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"The problem of the worst-off is dealt with after all other issues": The equity and health policy implementation gap in Burkina Faso☆

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Abstract

In West Africa, the famous "implementation gap" concept applies to health policies. During the implementation of the Bamako Initiative (BI), the actors were drawn to policies solely for their orientation towards efficiency, thereby neglecting the equity aspects. This paper aims to present an in-depth understanding of this situation, developed through a case study and socio-anthropological fieldwork. The study is informed by a policy framework of analysis that integrates streams theory and the anthropology of development. Multiple sources of data were used: concept mapping (2), in-depth interviews (24), informal interviews (60), focus groups (4), document analysis, and field observation (7 months). The results indicate that the equity aspect of health policies was omitted during training on the use of proceedings from drug sales and user fees; donor agencies and NGOs were more preoccupied with efficiency than equity; the peripheral actors were not driven to ensure that indigents had free access to health care; society was not concerned with the sub-groups of the population; centralized decisions were taken without consultation, remained vague, and were not followed-up; and the concept of equity was perceived differently from those who devised policies.

I offer a threefold explanation of why equity was neglected. First, the "windows of opportunity" for achieving equity goals were not seized, at least at the point that led to real change. Second, the policy entrepreneurs did not take on the task of coupling the problem streams with the solutions streams, which is necessary for a successful implementation. Third, the situation of the indigents did not exhibit the necessary characteristics for them to be considered a public problem. For scientific and social reasons it is urgent that we find a solution to halt the exclusion to health care among the poorest groups.
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Keywords: Equity; Bamako initiative; Burkina Faso; Policy streams; Access to health care

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Introduction

In the early 1980s, community-based funding was one of the mechanisms used to implement the policy of Primary Health Care (PHC) policy of Alma-Ata. However, the most notable change was the introduction and expansion of systems of payment of user fees, with sub-Saharan Africa being the area where they were probably most widely introduced. Numerous studies have shown, however, that this direct payment greatly inhibited access to care (James et al., 2006) among the worst-off (Stierle, Kaddar, Tchicaya, & Schmidt-Ehry, 1999) as well as in Burkina Faso (Ridde, 2003). Therefore, in 1987 in Bamako, African health ministers decided to re-launch the PHC with the help of a new public policy: the Bamako Initiative (BI). This had a double aim: to ameliorate both the quality and the accessibility of health care services (OMS, 1999). In contrast to the PHC policy, the BI is more concrete and goes beyond the intention of ''health for all''. Technically, the BI is translated by an endowment of an initial stock of generic essential drugs (GED) given to a village management committee of a dispensary. These drugs are sold to patients with a profit margin that is conserved locally. This margin, added to user fees in exchange for consultations, was supposed to permit the initial stock to be repurchased and improve access to health care and quality of services. In fact, although the BI had expressed a wish to intervene in favour of equity by extending PHC, implementation was something else.

As with many other public policies in the South (Brinkerhoff, 1996), even though this one was adopted in an African capital, the BI was largely exogenous in origin, and was undertaken due to the drive of international organizations, notably UNICEF and the WHO. Beyond the ultimate aim of universal accessibility to PHC, the BI was supposed to organize community auto-financing, while ensuring that measures were taken so the worst-off could access services (Principle No. 7: exemption fees). Faced with the risk of this implementation gap and its consequences for equity in access and the funding of services, certain voices (i.e. NGOs, academics) were raised following the launch of the policy (*The Bamako initiative – editorial*, 1988; UNICEF, HAI, & OXFAM, 1989). Despite these concerns the effectiveness of the BI was what attracted the attention of the stakeholders during its implementation, to the detriment of the equity aspect. This observation was made in Africa (Gilson et al., 2000; Wiseman, 2005) and was confirmed in Burkina Faso (Haddad, Nougtara, & Fournier, 2006; Nitièma, Ridde, & Girard, 2003). However, an observation does not constitute an explanation. Few papers explained what led stakeholders to focus on effectiveness at the expense of equity. This paper aims to present an in-depth understanding of this situation. It is yet not possible to study the impact of policies on equity in health outcomes. I will thus focus on equity in utilization of services and, most of all, on access to health care for the worst-off, who have been affected the most by the introduction of user fees. The worst-off have been defined as those who are permanently excluded from health care because of lack of financial means to pay for it.

Burkina Faso is ranked fourth to last in the 2006 Human Development Index. The country launched the BI in 1993. A central purchasing agency for essential drugs (CPAED) has been operational since 1994. A drug policy was formulated in 1996 and a hospital law in 1998. The national health policy was adopted in 2000. This was translated into a National Plan for Health Development (NPHD) for the period 2001–2010. In 2003, 7.2% of the State budget was allocated to the Ministry of Health. The country comprises 55 health districts. The organization of public health care follows a classical pyramidal model. The first contact service is composed of the Health and Social Promotion Centres (HSPC), dispensaries and maternity centres. Medical Centres with a surgical ward (MCCW) constitute the second level in any given district. The third level comprises eight regional hospitals and two national hospitals. The utilization rate of health services has increased since 2002, after a 20-year constant decrease (Haddad et al., 2006).

Conceptual framework

Public policies are usually viewed as being a process for regulating situations where there are problems in resource distribution. They are composed of three subprocesses: agenda, formulation and implementation (Lemieux, 2002). This process, which takes place in a specific context, is traversed by the three streams (problems, policies, orientations) which were initially defined by Kingdon (1995) in order to explain the agenda-setting of a policy. According to Kingdon, public policies emerge when policy entrepreneurs seize windows of opportunity to couple a problem stream with a political stream. The policy stream is also present, but is loosely coupled with the other two streams. Without this coupling, no policy can emerge. Problems remain unresolved, solutions may exist or be promoted by various stakeholders, but there is no receptivity to them. Taking this interpretation one step further, it has been demonstrated both theoretically and empirically

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(Lemieux, 2002) that implementation entails matching the solution stream with the problem stream, while the third stream (orientations) is loosely coupled. The convergence of these streams is initiated by a policy entrepreneur who decides to use these resources to promote convergence at a point where a window of opportunity appears. Entrepreneurs may emerge from any of the streams, depending on the situation and the degree to which a certain stream predominates.

Policy analysis can be undertaken by studying a process and the actors who take part (Walt, 1994). Four strategic actor groups are thus involved based on their expertise and their position in relation to the governmental apparatus (Lemieux, 2002). They are defined for the policy in Table 1. These persons are social actors who evolve in a social system and who possess, in spite of constraints, a certain margin of manoeuvre. The ‘‘néo-interactionnisme’’ theory from the anthropology of development is useful for studying the roles of actors (Olivier de Sardan, 2005). A detailed description of the analytical framework used in this study can be found elsewhere (Ridde, 2007) and is outlined in Fig. 1.

Methodology

This research was carried in the Souna Health District (fictitious name), using the case study methodological strategy (Yin, 1994). The case study is that of an international non-governmental organization (NGO) project which is implementing the BI through the support of a District Health Team (DHT). The case was selected in collaboration with ministry officials. The choice was based on the potential of the case to enhance comprehension of the problem under study. I spent 7 months on the field, and conducted a socio-anthropological field study. Stakeholders and actors who participated in the study were aware of the status of the investigator. An ethical consent was issued before the study commenced. I used a mixed-method approach in order to strengthen data triangulation (Table 1). Two concept mapping, in addition to the focus groups, allowed for a better understanding of the concept of social justice from an emic perspective. Some data collections were carried out during daily interactions, work meetings, and dispensary visits (e.g. for monitoring or drugs distribution). At least 40 interactions and 60 informal interviews were transcribed in the form of ethnographic field notes (Emerson, Fretz, & Shaw, 1995). This allowed for a profound analysis of issues concerning power and the control of resources. The selection of respondents for in-depth interviews ($n = 24$) was carried out after 4 months in the field. Participants to the study have been identified in a way that all relevant categories of actors would be covered and all relevant information would be accessed to. The author himself interviewed all French-speaking participants; while a national sociologist run interviews and focus groups in the local language (Moore). All interviews were recorded and transcribed in French. Qualitative data were analyzed according to the thematic analysis approach (Miles & Huberman, 1994).

Context and implementation process

The population of the Souna district is very young; villages are small and the majority of the inhabitants, who are Muslim and possess little or no education, are farmers or stockbreeders. The social context is predominantly Mossi, which can be described archetypically as follows: (i) solidarity remains very important although it is being eroded; (ii) it is a hierarchical, strict social organization that seeks stability; and (iii) there is a belief in a ‘‘natural’’ inequality among human beings, which is indispensable for social harmony. The health district comprises 500,000 inhabitants and around 70 health centres which lack personnel. Nine men make up the DHT which is charged with coordinating health-related activities. The following section first describes the process of implementing the BI at a national level, and then at the level of the Souna district.

Table 1
Data collection methods and social actor groups

Instruments/actor category	Interested	Individuals	Officials	Agents
Example of actors	NGO member, HMC team member, GEDS manager	Cultivators, worst-off, users (and non-users) of services	Deputies, consultants, experts	Nurses, physician
Focus groups (# persons)		4 (41)		
Informal interviews	23	4	1	32
In-depth interviews	6	6	4	6
Concept mapping (# persons)	1 (7)			1 (9)
Documentation/archives	Policy papers, reports, registers, newspapers, etc			
Observations, visits	7 months in the field, participation in all DHT and NGO activities (meetings, monitoring, training, informal discussion, etc)			

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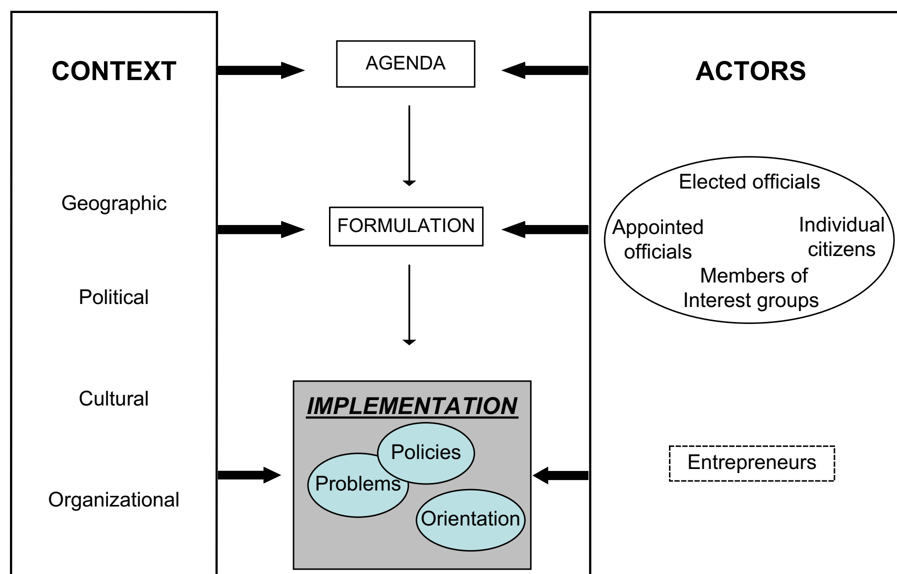

Fig. 1. Analytical framework. Source: adapted from Gilson et al. (2000); Kingdon (1995); Lemieux (2002); Olivier de Sardan (2005); Walt (1994).

Although the BI was adopted at the African level in 1987, it took until 1993 to implement it in Burkina Faso. Several events took place before implementation of the BI in Burkina Faso: the Benin mission (1998); operational research (1998–1989); founding of a BI committee, a national secretariat, and a follow-up committee (1988); and six pilot provinces (1989–1992). During a national workshop in 1992, the formulation of the BI was rendered operational with the production of the "*The BI Start-up Document*" (Ministry of Health, 1992). The official launch in October 1993 is considered the start of the BI implementation. The first training for trainers was delivered in July 1993. As for the NGOs, activities took place through the BI-NGO intercommittee, which seems to have ceased its activities after 1996. However, the 100% devaluation of the CFA Franc in January 1994, led to a reconsideration of the BI process, since the price of imported GED almost doubled. In March 1994, the "BI acceleration phase" was started. This phase constituted one of the two prongs of the National Emergency Economic Program financed by the International Monetary Fund and the World Bank (WB). Broad discussions took place amongst ministry employees and political officials when the strategy was adopted. Two sides of the debate confronted one another during a UINICEF meeting. One side specified that it was impossible to imagine the deployment of "*tons of drugs*" (agent) when no one was trained and the GED stores (GEDS) were not constructed and the population was not yet informed. The second side took a political stance and insisted that it was necessary to distribute drugs free of charge all over the country in order to avoid any political unrest that might be caused by the devaluation. The latter side of the argument won and "*a wave of drugs was unleashed on the country*" says a former high-ranking official, bringing with it its share of embezzlement, abuse and mismanagement, in the words of some who experienced this The acceleration phase ended in June 1996, no evaluation followed. The Ministry organized a confidential workshop in February 1999 in order to prepare a review of the BI for an African/UNICEF meeting.

In the Souna district, implementation started in chaos in the 1990s and was more seriously organized in the 2000s with the help of a NGO project. Up until the acceleration phase (1996) certain HSPCs "*could get a small amount of stock to start*" (agent). Then, drugs that were sent were stocked by regional officials, since the district was not ready to receive them. However, towards the end of 1996, these regional offices requested the head nurses (HNs) of the HSPCs to come and collect the drugs "*in order to be able to distribute the stocks*" (agent). At this time, the HNs managed the revenue generated from drugs: some used the funds to restock while others "*consumed, others mismanaged*" (agent). The analysis of the Ministry of Health regarding the management of drugs at the regional level was without compromise: "*Disappearance and expiration of GED, dissemination of GED kits without auxiliary measures, health workers who were not trained in the BI, etc.*" (Ouedraogo, Savadogo, & Yameogo, 1998, p. 17). In 1998, serious, albeit modest, developments occurred.

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A few members of the health management committees (HMC) at the village level were trained, some GEDS were built and their management was supervised. In the year 2000, the regional director negotiated a loan of 5 million GED with the CPAED and the first training dedicated to the BI was delivered to 19 nurses. In the beginning of 2001, the first valid wide-ranging project linked to the BI started for 3 years. The overall objective of the project, as declared by the NGO, was to improve the geographic and financial accessibility of the population to GED and to PHC. The NGO was to build the GEDS and provide them with drugs, carry out training programs, supervise and control the GEDS in cooperation with the DHT, etc. The final evaluation of the project demonstrated that the focus of the actors had been on achieving the effectiveness objectives to the detriment of equity (Ridde, Nitièma, & Dadjoari, 2005). The rest of this article will attempt to explain why this happened.

Actors and the problem stream

In order to understand if the absence of equity in the BI (i.e. protecting access for the worst-off under user charge policy) is perceived by actors as a *public* problem, nine elements (Table 2) have to be studied empirically.

1. At the central level, the importance given to equity is iterated in a few decrees made in 2002 and 2003, but in a very directive, top–down manner and as a result of external pressure (the WB and the Poverty Reduction Strategy Papers). The NHDP objective, which involves an approach that favours health care access for the poorest (objective No. 6) is one of only two objectives that are associated with a single evaluation indicator, and this indicator was not formulated from the perspective of equity: "*Average cost of health services acts and prescriptions*". The "framework and planning guidelines" send by the central level to DHT failed to include the NHDP activities designed to cover the worst-off. At a local level, amongst the 32 HSPC action plans consulted, none made mention of access to health care for the worst-off as a priority problem. In their situational analysis, none of the 140 problems raised by nursing students during their internships addressed health care access for the poorest.
2. For individuals, the user fees established by the BI, without the organization of exemption mechanisms, is an obvious cause of the absence of equity: "*It is because I do not have money that they sent me home without treating me*" (individual). Nevertheless, the interested group thinks that fees did not change anything, for the worst-off "*before, even when it was free, they did not come*" (NGO member).
3. Even if the association between user fees and death is sometimes trenchant: "*The sick will not go to sell their death to the health centre*" (individual), only the worst-off suffer the consequences.
4. The worst-off are excluded from so-called "vulnerable populations" in public policies documents. Thus, they do not benefit from the governmental measures for free services established in 2002: "*In accordance with the spirit of the Bamako Initiative, preventive care to vulnerable groups (pregnant women and infant consultancies) is free of charge.*" The Souna inhabitants do not perceive the existence of sub-groups in the population other than the large groups like the poor or women. The "verbal gymnastics" (Rochefort & Cobb, 1993) present in the definition of the worst-off do not support their inclusion.
5. The exclusion of the poorest from access to health care is customary. Some interested people confirm that it persists and implementation of the BI has not changed anything. Moreover, the fact that the worst-off do not go to the HSPCs does not help to explain the problem. A nurse mentioned that the situation is not new; it is simply not mentioned. He and others said that the fact that the researcher was raising this problem with them was uncommon.
6. One thing is clear, apart from the worst-off, all the other actors are too far removed from this exclusion situation: "*The problem of the worst-off does not preoccupy those in Souna*" (individual). The "BI unit" of the Ministry of Health decided in 1992 that it was necessary to carry out research on access to care for the worst-off. By 2005 nothing had been done due to the fact that "*In the* [BI Unit] *team we cannot find anyone to carry out these aspects*" (interested). Furthermore, "*We find that*

Table 2
The nine components of a public problem

For a situation to become a *public* problem, it is necessary…	
1	…that it be recognized as important
2	…that its causes be recognized
3	…that its consequences be determined
4	…that the populations affected be known
5	…that it be new
6	…that people be close to the situation
7	…that there be events, crises or symbols related to it
8	…that there be feedback about it
9	…that it be in line with the values of the society

Sources: adapted from (Kingdon, 1995; Rochefort & Cobb, 1993).

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those who are going to carry out evaluations or supervision are people who never were concerned with equity issues'' (interested).

7. To our knowledge, there has not been a major crisis concerning access to services, particularly for the worst-off. From time to time, events which can be qualified as micro-crises occur; these are one-off events at the HSPCs such as when an indigent arrives who asks to be covered. But this type of situation only happens rarely, and solutions are found in an *ad hoc* and individual manner.
8. It should be noted that the issue of exemption mechanisms for the worst-off is absent from all training programs. This holds true for the HN training program at the National School of Public Health (NSPH) and for continuing education delivered by the NGO and the DHT. The issue of the worst-off is not even brought up during the training of community health workers, managers of the GEMS or members of the HMCs. This short-sightedness regarding the permanently excluded was equally confirmed during supervisory visits to the HSPCs by the DHT and the NGO. The same findings were noted during the evaluation of the NGO project.
9. The value question is central and local conceptions of distributive justice are close to an egalitarian vision. Rousseau's explanation of the natural origins of inequality between human beings has a bearing on the discourse that was heard. Difference appears to be an integral part of social life, as ''*We must mix altogether*'' (individual), and above all, one needs to preserve ''*social peace*'' (individual). Nevertheless, if health inequalities are accepted, inequalities in heath care access are described as unjust by individuals. In order to contest them, the population cannot act spontaneously; it must be incited to take action. The classic dilemma of choosing the beneficiaries of a public policy (universality *vs* targeting) is resolved by officials by selecting a large segment of the population, the poor and women, but not the worst-off.

Actors and the solution stream

How do actors view the reduction of permanent exclusion from health care? What solutions do they suggest?

A health worker proposed payment modalities based on the ability of patients to pay; since the worst-off do not have the means, health care will have to be free for them. Nevertheless, as an indication of the current shortcomings of the health system, many of those interviewed highlighted the importance of informing the population of the fact that health care would be free. In order to finance health care exemptions, some suggested the use of grants and subsidies while others suggested using the revenue that comes from the population who pay for their services. Due to the keen interest in West Africa with respect to Community-Based Health Insurance (CBHI), certain experts suggested it as a possible avenue. Only one person, a nurse working in the city proposed that the Ministry of Social Action intervene on behalf of indigents. There have been rare individual initiatives to provide help to indigents. But they have remained isolated.

According to Kingdon (1995), proposed solutions are debated, analyzed and selected in the community of experts. During the initial training courses for nurses provided by the NSPH, the professor had written in his notebook that, ''*Certain aspects remain unresolved, notably that of equity*.'' It can, therefore, be deduced that the course did not present any realistic solutions to future HN. During a continuing education course, trainers raised the issue of the exclusion of the worst-off from health care. The medical doctor delivering the training suggested some solutions, which he appeared not to take seriously:

> User fees are not fixed. If a person cannot pay, the consultation is free of charge, including the worst-off. Solidarity has to be practiced…[laughter]…people discuss, if we do this [exemptions], people will say that they do not have the means (…) If we are going to say that payment is based on the ability to pay, we'd have to make it free of charge (…) but we don't have oil (author observation).

During a training course on the use of the proceedings from drugs sales and user fees, the issue of the worst-off did not come up. An expatriate medical doctor from the NGO tried to start the discussion on the social role of the HSPCs, but it was not followed up by the Head of the DHT. The discussion was oriented towards the obligation of the State to organize coverage for the worst-off. A nurse confirmed this: ''*Within the training there is a part where the worst-off are dealt with but it is not well defined. We do not know how to implement it*''. In training courses intended for all Heads of the DHTs in the country, the solutions given were theoretical and no technical guidelines for their application were provided. The problem was brought up ''*very seldom*'',

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a trainer told us, and the task of finding local solutions was left to them. DHT Heads were asked to "*mainly reserve resources for activities which would probably yield the best results*" (p. 22, Module 2. Emphasis added by the authors).

The ministerial drafters of the training manuals for community workers and GEDS managers put forward solutions for managing motivation (read 'remuneration') amongst members of the HMCs and even set a bonus of "*20% of user fees (..) for health care personnel every trimester*", but no mention was made of financial resources to cover the worst-off, despite the fact that the training document states that "*the use* [of profits] *will be in accordance with the spirit of the Bamako initiative*" (CADSS, 2000).

The general tendency has been the absence of discussion concerning solutions to health care exclusion. Although all health care policy documents formulated since 1992 have stressed the importance of finding solutions, no operational research has been undertaken to date (2005). This problem was not touched during the formulation of the NGO project in 1998/99. The NGO official further explained that, "*I realize at last that we pass over the subject quickly because…the priority…* [laughter]*…is really the largest number. Therefore the problem of the worst-off is dealt with after all other issues*". According to the stakeholders interviewed, there are numerous problems with the technical feasibility of solutions for promoting access to health services for the worst-off. Moreover, anticipation of the constraints related to including the worst-off generates an impression of calamity in the minds of stakeholders: "*We risk having all society against us. Who will turn back now to absorb us? We risk extinction* " (nurse).

Actors and the orientation stream

The global tendency towards the privatization of health care has been robustly analyzed for Africa (Turshen, 1999). Lee and Goodman (2002) demonstrated the mode by which reforms in health care financing were monopolized by a trans-national managerial class, who decided on the options they would promote. This tendency has influenced national and local health care officials in Burkina Faso. Participants' perceptions were generally orientated towards the disengagement of the State and heightened citizen participation in financing the health system in order to 'recover costs'. "*With time we realized that we had to take fees because the State was not going to honour this* (the payment for drugs)", said a NGO member. This stakeholder vision is reflected in that of the Burkinabe journalists and the population at large. Debating public hospital reconfiguration, journalists used a revealing title for their article: "*State institutions: The profitability stick grates the autonomy carrot*" (JJ, No. 619). The obligation of paying when using health services is well ingrained "*in the people's mind*" (agent). We have to "*make a profit*", says a physician. The motto "*Be ready to pay a price for health*" is displayed on the wall of HSPCs to remind patients of this "decree". Aid donors are not preoccupied with the worst-off either: "*You feel this even during meetings with donors and the national level…. No one will say, 'Why didn't the health management committee give out free medication?'*" says a physician.

A study of an independent newspaper (L'Indépendant) which has been in place for 15 years reveals the orientation streams. Out of a total of 105 issues comprising 982 articles published between 2002 and 2003, health system problems did not attract the attention of journalists. Less than 1% of the articles dealt with the subject. Although NGOs were party to the launching process of the BI (inter NGO-BI committee), they did not take advantage of their presence on this committee to engage a discussion on equity of access to health care, the worst-off were ignored during discourses.

A physician who is very well acquainted with the evolution of the health system proposes a double explanation for the lack of concern for the worst-off. Firstly, that it is not easy to understand national trends as certain contradictions persist between the orientation of the BI (cost recovery) and recent decisions for user fees abolition for some services driven by the World Bank (PRSP). Secondly, NGOs do not want to be involved in discussions on equity because "*decisions are made by stakeholders who are constantly changing*" (agent). Moreover, the politicization of the public administration was singled out on several occasions, notably by the National Committee on Ethics in 2003. The original equity in the PHC and BI strategy remains current (discursive). It has been too referred to numerous times in the texts of public policies. Nevertheless, a physician who was closely involved in the central organization of the BI, stated that:

> It is a vocabulary that constitutes part of a whole…. We must talk about equity, we have to talk about the worst-off because we know that they exist, but stakeholders in the field are well aware that politicians are not really concerned with the worst-off.

Why then must we have talk of equity? "*International organizations exert pressure on States, send technicians etc., and thus lead States to draft documents for which they have no vision*", said a former high-ranking official.

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Therefore, there is a pro-poor movement from Washington to Ouagadougou, but it stops short of front-line workers. Any decisions about helping the poor never move beyond the report stage to actual implementation. One's perception of the usefulness of such decisions (free access for certain service) leads one to believe that the principal objective is for a decision to be made or to appear in a report. The fact that everyone knows that these decisions are not implementable is not considered to be a problem. A member of an NGO stated, ''*In a meeting with the World Bank guys (...) I told one of them, 'Your measures are not implementable,' (...) but to him it was something that was already a done deal, and he couldn't do anything!*''.

As for the place of equity in the NGO intervention in the Souna district, it is clear that equity is kept on the backburner. The project objectives do not address population sub-groups. The project aims to ameliorate ''overall'' access to drugs both from a geographic and a funding point of view, although geographic access is emphasized. To achieve such results, it takes ''*so much effort that one ends up abandoning the worst-off*'' says a member of an NGO.

Discussion

After outlining some limitations of this study, a threefold explanation for the implementation gap will be put forward.

Limitations of the study

Inherent biases related to the socio-anthropologic approach were the backdrop to collecting and analyzing data. The study took them into consideration without ''controlling'' them; this was made possible due to the long stay in the field. In addition, two research result restitution sessions took place in Burkina in 2005. Despite the fact that the study was carried out in a single district, the transferable nature of the conclusions can be justified by similar conclusions in Burkina Faso (Haddad et al., 2006) and in West Africa (Gilson et al., 2000; Knippenberg et al., 2003). According to Bicaba, Ouedraogo, Ki, & Zida (2003), between 1997 and 2002, only 32 women have been identified as indigent in three regional hospitals, and entitled to be exempted. They represent 1.6% of all applied caesareans.

Windows of opportunity

Three reasons explain why the windows of opportunity which have reoccurred over the past 15 years in the health policy field were not used to promote equity.

i) The BI implementation process was inappropriate for the change that was necessary for taking equity into account. Four keywords, which appear widely in empirical material, seem to describe the implementation: parachuting, haste, acceleration, and politics. Despite certain previous experiences with cost-recovery schemes, the BI came from outside the country, and was not adapted to local context. In addition, the devaluation of the CFA Franc, imposed by France, had negative impacts. The influx of drugs, which were sent for purely political reasons, prompted no collective reflection for an equity oriented reform. Policy transfer by international organizations operates according to a diffuse, iterative and 'looped' process (Walt, Lush, & Ogden, 2004). This was the case of the BI in Burkina Faso (Table 3).

   Concerning PHC and BI in Burkina, Meunier (1999) reached the same conclusion: ''*The methods of action function according to predefined models; they are imposed on adopting countries*'' (p. 34). Obviously, this process of international standardization does not foster local adaptations. The need to take advantage of the windows of opportunity to test implementation of an exemption scheme for the worst-off was overlooked. No one

Table 3
Process of public policy transfer and the BI

Sub-process	Characteristics	BI international case	BI national case
Bottom-up	Knowledge and experience are produced	Pilot experiments started in Benin and Guinea	Pilot projects started by USAID and the World Bank
Standardization and formulation	Coalitions draw attention to the subject, resources are mobilized, best practices are formulated	UNICEF et WHO mobilize resources and formulate policy in Bamako in 1987	A workshop is held in 1992 and a launching document is drafted
Top-down	Practices are diffused and implemented locally	The BI is launched in Burkina in 1993	The BI is started in Burkina in 1993. The follow-up unit is created.

Source: adapted from Walt et al. (2004).

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mentioned it, not the World Bank, not UNICEF, none of the various bilateral cooperation programs and no NGO. This is because there was a process of "*building of consensus across different institutions and national settings defining the 'problem' of health care financing and potential solutions*" (Lee & Goodman, 2002, p. 116). There have been some discussions worldwide (Russel & Gilson, 1997). But still today, such experiences in favour of the worst-off remain rare, especially in Africa (Palmer, Mueller, Gilson, Mills, & Haines, 2004) and in the context of the BI (Gilson et al., 2001). Health Equity Funds (Noirhomme & Thomé, 2006) and fees abolition are commonly proposed for Africa, at present.

ii) At a local level, the failure to seize opportunities was due to the particular interpretation of the BI and the choice of the messages that were transmitted. This is a case in point of the famous principles of selection and diversion (Olivier de Sardan, 2005). Since no one really hears equity mentioned at these crucial moments, the issue is not put on the agenda. Moreover, point No. 7 of the BI (exemption) was omitted from all presentations of this public policy. This selection is not surprising since, at the time of the policy's advent, the policy promoters at UNICEF (who have since moved on to the World Bank) revisited the vision of equity and affirmed that the BI "*was not set initially at reaching the poorest groups but at restoring access to affordable quality care to the majority of the rural population*" (Knippenberg et al., 2003, p. 28).

iii) Social actors have the impression that they are unable to take action and therefore unable to take advantage of opportunities. Firstly, on both national and international levels, technical solutions for making health care financing more equitable are rare (Palmer et al., 2004). To paraphrase Kingdon (1995) concerning the primeval soup of solutions, those party to the policy were not offered anything to eat; the soup was not prepared, let alone served. Secondly, the dysfunction of the health system does not make the situation any easier: it is too centralized, poorly funded, and it still depends heavily on projects and their *modus operandi*, such as the practice *per diems* (Smith, 2003). Also, health staff use their influence to maintain the *status quo* (Paganini, 2004).

On the other hand, windows of opportunity were seized in the case of Poverty Reduction Strategic Papers. These were used to formulate policies to ameliorate access to health care for certain sub-groups of the population. Unfortunately, this was not carried out using a process that would have been effective in establishing greater equity. Firstly, there was a conflict in values, since to encourage free access for certain segments goes against emic perspectives of social justice (Ridde, 2006) and against the dominant stream of cost recovery and privatization in Africa (Turshen, 1999). Secondly, decisions were taken in a unilateral manner and were not participative: "*It was under pressure exerted by the WB within the PRSP, that we decided to undertake free preventive actions*" says a high-ranking officer. Lastly, the decisions were not explained to stakeholders in the field or followed up and, until the end of 2004, they remained unevaluated. We should not view the Burkinabe leaders as simple robots following orders coming from Washington. The relationships maintained between international agency officials and the national leaders and "*domestic acolytes*" (Grindle, 2000, p. 5), form an "epistemic" community (Lee & Goodman, 2002). This seems to provide part of the explanation.

The policy entrepreneurs

There have not been any individuals who want to use their resources to promote equity and thus stimulate a coupling of the solution and problem streams in implementing the BI. The issues of power linked to the functions of the members of an HMC are part of the reason for this (Gilson et al., 2000). NGO members are too dependent on donors to take alternative action and they must play their cards right with ministry personnel in order to bring their projects to fruition and obtain new funding (Pfeiffer, 2003). As for the WHO and UNICEF officials, it is no secret that they have lost their leadership roles to the WB. The Bank does not have a reputation of being closest to the poor, beyond a certain rhetoric, and concerned with social justice (Hibou, 2000). National and local socio-political organizations both appear to have a hierarchal nature. They are based on consensus and social peace, which does not favour the emergence of the entrepreneur. Health workers have "captured" the system (Paganini, 2004). As others said concerning the BI (Tizio & Flori, 1997), most of the agents are more attracted by the maximization of their profits than by the redistribution of revenues for the benefit of the worst-off. Elected political officials have not, to date, gone beyond the discursive logic of equity. Moreover, they lack the credibility they need to be concerned about the inequalities in health care access. Caricatures abound in local newspapers depicting

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Table 4
Actors, incentive measures and action-research to promote equity

Actor characteristics	Incentive measures	Action-research would make it possible to…
Resources	Techniques	Propose an intervention modality
	Laws and regulations	Remind actors about the existence of legal obligations and directives
Convictions, comprehension of phenomena	Information, explanations and knowledge	Make actors concerned about the problems of the worst-off
Intentions, projects	Moral values	Reflect upon inequality in access to health services
Capacity to act	Economic incentives	Promote action by health agents and national researchers

Source: adapted from (Contandriopoulos et al., 1996).

the public perception of resource pillaging by elected representatives. Having said this, one should not be surprised by the very relative ability of these politicians to act on public policy issues: "*Pressures arising from globalization are changing the capacity of the state to formulate and implement health policy* " (Lee, Buse, & Fustukian, 2002, p. 253).

A situation that is not perceived as a public problem

If acknowledging a problem is not a guarantee in itself that a public policy will be implemented—since coupling with the solution stream is necessary—it is essential that the situation be understood as a *public* problem. Generally speaking, none of the nine components of a problem is suitable for this cognitive transformation. The value system appears to rest on a theory of distributive justice guided by egalitarianism, as has already been confirmed for the Mossi (Fiske, 1990). This does not provide an incentive for taking sub-groups of the population into account. Besides, members of the community have to get along, respect one another, respect the social order and live in harmony. Conflict is the worst situation that can be imagined as Habgberg (2001) clearly demonstrated. Stakeholders concerned with the BI belong to societal spheres that are very far from the problems and people concerned by the situation. As in Benin, Zambia and Kenya, "*All countries simply failed to recognise and tackle the specific needs of the poorest*" (Gilson et al., 2001, p. 54). Farmer (2003) proposes an explanation: "*The suffering of the world's poor intrudes only rarely into the consciousness of the affluent, even when our affluence may be shown to have direct relation to their suffering*" (p. 31).

Conclusion

Going beyond this threefold explanation and beyond any conceptual interest in the extension of the stream theory to the implementation process, the question that begs reflection is how to promote access to health services for the worst-off. The corner-stone of this analysis and, therefore, of its proposed solution, depends upon the social actors. How can they be encouraged to change the *status quo* that is familiar to them? "*An actor will change if he is incited to do so, if he understands things in a different way, if the techniques he mobilizes are transformed, if laws and regulations change and, finally, if the predominant beliefs and moral values evolve*" (Contandriopoulos, Champagne, Denis, Sicotte, & Lemay, 1996, p. 16).

Furthermore, it is urgent that action-research be carried out to study community exemption mechanisms for indigents, not only to produce knowledge that will lead to action at the local level, but also to influence the behaviour of the social actors (Table 4).

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