Institutional analysis of safe motherhood in Burkina Faso

An Institutional analysis of the safe motherhood policymaking process in Burkina Faso

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**Key messages**

Donors play an important role in policymaking through the interface they constitute between international policy and national actors, and more importantly, through their policy advice and financial support to government.

The policy community has the technical and moral clout, but exercising little political entrepreneurship, which contributes to inadequate financial allocations to safe motherhood programmes.

Fragmented aid induces a high transaction cost of managing diverging interests of multiple stakeholders who are not optimally aligned amongst themselves. It seems this cost cannot be absorbed by the concerned MOH departments.

Over-centralised decision-making, a rigid bureaucratic organisation and a neglected health workforce hamper the implementation capacity, both at central and operational level.
Abstract
Burkina Faso is in the group of 18 countries with an MMR equal or above 1,000/100,000 live births. While both the direct and indirect causes of maternal mortality are well known and international recommendations have taken shape, progress in reducing maternal mortality is slow. This study analyses which institutional factors influence the process of decision-making and the application of these decisions into effective activities at health service level. The analytical framework is that of the institutional analysis, which describes the trans-national, the political, the economical and social dimension and the health system characteristics. To this end, 45 key actors in safe motherhood were interviewed and a document review was done.

Women's health is slowly gaining importance on the political agenda in Burkina Faso. The policy community has the technical and moral clout, but there is little political entrepreneurship. This explains in part why financial allocations, a key indicator of effective political will, remain inadequate. An inadequate health workforce, a still quite centralised health bureaucracy and neglected health infrastructure hinder further implementation of decisions and programmes. The multiple international actors shape the latter to an important degree. Concerns regarding the fragmented inputs of external actors emerge. Given that they provide little support to increase the institutional capacity of the Ministry, the effectiveness of the Ministry of Health is at risk. On the other hand, implementation is an actual problem, marred by inadequate attention given to the availability, competence and motivation of the health workforce and to adequate working conditions. The still not equal social and economic status of women in today's society in Burkina Faso may be the most important indirect determinant of the high maternal mortality.
Introduction
Maternal mortality in Burkina Faso remains among the highest in the world. The estimated rate of 484 maternal deaths per 100,000 live births presented by the Demographic and Health Survey of 2003 has been revised upwards and the WHO estimates now that the MMR stands at 1,000/100,000 (WHO et al., 2004). This puts Burkina Faso in the group of 18 countries with an MMR equal or above 1,000/100,000.

A clear consensus on what should be done has now emerged. The skilled attendance and basic and emergency obstetric care strategy (WHO 2004) tackles the direct causes of maternal mortality: haemorrhage, infection/sepsis and eclampsia. In Burkina Faso, the offer of maternal care was organised along two axes on the basis of the international consensus. First, the coverage of the antenatal consultations was increased, followed by increasing the coverage of assisted deliveries. In order to reach areas not served by health facilities, the MOH trained Traditional Birth Attendants (“village midwives”) to assist deliveries. However, the above-mentioned figures show that these strategies did not reach the objective, in part because of incomplete implementation, but also because the effectiveness is less than was thought at the time. Indeed, we now know there is little scientific evidence for the effectiveness of the risk approach and the training of TBA (Bergström and Goodburn, 2001; Carroli et al., 2001). Even when a more evidence-based safe motherhood policy is implemented, progress is slow. To be effective, maternal health care depends on a web of factors including health personnel competence, availability and motivation, effective supply chains and responsive district management teams.

If our knowledge regarding the direct causes of maternal mortality is now good, far less is known about the other underlying factors. Illiteracy, the status of women in society and geographical and financial barriers to health care are relatively well documented. In contrast, the determinants that shape the environment of safe motherhood programmes are less studied (Shiffman, 2003). These include the trans-national, political, economical and social dimension and the health system characteristics, which we group under institutional factors. Furthermore, many actors influence decision-making and the actual programmes. In this paper, we analyse which policy actors and institutional factors influence the process of decision-making and the implementation of these decisions into effective programmes and activities at health service level.

In a first part, we present a description of the political, institutional, socio-cultural, economic and health system dimensions. The trans-national context is developed in more detail and based mainly on interviews with key actors. We then discuss the results and limits of the study and relate the findings to past experience and other studies.

Institutional analysis: a theoretical framework
Institutional analysis is often seen as a prerequisite for policy and health sector reform (Hafez, 1996; L’Abbate, 2003), but there is by no means a universal framework for such analysis. Indeed, institutional analysis comes in various forms, ranging from evaluations of institutional capacity to the study of public policy making within the norms of institutions, or various combinations of these. Institutional analysis is perhaps best conceptualised as representing different levels of analysis. The first level is the macro-environment, which takes into account the strategic vision and priorities of governments and other relevant institutions. The second level is more directly concerned with the specific formulation of such programmes and the capacity for implementation in the context of such an environment. A related third level is concerned with operational aspects of subsequent service delivery. The latter level involves the study of far more than institutional and political factors (Coates et al., 2003).

Despite attempts to place boundaries around them, these levels of analysis are neither separate nor purely hierarchical, but rather are integrally linked, as Figure 1 indicates. Policymaking and programme formulation function in relation to institutional structures and capacity. On the one hand, policy makers do not operate in a political or institutional vacuum but are constrained by norms of institutional behaviour. Their decisions are also guided by their own assessments of existing institutional capacity and structures and their potential for change. Furthermore, the significance of other related factors, such as broader socio-economic factors and relevant evidence (in this case, related to safe motherhood) is taken into account. On the other hand,
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Institutions are themselves structured in relation to the broader political and policy environment. Similarly, programmes are formulated in response to macro-level policy and may themselves provoke shifts in institutional structures and norms.

The framework of analysis adopted by this research takes into account the inevitable links between the levels in attempting a holistic analysis of both the macro policy environment and processes of policy making, and the specifics of programme formulation within this environment. An additional framework of context dimensions has been used to bring together the elements necessary to describe a synthetic picture of the policy context and how the latter influences safe motherhood outcomes. These comprise the trans-national, political, socio-cultural, economic and health sector context (Figure 2).

**Methods**

Since the research strategy was explorative rather than explicative, we used the case study approach (Yin, 2003) that combines the collection and analysis of both qualitative and quantitative data, the case being the policymaking process and the study population therefore the actors involved in decisions.

The study started with a document review of safe motherhood policy in Burkina Faso since the 1920s. Documents were collected through electronic data base searching and in the libraries of...
the various departments of the Ministry of Health, the national library, the National Institute of Statistics and Demography, the Institute of Research for Development (IRD) in Ouagadougou and the Institute of Tropical Medicine in Antwerp. A review of the resulting documents was carried out, including the national newspapers, which were scanned for maternal health related articles (Observateur Paalga, Le Pays and Sidwaya). Relevant quantitative data were sourced from the DHS studies, the national health information system and health expenditure reports (See annex for the bibliography).

Key interviewees were identified through a stakeholder analysis. Additional key persons were identified by the interviewees. Interview guides were conceived for semi-structured interviews. After pre-testing, 30 interviews were carried out between June 2004 and January 2005. The latter included staff of the Ministry of Health (central and regional level), Finance, Promotion of Women, Economy and Development, and representatives of international and bilateral aid agencies. Also local and international NGO staff and members of parliament were interviewed. The results of this first phase were discussed with and validated by a small group of key stakeholders from the Ministry of Health, the Ministry of Finance and international agencies during a feedback workshop in December 2004. 16 additional interviews were carried out in April-May 2006 in order to explore some emerging hypotheses and to complete our understanding of the policymaking processes. Interviewees were mainly drawn from the Ministry of Health and international organisations.

The 2004 interviews were recorded by note taking and the 2006 interviews were tape-recorded. All were transcribed and a thematic textual analysis of the transcripts was conducted, during which coding and analysis was based on an interpretative analysis approach through a close examination of the data. Categories, similarities and differences between interviewees and also within the narratives of individuals themselves were identified and linked to the analytical framework.

This study was part of the IMMPACT research programme, for which ethical approval was obtained from the Comité Nationale d'Ethique. Informed consent was sought and obtained from all interviewees. Measures were taken to safeguard confidentiality and anonymity during data collection, analysis, storage and reporting.

Results

The national political context

The political stability that Burkina has known since 1987 has contributed to a relatively stable institutional context. Together with an emerging civil society and a neo-liberal orientation, relationships with the donors and especially with the World Bank, the African Development Bank and the International Monetary Fund were good. Despite this, the state’s capacity to conceive, develop and implement the core public health functions and development strategies remained weak (Ministry of Economy and Development, 2004). This in turn contributed to a low absorption capacity for external funding (Ministry of Economy and Development, 2003).

During recent years, Burkina Faso experienced a rise of civil society organisations. However, at policy level and specifically regarding the Poverty Reduction Strategy Paper (PRSP) process, government experienced difficulties to engage these organisations in the consultation process (IBRD/WB, 2003).

On the political scene, the will to confront women’s health problems was personalised by the First Lady, who emerged as a champion for women’s rights and maternal health. She was also a link person with the West and Central African scene of maternal health, participating in the Vision 2010 regional meetings with colleagues of neighbouring countries. The creation of the Ministry for the Advancement of Women (Ministère de la promotion de la femme) a few years ago and of the departments in other ministries to deal with women’s rights can be considered a formal sign of political will. In practice, however, the discourse was not supported by allocation of adequate means, which undermines the effectiveness of these institutions.
The socio-cultural context

The traditional role patterns that limit women's opportunities for education, economical activities and access to information remain strong. The combined gross enrolment ratio for primary, secondary and tertiary schools is 23% for women (30% for men), and the adult literacy rate is 15.2% for women (29.4% for men) (UNDP, 2006). The low educational status of women is officially acknowledged as a major determinant of low social and health status and is considered a top priority in the Poverty Reduction Strategy Plan (Ministry of Economy and Development, 2004).

More than 80% of the population lives in rural areas (UNDP, 2006). Inequality decreased in rural areas between 1994 and 1998, from a GINI coefficient of 0.39 to 0.35 and thereafter stabilised (Grimm and Gunther, 2004). However, in rural areas, 52.4% of the population lives below the national poverty line compared to 19.2% of the urban population (World Bank, 2006). Furthermore, poverty seems increasingly to affect the female half of the population.

Poverty being crushing, it is difficult for women to overcome certain cultural barriers (Ministry of Economy and Development, 2003) and to fully emancipate. Due to the unequal social and economic status of women in Burkina Faso, health care seeking behaviour remains the domain of husbands and the larger family.

While the status of women in Burkina Faso remains therefore precarious, some signs indicate that it is an important political issue. In 1983, the laws have been adapted to institute legal and political rights for women. Through the 1991 constitution, institutional and juridical reforms were introduced to stimulate a fairer representation of women. Members of parliament created a group to promote women's rights. Besides the Ministry for the Advancement of Women, a committee against female genital mutilation has been instituted and laws for the protection of women and girls have been passed in parliament. As already mentioned above, inadequate resource allocation reduces the impact of the new laws.

As a consequence, participation of women in social debates and health facility management is inadequate. At facility-level, the village health committees theoretically represent patients and the community. In practice, this does not always work out, and even when the community is participating in management of health facilities, women are underrepresented. At the level of individual care, women mostly are not in a position to demand high quality and to put pressure on providers, the regulation of whom is already quite problematic. A similar picture emerges at policymaking level. Despite the growth of women associations and their consultation in some of the policymaking debates, they don't represent an effective counterweight.

The economic context

In the 1990s, Burkina Faso embarked in economic reforms, including a devaluation of the national currency (Franc CFA) imposed by France. More prudent monetary and budget management contributed to an average growth rate between 1994 and 2004 that was higher than the average for the Sub-Saharan region (IBRD/WB, 2003). However, economic growth did not lead to reduced poverty (Grimm and Gunther, 2004). With a GDP of US$ 376/capita, Burkina Faso remains one of the poorest countries in the world (UNDP, 2006). 46% of the population lives under the poverty line as defined by national standards, 27.2% lives on less than 1 $US/day and 71.8% on less than 2 $US/day (World Bank, 2006).

Furthermore, the economy remains fragile and vulnerable to external shocks. A stronger dollar, higher oil prices, drought, lower commodity prices and lower remittances from Ivory Coast combined with the influx of Burkina citizens from Ivory Coast all contributed to reduced economic performance during the period 2000-2002 and a subsequent slower growth (Ministry of Economy and Development, 2003).

The link between the difficult economic environment, the unequal distribution of wealth and poverty has a major impact on utilisation of health care. Several studies showed that financial barriers determine access to and utilisation of healthcare in Burkina Faso (Haddad et al., 2006, Develay et al., 1996; Ridde, 2003), especially for the poor (Su et al., 2006). In one study, 31% of the interviewees classified as poor said that financial barriers stopped them from using health services (INSD, 2002).
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The overall poor resource availability among the population contributes to reduced government revenue. This substantially restrains the margins of freedom of government regarding investing in health infrastructure, communication, transport infrastructure and education. It also imposes limits on the wage bill. The international aid in a sense compensates for resource scarcity, but in its current form and volume does not ensure fulfilment of all social functions of government.

The health system context

The health sector in Burkina Faso underwent major changes during the last 30 years. The coverage of the national territory by health facilities, top priority of the 1978 reforms, improved but remained inadequate for years. In the 1990s, decentralisation of the health system figured high on the agenda (Edmond et al., 2002). A policy of user fees and generic drugs was introduced under the Bamako Initiative in 1992 (Mugisha et al., 2002, Ridde, 2005). In 1993, health districts were created (Ridde, 2003) and in 1998, the nine regional hospitals and the two national hospitals became Public Administrative Establishments (EPA) with an autonomous management structure. Gradually, a formal private sector emerged, mainly in the two major cities Ouagadougou and Bobo Dioulasso (Bodart et al., 2001) and mostly staffed by moonlighting public service personnel.

The health system now has a typical pyramidal structure with a well-developed central level, an intermediate level divided into 13 regions and 55 health districts that make up the lower operational tier (Ministère de la Santé, 2005). The decentralisation increased the autonomy of districts and hospitals, but their financial decision spaces remain limited (Haddad et al., 2006). Major decision-making powers regarding resource allocation, investment and distribution of personnel are retained at central level.

Public health expenditure increased four-fold between 1990 and 2000 from FCFA 7.7 billion to FCFA 33 billion (Haddad et al., 2006). Total health expenditure increased from PPP US$55 in 1999 to $68 in 2003 (WHO, 2006), compared with $30 for Niger, $62 for Togo, $39 for Mali and $98 for Ghana (UNDP, 2006). In 1999, out of a total health budget of approximately 30 billion francs CFA, 40% was funded by donors. Overall, official development assistance and external aid in 2003 amounted to 48US$ per capita (World Bank, 2006). Despite external aid, however, the 2003 health sector deficit was estimated at 17.8 billion FCFA for a planned budget of 68.126 billion FCFA. Health expenditure stands currently at between 7 and 10% of the government expenditure, whereas the 20/20 Initiative aims at bringing the government expenditure for the health sector and for the education sector to 20% of total government expenditure. Government spending makes up less than half. On the ground, working budgets remain small.

In summary, despite considerable efforts during many years, the performance of the health system remains under par (Ministry of Economy and Development, 2004). The performance in terms of utilisation has not significantly improved during the last decade, despite increased financing and investment (Bodart et al., 2001). Indeed, utilisation rates increased from 0.21 cases/inhabitant/year to 0.25 between 2000 and 2002 (Ministry of Economy and Development, 2004), but remain very low. In rural regions, only one fifth of the population uses modern healthcare services (Baltussen and Ye, 2006). The Bamako Initiative did not lead to improved access to care by the poorest and this even decreased in some districts (Ridde et al., 2005). An exception is the expanded immunisation programme, which improved its coverage significantly between 2000 and 2004 (Arevshatian et al., 2007).

Regarding maternal health services, assisted delivery rates remain poor. Only 37.7% of the deliveries is assisted by trained personnel. These numbers differ substantially across the regions, ranging from 63% for the Central region to 14.4% for the Sahel region (Ministère de la Santé, 2005). According to another study, birth was attended by skilled personnel in 31% of cases, 42.1 % of women were attended by a traditional birth attendant, almost 20 % by a relative, and 7% of women delivered alone (Edmond et al., 2002). Skilled attendance rates drop dramatically to 18% among the poorest quintiles (UNDP, 2006). The low rate of assisted deliveries can be explained in part by the low availability of staff in the rural facilities, but also by financial and/or geographical barriers to access.

Implementation is marred by the performance of the health workforce. The 2001 WHO data indicate deficiencies among all cadres. While the number of doctors increased from 350 in 1995 to 490 in 2001, the density remained low at 3.9 doctors per 100,000 inhabitants in 2003 (from
The density of nurses and midwives also improved slightly, but this hides the important imbalances between the cities and the rural areas. In 2002, Ouagadougou and Bobo Dioulasso had one midwife for 8,000 inhabitants, while in the poorest regions of Ouargaye, Gorom-Gorom, Bogandé, Diapaga and Ziniaré, there was one for 430,000 inhabitants (INSD, 2002). These rates have not improved since.

Despite being intangible (or because so), provider attitude, commitment and motivation in general constitutes a major determinant of quality of care (Buttiëns et al., 2004). From the interviews, a great gap between professional norms and standards and the actual practice of health professionals is emerging. The official norms and policies of the Ministry of Health are transmitted through seminars and workshops, but the actual practice of providers is steered to an important degree by local organisational culture. The latter is not always conducive to patient centred care because of generalised petty corruption and low commitment to patients. This is reinforced by the lack of equipment, supplies and basic infrastructure. The result is a vicious circle that hinders the provision of good quality care.

The trans-national context

The document review and interviews show that decisions taken at supra-national level influence the policymaking process in Burkina Faso and that these filter into the decision-making through several mechanisms, among which the presence of international agencies may be most influential.

First, the international agencies such as UNFPA, UNICEF and WHO strategically invite and finance the participation of national delegations to international conferences.

“We try to constitute a team with someone from the State, a member of Parliament, NGO staff, etc. We try to diversify so that each will take up these matters”. (Interviewee 5 – Representative of international agency)

This inspired the Ministry of Health to integrate the main elements of international strategies in national health policies. MOH units responsible for maternal health and safe motherhood programme units were consequently restructured. Recent policy shifts include adopting the strategy of developing a national roadmap.

“The meeting in Yaoundé was one of our meetings where we shared experiences and where we have recruited a number of countries that worked on maternal mortality. (…) This conference has determined the policy of Burkina. (…) From that point onwards, everything that was delayed, was accelerated a bit. I am talking for example of the roadmap and the subsidising of emergency obstetric care.” (Interviewee 5 – Representative of international agency).

Second, international agencies transmit international priorities through their funding of particular activities. The World Bank and the EU in theory do not have direct relationships with the Ministry of Health. In practice, however, their budget support and the conditions they impose through the PRSP indicate the margins of freedom of the MOH. Recently, the World Bank took up subsidising emergency obstetric care as a conditionality of its grants (Interviewee 9 - National level MOH staff) and offered technical support to the MOH, aiming to increase its negotiation capacity with the Ministry of Finance. Interviewees noted that the World Bank occasionally aims at directly influencing policy at the MOH. In the recent case of reducing the financial barriers to maternal care, it pushed for abolishing user fees for antenatal care and emergency caesarean sections. Furthermore, by imposing their own evaluation system to track the performance of the state regarding utilisation of loans and grants, donors influence what is actually done, indicators becoming objectives.

Other actors include the bilateral donors (e.g. Belgium, Denmark, the Netherlands, Switzerland and Sweden). These countries moved from a project approach to budget support, together with the EU (Ministry of Economy and Development, 2003). Interviewees noted that donor-government relationships were troubled by a division among donors with regard to the country’s capacity to deal with basket funding. The World Bank’s way of dealing directly with central government officials in shaping the policies without consultation with other donors is seen by
some of the latter as disruptive (IBRD/WB, 2003). More importantly perhaps, all funding agencies maintain to some extent their own agenda.

“Well, they have their own vision, their way of analysing the problems. It happens that some methods are pushed upon the MOH, or that the policy orientation is imposed, and that leads at times to problems.” (Interviewee 13 – Member of Parliament)

Third, influential agencies such as UNFPA, UNICEF and WHO do not contribute much to funding of programmes, but exert influence through their prestige and close contacts with key policymakers. Occasionally, they finance technical support and recruit consultants to work with the MOH on very specific issues pertaining to their domain of interest. As a multi-tiered organisation, with links between Geneva, regional- and the country-level delegations, WHO emerges as a key actor in agenda setting regarding safe motherhood. They were very instrumental in, for example, the development of the Road map to safe neonatal and maternal health.

“It is WHO that is behind this and they asked several countries to develop their national road map. We, we didn’t want to call it the road map, we called it the plan to accelerate the reduction of maternal mortality” (Interviewee 9, National level MOH staff).

Several interviewees confirm this norm-setting role of WHO in technical matters.

“If you take the case of WHO, for the validity of your undertaking, you will be forced to refer to that agency. (…) Your reference is clearly WHO.” (Interviewee 15 - National level Ministry staff).

Of the three agencies, WHO is also considered to exert the strongest political influence. Its representative has weekly meetings with the Minister, which are widely regarded to be quite influential.

“WHO has a political dimension, that is to say, they, it is as if they are a member of the cabinet of the Minister of Health” (Interviewee 7 – Representative of international agency)

Among themselves, the UN agencies coordinate their activities, leaving WHO to interact directly with Government. They also enter into partnerships with other, bilateral actors, mainly in search of additional funding for their own activities. These ‘partnerships’ allow them to support projects, which their own organisation’s procedures wouldn’t allow (for example construction works, which UNFPA by its own rules cannot finance). Interviewees note however “there is no cooperation without agenda” (Interviewee 15 - National level Ministry staff).

Other actors include the international NGOs that work with the Ministry of Health, including Save the Children-Netherlands, Family Care International, Maternal & Neonatal Health MNH, Pharmaciens Sans Frontières and Médecins Sans Frontières. Virtually all operate at service provision level in the districts. They have a limited impact on the national decision-making process, although they are consulted by the Directorate of Family Health for their operational experience.

Discussion

Limits to this study include the classic problem encountered when interviewing policymakers still actively involved in the small political circle of safe motherhood. Given that this policy community in Burkina Faso is relatively small, and that some may aspire to occupy posts at national level or with international agencies in the future, it was not always easy to have interviewees speak out frankly. To deal with this, a feedback workshop was held after the analysis of the first series of interviews, followed by a second series of interviews to explore specific topics in more detail.

At this point, one could conclude that given the above institutional characteristics, women’s health is gaining importance on the political agenda in Burkina Faso. A key factor is the political
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will for safe motherhood. Tight policy communities with moral and technical authority, and political entrepreneurs have been shown to influence agenda-setting and create political will (Shiffman, 2003). In Burkina Faso, the policy community may have the technical and moral clout, but there seemingly is little political entrepreneurship. This explains in part why financial allocations, a key indicator of effective political will, remain inadequate. An inadequate health workforce, a still quite centralised health bureaucracy and neglected health infrastructure hinder further implementation of decisions and programmes. The latter are shaped to an important degree by the multiple international actors.

International actors have indeed a marked presence in safe motherhood in Burkina Faso. They play an important role in policymaking through the interface they constitute between international policy and national actors, and more importantly, through their policy advice and financial and other support to government. This shift of the locus of decision-making to international actors has been described in settings of post-conflict rehabilitation when the national governance capacity may be weak (Lanjouw et al., 1999), but occurs in many poor countries (Okuonzi and Macrae, 1995; Buse and Walt, 1997; Walt et al., 2003). In Burkina Faso, one of the poorest, this influence is not to be underestimated. WHO emerges as a key actor, setting national norms in a process similar to what Shiffman described in Nigeria, Guatemala, India, Indonesia and Honduras (Shiffman, 2006). On top of their financial and technical clout, framing their priorities within the MDG discourse makes it even more difficult for national authorities to resist their policy ‘recommendations’.

Despite mechanisms such as the PRSP that aim to bring donors together, we found that donor attitudes to aid and the exact modalities of interacting with national government are not streamlined, similar to what was reported in 2002 by (Edmond et al., 2002). Some major players participate in the Burkina PRSP, but others stick to programme and project support. The result is a high transaction cost of managing diverging interests of multiple stakeholders who are not optimally aligned amongst themselves. In current conditions, it seems this cost cannot be absorbed by the concerned MOH departments.

The fragmentation of inputs of external agencies may also reduce effectiveness of aid. Lack of coordination among the multiple actors intervening at central, regional or district level, within and outside the public sector, may contribute to weaken the health system, despite the fact that a well-integrated health system is the key to reducing maternal mortality. Our findings go in the same direction as indicated by (Yazbeck, 2004): the global initiatives, health sector reforms (such as decentralisation) and new financing modalities such as PRSP have been justified by the system failure of the health system in many low and middle-income countries, but may not have much contributed to implement the reproductive health agenda. All require a strong MOH capable of getting safe motherhood on the agenda and developing the conditions for health services to offer good care. Paradoxically, the international actors provide little support to increase the institutional capacity of the Ministry.

Even in case of well-defined programmes, the implementation phase is marred by inadequate attention given by the MOH to quality of human resources in terms of midwifery training, recruitment, posting, availability and maintenance of competences. Given its financial and personnel constraints, the Ministry has little control over the logistical support needed to offer an effective technical environment, and none regarding important determinants such as communication and roads. Safe motherhood depends not only on a strongly committed human workforce at all levels, but also on a vision of development that should be supported by many other actors.

Conclusion

While in Burkina Faso, the international safe motherhood policies have been incorporated in the public health discourse and have led to some structural modifications of the organisation of the Ministry of Health, much remains to be done to achieve a lower maternal mortality. Similarly, in the political debates, the importance accorded to women and their health status has increased, but this has not been translated in actual improvements of the status of women in society. International organisations are exerting a major influence on the decisions because of their funding, connections and prestige. The underlying question is in how far the dominant role played by external actors, justified as it may be given weak institutional capacities, is itself not contributing to this weakness by keeping aid and support fragmented. The result is a high
transaction cost of managing diverging interests of multiple stakeholders who are not optimally aligned amongst themselves. Targeted inputs are hoped to lead to rapid results, but are unlikely to increase the institutional capacity of the ministry of health, a key actor in safe motherhood, and to contribute to permanent reduction of maternal mortality.

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Contributions of the authors

All authors participated in the writing of the paper. B. Marchal, A. Coates and V. De Brouwere designed the study and the analytical frame. Data were collected by MT Arcens. B. Marchal, MT Arcens and A. Coates analysed the data. B. Marchal, A. Coates and V. De Brouwere wrote the manuscript.

References


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Annex - List of selected documents that were reviewed


Anonymous (undated). Health system issues and challenges impacting on maternal and newborn health in Burkina Faso.

Banque Mondiale (undated). Santé et pauvreté au Burkina Faso. Progresser vers les objectifs internationaux dans le cadre de la stratégie de lutte contre la pauvreté.


