord, Centre Ouest, Est, Haut Bassins, and Nord regions. The Centre region, which hosts the capital of the country, remains the most populated region. We assumed that the region's economic characteristics (poverty index and GINI coefficient) pertain to all health districts within the region. Therefore, there is no variation in these characteristics within a region (SD = 0). Across the regions, the poverty index varied considerably. In 2010, the five regions with the highest poverty index were the Sahel (49.80%), Sud Ouest (44.00%), Est (42.14%), Centre Nord (22.10%), and Centre Ouest (19.60%). Compared to 2010, poverty was cut nearly in half in 2014 and the five regions with the highest poverty index were the Nord (25.20%), Boucle du Mouhoun (20.40%), Centre Est (13.90%), Est (12.60%), and Plateau Central (12.60%). The only region that remained in the five poorest regions in 2010 as well as in 2014 was the Est region. This region has also been known as the poorest region of the country where the less well-off province is located (Zida & Kambou, 2014). With regard to the GINI coefficient, in 2010, it ranged from 8.80% (Boucle du Mouhoun region) to 21.40% (Hauts Bassins region), and in 2014, from 23.80% (Nord region) to 37.70% (Centre region). Thus, compared to 2010, the inequality in income indicated by the GINI coefficient was considerably higher in 2014, and it literally doubled and even tripled in some regions (Boucle Mouhoun). The two regions with the highest income inequality were the Centre and the Hauts Bassins which include the two major cities of the country.

Table 5.2 shows some data on the availability of health resources (financial resources, human resources, and health infrastructures).

Table 5.1. Demographic and economic characteristics of health regions/districts of Burkina Faso, 2010 and 2014 (n=63)

Health Regions/ Number of Health Districts		2010			2014		
		Population[a]	Poverty index (%)[b]	GINI coefficient (%)[b]	Population[a]	Poverty Index (%)[b]	GINI Coefficient (%)[b]
Boucle du Mouhoun (N districts = 6)							
	Mean	264 458	12.70	8.80	295 316	20.40	25.40
	(SD)	55 798	0.00	0.00	63 948	0.00	0.00
	Median	268 854	12.70	8.80	299 650	20.40	25.40
Cascades (N districts = 3)							
	Mean	219 082	6.70	14.70	237 686	3.20	30.10
	(SD)	63 059	0.00	0.00	100 825	0.00	0.00
	Median	182 675	6.70	14.70	205 740	3.20	30.10
Centre (N districts = 5)							
	Mean	480 583	2.10	17.70	485 944	1.90	37.70
	(SD)	225 293	0.00	0.00	264 298	0.00	0.00
	Median	615 480	2.10	17.70	310 812	1.90	37.70
Centre Est (N district = 7)							
	Mean	180 397	14.20	14.70	203 903	13.90	31.70
	(SD)	59 254	0.00	0.00	67 821	0.00	0.00
	Median	176 246	14.20	14.70	199 773	13.90	31.70
Centre Nord (N district = 4)							
	Mean	333 715	22.10	12.70	375 749	11.80	27.90
	(SD)	139 689	0.00	0.00	158 846	0.00	0.00
	Median	335 666	22.10	12.70	378 222	11.80	27.90
Centre Ouest (N district = 5)							
	Mean	262 129	19.60	16.90	293 793	11.70	26.30
	(SD)	106 335	0.00	0.00	116 475	0.00	0.00
	Median	233 315	19.60	16.90	264 473	11.70	26.30
Sud Ouest (N district = 4)							
	Mean	175 840	18.40	13.70	195 858	10.50	27.60
	(SD)	73 582	0.00	0.00	82 982	0.00	0.00
	Median	170 196	18.40	13.70	189 279	10.50	27.60
Est (N district = 6)							
	Mean	228 206	42.14	11.00	260 691	12.60	25.10
	(SD)	133 578	0.00	0.00	151 082	0.00	0.00
	Median	227 860	42.14	11.00	257 411	12.60	25.10

Table 5.1. Continued

Health Regions/ Number of Health Districts		2010			2014		
		Population[a]	Poverty index (%)[b]	GINI coefficient (%)[b]	Population[a]	Poverty Index (%)[b]	GINI Coefficient (%)[b]
Hauts Bassins (N district = 7)							
	Mean	237 273	9.40	21.40	236 143	7.00	34.50
	(SD)	136 008	0.00	0.00	111 953	0.00	0.00
	Median	258 084	9.40	21.40	252 250	7.00	34.50
Nord (N district = 5)							
	Mean	261 324	17.60	15.20	324 592	25.20	23.80
	(SD)	122 701	0.00	0.00	130 285	0.00	0.00
	Median	185 199	17.60	15.20	370 272	25.20	23.80
Plateau Central (N district = 3)							
	Mean	254 858	13.80	12.40	284 179	12.60	24.30
	(SD)	100 846	0.00	0.00	113 579	0.00	0.00
	Median	261 892	13.80	12.40	291 759	12.60	24.30
Sahel (N district = 4)							
	Mean	271 563	49.80	9.70	308 390	4.00	24.20
	(SD)	92 117	0.00	0.00	104 186	0.00	0.00
	Median	258 296	49.80	9.70	293 106	4.00	24.20
Sud Ouest (N district = 4)							
	Mean	171 957	44.00	17.50	193 243	10.00	33.70
	(SD)	94 254	0.00	0.00	105 618	0.00	0.00
	Median	161 715	44.00	17.50	180 728	10.00	33.70

Sources of data: [a]Health Management Information System (HMIS) reports. [b] National Surveys on Households Leaving Conditions and Poverty

Data on financial resources in Table 5.2 indicated some variations in financial resources allocated and financial resources spent, and particularly in the difference between these two amounts. There was an increase in health financial resources allocated to health districts between 2010 and 2014. In 2010, the mean of resources allocated ranged from $570 286 (Centre Est region) to $1 005 200 (Centre region) against $820 627 (Centre Sud region) to $1 295 463 (Centre region) in 2014. For resources spent, the means ranged from $537 143 (Centre Est region) to $970 400 (Centre region) in 2010 and from $751 928 (Centre Sud region) to $1 254 791 (Centre region) in 2014. The Centre Est and the Centre Sud regions, which received the least amount in 2010 and 2014, respectively, had the lowest expenditures. However, the Centre region with the highest amount allocated in 2010 and 2014, registered the highest expenditures in the same period. With regard to differences in resources allocated and resources spent, the region with the lowest difference in 2010 was the Boucle du Mouhoun ($29 333) and the region with the highest difference was the Centre Nord ($126 000). In 2014, the highest difference between resources allocated and spent, was the Centre Nord region ($83 014) and the lowest difference was in the Sud Ouest region ($21 469).

With regard to health personnel availability, the density of health personnel (ratio per 10 000 capita) remained far below the WHO norms set at 23 per 10 000 capita. In 2010, the mean of the health personnel ratio ranged from 4.95 in the Sahel region to 9.68 in the Sud Ouest region. In 2014, the region with the lowest health personnel ratio was still the Sahel (4.96), being one of the rearmost parts of the country, against the Centre Sud region which presented the highest health personnel ratio in 2014 (12.24).

The distribution of health infrastructure did not improve during the period. In 2010 and 2014, the Sahel region had the lowest health infrastructure ratio estimated, respectively, at 0.73 and 0.84, while the Centre region, with an infrastructure ratio of 2.02 and 2.03, ranked first in both years. Overall, as indicated above, health resources were not equally distributed across the regions. The urban regions were privileged at the expense of the rural and more remote regions, especially with regard to health personnel and health infrastructures.

Table 5.3 presents a range of selected indicators for health service utilization and health outcomes. The number of health visits per capita in 2010 was less than one across all regions, indicating potential underuse of health services. In 2010, the number of visits ranged from 0.49 in the Centre Nord region to 0.93 in the Centre region and from 0.65 in the Centre region to 1.01 in the Centre Est region in 2014. The coverage of skilled birth attendance ranged from 58.40% in the Sahel region to 86.10% in the Centre region in 2010. There was a slight increase in skilled birth attendance in 2014. The lowest coverage was recorded in the Centre Sud region (73.73%) and the highest coverage in the Nord region (93.92%).

Table 5.2. Availability of health resources in health districts in regions of Burkina Faso, 2010 and 2014 (n=63)

Health Regions/ Number Health Districts	2010					2014				
	Financial resources allocated ($)	Financial resources spent ($)	Difference ($)	Ratio health personnel/ 10.000 capita	Ratio health infrastructure/ 10.000 capita	Financial resources allocated ($)	Financial resources spent ($)	Difference ($)	Ratio health personnel/ 10.000 capita	Ratio health infrastructure/ 10.000 capita
Boucle du Mouhoun (N district = 6)										
Mean	960 667	931 333	29 333	8.70	1.33	1 290 460	1 228 933	61 527	9.26	1.33
(SD)	172 049	160 111	12 737	1.81	0.14	205 659	242 184	67 725	1.43	0.13
Median	996 000	965 000	28 667	8.00	1.00	1 287 945	1 253 265	63 792	8.74	1.33
Cascades (N district =3)										
Mean	650 667	596 667	54 000	5.66	1.32	1 079 138	1 032 410	46 728	8.62	1.35
(SD)	199 342	228 843	75 020	2.91	0.58	229 209	264 467	46 945	2.37	0.57
Median	624 000	484 000	20 000	7.17	1.59	951 286	919 656	31 630	8.01	1.48
Centre (N district = 5)										
Mean	1 005 200	970 400	34 800	9.60	2.02	1 295 463	1 254 791	40 672	10.44	2.03
(SD)	628 580	607 866	26 668	4.13	1.59	649 431	608 548	68 453	1.67	1.10
Median	626 000	582 000	30 000	10.33	1.74	937 174	932 678	4 596	10.65	1.72
Centre Est (N district = 7)										
Mean	570 286	537 143	33 143	6.21	1.14	837 974	780 180	69 726	7.57	1.21
(SD)	190 061	176 007	39 036	1.41	0.20	285 419	260 894	57 578	1.84	0.25
Median	608 000	592 000	18 000	6.01	1.12	951 622	850 860	69 902	7.69	1.14
Centre Nord (N district = 4)										
Mean	897 500	771 500	126 000	5.48	0.98	941 202	858 188	83 014	5.27	0.97
(SD)	322 260	262 177	82 024	0.96	0.19	318 715	324 147	42 693	0.76	0.21
Median	907 000	822 000	92 000	5.32	1.01	918 029	822 996	71 137	5.28	1.06
Centre Ouest (N district = 5)										
Mean	750 400	692 000	58 400	7.01	1.37	1 087 087	1 009 555	77 533	6.74	1.41
(SD)	332 149	303 397	29 846	1.80	0.33	546 669	515 895	66 767	1.38	0.38
Median	734 000	688 000	54 000	6.69	1.48	1 098 977	1 059 838	66 255	6.89	1.52
Centre Sud (N district =4)										
Mean	647 500	591 000	56 500	9.62	1.63	820 627	751 928	68 699	12.24	1.66
(SD)	83 096	82 793	43 186	3.43	0.33	223 605	218 511	18 021	6.69	0.38
Median	620 000	587 000	54 000	9.28	1.56	769 637	716 467	69 520	10.42	1.65
Est (N district = 6)										
Mean	725 333	630 333	95 000	6.15	1.01	1 004 310	937 316	66 994	6.46	0.96
(SD)	363 533	378 959	137 042	1.84	0.32	481 948	427 867	84 170	2.76	0.26
Median	630 000	428 000	41 000	5.87	0.93	1 004 669	907 163	23 736	5.77	0.90

Table 5.2. Continued

Health Regions/ Number Health Districts	2010					2014				
	Financial resources allocated ($)	Financial resources spent ($)	Difference ($)	Ratio health personnel/ 10.000 capita	Ratio health infrastructure/ 10.000 capita	Financial resources allocated ($)	Financial resources spent ($)	Difference ($)	Ratio health personnel/ 10.000 capita	Ratio health infrastructure/ 10.000 capita
Hauts Bassins (N district = 7)										
Mean	691 143	639 714	51 429	8.50	1.57	1 087 053	1 050 557	36 496	9.89	1.64
(SD)	321 490	319 742	53 587	2.26	0.57	526 779	510 333	40 384	4.86	0.90
Median	570 000	516 000	28 000	8.04	1.42	1 150 931	1 064 283	24 534	7.14	1.31
Nord (N district = 5)										
Mean	744 800	715 200	29 600	7.04	1.42	1 083 190	1 053 545	29 645	6.80	1.36
(SD)	212 441	201 413	11 781	0.81	0.21	396 777	374 538	32 220	1.27	0.35
Median	768 000	734 000	34 000	7.31	1.39	1 260 936	1 253 018	25 674	6.85	1.35
Plateau Central (N district = 3)										
Mean	832 667	792 667	40 000	8.77	1.72	1 267 649	1 227 723	39 926	10.70	1.79
(SD)	291 591	259 356	36 056	2.37	0.35	383 195	370 263	36 924	3.44	0.42
Median	954 000	884 000	50 000	8.96	1.73	1 464 523	1 430 534	25 674	12.34	1.74
Sahel (N district =4)										
Mean	696 000	650 500	45 500	4.95	0.73	1 117 672	1 099 938	32 378	4.96	0.84
(SD)	326 537	303 541	34 732	0.39	0.09	230 946	229 260	1 420	0.32	0.11
Median	653 000	594 000	41 000	4.88	0.72	1 139 195	1 112 067	32 318	5.07	0.87
Sud Ouest (N district = 4)										
Mean	616 500	574 500	42 000	9.68	1.50	885 316	826 954	21 649	10.00	1.58
(SD)	147 814	148 937	24 386	2.76	0.07	256 888	206 059	2 353	3.29	0.15
Median	610 000	555 000	41 000	10.16	1.52	778 932	739 279	21 844	10.01	1.64

Source of data: Health Management Information System (HMIS) Report

With regard to the pregnancy outcomes, the situation did not improve between 2010 and 2014 with significant variations between regions. The maternal mortality ratio ranged from 38.93 in the Sud Ouest region to 97.93 in the Boucle Mouhoun region in 2010. In 2014, the Centre Ouest region registered the lowest maternal mortality ratio (26.78) against the Sahel region, with an alarming maternal mortality ratio (151.83). The most important variation in maternal mortality ratio in 2010 was in the Centre Ouest and Nord regions and in the Centre Ouest region once again in 2014. The proportion of under-five undernourished ranged from 3.10% in the Plateau Central region to 17.18% in the Nord region in 2010. This proportion ranged from 3.64% in the Centre region to 37.02% in the Nord region in 2014. The most important variation was observed in the Sud Ouest region in 2014.

Table 5.4 presents the results of the correlation analysis of the health district's demographic and economic characteristics, and the availability of resources. The results indicate a strong correlation between the district's population size and the availability of human resources for health, as well as health infrastructures ($p<.05$). We also found that a decrease in health personnel and health infrastructures ratio per capita is correlated with an increase in the population size and the poverty index ($p<.05$). A moderate correlation was found between the GINI coefficient and the health personnel, and health infrastructures ratio per capita ($P<.10$).

Table 5.5 shows the results of correlation between the health district's demographic and economic characteristics and health outcomes. The key health outcomes were correlated ($p<.05$) with the economic status of health districts. The poverty index increases, the number of health services visits per capita, and the percentage of skilled birth attendance decline, while the malnutrition among under-five recorded an increase. No correlation was found between the population size and health outcomes.

Table 5.6 provides the results of the correlation analysis of health resources and health outcomes. It can be inferred that health services visits are correlated with the availability of health infrastructures and health personnel. The number of visits per capita increases with the increase in the ratio of health personnel and health infrastructure per capita ($p<.05$). The results also suggest that malnutrition among under-five and maternal mortality decline when the ratio of health personnel and health infrastructure per capita increase ($p<.05$). No correlation is found between the financial resources and health outcomes.

Table 5.3. Selected health outcomes in health districts in health regions of Burkina Faso in 2010 and 2014 (n=63)

Health Regions/ Number Health Districts	2010				2014			
	Number of health visits /capita/year	Skilled birth attendance (%)	Malnutrition under 5 (%)	Maternal mortality ratio	Number of health visits /capita/year	Skilled birth attendance (%)	Malnutrition under 5 (%)	Maternal mortality ratio
Boucle du Mouhoun (N district = 6)								
Mean	0.59	83.02	4.68	97.93	0.74	91.33	14.75	68.12
(SD)	0.16	2.81	1.68	43.59	0.09	6.22	6.67	35.28
Median	0.52	82.55	4.84	101.77	0.73	91.42	14.63	71.11
Cascades (N district =3)								
Mean	0.54	74.47	5.20	60.10	0.86	87.13	8.43	29.57
(SD)	0.08	20.26	1.95	46.09	0.14	13.26	0.40	18.43
Median	0.56	67.00	5.10	66.10	0.90	88.60	8.50	37.50
Centre (N district = 5)								
Mean	0.93	86.84	4.02	55.12	1.00	91.92	3.64	29.02
(SD)	0.17	16.95	1.73	39.80	0.19	30.99	2.03	26.71
Median	0.99	84.40	4.70	43.60	0.94	97.20	2.80	29.70
Centre Est (N district = 7)								
Mean	0.80	79.60	3.57	53.03	1.01	86.10	9.03	40.00
(SD)	0.08	7.74	1.57	41.63	0.07	11.91	4.50	12.94
Median	0.82	81.00	3.30	45.30	1.02	86.60	7.60	41.40
Centre Nord (N district = 4)								
Mean	0.49	66.00	8.80	57.15	0.65	83.30	18.15	36.93
(SD)	0.08	9.44	1.69	33.31	0.13	10.51	13.14	27.37
Median	0.50	62.85	9.30	45.55	0.64	85.60	17.05	42.90
Centre Ouest (N district = 5)								
Mean	0.54	66.80	5.30	90.12	0.72	74.80	21.54	26.78
(SD)	0.14	5.04	2.22	95.15	0.12	11.85	5.15	26.89
Median	0.55	67.50	4.60	76.80	0.79	75.60	21.80	27.70
Centre Sud (N district = 4)								
Mean	0.67	81.15	8.23	74.70	0.86	73.73	3.90	49.75
(SD)	0.04	10.62	3.67	18.44	0.13	5.96	3.41	45.72
Median	0.66	76.95	8.60	75.80	0.83	73.55	2.35	41.30
Est (N district = 6)								
M	0.54	65.32	6.68	85.58	0.81	79.27	13.50	64.15
(SD)	0.09	5.98	1.78	73.79	0.14	12.62	8.80	34.16
Median	0.53	62.75	6.05	79.95	0.83	73.00	10.70	75.80

Table 5.3. Continued

Health Regions/ Number Health Districts	2010				2014			
	Number of health visits /capita/year	Skilled birth attendance (%)	Malnutrition under 5 (%)	Maternal mortality ratio	Number of health visits /capita/year	Skilled birth attendance (%)	Malnutrition under 5 (%)	Maternal mortality ratio
Hauts Bassins (N district = 7)								
M	0.59	80.01	5.73	54.07	0.83	89.44	6.16	40.56
(SD)	0.12	11.09	4.95	48.49	0.16	14.64	6.00	34.78
Median	0.61	85.30	2.70	50.70	0.88	94.60	3.80	35.30
Nord (N district =5)								
M	0.72	79.58	17.18	64.40	0.81	93.92	37.02	60.88
(SD)	0.21	15.43	8.47	71.16	0.18	12.40	15.48	26.12
Median	0.65	74.10	18.30	44.50	0.73	91.80	36.90	69.80
Plateau central (N district = 3)								
M	0.72	83.10	3.10	50.53	0.92	81.97	9.23	68.27
(SD)	0.03	6.65	1.82	13.56	0.08	14.12	2.10	53.90
Median	0.72	84.70	2.20	57.60	0.94	80.40	8.50	37.50
Sahel (N district = 4)								
M	0.59	58.40	14.63	92.45	0.86	77.83	19.33	151.83
(SD)	0.29	24.93	4.56	59.05	0.34	26.43	11.99	72.64
Median	0.57	55.55	15.75	101.35	0.85	76.75	21.00	181.35
Sud Ouest (N district = 4)								
M	0.60	61.48	6.90	38.93	0.86	77.73	10.13	31.93
(SD)	0.05	16.09	3.10	27.58	0.13	14.46	10.31	20.71
Median	0.58	60.00	6.90	46.85	0.83	81.35	5.95	28.70

Sources of data: Health Management Information System (HMIS) Report

Table 5.4. Health districts demographic and economic characteristics and availability of resources in Burkina Faso, 2010 and 2014

		2010					2014				
		Financial resources allocated ($)	Financial resources spent ($)	Difference ($)	Ratio health personnel/ 10,000 capita	Ratio health infrastructure/ 10,000 capita	Financial resources allocated ($)	Financial resources spent ($)	Difference ($)	Ratio health personnel/ 10,000 capita	Ratio health infrastructure/ 10,000 capita
Population size	*Correlation Pearson Test*	.778**	.754**	.239	-.282*	-.072	.742**	.723**	.324**	-.280*	-.064
Poverty index	*Correlation Pearson Test.*	-.142	-.177	.160	-.226	-.355**	-.013	-.021	.061	-.120	-.152
GINI coefficient	*Correlation Pearson Test*	-.107	-.097	-.069	.228	.318*	-.027	-.022	-.041	.296*	.347**

** p < .05

* p < .1.

Table 5.5. Health districts demographic and economic characteristics and health outcomes in Burkina Faso, 2010 and 2014

		2010				2014			
		Number of visit per capita/year	Skilled birth attendance (%)	Malnutrition among under 5 (%)	Maternal mortality	Number of visits per capita/year	Skilled birth attendance (%)	Malnutrition among under 5 (%)	Maternal mortality
Population size	Correlation Pearson Test	-.006	.040	.035	-.165	-.099	-.115	.068	.054
Poverty index	Correlation Pearson Test	-.329**	-.544**	.326**	.097	-.196	.113	.509**	.030
GINI coefficient	Correlation Pearson Test	.155	.134	.,130	-.226	.307*	.120	-.512**	-.389**

** p < .05.

* p < .1.

Table 5.6. Availability of resources and health outcomes in districts in Burkina Faso, 2010 and 2014 (n=63)

		2010				2014			
		Number of visits per capita/year	Skilled birth attendance (%)	Malnutrition among under 5 (%)	Maternal mortality	Number of visits per capita/year	Skilled birth attendance (%)	Malnutrition among under 5 (%)	Maternal mortality
Financial resources allocated (US $)	Correlation Pearson Test	-.041	.056	.045	-.019	.105	-.055	-.059	.128
Financial resources spent ($)	Correlation Pearson Test	.011	.089	.029	-.013	.129	-.029	-.049	.131
Difference ($)	Correlation Pearson Test	-.267*	-.159	.092	-.034	-.146	-.200	-.091	.017
Ratio health personnel/10,000 capita	Correlation Pearson Test	.367**	.230	-.117	.037	.297*	-.001	-.282*	-.133
Ratio health infrastructure/10,000 capita	Correlation Pearson Test	.411**	.108	-.160	-.119	.301*	-.234	-.205	-.308*

** p < .05.

* p < .1.

5.4. DISCUSSION

In this study, we used secondary regional-level data to analyze the relationship between health districts' demographic and economic status, and health outcomes, using a bivariate correlation analysis. We first determined the correlation between the health district's demographic and economic characteristics, on the one side, and the availability of resources and health outcomes, on the other side. Secondly, we determined the correlation between the availability of resources and health outcomes.

The results indicate sizeable variation in the population and poverty index across the regions and a variation in health resources and health outcomes across health districts. While the poverty index declined between 2010 and 2014, the inequality in income between regions has significantly increased during the same period. With regard to health resources, the data suggest inequality in their distribution, that is, urban regions are more privileged than rural regions, which also record poorer health outcomes.

The findings show an increase in health financing, which is a favorable trend. However, this progress is unequally distributed across health districts highlighting the unfairness in the allocation of health financial resources. Another major finding of our study is the relationship between health resources (personnel and health infrastructures), the population size and the poverty index. This suggests that an increase in poverty and population size is associated with a decrease in health personnel and health infrastructure ratio, thus showing that the poorest and the most populated health districts are less likely to have an optimal level of health personnel and health infrastructure that are key for ensuring adequate health services coverage. This reflects the failure of the health resources allocation policy to distribute health resources in a fair and equal manner across the country, thereby contributing to deepened inequality between urban and rural regions, as well as between well-off and poorest regions. Regional and district disparities were observed before the start of the healthcare decentralization as well.

A study on the health sector reform in Burkina Faso conducted about two decades ago (Bodart et al., 2001) found that there was a strong urban bias to public spending on health, with 70% of funds being directed to the 16% of the population that was urban, leaving 30% for the remaining 84% rural population. Part of the bias in the distribution of financial resources was reflected by the inequitable distribution of human resources, with 57% of physicians, 65% of pharmacists, 55% of midwives, and 47% of nurses being deployed in the two main cities of the country (Bodart et al., 2001). Ten years later, another study showed that this situation remained unchanged. Specifically, in a policy note, Zida et al. (2010) identified the key issues in resource allocation in Burkina Faso, which were the failure to account for problems encountered

by health facilities, the health status of the population, and the existing health system problems. The resources were allocated using a historical allocation key, which did not reflect the programs' performance and the population health's needs, resulting in poor performance of programs, multiplicity of resources allocation methods, poor access to health services, high morbidity, and mortality. These findings were similar to the results of a study for Ghana, which suggested that equity in resource allocation should consider the difference between health regions and the difference within the region as well (Danso et al., 2006).

Regarding the relationship between health outcomes and the economic performance of the health districts, this study found that a higher poverty rate was associated with less access to health services (health visits, skilled birth attendance decline) and poorer health status (more malnutrition among under 5 years old). It was also found that health services visits, malnutrition among under 5 years old, and maternal mortality were associated with the availability of health personnel and health infrastructures. The correlation between poverty and health has been widely explored in developing countries, including Burkina Faso, and economic status was found to be associated with healthcare access (Bado et al., 2005; WHO, 2015; Bado & Susuman, 2016). A review on inequalities in healthcare use and expenditures in eight developing countries and countries in transition revealed that richer groups had a higher probability of obtaining care when sick, to be more likely to be seen by a medical doctor, and to have a higher probability of receiving medicines when ill, than the poorer groups (Makinen et al., 2000). The inequity in malnutrition among under 5 years old (Zere, 2000) and inequalities in infant and under-five mortality (Wagstaff, 2000) had to do with households' income.

There is broad agreement that inequality is unfair, avoidable, and concerns everyone (Woodward & Kawashi, 2000; WHO, 2010). The causes or drivers of inequality are manifold and its resolution suggests a more in-depth understanding of equitable access to health services. Previous studies on health sector reform in Burkina Faso showed that the main causes of the unfair distribution of health resources are the over-centralization of resources leading to allocative and tecąical inefficiencies (Bodart et al., 2001). The over-centralization of resources, particularly for investments and staff recruitment, was found to be a barrier to equitable resource allocation at the health district level, although the district's managers could have the option to decide over district's health priorities and to readjust resources allocation (Von & Sawadogo, 2003). A study for Ghana indicated that equity in the allocation of resources within regions had been virtually ignored, creating a vacuum in knowledge regarding how resources were allocated intra-regionally and their potential influence on promoting health equity (Danso et al., 2006). The resource allocation method was found to be the main driver of inequity in resource allocation across geographic areas. The equity

of funding allocation was greatly influenced by the availability of human resources for health, local capacity to utilize funds, donor involvement in the health sector, and commitment to promote equity. As mentioned in the introduction, the decentralization of healthcare was aimed to increase health services provision and access in order to improve equitably the services coverage and population's health status across the health districts and health regions. The study findings show that the equality objective in health was not achieved in the period of healthcare decentralization in Burkina Faso. In relation to the issue of decentralization and health-related equity, a systematic review found that depending on the context, decentralization could either lead to equity gains or exacerbate inequities (Sumah et al., 2016). It can lead to inequities in health financing between sub-national jurisdictions. However, the impact of decentralization on inequities in health and healthcare depends on pre-existing socio-economic disparities and financial barriers to access. This suggests that addressing inequality between health districts and health regions would require the reduction of the gap between poor and rich, and the removal of financial barriers that impede equitable access to health services (Dlouhy, 2018). The selected indicators, although relevant to assess the health disparities, present some limitations because each indicator quantifies a different perspective of inequity. It is therefore imperative to consider how an indicator operationalizes inequities. In particular, it will be advantageous to determine and use a comprehensive set of indicators for a robust assessment of health inequities (Olakunle & David, 2015). This was not possible in our study because the availability of data comparable across the regions is limited in Burkina Faso.

The study used secondary data from the health management information system (HMIS) and national households' survey to carry out a bivariate correlation analysis, which presents four main limitations. First, the health management information system reports are official statistics published by the Ministry of Health that mainly focus on health facilities. They are not able to capture individual-level details relevant to the wider population. Second, the measurement instruments used for the preparation of these reports have changed over time, making it difficult to perform a period-to-period comparison, as well as a comparison across health regions and health districts. Third, some potential misinterpretation and sample representativeness issues might have occurred given our inability to control data quality and data interpretation. This could interfere with the statistical analysis. Fourth, the aim of the study was not to assess the effects of decentralization on the health system or on health. Therefore, the results should not be referenced as an evaluation of the decentralization impact on health inequality in Burkina Faso.

5.5. CONCLUSIONS

Through this study, we explored the relationship between health districts' demographics, economic status, and health outcomes in Burkina Faso. The results indicated demographic and economic differences in health outcomes between health districts, thus showing inequality in health among health districts. The main underlying causes or drivers of inequality are the economic difference among the population, the health resources allocation policy, and methods that should promote equity among and within the different geographical entities. The study has taken place in the context of decentralization in Burkina Faso, but it did not have the necessary data to link the results with the direct effect of the decentralization reform. However, it can be noted that the health and healthcare outcomes changed during the decentralization. Therefore, from a decentralization policy perspective, the findings suggest challenges in addressing the inequality between regions and districts to eliminate the inequality related factors and therefore enhance the equity in health services access, coverage and outcomes. This requires a more transparent resource allocation system based on regions and districts' needs considering the decentralization system, policies to address the socio-economic disparities and financial barriers to health services. Consideration should be given to a health inequality monitoring system to be able to determine the root causes of inequity and identify feasible approaches to address these causes (Hosseinpoor et al., 2018). Further research is needed to collect relevant data and investigate the effects of decentralization, which was not possible in our study.

CHAPTER 6

Factors associated with access to healthcare in Burkina Faso: evidence from a national household survey

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ABSTRACT

Background

Burkina Faso has undertaken major reforms, the cornerstone of which has been the decentralization of the health system with the aim to increase access to primary healthcare and to increase the effectiveness, efficiency, financial viability and equity of health services.

Objective

The aim of this chapter is to analyze the determinants of households' access to healthcare in Burkina Faso.

Methods

We used data from a national household survey conducted in 2014 in Burkina Faso. We carried out binary logistic and linear regression analysis using data from a national household survey. The statistical analysis explored the associations between socio-demographic characteristics on the one side, and the use of health services, satisfaction with health services and expenditures on health services, on the other side.

Results

The findings indicate an association between age, education, income and use of services ($p<.0005$). The results show that healthcare users' satisfaction is influenced by age, the association is stronger with age group under 24 ($p<.0005$) than the age group of 25-39 ($p<.005$). An association was found between the age group under 15 ($p<.005$) and the type of health facility used ($p<.0005$), the distance traveled to health facilities ($p<.005$) and households' individuals' health expenditure.

Conclusion

Specific policies are needed to enhance geographical access to healthcare, financial access to and satisfaction with healthcare in moving towards universal health coverage.

6.1. INTRODUCTION

Providing equal access to essential healthcare and financial risk protection are two core purposes of a health system that targets universal health coverage (UHC). Promoting and protecting health is essential to human welfare as well as to sustained economic and social development (WHO, 2010). Already in 1978, the Alma Ata declaration emphasized the importance of primary healthcare to achieve the health-for-all goal. The declared guiding principles, which are still largely applicable, concern community participation, which is needed to cater to community needs and to set priorities, values and vision for the health system (WHO, 1978).

Based on the Alma Ata declaration and the related policy momentum, several sub-Saharan African countries, including Burkina Faso, launched health system reforms aimed at operationalizing the declaration's recommendations to improve access to healthcare for all citizens (WHO, 2008). In some of these countries, the reforms were part of the wider macroeconomic policy and implementation of structural adjustment programs, which required control of public expenditure as well as changes in public and private sector institutional structures (Gilson and Mills, 1995).

In line with these changes, since the end of the 1980s, Burkina Faso has undertaken major reforms (Bodart et al., 2001), the cornerstone of which has been the decentralization of the health system. This included the creation of health directorates and health districts in 1993, the establishment of autonomy over financial and human resources management for hospitals, and the creation of a central procurement agency for essential medicines. In 1987, Burkina Faso endorsed the Bamako initiative that aimed to increase access to primary healthcare by raising the effectiveness, efficiency, financial viability and equity of health services (WHO, 2011). The notable elements of this initiative were the introduction of healthcare users' fees and the establishment of local health committees to enhance community participation in healthcare financing and management.

Despite the different reforms and initiatives undertaken in Burkina Faso, the population continues to face major challenges in access and use of health services. As suggested in the literature, a variety of factors may influence access and use of healthcare, including socio-demographic factors, policy and institutional considerations (Baltussen et al., 2002; Andersen and Newman, 2005; Prosser, 2007; Tanou, 2010; Allegri et al., 2011; Evans et al., 2013; Saeed et al., 2016; WHO and World Bank, 2017; Herrman, 2017; Zeng et al., 2017). This study explores the association of household-level factors with access to and utilization of health services in Burkina Faso.

In particular, the study aims to analyze the socio-demographic determinants of households' access to healthcare in Burkina Faso. We apply quantitative analytical

methods to national household survey data to better understand health service utilization in Burkina Faso. The study contributes to a further exploration and explanation of the inequitable access and use of healthcare in Burkina Faso. The study could be useful for policy in Burkina Faso when assessing the reform progress as well as for other countries in the region that struggle with problems in healthcare access.

6.2. MATERIALS AND METHODS

The study was quantitative. We used data from a national household survey conducted in 2014 in Burkina Faso by the National Institute of Statistics and Demography. This survey was designed to be representative for the country and involved a large sample of households selected across all 45 provinces of the country, covering all 13 regions.

The survey employed a two-stage stratified sampling approach. At the first stage, 900 sampling units were drawn across the provinces with a probability proportional to the size of the population in the provinces. At the second stage, a sample of 12 households was selected at random (with equal probability) from each sampling unit selected at the first stage. For this purpose, the list of households registered during the last census in the 900 sampling units, was used. The sampling procedure resulted in 10 800 households including 72 401 individuals (household members) who were invited to participate (INSD, 2014).

The structured questionnaire used in the survey includes questions on socio-demographic factors, access to and utilization of health services, access to education, housing, sanitation, food security, savings and access to credits, and new information tecąologies. The list of questions used to collect data on health use is presented in Appendix E. The questionnaire was pretested before the data collection through a pilot test to assess the data collection and processing mechanisms (INSD, 2014). Ninety-one (91) qualified data collectors were recruited in two phases. During the first phase, the shortlisted data collectors were trained during a workshop at the end of which, the most suitable candidates were selected and trained on the survey concept and rationale, questionnaire, data collection process, data quality assessment and ethical compliance. Data collectors were divided into three-person teams with an average of 30 clusters of 12 households per team led by a supervisor. Data were collected at the household level (respondents' home) over the period of one year (January to December 2014) during which data collectors visited the sampled households. For the respondents under the age of 15, their legal representative was interviewed. Data collected were related to household consumption, which varies depending on the periods of year (dry season, growing and harvest seasons). To capture these seasonal variations, data were collected every three months (four phases). Households that

participated in at least three phases, were included in the dataset. The dataset that we used, was anonymized. Data entry was processed with the Census and Survey Processing System (CSPro).

The study used secondary data collected in a national household survey, which did not require ethical approval. The survey was conducted by a governmental institution, namely the National Institute of Statistics and Demography. As confirmed by the managers from the survey department of the institute, ethical approval was not required to carry out the survey.

For our study, we used the data on households' socio-demographic characteristics, utilization of health services and satisfaction with health services used. The following variables were included in the analysis:

- *Dependent variables*:
  - Service utilization in the preceding 15 days (used services or not)
  - Satisfaction with health services used in the preceding 15 days (satisfied or not)
  - Expenditures on health services (sum of all fees paid during the last episode of care-seeking). These included fees for consultation, medical checks, drugs, hospital admission, other expenditures and informal payments.
- *Independent variables*:
  - Age (categorized into six groups: 0-5, 6-14, 15-24, 25-39, 40-59 and ≥ 60 years)
  - Gender (male, female)
  - Residence (urban, rural)
  - Education (no education**,** primary, secondary, university)
  - Employment status (employed, self-employed and unemployed)
  - Distance to the health facility (<1 km, 1-4 km, 5-9 km, ≥ 10 km).
  - Type of health facility (teaching hospitals, regional hospitals, district hospitals, medical centers, primary healthcare center, private clinics, non-profit organizations, pharmacy and other health facilities). For the analysis, teaching hospitals and regional hospitals were categorized as referral hospitals. The medical centers were included in the category of district hospitals, the non-profit organizations and pharmacy were included in the category of other health facilities.
  - Income level: Given that data on income were not disaggregated to the individual level, the regional poverty index was used as a proxy to determine individual income that was divided into three categories: high income region, low income region, very low-income region. The poverty index of each region was applied to all household members in the respective region.
  - Region: Administrative breakdown which corresponds to the 13 regions of the country.

We carried out regression analysis to determine the association between the dependent and independent variables listed above. Specifically, for the analysis of the first two dependent variable, use of health services and satisfaction with services, we applied binary logistic regression and for the analysis of expenditures on health services, we applied linear regression. In all three regressions, the set of independent variables included age, gender, residence, education, employment status, regional income level, and region. Distance to health facilities, and type of health facilities were only included in case of satisfaction with services and expenditures on health services. In case of health service use, we included respondents who were ill in the preceding 15 days, and in case of satisfaction with services and expenditures on health services, we only included respondents who had used health services in the preceding 15 days. Data analyses were performed with the Statistical Package for the Social Sciences (SPSS) version 25. Associations were accepted to be significant when the p-value was smaller than 0.05 (95% CI).

6.3. RESULTS

From the initial sample of 10 800 households, 10 411 households (about 96%) participated in at least three phases of the data collection and were included in the dataset. The household sample included 72,401 individuals (households' members). From those, a total of 10,009 individuals (about 13.82%) reported to have been ill in the preceding 15 days and were included in our analysis.

Table 6.1 presents the general socio-demographic characteristics of respondents (household members) included in the analyses. The under 5 years was the largest age group (31.20%) and older than 60 years was the smallest age group. More than half of the respondents (53.13%) were male. Most respondents (59.30%) were living in an urban area. With regard to education and employment status, the vast majority of respondents (78.12%) had no education and more than half (65.56%) were self-employed. On the income side, the classification showed that 79% of individuals were living in a very low-income region (high regional poverty index).

Table 6.2 presents the patterns of morbidity among sick individuals by age group and gender. The two most frequent diseases across all age and gender groups are malaria/fever (68.02% and 67.69% respectively) and diarrheas/stomach pains (9.23% and 9.44% respectively).

Table 6.1. Socio-demographic characteristics of respondents who were ill in the preceding 15 days (N=10,009), Burkina Faso, 2014

Variables	Modalities	n (%)
Age group [a]	0-5 yrs	2,918 (31.20%)
	6-14 yrs	1,916 (20.48%)
	15-24 yrs	1,093 (11.68%)
	25-39 yrs	1,449 (15.49%)
	40-59 yrs	1,215 (12.99%)
	60 yrs +	763 (8.16%)
Gender	Male	5,318 (53.13%)
	Female	4,691 (46.87%)
Residence	Urban	5,935 (59.30%)
	Rural	4,074 (40.70%)
Education [b]	No education	7,240 (78.12%)
	Primary	1,127 (12.16%)
	Secondary	751 (8.10%)
	University	150 (1.62%)
Employment status	Employed	2,052 (20.50%)
	Self employed	6,562 (65.56%)
	Unemployed	1,395 (13.94%)
Regional income level based on the regional poverty index	High income (well off regions)	2,102 (21.00%)
	Low income (poor regions)	4,932 (49.28%)
	Very low income (very poor regions)	2,975 (29.72%)

[a] missing data for 655 respondents; [b] missing data for 741 respondents

Table 6.3 presents descriptive statistics on healthcare seeking behavior among the respondents who were ill in the 15 days preceding the survey. Data indicate that more than half of the respondents (59.30%) have sought care in health facilities. The data also show that 42.70% of the respondents traveled 1 to 4 km to obtain healthcare and almost three-quarter of the respondents lived within 5 km distance from the health facility. The most visited health facilities (81.39%) were the primary healthcare centers. About 89.55% of the healthcare users were satisfied with the care used. With regard to health expenditures, the data show that the fees incurred by the respondents during the last episode of healthcare seeking, ranged from $.004-$6,000 and the average amount paid was estimated to be $28.

Table 6.4 and 6.5 present the results of the regression analysis to investigate the association between the socio-demographic characteristics on the one side, and the use of health services, satisfaction with health services and expenditures on health services, on the other side.

Table 6.2. Morbidity patterns among respondents who were ill in the preceding 15 days (N=10,009), Burkina Faso, 2014

AGE GROUP n (%)													AGE GROUP n		GENDER n (%)			
	(%)																	
	0-5 years		6-14 years		15-24 years		25-39 years		40-59 years		60 years +		Total [a]		Male		Female		Total [a]	
Fever/Malaria	2,370	(81.42%)	1,477	(77.49%)	728	(66.91%)	881	(60.84%)	621	(51.11%)	270	(35.39%)	**6,347**	**(68.02%)**	3,317	(69.86%)	3,440	(65.72%)	**6,757**	**(67.69%)**
Diarrheas/ Stomach pains	218	(7.49%)	146	(7.66%)	126	(11.58%)	194	(13.40%)	114	(9.38%)	63	(8.26%)	**861**	**(9.23%)**	402	(8.47%)	540	(10.32%)	**942**	**(9.44%)**
Back pains/ Muscular or joint pains	16	(0.55%)	36	(1.89%)	45	(4.14%)	93	(6.42%)	186	(15.31%)	216	(28.31%)	**592**	**(6.34%)**	251	(5.29%)	371	(7.09%)	**622**	**(6.23%)**
Dentals pains/ Teething problems	9	(0.31%)	15	(0.79%)	18	(1.65%)	36	(2.49%)	30	(2.47%)	12	(1.57%)	**120**	**(1.29%)**	46	(0.97%)	78	(1.49%)	**124**	**(1.24%)**
Skins disorders	47	(1.61%)	21	(1.10%)	7	(0.64%)	18	(1.24%)	12	(0.99%)	8	(1.05%)	**113**	**(1.21%)**	50	(1.05%)	77	(1.47%)	**127**	**(1.27%)**
Eye diseases	13	(0.45%)	14	(0.73%)	5	(0.46%)	7	(0.48%)	23	(1.89%)	28	(3.67%)	**90**	**(0.96%)**	46	(0.97%)	57	(1.09%)	**103**	**(1.03%)**
Blood pressure issues	2	(0.07%)	0	(0.00%)	5	(0.46%)	9	(0.62%)	39	(3.21%)	57	(7.47%)	**112**	**(1.20%)**	54	(1.14%)	61	(1.17%)	**115**	**(1.15%)**
Typhoid fever	5	(0.17%)	2	(0.10%)	0	(0.00%)	3	(0.21%)	1	(0.08%)	0	(0.00%)	**11**	**(0.12%)**	2	(0.04%)	10	(0.19%)	**12**	**(0.12%)**
Ear. Nose and throat diseases	79	(2.71%)	50	(2.62%)	26	(2.39%)	26	(1.80%)	19	(1.56%)	12	(1.57%)	**212**	**(2.27%)**	117	(2.46%)	120	(2.29%)	**237**	**(2.37%)**
Diabetes	10	(0.34%)	4	(0.21%)	4	(0.37%)	3	(0.21%)	6	(0.49%)	6	(0.79%)	**33**	**(0.35%)**	18	(0.38%)	17	(0.32%)	**35**	**(0.35%)**
Meningitis	3	(0.10%)	2	(0.10%)	1	(0.09%)	0	(0.00%)	0	(0.00%)	0	(0.00%)	**6**	**(0.06%)**	2	(0.04%)	5	(0.10%)	**7**	**(0.07%)**
Accident and injuries	34	(1.17%)	67	(3.52%)	36	(3.31%)	50	(3.45%)	35	(2.88%)	20	(2.62%)	**242**	**(2.59%)**	161	(3.39%)	99	(1.89%)	**260**	**(2.60%)**
Stomach ulcer	5	(0.17%)	0	(0.00%)	4	(0.37%)	22	(1.52%)	10	(0.82%)	2	(0.26%)	**43**	**(0.46%)**	15	(0.32%)	29	(0.55%)	**44**	**(0.44%)**
Other disease	100	(3.44%)	72	(3.78%)	83	(7.63%)	106	(7.32%)	119	(9.79%)	69	(9.04%)	**549**	**(5.88%)**	267	(5.62%)	330	(6.30%)	**597**	**(5.98%)**
Total [a]	**2,911**	**(100%)**	**1,906**	**(100%)**	**1,088**	**(100%)**	**1,448**	**(100%)**	**1,215**	**(100%)**	**763**	**(100%)**	**9,331**	**(100%)**	**4,748**	**(100%)**	**5,234**	**(100%)**	**9,982**	**(100%)**

[a] Totals vary because of missing data, which are not reported in the table

Table 6.3. Healthcare use among respondents who were ill in the preceding 15 days (N=10,009), Burkina Faso, 2014

Variables	Modalities	n (%)
Use of health services (n=10,009)	1 = Yes	5,935 (59.30%)
	0 = No	4,074 (40.70%)
Distance to health facilities (n=5,876) [a]	Less than 1 km	1,899 (32.22%)
	1 to 4 kms	2,509 (42.70%)
	5 to 9 kms	940 (16.00%)
	10 kms and More	528 (8.99%)
Type of health facility used (n=5,786) [b]	Referral Hospitals	220 (3.80%)
	District Hospitals	567 (9.80%)
	Primary Healthcare Center	4,709 (81.39%)
	Private Clinics	220 (3.80%)
	Other Health Facilities	70 (1.21%)
Patient satisfaction (n=5,935)	1 = Satisfied	5,315 (89.55%)
	0 = Not satisfied	620 (10.45%)
Health expenditures (n=5781) [c, d]	Min – Max	$.004-$6,000
	Mean (SD)	$28 ($163)

[a] missing data for 59 respondents; [b] missing data for 149 respondents; [c] missing data for 154 respondents; [d] 1$ = 500 XOF

Table 6.4 presents the association between the socio-demographic characteristics and use of health services, as well as the association between the socio-demographic characteristics and satisfaction with health services using a binary logistic regression. The results indicate a strong association between all age groups and the use of services ($p<0.0005$), which decreases with an increase in age, showing thus that young individuals are the largest healthcare consumers. There is a strong negative association ($p<0.005$) between education and the use of health services, indicating that a higher level of education does not lead to greater use of health services. This finding was similar to that for income level where data showed that individuals with a high income use health services less than those with low-income ($p<0.0005$). The results show an association between almost all regions and the use of health services ($p<0.0005$), excepted for the region of Cascades. Among those who used health services, 89.55% were satisfied with the health services. This satisfaction was very strongly associated with the age group under 24 ($p<0.0005$) and moderately with the age group of 25-39 ($p<0.005$). Regarding the regions, an association was only found between the economic city of the country (region of Bobo-Dioulasso) and users' satisfaction ($p<0.0005$).

Table 6.5 presents the association between the respondents' socio-demographic, economic characteristics and their expenditures on health services using a linear regression. The results indicate a strong association between the age group under 5 years and expenditures on health ($p<0.0005$) and a moderate association for the age group of 6-14 ($p<0.005$). These findings show that an increase in age was associated with a decrease in health expenditures, suggesting that household's health expenditures were mostly on young children, which supported the hypothesis that children were

the largest consumers of healthcare. Regarding the type of health facility, the results showed that health expenditures were strongly associated (p<0.0005) with district hospitals, primary healthcare facilities and other health facilities (pharmacies, non-profit organizations). The distance traveled by respondents to health facilities was associated with health expenditures (p<0.005) as well the vast majority of regions (p<0.0005) except for the region of Hauts Bassins (economical city) and the region of Sud Ouest.

Table 6.4. Binary logistic regression: use of health services and satisfaction with health services, Burkina Faso, 2014

	Use of health services in the past 15 days *0 = No; 1 = Yes*				Satisfaction with health services used *0 = Not satisfied; 1 = Satisfied*			
Variables	**B**	**S.E.**	**Sig.**	**Exp (B)**	**B**	**S.E.**	**Sig.**	**Exp (B)**
Age group 0-5	-1.061	.087	.000	.346	1.106	.179	.000	3.021
Age group 6-14	-.461	.090	.000	.630	1.006	.196	.000	2.734
Age group 15-24	-.546	.100	.000	.579	.736	.208	.000	2.087
Age group 25-39	-.573	.095	.000	.564	.586	.193	.002	1.796
Age group 40-59	-.444	.097	.000	.642	.241	.190	,206	1.272
Age group 60 & plus (reference)								
Gender (1 male, 2 female)	.039	.044	.376	1.040	.107	.097	.267	1.113
Residence (1 urban, 2 rural)	.065	.050	.198	1.067	-.125	.122	.306	.883
Education (1 no education, 2 primary, 3 secondary, 4 university)	-.119	.037	.001	.888	-.121	.073	.097	.886
Employed	.141	.093	.131	1.151	.178	.188	.344	1.195
Self Employed	.115	.084	.169	1.122	.204	.169	.227	1.226
Unemployed (reference)					.178	.188	.344	1.195
Regional poverty index (1 high income region, 2 low-income region, 3 very low-income region)	-.873	.126	.000	.418	-.269	.274	.326	.764
District hospitals					.143	.121	.240	1.153
Primary healthcare facilities					.142	.072	.048	1.152
Private clinics					.125	.080	.119	1.133
Other health services					.062	.091	.499	1.064
Reference hospitals (reference)								
Distance to health facilities (in km)					.019	.056	.729	1.020
Region of Hauts Bassins	-.448	.118	.000	.639	-1.269	.242	.000	.281
Region of Boucle Mouhoun	1.571	.113	.000	4.810	-.335	.232	.148	.716
Region of Sahel	2.181	.221	.000	8.858	.348	.461	.451	1.416
Region of Est	1.426	.224	.000	4.160	.017	.441	.969	1.017
Region of Sud Ouest	1.575	.229	.000	4.833	-.441	.440	.317	.643
Region of Centre Nord	2.049	.221	.000	7.764	.226	.455	.619	1.254
Region of Centre Ouest	1.375	.124	.000	3.954	-.109	.270	.686	.897
Region of Plateau Central	.672	.129	.000	1.958	.318	.290	.272	1.375
Region of Nord	.840	.120	.000	2.316	.125	.255	.624	1.133
Region of Centre Est	.652	.126	.000	1.919	-.557	.232	.017	.573
Region of Cascades	.200	.116	.085	1.221	-.626	.274	.022	.535
Region of Centre – capital city (reference)								
Constant	.966	.243	.000	2.626	1.886	.577	.001	6.595
N	9,268				5,285			
Nagelkerke R Square	.088				.060			

Table 6.5. Linear regression: Expenditures on health services (in XOF; 1$ = 500 XOF), Burkina Faso, 2014

	Unstandardized coefficients	Standard error	Standardized coefficients	Significance
Constant	65880.592	10902.686		.000
Age group 0-5	-21728.797	5328.626	-.122	.000
Age group 6-14	-18986.395	5628.844	-.088	.001
Age group 15-24	-15867.354	6062.324	-.058	.009
Age group 25-39	-12242.446	5825.687	-.051	.036
Age group 40-59	-13486.427	5969.038	-.051	.024
Age group 60 & plus (reference)				
Gender (1=male, 2=female)	-1997.472	2389.149	-.012	.403
Residence (1=urban, 2=rural)	-940.847	2976.286	-.005	.752
Education (1=no education, 2=primary, 3=secondary, 4=university)	502.259	1912.551	.004	.793
Employed	3891.259	5086.551	.019	.444
Self Employed	1360.807	4601.008	.007	.767
Unemployed (Reference)				
District hospitals	-17913.027	3626.737	-.125	.000
Primary healthcare facilities	-13016.295	2184.219	-.178	.000
Private clinics	-3498.486	2185.418	-.031	.109
Other health services	-8832.967	2514.848	-.056	.000
Referral hospitals (reference)				
Distance to health facilities (in km)	4292.265	1409.884	.046	.002
Region of Boucle Mouhoun	-20489.936	5893.710	-.069	.001
Region of Sahel	-26932.248	6592.869	-.075	.000
Region of Est	-23318.477	5960.513	-.078	.000
Region of Sud Ouest	-17411.574	6411.346	-.050	.007
Region of Centre Nord	-23419.934	6408.273	-.068	.000
Region of Centre Ouest	-23492.180	6467.619	-.065	.000
Region of Plateau Central	-23286.334	6239.037	-.071	.000
Region of Nord	-18696.484	5881.376	-.064	.001
Region of Centre Est	-25414.368	6067.694	-.082	.000
Region of Cascades	-23190.205	6414.380	-.065	.000
Region of Centre Sud	-23973.220	5880.809	-.082	.000
Region of Hauts Bassins (Economical city)	-15027.095	5913.452	-.050	.011
Region of Centre – capital city (reference)				
N	5,781			
R Square	.028			

6.4. DISCUSSION

This study provides evidence on the health status and socio-demographic factors associated with health service use in Burkina Faso. The morbidity data from the household survey show that the main health problem in Burkina Faso is malaria. The high malaria morbidity is confirmed by the health management information system (HMIS) reports. In 2014, malaria represented 58.4% of all outpatients (HMIS[6] report, 2014), which is comparable to our results. In 2018, the proportion of malaria was lower, 25.9% of all outpatients had malaria (HMIS, 2018). The study's results also show differences in health services use by socio-demographic characteristics of households surveyed.

Use of health services is higher among younger age groups than among the older age group. This finding is consistent with the official statistics, which indicate that young people were the largest healthcare consumers in 2014. In that year, children under 5 years made up 39% of outpatients in health facilities (HMIS report, 2014) and this proportion was estimated to 45% in 2018 (HMIS report, 2018).

Healthcare use is higher among the poorest. A study conducted in Zimbabwe (Zeng et al., 2017) found that the poorest households relied on primary healthcare facilities and the richest households had greater hospital utilization. In 2014 and 2018, the primary healthcare facilities represented 80% (HMIS report, 2014) and 88% (HMIS report, 2018) of public health facilities in Burkina Faso respectively. It could be argued that the greater use of health services by the population with low-income in our study is explained by the fact that the primary healthcare facilities are the most numerous (81.39%) and the most available source for healthcare seeking by the population, especially in rural areas. This is consistent with a study from Asia (Donnell et al., 2005) that showed inequality in health centers utilization in favor of poorer households.

The results indicated that literate patients use health services less than those who are illiterate. These findings are similar to those from a household survey in rural Burkina Faso (Mushiga et al., 2004), which indicated that the proportion of people with no education who used health modern health services was 56.5% against 17.4% for those with primary education and 25.1% for those with secondary education. An interpretation of the negative education effect is that education makes households more efficient in maintaining health (Grossman 1972). For instance, in 2015, nearly 72% of the population of Burkina Faso was living in rural areas (INDS, 2015) where the choice of healthcare facilities is limited to primary healthcare as an entry point into the health system. The relation between education and health could also suggest that improvements in education will raise the average income, make health services more affordable and equip people with the awareness needed to demand and obtain the health service they need (David et al., 2013).

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Concerning users' satisfaction, the main factor associated with being satisfied was the services provided during the visit to the health facility. Those who were not satisfied complained about the long waiting time, the low responsiveness of health personnel and the high cost of care. This is consistent with another study in Burkina Faso (Philibert et al., 2014) on women's satisfaction with delivery care, showing that 90% of service users were satisfied with the provider-patient interaction, the nursing care services and the environment. The satisfaction rates that we find are higher than those reported by another study on the quality of care of modern health services in Burkina Faso, which showed that 82.7% of users were satisfied with the way the medical doctors examined them (Baltussen and Ye, 2005). The dissatisfaction was related to the time spent to see a medical doctor. Similar to our findings, in Nigeria, it has been observed that a major group of respondents were satisfied with food and courtesy (53%), and with respect (61.5%) (Ogbeyi et al., 2018). Significant association was found with the age group of 35 to 44.

Four points have emerged from the households' expenditures on health. The first point is the high health expenditures by the age group under 15. This could be explained by the fact that over half of sick people that have sought care in health facilities, was from this age group. A household survey in Sri Lanka (Kumara, 2016) showed that the number of pre-school children is a stronger predictor of out-of-pocket payments than the number of elderly echoing Brown et al. 2014 who suggests that pre-school children might need more preventive healthcare and often experience early-age illnesses.

The second point is the higher costs associated with the primary healthcare facilities and district hospitals. The higher costs observed in the primary healthcare facilities in our study are unexpected. The results of a study on out-of-pocket costs for facility-based maternity care in Burkina Faso, suggest that costs at health centers and dispensaries are less than those paid at hospitals (Perkins et al., 2009). The result observed in the study could be explained by the fact that the primary healthcare facilities were the first source of healthcare seeking (81.39%) with a proportional increase in health expenditures. The high costs associated with hospitals are consistent with the findings of several studies in Burkina Faso (Perkins et al., 2009; Meda et al., 2019), in Kenya and Tanzania (Perkins et al., 2009). These costs are related to the treatment of complicated cases referred in hospitals.

Thirdly, the distance traveled to health facilities was associated with health expenditures. In a study on households' costs to severe malaria treatment in rural Burkina Faso, it was found that the main driver of the cost difference was the transportation (Castellani et al., 2018). Findings from a study in rural Bangladesh on the use of facility-based maternity services, showed that for each additional kilometer, the cost increased by $0-13 for antenatal care, $0-44 for delivery, and $0-11 for postnatal care (Keya et al.,

2013). According to the WHO, the transport costs can be even more prohibitive than the charges imposed for the services (WHO, 2010). Beyond the cost, several studies have shown that distance is one of the key barriers that hamper access to health services in Burkina Faso and Sub Saharan countries (Mwase et al., 2018; Allegri et al., 2011; Baltussen et al., 2002; Geleto et al., 2018; Okedo et al.,2019) to the point that people cannot use services if they are not available close by, even if they are free of charge (WHO, 2010). This requires particular attention, given that nearly 25% of the service users in our studies have traveled more than 5 kilometers.

Finally, households' expenditures were high in most of the regions and the capital city. This could be due to the urbanization of the region associated with the availability of diverse healthcare seeking sources, especially the private healthcare facilities compared to the other regions. A study conducted in Burkina Faso showed that patients in private facilities paid about 50% more for their drugs and 100% more for consultation fees than those in public facilities (Beogo et al., 2016). A national survey on out-of-pocket payments for maternal healthcare indicated that the amounts paid by women were higher in urban areas (Meda et al., 2019).

The study findings showed poor access and inequality in health services utilization in Burkina Faso where the UHC policy was accepted throughout the government and the health system. For the country to achieve UHC, policy makers, partners and other stakeholders should explore actions that guarantee that all people obtain the health services they need. UHC cannot be attained unless both health services and financial risk protection systems are accessible, affordable and acceptable (Brown et al., 2013). To achieve both goals of health decentralization and the reforms are undertaken, the government needs to focus on policy interventions that make health services physically accessible, financially affordable and acceptable to the population.

We used secondary data from the national households' survey to carry out a regression analysis, which presents some limitations. First, we could not include all relevant variables but we had to limit our analysis to variables available in the dataset. Second, our study could only study associations between the households' socio-demographic and economic characteristics, and their use, satisfaction and expenditures on health services. It was not possible to identify causal factors of access to healthcare in Burkina Faso. Third, the dataset included information on episodes of illness which were self-reported by the interviewees.

We were unable to determine if those were clinically confirmed cases. Finally, the dataset did not contain sufficient data on the period of the year when the interview was conducted. Thus, we did not have data for the analysis of seasonal variability in morbidity and healthcare seeking behavior.

6.5. CONCLUSIONS

Our study shows that primary healthcare facilities are the main source of care for households in Burkina Faso, particularly for young people and those with low income. Despite a high level of service users' satisfaction, the study has identified some reasons of dissatisfaction that can considerably discourage communities to use health facilities. Another key finding highlighted the high cost of healthcare driven by the youngers' health demand and cost of transportation. Overall, the results of this study suggest that specific policies are needed to enhance geographical access to health services by reducing distance coverage, financial access through effective financial protection and to improve the quality of healthcare towards universal health coverage (UHC).

CHAPTER 7

General discussion and concluding remarks

7.1. INTRODUCTION

This dissertation has examined the decentralization and health resources transfer to local governments in Burkina Faso. The aim was to explore the process and mechanisms of the transfer of health resources from the central government to the local governments in Burkina Faso. The dissertation also sought to analyze the differences in the distribution of health resources and the differences in health outcomes, and to assess the determinants of access to healthcare during the period of healthcare decentralization in Burkina Faso in order to contribute to a better understanding of the issues and challenges involved in the decentralization process. This topic is of interest not only for Burkina Faso but also for other countries in West Africa and Sub-Saharan Africa that have undertaken decentralization and health system reforms.

To address the aim of the dissertation presented above, five objectives were defined in Chapter 1. First, a systematic review of the literature was conducted to provide evidence on local governments' achievements, challenges and issues encountered in healthcare provision in Sub-Saharan Africa during decentralization reforms. Second, a qualitative approach was applied to investigate the key decision-makers' knowledge, attitudes and practices (KAP) related to the transfer of health resources in Burkina Faso. Third, we explored the different factors that could enhance or hamper the resources transfer process in Burkina Faso by analyzing the strengths, weaknesses, opportunities and threats (SWOT) associated. with the decentralization in the health sector. Finally, the focus was on the distribution of health resources, health outcomes and healthcare access during the period of healthcare decentralization. The two studies that focused on this topic, included a quantitative analysis of macro-level data from the health management information system (HMIS) and national households' survey data in Burkina Faso.

This final chapter of the dissertation discusses the key research findings reported in the dissertation. These findings are presented in the form of statements and are discussed from the perspective of future policy and research. Before the statements, a brief summary of the main findings in this dissertation is presented. The chapter ends with conclusions on the ways to address the challenges and issues involved in the decentralization and resources transfer in order to ensure a sustainable provision of health services by local governments in Burkina Faso.

7.2. SUMMARY OF THE MAIN FINDINGS

Chapter 2 has systematically reviewed the experiences of local governments of Sub-Saharan African countries with the provision of health services during and after the decentralization reforms. The review shows that most countries have focused on the process by enacting numerous policies, regulations and standards with mixed outcomes for health service delivery. Decentralization in general, and resources transfer from the central to local governments in particular, are a highly political issue that influences the health reform strategy on decentralization. The literature highlights the complexity of implementing decentralization schemes, which strongly impact the health service organization and delivery. The theory of decision space applied in a comparative analysis found that some functions, particularly financing, remain under the control of the central state. Despite the numerous challenges, this review identifies some good practices in resources transfer, key determinants being the type of decentralization and the government's will to make legislative and administrative changes required for the effectiveness of decentralization.

In Chapter 3, we have examined the decision-makers' knowledge, attitudes and practices (KAP) about the decentralization and health resources transfer to local governments in Burkina Faso. The findings suggest that all respondents are knowledgeable of the rationale of the decentralization and resources transfer to local governments. The vast majority of them have a positive opinion towards decentralization and the main elements that appear to be motivating their attitude are the expected outcomes from decentralization, notably: i) better management of health facilities; ii) improved capacities of local governments to provide services of better quality to communities, iii) better management of resources transferred, iv) increased population's access to health services, and v) increased local governments' accountability towards communities and beneficiaries. The decision-makers' practical experience with resources transfer was limited to awareness raising, training, supervision, tecąical assistance and resources mobilization. Poor collaboration between health districts and local governments, the control of certain resources by the state and the health districts constrain the implementation of health resources and skills transfer policy at the grassroots level. Careful attention should be paid to the country's political context and institutional design.

Chapter 4 has explored the strengths, weaknesses, opportunities, and threats (SWOT) associated with the health resources transfer in Burkina Faso, from the perspective of decision-makers. The most cited strength was the improvement of local governance, which also created the opportunity for an enhanced partnership and decentralized cooperation. As expected, however, the limited financial capacity of local governments is an important weakness. Furthermore, misuse of financial resources threatens

the resources transfer. Recommendations to improve decentralization and health resources transfer include effective enforcement of decentralization laws and policies, strengthening local governments' capacities, adequate funding, and evaluation of the resources transfer process. An analysis of the preconditions for a successful resources transfer is needed to provide guidance to policy.

In Chapter 5, we have analyzed the differences in health outcomes by health district's demographic and economic status, and the distribution of health resources during the period of healthcare decentralization. The findings indicate a strong correlation between the district's population size and the availability of health resources. The health visits per capita and skilled birth attendance are correlated with the economic status of the health district. Malnutrition among under-five and maternal mortality was associated with the availability of health personnel and health infrastructure. The ways to address this inequality include more transparent resource allocation, as well as policies to address the socio-economic disparities and financial barriers to health services. Further research is needed to collect relevant data and investigate the effects of decentralization, which was not possible in our study.

Chapter 6 has analyzed the determinants of households' access to healthcare in Burkina Faso. The findings indicate an association between age, education, income and use of services ($p<.0005$). The results show that healthcare users' satisfaction is influenced by age. The association is stronger with age group under 24 than the age group of 25-39. An association was found between the age group under 15 and the type of health facility used. The distance traveled to health facilities and households' individuals' health expenditure. Specific policies are needed to enhance geographical access to healthcare, financial access and quality of healthcare in moving towards universal health coverage.

The Chapter 5 and 6 focused on the distribution of health resources and the differences in health outcomes, the healthcare services access and use by the population during the period of decentralization and health resources transfer to local governments. As set out in the study central aim, these results should not be referenced as an impact evaluation of the decentralization and health resources transfer in Burkina Faso. These studies rather provided an opportunity to gauge the overall situation in health inequalities and to assess the magnitude of the efforts to be deployed by the local governments to meet the health needs of communities as part of the health resources transfer policy.

7.3. DISCUSSION OF THE MAIN FINDINGS

Based on the main findings of this dissertation summarized above, five cross-chapter statements are formulated. Each statement is presented and discussed below based on empirical evidence reported in the dissertation as well as other literature. Study limitations and further research are also defined.

Statement 1: Despite the progress in Sub-Saharan African countries, the decentralization reforms are yet to achieve their objectives.

The results of the systematic review on local governments' experiences in health services provision presented in Chapter 2 indicate that decentralization often fails to achieve its desired ends in Sub-Saharan Africa. As suggested by the literature review, the major rationale put forward to implement decentralization policy in the vast majority of countries, with the support of international donors, are the expected improvements of public services planning and delivery. The decentralization policies are built around the transfer of authority and functions from the central state to local governments, although the exact policy content varies across the Sub-Saharan African countries. The question is whether these various decentralization policies have succeeded in improving public services planning and delivery.

The empirical evidence suggests that the outcomes of decentralization in the field of healthcare are mixed with no clear evidence of a positive impact of decentralization on health services (as outlined in Chapter 2). The outcomes and effectiveness of decentralization on health services delivery in terms of access to services, equity and quality of care are inconclusive (Bossert & Beauvais, 2002; Bossert et al., 2003; Conyers, 2007; Cobos et al., 2016; Dwicaksono & Fox, 2018). The improvements in healthcare associated with decentralization that are reported by few papers (2/21) included in the review, are related to an increase health services access and use. The key contributing factors are community ownership, community participation and the availability of resources, particularly from international donors, (Anokbonggo et al., 2004; Hutchinson et al., 2006; Soura & Coulibaly, 2014). In Burkina Faso, the outcomes of decentralization in healthcare have not yet been measured. The figures available at this stage are related to the process of decentralization and health resources transfer.

The findings indicate that donor support is key to the improvement of healthcare credited to decentralization while other external financing has dropped significantly in Sub-Saharan African countries. This raises the issue of how sustained foreign aid is and what its impact on policy reform is. A study on the influence of health sector reform and external assistance in Burkina Faso (Bodart et al., 2001) found that the health budget as a percentage of the total public budget has decreased from 11%

to 9% between 1996 and 1998 due to a sharp reduction in external aid. More recent data suggest that external aid was slashed by half between 2010 and 2017. External health expenditure as a percentage of total health expenditure decreased from 41% to 18% and external health expenditures per capita decreased from $14 to $8 within that period (WHO, 2017). Regarding domestic funding, data show that the government health expenditure as a percentage of general government expenditure increased from 6% to 10%, which is still below the target of 15% recommended by the Abuja declaration to strengthen Africa's health systems (WHO, 2011). This suggests that the funding of the implementation of decentralization policy should be secured through a proper mobilization and allocation of domestic resources.

From the systematic literature review in Chapter 2, it appears that the effects of decentralization in healthcare in Sub-Sahara Africa are limited. The overall trends seem to indicate that the expected outcomes have not materialized yet. The reasons for this failure are twofold. The first reason is policy related, notably the type of decentralization and the decentralization implementation scheme. Evidence from the literature review shows that the satisfactory results observed in Ghana (Opare et al., 2011) and Tanzania (Frumence et al., 2013) have to do with the type of decentralization, notably the decentralization structure that granted large autonomy and decision space to local governments. Regarding the decentralization implementation scheme, it strongly impacts the health service organization and delivery, especially the relationships and responsibilities between local governments and health boards (Maluka et al., 2011), the coordination and monitoring mechanisms and the decentralization implementation bodies (Guiro et al., 2011; Ministère de la Décentralisation, 2014). The second reason is related to the institutional context of the country, such as the central government's will to make the legislative and administrative changes required for the effectiveness of decentralization (Khemani, 2006). Furthermore, the discussion of decision-makers' knowledge, attitudes and practices (KAP) related to decentralization in Burkina Faso presented in Chapter 3, highlights the policy and institutional factors that impede the effectiveness of decentralization. These include the intensive state intervention and political interference (Chapter 3), the insufficient central political and bureaucratic support, and the failure to transfer sufficient financial resources (Rondinelli, 1983).

Another major finding from the literature is the difference between the anglophone countries and the francophone countries in West Africa. In the first group, the decentralization process is in a fairly advanced stage, with decentralized bodies granted with a considerable degree of management and decision-making autonomy. By contrast in the second group including Burkina Faso, the countries are very centralized and hierarchical with a strong presence of the central state at all levels. This supports the view that francophone countries are still heavily influenced by their colonial past which portrays nearly all policies, including decentralization.

Limitations of the study and suggestions for future research

It should be acknowledged that we base our conclusions on limited empirical evidence. Specifically, our literature search resulted in a limited number of relevant publications with evidence on the link between decentralization and health services. Also, our review of the validity and reliability of the studies presented in the publications, suggests limitations in the study designs and methods, which prevent generalizations based on the available literature. To enlarge the knowledge based on decentralization in healthcare, which is particularly absent in Sub-Saharan Africa, and to provide evidence useful for policy-making in this region, attention should be paid to a systematic and rigorous assessment of related policy interventions. Such assessment will be useful for the given countries to decide on their decentralization reforms as well as for other countries in the region that consider decentralization in the health sector.

Statement 2: Despite the limited evidence on the effects of the decentralization policy on health services delivery, decision-makers are positive about the decentralization and health resources transfer in Burkina Faso.

The qualitative study that examined decision-makers' knowledge, attitudes and practices (KAP) about the decentralization and health resources transfer to local governments in Burkina Faso in Chapter 3, showed that all respondents are aware of health resources transfer policy. The main channel of information was the information notes released by the central state. We also find that the decision-makers are also knowledgeable of the rationale that led to the decentralization and transfer of health resources by providing arguments, which are in line with evidence reported elsewhere. This broad level of knowledge and awareness is key to policy implementation and helps prevent uncertainty over the policy objectives (Sakyi, 2011). Another important element uncovered in this study is the positive opinions expressed by the vast majority of the decision-makers, which likely reflects their support of the decentralization and health resources transfer policy. This positive attitude has its basis in the expected outcomes of decentralization, coupled with their awareness and understanding of the health resources transfer policy. The expected outcomes of decentralization that are supportive factors to decentralization policy, are also identified as enabling factors for decentralization in our study that assessed the strengths, weaknesses, opportunities and threats (SWOT) associated with decentralization in Burkina Faso (Chapter 4).

However, the question arises why decision-makers are positive about decentralization when the available evidence does not demonstrate the effectiveness of decentralization? Based on the study findings presented in Chapter 3, we could argue that the decision-makers' attitudes rely mainly on their perceptions that the implementation of the decentralization policy issued by the central state must always

be for the good of the nation. This perception is summarized by one decision-maker claiming that the decision to transfer health resources to local governments is part of the decentralization policy. As such, the resources transfer should be seen as a logical continuation of the decentralization policy. Given that the impact of resources transfer in Burkina Faso has not been assessed, we are therefore tempted to agree that the decision-makers' attitudes were guided by the theoretical objectives and expected outcomes of decentralization rather than by evidence on concrete achievements.

Based on the results in Chapter 3, we found that most decision-makers surveyed have not directly participated in the resources transfer process, either because they were not employed in their current position at that time or they were not entitled to participate in that policy phase. This has not influenced their positive opinions and attitude, suggesting that the direct contribution of stakeholders or beneficiaries in the implementation process of a given policy would not make a condition for their support to that policy.

Two major issues related to health resources transfer emerged from the discussion. The first is the poor collaboration among health districts and local governments. This could result from the frustration of health personnel, who fear the loss of some of their prerogative authority over the resources transferred, and the gap in the decentralization stage between the health sector and the political sector. Other reasons include the unclear definition of the distribution of functions between central government agencies and local authorities (Viglo, 2014), and the lack of coordination of the actors involved (Smoke, 2003). An additional reason is the ineffectiveness of health resources transfer to local governments. These issues were reported in the review in Chapter 2. In fact, the challenges in the collaboration between the decentralization stakeholders in Burkina Faso, were found to be a barrier to a proper implementation of health resources transfer (Guiro et al., 2011; Ministère de la Décentralisation, 2014). The ineffectiveness of health resources transfer has also to do with the intensive state intervention with delay in the resources transfer due to political interference in the resources transfer process and the central government's control over resources (Bossert & Beauvais 2002; Bossert et al. 2003; Maluka et al., 2011; Soura & Coulibaly, 2014). To that must be added the complexity of implementing decentralization schemes, which strongly impacts the health service organization and delivery, especially the relationships and responsibilities between local governments and health boards, the coordination and monitoring mechanisms among the stakeholders and decentralization agencies.

Limitations of the study and suggestions for future research

Our study used a qualitative method to provide an insight into the health resources transfer to local governments in Burkina Faso. The sample was limited to 20 participants

from the targeted organizations and institutions that are not representative of all organizations and institutions involved in the decentralization process. Therefore, the findings should be seen as indications of the selected key decision-makers' knowledge, attitudes and practices (KAP) towards health resources transfer, rather than a representative picture and causal effects that can be generalized to the entire country. As such, future studies are needed to thoroughly evaluate the decentralization process in Burkina Faso.

Also, we acknowledge that this study does not include the voices of beneficiaries (populations) for whom the policies are designed. We have assumed that the people, particularly in rural area do not have an in-depth knowledge of decentralization and the resource transfer process. We have therefore focused on their expectations about healthcare services quality, access and use that represent key expected achievements from decentralization and resources transfer, rather than their opinions on the decentralization policy. This path that has not been covered in our study suggests a way for future research.

Statement 3: The type of decentralization can be a factor of success or failure of decentralization reforms in Sub-Saharan Africa.

The studies reviewed in Chapter 2 suggest that there is limited evidence on the impact of decentralization on health system performance. We have therefore attempted to explore the association between the type of decentralization reported in these studies and the range of functions transferred to local governments, that is, the decision space. The question is whether the most decentralized countries, i.e. where the local authorities have been granted a wider range of control over the key functions, were more likely to improve the health system performance in comparison with the overcentralized countries.

The empirical evidence presented in Chapter 2, in which the decision space in selected Sub-Saharan African countries is reviewed, indicates that whatever the type of decentralization is, the decision space over the different functions transferred to local authorities may vary considerably. The findings suggest no relationship between the type of decentralization and the ranges of control over the functions transferred. Taking as an example Cote d'Ivoire and Zambia with the same type of decentralization that is de-concentration, the decision space over all the functions is narrow for Cote d'Ivoire, whereas for Zambia, the decision space ranges from narrow to wide. Another example from the literature is the deconcentrated health system in Zambia, where the shift in authority is to regional or district offices. These offices offer the same range of choice over functions as the health system in Uganda, where the shift is to autonomous elected district councils through devolution (Bossert & Beauvais, 2002).

A different view was reported by a study in Mali, which suggests that holding of the core functions such as financing, services organizations, human resources, health access rules, and governance, is influenced by the type and level of decentralization (Bossert & Beauvais, 2002). Decentralization can increase autonomy in generating financial resources from local sources, and the possibility of deciding on how to use them. Based on these findings, we would suggest that the range of choice over functions to be granted to local governments, should be guided by the desired level of health system performance, regardless of the degree of decentralization.

Beyond the type of decentralization, a key dimension to consider is the country-specific context within which the policy is formulated and executed. There are some important context-related factors that facilitate a successful implementation of the decentralization policy. These factors include: the appreciation of the role of all stakeholders by politicians, adequate availability and efficient utilization of resources, a reasonably developed infrastructure prior to the policy change, appropriate sensitization and training of those implementing policies, and good will and active involvement of the local community (Walt & Gilson, 1994; Litvack et al., 1998; Smoke, 2003; Olum, 2010) as also reported in Chapter 2. According to Khemani (2006), the way in which decentralization is carried out can be just as important to service delivery as the decision to decentralize itself.

Limitations of the study and suggestions for future research

Our literature review on the decision space in Chapter 2 is based upon limited empirical evidence from five countries. This could limit the generalization of the findings to other Sub-Saharan African countries that have implemented decentralization policies. The range of choices varies from country to country, with some governments granting more autonomy than others. There was insufficient evidence on the impact of decentralization to assess how these differences in decision space influenced the performance of each health system. This remains a major area for future research as also pointed about two decades ago (Bossert & Beauvais, 2002).

Statement 4: The healthcare decentralization in Burkina Faso has not resulted in a reduction of health inequalities.

The findings of the quantitative study presented in Chapter 5, based on data from the health management information system (HMIS), show disparities in health during the period of healthcare decentralization in Burkina Faso. The findings indicate a decline in poverty between 2010 and 2014, thereby suggesting a progress in the poverty reduction through the implementation of the poverty reduction strategy, one of these strategic areas being the strengthening of local governance through decentralization

("Ministère de l'Economie et des Finances," n.d.). Despite this progress in poverty reduction, there was a significant increase in inequality in income between the different regions and an unequal distribution of resources across health districts. As an example, the worst-off health region in 2010 has benefited from the lower allocation while the largest financing was allocated to the richest health region.

The findings in this dissertation show that the poorest and the most populated health districts are less likely to have an optimal level of health personnel and health infrastructure, reflecting the failure of the health resources allocation policy to distribute health resources in a fair and equal manner across the country. This has contributed to the deepening of inequality between urban and rural regions, as well as between well-off and poorest regions. The inequality in households' income was exacerbated predominantly in better-off regions, doubling or tripling in some regions. The poor health outcomes were associated with the health districts' poverty index and the availability of health resources. Although the findings suggest a decline in poverty broadly, this decline would not improve health outcomes if the inequality in household's income and the availability of health resources are not adequately addressed. This is also supported by the household-level results reported in Chapter 6, which indicate disparities in the use of health services in terms of age, education and income.

The literature review in Chapter 5 indicates that the health disparities in Burkina Faso are not only today since this problem has been observed before the start of decentralization (Bodart et al., 2001; Zida et al., 2010). Central to these disparities were the strong urban bias to public spending on health and the inequitable distribution of human resources. The major cause of inequality in health is the unfair distribution of health resources due to the over-centralization of resources leading to allocative and tecąical inefficiencies (Bodart et al., 2001; Von et al., 2003). The study findings in the context of health resources transfer in Burkina Faso show that decentralization could either lead to equity gains or exacerbate inequities (Shumah et al., 2016). Depending on the context, decentralization may foster inequities in health financing between sub-national jurisdictions. Aside from the financing, it is recognized that inequality could be substantially increased by the pre-existing socio-economic disparities and financial barriers to health access.

Limitations of the study and suggestions for future research

Our study used secondary data from the health management information system (HMIS) and national households' survey in Burkina Faso to carry out a bivariate correlation analysis. This approach may present some limits. First, the HMIS reports mainly focus on health facilities and they are not able to capture individual-level details

relevant to the wider population. Second, the measurement instruments used for the preparation of these reports have changed over time, making it difficult to perform a period-to-period comparison, as well as a comparison across health regions and health districts. Third, some potential misinterpretation and representativeness issues with the samples might have occurred, given our inability to control data quality and data interpretation. This could interfere with the statistical analysis. Fourth, the aim of the study was not to assess the effects of decentralization on the health system or on health. Therefore, the results should not be referenced as an evaluation of the decentralization impact on health inequality in Burkina Faso. This suggests that further research is needed to collect relevant data and investigate the effects or impact of decentralization on health.

Statement 5: Despite the decentralization of healthcare, the use of health services by households in Burkina Faso is limited by direct and indirect healthcare costs.

In Chapter 6 of this dissertation, we conducted a quantitative analysis to explore the factors associated with households' access to healthcare in Burkina Faso. The findings show that the main source of health-seeking were the primary healthcare facilities placed under the responsibility of local governments within the health resources transfer policy. Further analysis found that young children are the largest healthcare consumers. With the user's fees policy adopted by Burkina Faso since 1991, the healthcare costs constitute a major barrier to access to health for the vast majority of households. The study findings show that the average direct costs of health services incurred by households during the last episode of care-seeking care, is estimated to be $28, in a context where the social welfare system is very limited, thereby exposing households to catastrophic expenditures. The latest figures estimate per capita income at $642 and the voluntary health insurance as a percentage of current health expenditure at 1.43%. The out-of-pocket expenditure is estimated to constitute 31.7% of total healthcare spending (WHO, 2017).

It emerges from the analysis that the key factors that affect the households' health expenditures are age, the type of healthcare facility used, the distance travelled and the place of residence. Thus, households spend more on health services for children under 5 years old compared to other age groups. This suggests that the number of young children is a stronger determinant of households' out-of-pocket payments because of the early-age illnesses. This is a major rationale for the implementation of the free healthcare policy for vulnerable groups, which has been going on since 2016. This policy exempts children under 5 years old and pregnant women from all direct healthcare expenses during health-seeking in public health facilities. Seeking care in district hospitals, and primary healthcare facilities, which account for 81.39% of health-seeking sources, increase the healthcare expenditures for households. Households'

healthcare expenditures are heightened by indirect costs such as travel costs due to the distance to healthcare facilities and the area of residence. Distance to healthcare facilities incurs high treatment costs for households. Evidence from the literature indicates that transportation can be the main driver of cost difference during health-seeking (Keya et al., 2013; Castellani et al., 2018) and can be even more prohibitive to seeking necessary healthcare than the cost of services (WHO, 2010). This poses a strong challenge to the free healthcare policy in Burkina Faso and in other Sub-Saharan African countries. The main characteristic of those policies being the exemption of fees at the point of service delivery, not taking account of the indirect charges such as the transport. The findings also suggest that patients place of residence impacts costs. The healthcare costs in urban areas are much higher than the rural areas, as confirmed by previous studies in Burkina Faso (Beogo et al., 2016; Meda et al., 2019). These figures suggest that the objectives of the health system to ensure equal access to healthcare for all and to guarantee financial risk protection towards universal coverage have no yet materialized. Similarly, the purpose of the decentralization to deliver equitable and efficient health services is very far from being converted into reality, thus presenting a serious challenge to the local governments, which are now responsible for healthcare provision under the health resources transfer policy.

Limitations of the study and suggestions for future research

We used secondary data from a national household survey to carry out regression analysis, which presents two main limitations. First, we could not include all relevant variables but we had to limit our analysis to variables available in the dataset. Second, our study could only study associations between the households' socio-demographic and economic characteristics and their use of, satisfaction with and expenditures on health services. It was not possible to identify causal factors of access to healthcare in Burkina Faso. Again, the results should not be referenced as an evaluation of the decentralization impact in Burkina Faso but an account of the current situation, which needs to be investigated further to determine the relationship between healthcare use and decentralization processes.

7.5. CONCLUDING REMARKS

As conclusion remarks, it should be noted that decentralization policy and reforms are primary intended to improve the delivery of public services, including health services. This involves the effective transfer of functions, power and authorities to local entities. Our research on this topic for Sub-Saharan Africa indicates that decentralization often fails to achieve its end, despite the progress in the countries. The findings and previous research suggest that most of the countries have mainly focused on the

process by enacting numerous policies, regulations and standards that resulted in mitigated outcomes in health services delivery. However, we should recognize that decentralization is part of a long, slow process of state building and thus to be realistic about what it can be expected to achieve (Conyers, 2007). Decentralization remains a political decision and its implementation is a reflection of a country's political process (Rondinelli, 1983). Decentralization is neither good or bad but rather depends on its implementation and the country-specific institutional design (Dafflon & Madies, 2008; Ky, 2008). This should help guide decentralization policy design and reforms for the provision of equitable, efficient and quality healthcare to achieving universal health coverage in Sub-Saharan Africa.

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APPENDICES

Appendix A, B, C, D & E
Summary in English and French
Impact statements in English and French
Acknowledgments
Curriculum Vitae
List of publications

APPENDIX A,B,C,D&E

APPENDIX A

LIST OF PUBLICATIONS INCLUDED IN THE REVIEW (CHAPTER 2)

Anokbonggo, W.W., Ogwal-Okeng, J.W., Obua, C., Aupont, O. & Ross-Degnan, D. (2004a). Impact of decentralization on health services in Uganda: a look at facility utilization, prescribing and availability of essential drugs**.** *East African Medical Journal*, *Supplement*, 2-7.

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APPENDIX B

ENGLISH WORDING OF QUESTIONS USED TO COLLECT QUALITATIVE DATA AMONG THE PARTICIPANTS OF IN-DEPTH INTERVIEWS (CHAPTER 3 AND 4)

Before the start of the interview, the interviewers got a verbal agreement of respondents to participate in the study and the following information was provided:

- The objective of the survey to collect data on decision-makers opinions, knowledge, attitudes and practices about the decentralization and health resources transfer to local governments in Burkina Faso.
- The survey is part of an academic research.
- The survey is carried out in several departments at central level, as well at regional, local government and district level.
- The data collected will be exclusively used for the study purpose.
- The answers and information provided will not be related to your identity and the data will be processed and kept in the strictest confidentiality.
- The participation in the survey is completely voluntary and you have the right to decline to answer any question or to end the interview.

Section 1. General knowledge, experience, opinion and attitudes about decentralization and health resources transfer

- Are you aware of the health resources transfer from Central State to Local Governments?
- How have you been informed of the decentralization policy in Burkina Faso and the decision to transfer health resources to local governments? Please consider information sources such as newspaper, TV/Radio, Ministry of Health and Local Governments documents, or any other sources.
- Do you have any documents relating to this transfer of health resources to local governments in Burkina Faso? If yes, could you please list them?
- From your view what are the rationale of decentralization? What are the main implications of this policy?
- Have you participated or have you been involved in the process of health resources transfer? If yes, in which way were you involved and what was your experience with this?
- What is your overall attitude towards the shift of responsibilities from health districts to local governments in Burkina Faso? Positive, negative, neutral? Please explain why.

Section 2. Decentralization effectiveness

- What are the key expected outcomes from the decentralization in general and the health resources transfer in particular?
- As of today, how would you rate the health resources transfer to local governments? Have all the required resources and skills been effectively transferred? If not why?

Section 3. Strengths, weaknesses, opportunities and threats related to decentralization

- In your opinion, what are the strengths of the decentralization and the resources transfer to local governments in Burkina Faso?
- In your opinion, what are the opportunities opened up by the decentralization and the resources transfer to local governments in Burkina Faso?
- In your opinion, what are the key weaknesses in the decentralization, particularly the health resources transfer to local governments in Burkina Faso?
- In your opinion what risks or threats are involved in the decentralization and the resources transfer to local governments in Burkina Faso?

Section 4. Challenges and recommendations

- What are the key issues/challenges in implementing the decentralization, particularly the health resources transfer to your commune?
- What would you suggest or recommend to improve the provision of health services in the context of decentralization and resources transfer in Burkina Faso?

APPENDIX C

AN OVERVIEW OF PARTICIPANTS IN-DEPTH INTERVIEWS (CHAPTER 3 AND 4)

Profile of respondents (1 interview per respondent)	Urban	Rural	Total
	Numbers of respondents		
National policy and decision-makers	2	-	2
Regional council President	-	1	1
Health regional Directors	1	2	3
Health district team Managers	2	1	3
Mayor of municipalities	2	2	4
Primary healthcare center Managers	2	3	5
Country Donors	2	-	2
Total numbers of participants/respondents	11 (55%)	9 (45%)	20

APPENDIX D

DESCRIPTION OF QUANTITATIVE DATA COLLECTION REGARDING REGIONS (CHAPTER 5)

In **Chapter 5**, the analysis is drawn upon data collected through the health management information system (HMIS) and a national household survey:

- The HMIS reports are published yearly by the Ministry of Health to release key information and data on the health system functioning and services organization, the health services resources available and the distribution, access, utilization and coverage of healthcare, as well as health outcomes and health status. These reports are used to evaluate health system performances and health planning. In this study, HMIS reports were reviewed to gather the secondary data by health districts, namely demographic, health sources, health use, and health outcomes data.
- Two national households' surveys were used to gather secondary data on the economic profile of the 13 administrative regions, which also correspond to the territorial breakdown of the 13 health regions covering the 63 health districts of Burkina Faso:
  - *The Demographic and Household Survey (DHS)* conducted in 2010 and which included 15 000 households, used a quantitative method to collect data on household members' characteristics, education level, health services availability and access, use of iodized salt, household's welfare indicators.
  - *The Households Living Conditions Survey* conducted in 2014 has included 10 411 households. A quantitative method was used to collect data on household members' characteristics, education level, health, occupation, income, and housing.

The data collection points were 2010 and 2014 to allow for the changes in the socio-economic status, health services access, and health outcomes in health districts during the decentralization period, which started in 2009. The number of health districts was 63 during the period covered in the study. Another rationale for selecting the years 2010 and 2014 was the availability of data on economic characteristics collected through the national household surveys during the same periods.

APPENDIX E

WORDING OF THE QUESTIONS USED TO COLLECT QUANTITATIVE DATA AMONG THE PARTICIPANTS IN THE HOUSEHOLD SURVEY (CHAPTER 6)

In **Chapter 6,** we used data from a national household survey conducted in 2014 in Burkina Faso. This survey involved 10 800 households selected across all 45 provinces of the country, covering all 13 regions. A quantitative method was used to collect data on households' socio-demographic factors, access to and utilization of health services, access to education, housing, sanitation, food security, savings and access to credits, and new information tecąologies. Below, the exact wording of the questions is presented.

1. Socio-demographic characteristics
- Age
- Occupation
- Residence
- Gender
- Education
- Socio-professional status
- Income level (region poverty index)

2. Interview questions
- Did [householder member's Name] has a health problem within the preceding 15 days?
- What was the health problem/issue?
- Did [householder member's Name] sought care in health facilities or with a traditional healer?
- For what reasons [householder member's Name] has not sought care?
- Where [householder member's Name] has sought care [type of health facilities]?
- Who [profile of health personnel] has seen [householder member's Name] during health visit?
- Did [householder member's Name] was satisfied with the service provided at the health facilities?
- What is the distance from [householder member's Name] home to the health facility?
- What was the total amount paid by [householder member's Name] for consultation fees?
- What was the total amount paid by [householder member's Name] for laboratory check fees?
- What was the total amount paid by [householder member's Name] for drugs fees?
- What was the total amount paid by [householder member's Name] for hospital

admission fees?

- What was the total amount paid by [householder member's Name] for other health expenses?
- What was the total amount paid by [householder member's Name] for informal payment?

SUMMARY
IN ENGLISH AND FRENCH

SUMMARY

DECENTRALIZATION AND HEALTH RESOURCES TRANSFER TO LOCAL GOVERNMENTS IN BURKINA FASO

This dissertation examines the decentralization of health resources to local governments in Burkina Faso.

The aim was to explore the process and mechanisms of the transfer of health resources from the central government to the local governments in Burkina Faso. The dissertation also sought to analyze the differences in the distribution of health resources and the differences in health outcomes, and to assess the determinants of access to healthcare during the period of healthcare decentralization in Burkina Faso.

The general introduction of the dissertation presented in **Chapter 1,** provides an overview of the concept of decentralization and its rationale.

Decentralization refers to the restructuring or reorganization of authority so that there is a system of co-responsibility between institutions of governance at the central, regional and local levels according to the principle of subsidiarity. Decentralization may also be defined as any act through which a central government formally cedes powers to actors and institutions at lower levels in a political-administrative and territorial hierarchy. Over the past decades, many Sub-Saharan African countries have undergone decentralization reforms with the overall goal of improving efficiency, access and equity in the delivery of public services provided through or facilitated by local government authorities. These decentralization policy reforms were largely supported by international institutions such as the World Bank. Like other Sub-Saharan African countries, since 2009, Burkina Faso has engaged in a process to transfer health resources to local levels in accordance with the decentralization policy. This dissertation specifically explores the process, mechanisms and impacts of the transfer of health resources.

To outline the available empirical evidence and provide a basis for the subsequent empirical investigation, **Chapter 2** systematically reviews previous studies on local governments' experience with the provision of health services during and after decentralization reforms in Sub-Saharan African countries. The review was carried out in 2016 and included English and French-language publications that report on empirical studies that addressed the issue of decentralization in relation to health services provision by local governments in Sub-Saharan African countries. In total, 21 publications that met the relevance criteria, were included in the literature review. The analysis of the content of the publications and reports was related to the type

of publication and study design, key findings regarding the decentralization content, process and effects, as well as conclusions and recommendations.

The review results show that decentralization in general, and resources transfer from the central to local governments in particular, are a highly political issue that influences the healthcare reform strategy on decentralization. As such, most countries in Sub-Saharan Africa have focused on the decentralization process by enacting numerous policies, regulations and standards with mixed outcomes for health services delivery.

The literature highlights the complexity of implementing decentralization schemes, which strongly impact the health service organization and delivery. The theory of decision space applied in the review indicated that some functions, particularly financing, remain under the control of the central state. A major finding from the literature review is that the effects of decentralization in the field of healthcare are mixed with no clear evidence of a positive impact of decentralization on health services. The expected outcomes in the field of health services delivery in terms of access to services, equity and quality of care are inconclusive. The review has identified some good practices in decentralization and resources transfer, key determinants being the type of decentralization and the government's will to make legislative as well as administrative changes required for effective decentralization.

In **Chapter 3,** the key decision-makers' knowledge, attitudes and practices (KAP) related to decentralization and health resources transfer in Burkina Faso are investigated. Data were collected through a qualitative study using in-depth semi-structured interviews with decision-makers, namely the mayors of municipalities, health district managers and managers of healthcare center as well as policy decision-makers at a regional and national level, and donors/partners. A non-probabilistic sampling method was applied and the participants were selected purposely. We use the KAP framework to explore the three dimensions: Knowledge, Attitudes and Practices.

The findings show that all decision-makers who participated in the study, are knowledgeable about the objective and the rationale of decentralization and transfer of health resources to local governments in Burkina Faso. An important finding of this study is the positive opinion expressed by the vast majority of the decision-makers, which likely reflects on their support of the decentralization and health resources transfer policy. The main elements that appear to be motivating their attitude are the expected outcomes from decentralization, notably: i) better management of healthcare facilities; ii) improved capacities of local governments to provide services of better quality to communities, iii) better management of resources transferred, iv) increased population's access to health services, and v) increased local governments' accountability towards communities and beneficiaries.

While the findings in Chapter 2 suggest that the expected outcomes of decentralization have not yet been demonstrated, the decision-makers' positive attitudes found in this study mainly rely on the theoretical objectives and expected outcomes of decentralization rather than on evidence or concrete achievements. Most of the decision-makers surveyed have not directly participated in the resources transfer process, either because they were not employed in their current position at that time or they were not entitled to participate in that policy phase. The findings highlight, however, that this has not influenced their positive opinion and attitude towards decentralization and resources transfer.

Some major issues were identified by the study as factors that constraint the health resources transfer process to local governments. These include the poor collaboration among health districts and local governments, the delay in the resources transfer due to the central state control over the resources, the complexity of implementing decentralization schemes, which strongly impact: i) the health service organization and delivery, ii) the relationships and responsibilities between local governments and health boards, iii) the coordination and monitoring mechanisms among the stakeholders, and iv) decentralization agencies.

The methodology applied in Chapter 3 was extended to **Chapter 4** where the strengths, weaknesses, opportunities, and threats (SWOT) associated with the decentralization and health resources transfer in Burkina Faso were explored from the perspective of decision-makers. We used a qualitative research approach to conducted semi-structured interviews with the same key decision-making groups as indicated in chapter 3. The SWOT framework was used for the directed content analysis.

The most cited strengths in this study are political will and improvement of local governance, which also create the opportunity for an enhanced partnership and decentralized cooperation. As expected, however, the limited financial and human resources capacities of local governments are important weaknesses. Furthermore, misuse of financial resources and political interference threatens the resources transfer.

The disaggregation of the responses according to the participants' professional affiliation (health sector and decentralization sector) indicates that the responses seem to be converging to a certain extent. Further analysis done on the basis of mayors' political affiliation (governing and opposition), which is publicly known in contrast with other decision-makers in the study, shows some differences, thereby confirming the highly political nature of decentralization and resources transfer. Decision-makers in this study suggest ways to address the weaknesses and threats related to health resources transfer, which include the enforcement of decentralization's policies and laws, the strengthening of local government capacities, as well as their adequate funding and the regular review of the process of resources transfer.

In **Chapter 5**, the differences in health outcomes by health district's demographic and economic status were analyzed, and the distribution of health resources during the period of healthcare decentralization in Burkina Faso was studied. A quantitative analytical method was applied to explore associations between districts' demographics and economic profile, health resources, health outcomes, and health status. For this purpose, a database was created using district and region level data sourced from the health management information systems (HMIS) and national households' surveys. The data collection points for all sources were 2010 and 2014.

The findings indicate a strong correlation between the district's population size and the availability of health resources ($p<.05$). Health outcomes such as healthcare visits per capita and skilled birth attendance are correlated with the economic status of the health district. Also, malnutrition among children under-five and maternal mortality were associated with the availability of healthcare personnel and health infrastructure ($p<.05$). The data collected show that poverty has dropped considerably between 2010 and 2014, and it has even halved in some districts. This suggests a great achievement in poverty reduction, one of the stated aims of decentralization. However, this progress has not resulted in a reduction of inequality in income between the different regions and a more equitable distribution of resources across health districts. The inequality between urban and rural regions has even deepened, as well as between the well-off and poorest regions. The inequality in households' income was exacerbated predominantly in better-off regions, doubling or tripling in some of these regions. The root causes of these disparities across health districts and regions are to be found in the resource allocation approaches and mechanisms, as well as the policies to address the socio-economic inequalities and financial barriers to health services.

In **Chapter 6**, a quantitative research method was applied to analyze the factors associated with households' access to healthcare in Burkina Faso. The data were sourced from a national household survey conducted in 2014.

The findings show that the main source of health-seeking by the majority of patients (81.39%) are the primary healthcare facilities placed under the responsibility of local governments within the health resources transfer policy. Further analysis found that young children that represent 31.20% of the patients are the largest healthcare consumers. The average direct costs of health services incurred by households during the last episode of seeking care, is estimated to be $28, in a context where the social welfare system is very limited, thereby exposing households to catastrophic expenditures. The out-of-pocket expenditures were estimated to constitute 31.7% of total healthcare spending (WHO, 2017). It emerges from the analysis in this chapter that the key factors that affect the households' healthcare expenditure are age, type of healthcare facility used, distance traveled and place of residence. Thus, households

spend more on health services for children under 5 compared to other age groups. This suggests that the number of young children is a stronger determinant of households' out-of-pocket payments because of the early-age illnesses. Seeking care in district hospitals and primary healthcare facilities, which accounts for 81.39% of health-seeking sources, increases healthcare expenditure for households. Households' healthcare expenditures are heightened by indirect costs such as travel costs due to the distance to healthcare facilities and the area of residence. Distance to healthcare facilities leads to high treatment costs for households. The findings also suggest that patients' place of residence impacts costs. Overall, the objective of the health system to ensure equal access to healthcare for all and to guarantee financial risk protection towards universal coverage, has not yet materialized.

Finally, in **Chapter 7** the main findings are summarized and discussed from the perspective of policy development and policy implications. We draw conclusions on how to strengthen decentralization and improve health resources transfer to local level.

The chapter indicates that the decentralization policy and reforms implemented in Sub-Saharan African countries are primarily intended to improve the delivery of public services, including health services. This involves the effective transfer of functions, power and authorities to local entities. Based on the results of the research in Sub-Saharan Africa, the chapter discusses the effects of decentralization on health services delivery. The overall conclusion is that decentralization often fails to achieve its end in Sub-Saharan Africa, despite progress in individual countries. Most of the countries have mainly focused on the process by enacting numerous policies, regulations and standards that result in mitigated outcomes in health services delivery. The expected outcomes in terms of the provision of equitable, effective and quality healthcare are inconclusive. It is important to recognize that decentralization is a political decision and its implementation is a reflection of a country's political process and institutional design.

This final chapter also emphasizes the policy implications for Burkina Faso and other Sub-Saharan African countries for the provision of equitable, efficient and quality healthcare for achieving the goal of universal health coverage. Hence, countries need to assess their decentralization and health resources transfer policies with particular attention to the definition of decentralization objectives and expected outcomes, the political dimensions and country institutional context, the stakeholders' awareness and understanding, as well their roles and responsibilities, local governments capacities, funding of the decentralization policy implementation, policies that address health inequalities and barriers in healthcare access, monitoring-evaluation and accountability mechanisms.

RESUME

DÉCENTRALISATION ET TRANSFERT DES RESSOURCES EN SANTÉ AUX COMMUNES AU BURKINA FASO

La présente dissertation porte sur le transfert des ressources dans le domaine de la santé aux communes au Burkina Faso. L'objectif est d'explorer le processus, les mécanismes du transfert des ressources en santé de l'Etat aux communes ; d'analyser les différences dans la distribution des ressources en santé et l'état de santé des populations ; d'analyser les déterminants de l'accès aux services de santé pendant la période de la décentralisation au Burkina Faso en vue de contribuer à une meilleure compréhension des questions et défis inhérents au processus de transfert des ressources en santé.

Le **Chapitre 1** de la thèse présente l'introduction générale, un aperçu du concept et de la justification de la politique de décentralisation.

Le concept de décentralisation renvoie à la restructuration ou la réorganisation de l'autorité pour instaurer un système de coresponsabilité entre les institutions de gouvernance du niveau central, régional et local selon le principe de subsidiarité. La décentralisation peut être également définie comme tout acte par lequel l'Etat central cède formellement des pouvoirs aux acteurs et institutions du niveau local suivant l'organisation politico-administrative et territoriale du pays. Au cours de ces dernières décennies, plusieurs pays d'Afrique subsaharienne ont mené des réformes dans le domaine de la décentralisation avec pour objectif général d'améliorer l'efficience, l'accès et l'équité dans l'offre des services publics par les autorités communales. Ces réformes dans le domaine de la décentralisation étaient largement soutenues par les institutions internationales telle que la Banque Mondiale. A l'instar des pays d'Afrique subsaharienne, le Burkina s'est engagé depuis 2009 dans un processus de transfert des ressources en santé aux communes dans le cadre de la politique globale de la décentralisation. Plus spécifiquement, cette dissertation se propose d'explorer le processus, les mécanismes et effets de cette politique de transfert des ressources en santé aux communes.

Pour documenter les évidences empiriques disponibles et fournir une base pour les études ultérieures, le **Chapitre 2** examine à travers une revue systématique de la littérature, des études antérieures sur les expériences des communes en matière d'offres des services de santé, pendant et après la période des réformes des politiques de décentralisation en Afrique Subsaharienne. Cette revue a été réalisée en 2016 et a inclus des publications en langue française et anglaise ayant étudié la question de la décentralisation et de l'offre des services de santé par les communes en Afrique

Subsaharienne. Au total, 21 publications et rapports répondant aux critères de sélection ont été incluses dans la revue de littérature. L'analyse de contenu des publications et rapports a porté sur : i) le type de publication ou de rapport, ii) la méthodologie de l'étude, iii) les principaux résultats en lien avec le contenu, le processus et les effets de la décentralisation, ainsi que iv) les conclusions et les recommandations.

Les principaux résultats de la revue de la littérature indiquent que la décentralisation en général, et le transfert des ressources de l'Etat central aux communes en particulier revêtent un caractère hautement politique qui influence les stratégies de réformes de la santé en lien avec la décentralisation. Ainsi, la plupart des pays d'Afrique subsaharienne se sont focalisés sur le processus de décentralisation en adoptant de nombreuses politiques, régulations et standards avec des résultats mitigés en matière d'offres de services de santé.

La revue relève par ailleurs la complexité du cadre de mise en œuvre de la décentralisation, ce qui impacte fortement l'organisation et l'offre des services de santé. L'application de la théorie de l'espace de décision ou du pouvoir de décision lors de la revue révèle que certaines fonctions ou domaines, en particulier les finances, demeure sous le contrôle de l'Etat central. Un des constats majeurs de cette revue est que les effets de la décentralisation dans le domaine de la santé sont mitigés, sans une claire évidence de l'impact positif de la décentralisation sur les services de santé. Les résultats attendus dans le domaine de l'offre des services de santé en termes d'accès, d'équité et de qualité des services sont peu concluants.

La revue a toutefois identifié des bonnes pratiques en matière de décentralisation et de transfert des ressources dans certains pays. Les facteurs déterminants sont le type de décentralisation, la volonté de l'Etat central d'opérer les changements législatifs et administratifs nécessaires pour une décentralisation effective.

Dans le **Chapitre 3,** nous investiguons les connaissances, attitudes et pratiques (CAP) des décideurs clés en lien avec la décentralisation et le transfert des ressources. Les données ont été collectées à travers une étude qualitative. Un interview semi-structuré a été réalisé avec les décideurs, notamment : les maires de commune, les responsables de district sanitaire, les responsables de centre de santé , les décideurs politiques au niveau régional et central, ainsi que les partenaires du Burkina dans le domaine de la décentralisation. Un échantillonnage non probabiliste a été réalisé et les participants ont été sélectionnés de manière raisonnée.

Les résultats montrent que toutes les personnes interviewées connaissent les objectifs et la justification de la décentralisation et du transfert des ressources en santé aux communes au Burkina Faso. La grande majorité des décideurs rencontrés ont exprimé

une opinion positive, ce qui traduirait leur soutien à la politique de décentralisation et de transfert des ressources. Les principaux éléments qui semblent motiver leur attitudes positives sont les résultats attendus de la décentralisation, notamment : i) une meilleure gestion des centres de santé, ii) une amélioration des capacités des communes à fournir des services de qualité aux communautés, iii) une gestion efficiente des ressources transférées, iv) un meilleur accès des populations aux services de santé, et v) un renforcement de la responsabilité et de la redevabilité des communes envers les communautés et les bénéficiaires.

La plupart des décideurs enquêtés n'ont pas directement été impliqués dans le processus de transfert des ressources, soit parce qu'ils n'étaient pas employés dans leur poste actuel ou soit ils n'étaient pas habilités à participer directement au processus. Cependant les résultats montrent que cela n'a pas influencé ou affecté leurs opinions ou attitudes positives envers la décentralisation et le transfert des ressources.

Les résultats de la revue de la littérature présentés dans le Chapitre 2 suggèrent que les effets attendus de la décentralisation en matière d'offres de services de santé n'ont pas été concluants. Cependant, les décideurs interviewés dans cette étude expriment une opinion positive en soutien à la politique de décentralisation au Burkina Faso. Cette attitude positive des décideurs serait fondée principalement sur les objectifs et résultats théoriques de la décentralisation, plutôt que sur des évidences ou des réalisations concrètes

L'étude a révélé des facteurs majeurs qui contraignent le processus de transfert des ressources en santé aux communes. Il s'agit de la faible collaboration entre les équipes de district et des communes, le retard dans le transfert des ressources, la complexité du schéma de mise en œuvre de la décentralisation qui influence grandement : i) l'organisation et l'offre des services de santé, ii) les relations et les responsabilités entre les autorités communales et sanitaires, iii) les mécanismes de coordination et de suivi entre les différentes parties prenantes, et iv) les organes de la décentralisation.

Le **Chapitre 4** explore les Forces, Faiblesses, Opportunités et Menaces (FFOM) de la décentralisation et du transfert des ressources en santé aux communes au Burkina Faso. Pour cette étude, nous avons utilisé une méthode d'étude qualitative identique à celle du Chapitre 3, notamment un entretien semi-structuré avec les différents groupes de décideurs dont les profils sont présentés dans le Chapitre 3. La matrice FFOM a été utilisée pour l'analyse de contenu.

Les forces les plus citées par les participants sont la volonté politique et l'amélioration de la gouvernance locale, qui par la même occasion crée une opportunité pour un partenariat renforcé et une coopération décentralisée. Les faiblesses identifiées par

les enquêtés sont les capacités limitées en ressources financières et humaines des communes qui constituent des goulots d'étranglement majeurs dans le processus de transfert des ressources. En outre, la mauvaise gestion des ressources financières et l'interférence politique menacent le transfert des ressources.

La désagrégation des réponses selon l'affiliation professionnelle des enquêtés (secteur de la santé et secteur de la décentralisation) indique que les réponses semblent convergentes. Une analyse plus approfondie a été réalisée sur la base de l'affiliation politique des maires des communes (parti au pouvoir et opposition), laquelle affiliation est publiquement connue contrairement aux autres groupes de décideurs enquêtés. Les résultats de cette analyse montrent quelques différences, confirmant ainsi le caractère politique de la décentralisation et du transfert des ressources.

Les participants à l'étude ont formulé des suggestions pour la mitigation des faiblesses et des menaces, notamment l'application effective des lois et politiques de la décentralisation, le renforcement des capacités des communes, y compris leur financement adéquat et une revue régulière du processus de transfert des ressources.

Dans le **Chapitre 5,** une analyse des différences dans la couverture des interventions de santé, du statut de santé des populations selon le profil démographique et économique des districts sanitaires est réalisée. La distribution des ressources en santé pendant la période de décentralisation du système de santé au Burkina Faso est également étudiée. Une méthode d'analyse quantitative a été appliquée pour explorer l'association entre le profil démographique et économique des districts, les ressources en santé, la couverture des interventions et l'état de santé des populations. Pour ce faire, une base de données a été créée en utilisant les données des districts et régions sanitaires provenant du système national d'information sanitaire (SNIS) y compris les données des enquêtes ménages. La collecte des données pour les deux sources (SNIS et enquêtes Ménage) a porté sur l'année 2010 et 2014 en vue d'apprécier les différents changements intervenus au cours de la période du transfert des ressources en santé qui a débuté au Burkina Faso en 2009.

Les résultats indiquent une forte corrélation entre la taille de la population des districts et la disponibilité des ressources en santé ($p<.05$). La couverture des interventions de santé telles que le nombre de visites/an/habitant et les accouchements assistés sont corrélés avec le statut économique des districts sanitaires. De même, la malnutrition chez les enfants de moins de 5 ans et la mortalité maternelle sont associées à la disponibilité du personnel et des infrastructures de santé ($p<.05$). Les données collectées montrent que la pauvreté a considérablement diminuée entre 2010 et 2014, et aurait même baissé de moitié dans certains districts sanitaires. Ceci témoigne des progrès considérables réalisés dans la lutte contre la pauvreté qui est l'un des

objectifs assignés à la décentralisation. Cependant, ces progrès n'ont pas contribué à réduire les inégalités des revenus entre les différentes régions et à assurer une distribution équitable des ressources entre les districts sanitaires. Entre 2010 et 2014, les inégalités entre les régions rurales et urbaines se sont accentuées, aussi bien entre les régions pauvres et les régions riches. Les inégalités de revenus des ménages se sont exacerbées particulièrement dans les régions riches, doublant ou triplant dans certaines régions. Les causes profondes de ces disparités entre les régions et districts sanitaires se trouvent dans les méthodes et mécanismes d'allocation des ressources, aussi bien que dans les politiques de réduction des inégalités socio-économiques et des obstacles financiers dans l'accès aux services de santé.

Dans le **Chapitre 6,** une méthode quantitative de recherche est appliquée pour étudier les déterminants de l'accès des ménages aux services de santé au Burkina Faso. Les données utilisées proviennent de l'enquête nationale sur les conditions de vie des ménages réalisée en 2014.

Les résultats indiquent que les principales sources pour le recours aux soins pour la majorité des patients (81,39%) sont les centres de santé et de promotion sociale (CSPS) qui sont désormais placés sous la responsabilité des communes dans le cadre de la politique de transfert des ressources. L'analyse des données révèle que les enfants qui constituent 31,20% des patients sont les plus grands consommateurs des soins de santé. Le coût direct moyen des soins payé par les ménages lors du dernier recours aux soins est estimé à $28 (environ 14 000 FCFA) dans un contexte où le système de protection sociale est limité, exposant ainsi les familles à de potentielles dépenses catastrophiques de santé. Selon l'OMS (2017), les dépenses directes de santé supportées par les ménages constituent 31,7% de leurs dépenses totales de santé. Il ressort de l'analyse dans ce chapitre que les principaux facteurs qui influencent les dépenses de santé des ménages sont l'âge, le type de formation sanitaire utilisée, la distance et le lieu de résidence. Ainsi, les ménages dépensent plus pour la santé des enfants de moins de 5 ans que pour les autres groupes d'âge. Ce qui indique que le nombre de jeunes enfants est un facteur prépondérant des dépenses directes de santé des ménages en raison des maladies infantiles plus fréquentes. Le recours aux soins dans les hôpitaux de districts et les CSPS (81,39% des sources de recours aux soins) augmentent les dépenses de santé des ménages qui par ailleurs sont accentuées par les coûts indirects liés au transport et le milieu de résidence.

D'une manière générale, l'objectif du système de santé d'assurer un accès égal aux soins pour tous et de garantir une protection contre les risques financiers vers la couverture sanitaire universelle, n'est pas encore atteint au Burkina Faso.

Finalement dans le **Chapitre 7,** les principaux résultats sont résumés et discutés dans la perspective de l'élaboration et de l'implication des politiques et réformes de la décentralisation. Nous formulons les conclusions pour le renforcement de la décentralisation et l'amélioration du transfert des ressources au niveau local.

Ce chapitre rappelle que les politiques et les réformes de décentralisation mises en œuvre dans les pays d'Afrique subsaharienne avaient pour objectif principal d'améliorer l'offre des services publics, y compris les services de santé. Ce qui implique un transfert effectif des fonctions, des pouvoirs et autorités au niveau local. Sur la base des résultats de notre recherche en Afrique Subsaharienne, les effets de la décentralisation sur l'offre des services de santé sont discutés dans ce chapitre. Il en ressort que la décentralisation ne parvient pas à atteindre sa finalité, malgré les progrès enregistrés dans chaque pays. Dans la plupart des pays, les efforts se sont focalisés essentiellement sur le processus législatif et réglementaire. Les résultats attendus en termes d'offres de services de santé équitables, efficientes et de qualité sont mitigés. Il est important de reconnaitre que la décentralisation est une décision politique et sa mise en œuvre est à l'image du processus politique et de l'organisation institutionnelle du pays.

Dans ce chapitre final, nous soulignons également les implications de la politique de décentralisation au Burkina Faso et dans les autres pays de l'Afrique Subsaharienne, notamment la question de l'offre de services de santé équitables, efficients et de qualité dans la perspective de la couverture sanitaire universelle.

Par conséquent, les pays doivent réévaluer leurs politiques de décentralisation et de transfert des ressources en santé, en portant une attention particulière aux aspects clés ci-après : i) la définition des objectifs et résultats attendus de la décentralisation, ii) les dimensions politiques et l'organisation institutionnelle du pays, iii) l'information et la sensibilisation des différentes parties prenantes ainsi que leurs rôles et responsabilités, iv) les capacités des communes, v) le financement de la politique de décentralisation, vi) les politiques de réduction des inégalités en santé et des obstacles dans l'accès aux soins, vii) les mécanismes de suivi-évaluation et de redevabilité.

STUDY IMPACT STATEMENTS
IN ENGLISH AND FRENCH

IMPACT STATEMENTS

Introduction

This dissertation revolves around the transfer of resources to local governments in Burkina Faso within the overall decentralization policy. The aim was to explore the process and mechanisms of the transfer of health resources from the central government to the local governments in Burkina Faso. The dissertation also sought to analyze the differences in the distribution of health resources and the differences in health outcomes, and to assess the determinants of access to healthcare during the period of healthcare decentralization in Burkina Faso. Much like most of the Sub-Saharan African countries, the goal of the decentralization reform in Burkina Faso was to improve quality, access and equitable delivery of health services through or facilitated by local government authorities. This involves the effective transfer of functions, power and authorities from the central state to local governments. In the health sector, decentralization was part of the reform policies of many countries with the aim of improving efficiency, effectiveness and equity in health (Ribot, 2002; Junaid et al., 2005; Conyers, 2007; Saltman et al., 2007; Regmi, 2014). This reform has received a boost following the Alma Ata conference on primary healthcare since decentralization was viewed as a means for achieving primary healthcare goals (Green, 1992). The overall findings of this dissertation suggest that despite the progress in Sub-Saharan African countries, the decentralization reforms are yet to deliver their promised results. As discussed in this dissertation, decentralization is a very complex issue with varying facets according to the sociopolitical context of the various countries. In the health sector, concrete outcomes are therefore slow to appear in terms of access to services, equity and quality of care. Based on study findings and evidence gathered from the literature review, we outline in this section the key factors for policy considerations when implementing or amending a policy of resources or power transfer to local governments.

Setting of decentralization objectives and outcomes

It should be acknowledged that decentralization reforms in Sub-Saharan Africa were pushed by international donors, particularly the World Bank (Litvack et al., 1998). In the health sector, these reforms were driven by a wider macroeconomic policy and implementation of structural adjustment programs, which require control of public expenditure as well as changes in public and private sector institutional structures (Gilson and Mills, 1995). According to Kawonga (2017), the decentralization reforms have been initiated in many settings on the basis of its theoretical benefits rather than concrete evidence of its beneficial impact on health system performance. As outlined in this dissertation, the positive opinions and attitudes of decision-makers

towards decentralization are motivated by the theoretically expected outcomes. For Conyers (2007), there is a need to reappraise what democratic decentralization can realistically be expected to deliver in terms of improved service delivery. Therefore, when designing or amending decentralization programs or policies, the definition of objectives and expected outcomes should be evidence-based and appropriate to the country context for fostering ownership and successful implementation.

Political dimensions and country institutional context

Decentralization is a highly political process that influences policy reform because it changes the balance of power between national, regional and local levels (Derick & Leighton, 2001). The empirical evidence suggests that the highly political nature of the health resources allocation and skills transfer leads to continuous state intervention and political interference (see Chapter 2), often resulting in an untimely revision of decentralization laws and regulations with the aim of speeding up the implementation of decentralization. But sometimes, the unstated objective is to counter the influence of existing political forces or to maintain political interest and local powers (Hentic & Bernier, 1999; Crook, 2003; ERNWCA, 2011). This suggests that beyond the tecąical arguments and rationale in favor of decentralization, emphasis should be consistently placed on the political dimension of decentralization, as well as the country-specific context for achieving the expected outcomes. The country-specific context also deals with the type of decentralization, the design of resources transfer, and the decision space granted over the functions transferred that can be factors of success or failure of decentralization reforms.

Stakeholders' awareness and understanding

The attitudes of beneficiaries or stakeholders towards a given policy are key to the success of its implementation. Where the implementers of a policy are perceived to be favorable to the policy, their attitude to the implementation is highly positive (Makinde, 2005). A lack of knowledge on decentralization among other stakeholders might be a reason for them to avoid participation in the decentralization process. The findings in this dissertation indicate that the different stakeholders are likely to be supportive to decentralization and resources transfer policy when they are aware and when they understand what these reforms are all about. Nevertheless, a point commonly made in most of the Sub-Saharan African countries tends to demonstrate that decentralization is still reserved for political elites as a strategy for mobilizing and maintaining regional power bases (Crook, 2003); or expanding their control through developing new local institutions or re-structuring existing ones (Smoke, 2003). The ways of increasing the chance of success in decentralization policy implementation include an appropriate awareness-raising strategy of stakeholders at all levels, with

particular attention to the policy aims and outcomes, the implementation agenda, as well as the roles and responsibilities of the different stakeholders. This could enhance the degree of acceptability of decentralization reforms and avoid opposition at both central and local levels.

Roles and responsibilities of stakeholders

The study findings in this dissertation also raise the challenges in collaboration between the different stakeholders in the process of resource transfer. The main causes are the lack of coordination between local governments and health district staff, and a misunderstanding over the roles and responsibilities. The empirical evidence suggests that the reasons for the failure of decentralization often include the unclear definitions of the distribution of functions between central government agencies and local authorities (Viglo, 2014) and the lack of coordination of the actors involved (Smoke, 2003). This can lead to a failure to build linkages among the components of decentralization at the national and local levels. For improving the coordination towards decentralization policy implementation, the focus should be made on a clear definition of stakeholders' roles in addition to a formal collaboration or consultation mechanism among stakeholders (Derick & Leighton, 2001).

Local governments capacities

The study findings and the previous empirical evidence highlight that the local governments' capacities to manage the resources transferred are being squeezed in most of the Sub-Saharan African countries where decentralization policies are implemented. The main bottlenecks are the retention of financial and human resources at the central level and the insufficient training of local stakeholders. The transfer of resources is not always accompanied by corresponding measures of financial, material resources and particularly human capacities to adequately manage these resources (Derick & Leighton, 2001). Therefore, local governments do not have the required competencies and experiences to plan, implement, and evaluate development actions or initiatives at the local level (ERNWCA, 2011). In the health sector, local governments have limited financial and tecąical capability to manage the health personnel, equipment, and tecąical activities to deliver health services (Bossert & Beauvais, 2002). Under the implementation of decentralization and resources transfer policy, the strengthening of local governments' capacities is key for the optimal management and efficient utilization of resources. This implies adequate support with corresponding material, financial and especially in qualified human resources.

Funding of policy implementation

The empirical evidence indicates that nearly 30% of projects with decentralization components in Sub-Saharan Africa were supported by the World Bank (Litvack et al., 1998). Similarly, in the health sector, external funding contributes greatly towards filling the gaps in health financing in the vast majority of these countries. This raises in particular, the thorny issue of the sustainability of external support and the risk of interruption in the funding of any given policy implementation with the withdraw of donors. To illustrate the downward trend in donors' support to the health sector in Burkina Faso, data from the National Health Accounts (NHA) indicate that the external health expenditure as a percentage of health expenditure has been halved (from 41% to 18%) between 2010 and 2017.

Financial resources are the crux of the decentralization policy implementation in Sub-Saharan African countries, as shown by the study findings and confirmed by previous empirical evidence (Bossert & Beauvais, 2002; Muriisa, 2008; Sidibé, 2011; ERNWCA, 2011; Bekalé, 2011; Soura & Coulibaly, 2014). According to Rondinelli et al. (1983), in nearly all countries where governments have attempted to decentralize, the process was weakened by the failure to transfer sufficient financial resources to those organizations to which responsibilities were shifted. The underfinancing of local governments limits their capacities to deliver services. To effectively implement decentralization and resources transfer objectives, an appropriate level of funding must be guaranteed through sustainable domestic funding. The aim is to increase the local governments' own financial resources to deliver services. This should take account of a more transparent and equitable allocation of resources, as well as an accelerated resource transfer to local governments.

Policies to address health disparities and barriers in access to healthcare

The study findings indicate that health disparities remain widespread in Burkina Faso, despite the different health reforms undertaken to improve the performance of the health system. This resulted in demographic and economic differences in health outcomes between health districts. Equitable healthcare access and use are hampered by geographical and financial barriers that peaked direct and indirect healthcare costs. As Burkina Faso moves forward on the pathway towards universal health coverage, there is an urgent need to address these inequalities by requiring appropriate measures to mitigate the socio-economic disparities and financial barriers to health services. More significantly, future efforts need to focus on more transparent resource allocation that promotes equity among and within the different geographical entities, notably the local governments.

Monitoring-evaluation and accountability mechanisms

The study findings and previous research indicate that the effects or impacts of decentralization on health service delivery remain to be proven in Sub-Saharan African countries. In Burkina Faso, the health resources transfer is in the learning process, though with an insufficient monitoring system (Ministère de l'Administration Territoriale, 2014). For countries, which implement decentralization policy, it is imperative to design or strengthen the monitoring and evaluation system to provide evidence to guide the policy design and reform, as well to improve the accountability and transparency of local governments to their citizens.

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IMPLICATIONS DES RÉSULTATS DE L'ÉTUDE

Introduction

Cette thèse porte sur le transfert des ressources en santé aux communes dans le cadre de la politique globale de décentralisation au Burkina Faso. L'objectif est d'explorer le processus, les mécanismes du transfert des ressources en santé de l'Etat aux communes, d'analyser les différences dans la distribution des ressources en santé et de l'état de santé des populations, ainsi que les déterminants de l'accès aux services de santé pendant la période de la décentralisation au Burkina Faso. A l'instar des autres pays d'Afrique Subsaharienne, l'objectif des réformes de la décentralisation au Burkina Faso était d'améliorer la qualité, l'accès et la fourniture équitable des services par les collectivités décentralisées. Ce qui requiert un transfert effectif des fonctions, des pouvoirs et autorités de l'Etat aux communes. Dans le secteur de la santé, la décentralisation s'inscrivait dans le cadre des politiques de réformes dans plusieurs pays avec pour objectif d'améliorer l'efficience, l'efficacité et l'équité dans le domaine de la santé (Ribot, 2002 ; Junaid et al., 2005; Conyers, 2007; Saltman et al., 2007; Regmi, 2014). Ces réformes ont connu un certain regain après la conférence d'Alma Ata sur les soins de santé primaires, la décentralisation ayant été promue comme un moyen d'atteindre les objectifs des soins de santé primaires (Green, 1992). Les résultats globaux de cette dissertation suggèrent que malgré les progrès réalisés dans les pays d'Afrique Subsaharienne, les réformes de la décentralisation n'ont pas encore livré les résultats promis. Comme discuté dans la présente dissertation, la décentralisation est un sujet très complexe avec des facettes variables selon le contexte socio-politique des différents pays. Dans le domaine de la santé, les résultats concrets semblent lents à se manifester en termes d'accès aux services, d'équité et de qualité des soins. A partir des résultats de l'étude et des évidences issues de la revue de littérature, nous présentons dans cette section les éléments ou facteurs clés à considérer lors de la mise en œuvre ou de la revue d'une politique de transfert des ressources ou de pouvoirs aux communes.

Définition des objectifs et résultats attendus de la décentralisation

Il convient de reconnaitre que les réformes de la décentralisation dans les pays d'Afrique Subsaharienne étaient impulsées par les donateurs internationaux, en particulier le Banque Mondiale (Litvack et al., 1998). Dans le domaine de la santé, ces réformes étaient motivées par une politique macroéconomique et la mise en œuvre des programmes d'ajustement structurels qui prônent un contrôle des dépenses publiques, aussi bien que des changements dans la structure des institutions publiques et privées (Gilson and Mills, 1995). Selon Kawonga (2017), les réformes de la décentralisation ont été initiées dans beaucoup de contextes sur la base de ses avantages théoriques plutôt

que sur la base d'évidences concrètes des effets bénéfiques sur la performance du système de santé. Comme présenté dans cette dissertation, les opinions et attitudes positives des décideurs envers la décentralisation étaient motivées par les résultats théoriques attendus de la décentralisation. Selon Conyers (2007), il est impératif de réexaminer d'un point de vue réaliste ce que l'on peut attendre de la décentralisation démocratique en termes d'amélioration de la fourniture des services. Par conséquent, lorsqu'on conçoit ou révise des programmes ou politiques de décentralisation, la définition des objectifs et résultats attendus doivent être basés sur des évidences et adaptés au contexte du pays pour favoriser une appropriation et un succès dans la mise en œuvre.

Dimensions politiques et contexte institutionnel du pays

La décentralisation est un processus hautement politique qui influence les réformes des politiques parce qu'elle change l'équilibre des pouvoirs entre le niveau national, régional et local (Derick & Leighton, 2001). Les données empiriques portent à croire que le caractère hautement politique du transfert des ressources engendre une intervention continue de l'Etat central et une interférence politique (voir Chapitre 2 de la dissertation), entrainant souvent une révision intempestive des lois et textes de la décentralisation avec pour objectif d'accélérer la mise en œuvre de la décentralisation. Mais parfois, l'objectif inavoué est de contrer l'influence des forces politiques existantes ou de maintenir les intérêts politiques et les pouvoirs locaux (Hentic & Bernier, 1999; Crook, 2003; ERNWCA, 2011). Cela suggère qu'au-delà des arguments tecąiques et les justifications en faveur de la décentralisation, une attention particulière doit être portée sur la dimension politique de la décentralisation, aussi bien que sur le contexte spécifique du pays pour l'atteinte des résultats attendus. Le contexte spécifique du pays porte également sur le type de décentralisation, la conception du transfert des ressources et le pouvoir de décision accordé pour la gestion des ressources transférées qui peuvent être des facteurs de succès ou d'échec des réformes de la décentralisation.

Connaissances et compréhension des parties prenantes

Les attitudes des bénéficiaires envers une politique donnée est un facteur clé de succès dans sa mise en œuvre. Lorsque les responsables de la mise en œuvre d'une politique semblent favorables à cette politique, leurs attitudes à sa mise en œuvre est très positive (Makinde, 2005). La méconnaissance de la décentralisation par les parties prenantes pourrait être la raison de leur non-participation ou de leur désintéressement au processus de la décentralisation. Les données de la dissertation indiquent que les différentes parties prenantes sont enclins à soutenir la politique de décentralisation et de transfert des ressources quand elles sont informées et comprennent le sens de ces réformes. Cependant, le point commun relevé dans les pays d'Afrique Subsaharienne

tend à démontrer que la décentralisation est encore réservée aux élites politiques comme stratégie de mobilisation et de maintien des bases locales de pouvoir (Crook, 2003); ou d'expansion de leur contrôle à travers la création de nouvelles institutions locales ou de restructuration de celles qui sont déjà en place (Smoke, 2003). Les voies pour augmenter les chances de succès dans la mise en œuvre de la politique de décentralisation incluent une stratégie appropriée d'information et de sensibilisation des parties prenantes à tous les niveaux, avec une attention particulière accordée aux objectifs et résultats attendus de la politique, aussi bien qu'aux rôles et responsabilités des différents acteurs. Ceci pourrait renforcer l'acceptabilité des reformes de la décentralisation et éviter les oppositions tant au niveau central que local.

Rôles et responsabilités des parties prenantes

Les résultats de l'étude soulèvent également les défis dans la collaboration entre les différentes parties prenantes au processus de transfert des ressources. Les principales causes sont le manque de coordination entre les communes et les districts sanitaires et une incompréhension sur les rôles et responsabilités. Les évidences empiriques suggèrent que parmi les raisons de l'échec de la décentralisation figurent souvent la définition imprécise de la distribution des fonctions entre les structures centrales de l'Etat et les autorités locales (Viglo, 2014) et le manque de coordination des différents acteurs impliqués (Smoke, 2003). Ceci peut engendrer un échec dans l'établissement des liens ou de passerelles entre les différentes composantes de la décentralisation au niveau national et local. Pour améliorer la coordination dans le cadre de la mise en œuvre de la politique de décentralisation, l'accent doit être porté sur une définition claire des rôles et responsabilités des différentes parties prenantes en plus d'un mécanisme formel de collaboration ou de consultation entre les acteurs (Derick & Leighton, 2001).

Capacités des Communes

Les résultats de l'étude et les évidences empiriques antérieures soulignent que les capacités des communes à gérer les ressources transférées ont été mises à rude épreuve dans la plupart des pays d'Afrique Subsaharienne où des politiques de décentralisation sont mises en œuvre. Les principaux goulots d'étranglement sont la rétention des ressources humaines et financières au niveau central et la formation insuffisante des parties prenantes au niveau local. Le transfert des ressources n'est toujours pas accompagné des mesures correspondantes en matière de ressources financières et matérielles, et particulièrement en ressources humaines pour gérer de manière adéquate ces ressources (Derick & Leighton, 2001). Par conséquent, les communes n'ont pas toujours les compétences requises et expériences nécessaires pour planifier, mettre en œuvre et évaluer les actions ou initiatives de développement

au niveau local (ERNWCA, 2011). Dans le secteur de la santé, les communes ont des capacités financières et tecąiques limitées pour gérer le personnel, les équipements et les activités tecąiques pour fournir les services de santé (Bossert & Beauvais, 2002). Dans le cadre de la mise en œuvre de la politique de décentralisation et de transfert des ressources, le renforcement des capacités des communes est essentiel pour une gestion optimale et une utilisation efficiente des ressources. Ce qui implique un appui adéquat en ressources matérielles, financières et humaines appropriées.

Financement de la mise en œuvre de la politique

Les évidences empiriques indiquent que près de 30% des projets incluant une composante sur la décentralisation dans les pays d'Afrique Subsaharienne étaient financés par la Banque Mondiale (Litvack et al., 1998). De même, dans le secteur de la santé les financements externes contribuent grandement à combler les gaps de financement de la santé dans la grande majorité de ces pays. Cette situation soulève en particulier l'épineuse question de la pérennité de l'appui externe et le risque d'interruption du financement de la mise en œuvre de toute politique avec le retrait des donateurs. Pour illustrer la tendance à la baisse de l'appui des donateurs au secteur de la santé au Burkina Faso, les données des comptes nationaux de la santé indiquent que les dépenses de santé du reste du monde (financements extérieurs) en proportion des dépenses totales de santé ont baissé de moitié (de 41% à 18%) entre 2010 et 2017.

Les ressources financières sont le nerf de la guerre dans la mise en œuvre de la politique de décentralisation dans les pays d'Afrique Subsaharienne, comme l'ont démontré les résultats de l'étude et confirmé par les évidences empiriques antérieures (Bossert & Beauvais, 2002; Muriisa, 2008; Sidibé, 2011; ERNWCA, 2011; Bekalé, 2011; Soura & Coulibaly, 2014). Selon Rondinelli et al. (1983), dans presque tous les pays où les gouvernements ont tenté de décentraliser, le processus a été fragilisé par le manque de transfert de ressources financières suffisantes aux organisations auxquelles les responsabilités ont été transférées. Le sous financement des communes limite leurs capacités à fournir les services. Pour une mise en œuvre efficace des objectifs de la décentralisation et du transfert des ressources, un niveau de financement adéquat doit être garanti à travers un financement domestique durable. L'objectif est d'augmenter les capacités financières propres des communes à fournir les services. Ceci doit prendre en compte une allocation transparente et équitable des ressources, aussi bien qu'un transfert accéléré des ressources aux communes.

Politiques pour remédier aux inégalités et obstacles dans l'accès à la santé

Les résultats de l'étude indiquent que les inégalités dans le domaine de la santé demeurent répandues au Burkina Faso, malgré les différentes réformes entreprises

dans le secteur de la santé pour améliorer les performances du système de santé. Il en a résulté une différence dans la répartition des ressources, la couverture des services et l'état de santé des populations entre les districts sanitaires. L'accès et l'utilisation équitables des services de santé sont entravés par les barrières géographiques et financières qui accroissent les coûts directs et indirects des services. Etant donné que le Burkina Faso est engagé dans la dynamique de la couverture sanitaire universelle, il y'a un besoin urgent de remédier à ces inégalités en adoptant des mesures appropriées pour atténuer les disparités socio-économiques et les barrières financières dans l'accès aux services de santé. De manière plus importante, les futurs efforts doivent être axés sur une allocation plus transparente des ressources pour favoriser une équité entre et au sein des différentes entités géographiques, notamment les communes.

Mécanismes de suivi-évaluation et de redevabilité

Les résultats de l'étude et ceux les études antérieures indiquent que les résultats attendus de la décentralisation sur la fourniture des services de santé restent à être prouvés dans les pays d'Afrique Subsaharienne. Au Burkina Faso, le transfert des ressources est dans une phase d'apprentissage, cependant avec un system de monitoring insuffisant (Ministère de l'Administration Territoriale, 2014). Pour les pays qui mettent en œuvre une politique de décentralisation, il est impératif de concevoir ou de renforcer le système de suivi-évaluation en vue de fournir des évidences pour guider la formulation et la réforme de la politique, aussi bien que pour améliorer la redevabilité et la transparence des communes envers leurs citoyens.

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CURRICULUM VITAE

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Hilaire has joined the PhD program in 2015 on a part-time basis at the Department of Health Services Research, Maastricht University with a self-funding and the support of Maastricht University. His research was focused on the transfer of health resources to local governments in the context of decentralization policy in Burkina Faso. In parallel to this, he worked with the Ministry of Health and also provided tecąical expertise as Consultant.

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