

## Reducing financial barriers to emergency obstetric care: experience of cost-sharing mechanism in a district hospital in Burkina Faso

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### Summary

**OBJECTIVE** To describe the implementation of a cost-sharing system for emergency obstetric care in an urban health district of Ouagadougou, Burkina Faso and analyse its results after 1 year of activity.

**METHODS** Service availability and use, service quality, knowledge of the cost-sharing system in the community and financial viability of the system were measured before and after the system was implemented. Different sources of data were used: community survey, anthropological study, routine data from hospital files and registers and specific data collected on major obstetric interventions (MOI) in all the hospitals utilized by the district population. Direct costs of MOI were collected for each patient through an individual form and monitored during the year 2005. Rates of MOI for absolute maternal indications (AMI) were calculated for the period 2003–2005.

**RESULTS** The direct cost of a MOI was on average 136US\$, including referral cost. Through the cost-sharing system this amount was shared between families (46US\$), health centres (15US\$), Ministry of Health (38US\$) and local authority (37US\$). The scheme was started in January 2005. The rate of cost recovery was 91.3% and the balance at the end of 2005 was slightly positive (4.7% of the total contribution). The number of emergency referrals by health centres increased from 84 in 2004 to 683 in 2005. MOI per 100 expected births increased from 1.95% in 2003 to 3.56% in 2005 and MOI for AMI increased from 0.75% to 1.42%.

**CONCLUSIONS** The dramatic increase in MOI suggests that the cost-sharing scheme decreased financial and geographical barriers to emergency obstetric care. Other positive effects on quality of care were documented but the sustainability of such a system remains uncertain in the dynamic context of Burkina Faso (decentralization).

**keywords** emergency obstetric care, access to health care, financing, equity, urban health, Burkina Faso

### Introduction

Of the 18 countries with a maternal mortality ratio equal to or higher than 1000/100 000 live births in the mid-1990s, 17 are located in sub-Saharan Africa (WHO 2004). The reduction of maternal mortality by three-quarters is one of the Millennium Development Goals but reaching this target seems improbable in sub-Saharan Africa taking into account the increase of poverty, the absence of progress in coverage of skilled attendance at delivery (40% in 1990, 41% in 2003) and a maternal mortality that does not decrease [870/100 000 live births in 1990, 1100 in 1995 and 920 in 2000 (AbouZahr & Wardlaw 2001; WHO 2004; United Nations Statistics Division 2005)].

Burkina Faso is one of the countries where maternal mortality is about 1000/100 000 live births according to WHO estimates. It is a poor country (GDP 1120US\$ PPP per inhabitant) with 46.5% of the population living below the poverty line (INSD (Institut National de la Statistique et de la Démographie) 2003; UNDP 2003). The annual health care expenses of a family in Ouagadougou amount to 88.5US\$ on average and to only 22.3US\$ for the poorest quintile (INSD (Institut National de la Statistique et de la Démographie) 1998) while the modal price for a C-section observed in three regional public hospitals is 137.6US\$ (all expenses included) with a maximum of 550US\$ (Bicaba *et al.* 2003).

In order to reduce the financial barriers to care in Burkina Faso, various initiatives have been launched in

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rural districts with the support of UNICEF. They all focus on cost-sharing mechanisms between the ministry of health, families and health centre management committees and have proved successful in reducing direct costs to families by 60–70% (Nacoulma *et al.* 2003). In urban areas, financial accessibility remains a problem, with no community-based mechanisms available (GTZ 2001; Kakambega 2005). In 2005, the first urban cost-sharing system was launched in an urban health district of Ouagadougou. This paper describes the different steps of its implementation and analyses its results of the first year.

### Context

The Centre Region is divided into four health districts, three of them with a rural extension. The ‘Secteur 30’ health district is one of these four districts (Figure 1). It stretches over an area of 1534 km<sup>2</sup> with a large rural extension. In 2005, ‘Secteur 30’ had a total population estimated at 470292 inhabitants, covering the municipality of Bogodogo (314970 inhabitants over five urban areas and two villages). This is part of the capital city of Ouagadougou and the rural departments (counties) of Saaba (53668 inhabitants in 23 villages), Koubri (59195 inhabitants in 25 villages) and Komsilga (42459 inhabitants in 36 villages).

The commune of Bogodogo is managed by a municipal council, led by an elected mayor. The rural departments are administrative constituencies, led by Prefects.

The health district has 41 health centres [32 public facilities ‘Centre de Santé et de Promotion Sociale (CSPS)’, 8 NGOs including 7 denominational, 1 army] and one district hospital ‘Centre Médical avec Antenne Chirurgicale (CMA)’. Eighty-five per cent of the district population live within 5 km of a health facility. The management of health centres is in the hands of the community, through Health Committees (Comités de Gestion so called COGES, based on the Bamako Initiative model). The health district receives additional technical and financial support from donors who contributed to the improvement of infrastructure and equipment of the referral hospital and of the health centres.

The district hospital (CMA) comprises 57 beds in four inpatient departments (paediatrics, surgery, medicine and a 24-bed maternity unit), an outpatient service, a laboratory and a service of Medical Imaging (x-ray and ultrasound). The operating theatre has been operational since August 2003. Emergency obstetric surgery has been available around-the-clock since 1st October 2004. The hospital has three obstetricians and one surgeon. External obstetricians assist in night and weekend duty. The hospital has a blood



**Figure 1** Health map of Centre Region, Burkina Faso.

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supply renewed once a week by the regional transfusion centre, but the quantity of blood available is not always sufficient to meet emergency needs. Twenty-four hour care in the delivery ward is provided by two midwives, one auxiliary midwife and one non-qualified aid per shift.

**Implementation of the cost-sharing mechanism**

The main objective of the cost-sharing scheme is to improve access to emergency obstetric care for women who live in the health district. So far, in Burkina Faso the cost of care is partly sponsored by the government (health workers' salaries, infrastructure, part of the drug supply) but for the main part is covered by the households with only a very small proportion of the population affiliated to a health insurance or a mutual health organization (Kakambega 2005; Su *et al.* 2006). This means that the C-section at a price of 137.6US\$ (direct costs) represents a huge barrier for a Burkina family (about 1.5 month salary for intermediate civil servants or 2.5 guaranteed minimum wages).

**Preparatory phase**

The preparatory phase lasted 18 months, starting in May 2003 with the organization of a first meeting gathering representatives of the health committees, the Ministry of Health authorities at district, regional and central level, various international partners, professional associations (midwives and obstetricians), the nursing and midwifery school, municipality, civil society (women's associations) and maternity health workers. During this meeting, principles and scope of a cost-sharing mechanism were defined: the scheme would cover only severe complications at delivery including emergency transport. The direct costs of the interventions would be shared between the ministry of health, the health committees (COGES), the municipalities and families. Family would be asked to pay a lump sum.

First, estimates of the direct cost for an intervention including transportation from home were calculated to be around 136US\$ (Table 1). Several meetings followed and negotiations between stakeholders continued until the consensus meeting of October 2004 where an agreement was reached on who would contribute and the relative and absolute share of the scheme; the target population, the eligibility of women and the complications/interventions that will be covered and the mechanisms to manage the funds. Parallel to the participatory process of defining the cost-sharing scheme with influential stakeholders, a community information campaign was started through a local NGO (ASMADE).

**Table 1** Estimated cost of a major obstetric intervention in US\$, Secteur 30 district, 2005

	US\$
Intervention	
Surgical treatment	16.07
Standard kit for surgery	31.20
Specific consumables (surgical threads, anaesthetics, oxygen)	33.04
Hospital stay (lump sum)	11.02
Post-intervention drugs (mother and newborn)	29.37
Examination (laboratory, sometimes ultrasonography)	3.68
<b>Subtotal</b>	<b>124.38</b>
Transport	
Driver (premium/transportation)	2.78
Gas (20 l/100 km; 1.28\$/l; 24 km on average)	6.18
Maintenance	2.65
<b>Subtotal</b>	<b>11.61</b>
<b>Total intervention + transport</b>	<b>135.99</b>

**Implementation****Financing the scheme**

A formal agreement was signed between the main partners of the cost-sharing scheme, i.e. the health committees for the public health centres and the directors of the denominational health centres, the health district authority (representing the state), and the mayors. The cost-sharing scheme started on the 5th of January 2005. Each partner contributed to the scheme following the agreed share summarized in Table 2. Calculations of the global budget necessary to cover the C-section needs of the whole district for 1 year were made with an expected C-sections rate of 2.5% (i.e. 537 C-sections) and a weighted average distance for emergency referral of 24 km. We assumed that prices for drugs and C-section kits would remain stable for a year.

**Target population, eligibility and the coverage of the scheme**

The cost-sharing system covered all major emergency interventions related to the pregnancy (C-section, hysterectomy, laparotomy, perineal or cervical tear/laceration requiring a general anaesthesia), the transportation fee from the health centre to the hospital and all required care for the mother and her baby during or after the hospital stay until full recovery. For the woman and her family, the procedure was simple: in case of an intervention she paid 25000 FCFA (approximately 46US\$). To be eligible, she had to prove that she lived in the Secteur 30 health district. Very poor patients were exempted after

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	Total	Families	Health centres	Ministry of Health	Local collectivities
To be paid for one patient	136 100%	46 34%	15 11%	38 28%	37 27%
Total budget (based on an expected 2.5% C-sections)	73049	24679	7897	20730	19743*

\*City council of Ouagadougou: 13064\$; rural county of Saaba: 2239\$; rural county of Koubri: 2459\$; rural county of Komsilga: 1983\$.

†1US\$ = 545FCFA.

**Table 3** Major obstetric interventions performed among Secteur 30's residents (per cent of expected births), 2003–2005

	2003	2004	2005	P-value X <sup>2</sup> ddl 2
<b>Urban</b>				
Expected births	12957	13606	14237	
AMI*	133 (1.03%)	174 (1.28%)	273 (1.92%)	<i>P</i> < 0.01
Non-AMI	200 (1.54%)	322 (2.37%)	431 (3.03%)	<i>P</i> < 0.01
Unknown	16 (0.12%)	–	–	
Total MOI	349 (2.69%)	496 (3.65%)	704 (4.94%)	<i>P</i> < 0.01
<b>Rural</b>				
Expected births	6257	6750	7275	
AMI	12 (0.19%)	15 (0.22%)	33 (0.45%)	<i>P</i> < 0.01
Non-AMI	8 (0.13%)	15 (0.22%)	29 (0.40%)	<i>P</i> < 0.01
Unknown	1 (0.02%)	–	–	
Total MOI	21 (0.34%)	30 (0.44%)	62 (0.85%)	<i>P</i> < 0.01
<b>Total</b>				
Expected births	19214	20356	21512	
AMI	145 (0.75%)	189 (0.93%)	306 (1.42%)	<i>P</i> < 0.01
Non AMI	208 (1.08%)	337 (1.66%)	460 (2.14%)	<i>P</i> < 0.01
Unknown	17 (0.09%)	–	–	
Total MOI	370 (1.93%)	526 (2.58%)	766 (3.56%)	<i>P</i> < 0.01

AMI, absolute maternal indication; MOI, major obstetric intervention.

a rapid social enquiry. The family was no longer asked to buy drugs in private pharmacies, except in rare case of shortage of drugs. Then patients were reimbursed by the scheme.

### Managing the scheme

A management committee consisting of 12 members (district hospital staff and COGES representative) met every 2 weeks. All hospital departments concerned were represented in this committee (maternity ward, surgery ward, pharmacy, laboratory, cash desk, social services and so on). One 'cost-recovery agent' was recruited (paid on the budget of the cost-sharing system). He visited on a daily basis all the women who underwent an intervention and explained modalities of the cost recovery to the patient and her family. A social educator (MoH personnel) joined the management committee in July 2005. His role was to identify those eligible for fee exemption on the basis of poverty and make sure they got the intervention they

needed without paying the fees. A monitoring committee including different financial contributors and the hospital representatives (30 members) met every 3 months to monitor the correct use of the funds and the quality of care offered to the pregnant women within this system.

### Information to the community

Community information meetings were organized in urban and rural areas with the support of ASMADE, a local NGO specialized in communication. The participants were the community leaders, representatives of women associations, health committees and community health insurance committees and village birth attendants. More than 7600 key actors attended these information meetings. A play was created to introduce the discussion of emergencies during pregnancy and delivery and was performed in health centres on antenatal clinic days. Meetings were also organized for health personnel during which leaflets were distributed explaining the modalities of the system.

## Methods

We conducted a before and after study. Data collection tools were designed to measure: (i) service availability and use, (ii) service quality, (iii) knowledge and appreciation of the cost-sharing system in the community and (iv) financial viability of the system.

## Qualitative studies

A community survey was carried out before the implementation of the cost recovery in order to know the population's capacity and willingness to pay for emergency obstetric care. This survey, performed by ASMADE, consisted of group discussions (30 meetings: 12 in urban settings and 18 in rural villages of the district) and family interviews (42 families visited: 9 urban and 32 rural families), i.e. 818 district residents polled.

Anthropological studies were carried out with the objective of assessing changes in knowledge and perception of the services by the community. Five discussion groups comprising patients of different health centres (four urban and one rural) were held at 2-year intervals (involving 63 participants in 2004 and 77 in 2006). Exit interviews were organized at the district hospital after 6 months (24 patients or one of their family members) and after 1 year of implementation of the cost-sharing scheme (26 patients).

## Quantitative data of Secteur 30 district hospital

- The chief midwife systematically retrieved referral records from the health centres to the district hospital and from the district hospital to the university hospital, as well as counter-referrals to health centres.
- Routine data on maternity and theatre activities (number of deliveries, of C-sections and their indications, post-surgery morbidity and mortality, number of stillbirths and early neonatal deaths among babies born by C-section), pharmacy (shortage of essential drugs) and laboratory activities.
- Data on the contributions by stakeholders, on the number of women who paid the lump sum and on the level of cost recovery, to monitor financial viability of the system.
- Monitoring of the direct cost of hospitalization and care through an individual form where the entire treatment was recorded (surgery, lab exams, drugs, duration of hospitalization).
- Furthermore, data on C-sections and other major obstetric interventions (MOI) were recorded in all private and public hospitals in Ouagadougou for the

residents of the district in order to calculate the proportion of births with a life-saving intervention (UON Network 1998). Data were collected on individual forms every month in the district hospital and twice a year in the other hospitals of Ouagadougou by two midwives.

EPI Info 6 was used for building the database and SPSS for the analysis.

## Role of the funding source

The French Ministry of Foreign Affairs sponsored the implementation of the cost-sharing mechanism through a grant managed by three institutions in the north (Institute of Tropical Medicine - Antwerp, Institute de Recherche pour le Développement - Marseille and Equilibre & Populations - Paris) without interfering in any decision regarding the intervention or the analysis of data and the resulting publications.

## Results

### Referrals from health centres

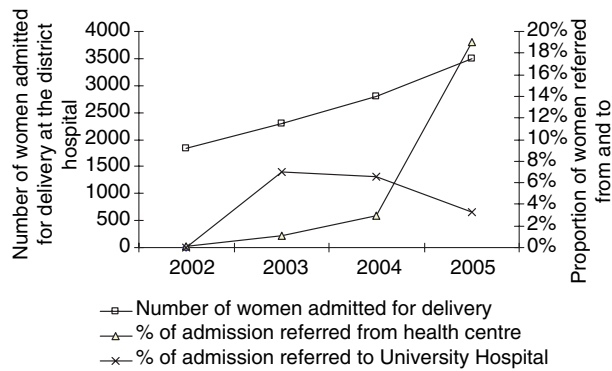
At the district hospital, the number of emergency cases referred from health centres increased from 84 in 2004 to 683 in 2005, or proportionally from 3% to almost 20% ( $P < 0.01$ ) of all women admitted for delivery. The proportion of women transferred from the Secteur 30 hospital to the university hospital decreased at the same time from 7.0% to 3.2% ( $P < 0.01$ ).

### Major obstetric interventions

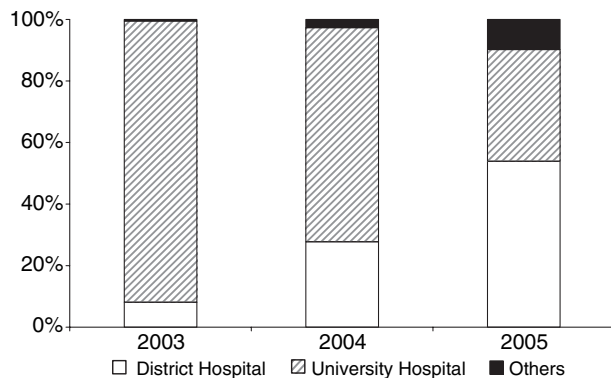
In 2005, 511 women underwent an MOI at the reference hospital, of whom 425 were recorded as residents of the district and benefited from the cost-recovery scheme. The MOI for the women living in the district (all facilities together) increased from 1.93% of expected births in 2003 to 3.56% in 2005 ( $P < 0.01$ ). The absolute maternal indications<sup>1</sup> showed a similar trend: from 0.75% to 1.42% on average ( $P < 0.01$ ).

However, MOI rates were almost six times higher in the urban part of the health district (4.9% of expected births) than in the rural one (0.85%) ( $P < 0.01$ ) (Table 3). The district hospital progressively took up its role of referral hospital taking 54% of MOI performed on patients from the

<sup>1</sup>Absolute maternal indications (AMI) comprise severe antepartum haemorrhage and post-partum haemorrhage, and obstructed labour for which an MOI is required (UON Network 1998).

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**Figure 2** Proportion of admission referred to and from the district hospital, 2002–2005.



**Figure 3** Proportion of major obstetric interventions performed by the hospital on district's residents, 2003–2005.

district in 2005 compared with 8% in 2003 (Figure 2 and 3). Along with the increase of C-section rates, the proportion of stillbirths and very early neonatal death (<12 h) among babies born by C-section decreased from 8.1% (2003) to 3.4% (2005) ( $P < 0.01$ ).

#### Major obstetric interventions performed among Secteur 30's residents (per cent of expected births), 2003–2005

Of the 425 eligible women, 91.3% paid the required 25000 FCFA; 43 women (10.1%) checked out without settling their full bill. Most of these cases occurred before the cost-recovery agent was appointed to improve cost recovery. As no formal system to identify eligibility for fee exemption was in place before September 2005, it was difficult to know if those women truly were eligible.

After 1 year, the system had a positive balance of 2036US\$ (4.7% of the contributions made by the stakeholders). Only one public health centre out of 22 and one

denominational health centre out of six did not pay their contribution.

#### Rationalization of care

Defining what should be included in the cost of the case management of an emergency obstetric case forced the health professionals to agree on standards of care. The obstetricians adapted the list of drugs according to their cost and their availability in public services. They accepted a standard surgical procedure for the C-section and for post-intervention care and tried to optimize the organization of care and the surgical technique to increase efficacy and to reduce cost. The introduction of the individual prescription forms necessary to get drugs at the hospital pharmacy (replacing the former uncontrolled prescriptions by a variety of staff) also helped to contain costs. Women living outside the district, and therefore excluded from the cost-sharing scheme (17%, 86/511), indirectly benefited from the rationalization of care: the average price of a C-section (cost of transport not included) 91US\$ compared with the 200–300US\$ fee at the university hospital.

#### Perceptions of the services by the community

Hospital users were asked about their perception of the scheme and the quality of care through focus groups and exit interviews. They were unanimous in saying that the scheme relieved them from a burden, but most had not been aware of the cost-sharing scheme before admission. Their principal demands were the assurance of the sustainability of the cost-sharing system and its extension to gynaecological problems.

#### Limitations of the study

The first limitation results from the population structure of the district with its urban part (Municipality of Bogodogo) and rural areas (three departments) and movements of the population. The numerator of the urban area may contain women from rural areas. In Mossi culture, the majority ethnic group in Ouagadougou, unmarried women move to their partner's family when they are pregnant and thus do not deliver in their parents' village (Ouattara 2006). The denominator may also be overestimated in rural areas; the last census dates from 1996 and migration from rural areas to the capital city is well recognized (Beauchemin & Schoumaker 2004; Ministère de la Santé 2006).

Another limitation of the study is the inability to identify the urban poor and check whether they benefited from the increase of service use. Records included information on sector of residence, but within each sector there was

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considerable disparity of wealth, with some areas lacking electricity, running water and passable road. A more precise registration of the women's address or type of housing could allow a better analysis of service use (Kobiane 1998).

**Discussion**

The success of this scheme relies mainly on the following elements: a participatory process, a committed opinion leader at the maternity unit, an effective management committee and good quality of care. The steep increase in C-sections (from 189 C-sections in 2004 to 511 in 2005) and in emergency referrals from health centres (from 84 in 2004 to 683 in 2005) can reasonably be attributed to the improved provision of comprehensive obstetric care and to the decrease of financial and geographical barriers (transport) as a result of the cost-sharing mechanism. Even if we consider the limitations of the study regarding rural data, the rural population does not seem to have benefited much from this scheme. Fear that traditions would not be respected if women deliver in the hospital and fear of the C-section may also have prevented rural women to go to the hospital (Zongo 2005). Despite our initial assessment of capacity and willingness to pay for obstetric emergency care, the level of out-of-pocket contributions may be too high for rural populations while it may be acceptable for urban citizens. Rural poverty contributed to 92.2% of national poverty in 2002 (Ministère de L'Economie et du Développement 2004). Even if the poor are exempted, rural populations may be not sufficiently informed. Indeed, exit interviews with patients and their relatives showed that only a few maternity users were aware of the scheme despite the community awareness campaign. This highlights the difficulty of community information and casts doubt on the efficiency of the traditional way of sensitizing the population using representatives from the population (Jewkes & Murcott 1998).

**Comparison with other financing mechanisms of maternal health services**

A number of ways to finance maternal health services have been documented (La concertation sur les mutuelles de santé en Afrique 2004; Waelkens & Criel 2004; Ensor & Ronoh 2005). They range from user charges at the time and place of use to indirect methods (like prepayment and insurance). Each type of payment has its own trade-off in terms of equity and efficiency.

The main advantage of the cost-sharing system in Ouagadougou is that all pregnant women living in the

health district can benefit, as opposed to insurance systems where only the women who have paid a premium can benefit. A cost-sharing scheme for expensive events such as C-sections is not incompatible with community health insurance schemes, which generally cover small risks and coexist well in Secteur 30 health district (Béré 2005). It would have been interesting to compare with experiences of fee-exempted C-section introduced by the government of Burundi, Mali, Senegal and Ghana, but no formal evaluation is available yet. However, studies in other countries claiming to have free maternal services at government facilities show that hidden costs are in fact quite considerable. This is the case of Bangladesh (Nahar & Costello 1998) where the family has to pay an average of 117.5US\$ for a C-section (travel, drugs, tips) while the services are said to be 'free'. The same unofficial payment has been documented in Tanzania (Abel Smith & Rawal 1992). Although user fees are generally regressive, a review of the literature suggests that a formalized and transparent user fee system is preferred by households over unofficial but quite unpredictable payments (Ensor & Ronoh 2005). This matches the findings of our preliminary community-based study in which households declared to be ready to pay 55US\$ for the proposed package if they were sure it was a fixed charge that would encompass the entire episode. The contents of the package covered by the system (be it cost sharing or insurance) therefore determines its success. Most of the systems covering maternal health services fail to address the indirect costs faced by women in accessing care during pregnancy. This is the reason why emergency transport has been included in the Secteur 30 cost-sharing scheme, as well as care for the newborn and post-natal care.

**Equity**

Fee exemption for the poor has been planned and special funds were allocated for the same. However, evaluation needs to be improved to determine whether the needy actually benefited from the exemption. Identification of the poor for fee exemption is theoretical in many insurance schemes (Stierle *et al.* 1999; Murray & Pearson 2006). Values of a community and its perception of social justice play an important role in analysing equity (Sen 2000). Anthropological studies showed that in Mossi culture, a belief seems to remain that natural, intrinsic inequality between human beings is essential for social harmony. 'Even the fingers of the same hand don't have the same length', says a Mossi proverb. Viewed from this angle, positive discrimination to the destitute, necessary to reach equity, is not a priority (Ridde 2006). Local concepts of

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social justice could therefore explain to a certain extent the difficulties in organising fee exemption for the poor and obtaining equity in access to care, even if funds are available.

**Sustainability of cost-sharing system**

One of the major challenges of cost sharing as it has been implemented in Burkina was sustainability. First, it relied on several funding sources. If one party interrupts its contribution, the entire system may break down. The impact of the ongoing decentralization process in Burkina Faso on the financial resources of local authorities is unknown. Second, the system does not compensate hospital staff for reduced income that results from the cessation of the unofficial payments (decision of the monitoring committee at the beginning of the system). Third, in March 2006 the government passed a decree to fund 80% of the direct costs of maternal care at delivery (normal deliveries, complications, emergency obstetrical interventions) with the help of the World Bank and other donors (Ministère de la Santé 2005). This applies to the entire country and all levels of care (hospitals and health centres). This extra funding for obstetric care can be an opportunity for the district to allocate the funds of cost-sharing system to other cases (such as gynaecology or post-abortion cases) or to pay the duty staff, but it can also be an argument for the local authority to stop their support.

**Conclusion**

Results after implementing this cost-sharing mechanism in Ouagadougou showed a decrease in financial and geographical barriers for the urban part of the population. Our findings confirmed that cost sharing can be adapted to urban settings involving stakeholders such as the local authority and denominational structures, and can be 'district-driven' even in an urban district. Another major effect was the improvement of quality of care thanks to the availability of all items required for the management of severe maternal conditions and to the standardization of the protocols. Efficient dissemination of information to the community and community participation remain a challenge. In addition, if the system of identification and exemption of the poor is to be improved, the perception of social justice within the communities should be re-examined. The sustainability of such a system remains uncertain in the dynamic context of Burkina Faso. The decentralization process and the implementation of a new government subsidy of maternal health services may have a serious impact.

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F. Richard *et al.* **Cost-sharing mechanism for safe motherhood in Burkina Faso****Réduire les barrières financières aux soins obstétricaux d'urgence au Burkina Faso: mécanismes de partage des coûts**

**OBJECTIF** Décrire l'implémentation d'un système de coût partagé pour les soins obstétricaux d'urgence dans un district urbain de santé à Ouagadougou au Burkina Faso et analyser les résultats obtenus après une année d'activité.

**MÉTHODES** La disponibilité du service et son utilisation, la qualité du service, la connaissance du système de coût partagé dans la communauté et la viabilité financière du système ont été mesurées avant et après la mise en place du système. Différentes sources de données ont été utilisées: enquête sur la communauté, étude anthropologique, données de routine provenant des fichiers et registres d'hôpital et données spécifiques collectées lors d'interventions obstétricaux majeures dans tous les hôpitaux utilisés par la population du district. Les coûts directs d'interventions obstétricaux majeures ont été collectés pour chaque patient à partir d'un formulaire individuel et ont été suivis durant l'année 2005. Les taux d'interventions obstétricaux majeures pour des indications maternelles absolues ont été calculés pour la période 2003–2005.

**RÉSULTATS** Le coût direct d'une intervention obstétrique majeure était en moyenne de 136 dollars US, y compris le coût du transfert. Par le système de coût partagé ce montant est partagé entre les familles (46 dollars US), les centres de santé (15 dollars US), le ministère de la santé (38 dollars US) et l'autorité locale (37 dollars US). Le schéma a commencé en janvier 2005. Le taux de rétablissement du coût était de 91,3% et l'équilibre à la fin de 2005 était légèrement positif (4,7% de la contribution totale). Le nombre de transferts d'urgence par les centres de santé a augmenté de 84 en 2004 à 683 en 2005. Les interventions obstétricaux majeures par 100 naissances prévues ont accru de 1,95% en 2003 à 3,56% en 2005 et les interventions obstétricaux majeures pour des indications maternelles absolues ont accru de 0,75% à 1,42%.

**CONCLUSIONS** L'augmentation dramatique des interventions obstétricaux majeures suggère que le schéma du partage des coûts a diminué les barrières financières et géographiques aux soins obstétricaux d'urgence. D'autres effets positifs sur la qualité des soins ont été documentés mais la durabilité d'un tel système demeure incertaine dans le contexte dynamique du Burkina-Faso (décentralisation).

**mots clés** soins obstétricaux d'urgence, accès à la santé, financement, équité, santé urbaine, Burkina-Faso

**Reducción de las barreras financieras en el cuidado obstétrico de emergencia en Burkina Faso: mecanismo de repartición de costes**

**OBJETIVO** Describir la implementación de un sistema de repartición de costes, para cuidado obstétrico de emergencia, en un distrito sanitario urbano de Ouagadougou, Burkina Faso, y analizar los resultados obtenidos tras un año de actividad.

**MÉTODOS** Se midió la disponibilidad y uso del servicio, la calidad del servicio, el conocimiento del sistema de repartición de costes en la comunidad y la viabilidad financiera del sistema antes y después de haberse implementado. Se utilizaron diferentes fuentes de datos: una encuesta comunitaria, un estudio antropológico, datos de rutina provenientes de los archivos y registros hospitalarios y datos específicos recolectados en intervenciones obstétricas mayores (IOM), en todos los hospitales utilizados por la población del distrito. Los costes directos de las IOM se recogieron para cada paciente mediante un cuestionario individual, y fueron monitorizados durante el año 2005. Se calcularon las tasas de IOM para indicaciones maternas absolutas (IMA) para el periodo 2003 a 2005.

**RESULTADOS** El coste directo de IOM fue, en promedio, de 136 US\$, incluyendo los costes de derivación. A través del sistema de repartición de costes, esta cantidad fue compartida entre familias (46US\$), centros de salud (15US\$), ministerio de sanidad (38US\$) y autoridades locales (37US\$). El proyecto comenzó en Enero del 2005. La tasa de recuperación de costes fue del 91.3% y el balance al final del 2005 fue ligeramente positivo (4.7% de la contribución total). El número de derivaciones de emergencia por los centros de salud aumentó de 84 en 2004 a 683 en 2005. El IOM por 100 nacimientos esperados aumentó de 1.95% en 2003 a 3.56% en 2005 y el IOM para IMA aumentó de 0.75% a 1.42%.

**CONCLUSIONES** El aumento dramático de IOM sugiere que el mecanismo de repartición de costes disminuyó las barreras financieras y geográficas de los cuidados obstétricos de emergencia. Otros efectos positivos sobre la calidad del cuidado fueron documentados, pero la sostenibilidad del sistema continúa siendo incierto en el contexto dinámico de Burkina Faso (descentralización).

**palabras clave** Cuidados obstétricos de emergencia, acceso a los cuidados sanitarios, Financiamiento, Equidad, Salud urbana, Burkina Faso