Author's response to reviews

Title: An implementation evaluation of a policy aiming to improve financial access to maternal health care in Burkina Faso

Authors:

Loubna Belaid (loubna.belaid@umontreal.ca)
Valéry Ridde (valery.ridde@umontreal.ca)

Version: 8 Date: 4 November 2012

Author's response to reviews: see over
Comments reviewer 1

The English writing manuscript was revised

Major Compulsory Revisions:

1. In abstract, the first sentence should be completed for more detailed information. It is not enough to describe that 'some activities to improve quality of care' were not implemented.

   Thank you for this comment. To be complete, we added some examples in the abstract. We changed the sentence as it follows: "All the activities were implemented as planned except for completely subsidising the worst-off and some activities such as surveys for patients and quality assurance service team aiming to improve quality of care".

2. It remained unclear why there were no local ethical clearance.

   Thank you for this comment. To be clearer, we added some information. The health research ethics committees of the Ministry of Health of Burkina Faso (no. 2010-072) and the University of Montreal (CRCHUM) approved the study (10.178). Authorization (2010 06 04 MS-RSHL-DRS) was given by the direction of the health region in the Sahel to conduct the study. The anonymity of participants was maintained throughout the study. Informed consent was obtained from the participants.

3. Instead of a fictitious name, remove the references to district name. I cannot see any reason why the real name of the district could not be given.

   Thank you for this comment. The name of the district was given. In the ethic certificate we have mentioned that we will ensure the anonymity of the health centres and the names of participants.

Minor Essential Revisions:

1. Always when referring to local currency, give the amount systematically in Euro.

   Thank you for this comment. It is done in the whole manuscript.

2. Avoid the use of 'billion', which can be interpreted differently.

   Thank you for this comment. To be clearer, we removed the word ‘billion’ and we put the numeric digit.

3. Systematise decimal points instead of commas.

   Thank you for this comment. It is done in the whole manuscript.

4. Close the gap between percentage units and percent.

   Thank you for this comment. It is done in the whole manuscript.

5. Page 7. The abbreviation TBA has already been given earlier.
6. Some of the figures are given very detailed, e.g. page 11 the distance of 11.42 km or the rate of assisted deliveries. One decimal (or even no decimals) could be considered.

Thank you for this comment. It is done in the whole manuscript.

Comments reviewer 2

The English writing manuscript was revised

• Major Compulsory Revisions

1. Intervention background: The first level of the district health system should not be addressed as “health facilities”, but more specifically as “health centres”. Health facility is a generic term which includes all institutions where formal health care is provided, from health centres to university teaching hospitals. Health centre comes close enough to the Burkinian term ‘Centre de santé et promotion sociale’ (CSPS). Change terminology throughout text, tables and figures.

Thank you for this comment. The change was done in the whole manuscript.

2. Intervention background: The second level of the district health system should be addressed as district hospitals, as they are the level where comprehensive non-specialist clinical care is delivered. The term ‘referral hospitals’ is more appropriate for the regional and national hospitals – they take patients who cannot be handled at district hospital level. Change terminology throughout text, tables and figures.

Thank you for this comment. The change was done in the whole manuscript.

3. Intervention background: The statement “all emergency obstetric care is handled at this level [i.e. the district hospital level]” is likely to be incorrect. Health centres are supposed to deliver basic emergency obstetric care, district hospitals are supposed to provide comprehensive obstetric care. I am sure that there are dysfunctional health centres that do not deliver what they are supposed to deliver, but it is not true that no emergency obstetric care happens at the first level.

Thank you for this comment. To avoid any ambiguous, we reformulate the statement as it follows:” They also provide basic emergency obstetric care (EMOC), which includes antibiotics, oxytocics and convulsants, manual removal of the placenta, assisted vaginal delivery and newborn care

4. Intervention background: The statement “cases that require … blood transfusion are sent to a higher level [i.e. higher than district level] ” is inaccurate as well. District hospitals are supposed to provide comprehensive emergency obstetric care which includes blood transfusion. There are certainly district hospitals that are not fully functional, but it is not correct to say that as a rule blood transfusions requires treatment at a higher than district level. In an assessment of 42 district hospitals we carried out in 2007 we found 86% of these
hospitals offering blood transfusions.

Thank you for this comment. The statement was changed as it follows: The second level is the district hospitals (CMA), which are located in towns. These serve the population of the entire district and all emergency cases from CSPS. There is a surgery department in the district hospital and a blood transfusion service. This level provides comprehensive emergency obstetric care, which means all the basic emergency obstetric care plus caesarean sections and care to sick and low birthweight newborns.

5. Intervention background: The statement “cases that require more complex care and blood transfusion are sent to a higher level (national, university hospital)” is not accurate. The next level most district hospitals should and do refer to is the regional hospital (‘Centre hospitalier régional’, CHR) where specialist care normally is available. District hospitals for which one of the national hospitals is better accessible may refer there, but normally the referral hospitals for district hospitals are the regional ones.

Thank you for this comment. The statement was changed as it follows: The third level of the health system is the regional hospitals.

6. Intervention background: I was surprised to read that TBAs today have the role “to help health workers in their daily activities”. This may well happen occasionally, but if this means it is general policy and practice I would like to have a reference.

We added the official decree that states that TBAs are no longer allow to perform deliveries. It is true that it is not everywhere but it happens occasionally. We changed the statement as it follows: Today, their role is to help women to reach a health centre. However, they still perform deliveries in some villages that are far from a health centre. In some health centres, they are invited to participate informally in activities (e.g. increasing awareness, cleaning the delivery room). In some health centres, they receive a bonus fee.

7. Intervention: The sentences “This policy consists of subsidizing between 20 and 80 % of the price of deliveries and emergency obstetric care at different level of care. Women pay 20 to 40 % of the total cost remaining” raise two questions: firstly, what determines whether the subsidies constitute 20% or 80% of the costs – this is a huge range; secondly how is it possible that subsidies may be as low as 20%, and yet women pay 40% of the total cost? 20%+40%=60% - who pays the remaining 40%?

To be clearer, we changed the sentence as it follows: “The policy consists of subsidizing 60% to 80% of the cost associated with assisted deliveries and emergency obstetric care depending on the level of care. Women pay the remainder [32]. For example, for an uncomplicated delivery at a health centre, women have to pay 900 CFA (1.4 Euros).

8. Method: “This district was chosen because an information system collecting data on deliveries in health centres was established”. There is a national MoH health information system, which includes data on deliveries and is used in all districts. So what was special about the system in Inna district?

This district was chosen because it is part of a larger research program on the effect of the elimination of user fees at point of service on the use of health services[36]. In this research program, the district of Djibo was used as a control district, since only the national subsidy of obstetric care was applied (no
intervention of NGOs freeing up health care). Therefore, the data quality of the HIS (Health Information System) of the MoH (Ministry of Health) was verified and due to the context of the program (national policy implementation without NGO support), the district of Djibo was chosen to conduct the study.

9. Method: It needs to be described how the focus groups participants were selected – it is not sufficient to state the objectives of the selection process (“... formed to include individuals who have used maternal health services / who have lived in the village for several years ...”).

Community health workers were asked to gather a group of 8 to 10 women and 8 to 10 men in the villages. Men and women were gathered in the public square of the village. The selection process involved gathering participants who share common characteristics (people who live in villages, rural areas, agriculture and husbandry as main economic activities) in relation to the topic (the national subsidy of obstetric care). The objective of the selection was to mix opinions in order to highlight points of view, perspectives on this national subsidy of obstetric care and relations with the health centre.

10. Method: Did the community health workers / TBAs participate in the focus groups of villagers? If so, how may this have influenced the views expressed by the villagers? Would they have expressed satisfaction with the new policy (which takes functions and importance away from TBAs) perhaps less easily in the presence of the TBA? To be discussed as possible limitation in the discussion section.

TBAs and CHWs were not systematically present during the focus groups. Data do not show any difference when they were present or absent. It was ensured that all participants express their ideas, views on this policy and their relationship with the health center. During the focus groups, TBAs and CHWs were considered participants as well as others. People were expressing their ideas freely.

11. Ethical considerations: Please provide information on ethics clearance by the relevant Burkinian authorities.

The health research ethics committees of the Ministry of Health of Burkina Faso (no. 2010-072) and the University of Montreal (CRCHUM) approved the study (10.178). Authorization (2010 06 04 MS-RSHL-DRS) was given by the direction of the health region in the Sahel to conduct the study. The anonymity of participants was maintained throughout the study. Informed consent was obtained from the participants.

12. Incentive measures: Is a 20% bonus per medical act now “usual” in Burkina Faso? 20% of what? If so, it should be said in the introduction or setting section, when the health system is described. In that context it would also be good to provide some information on the salaries for health workers in BF, which are, in my understanding, quite high and reliable for African standards. This to put the never-ending quest for more “motivation” into context.

To be more complete, we added information on the 20% bonus in the background section. Health workers receive bonuses based on their medical activities. They are entitled to 20% of medical consultations and actions per patient [34]. According to a study published in 2009, the net salary of nurses with less than 5 years experience working in the public sector is estimated at 110,409 CFA (168 Euros) (median amount).

13. Incentive measures: the sentences “Some health facilities … to motivate them” are not clear.
To be clearer, we reformulate the statement as it follows: According to health workers, this policy should have been planned to offer a formal financial incentive measure to encourage them in their work in addition to the 20% bonus.

14. The TBA and the community health worker are not sufficiently differentiated. Some time ago, the term “accoucheuse villageoise” has been coined in Burkina, and these women constituted together with the male agent de santé villageois the “staff” of the poste de santé primaire, i.e., they became community health workers. Often, but not always, villages chose their (untrained) accoucheuse traditionelle to become the (trained) accoucheuse villageoise. So what is the role of the TBA and the CHW in the context of maternal health nowadays? Do they have the same role? Should they have the same role?

It is true that their role is not sufficiently differentiated because nowadays in the context of maternal health they have informally the same role. They have to help women to reach a health centre for childbirth. They are involved in the management of the transport of the parturient. They have to sensitized women to do antenatal care and childbirth in health centres.

To be more complete, we added the statement as it follows: In the context of maternal health services, TBAs and community health workers play the same informal role (helping women to reach a health centre to give birth, increasing awareness). However, TBAs are more inclined to perform deliveries.

15. A fairly effective implementation: “Indeed, all the information about health care is transmitted to [the TBAs]”. Which information is transmitted TO the TBAs, by whom? Or does it mean transmitted through them [to the population]?

To be clearer, we reformulate the statement as follows: Indeed, information on health care activities, such as vaccination campaigns, vitamin A supplement campaigns, antenatal care and new health policies is transmitted through them to the population.

16. District health managers and health workers: “Therefore, the objectives of the policy could be not achieved”. It is not clear which policy is meant here, and the causal link to the sentences before is not convincing. It may be true, that street level workers (are they different from frontline health workers? If not, why introduce a synonym?) have power, but it is not evident that this implies “the policy” could not be achieved.

- Which policy is meant here? The policy we meant is the national subsidy of obstetric care (the policy that is at under study in this article). To be clearer we mentioned within the article which policy we are talking about.
- The causal link to the sentence before is not convincing?
  To be clearer we reformulate the statement is it follows: The discretionary power of health workers may be one of the reasons why the national subsidy of obstetric care failed to achieve its objectives
- The street level workers are the frontlines workers. We used the term street level worker to refer to the concept developed by Lipsky to describe this category of actors. We are interpreting our data according to this concept. Thus, front line workers and street level bureaucrat it refers to the same idea.
17. Providers and patients: “High rates of absenteeism of health workers in health facilities, delays in starting health facility activities, and the indifference and authority expressed by health workers toward patients are routine practice in daily health care.” I don’t necessarily doubt that this is true, but such a stark statement requires either a reference if it comes from the literature, or it needs to be reported in the findings if it is an observation, or it needs to be qualified as “reportedly routine practice” if it comes from discussing with community members.

Thank you for this comment. It comes from our observations and what has been said by communities in villages during group discussions and interviews with women. We mentioned these elements in the results sections on page 19. The informal payments, the rate of absenteeism, the unavailability of health workers, the expression of authority by health workers towards patients are the main issues highlighted by communities: “When you go to pay for drugs at the pharmacy, they cheat all your money. I have had to pay drug out there that rose from 35000 to 50 000 CFA”. “The skilled birth attendant did not assist me to deliver, she came when I have already delivered” (health facility 1).

We added other verbatims to illustrate the unavailability of health workers and their expression of authority towards patients in the results section.

18. Providers and patients: “As for relationships between district health managers and health workers, this seems inherent in the health system specifically in low-income countries. Therefore, in the context of implementation of a health policy, “failures” of the health system should be interviewed.” Why is this situated under the heading “providers and patients”? And what does it mean to interview failures?

To be clearer, we reformulate the statement as it follows: These power relations seem inherent in the health system, specifically in low-income countries. Therefore, in the context of implementing health policy, these power relations within the health system should be discussed.

• Minor Essential Revisions

19. Intervention: “Women pay 20 to 40 % of the total cost remaining”. Delete “remaining” – women have to by either 20-40% of the total cost, or 20-40% of the remaining cost: probably the former.

Thank you for this comment. To be clearer we changed the statement as follows: The policy consists of subsidizing 60 % to 80 % of the cost associated with assisted deliveries and emergency obstetric care depending on the level of care. Women pay the remainder [32]. For example, for an uncomplicated delivery at a health centre, women have to pay 900 CFA (1,4 Euros).

20. Intervention: Replace “each dystocia labour” by “each dystocic labour” – grammar: dystocia is the noun, dystocic the adjective. Correct throughout the manuscript.

Thank you for this comment. The change was done in the whole manuscript.

21. Method: Replace “to increased the validity” by “to increase the validity” –
Thank you for this comment. The change was done.

22. Feedback session: replace “allowing them participate” by “allowing them to participate”

Thank you for this comment. The change was done.

23. The grand for the most disadvantaged: “A grant of 20% was planned” – 20% of what?

To be clearer, we changed the statement as follows: The policy planned to fully exempt the poorest patients from all costs associated with assisted deliveries and emergency obstetric care [43]. A budget from the national subsidy obstetric care policy of 50000000000 CFA (76 224 509 Euros) was planned to fund the poorest patients.

24. Supplies and equipment delivery: delete “delivery” in the title

Thank you for this comment. The change was done.

25. Supplies and equipment delivery: replace “resulting difficulty” by “resulting in difficulties”

Thank you for this comment. The change was done.

26. System of monitoring: replace “manager hired … from its own budget” by “manager hired … from the district’s own budget”

Thank you for this comment. The change was done.

27. Traditional Birth Attendant …: Replace “activities of health facility” by “activities of health facilities”.

Thank you for this comment. The change was done.

28. A fairly effective implementation: Replace “is sufficient allow” by “is sufficient to allow”

Thank you for this comment. The change was done.

29. The benefits of evaluating the implementation process: replace “except for the subsidy the most disadvantaged and some activities” by “except for the subsidy for the most disadvantaged, and for some activities”

Thank you for this comment. The change was done.
30. The benefits of evaluating the implementation process: Replace “Therefore, in the case of this policy, the most disadvantaged and quality of care should be targeted” by “Therefore, in the case of this policy, subsidies for the most disadvantaged and improving quality of care should be targeted”

Thank you for this comment. The change was done.

31. “Power is at the heart of implementation health policy process”. Four nouns in a row – something missing here? And if it is a quote – by whom?

To be clearer, we changed the statement as follows: **Power is at the heart of implementation of the health policy** And we added the reference.

32. COGES and health workers: Replace “management of health facility” by “management of the health facility”

Thank you for this comment. The change was done.

33. Limitation of the study: Replace “The findings of this study are similar to others districts [17] and other country [35]” by “The findings of this study are similar to the ones from others districts [17] and other countries [35]”

Thank you for this comment. The change was done.

34. Table 1: For focus groups, the number of groups should be stated as well, plus the range of group size.

Thank you for this comment. The change was done.

• Discretionary Revisions

35. Intervention: to be consistent with figure 1, replace “effects” by “goals”: “…the available resources, the intended objectives and the goals that this policy aims…”

Thank you for this comment. The change was done.

36. Method: “district of Inna located in the north of Burkina Faso”. Specify province and/or region. The North is a bit ambiguous for a country which predominantly stretches from West to East.

Thank you for this comment. We added the information.

37. Individual interviews and focus groups: delete “the process of” in “with the
process of its implementation” – redundant.

Thank you for this comment. The change was done.

38. Data analysis: Consider replacing “logic model” by “conceptual framework”.

We choose to not replace it because it is not the same thing. A conceptual framework refers to concepts that help us to interpret the data where as a logic model is related to a program, a policy and refers to the way it is operating. The logic model is a graphical representation of a program, policy.

39. Perceptions of the health policy: when the verbatim quote repeats what the author has written, reading becomes cumbersome. Example: “This health policy alone … people’s behaviour” adds nothing to what has been said in the sentence before.

Thank you for this comment. It was done when it was possible.

40. The reimbursement system: Perhaps it’s only me, but I can’t quite understand from the last paragraph who in the end paid which proportion of which total cost for a caesarean section.

To be clearer, we changed the statement as follows The estimated cost per patient for a caesarean section, as planned in the policy, was 11,000 CFA (17 Euros). In 2008, health district managers decided to pay 5,000 CFA (7.6 Euros) of this cost by drawing on the budget line for drugs provided by the state. In 2009, the remaining 6,000 CFA (9 Euros) was paid by each COGES each month. Therefore, parturients do not pay for caesarean sections (which cost 11,000 CFA). This initiative came into effect in July 2010 and the impact remains to be studied.

41. Transportation: “Only one ambulance is functional…” It would be interesting to know whether the ambulance was used (never/rarely/frequently) for other travel than emergency transports. What kind of car was it – a multi-purpose pick-up or a specialised ambulance?

Thank you for this comment. Information was added.

42. Quality of care: replace “… recommended strengthening the improvement…” by “… recommended improving…”

Thank you for this comment. The change was done.

43. Traditional Birth Attendant …: The forgotten of the policy: I am not sure that “having/being forgotten” is the best possible description of the problems addressed in this section. Obviously, policy makers have not forgotten about them, but have assigned them a new role – so it is not “the policy” who is to blame for the interactional problems between the formal and the traditional health sector. It is more that health workers don’t quite know how to approach and integrate these people, or don’t have positive feelings for them, for a range of reasons. Consider rephrasing.
We used the term forgotten to show that the policy has shifted their role in the decree, but did not think to compensation in exchange. Moreover, in the national subsidy obstetric care no role was assigned to them.

44. The benefits of evaluating the implementation process: I am not sure that you are doing yourself a favour by choosing the “limited number of ambulances” as an example for the value of implementation evaluation – this is so unsurprising! Can’t you find something more interesting?

Thank you for this comment. We used this example to be the very clear. We choose another example. In the case of this study, implementation evaluation has identified the challenges that implementers face, such as problems with entering data on the software, resulting on long delays in reimbursement.

45. “Power is at the heart of implementation health policy process”: Replace “doing an analysis of implementation health policies involves” by “analysing the implementation of health policies involves”

Thank you for this comment. We changed it.

46. Limitation of the study: “However, the objective of this study is not to make statistical inferences”. Since this is a qualitative study, it is quite obvious that its objective is not to make statistical inferences. But even for a qualitative study it might have been interesting (but may not have been feasible) to collect data from another region in Burkina Faso which is less disadvantaged than the country’s North. Are the limitations due to choosing only one district, and to choosing a district in the North, with respect to generalisability sufficiently addressed? No notion of caution necessary?

Because of budget and time contrains we limited our study to one district. However, it would have been very interesting to do a study in another region of Burkina Faso to increase the generalisability of the results. However, using a multiple case study as a design of a research allows to strengthen the external validity of the case. However, It is obviously impossible to generalize the results to the whole country.