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The influence of health sector reform and external assistance in Burkina Faso

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Despite health reform and increasing public investment in the health sector, utilization of curative health services, immunization coverage and patient satisfaction with the public health care system are steadily decreasing in Burkina Faso. It seems that the health care system itself is 'ill'. This paper examines the major symptoms associated with this illness. The central thesis suggests that any further improvement of health care performance in Burkina Faso will be subject to profound central reform in the area of human resources and financial management of the sector. Such a broad reform package cannot be achieved through the current project approach, but a sector-wide approach (SWAp) does not seem to be realistic at the present time. Policy discussions at a level higher than the Ministry of Health could be beneficial for achieving better donor coordination and increasing the commitment of the Ministry of Health to a sector-wide approach. Health sector reform issues and priorities and the role of international cooperation are reviewed and discussed.

Introduction

Burkina Faso, in sub-Saharan Africa, is considered to be among the poorest countries in the world, ranked 172 out of 175 countries on the Human Development Index.[1] GNP per capita in 1995 was US$230.[2] It is a low-income country with high population growth, high fertility and mortality rates, with over 5% economic growth and a fairly stable currency. Major health, demographic and socioeconomic indicators are presented in Table 1.

Burkina Faso has inherited a highly centralized country from the French colonial era. However, since the end of the 1980s, the country has undertaken major reforms towards decentralization, including reform of the health sector. A law passed in August 1998 (Textes d'orientation sur la décentralisation) created two types of decentralized entities: provinces and communes. Although the implementation of the law will take several years, it presents some interesting opportunities for the health sector. Elected local governments ('Collectivités territoriales') will be responsible for: (1) the management of health facilities including district hospitals; (2) the procurement and distribution of drugs; and (3) the implementation of local public health programmes.

The health care system in Burkina Faso is divided along administrative borders into 11 regions and 53 health districts (population covered varies from 150 to 200 000) with five levels of care (health post; health centre; district, regional and national hospitals). Over 95% of health facilities and health care providers are in the public sector.

Since 1991, the country has initiated important reforms in the health system:

- National and regional hospitals have been given progressive autonomy in financial and personnel management.
- In 1992, 53 health districts were created under the management of district health teams.
- Since 1992, the central drug procurement and distribution agency (CAMEG[i]) has been created, with progressive implementation of the system allowing for a better accessibility to drugs in rural areas.
- In 1993, health centres were allowed to retain funds collected from fees and the sale of drugs. Elected local bodies were responsible for the management of these funds.
- In 1996, an intermediate level of the Ministry of Health was created at the regional level in order to improve support to health districts.

To date only a few health districts are considered fully operational. Less than five have the required number of doctors (three) and only 17 out of 53 district hospitals are able to perform caesarean sections, because of lack of skilled staff and appropriate equipment. However, the number of health centres increased from 556 in 1987 to 877 in 1996.

Precise data regarding the private sector, which has been officially allowed since 1990, are difficult to gather. As the opening of a private health facility is subject to payment of taxes, the official figures underestimate the situation. According to Ministry of Health statistics, the number of private health facilities increased from 106 to 155 between 1991 and 1996. During the same period the number of private pharmacies increased from 40 to 69. Eighty-nine percent of private health facilities and 80% of private pharmacies are located in the two biggest cities (Ouagadougou and Bobo Dioulasso). In addition to these official data, there is a growing informal private health sector concentrated in urban areas where

Table 1. General demographic, health and socioeconomic indicators, Burkina Faso

Indicator	Data
Demographic	
Population growth	2.37%[a]
Crude birth rate	49.6%[b]
Life expectancy at birth	52.2 years
Fertility index	6.6[c]
Health	
Infant mortality	93.7 per 1000
Maternal mortality	556 per 100 000
Socioeconomic	
Poverty index	74% (rural areas)[d]
Urban population	16%
Adult literacy rate	19.2%[e]
Health expenditures	
% of GDP	1.6%
Health budget as a % of total public expenditures	9%[f]
Annual household health expenditures	US$63 or 7.2% of household expenditures[g]
% of health expenditures spent on drugs	88%[a]
Per capita public and private spending in the public sector	US$8.00[h,i]

Sources:
[a] Institut National de la Statistique et de la démographie (1996).[26]
[b] Institut National de la Statistique et de la démographie and Macro International Inc. (1993).[27]
[c] Organisation Mondiale de la Santé (1998).[2]
[d] Centre Européen de Gestion des Politiques de Développement (1997).[4]
[e] United Nations Development Program (1998).[1]
[f] Service Informatique DGT-CP (1998).[28]
[g] Institut National de la Statistique et de la démographie (1996).[29]
[h] Ministère de l'Economie et des Finances, Loi des Finances, Budget (1998).[30]
[i] Ministère de la Santé-ESOP-CD (1997).[31]

nurses and doctors are recruited from the public sector. They practice privately in addition to their official public sector duties.

It is thought that the combination of a highly centralized country and a lack of flexibility in the management of civil servants leads to a strong imbalance in the distribution of personnel, low levels of motivation and consequently provision of low quality of care. Recently, Burkina Faso started a reform process for the civil service, which aims at more flexible management and better performances of personnel. This process, however, is highly controversial and is fought by trade unions, which have a long tradition in the country.

Although the Ministry of Health's budget has increased from 1996 to 1998 (up FCFA 2.6 billion), the health budget as a percentage of the total public budget has decreased from 11 to 9%. This trend is explained by a sharp reduction in external aid during the same period; the share of domestic financing has remained constant at about 10% (see Table 2).[3] The question is whether the decreasing foreign investment in the health sector in Burkina Faso is a sign of donor fatigue. The European Union plans to make a major investment in the sector under the Eighth European Development Fund. Most of this aid would be in the form of budget support for institutional development, specific financing of the decentralization process and the restructuring of the pharmaceutical sector. These

Table 2. Public budgets in thousand FCFA, 1996–98, Burkina Faso

Public budgets	1996	1997	1998
Health budget			
Domestic financing	14 467 827	17 222 657	20 778 242
Foreign aid	16 377 010	14 463 932	12 637 821
Total health budget	30 844 837	31 686 589	33 416 063
National public budget			
Total domestic financing	140 886 427	168 264 162	198 677 190
Total foreign aid	144 654 600	146 963 931	176 009 405
Total public budget	285 541 027	315 228 093	374 686 595

Source: European Commission (1998).[3]

funds are welcomed by the government and the donor community, although there is some concern that the funds might support policies which have not proven to be effective in the past as the performances of the health sector are considered poor. A recent study of the education and health sectors noted that what is missing compared with other African countries is not quantity of public investment, but rather quality, i.e. the effectiveness of investments in these sectors.[4]

Despite the high priority given to the social sector by governments and donors in general, there is growing evidence that in many countries the existing health systems have limited impact on health conditions because they do not reach the majority of women and children, and the quality of health services delivered is often too low to make a difference.[5] Burkina Faso is one such country where successive policy measures have been partly or fully implemented over the past 20 years with no positive effects on the utilization of services. To the contrary, utilization and people's confidence are decreasing, as detailed later in this paper.

The poor results of the health care system in Burkina Faso have led the authors to look more closely at the reasons for its poor performances and to suggest some directions for the future.

Methods and data

Figure 1 illustrates the framework of analysis used in this article. The 'illness' of the health care system is illustrated by curative and preventive output indicators; the 'symptoms' are represented by selected input and process indicators.

There is a scarcity of peer reviewed articles on the health sector in Burkina Faso. Most data presented in this article are drawn from the grey literature, mostly published over the last 3 years and originating from the following three sources:

(1) *National statistics published between 1986 and 1996 by the Ministry of Health*: the Ministry of Health publishes annual statistics covering all public health facilities.
(2) *Published data from various national and international organizations*: mission and consultancy reports from the World Bank, the European Union, and Save the Children (Netherlands); vaccination monitoring data from UNICEF; special studies from the Ministry of the Economy and Finance, the PRAPASS[ii] project and GTZ[iii] health projects in Burkina Faso.
(3) *Health district peer review*. This review performed in late 1997 covered 10 health districts supported by the German Development Cooperation (GTZ). The 10 districts cover about 2 million people, almost 20% of the total population of Burkina Faso. The peer review process included a thorough preparation involving the district health teams (questionnaire development, definition of sources of data, training in interview techniques and data collection).

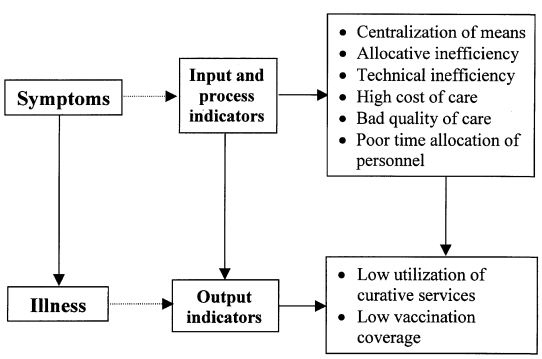

Figure 1. Framework of analysis

Reliability and validity of data sources are discussed later.

Results

The illness

This section illustrates how the decrease in the performance of the health care services concerns both curative and preventive services.

Figure 2 shows a downward trend in the utilization of curative services nationwide between 1986 and 1997, from 32% to 17% (0.32–0.17 new cases per year and per inhabitant).[6] These institution-based data include the total new cases for health centres, district, regional and national hospitals. The major policy measures concerning the health sector are also represented. It is striking that none of the heath policy reforms of the past 12 years had any positive effect on health services' utilization as shown in Figure 2. The Bamako Initiative was introduced in 1992, allowing health centres to retain funds collected from users fees and sales of drugs as well as the co-management of health centres by communities, but it did not impact on the negative trend of utilization. The managerial autonomy given progressively since 1991 to 11 regional and national hospitals also had no effect on utilization. Since 1994, the national drug supplier (CAMEG) has improved the supply of essential drugs to public facilities in the country. Essential drugs that were widely available in the GTZ-supported areas by 1994 had no effect on utilization, although the cost of drugs fell sharply, between 30–60%. The abrupt devaluation of the CFA Franc in January 1994, which boosted consumer prices by up to 25%, had no particular effect on utilization of care. In 1996, the Ministry of Health regionalized the public health system, giving more power to the 11 regions with respect to supervision and management of health districts. Again, this reform could not reverse the downward utilization trend.

A community-based longitudinal study on health-care seeking behaviour in the district of Nouna (PRAPASS Project with support from GTZ) confirmed the decline in utilization of modern care (health centres and district hospitals) between April 1993 and December 1995 (see Figure 3).[7] Noticeable is the increase in self and family treatment after April 1994. Utilization of traditional medicine remains fairly constant over time.

The performance of immunization activities is also in decline, as illustrated in Table 3. Cluster sampling surveys performed in 1991 and 1998 show a clear decline in immunization coverage in children aged 12–23 months.[8]

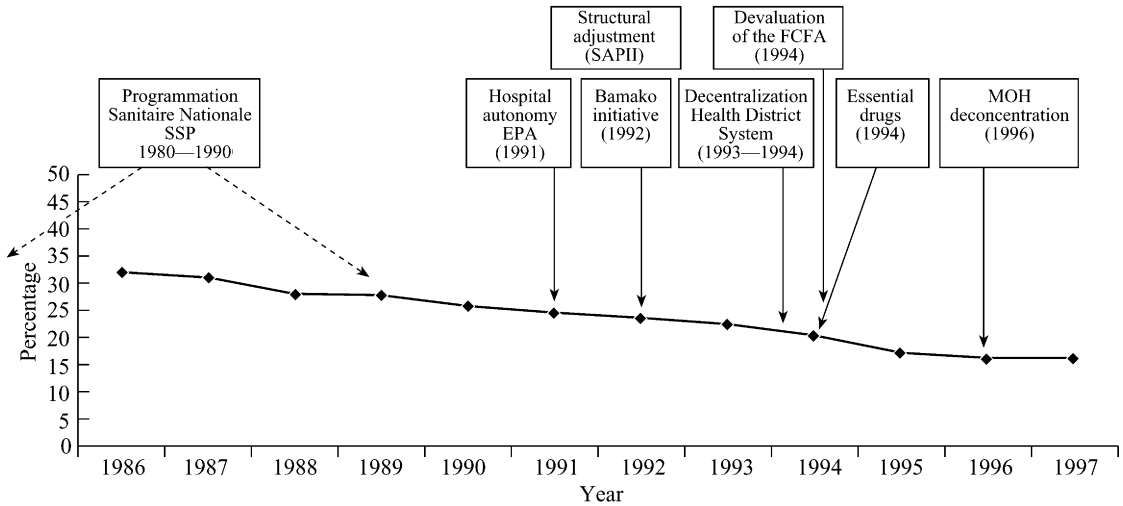

Figure 2. Policies and national trend in utilization of curative services, Burkina Faso
Source: Ministry of Health, 1998.[6]

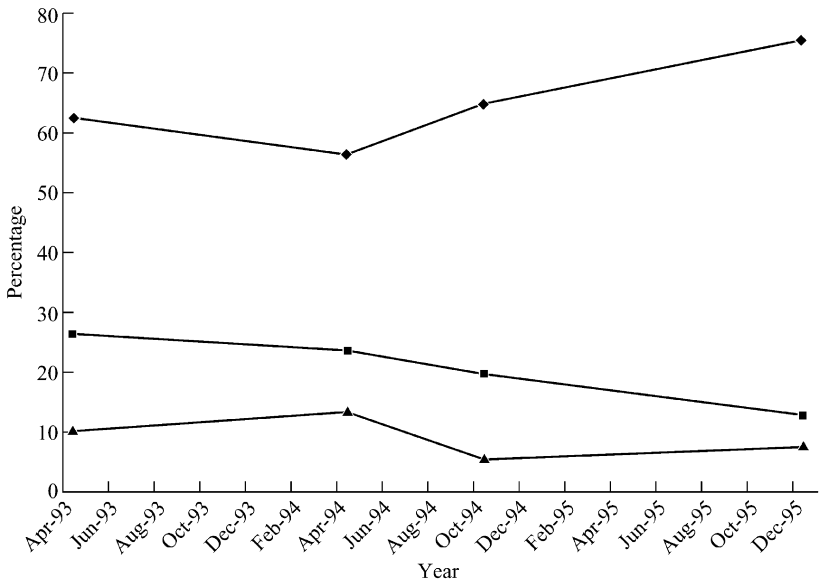

Figure 3. Sources of health care, district of Nouna. Diamonds, self-treatment/family; squares, modern care (HC and DH); triangles, traditional medicine
Source: Ministry of Health, 1997.[7]

Table 3. Immunization coverage (12–23 months) in Burkina Faso, 1991 and 1998

	1991 (%)	1998 (%)
BCG	95	73
DTC3	66	37
Measles	79	41
Fully immunized	61	26

Source: Ministry of Health (1998).[8]

The symptoms

The symptoms associated with the ill health of Burkina Faso's health care system are illustrated by several input and process indicators.

Symptom 1. Over-centralization of resources leading to allocative and technical inefficiencies

The recurrent public budget per civil servant is about 24 times higher at central level compared to the periphery (including regional hospital budgets),[9] illustrating the concentration of

Table 4. Distribution of health personnel in Burkina Faso, 1996

	Ouagadougou and Bobo Dioulasso (16% of total population)			Rest of the country (84% of total population)		
	Staff		Population per staff member	Staff		Population per staff member
	No.	%		No.	%	
Doctors	210	57	8 200	151	43	59 874
Pharmacists	31	65	55 551	17	35	531 821
Midwifes	204	55	8 442	165	45	54 794
Certified nurses	610	47	2 823	699	53	12 934

Source: Ministry of Health (1998).[6]

financial resources at the central level of the Ministry of Health, which results in allocative inefficiencies. Part of this central recurrent budget funds activities that actually take place in the periphery, leading to a lack of transparency in the use of funds, and thus, to technical inefficiencies.

In 1998, the Ministry of Finance made an effort to decentralize more funds to the regional health directorates. However, administration of these funds remains at the central level as the actual payment of goods or services occurs at that level.

Symptom 2. Poor allocative efficiency

There is a strong urban bias to public spending on health, with 70% of funds being directed to the 16% of the population that is urban, leaving 30% for the remaining 84% rural population.[10] Part of the bias in the distribution of financial resources is reflected by the inequitable distribution of human resources, as shown in Table 4. In this table, the distribution of different types of personnel and the average population numbers per staff member are compared between the two main cities (Ouagadougou and Bobo Dioulasso) and the rest of the country.[6]

Financial allocation between the three levels of the health care system is difficult to measure due to the lack of clarity from the public budget lines. However, a recent budget analysis from the Ministry of Health shows that Burkina Faso's two teaching hospitals (in Ouagadougou and Bobo-Dioulasso) absorb 22% of the non-salaried recurrent budget of the Ministry.[iv] Table 5 shows the recurrent budget share for each level, with only 14% being allocated to all 53 health districts including the district administration, the health centres and the district hospitals.

Symptom 3. Poor technical efficiency

Typically health districts and regional health directorates are financed through at least five different sources and have to cope with at least 10 different financing mechanisms, each one having its own procedures, as illustrated in Figure 4. This financing strategy is implemented in a managerial environment that is not highly computerized. The staff in charge of managing funds are not adequately trained, and the procedures for supervision and auditing of management staff are not adequately developed.

Table 5. Share of recurrent budget by health system level (salaries excluded)

Level	%
Teaching hospitals (2)	22
Central administration	29
Regional hospitals (9)	9
Regional administration (11)	1
Health districts (53) (district administration, health centres, district hospitals)	14
Other expenses (School of Public Health; national centres and laboratories; training, emergency care, international contributions)	25

Source: Ministry of Health, Budget 1998.

Symptom 4. High cost of care to patients

Selling prices (for patients in the public sector) for five of the most common generic drugs (acetylsalicylic acid, amoxicillin, chloroquine, metronidazol, paracetamol, oral rehydration salts) have been compared between Burkina Faso, Mali and Côte d'Ivoire. The prices are generally set so as to recover part or the full cost of the procurement and distribution system, depending on the country. All five drugs are more expensive in Burkina Faso compared to Mali, and four out of five are more expensive in Burkina compared to Côte d'Ivoire.[v] The price differences would be even higher if purchasing power was taken into account, as the average household income is lower in Burkina Faso compared to Côte d'Ivoire.

In 1997, fee-for-service was introduced in 10 health facilities in the project area of Save the Children (Netherlands). The cost of care to patients increased by 13%. This led to a 17% drop in health facility attendance when compared with the same period in 1996 (June to November). It shows that even for a slight price increase, demand is price elastic.[11] No other

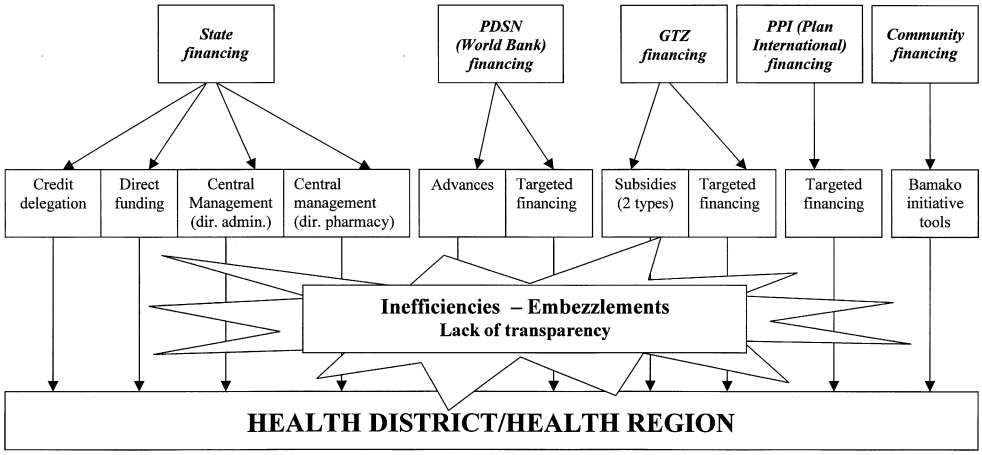

Figure 4. Financing sources and mechanisms for health districts and regions

obvious factor can explain the reduction in health facility attendance.

The beneficiaries' contribution to the financing of the district health system is high, essentially through the purchase of drugs. In the rural health district of Tougan, an in-depth cost-analysis revealed that the population's direct contribution amounted to 43% of the district's total costs including salaries (see Figure 5).[12]

Symptom 5. The perception of poor quality of care

Two studies on the perception of quality of care by the population in the GTZ project area[13,14] showed that communities are highly dissatisfied with the quality of care. The most frequently cited problems concern the high cost of care and the poor performance of health personnel. These results can be generalized for the country as a whole as GTZ-supported areas are generally considered to have attained a higher degree of development in the health care system, with better availability of drugs and better trained personnel. More detailed information is summarized in Table 6.

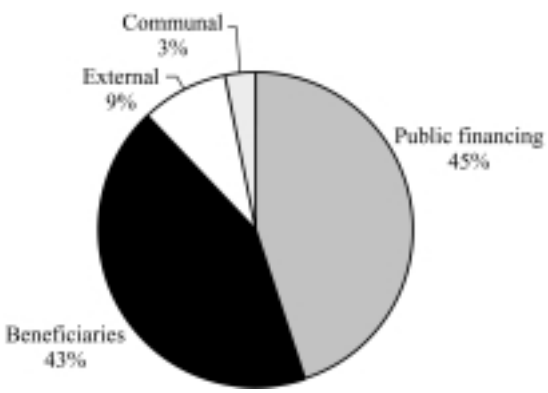

Figure 5. District financing, fiscal year 1996–97, district of Tougan
Source: GIS Eco – GTZ, 1997.[12]

Symptom 6. Poor performances of health personnel

The community's perception of the performance of health workers is illustrated in Table 6. Performance has also been assessed objectively by measuring productivity, absenteeism and effectiveness of time allocation.

A health district peer review performed in 1997 in 10 districts of the GTZ project area revealed extremely poor productivity of personnel for curative services. Staffing patterns followed national norms and did not taken into account low utilization rates of health facilities. The number of consultations per health worker has been determined on the basis of 240 working days per year, and averages at an extremely low productivity of 1.6 consultations per staff-day.[15]

Medical doctors' absenteeism was assessed during the peer review in 1997 by measuring the number of doctor-days available during the 2 months preceding the study. Average absenteeism is 37% – at this rate the districts would be without the presence of a doctor for 135 days a year (see Figure 6).[15]

Time allocation of the 11 regional directors for health was assessed in mid-1997, after they had been functioning for one year.[16] Although district support should be their main task, they actually devoted only 10% of their time to the direct support of their districts. Thirty-five percent was spent in managing the regional directorate and 55% was spent in the capital city, Ouagadougou, on meetings, seminars, etc.

Discussion

Limitations and informative value of the data

The interpretation of curative care utilization is subjective in itself, for the question of how much curative care a population needs is not easy to answer. WHO has often suggested an 'objective' of one new case per inhabitant per year; however, in Burkina Faso no objective has been set for curative care. In 1989, Nougtara et al.[17] reported under-utilization of professional services in Burkina Faso and showed that most of

Table 6. The community's perception of quality of care, districts of Nouna and Tougan, Burkina Faso, 1997

Perception	Problem cited
Cost of care is too high	High drug prices and service fees. Indigents are not taken care of.
Health workers perform well below people's expectation	Behaviour not compatible with people's expectation. Skills are questioned. Prescription of too many drugs not all available at the local pharmacy.
Quality of resources is not sufficient	Infrastructure (dirty, exiguity, pregnant women mixed with patients, no water point). Equipment lacking (emergency kit, beds and mattresses). Drugs not always available.
Organization of health services is not always acceptable	Emergency care not well organized. Health services do not allow credit. Patients must pay before they are taken care of. Waiting time too long. Transfer to higher level of care not satisfactory.

Source: Kaboré (1997); [13] Nikiéma-Heinmueller and Borchert (1997).[14]

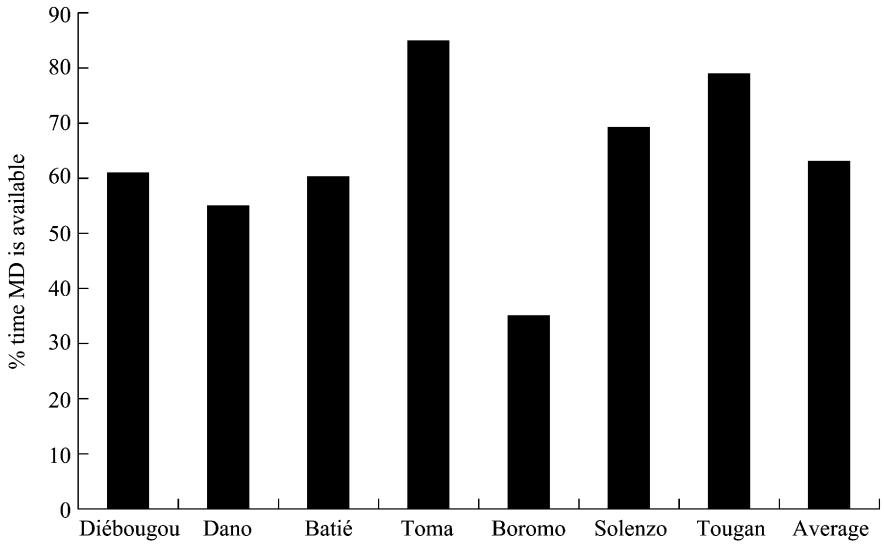

Figure 6. Absenteeism of health district doctors in seven rural districts, 1997
Source: Ministry of Health – GTZ, 1997.[15]

the need for curative care was satisfied outside the formal health sector. The denominator used the total population of the catchment area of the health facilities. The question of whether this denominator was accurate is not relevant in this case for the discussion is about the relative value of the utilization rate from one year to another, rather than its absolute value.

Generally, data and information produced by national routine information systems lack accuracy. Although the compilation of the data may be done seriously, the collection and completeness of the data are questionable, as is generally the case for most routine information systems in developing countries. This should not prevent us from drawing some conclusions from the data, for various reasons.

- The constant and consistent decrease in attendance of curative services for more than 10 years demonstrates in itself the validity of the data.
- The prospective longitudinal study on health-care seeking behaviour reported in this article[7] is the only one of its kind available in the country providing reliable community-based data which confirm the decline of curative services utilization over a 2 year period (1993–95).
- A facility-based survey conducted in 1998 using a random sample of 13% of the primary facilities (excluding the facilities not fully equipped according to the norms of the Ministry of Health) reported curative care utilization rates of 0.43 and 0.37 contacts per person in 1997 and 1998, respectively (contacts per person includes all types of curative contacts not only first contacts for new episodes).[18] When

considering first consultation only, attendance rates for 1997 amount to 0.20, a figure similar to the 0.17 reported in the Ministry of Health statistics. The difference between these two rates could be explained by the selection of facilities in the 1998 survey that matched specific norms, thus performing slightly better.

- National vaccination figures from UNICEF's routine information system confirm the reduction of immunization coverage reported by the Ministry of Health between 1991 and 1998. UNICEF data show a sharp downward trend in immunization coverage in Burkina Faso over the last 3 years. UNICEF figures for 1997 are: BCG, 46%; DTP3, 28%; measles, 33%.[19]
- All steps of the health district peer review were performed under the close supervision of regional staff supported by GTZ. It is generally considered that health care performance in the GTZ-supported areas is better than in other areas with no donor support. This assumes that national data on health staff productivity and absenteeism (if they were available) would be worse than those reported.
- The two studies on perceived quality of care were implemented by local sociologists and public health experts, with strong support from scientists of the University of Heidelberg in Germany and GTZ experts in Burkina Faso.[13,14]

Explaining the illness of the health care system

Examination of the illness of Burkina Faso's health care system and the related symptoms leads us to three main conclusions:

- the system is profoundly ill (the drop in curative care utilization and preventive care coverage has lasted for more than 10 years);
- people's confidence in the modern health care system is very poor; and
- the successive policy measures and the various programmes and projects implemented over the last 17 years have not improved the health care system.

Few financial resources get to the periphery (14% of the recurrent budget) with a strong bias toward urban areas. The scarcity of financial resources reduces staff motivation. The little money that does get to the periphery is badly managed (technical inefficiencies), which in turn leads to higher out-of-pocket contributions by patients (up to 43% of the total annual cost of a district). The high cost of care occurs in a context of extreme poverty with the demand for care decreasing with slight price increases. Dissatisfaction with the high cost of care, staff performances and organization of care leads to an extremely low utilization of services.

Cost and perception of the quality of care are two major determinants of the utilization of health services,[20] especially in Burkina Faso where people living in rural areas are extremely poor and out-of-pocket spending is high. Figure 7 shows that the symptoms leading to high cost and poor quality care have two origins: (1) poor financial policies and management, and (2) deficiencies in human resources' policies and management. One could argue that infrastructure, equipment and drugs are not directly linked to human resources' policies and management. In fact, the experience in the GTZ project area shows that most drug shortages could have been prevented by good management practices (timely ordering, proper handling, etc.) and rational prescribing. Furthermore, although district health teams were invited to apply for funds for the maintenance of infrastructure and equipment through simple and well-defined procedures, more than 50% of the districts did not make full use of their funds and were more than 6 months behind schedule in the application process. Most of the organizational problems of health services (organization of emergency care, waiting time, transfer to higher level of care, paying before getting services, etc.) could have been solved locally at the level of the health district teams or at the regional level without any extra resources.

The recent study from the Ministry of Health on utilization of services[18] reported geographical accessibility as a third important factor in the low utilization of health facilities. However, the number of first-level health facilities (including health centres, maternity clinics and dispensaries) increased from 566 in 1988 to 878 in 1996, lowering the average radius

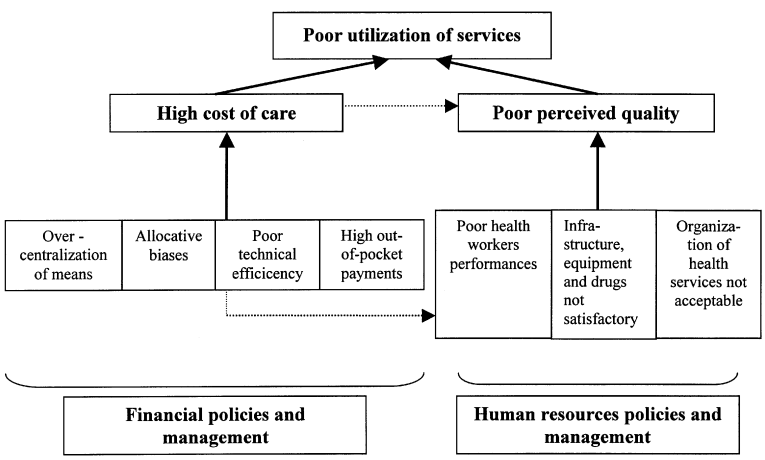

Figure 7. Explaining the illness of the health care system

of the catchment area from 12.4 km in 1988 to 10 km in 1996. During the same period, utilization declined further; thus the increase in geographical accessibility had either no effect on utilization or was offset by the worsening of some other factor in the accessibility (e.g. financial) or acceptability of care.

Over the past 15 years, an important part of aid in Burkina Faso has been directed toward the improvement of management capacity. Management capacity of district health workers has dramatically improved, especially in the area of planning, budgeting, and management of drugs. Nevertheless, the environment and the incentive structure in which health workers act has not changed fundamentally. Many civil servants in the health sector still have little sense of responsibility toward the community they serve, nor have they sufficient internal motivation to use their own dynamism to overcome problems and build the future. What is needed is the development of a sense of responsibility and ownership among health professionals, which arguably can only be attained if one is at risk of losing something important if things go wrong (as is the case for a shop owner or a person under contract). At present, civil servants are poorly evaluated and almost no sanctions or rewards are implemented. Furthermore, a shift in the balance of power between the community at large (civil society, local governments, associations, third-party payers, etc.) and the health workers needs to take place in order to empower health care consumers. The conjunction of these two forces (increase in internal motivation and shift in power) could positively impact on the behaviour and performance of health staff.

The profound deficiencies in the area of financing and human resources explain why increasing investments (programmes and projects) in health have no long-term effect on the performance of the health care system. It also explains partly the lack of sustainability of health programmes. This situation applies to many countries in sub-Saharan Africa.

A possible solution, that could lead to radical change in human resources and financial management to improve the health care system's performance, could be a sector-wide approach (SWAp).[21] The SWAp is being promoted by several donors and to some extent by the country itself. The fragmented project-by-project and donor-by-donor approach, as is presently the case in Burkina Faso, leads to confusion, dissipation, wasting of scarce resources and lack of sustainability. A SWAp would mean concerted action by donors and the recipient country in the management of internal and external resources based on a comprehensive analysis of the sector. If a SWAp is a plausible direction to follow, two questions will need to be answered: (1) what are the reform priorities and issues, and (2) is a SWAp feasible in the present context of Burkina Faso? These two questions are discussed below.

Reform priorities and issues

The determination of reform priorities should be based on a thorough sector analysis, which is not available at present. Nevertheless, existing literature and experience suggest that reform priorities and issues in the health sector in Burkina Faso can be roughly grouped into four categories: (1) reform of human management, (2) reform of financial management, (3) redefinition of the role of the central Ministry of Health, and (4) articulation of the general State decentralization (devolution) and the health system decentralization (see Figure 8).

Reform human resources management

Human resources should become the central focus for reform over the next years. Most of the decisions to be made do not lie in the hands of the Ministry of Health, hence the importance of involving other Ministries, major donors and parts of civil society such as trade unions in the process. The administrative devolution should be taken as an opportunity to devolve the recruitment, payment and management of civil servants to local governments. New staff should only be recruited on a contractual basis because this provides more flexibility in the their management (currently about 55% of the trained midwifes are concentrated in the two major cities in Burkina Faso).

In the past, the authorities were very reluctant to pilot reforms in the area of human resources.[22] A special effort should be made in this direction over the coming years in order to test some specific personnel management reforms.

Reform financial resources management

The per capita health expenditure in Burkina Faso (adding public and private spending in the public sector) amounts to roughly US$8. Given the extremely low utilization of services, this figure seems to be acceptable when compared with the figure of US$13 per capita health expenditure that is published in the literature for low-income countries.[23] The problem is rather the allocation of these funds (with only 14% of public spending allocated to districts) and their poor utilization.

The reforms should redirect a large part of the budget to the periphery. This is quite feasible technically (there are trained accountants and managers at the regional level and in the districts), but it needs strong commitment from the government as funds would need to be redirected at the expense of higher levels of the administration. Increased financial autonomy of health districts under the supervision of decentralized bodies (regional auditors in the beginning and local governments later) could improve the accountability of financial resources, and hence make better use of funds. Reforming the management of financial resources needs to happen in the context of the administrative devolution as local governments become new partners in the health sector in Burkina Faso.[24] Basket funding at the district level (where all donor funds, local and central governments subsidies and local revenues are gathered), with common management procedures, should be tried as a way to increase the technical efficiency of the utilization of funds.

The development of local prepayment and health insurance schemes needs to be supported, especially in areas where cash crops are grown (south and southwest), as a means to alleviate the financial burden of disease. Central and local

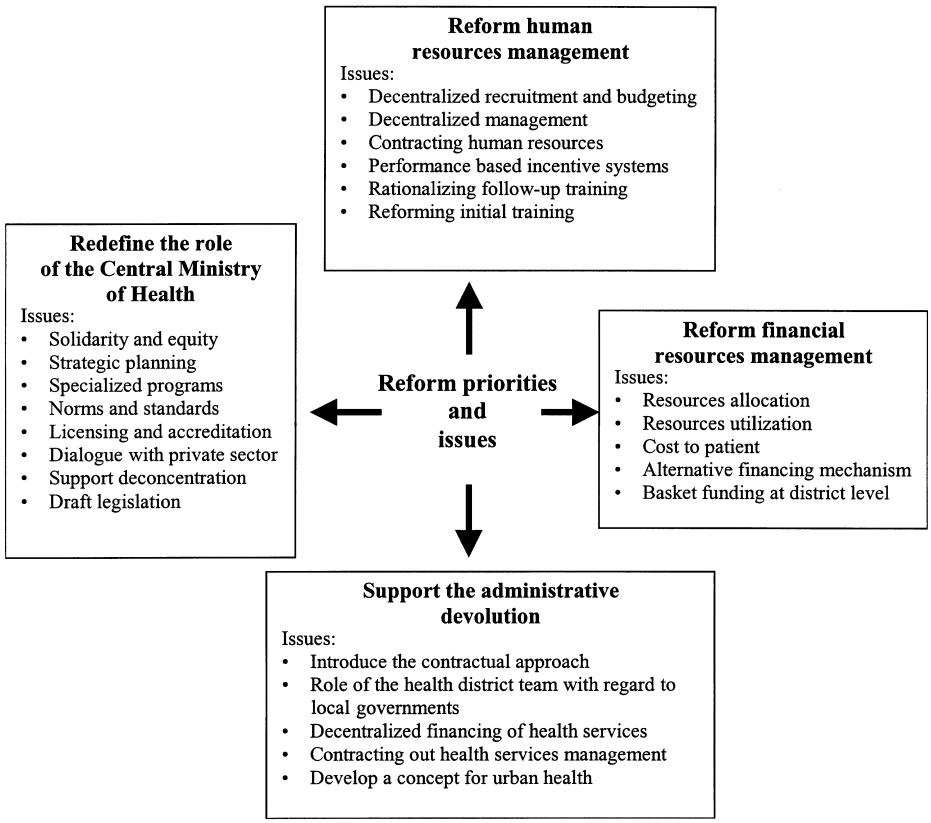

Figure 8. Reform priorities and issues

government should support these initiatives by co-financing the premiums paid by members of these voluntary schemes. This should not increase the total health budget of the central government, but would rather redirect the public budget toward the support of local health care purchasers.

Strengthen the administrative devolution

The administrative devolution, which plans to transfer responsibility and resources to local government areas for the management of health facilities, public health programmes and drug supply, should be a major point of interest. The role of the district health team with regard to the local government authorities should be clarified. Local government should have the capacity to contract with health facilities, health providers, local financing schemes, etc. Public financing of health districts will need to be redefined in light of the new responsibility of local governments.

Redefine the role of the central Ministry of Health

Redefining the role of the central Ministry of Health is essential in order to strengthen the decentralization process, increase accountability and redirect resources to the periphery. The central level should limit itself to policy and strategic issues, such as fostering solidarity and equity, setting norms and standards, licensing institutions and providers, leading the dialogue with the private sector and drafting legislation. Management of drugs, vaccines and other materials should be left to the private sector (non-profit and for-profit). In fact, the recent experience with the essential drug procurement agency (CAMEG), a private association, illustrates the benefit of taking the responsibility for drug procurement and distribution out of public hands. However, more time is needed to judge the long-term viability of this structure.

The relevance and relative importance of these issues needs to be assessed through a sector-wide analysis. The reform issues presented above have to be seen as long-term processes for which results are not entirely predictable; they should not be seen as short-term project goals.

Is Burkina Faso ready for a sector-wide approach in the health sector?

According to our assessment, at the present time Burkina Faso is not ready for a SWAp in the health sector. Readiness for a SWAp was assessed against a number of 'enabling' factors mentioned in the literature (see Table 7).[25]

The assessment shows that classical macro-economic conditions are favourable to a SWAp. However, the Burkina Faso government (in this case the Ministry of Health) is plagued by internal divisions and a high turnover of staff. It has shown reluctance to support innovative processes, has insufficient non-medical expertise such as health economists, sociologists, and legal experts, and decision-making is too centralized.

Although donors in the health sector have instituted some

Table 7. Is Burkina Faso ready for a sector-wide approach (SWAp)?

SWAp enabling factors[a]	Evaluation
Macroeconomic conditions	
• Equilibrated budget and balance of payment	Favourable
• Low inflation rate	Favourable
• Favourable intersectoral allocation	In progress
Government capacity	
• Strong sectoral ministry	Weak (insufficient technical capacity such as health economics, sociology; strong vertical programmes; strong internal divisions; high turn-over of staff)
• Openness to innovation and change	Weak
• Ready for self-criticism through sectoral analysis	The need for a thorough sectoral analysis as a precondition for sound policy work and strategic planning is not commonly accepted.
• Leadership with regard to donors	Satisfactory
• Readiness to collaborate with other stakeholders (civil society . . .)	Weak
Donors capacity	
• Successful donor coordination	Weak
• Existing UN coordination or of EU member States	Weak
• Readiness to support Ministry of Health	Acceptable
• Prospects for a harmonization of procedures (procurement, monitoring, evaluation)	Bleak
• Prospects for a common financial basket	Bleak at central level Less bleak at district level

[a] From Cassels (1997)[21] and Harrold and Associates (1995).[25]

coordination mechanisms (under the leadership of WHO), they are far from effective in coordinating their efforts to support the Ministry of Health. Coordination between European member states is still too weak. UN agencies have instituted some coordination mechanisms that lack focus and results, except in the areas of AIDS/STD and reproductive health. Because of the lack of government capacity and donor coordination, it is unlikely that a SWAp would be feasible at the present time.

In late 1997, during the Annual Conference of Health Sector Development Partners (multilateral, bilateral and NGOs), it was decided to jointly develop a 10-year strategic plan. In fact, this process started with the participation of only one multilateral partner (the others were not invited). This exercise has now been formalized by the creation of a technical secretariat, which was given the responsibility for the development of a national 10-year plan (2001–2010).

It is important to mention that the quality of the development process of the 10-year plan is as important as its content. In Burkina Faso, the partners are invited to participate in different working groups. Such a long process (it is expected that the plan will be ready within the next 2 years) needs to remain highly participative, ensuring the involvement of the major partners and especially the primary stakeholders (civil society and the legitimate community representatives). In addition, a thorough and unbiased situational analysis of the health sector must be undertaken by an independent and multisectoral group of experts. Without such an analysis and a democratic spirit, it is likely that the planning process will lead to the reinforcement of present policies that have been inadequate in responding to the sector's problems.

In fact, for successful development of the 10-year plan, strong support is needed from high levels of government and the donors. The initiative to improve the formulation and monitoring of conditionalities on adjustment lending,[vi] founded by the EU and the government in close collaboration with eight other major donors (SPA Working Group on Economic Reform in the Context of Political Liberalization), could lead to such support. This initiative, instigated at a level above the Ministry of Health, could be beneficial for achieving better donor coordination (i.e. the coordination between the HIPIC-Initiative of the World Bank and the expectations of other donors and sectoral ministries) and increasing the commitment of the Ministry of Health to a sector-wide approach.

Conclusion

The health care system in Burkina Faso is seriously 'ill', as illustrated by the downward trend in service utilization for over 10 years and the communities' perception of low quality health care. Profound reforms are needed, essentially in the area of human resources, financial policies and management, which the project-by-project approach of the last 20 years has not been able to address correctly. A sector-wide approach would be a possible long-term strategy to implement the necessary reforms, but currently not all the conditions necessary for this are met.

The authors are convinced that, considering the right of the people of Burkina Faso to an acceptable and affordable health care system, international donor agencies should continue to support the health sector, despite its poor performance. The decentralization process, although in its infancy, opens new avenues for the health sector, through support to

local decentralized governments ('Communes') and society in general.

Burkina Faso has taken several steps towards the development of a strategic 10-year health plan in coordination with its partners in the sector. However, for such an approach to succeed, three conditions need to be met: (1) donor coordination needs to improve, commitment to invest in the sector should remain high; (2) the Ministry's leadership and openness to other partners (especially civil society) needs to improve; and (3) the strategy needs strong support from higher bodies within government and the donor community.

Endnotes

[i] CAMEG stands for Centrale d'Achat des Médicaments essentiels Génériques.

[ii] PRAPASS stands for Projet de Recherche-Action Pour l'Amélioration des Soins de Santé, a collaborative research effort of the Ministry of Health of Burkina Faso and the University of Heidelberg (Germany).

[iii] GTZ (Deutsche Gesellschaft für Technische Zusammenarbeit) is the implementing agency for technical cooperation of the German Federal Ministry of Economic Cooperation and Development (BMZ). Besides GTZ there are other German implementing agencies such as KfW (Financial cooperation) and DSE (Human resources development).

[iv] Ministry of Health, Budget 1998, Title III (expenses for material including interministerial budget) and Title IV (subsidies and transfers to hospitals). Salaries and investments deducted.

[v] Data collected through telephone interview in 1998 from the Public Central Procurement Agencies of the different countries.

[vi] Test sur la nouvelle démarche en matière de conditionnalités des appuis à l'Ajustement.

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