Global policies and the provision of birth care in Burkina Faso

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Scientific environment

This research was conducted while I was a medical research student (forskerlinjestudent, 2010-2017) and PhD candidate (2017-2019) at the Centre for International Health, Department of Global Public Health and Primary Care, Faculty of Medicine at the University of Bergen, Norway. I have been affiliated with the Global Health Anthropology research group throughout the study.

During fieldwork in Burkina Faso, I collaborated closely with research partners at the Centre Muraz in Bobo-Dioulasso.

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List of abbreviations

ANC: Antenatal care

CHR: Centre hospitalier régional

CMA: Centre médical avec antenne chirurgicale

CSPS: Centre de santé et de promotion sociale

DHS: Demographic and health survey

EMONC: Emergency obstetric and neonatal care

FCFA: Franc de la Communauté financière africaine

FGD: Focus group discussion

HIV: Human immunodeficiency virus

IDI: In-depth interview

MCH: Maternal and child health

MDG: Millennium development goal

MMR: Maternal mortality ratio

PAC: Post-abortion care

SBA: Skilled birth attendance

SDG: Sustainable development goal

UN: United Nations

UNFPA: United Nations Population Fund

WHO: World Health Organization

Summaries

1.1 Abstract

Background: Targets and indicators set at global level are powerful measures that influence health systems in low-income countries. Facility-based births have been promoted as the main strategy for reducing maternal and neonatal death risks on the global scale. Further, measurements of facility-based births are used as an important indicator for monitoring maternal mortality reduction worldwide. However, there is a need to explore how the policy of institutional birth is implemented and how it resonates with health systems characterised by extensive resource scarcity.

Objective: In this PhD project, I aim to describe and analyse the links between the global policy of skilled attendance and actual practices of birth care provision in Burkinabè primary health care centres.

Methods: The study is based on multi-sited ethnographic fieldwork over 4 months in 2011-2012 in 4 primary health centres in rural Burkina Faso. Observational data from the maternity units was supplemented by 14 in-depth interviews with health workers and a total of 21 in-depth interviews and 8 focus group discussions with women who had given birth recently and community members.

Findings and discussion: Paper I documented how health workers provided birth care in a context of limited financial resources, insufficient personnel and poorly equipped facilities; the quality of the birth care provided was severely compromised. Health workers tended to place the responsibility for poor quality of care on infrastructural limitations and patient behaviour. Health workers felt disempowered, had limited abilities to prevent and treat birth complications and resorted to alternative and potentially harmful care strategies.

Paper II found that community members experienced strong pressure to give birth in health facilities. Women and their families reported being subjected to verbal, economic and administrative sanctions if they did not attend services or adhere to

health workers' recommendations. Women, who for social and economic reasons had limited access to health facilities, found that the sanctions came with increased cost for health services, led to social stigma and acted as additional barriers to seeking skilled care at birth. Pressure to use facility care and sanctions experienced by women who do not comply with health worker instructions may compromise trust in the health system. It may further marginalise women who already have poor access to facility care and may contribute to worsened health outcomes.

Paper III uncovers the magnitude of reporting demands that health workers experience and the pressure placed on them to provide the 'right' results, in line with global policy targets. The paper describes the way in which health workers document inaccurate accounts. One example is how they complete the labour surveillance tool partograph after birth, transforming it into a 'postograph', to adhere to the expectations of district health officers. The drive for the 'right' numbers might encourage inaccurate reporting practices and produce knowledge that feeds into policies that are incapable of addressing the realities experienced by frontline health workers and patients.

Conclusion: The study has documented the unintended effects of global policies on institutional care in Burkinabe health facilities: The quality of care was severely compromised, health workers employed sanctions towards women to increase uptake of institutional care, and the focus on indicators affected reporting practices in primary health care facilities. Drawing on ethnographic fieldwork set in a context of extreme resource scarcity, this PhD thesis constitutes a case study of how indicators in the field of maternal health affect care provision and our knowledge about care.

1.2 Résumé

Introduction : Les objectifs et les indicateurs fixés au niveau global sont des mesures puissantes qui influencent les systèmes de santé des pays à faible revenu. Le fait d'accoucher dans une maternité a été présenté comme la principale stratégie de réduction des décès maternels et néonatals à l'échelle mondiale. En outre, le taux d'accouchement assisté par du personnel de santé qualifié constitue un indicateur important pour suivre les progrès réalisés dans la réduction de la mortalité maternelle dans le monde. Cependant, peu de données sont disponibles sur la manière dont la politique d'accouchement institutionnel est mise en œuvre et comment elle résonne avec les systèmes de santé caractérisés par une grande pénurie de ressources.

Objectif : Dans ce projet de thèse doctorale, j'ai pour objectif de décrire et d'analyser les liens entre la politique globale d'accouchement assisté et les pratiques d'accouchement dans des centres de de santé et de promotion sociale burkinabés.

Méthodes : Cette étude s'appuie sur un travail ethnographique de terrain multi-situé, mené dans 4 centres de santé ruraux au Burkina Faso. La collecte des données a duré 4 mois en 2011-2012. Les données d'observation provenant des maternités ont été complétées par 14 entretiens approfondis avec des agents de santé, un total de 21 entretiens approfondis et 8 discussions de groupe dirigées avec des femmes qui venaient d'accoucher et des membres de la communauté.

Résultats et discussion : L'article I décrit la façon dont les agents de santé fournissaient des soins pendant l'accouchement dans un contexte de ressources financières limitées, de personnel insuffisant et d'établissements mal équipés. La qualité des soins lors de l'accouchement était gravement compromise. Les agents de santé avaient tendance à attribuer la mauvaise qualité des soins aux limitations des infrastructures et au comportement des patients. Ils se sentaient impuissants, ayant une capacité limitée à prévenir et à traiter les complications de l'accouchement et prenaient recours à des stratégies de soins alternatives et potentiellement dangereuses.

L'article II a révélé comment les membres des communautés subissaient une forte pression pour accoucher dans des établissements de santé. Les femmes et leurs familles ont déclaré avoir été soumises à des sanctions verbales, économiques et administratives si elles n'adhéraient pas aux recommandations des agents de santé. Les femmes qui, pour des raisons sociales et économiques, avaient un accès limité aux services et centres de santé ont découvert que les sanctions entraînaient une augmentation du coût des services, une stigmatisation sociale et constituaient un obstacle supplémentaire à l'assistance qualifiée à l'accouchement. La pression pour utiliser les soins de maternité et les sanctions imposées aux femmes qui ne se conforment pas aux instructions des agents de santé peuvent compromettre la confiance dans le système de santé. De plus, les femmes ayant déjà un accès limité aux soins en établissement pourraient être davantage marginalisées, entravant l'amélioration de la santé maternelle.

L'article III met en lumière l'ampleur des exigences en matière de rapports écrits que les agents de santé sont tenus de présenter. Il documente aussi la pression qui s'exerce sur eux pour fournir les 'bons' résultats, conformément aux objectifs politiques mondiaux. L'article décrit la manière dont les agents de santé documentent des comptes inexacts. Un exemple est la façon dont ils remplissaient le partogramme, un outil de surveillance du travail, après l'accouchement, le transformant ainsi en un 'postogramme', afin de répondre aux attentes des responsables des districts sanitaires. La forte valorisation des 'bons' résultats pourrait encourager des pratiques d'établissement de rapports inexactes. Celles-ci produisent des connaissances qui, par conséquent, alimentent des politiques de santé incapables de prendre en compte les réalités vécues dans les centres de santé.

Conclusion : Cette étude a permis de documenter les effets inattendus des politiques globales d'accouchement institutionnel dans des centres de santé burkinabè: la qualité des soins était gravement compromise, les agents de santé ont imposé des sanctions aux femmes pour améliorer le taux d'accouchement assisté, et l'accent mis sur les indicateurs numériques a influencé les pratiques relatives à l'établissement des rapports dans les centres de soins de santé primaires. S'appuyant sur un travail de terrain

ethnographique fixé dans un contexte d'extrême pénurie de ressources, cette thèse doctorale constitue une étude de la manière dont les indicateurs dans le domaine de la santé maternelle transforment les pratiques de soins et nos connaissances sur les soins de santé maternelle.

1.3 Sammendrag

Bakgrunn: Globale kvantitative mål og indikatorer påvirker helsesystemer i lavinntektsland. Institusjonsfødsler er blitt fremmet som en hovedstrategi for å redusere mødre- og nyfødtdødeligheten globalt. Andelen som føder på institusjon er over hele verden også en viktig indikator for å overvåke nedgang i mødredødelighet. Få studier har imidlertid undersøkt hvordan strategiene for å øke institusjonelle fødsler implementeres i og resonerer med helsesystemer preget av omfattende ressursknapphet.

Mål: I dette doktorgradsprosjektet tar jeg sikte på å beskrive og analysere koblingen mellom den globale politikken for institusjonell fødselsomsorg og praksis på helsestasjoner i Burkina Faso.

Metoder: Studien er basert på etnografisk feltarbeid ved fire helsestasjoner på landsbygden i Burkina Faso. Dette ble gjennomført over 4 måneder i 2011-2012. Observasjonsdata fra helsesentrene ble supplert med 14 dybdeintervjuer med helsearbeidere og totalt 21 dybdeintervjuer og 8 fokusgruppediskusjoner med kvinner som hadde nylig født og andre samfunnsmedlemmer.

Funn og diskusjon: Artikkel I dokumenterer hvordan helsearbeidere ga fødselsomsorg i en setting med begrensede økonomiske ressurser, utilstrekkelig personell og dårlig utstyrte fasiliteter. Kvaliteten på fødselsomsorgen var alvorlig kompromittert. Helsearbeidere hadde en tendens til å legge ansvaret for dårlige tjenester på infrastrukturelle begrensninger og pasientens atferd. Helsearbeidere hadde begrensede evner til å forhindre og behandle fødselskomplikasjoner, og benyttet seg av alternative og potensielt skadelige strategier i møte med komplikasjoner.

Artikkel II beskriver hvordan innbyggerne i disse samfunnene opplevde et sterkt press for å føde på helsesentre. Kvinner og deres familier rapporterte å bli utsatt for muntlige, økonomiske og administrative sanksjoner hvis de ikke kom til helsesentrene når de skulle eller ikke overholdt helsearbeidernes anbefalinger. Kvinner som fra før, av sosiale og økonomiske årsaker, hadde begrenset tilgang til helsetjenester opplevde

at sanksjonene ga økte kostnader for helsetjenester, førte til sosial stigmatisering og fungerte som en ekstra barriere mot å søke fødselshjelp. Presset til å bruke helsetjenester og sanksjonene mot kvinner som ikke adlyder helsearbeideres innstruksjoner kan svekke tilliten til helsesystemet. Det kan også ytterligere marginalisere kvinner med allerede dårlig tilgang til fødselsomsorg og bidra til forverrede helseutfall.

Artikkel III avdekker omfanget av rapporteringskrav som helsearbeidere opplever, og presset som blir lagt på dem for å rapportere de 'riktige' resultatene, i tråd med globale politiske mål. Artikkelen beskriver hvordan helsearbeidere dokumenterer og rapporterer på en villedende måte. Et eksempel er hvordan de fullfører fødselsovervåkingsverktøyet partograf etter fødselen, og dermed omgjør det til en 'postograf', for å blidgjøre helsedistriktet. Presset til å rapportere gode tall kan oppmuntre til en rapporteringspraksis som produsere feilaktig kunnskap som igjen leder til politikk og retningslinjer ute av stand til å forbedre realitetene på disse helsesentrene.

Konklusjon: Dette doktorgradsprosjektet har dokumentert utilsiktede effekter av den globale strategien for institusjonelle fødsler i Burkina Faso. Kvaliteten på fødselsomsorgen var alvorlig kompromittert, helsearbeidere satte inn sanksjoner mot kvinner for å øke antallet institusjonsfødsler, og fokuset på indikatorer påvirket rapporteringspraksis på helsesentrene. På bakgrunn av et etnografisk feltarbeid i en kontekst med ekstrem ressursknapphet utgjør denne doktorgradsavhandlingen en studie av hvordan indikatorer former helsetjenester og vår kunnskap om dem.

List of Publications

This thesis is based on the following original articles, which will be referred to as papers I-III.

Paper I

Melberg A, Diallo AH, Tylleskär T, Moland KM. 2016. 'We saw she was in danger but couldn't do anything': Missed opportunities and health worker disempowerment during birth care in rural Burkina Faso. BMC Pregnancy Childbirth. 2016 Sep 29;16(1):292.

Paper II

Melberg A, Diallo AH, Ruano AL, Tylleskär T, Moland KM. 2016. Reflections on the Unintended Consequences of the Promotion of Institutional Pregnancy and Birth Care in Burkina Faso. PLoS One. Jun 3;11(6):e0156503

Paper III

Melberg A, Diallo AH, Storeng KT, Tylleskär T, Moland KM. 2018. Policy, paperwork and 'postographs': Global indicators and maternity care documentation in rural Burkina Faso. Social Science & Medicine. 215(28-35).

Contents

2. INTRODUCTION

Donner la vie sans périr

During fieldwork for this PhD dissertation, I often came across Burkinabè men and women wearing clothes made of the pagne or loin cloth distributed on the occasion of the International Women's Day of 2011. Written on the cloth, was the slogan *Donner la vie sans périr*, literally translated as *give life without perishing*. But to what extent were women in this resource-constrained setting able to do so? Based on ethnographic fieldwork in Burkina Faso, this thesis aims to examine critically the ways in which global and national efforts to reduce maternal mortality interact with everyday realities in health care centres and their surrounding communities.

I will, in the following, first introduce the concept of maternal mortality. Secondly, I will look at efforts and policies to reduce maternal mortality in the field of global health. Thirdly, I will examine the concept of quality in maternal health care. I will then reflect on the nature and role of global health policies in general, and on the policy of skilled birth attendance in particular. Lastly, before introducing the aims, I will spell out the rationale for this PhD study.

2.1 Maternal mortality

2.1.1 Definition and measurement

Despite decades of international attention, maternal mortality remains a major health problem, especially in sub-Saharan Africa. More than 300,000 women died from pregnancy-related complications in 2015, the overwhelming majority of them living in resource poor settings (Alkema et al., 2016). Maternal mortality is defined by the World Health Organization (WHO) as 'the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes' (WHO, 2004a). The burden of maternal mortality is unevenly shared and constitutes a brutal reminder of the enormous health inequalities both between and within countries. It is estimated that

only 1 of 30 000 Norwegian females will die of pregnancy and childbirth-related causes, whereas as many as 1 in 48 women in Burkina Faso will perish while giving life. Massive disparities can also be found within countries, as maternal mortality is closely associated with systemic inequalities disproportionately affecting poor, rural, and uneducated women (Ronsmans & Graham, 2006).

Maternal mortality is most commonly expressed using the maternal mortality ratio (MMR): the number of maternal deaths per 100 000 live births (Alkema et al., 2016). From a measurement perspective, MMR is difficult to estimate, especially in countries without civil registration systems, where both the number of deaths and the number of live births are uncertain figures. Maternal deaths have been shown to be chronically underreported both routinely from health facilities and from surveys (Wendland, 2016). Most maternal mortality estimates from sub-Saharan Africa originate from demographic and health surveys (DHS), where the sisterhood method is employed (Stanton, Abderrahim, & Hill, 2000). This method entails asking adult women in a representative sample of households about the causes of death of their own siblings. The aim is to identify suspected maternal deaths among women dying in their reproductive years, between the ages of 15 to 49. These reported figures are then compared to the number of live births for the same population, and adjusted based on assumptions about underreporting, the effects of HIV infection, institutional birth care, fertility rates and national wealth on maternal mortality (Wendland, 2016). All of these estimates are also questionable, as basic population numbers, used both to estimate wealth and fertility, are flawed by the lack of national censuses in most countries (Jerven, 2013). Maternal mortality figures and the effect of policies and interventions are, in most resource-deprived areas, estimates with a great range of uncertainty (Storeng & Béhague, 2017; Wendland, 2016). There are also a great number of uncertainties and controversies between the different MMR produced and presented by nation states, the WHO and other research institutions (Wendland, 2016).

For every woman dying from pregnancy-related causes, many more experience severe maternal morbidities, ranging from ‘maternal near-misses’ when women nearly die in childbirth (WHO, 2011), to chronic disabling conditions such as obstetric fistula and

pelvic organ prolapse (Firoz et al., 2013). The burdens of maternal morbidity have consequences for women and their families far beyond the obstetric crisis itself (Gjerde, Rortveit, Muleta, Adefris, & Blystad, 2017; Storeng et al., 2008; Storeng et al., 2012). However, estimating the burden of maternal morbidities, including near misses, has been shown to be even more challenging than estimating mortality itself (Chou et al., 2016). MMR therefore remains the figure most often used when the aim is to measure levels of maternal ill health, even though MMR represents only the tip of the iceberg of pregnancy-related morbidities.

2.1.2 Trends in maternal mortality

The past decades have seen massive global support for maternal mortality reduction, which has been targeted through the United Nations' Millennium Development Goal (MDG) 5 from 2000 to 2015 and from 2015 through the Goal 3.1 of the Sustainable Development Goals (SDGs). Whereas the MDGs aimed to reduce by three quarters, between 1990 and 2015, the maternal mortality ratio, the SDGs aim for an absolute reduction of MMR to 70/ 100 000 live births in all countries by 2030 (United Nations, 2018).

Indeed, there has been a decline of maternal mortality the past decades. In 1990 the global MMR was estimated at 380/100 000 live births, whereas it was 216/100 000 in 2015 (WHO & UNICEF, 2015). However, there have been major concerns about the slow progress in maternal mortality reduction, as compared to other global health goals (Storeng & Béhague, 2014). In the MDG era, maternal mortality reduction was lagging behind (Hogan et al., 2010). Globally, only eight high-burden countries achieved a 75% reduction of MMR in 2015 as compared to 1990 baseline levels, out of which only Cape Verde and Rwanda are located in Africa (Alkema et al., 2016). Whereas child mortality reduction has been possible through of vertical interventions such as vaccination and oral rehydration therapy, maternal mortality reduction is more dependent on a well-functioning health system, including referrals between different levels of care (Ronsmans & Graham, 2006).

2.1.3 Causes of maternal mortality

'Women are not dying because of untreatable diseases. They are dying because societies have yet to make the decision that their lives are worth saving: We have not yet valued women's lives and health highly enough'. This often-cited statement, made by professor Mahmoud Fatallah in 2006, builds on the scientific consensus that the majority of maternal deaths are avoidable, as the direct causes of maternal deaths, and the medical interventions to prevent and treat these, are well known (Ronsmans & Graham, 2006).

Commonly, maternal deaths are said to be the result of either direct or indirect causes. Direct causes are complications of the pregnancy or delivery, or their management, whereas a pregnancy-related death in a female patient with a pre-existing or newly developed health problem is classified as an indirect cause (Say et al., 2014). Globally, direct causes are thought to account for about three quarters of maternal deaths, and indirect causes the remaining quarter. The main direct causes are haemorrhage, pregnancy-related hypertensive disorders, infections and (unsafe) abortions (Say et al., 2014). The causes of maternal deaths vary depending on the absolute burden of maternal mortality. Whereas indirect causes constitute a large proportion of maternal deaths in sub-Saharan Africa (mostly due to HIV), abortion is a comparatively more common cause of maternal mortality in Latin America and the Caribbean due to limited access to safe abortion (Say et al., 2014).

2.2 Efforts to reduce maternal mortality

To reduce maternal deaths, the global community has fostered a number of initiatives, policies and goals. These global initiatives have mobilised attention and funds for maternal mortality reduction, and at the same time they have transformed the field of maternal health and influenced national health system governance (Roalkvam & McNeill, 2016; Storeng & Béhague, 2014).

Maternal health emerged as a major global health concern in the mid 1980s (Smith & Shiffman, 2016). There was a growing concern that maternal health was disappearing

in the maternal and child health (MCH) efforts of the 1980s, which foremost targeted children through vaccination campaigns and the treatment of infectious diseases. In a pioneering publication in The Lancet in 1985, Rosenfield and Maine, asked the rhetorical question of, *Where is the M in MCH?* (Rosenfield & Maine, 1985). Two years later, the Safe Motherhood Initiative was launched at the first Safe Motherhood Conference. During the 1980s and 1990s, efforts to reduce maternal mortality were inspired by the risk approach launched by the WHO in the 1970s, to identify women with high risk of obstetric complications during antenatal care and refer them to adequate levels of care (WHO, 1978). Efforts to improve maternal healthcare also specifically encouraged the use, and training of, 'traditional birth attendants' in the absence of an adequate number of skilled health workers (Jokhio, Winter, & Cheng, 2005; WHO & UNICEF, 1992).

2.2.1 Skilled birth attendance

The tenth anniversary of the Safe Motherhood Initiative 1997 marked two major shifts in global maternal health policies. Based on evidence of limited progress in maternal mortality reduction and the fact that most maternal deaths occur among low-risk mothers (Villar et al., 2001), the conference concluded that *'every pregnancy faces risk'*. Consequently, the strategy of *skilled attendance at birth* for all, including universal access to emergency obstetric care was articulated (Starrs, 1998). Importantly, traditional birth attendants were not included in the definition of skilled birth attendants in the 1997 conference. Based on this line of argument, the WHO has, since 2000, recommended that childbirth care should be relocated to clinical settings, where health workers with modern midwifery and medical training are assumed to be the sole providers of skilled care (WHO, 2004b).

Since the start of the millennium, ensuring that all women have access to routine and emergency skilled care at and around the time of birth has been the central global strategy to reduce the burden of maternal morbidity and mortality (Campbell & Graham, 2006; Tita, Stringer, Goldenberg, & Rouse, 2007; WHO, 2004). Skilled birth attendance implies giving birth with a provider with midwifery skills, trained in the management of normal deliveries and the detection and management of complications

during birth with the ability to refer to a higher level of care when needed (WHO, 2004b). At all primary health care facilities, the provision of basic emergency obstetric and neonatal care (BEMONC) has been promoted to treat the most common obstetric complications by providing parenteral antibiotics, anticonvulsants, oxytocic drugs, removal of placenta and retained products of conception and assisted vaginal delivery (WHO, 2009). Effective transportation systems to facilities with comprehensive emergency obstetric care including competence to carry out caesarean sections and blood transfusions are essential for timely treatment of complications (Samai & Sengeh, 1997).

The ways in which the safe motherhood movement advocated for maternal health has also changed over the years from invoking a sense of international responsibility for maternal deaths to 'evidence-based advocacy', building on quantitative 'objective' evidence showcasing the economic benefits of investing in women's health (Storeng & Béhague, 2014). Reduced distance and cost are the strategies that have been used to try to improve access to and use of facility delivery services, but also improved user satisfaction as a result of enhanced quality of care within the facilities (Campbell & Graham, 2006; Metcalfe & Adegoke, 2012).

2.3 Quality of institutional birth care

Giving birth in a health facility is not enough. As Miller et al. (2016, p) state, 'a push towards births in facilities that have inadequate staff, training, infrastructure, and commodities, as well as insufficient evidence-based clinical practice, often results in poor quality care' (p. 1). Both non-utilisation of facility birth care and the provision of poor-quality facility birth care cause maternal deaths (Kruk, Gage, Joseph, et al., 2018). Emerging evidence suggests that the scaling up of the number of facility births does not necessarily lead to decreased maternal or perinatal mortality for women and their babies (Gabrysch et al., 2019; Gitobu, Gichangi, & Mwanda, 2018; Randive, Diwan, & De Costa, 2013). In order to prevent mortality and morbidity when increasing the proportion of facility care, the quality of the institutional care provided needs to be sufficient (Graham & Varghese, 2012).

There is however little consensus on how quality in healthcare should be defined in general, and in birth care in particular (Raven, Tolhurst, Tang, & van den Broek, 2012). Campbell Roland, & Buetow (2000) highlight two components of quality of care: *accessibility of services* and *effectiveness of the services provided.* Effectiveness is divided into clinical and inter-personal care and involves different dimensions of the health system based on Donabedian's (1988) notion of the structure or organisation of the services, the process of care, and the outcome of the care provided. These dimensions are interlinked; in order to achieve desired outcomes such as decreased infection rates in a facility, the availability of structures such as water and soap for hand washing is a prerequisite but does not by itself ensure that the process of hand washing is carried out by birth attendants.

In addition, quality of birth care should be considered differently from other areas of health care provision since most women and new-borns are well, and only some develop complications and will need a high level of care during birth (Pittrof, Campbell, & Filippi, 2002). Clinical birth care hence balances between intervening 'too little too late' and overmedicalisation by intervening 'too much too soon' (Graham et al., 2016). This can be illustrated by caesarean section practices. Caesarean section remains a key obstetric intervention with the capacity to save women's and babies' lives, but with considerable short- and long-term health effects for both. Caesarean section rates vary substantially between countries, and between wealth quintiles within countries. Whereas the WHO recommends a caesarean section rate of about 10-15% of all births in a population, both caesarean section rates of 55% in Brazil and 3% in Burkina Faso represent poor quality birth care (Boerma et al., 2018).

Given the numerous definitions of quality birth care, there are a variety of frameworks available to try to assess this outcome (Raven et al., 2012). These frameworks make trade-offs between the level of detail assessed in each facility and the number of facilities included in quality assessments (Nesbitt et al., 2013; Pitchforth et al., 2010). Various dimensions of health care are given different emphasis in different frameworks. Many focus on outcomes such as case-fatality rate and caesarean section rate, and some consider structures such as equipment and personnel available. Few

frameworks assess process, since this would require costly and time-consuming direct observations of the provision of care (Raven et al., 2012). Hence, many frameworks build on assumptions about the associations between structure, process and outcome. These assumptions are however brought into question by limited evidence on the association between facility infrastructure and the process of delivering routine quality birth care (Leslie, Sun, & Kruk, 2017). The meaning of quality of care also depends on the assessor's viewpoint. Users of health care would, for example, emphasise inter-personal features of care when evaluating the quality; providers would highlight more technical aspects whereas cost-effectiveness is a typical management concern (Campbell et al., 2000; Hulton, Matthews, & Stones, 2007).

Regardless of definitions and evaluation frameworks, poor quality of institutional care in settings with a high burden of maternal mortality remains a global concern. Numerous studies employing different methodologies have documented how the quality of institutional birth care is poor across sub-Saharan Africa (Delvaux et al., 2007; Hofmeyr et al., 2009; Miller et al., 2016). The proportion of women receiving quality skilled attendance is substantially lower than the number having institutional births, revealing a large quality gap within facilities (Nesbitt et al., 2013). The situation is especially precarious in primary health care centres with low numbers of births, where a substantial number of institutional births take place (Kruk et al., 2016). A study of five East African countries reported that only 11% of primary health care facilities had access to electricity, 36% had access to safe water and only 39% had the capacity to refer to a higher level of care (Kruk et al., 2016). Providing birth care in primary health centres which lack the possibility of referring women for caesarean sections or blood transfusion severely compromises the ability to prevent maternal deaths. Regarding the process of care, there is also a great concern around the high prevalence of disrespect and abuse that women encounter during facility-based childbirth (Bohren et al., 2015; Freedman & Kruk, 2014). Disrespect and abuse affect women's trust in the health system and can determine whether a woman would decide to seek care at a health facility for future needs.

2.4 The global policy of skilled attendance at birth

2.4.1 Health policy

In this thesis, I broadly define policy as 'the decisions, plans, and actions that are undertaken to achieve specific health care goals within a society' (WHO, 2019). Health policy purposes are manifold; they define a vision for the future, establish targets, outline priorities and the expected roles of different stakeholders, build consensus and inform people within and outside the health system. Policies may be public, portrayed by governments, or private, as seen in private industry or non-governmental organisations. Policies in the field of global maternal health range from broad ones, like skilled birth attendance, to the more targeted guidelines or interventions, such as the prevention of mother to child transmission of HIV programmes.

Policies are implemented with specific goals in mind, yet determining their success or failures remains challenging, as there often is lack of evidence of simple causality. Policies are implemented and adopted in specific historical and socio-political contexts, and not in a uniform manner across and within countries (Walt et al., 2008). They also interact with other health and non-health policies. In addition, any purposive social action, as put by Merton (1936), has both intended and unforeseen or unintended consequences when implemented.

2.4.2 The global nature of maternal health policies

In the field of maternal health, policies and related interventions promoted by international organisations and donors in settings with high burden of MMR are often highly standardised. Whether in Ethiopia or in Burkina Faso, similar and standardised programmes targeting prevention of mother to child HIV transmission, skilled birth attendance and focused antenatal care are found. They can be considered to be global policies, implemented in local contexts. I will in this thesis, paraphrase Spangler (2011) building on Ginsburg and Rapp (1995) and refer to global as wide spheres of knowledge and power that come to influence a range of contexts. Local contexts are

thus small-scale arenas where 'social meanings are informed and adjusted through negotiated face-to-face interaction' (Rapp & Ginsburg, 1995, p. 8).

The decision-making processes where global policies are formulated involve various actors such as states, UN agencies, non-governmental organisations and philanthropies at different levels. It mirrors the field of global health, and is characterised by an abundant and growing number of actors, with no clear governance structure (Frenk & Moon, 2013). In the classic policy triangle, both the process of policy making, the policy content, and the policy context are seen to affect policy and its implementation (Walt et al., 2008). Formulating policy at the global level is a dynamic process, far from being a permanent entity with well-defined actors, beneficiaries, mandates and ways of working (Ferguson & Gupta, 2002). It depends on broader international processes and on which actors are able to grasp the windows of opportunity facilitated by shifts in national and international politics.

How policies formulated in the global sphere are translated into country-level programmes is largely determined by the power and priorities of global actors and national governments. Skilled birth attendance has been promoted widely by powerful and influential organisations in the field of global health such as the WHO, the World Bank and the experts of the Lancet's Maternal Survival Steering Group (Tita et al., 2007). A relevant example is how UNFPA in the mid 2000s provided technical and financial support to 33 countries in Africa to develop or improve national maternal health plans. Skilled attendance emerged as one of three main pillars in all countries (together with emergency obstetric and neonatal care and family planning) (de Bernis & Wolman, 2009; Smith & Shiffman, 2016). When a policy is introduced into a national health programme, it is often accompanied by economic and technical support by donor agencies (Smith, Ameh, Roos, Mathai, & van den Broek, 2017).Weak states that heavily rely on technical assistance and external donors for their healthcare expenditures have limited power to refuse or modify global health policies (Fischer & Strandberg-Larsen, 2016). A country's degree of discretionary power over policy adoption is seen to be reliant upon its level of donor dependency, the functioning of its civil society and the availability of healthcare expertise (Sandberg & Justice, 2013).

Donors or development assistance partners also tend to influence priority setting at all stages of the policy process. This includes the development of national and lower level policies, and the monitoring and evaluation of their implementation, where policies are tracked using indicators to measure the success or failure of policies and programmes (Khan, Meghani, Liverani, Roychowdhury, & Parkhurst, 2018).

2.4.3 Policy indicators and their implications

An indicator is, simply put, the representation of complex data in a simple number or rank that is meaningful for policy makers and the public (Merry, 2011). As Merry (2011) points out, indicators have the 'capacity to convert complicated contextually variable phenomena into unambiguous, clear, and impersonal measures' (p. S84). While global policy indicators are presented and treated as objective comparable facts in the field of public health, they are neither neutral nor apolitical (Adams, 2016; Erikson, 2015). In the last few decades there has been a rapid bourgeoning of indicators in the field of development, linked to neo-liberal shifts in the broader field of development, and increased results-based financing of development and health care.

Indicators, like skilled birth attendance, shape our knowledge by the way they are named and who is given the authority to decide what they represent. Skilled attendance is, at the same time, a policy to address maternal mortality and is used as an indicator to measure success in maternal mortality reduction. The picture is also complicated by the fact that most countries consider women giving birth in health institutions to be provided with skilled attendance.

Using institutional births to represent MMR reduction is based on the assumption that there are sufficiently trained health workers and well-functioning referral systems in those institutions (Koblinsky et al., 2006). In settings where the proportion of women giving birth in health facilities has increased dramatically, there is limited empirical evidence that increased numbers of facility births has reduced MMR (Randive et al., 2013). Several studies on user-fee removals find increases in facility birth rates, but few find significant reductions in mortality (Dzakpasu, Powell-Jackson, & Campbell, 2013; Gitobu et al., 2018). In India, an evaluation of a conditional cash-transfer

programme paying women to deliver in health institutions found no association between district facility birth rates and maternal mortality (Randive et al., 2013). Recently, a cohort study following over 100 000 pregnancies in Ghana could not provide evidence of decreased maternal or perinatal mortality for women giving birth in health facilities, even after adjusting for inherent selection biases of facility birth care (more women with complications access health facilities than women with uncomplicated deliveries) (Gabrysch et al., 2019). These findings point to the inadequate capacity to identify and manage complications in many health care facilities in low income settings (Campbell et al., 2016).

Indicators are also closely tied to governance, as they influence the allocation of resources, the nature of political decisions, and the assessment of which countries prioritise maternal health (Merry, 2011). Global targets on skilled birth attendance can alter and incentivise nation states, health systems and women giving birth in several ways (Oni-Orisan, 2016; Roalkvam & McNeill, 2016; Storeng & Béhague, 2014). In a context where maternal mortality constitutes an important measure of social development, women's status, and general health system functioning, skilled attendance at birth also becomes an indicator of the success of the state vis-à-vis the international community. MMR, and thus the levels of skilled attendance, is often used to compare the performance of countries and regions (Oni-Orisan, 2016). Policymakers and governments view the focus on numerical targets in MMR reduction as a tool to stimulate improvements in maternal healthcare and, thereby, to justify donors' investments (Storeng & Béhague, 2017). However, the goal of skilled attendance has been criticised for shifting the focus from a comprehensive sexual and reproductive health agenda to a narrow focus on the number of maternal deaths and , an even narrower focus on the number of institutional deliveries, obscuring issues about the quality of care provided when women give birth in health facilities (Austveg, 2011).

The focus on indicators and numerical targets might influence the care provided to women and their families, as it modifies health workers' practices and accountability within health systems (Lester, Suman, & Gauri, 2000). The pressure to meet

performance indicators and to report increased numbers of institutional deliveries has pushed health workers to report incorrect data and led to efforts to persuade women to use the services ‘correctly’ (Kvernflaten, 2013; Storeng & Béhague, 2014). In several settings, there have been reports of health workers and other authorities introducing penalties, including fines, for births outside health institutions (Cogburn, 2019; Danielsen, 2017; Greeson et al., 2016).

3. SITUATING THE STUDY IN CRITICAL SOCIAL THEORY

Critical theorists have long recognised the importance of power structures in the building and management of healthcare systems and these are indeed relevant to an analysis of the link between global and national policies, and women's risk of dying in childbirth. Power, in the Foucauldian notion, is 'not only in the most obvious forms of institutional power or authorative power as demonstrated in health care institutions, but also the configuration of power in specific social settings in the more subtle form of self-discipline' (Samuelsen & Steffen, 2004, p. 7). The Foucauldian understanding of power, and the notions of biopower and a biopolitical form of governance thus provides a foundation for this PhD work (Foucault, 1977; Foucault, 1998; Mills, 2018). Bio-politics refers to governmental practices and political strategies seeking to regulate issues concerning 'living beings forming a population'. The term therefore encompasses topics related to biological occurrences within a population, such as the regulation of birth-rate, life expectancy and race, and the ways in which biomedical interventions come to govern populations. The PhD study is equally based in the critical medical anthropology tradition which seeks to go beyond a locally focused level of analysis and situate individual suffering within larger political and economic contexts (Farmer, 1997; Pfeiffer & Nichter, 2008).

In the field of global maternal health, interventions promoted by donors and international organisations are often highly standardised: they can be seen as global (Olivier de Sardan, Diarra, & Mahaman, 2017). The policy of skilled attendance is a key pillar in efforts to decrease MMR in high burden countries and is set to be implemented by frontline workers in different geographical, economic, political and cultural contexts (Blystad et al., 2010; Smith, 2001). In recent decades, the research agenda and policy discussions have focused on how to increase the number of facility births. Yet, the articulations between standardised policies, local healthcare systems and local health workers at the point of service delivery still remains poorly understood (Olivier de Sardan et al., 2017). In the words of Jaffré (2012), 'quality care

and maternal mortality must be documented “from below” in order to understand them’ (p. 4).

Health facilities constitute the interface between global norms around delivery care, patients’ practices and understandings, and health workers’ actions (Jaffré & Suh, 2016). Frontline health workers have the ability to mould policies through their discretion over which services are offered, how they are offered and the benefits and sanctions allocated to patients as ’the routines they establish, and the devices they invent to cope with uncertainties and work pressure, effectively become the public policies they carry out’ (Lipsky, 1980, p. xii). To understand how the policy of skilled birth attendance is implemented, the lived experiences of end-users such as health workers, women and their families is key.

Health facilities are sites where our knowledge about policy implementation is produced through paperwork and the categorisation of complex realities into countable events and indicators (Merry, 2011). As Smith (2006) formulated, health workers here ‘make the linkages between clients and ruling discourses, “working up” the messiness of an everyday circumstance so that it fits the categories and protocols of a professional regime’ (p. 27). By deciding what should be reported, when and how, we consider that health workers shape both our knowledge on the policy of skilled attendance, but also on maternal health more generally.

Understanding documentation practices is key to understanding the dynamics of the policy of skilled birth attendance (Jaffré & Suh, 2016). Health workers’ policy implementation and adherence is negotiated through written registries and reports (Hull, 2012; Suh, 2014). Registries are simultaneously technologies of self-discipline in the Foucauldian sense, and enablers of the surveillance, control and discipline of health workers from above (Ferguson & Gupta, 2002). While documentation is often seen as a way to formalise and standardise care, it also creates possibilities for adaptation and manipulation from health workers (Suh, 2014). With regards to the policy aims on skilled birth attendance, health workers can modify the written representation both of the number and the content of the care provided during

institutional births. As Rose and Miller (1992) articulated, they have the possibility to find (sometimes creative) ways of going from ‘where they are’ to ‘where they should be’ (p. 187).

4. OBJECTIVES

4.1 Primary objective

The study aimed to describe and analyse the links between the global policy of skilled attendance and practices of birth care provision in Burkinabè primary health care centres.

4.2 Sub-objectives

The study focused on the following sub-objectives:

1) To explore health workers' perceptions about access to facility birth; the effectiveness of the care provided and obstacles to quality birth care.

2) To examine how communities in rural Burkina Faso perceive the promotion and delivery of facility pregnancy and birth care, and how this promotion influences healthcare-seeking behaviour.

3) To assess how health workers negotiate policy implementation in maternal health care through the translation of clinical care into registries and reports.

5. METHODS

The study was carried out in four primary health centres in the Banfora region, situated in the south-western part of Burkina Faso drawing on ethnographic methodology. Participatory observations, interviews and focus group discussions constitute the main data material. In this section, I will give an introduction to the study setting before I embark on a comprehensive description of the fieldwork, data-analysis and the writing phase of this project. I will end up by critically reflecting upon the soundness of the methodology and the ethical implications of this project.

5.1 Study setting

5.1.1 Burkina Faso

Burkina Faso is landlocked in West Africa, surrounded by Cote d'Ivoire, Ghana, Benin and Togo in the South, by Mali in the north-west and by Niger in the north-eastern part. The climate ranges from a Sahelian desert climate in the northern part to a savannah climate in the south western part of the country. The country is divided into 13 administrative regions (Institut national de la statistique et de la démographie, 2010).

Figure 1: Map of Burkina Faso from Wikimedia Commons

Formerly known as Upper Volta, the country gained its independence from France in 1960 and was renamed Burkina Faso (meaning fatherland of the honest or *pays des hommes intègres*) by the leftist president Thomas Sankara in 1984. With a political standpoint grounded in anti-imperialism (Sankara, 1985), Sankara also lay the foundation of the primary health care system. He launched massive vaccination campaigns and encouraged a roll-out of primary health care centres. Sankara was assassinated in a military coup led by his former ally Blaise Compaoré in 1987. Despite relative political stability during the presidency of Blaise Compaoré from the 1987 coup until the 2014 uprising, the country is among the world's poorest and least developed, ranking 181th of 187 on the Human Development Index of 2011 (United Nations Development Programme, 2011). The population of approximately 15 million inhabitants are predominantly rural, and literacy rates are low (Institut national de la statistique et de la démographie, 2010). Life expectancy at birth in 2012 was 57 years for men and 59 years for women (United Nations Development Programme, 2011).

5.1.2 The Burkinabè health system

The Burkinabè health system consists of four levels of health care institutions: primary health centres (Centres de Santé et de Promotion Sociale CSPS), district hospitals (CMA), regional hospitals (CHR), and three University hospitals situated in Ouagadougou and Bobo-Dioulasso (Diréction générale de l'information et des statistiques sanitaires, 2012). At the time of the study, 13 regional health directorates, divided into 67 health districts, organised the country's health services. These health districts were responsible for the management and supervision of primary health centres.

The health centre is the most basic unit of the Burkinabè health system and is responsible for the provision of preventive and curative primary health services. The CSPS are commonly headed by a registered nurse, the *infirmier chef de poste.* Most health centres are divided into two buildings: the dispensary and the maternity unit. Whereas the maternity unit provides pregnancy and birth care services, the rest of the preventive and curative health services are organised through the dispensary. The primary health centres mostly provide assistance to women with uncomplicated deliveries, as they do not have the option of providing assisted vaginal deliveries, blood transfusions or caesarean sections.

5.1.3 Maternal health in Burkina Faso

Burkina Faso has one of the highest fertility rates in the world. On average, every woman gives birth to nearly 6 children (United Nations Development Programme, 2011). Maternal mortality remains high, with an estimated maternal mortality ratio of 400 per 100 000 live births in 2013 (Kassebaum et al., 2013). The promotion of facility birth care has been the core official strategy to reduce maternal mortality and to reach MDG 5 on maternal mortality reduction. The Ministry of Health set an ambitious goal of increasing the proportion of women giving birth with skilled attendance from 50% to 80% between 2006 and 2015 (Ministère de la Santé, 2006a). In this context, a subsidiary policy for pregnancy and birth care was implemented from 2006 to reduce financial barriers to accessing facility care, reducing the out-of-pocket

payments by approximately 80% (Ministère de la Santé, 2006b; Ridde, Richard, Bicaba, Queuille, & Conombo, 2011). In 2010, the skilled attendance rate was 65.9% (United Nations Statistics Division, 2017). Despite policies to increase attendance, Burkinabè primary health centres continue to be characterised by low quality birth care with an ongoing lack of material resources and of staff with sufficient skills (Duysburgh et al., 2013; Nikiema, Kameli, Capon, Sondo, & Martin-Prével, 2010).

5.1.4 The Banfora Region

The study was conducted in the two neighbouring health districts Banfora and Mangodara in Banfora Region. Situated in the south-western corner of the country, the town of Banfora is the fifth largest city in the country, and home to approximately 75 000 people. The region has a tropical climate, and the city of Banfora is the centre of the country's sugar cane industry. However, subsistence farming remains the main economic activity in the area.

The annual number of expected deliveries for the health districts of Banfora and Mangodara in 2011 was 24 500 for a population of approximately 500 000 (District sanitaire de Banfora, 2011; District sanitaire de Mangdodara, 2011). The proportion of deliveries taking place with a skilled attendant was 67% in Banfora and 59% in Mangodara. At the time of the study, the two districts had 39 primary health centres and one regional referral hospital located in Banfora town. In the study area, maternal literacy remains very low. A study among pregnant women in the area conducted in 2006 indicated that 83% never had attended school (Tylleskar et al., 2011).

5.1.5 Field sites

On the assumption that facility care would differ between urban and rural areas and also taking into consideration the monthly number of births, one urban, one semi-urban and two rural facilities were purposively selected to achieve maximum diversity. Three of the health centres were situated in Banfora health district. According to health district data, the selected health centres had an assisted delivery rate varying from 48 to 77% (District sanitaire de Banfora, 2011; District sanitaire de Mangdodara,

2011). The health centres varied in size and had from 2-12 health workers with different levels of training. Their infrastructure also varied substantially; some had electricity and running water, while others relied on torches as the only source of light; and water was provided from wells situated up to one kilometre from the health centre.

5.2 Positioning the researcher

In ethnography, the researcher as a person constitutes the main research instrument, and his or her characteristics influence the access to the field of study. Before I proceed with the description of the data collection and analysis, I will therefore present some information about the rationale behind the initiation of the study and myself as a researcher.

This PhD study was initially designed as a follow-up study of a cluster-randomised breastfeeding promotion trial carried out in the Banfora area from 2006-2008 (Tylleskar et al., 2011). The study included nearly 900 women in the second semester of pregnancy and followed the children until one year of age. The study found surprisingly high levels of perinatal and infant mortality; 79 and 113 per 10000 live births respectively (Diallo et al., 2012; Diallo et al., 2010). In addition, the study could not document that perinatal mortality was lower among women who had given birth in a health institution as compared to those who delivered at home. The trial did not collect data on quality of birth care in health facilities, but our research team expected that the high perinatal mortality rate was primarily associated with poor quality of care at health centre level.

I entered the field as a Norwegian female student in my early twenties, having just completed two years of (pre-clinical) medical school focusing on cell biology, anatomy and physiology. I had very limited knowledge about the study context: this was my first encounter with births, birth care and West Africa. I was equally a novice to qualitative research methodologies and social science theories. Although I had almost no experience from clinical work from medical school, I had started on the long journey towards a professional identity as a medical doctor and identified myself with

health workers in the study area. Linguistically, I benefitted from a high proficiency level in French acquired during three high school years in France.

Researcher positionality is not a constant entity, but a continuous changing process. Data analysis and the writing of three articles and this thesis took place over many years, and my positionality has gradually been influenced by various life events: I have completed medical school, I have been working as a medical doctor at the women's clinic in Haukeland University Hospital, and I have experienced pregnancy and birth care myself. In addition, my growing interest in social theories about global policy analysis, and the power dynamics of care provision have framed my understanding and interpretation of the data collected during the 2011/2012 fieldwork.

5.3 Access to the field sites

To access the data needed to answer the research question is a central challenge in ethnographic research. Although most intense in the beginning of fieldwork, it involves continuous negotiations with research participants (Hammersley & Atkinson, 1995). My entry into the field was facilitated by previous cooperation with the health authorities in question established during the aforementioned breastfeeding promotion trial carried out by our research consortium in the area from 2005 till 2008 (Tylleskar et al., 2011). In addition, many of the head nurses and health centre staff had, in some way or other, been involved during this data collection in the villages of the catchment areas of the health centres.

During fieldwork the heads of the medical districts became key gatekeepers who facilitated my access to the study health centres. In the study health centres, the head nurse and the head of maternity (midwife or auxiliary midwife) were important gatekeepers who had the authority to grant access to activities in the maternity wards. With a study aiming to assess the quality of the services provided, gatekeepers will 'have practical interests in seeing themselves and their colleagues presented in a favourable light' (Hammersley & Atkinson, 1995, p. 66). Access to the field sites in the four health centres was about more than my physical presence in the clinic

buildings and was a continuous negotiation of going beyond the pictures of quality care that the health centre management wanted to paint. A week into the stay in one of the health centres, for example, I was told during informal conversation over sodas that the head of the health centre, in the days prior to my arrival, had engaged all health workers in a major clean-up. The maternity building had been refurnished with delivery kits containing disposables such as gloves, scissor blades and umbilical cord clamps.

My access to the health centres also depended on how the research assistant and myself were housed during the different phases of fieldwork. For the urban and semi-urban health centre we lived in a house in the regional hospital compound in Banfora town and tried to be at the health centres as much as possible during the daytime. Observation during evenings and nights were planned with the health worker on duty in advance, and I would stay the whole night. In the rural health centres, we were housed in close proximity to the health centre and the health worker housing. This facilitated my participation in the daily life of the maternity services. I could have a more flexible presence in the clinics, and health workers would contact me whenever they were called upon outside office hours or if they identified situations that would be interesting for me to observe.

5.4 Doing (institutional) ethnography

Even though ethnography to a large degree is associated with long term engagements in single communities, my four months of fieldwork was defined in terms of a more focused ethnographic approach with participation in the daily life of primary health centres 'watching what happens, listening to what is said, asking questions –in fact collecting whatever data are available to throw light on the issues that are the focus of the research' (Hammersley & Atkinson, 1995, p.1). The combination of participant observations, IDIs and FGDs allowed me to study the topic of pregnancy and birth care from different angles, bringing out the perspectives of women, community members and health workers, and comparing these perspectives to the observation of the care provided.

The point of departure in this study was to explore the strategies used to provide quality pregnancy and birth care within Burkinabè primary health centres. However, as ethnographic research design is exploratory and flexible in nature, the research themes can be modified in the course of fieldwork to pursue emerging lines of inquiry. One major emerging theme in this study was the importance attached to achievement of policy, indicators and the role of the documentation of care in the study health centres. Although not initial study objectives, these issues emerged as crucial parts of birth care providers' everyday practices, concerns and frustrations early on during fieldwork. The study of written records in the health facility was, therefore, gradually given more attention during observation, informal conversations with health workers and informal interviews.

The importance of the written texts led me into the works of Dorothy E. Smith on institutional ethnography, which has guided the analysis of the findings from this fieldwork. Based in experiences, like the ones of birth care providers in our study, institutional ethnography sets out to 'find the extra-local ruling relations in the small, daily routines' (D. Smith, 2006, p.54). To bridge the gap between the local experiences of health workers and the translocal power structures, the study of texts such as patient files, monthly reports, and global, national and health district policy documents and action plans is paramount. As Smith (2006) points out, the incorporation of texts into ethnographic practice 'is what enables it to reach beyond the locally observable and discoverable into the translocal social relations and organization that permeate and control the local' (p. 65).

5.4.1 Participant observation

The participatory observations were carried out both day and night for 12 weeks; three weeks in each of the four primary maternity units. Participant observations in health centres became the main source of data during the fieldwork, and, as Hammersley and Atkinson (1995) point out, have a great capacity to inform other methods of data collection.

Observations can be carried out with different levels of participation, from observations without interactions with the research participants, as exemplified by observing through a one-way mirror, to the complete immersion in a society where the ethnographer's role as a researcher is concealed. According to Junker (1960), the ethnographer's role in the field can be one of the following, with increasing levels of participation and immersion: the complete observer, the observer-as-participant, the participant-as-observer and the complete participant. My role in the field could be characterised as an observer-as-participant as I did not act as an independent health worker in the health centres, but rather followed the healthcare providers at work engaging in conversations and asking questions about different practices.

My background as a medical student facilitated the access to the field, as I was perceived as a fellow health worker and an 'acceptable incompetent' (Hammersley & Atkinson, 1995). I could learn the clinical management of pregnancy and birth care from the study participants, who would also explain different aspects of the everyday life and practices at the health centre. In the mornings, I typically participated in outpatient activities like ANC consultation, healthy baby clinics and family planning activities. During afternoons and nights, I followed the health workers on duty as they performed their administrative tasks, attended to women in birth and provided post-partum care. I also participated in other health centre activities such as outreach vaccination days, community meetings and supervisory visits from the health district. To negotiate my presence in the health centres I helped out with small tasks like getting the necessary drugs and equipment ready. As fieldwork proceeded, I gave gradually more emphasis to the ways in which health worker practices were negotiated through written texts such as guidelines, patient charts and reports. Observations and reflections were noted daily in a field diary where I tried to make a clear distinction between observations, reflections and preliminary analysis of the data collected that day. I also carried a small notebook with me during the observations, in which I noted down valuable quotations from informal interviews, observational findings that I would like to discuss with health workers at some later points and other information daily (Fangen, 2010).

5.4.2 Formal interviews

During fieldwork, a total of 35 in-depth interviews (IDI) and 8 focus group discussions (FGD) were conducted to complement the data emerging from participatory observations.

Figure 2: An overview of IDIs and FGDs

		Article 1	Article 2	Article 3
In-depth interviews: (A total of 35)	12 frontline health workers	x		x
	2 medical doctors in the health district	x		x
	13 women with a recent health centre birth		x	
	5 women with a recent home birth		x	
	3 partners		x	
Focus group discussions: (A total of 8)	4 groups with female participants		x	
	3 groups with male participants		x	
	1 mixed-sex group		x	

5.4.3 Health workers

The findings from the observational data were supplemented by 12 in-depth interviews with birth care providers selected on the basis of observations. Two of the interviewees were selected to represent the view of health workers in small rural health

centres where, for practical reasons, observations could not be carried out. The 12 interviewees had different levels of training and were nurses, outreach health workers or auxiliary or registered midwives. In addition, two medical doctors in the health district management team were interviewed at the end of the data collection period. The interview guides explored issues such as quality of care, working conditions, and the role of documentation. All interviews were conducted in French in a separate room at the interviewees' workplace and lasted from 45 to 90 minutes. They were recorded and transcribed verbatim.

5.4.4 Women and partners

A total of 21 IDIs and 8 FGDs with women who recently experienced childbirth, their partners and community members were conducted. A research assistant trained in sociology and fluent in Dioula and French recruited the participants in the IDIs and FGDs that had from 6 to 10 participants. She was assisted by community health workers in semi-urban and rural communities in the areas covered by the four health centres. Participants were purposively selected for the interviews, on the basis that they or their partner had given birth within the last three months. The age of the interviewees ranged from 18 to 42 years, they had none to 13 living children, and lived from one to 20 km from their local health centre. A good majority relied on subsistence farming, and only a handful had attended school. The recruitment of study participants ended at the point of data saturation.

Both IDIs and FGDs were conducted in Dioula; I conducted the IDIs with the research assistant as an interpreter, while the research assistant facilitated the FGDs in Dioula with me as an observer. The IDIs took place in the interviewees' homes, while the FGDs took place outdoors in a public place in the community where the participants lived. Both IDIs and FGDs lasted between 45 and 90 minutes.

The interview guides for the IDIs and the topic guides for the FGDs included open-ended questions about practices during pregnancy and childbirth, the place of birthing and personal, as well as community, perceptions on the care provided in the health centres. My supervisors contributed to the development of the interview guides, which

were translated from French to Dioula by a certified Dioula translator. The interview guides were modified throughout the fieldwork on the basis of emerging themes and findings in the preliminary analysis. Both IDIs and FGDs were recorded and transcribed verbatim in Dioula before translation into French by the research assistant.

5.5 Analysis

The process of analysis is not a distinct stage in ethnography but spans from the formulation of the research problem throughout fieldwork and the writing up of the findings (Hammersley & Atkinson, 1995). During the fieldwork, the transcription of health worker interviews, the regular reading of the field notes and the interview transcripts allowed a preliminary analysis of the data. The preliminary analysis, as well as the meanings of the verbatim transcripts and the culturally embedded expressions, were continuously discussed with the research assistant and emerging lines of enquiry were identified and pursued. This preliminary analysis also allowed for a clarification and delimitation of the research problem into the role of global policies and policy implementation in this local setting, a topic somewhat different from my 'foreshadowed problem' when entering the field.

Returning home after fieldwork, I was overwhelmed by the amount of data gathered, and was unsure how to go about the analysis process. The process of analysis thus commenced with several re-readings of the transcripts and field notes to try to make sense of the entire data set, a common entry point for many qualitative analyses (Hammersley & Atkinson, 1995; Malterud, 2003). After several attempts (and failures) at analysis, I finally decided to examine the transcripts by drawing upon qualitative content analysis (Graneheim & Lundman, 2004). As the process of analysis was carried out in parallel with full-time medical studies, I chose to conduct three separate analyses based on three overarching themes identified during preliminary analysis while still in the field, and the initial readings of the data set. Figure 2 illustrates the data employed in different analyses.

After re-familiarisation with the dataset during several readings, initial meaning units or codes were identified in the interviews. These codes were grouped into categories and subsequently into themes. For example, the quote,

> *'If you don't do the weighing [attend antenatal care (ANC)] she [health worker] will say, "Why haven't you come to be weighed [attended ANC]? It's when your child is sick, you're coming." She growls like that. She will care for you, but she will disrespect you while caring for you.'*

was grouped into the category *imposing a sanction by use of verbal reprimands* and consequently into the theme *sanctions for not using the pregnancy and childbirth services as prescribed*. NVivo 9 software (QSR International) was used to code and organise the data of paper one, whereas paper two and three were coded manually as I found that the manual work of moving bits of paper around on my desk gave a better overview of the data and facilitated the process of analysis. During the writing up of the papers, the themes were repeatedly assessed and refined in discussion with the main supervisor and by going back to the original dataset. Finally, themes were narrated, and representative quotes identified.

In this process I also drew upon institutional ethnography (Smith, 2005). I was therefore particularly sensitive to the excerpts where institutional discourses surfaced in the participants' accounts. These types of discourses, defined as 'any widely shared professional, managerial, scientific, or authoritative way of knowing (measuring, naming, describing) states of affairs that render them actionable within institutional relations of purpose and accountability' (McCoy, 2006, p. 118) echoed global, national and district level policy documents on maternal health. Throughout the analysis and writing process, I strived to use these policy texts to embed the experiences of women and health workers within larger institutional processes such as the push towards increased measurability in global maternal health, to show how these translocal processes (or ruling relations) shape women's and health worker's everyday experiences.

5.6 Reflections on methods

To assess whether an ethnographic study is employing a sound methodology, different standards have been proposed. One of the most widespread set of standards is the four criteria to assess trustworthiness proposed by Guba (1981); namely credibility, transferability, dependability and confirmability. These notions correspond to the quantitative criteria of internal validity, generalisability, reliability, and objectivity, and have been criticised for leading to a mechanical evaluation of qualitative studies. Malterud (2001) points to the fact that the qualitative researcher must use strategies to question findings and interpretations, assess validity, be sensitive to the effects of context and bias, and display and discuss the process of analysis. She proposes, by building on Mays and Pope (1995), relevance, validity and reflexivity as essential standards to evaluate qualitative research but emphasises that the assessment of these criteria is not straightforward; it requires judgements by the assessor. In the following section I will draw on Malterud's (2001, 2003) writings on qualitative methodology, and critically reflect on my research through a discussion of reflexivity, validity, and relevance.

5.6.1 Reflexivity

All research, both quantitative and qualitative, is conducted from the specific viewpoint of the researcher(s), which has significance for the research question, for how the data collection is carried out and for what findings are presented as meaningful.

In ethnography, where the ethnographer as a person constitutes the research instrument, this influence on the field is acknowledged and the researcher should 'try continually to be aware of how his or her presence may have shaped the data' (Hammersley & Atkinson, 1995, p. 223) to improve the validity of the findings. I have, earlier in this thesis, positioned myself as a researcher, and will now, in accordance with the principle of Malterud (2001), present and discuss how this may have affected this research project.

A researcher always enters the field with 'foreshadowed' research problems and pre-conceptions. I entered the field 'knowing' that facility births did not improve perinatal deaths in this area (Diallo et al., 2010), and suspected that these facilities were unable to provide care that could prevent stillbirths and early neonatal deaths. With no prior clinical experience, I was only able to assess the health workers' performance on the basis of limited theoretical knowledge and nationally established guidelines as communicated to local health workers. I was therefore strongly influenced by the public health discourse in the field of maternal health, for example, the taken-for-granted goal that skilled attendance is a prerequisite for maternal mortality reduction, and the list of seven basic emergency obstetric and neonatal care services (BEMONC) that health centres 'should' be offering to their patients (WHO, 2009). These pre-conceptions formed the initial line of inquiry but were gradually given less attention in interview transcripts as fieldwork progressed.

A researcher's presence will always influence the 'natural setting' of fieldwork and hence the data gathered. When I entered the field with a research problem that openly problematised the quality of care provided in the study health centres, health workers' expectations of expert critical surveillance may have limited my access to the field as described earlier. Social desirability bias may have influenced study participants both to describe and to perform best practices in my presence. As I stayed for several weeks in each health centre, the health workers may have forgotten my role as a researcher and disclosed issues that they may not have revealed during formal interviews. As I myself experienced the practical constraints in the provision of quality care, such as lack of water, electricity, referral possibilities and necessary drugs, my presence at the health centres may have led to identification with health workers and a positive interpretation of their actions.

The encounters with women and community members were to a larger degree influenced by my otherness than interactions with health workers. Many of the women and community members had seen me with the white health worker coat in the health centre, and naturally associated me with the formal health system. Additionally, being a European not familiar with their language or background made me clearly an

outsider. These interviews were facilitated by a research assistant, who also had a very different background from most of the participants, as she normally lived in the city of Bobo-Dioulasso and had a university degree in sociology. Our backgrounds probably influenced the women's encounters with us, and the ways in which they shared their experiences. In many of the interviews, especially the ones with female participants, going beyond the official discourse of the health centre as the only and best option for birth care proved difficult, particularly in the beginning of interviews. One example is a woman who started out by expressing her contentment with the services, although she eventually described how she ended up being abandoned by the health worker to give birth alone on the floor of the health centre, and preferred to give birth at home in the following pregnancy.

The researcher also influences the processes of analysis and writing. To improve reflexivity, the researcher should be able to display and discuss the process of analysis. The theoretical framework underlying the interpretation of the data should also be spelled out as 'knowledge never emerges from data alone, but from the relation between empirical substance and theoretical models and notions' (Malterud, 2001, p. 486). I have therefore, throughout this methods section, attempted to spell out the process of analysis and the theoretical considerations that form my interpretations of the data material.

5.6.2 Validity

Mays and Pope (1995) propose triangulation, respondent validation, attention to negative cases, reflexivity and fair dealing as strategies to enhance validity. In this study, we have strived to improve validity by engaging in persistent participatory observations over some time in four different primary health centres to overcome distortions produced by my presence (Guba, 1981). In addition, triangulation of data collection methods, such as interviews, focus groups and participatory observation as well as source triangulation with different categories of informants such as women, health workers, community members, and members of the local health administration have improved validity. This allowed for cross-checking of the data for inconsistencies and contradictions in the phase of analysis. These contradictions have been presented

and reflected upon in the presentation of the findings. Finally, the emergent research design allowed me to explore and clarify different topics during fieldwork, both by peer debriefing with the research assistant and supervisors, and by 'member checks' where I discussed preliminary analysis with health workers.

Language, translation and research assistance also influence validity. French is both the former colonial language, and the official language in Burkina Faso. It dominates the official administration and is employed in all guidelines and registries in health centres. In the study area Dioula (or Dyula) is the lingua franca, however different ethnic groups also speak other languages such as Karaboro, Fulfulde and Goin. Nurses and other formal health workers were all trained in French, and communication with health workers was undertaken without interpretation. I also chose to carry out the participant observations without the research assistant. As I had very limited understanding of Dioula, this was a limitation when observing the patient/provider interaction and when the interaction between health workers took place in Dioula. In these settings, the information gathered was based on the participants' non-verbal communication, and sometimes also on health workers' explaining the situations to me in French afterwards.

I relied heavily on assistance from my Dioula-speaking Burkinabè research assistant for translation and cultural knowledge throughout the fieldwork period. The challenges of interpreting in an interview setting are two-fold: as I was conducting the individual interviews, the research assistant orally translated what was said. When reading out the interview transcripts some days later, I could find details that I had not picked up, and that would have been interesting to explore further with follow-up questions. However, as fieldwork progressed, and the research assistant and I got to know each other, the project and the interview situation better, such missed opportunities became rare. The other major challenge in translation, is that the choice of wording orally or in text is not neutral, but always a result of an initial interpretation done by the translator. As such, my interpretation of the findings may actually be an analysis of the research assistant's interpretations.

5.6.3 Relevance

The relevance of a study is fundamentally related to the research question and can be enhanced through detailed reports and adequate sampling techniques (Malterud, 2001). Ethnographers have difficulties claiming generalisability of their findings, as they are inherently context dependent. To ensure the applicability of ethnographic findings, researchers should rather produce knowledge that is context relevant. This study has, in accordance with the strategies proposed by Guba (1981), employed a purposive sampling of study participants and study sites in order to increase diversity with regards to health centre characteristics and the health workers' and women's background. Another factor that enhances relevance is what Geertz (1973) refers to as thick descriptions. By providing detailed descriptions of the context of the study health centres, we provide the readers with the ability to judge the transferability to other similar contexts. So, even though the findings in this study are limited to four health centres in the Banfora area and cannot be generalised beyond these study sites, the health centres in the study are subjected to the same health policy and the same health system culture and resource scarcity as health centres in other parts of francophone West Africa (Olivier de Sardan, 2015). Furthermore, the services are provided in a socio-economic context with high levels of poverty and illiteracy, which is not much different from other areas in the region. There is therefore reason to believe that the findings can be relevant and transferable to similar rural health care settings.

5.7 Ethics

Research ethics is not limited to the obtainment of authorisations and signatures of informed consent, but encompasses the continuous negotiations of key principles such as informed consent, the right to a private life, respect for personal integrity, doing no harm and not exploiting participants throughout the research process (Hem, Heggen, & Ruyter, 2008). This is especially the case for ethnography, where data collection takes places over a prolonged period of time, and in different, naturalistic settings. In the following section I will limit the reflection to some of the issues, namely the ones of consent, confidentiality and the benefits and harms resulting from this PhD project.

5.7.1 Authorisations

The study was approved by the national health research ethics committee of the Ministry of Health, Ouagadougou, Burkina Faso (Comité d'éthique pour la Recherche en Santé, CERS, No2011-9-57) and retrospectively by the Regional Committee for Medical and Health Research Ethics West, Norway (2017/2500/REK vest). The Banfora regional health directorate Chief and the Heads of Banfora and Mangodara health districts provided administrative authorisations.

5.7.2 Informed consent

Informed consent in ethnographic fieldwork is not a one-time procedure nor a box to be checked, but a continuous process throughout fieldwork where the degrees of openness about the researchers' role and the extent of information about the research project provided are negotiated (Hammersley & Atkinson, 1995).

Prior to the initiation of the study, members of the health directorate of Cascades and the Banfora and Mangodara health districts as well as the head nurses and the heads of the maternity of each of the participating health centre were invited to a meeting hosted by the Centre Muraz in Banfora town. In this meeting, the background findings of high perinatal mortality in the study area, with no difference in risk between home and facility deliveries, were presented along with the aims and methods of the current study on the access to and quality of pregnancy and birth care in the area. During this meeting, we also highlighted how study participation in the current study was voluntary for health workers, patients and community members, and that the findings resulting from both observations and formal interviews were to be treated confidentially.

Written informed consent was obtained from all participants prior to IDIs and FGDs based on an information form in French or in Dioula where voluntary participation, confidentiality and the right to withdraw from the study at any point without consequences was emphasised (se appendices). As a great majority of the study participants were illiterate, the research assistant would, when appropriate, read a

written consent form in Dioula before signed or thumb-printed informed consent was obtained from all interviewees.

Consent and participant observation

As described earlier in this section, the ethnographic fieldwork consisted mainly of accompanying health workers in their daily tasks and helping out with minor tasks in the health centres. Every time I entered the health centres, verbal consent to participate at the care provision was granted by health workers. Although I was given the white health worker coat, my role in the field was clearly one as an outsider, and I perceived that my position as a researcher interested in the quality of maternal care was well known to the staff at the study health centres. As I spent a lot of time with health workers to gain their trust, health workers may have become less aware of my role as a researcher (Hammersley & Atkinson, 1995), and may have revealed information they would have concealed in formal interviews. Throughout the clinical observations I therefore tried to remind study participants about my role and emphasise how these observations contributed to my understanding of the provision of pregnancy and birth care in the area and formed a part of my research.

By shadowing health workers during their shifts, I observed them in their everyday routines where they interacted with other staff, patients and members of the general public. As public servants, they were in constant interaction with a considerable number of clients, and as Punch (1986) points out, it became physically impossible to carry out the observation if I were to provide information to and seek consent from each and every person the health workers interacted with during a shift. Additionally, by doing research in a natural setting, I had limited control over the processes taking place and hence limited power to ensure that participants were fully informed (Hammersley & Atkinson, 1995). Health institutions as sites for participatory observations pose an additional challenge to the principle of individual informed consent, as patients are often in a vulnerable situation, but such observations can nonetheless be justified if the researcher finds alternative ways to preserve the participants' interests (De nasjonale forskningsetiske komiteer, 2010).

> *'Participant observation creates a problem for obtaining informed consent, because informed consent is an individual-based ethical guideline and participant observation is based on observing interaction between participants, which makes it a collective approach. When doing participant observation we will often observe participants interacting when one or more participants are believed to have impaired decision-making capacity, or have not yet given their consent to be observed)' (Oeye, Bjelland, & Skorpen, 2007, p. 2304),*

Faced with these challenges to obtain individual informed consent during health centre-based observations, I relied on different strategies to safeguard the participants' welfare and integrity. As an overall rule, I chose to leave the room whenever I could sense an apprehension on the part of the woman about my presence. When following health workers on the health centre premises, during informal conversations and short consultations like the ANC consultations that typically lasted less than 5 minutes and could be repeated over 40 times during a morning, I met a considerable number of patients and family members. I chose not to divert attention and time from health workers' chores to provide information to and obtain consent to participate from everybody. As a consequence, I focused my observations on the health workers' action rather on the patients' medical stories and complaints. However, during birth care, when a woman was cared for by a health worker over a prolonged period of time, I asked health workers to inform women in labour about the study and ask them to consent to my presence. Health workers were charged with obtaining consents, as I was not able to communicate with the women in Dioula and did not want to further intrude on the women's privacy by bringing in the research assistant. This was suboptimal as I did not understand how consent was obtained, and one might question the real ability of women in labour to decline study participation when she crucially depended on care from the one asking for consent. I therefore focused my observations on the health workers' actions and work processes rather than on the patient. However, in the course of these birth observations, some patient stories emerged as key findings, and I therefore contacted the women in question after they returned home to obtain consent to use the observational data, and to carry out formal follow-up interviews.

5.7.3 Confidentiality

Utmost care was taken to secure privacy and confidentiality during the interviews and throughout the entire research process. All data files were kept secure, the original in locked cupboards at the Centre Muraz, paper copies at the Centre for International Health, and electronic files on external hard drives only accessible to the investigators. All data material was coded to secure anonymity. In the dissemination of the findings, the health centres participating in the study are not named, and health workers are only referred to by their level of training. All names employed in the articles making up this thesis are pseudonyms.

5.7.4 Benefits and harm

Research participation will always influence the study participants in both positive and negative ways. This also applies to ethnography, even though the consequences of research participation are less clear-cut than in, for example, trials of biomedical interventions. In the following section I aim to discuss critically how this study may have resulted in different benefits and harms to the study participants during and after fieldwork, starting out with the interviews with women and community members.

Issues surrounding childbirth and caregiving are sensitive in nature. The women participating in the study may have experienced the interview setting as uncomfortable, where our questions led them to re-live a traumatic childbirth experience. Moreover, we asked to women and community members to evaluate the care provided. Largely dependent on the services provided by the local health centre, the study participants may be reluctant to challenge the local power structure by criticising health workers (Goetz, 2003). We therefore strived to provide a secure interview setting in the communities where we emphasised our independent role and the participants' confidentiality. Despite these challenges, I often got the impression that the interview was as a positive experience for the study participant – that they appreciated someone being truly interested in hearing their story and perspectives.

The observations may have led to a stressful working situation for health workers, where they felt as if they were being constantly 'evaluated' (Hammersley & Atkinson,

1995). During the first couple of days in each of the field sites, I could sense an apprehension about my presence among some of the health workers. However, I had the impression that health workers were quickly familiarised with my presence and lowered their shoulders accordingly.

Although I had limited medical training prior to fieldwork, I was faced with situations where health workers engaged in practices that I considered harmful to their patients. This included the absence of certain actions such as not monitoring women in active labour, but also more direct malpractices such as verbal and sometimes physical abuse of patients in labour, and the reuse of needles and gloves. Rather than intervening during observations, as I was not certified to act as a health worker during fieldwork, I rather asked the health workers to explain the practices and to some extent problematised them in informal conversations after caregiving. On one occasion I did, however, make an exception and intervened during the process of care: when premature new-born twins were put aside on a table wrapped in wet clothing after birth. To avoid the immediate risk of hypothermia in the relatively cold night, I placed them in dry clothing close to their mother.

In addition to the ethical dilemmas encountered during fieldwork, the writing and publication of the findings resulting from ethnographic fieldwork also have ethical implications for the participants both in a direct and a more indirect way (Hammersley & Atkinson, 1995). The overall aim of this study was to identify barriers to access and to explore the provision of quality pregnancy and birth care in the region, and to contribute to the body of knowledge on the provision of birth care in resource-constrained settings. The findings have therefore been presented to relevant stakeholders, at national and international conferences, as well as peer-reviewed articles in open-access scientific journals. The study findings describe health workers who are sometimes acting in conflict with the prevailing official norms of care. Being sensitive to the structural factors which influence health workers' ability to provide quality care and maintaining their confidentiality has been a main concern throughout this study.

Research may also have wider ramifications for larger categories of actors beyond the study participants (Hammersley & Atkinson, 1995). In this project, there are some fundamental ethical issues that I have spent countless hours discussing with friends, family, and fellow researchers in the field of global health. As a (future) Norwegian medical doctor engaged in research on birth care provision in a setting of extreme resource deprivation, I may unintentionally have consolidated and reinforced uneven power relations resulting from a colonial history and the extremely uneven distribution of the world's resources. Even though this work is grounded in a humanitarian rationale and addresses one of the major health problems where the need is greatest, the lacking reciprocity in the field of global health is problematic. As Birn (2017) points out, it is not incidental that Europeans and North Americans are studying health care problems and acting as experts by proposing changes in low income settings, but that there are no Burkinabè researchers evaluating the quality of care provided at the obstetric department in Bergen. On a wider note one might fear that this study leads to further exploitation of Burkinabè women as I, in some way, benefit more from our interactions and use their suffering as a way to promote my own interests and career with scientific publications and this PhD. This concern is not unique to me as a researcher in the field of global health but will apply to all research 'studying down' on disadvantaged groups regardless of study settings.

6. Results

6.1 Synopsis of paper I

Health workers presented the health centre as the only safe and responsible place for pregnant women to give birth. However, they provided birth care in a context of limited financial resources, insufficiently trained personnel and poorly equipped facilities. The health workers expressed how the quality of the birth care provided was severely compromised. The accounts of birth care providers in rural Burkina Faso revealed how health workers' ability to assure timely detection and management of birth complications is severely limited, both by inadequate recognition of birth complications, incapacity to manage complications at the health centre level and inaccessibility of transportation to higher levels of care. The combination of limited possibilities to manage complications at the health centre and little or no access to emergency transport turned health workers into disempowered bystanders when life-threatening emergencies occurred. Health workers resorted to alternative and potentially harmful strategies such as fundal pressure, contra-indicated use of uterotonics and verbal and physical abuse to manage births within primary health care facilities. Health workers tended to place the responsibility for poor quality of care on infrastructural limitations and patient behaviour, while our observational data also identified missed opportunities that would not demand additional resources, such as early initiation of breastfeeding and skin-to-skin contact after birth.

6.2 Synopsis of paper II

Women and their families experienced a strong pressure to give birth in a health facility and perceived that authorities, health workers and community members defined institutional birth as the only acceptable option for birth care. Giving birth at the health centre was thus seen as moral obligation for pregnant women. Non-institutional births resulted in verbal, economic and administrative sanctions towards women and their families such as verbal harassment and abuse, increased payment for services and medications and the withholding of birth certificates. Women and their

family members did not consider themselves competent enough to evaluate the quality of the birth care provided and considered that health workers had superior knowledge and training. They also reported that they felt incapable of questioning health workers' knowledge and practices because of power hierarchies and fear of consequences for future care provision. Women who, for social and economic reasons, had limited access to health facilities found that the sanctions came with increased cost for health services, led to social stigma and acted as additional barriers to seeking skilled care at birth.

6.3 Synopsis of paper III

Health workers spent a vast proportion of their time and assigned a great deal of importance to documentation and to reporting the clinical care provided. In addition to the information registered during and after patient interactions, the health workers summarised the number of visits and the services provided in monthly paper-based reports. Health workers often expressed frustration about the time spent on paperwork as it took time and focus from clinical work. The number and coverage of different services provided at the health centres was an important part of the health district's evaluation of the health centres. Some services, such as the number of women receiving more than two antenatal care consultations and the number of deliveries at the local health centre, were particularly important indicators that were used to evaluate a facility's performance. Health workers gave less attention to the clinical provision and documentation of services and outcomes that were less closely monitored by the health district. Throughout the observations, a wide discrepancy appeared between the care that was *reported* and the care that was actually *provided* in the health centres. One example is how the labour surveillance tool partograph was routinely completed after birth with measurements that never were performed, thus transforming it into a 'postograph'. Health centre workers repeatedly acknowledged that the monthly reports did not reflect the actual care provided on the ground. Data fabrication was seen as a way for health workers to adhere to the expectations of health district officers and to demonstrate their professional competence.

7. DISCUSSION

The major aim of this dissertation is to describe and analyse the links between the global policy of skilled attendance and the actual practices of birth care provision in Burkinabè primary health care centres. The findings have illustrated how the policy of skilled birth attendance disciplined both health workers and women in the study setting. I will now shed light on the findings of this study, drawing on empirical literature on skilled birth attendance in low resource settings as well as on medical anthropology and social policy theories highlighting the importance of global and local power structures. With an emphasis on the most central findings of this thesis, I will discuss the negotiations taking place in the enacting of skilled birth attendance and reflect on the role of numerical accountability in the study setting, and more broadly in the field of global maternal health.

7.1 Negotiations of skilled birth attendance

As this thesis has emphasised, there is a dynamic relationship between patients' and providers' practices, which affect the policy of skilled attendance when implemented in primary health centres of Burkina Faso. Women, their families and health workers are engaged in continuous negotiations over place of delivery, provision of quality care and the consequences of poor pregnancy outcomes.

7.1.1 Provider negotiations

The policy of skilled attendance is enacted in settings where women receive care at birth. Our study has revealed how material scarcity, inadequate training and staff shortages contributed to the severe limitation of health workers' ability to assure routine quality birth care and timely detection and management of birth complications. The birth care provided in the health centres was characterised by the inability to provide both skilled attendance and emergency care, evoking Masquelier's (2001) influential work from Niger, describing bare shelves and hollowed-out health centres 'empty of medicine'. Resource scarcity also affected health workers and their strategies for providing birth care and so affected how the policy of skilled attendance

was experienced on the ground. As Lipsky (1980) notes, the routines health workers establish, and 'the devices they invent to cope with uncertainties and work pressure, effectively become the public policies they carry out' (p. xii). According to Østergaard (2016), the occupational citizenship of Burkinabè primary health workers is formed by the fact that the 'kinds of health care services that could be delivered at these dispensaries were interventions independent of technology' (p. 255). Based on this context of deprivation, health workers in our study evaluated the adequacy and usefulness of guidelines and technical standards of birth care, as has also previously been reported from other parts of the country (Baker et al., 2012; Prytherch et al., 2013). Women's limited financial possibility to access a hospital birth and widespread teenage pregnancies were, for instance, realities that superseded guidelines to refer all women under the age of 18 to Banfora hospital.

Health workers also negotiated responsibility for death and disability, by routinely blaming poor pregnancy outcomes on women's and communities' practices and behaviours in and outside health facilities. Similar findings have been reported from Burkina Faso and other resource poor settings (Jaffre & Prual, 1994; Lange, Mfaume, & Blystad, 2018; Prytherch et al., 2013). In addition to material scarcity, non-compliant patients have been reported by Burkinabè primary health workers as a main obstacle to the provision of care (Østergaard, 2016). Blaming women and their non-compliant behaviour for poor pregnancy outcomes can also be seen as a way for health workers to justify the mistreatment of women as reported in this study. Threats or physical violence were seen as necessary to make women push harder during labour and fundal pressures were seen to solve complications of obstructed labour in a setting with no real possibility of hospital referral. It also seems reasonable to suggest that health workers use coercive methods such as verbal, economic and administrative sanctions deliberately to gain compliance from women with regards to facility attendance, as reported from South Africa (Jewkes, Abrahams, & Mvo, 1998).

Through monthly reports, the complex realities in the health centres were transformed into a set of standardised and comparable indicators (Merry, 2011). These reporting practices can be characterised in the words of Street (2012), as 'bureaucratic

technologies of visibility'. The health centre relationship to the state was articulated and negotiated through numerical targets and reports. Documentation and data standardise and render visible the activities carried out in rural health centres at the peripheries of the state and mediates access to recognition and material supplies such as medications. The production of data by frontline health workers is also a prerequisite for the state's ability to gain access to global health funding, as exemplified in the Senegalese data retention strike where health workers withheld routine data from the Ministry of Health (Tichenor, 2017). However, primary health workers in our study, as also reported from elsewhere in Burkina Faso, rather perceived their bureaucratic tasks as imposed on them or as 'a way of creating value for the state rather than for their patients' (Østergaard, 2016, p. 260). Documentation and reporting hence acted as disciplinary technologies in the Foucauldian sense (Ferguson & Gupta, 2002; Foucault, 1998), where targets formed both health workers' reporting and care practices (Rose & Miller, 1992).

Written records serve as sites where health workers negotiate how policies are translated into practice. They allow considerable room for discretion and manipulation from health workers (Hull, 2012; Suh, 2014). In this study, there were widespread discrepancies between the care reported and that provided. Through documentation practices both the quantity and the content of institutional birth care was amended. Reporting practices documented in this study produced an improved story about the institutionalisation of birth care. As reported from South Africa (Hull, 2012), paperwork also served to protect the health workers against accusations from district-level supervisors of poor working morale or clinical malpractice. Data fabrication was common and served as a tool to manage everyday challenges. It was a response to high demands, material scarcity, difficult working conditions and unsupportive supervision, as observed in clinical studies in sub-Saharan Africa, and in the context of performance-based financing in Burkina Faso, (Biruk, 2018; Kingori & Gerrets, 2016; Turcotte-Tremblay, Gali-Gali, De Allegri, & Ridde, 2017). The discrepancies between provided and reported care that we discuss in this study are seldom reflected in the knowledge produced in official reports, policies and guidelines, or in the public health

literature. As Olivier de Sardan and colleagues (2017) argue, these practices have considerable consequences. Policy responses based on such a flawed knowledge base may, in turn, produce remedial actions that are unfit to address and tackle systemic problems in health care delivery as experienced by women and health workers.

7.1.2 Patient negotitaions

Giving birth in Burkina Faso encompasses economic, social and physical risks for women and their families (Murray, Akoum, & Storeng, 2012; Storeng et al., 2008). Faced with fragile public health systems, women have been reported to employ different strategies to negotiate access to safe care at birth (S. Lange, D. Mfaume, & A Blystad, 2018; Spangler, 2011; Østergaard, 2015). In our findings, these strategies were not only aimed at receiving good quality care, but also formed ways in which sanctions imposed by health workers could be avoided. As reported by Østergaard (2015) from Eastern Burkina Faso, women employ different tactics to become worthy of future assistance by health workers (Østergaard, 2015). They invest in their relationship with health workers during ANC by presenting themselves as cooperative future patients, care for their ANC booklet and adhere to recommendations regarding ANC and place of birth. As also exemplified from Tanzania, bringing the required number of clean cloths and presenting gifts and informal payments were, also in this study, observed as entry points to receive the expected level of care at health facilities (Spangler, 2011).

ANC and delivery place compliance as documented through health cards was, in this study, important to avoid verbal, economic and administrative sanctions. As proposed by Street (2012), health cards are both governing and relational technologies for pregnant women, evoking Foucault's notion of bio-politics (Foucault, 1998). Health cards have been criticised for transferring responsibility for health outcomes from the welfare state to the individual, making it possible to govern pregnant women 'at a distance' (Cogburn, 2019; Rose & Miller, 1992). However, the health card or booklet also acts as a transactional device, that compels state institutions to provide requested services (Street, 2012). Through health cards, women can enact their biological citizenship and the care entitlements linked to it (Petryna, 2013; Pienaar, 2016).

Presenting a well-kept ANC card becomes a tool for women to transform themselves into worthy patients. As put by Street (2012), 'caring for and looking after a health card can thus be understood as a means by which people self-consciously construct themselves as patients who are visible to a state that is otherwise blind to their existence and needs' (p. 15).

Several studies, including ours, have documented how women do not declare their dissatisfaction, even in cases of abusive treatment during birth (Behague, Kanhonou, Filippi, Legonou, & Ronsmans, 2008; Cogburn, 2019). The asymmetric distribution of power between the poor illiterate women and the more educated healthcare providers may create so-called norms of passivity (Behague et al., 2008). Community members are largely dependent on the services provided by the local health centre, and they stand to lose their only access to health care if they challenge the local power structure (Goetz & Jenkins, 2002). In a setting where health workers see uncooperative and non-compliant patients as a major problem (Østergaard, 2016), women aimed to show subordination by 'rapidly following instructions to undress, to swallow pills and to say nothing unless asked' (Østergaard, 2015, p. 101). In line with Østergaard, I argue that women saw passivity as the best strategy to secure future care at the health centre (Østergaard, Bjertrup, & Samuelsen, 2016).

7.2 Numerical accountability for maternal health

7.2.1 Political numbers

The findings in this PhD study can be situated within the broader move towards accountability and measurement in global health in general, and more specifically in the field of maternal health (Storeng & Béhague, 2014). Quantitative objective evidence and cost-effectiveness evidence from interventions to reduce MMR increasingly form the basis of advocacy efforts by the safe motherhood movement (Storeng & Béhague, 2014). Through the MDG and SDG era, indicators have gained a chief seat at the table. Indicator-based data has been seen to render health

policymaking more objective, effective, and cost-effective. More importantly, the numerical truths on which policy making is increasingly grounded, are seen as less subjective and less dependent on political ideologies than other types of data. Similar trends to depoliticise poverty and inequity-related matters have been seen in the wider field of international development, which in the words of Ferguson (1990) have been characterised as the 'anti-politics machine'.

Although indicators are used to give an allure of certainty and objectivity to policies aimed at improving maternal health, they are both highly uncertain and highly political (Erikson, 2015; Melberg, Mirkuzie, Sisay, Sisay, & Moland, 2019; Storeng & Béhague, 2014). This PhD study has shed light on how global and state policies exert a strong hold on national healthcare and thus on its people through such indicators, Inspired by Fassin's (2009) 'politics of life', and call to 'insist on the issues involved in the way human beings are treated and their lives are evaluated' (p. 52), we have addressed the inequalities and differentiation entailed in the governmental technologies embedded in the policy of skilled birth attendance. In the focus on numerical increases and individual patient compliance, issues of structural inequalities in access to facility birth are forgotten. The ethnographic approach of this study has allowed us to explore the values involved when place of birth and maternal deaths are made political, and how they are produced, circulated and appropriated (Fassin & Brown, 2015, p. 9). Through sanctions towards women unable or unwilling to adhere to recommendations regarding institutional pregnancy and birth care, 'technologies of government produce inequalities of life but simultaneously erase their traces' (Fassin, 2009, p. 55). The inequalities produced by such sanctions are made invisible in policy evaluations.

7.2.2 Numbers and standardisation

Skilled birth attendance is an indicator used to measure maternal mortality on the assumption that skilled care at delivery has the capacity to reduce maternal deaths (Wendland, 2018). Our findings from health centres in Burkina Faso have showcased how the indicator of skilled attendance affects both our knowledge about birth care and

the ways in which health systems are governed. As eloquently put by Merry (2011), 'those who create indicators aspire to measure the world, but in practice, create the world they are measuring' (p. 21).

When health workers produce data on the care provided in health centres, they enable comparison of birth care in rural Burkina Faso to other localities across regions and states, 'at a distance' (Erikson, 2012). Data production involves a simplification and categorisation of provided care to fit into the prevailing numerical regime (Merry, 2011; Tichenor, 2017). Birth care that was in many ways incapable of identifying, managing or referring complications, and thus of preventing poor maternal and perinatal health outcomes, was categorised as 'skilled care', contributing to the growing proportion of births with skilled attendance in Burkina Faso. I argue that such numbers are too different from the realities of birth care in health centres to be 'meaningful representations' of skilled attendance. As indicated by Eriksson (2012), this does not change their role in the global health complex. The standardising and obscuring of context through indicators enables the burgeoning of universally applicable interventions and policies to reduce MMR (Olivier de Sardan et al., 2017) and the 'master narratives' involved in their production and dissemination (Nichter, 2008; Pfeiffer & Nichter, 2008).

However, metrics do not only enable comparison across contexts, they also frame our understanding of maternal health and the global health interventions that are worth investing in. As Adams (2016) writes, 'Metrics used today are imagined to offer uniform and standardized conversations about how best to intervene, how best to conceptualize health and disease, how best to both count and be accountable, and how best to pay for it all' (p. 6). Moreover, metrics are also used while assessing different policies, populations and behaviours. In the words of Suh (2019), metrics are 'one of the mechanisms through which global reproductive governance unfolds, and through which certain reproductive behaviours, identities, and interventions are valued over others' (p. 154). In her study of post-abortion care (PAC) in Senegal, Suh highlights how the improved PAC indicators such as the availability of syringes is translated into adherence to the prevailing rights-based discourses in maternal mortality reduction.

Through metrics, PAC patients are, in numerical narratives, portrayed as expectant mothers and, importantly, not women who seek to terminate pregnancy. Suh argues that these numerical narratives contribute to abortion stigma within and beyond health facilities (Suh, 2018). As seen in the public debate on post-abortion care in Burkina Faso (Storeng & Ouattara, 2014), the successes of PAC indicators produce a narrative that abortion-related MMR is successfully addressed through PAC, and are used as an argument not to reform abortion legislation (Suh, 2019). A similar line of reasoning pertains to skilled attendance and maternal mortality. I argue that the focus on the metrics of skilled attendance in the study setting contributes to the portrayal of non-compliant mothers and factors outside the control of health facilities as major causes of maternal mortality and disregards the inadequate quality of institutional care. Hence, through data production efforts, root health system problems are obscured and options for improving health care are prematurely foreclosed (Fordyce, 2014).

7.2.3 Numerical accountability

Together with transparency and governance, accountability has become a buzzword within international development and global health. The reliance on a growing number of indicators and a marked logic in the public sector to achieve accountability has catalysed what Strathern (2000) names an 'audit culture' globally, and also within the field of maternal health. Brinkerhoff (2004) defines accountability within a health system as 'the obligation of actors to provide information about and justification for their actions to other actors, along with the imposition of sanctions for failure to take appropriate action' (p. 372). Hence, accountability encompasses both answerability and enforceability (Goetz & Jenkins, 2002).

Accountability relationships exist between actors at various levels of governance and draw on different discourses. In the study setting, district-level supervisors constituted the only group that was able to claim accountability from frontline health workers by demanding results and enforcing desired actions. Patients and the local communities did not have such power. As Østergaard (2016) formulates, 'health workers perceived accountability as involving a relationship between the health workers and the district

supervisors that was mediated by the reports, rather than a relationship between the staff and the village health committee' (p. 258).

Although they are simply tools to measure progress towards the goal of improved maternal health, 'it is the indicators and quantitative targets that dominate progress reporting and demands for accountability' (Fukuda-Parr & McNeill, 2019, p.6). As Roalkvam and McNeil (2016) argued regarding policies to increase skilled attendance in India, the focus on performance accountability expressed in terms of the numbers of women giving birth at facilities, moves upwards from health facilities and creates a reversed accountability. Health professionals from frontline health workers to Ministry of Health officials, become accountable to global agencies and development assistance partners rather than to women in need of pregnancy and birth care. Similarly, in her ethnography of a South African hospital ward, Hull (2017) describes how institutional management was perceived as in conflict with individual patient care. As expressed also by health workers in our study 'bureaucracy is the object of complaint, the perpetual obstacle to achieving patient care' (Hull, 2017, p. 129).

In this study, the focus has been on frontline health workers' performance accountability, defined as 'accountability for the outputs and results of public agencies and programmes' (Brinkerhoff, 2004), in other words, the measurable outcomes of the services provided in maternity units. A single-minded emphasis on performance accountability, defined by Brinkerhoff (2004) as 'demonstrating and accounting for performance in view of agreed-upon performance targets' (p. 374), can modify the accountability between health workers and their superiors (George, 2009). The metrics produced about maternal mortality are tied to the kind of political legitimacy and global health funding that can be attracted from them. As Oni-Orisan (2016), exemplified from Nigeria, the metrics of health aid become a new form of governance where political legitimacy trickles down to decision making and accounting at the hospital bedside. The effects of indicators are, however, not limited to health workers. As seen in Malawi, village leaders and the community as a whole worked to increase institutional deliveries and to position themselves for future development investments by producing the right results in line with MDG 5 (Danielsen, 2017).

While studying primary health workers' documentation practices, one pitfall is to interpret all bureaucratic tasks as an expression of numerical accountability and as an obstacle to clinical care. Certain levels of paperwork are, of course, a prerequisite for health centres' ability to provide a continuum of care from visit to visit and from one care provider to the next, to allocate materiel resources and to monitor how clinical care is provided to patients. However, in a setting with enormous resource scarcity, the balance between administrative and clinical demands on health workers is fragile (Hull, 2012). This PhD thesis has exemplified how an over-emphasis on numerical forms of accountability affects health worker practices and patient care in primary health centres in Burkina Faso.

8. CONCLUSIONS

Skilled birth attendance (and, by implication, institutional births), forms the cornerstone of efforts to reduce the unacceptably high levels of maternal mortality still seen in resource-constrained areas. At the same time, it acts as the main indicator to measure progress in maternal mortality reduction. This PhD study has documented and analysed the links between the global policy of skilled attendance and actual practices of pregnancy and birth care provision in Burkinabè primary health care centres. The study has documented how the quality of the institutional care in these health facilities was severely compromised, how health workers employed sanctions towards women in order to increase use of institutional care and how the focus on indicators affected reporting practices. Drawing on ethnographic fieldwork in health facilities and communities in a context of extreme resource scarcity, the PhD constitutes a case study of how indicators in the field of maternal health have the power to 'create the world they want to measure'.

9. FUTURE PERSPECTIVES

9.1 Measuring the unmeasurable

Globally, skilled birth attendance is still the principal indicator used to capture progress towards maternal mortality reduction, even though it silences issues such as poor-quality institutional birth care and women's birthing experiences. The gap between the ambitions of the goal to reduce maternal mortality and the indicator of skilled birth attendance opens up a debate over the future role of metrics in maternal health. Is there a need for more numerical evidence, or simply other types of evidence? Many argue, paraphrasing Einstein, that 'What gets counted counts', and that further methodological developments and data production efforts should be made to propose indicators that better reflect the content and the quality of skilled care at birth (Wendland, 2018; Kruk, Gage, Arsenault, et al., 2018). However, as Merry (2019) cautions, and as this PhD has exemplified, there are inherent constraints on accurate knowledge resulting from the infrastructure of measurement in poor countries.

Others question the epistemic grounds of indicators in measuring progress in maternal health. As Yamin (2019) argues, the reliance on objective metrics of the MDG and SDG era has fundamentally obscured politics and ideology as root causes of social injustice. In her words, 'there is a danger that measurement based on abstracted data systematically obscures structural obstacles to achieving those rights, and displaces the political energy needed to combat injustice' (p. 52). This thesis has exemplified how there clearly is a need for contextual, qualitative information to nuance and balance numerical evidence in the quest for reduced maternal mortality.

9.2 Studying quantification

The shift from the MDGs to the SDGs marked a move towards increasing focus on indicators and quantification in the field of global health. With no fewer than 27

indicators to monitor progress towards the third sustainable development goal on health and wellbeing, quantification will be a central part of the global health complex in the years to come (United Nations, 2018). In their recent review of the sociology of quantification, Popp Berman and Hirschman (2018) argue that the study of quantification should cluster around four main questions: 1) What shapes the production of numbers? 2) When and how do numbers matter? 3) How do we govern quantification? And lastly 4) How should quantification be studied? Based on this PhD study, I propose that there is need for improved understanding of how and where indicators in the field of global maternal health are constructed, the workings of the bureaucratic or computational technologies and practices that make them possible, and lastly the mechanisms through which indicators are given meaning and the power to govern health systems.

10. LIST OF APPENDICES

Paper I

Paper II

Paper III

Ethical approval: Regional Committee for Medical and Health Research Ethics, Western Norway (REC Western Norway)

Ethical approval: Comité d'éthique pour la recherche en santé (CERS), Burkina Faso

Informed consent forms (available in Dioula upon request)

Interview and focus group discussion guides (available in Dioula upon request)

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12. APPENDICES

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RESEARCH ARTICLE Open Access

'We saw she was in danger, but couldn't do anything': Missed opportunities and health worker disempowerment during birth care in rural Burkina Faso

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Abstract

Background: Facility-based births have been promoted as the main strategy to reduce maternal and neonatal death risks at global scale. To improve birth outcomes, it is critical that health facilities provide quality care. Using a framework to assess quality of care, this paper examines health workers' perceptions about access to facility birth; the effectiveness of the care provided and obstacles to quality birth care in a rural area of Burkina Faso.

Methods: A qualitative study was conducted in 2011 in the Banfora Region, Burkina Faso. Participant observations were carried out in four different health centres for a period of three months; more than 30 deliveries were observed. In-depth interviews were conducted with 12 frontline health workers providing birth care and with two staff of the local health district management team. Interview transcripts and field notes were analysed thematically.

Results: Health workers in this rural area of Burkina Faso provided birth care in a context of limited financial resources, insufficient personnel and poorly equipped facilities; the quality of the birth care provided was severely compromised. Health workers tended to place the responsibility for poor quality of care on infrastructural limitations and patient behaviour, while our observational data also identified missed opportunities that would not demand additional resources throughout the process of care like early initiation of breastfeeding and skin-to-skin contact after birth. Health workers felt disempowered, having limited abilities to prevent and treat birth complications, and resorted to alternative and potentially harmful strategies.

Conclusions: We found poor quality of care at birth, missed opportunities, and health worker disempowerment in rural health facilities of Banfora, Burkina Faso. There is an urgent need to provide health workers with the necessary tools to prevent and handle birth complications, and to ensure that existing low cost life-saving interventions in maternal and new-born health are appropriately used and integrated into the daily routines in maternity wards at all levels.

Keywords: Childbirth, Primary healthcare, Quality of healthcare, (Sub-Saharan) Africa

Background

At the end of the Millennium Development Goal era, maternal and neonatal mortality rates remain unacceptably high in many countries in sub-Saharan Africa. In Burkina Faso, the lifetime risk of maternal death is one in 55, and about one in ten children will not survive their fifth birthday [1]. Whereas under five mortality has been declining during the last decades, neonatal mortality remains unchanged [2]. The time around birth is critical for both mothers and new-borns [3, 4]. Timely access to care at and around the time of birth is one of the main strategies to reduce maternal and neonatal morbidity and mortality [5, 6], as important is the quality of the care provided in health facilities [7]. Low quality facility birth care represents a missed opportunity to improve birth outcomes and increase the demand for facility birth care.

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There is a unanimous call for improved quality care to prevent maternal and child deaths, but little consensus on how quality in healthcare should be defined [8]. Campbell et al. divide quality of care into *accessibility of services* and *effectiveness of the services provided* [9]. Accessibility is ensured when users can access the health structures and processes of care which they need. Effectiveness is divided into clinical and inter-personal care and involves different dimensions of the health system such as the structure or organisation of the services, the process of care, and the outcome of the care provided [9]. These dimensions are interlinked; for example, in order to achieve desired outcomes such as decreased infection rates in a facility, the availability of structures such as water and soap for hand washing is a prerequisite, but does not by itself ensure that birth attendants wash their hands.

Since most women and new-borns are well, and only some develop complications, quality of birth care should be considered differently from other areas of care provision [10]. As it is difficult to predict birth complications, it is an expressed goal in the global health community that all women should give birth assisted by skilled birth attendants [5]. This implies giving birth with a provider with midwifery skills, trained in the management of normal deliveries and the detection and management of complications during birth with the ability to refer to a higher level of care when needed [5]. At all primary health care facilities, basic emergency obstetric and neonatal care (BEmONC) should be made available to treat complications. This includes the possibility to carry out the following six key functions: providing parenteral antibiotics, anticonvulsants, oxytocic drugs, removal of placenta and retained products of conception, assisted vaginal delivery and resuscitation of new-borns [11]. Effective transportation systems to facilities with comprehensive care, including competence to carry out caesarean sections and blood transfusions, are essential for timely treatment of complications [12].

Given the numerous definitions of quality birth care, a variety of frameworks have been suggested to assess this outcome [8]. Many focus on outcomes such as case-fatality rate and caesarean section rate, some focus on structure such as equipment and personnel available, fewer focus on the process of care. One reason for this could be that the gold standard for assessing process is direct observations of the provision of care, which is costly and time-consuming [8]. The meaning of quality of care also depends on the assessor's viewpoint. Users of health care would, for example, emphasize interpersonal aspects of care when evaluating the quality, whereas cost-effectiveness is a typical concern for managers [9, 13]. To gain knowledge about quality of care, the providers' perspective plays an important role since they are situated at the point of service delivery and are able to technically evaluate the quality of clinical care more accurately than users of services.

In Burkina Faso, it is estimated that 66 % of births take place in a health facility with a skilled attendant [1]. Out of pocket costs for delivery care have previously been reported to impoverish patients and their families and to constitute an important access barrier [14]. A national subsidiary policy for deliveries and emergency obstetric care was implemented in 2006, subsidising 80 % of the costs of care and providing free emergency transportation [15]. Other reported barriers to facility birth have been distance to health facilities and women's limited decision-making power within households [16].

The great majority of facility births in Burkina Faso take place in primary health centres (Centres de Santé et de Promotion Sociale). The data on outcomes of these facility births are suggestive of poor quality care; few are able to provide BEmONC and one prospective study found no difference in perinatal death risk between home-based and institutional deliveries [17, 18]. Studies of the quality of care provided in health centres have shown limited knowledge and compliance with guidelines among health personnel, unavailability of necessary drugs and diagnostic tests, delayed provision of care and inadequate counselling about danger signs during pregnancy and childbirth [18–21]. Even so, women giving birth in these health centres report a high degree of satisfaction with the services provided [22].

We conducted an exploratory qualitative study in four primary health care centres. In line with Campbell et al.'s framework we focused on access to care and the effectiveness of clinical and interpersonal care. We explored health workers' perspectives on women's access to facility birth and safe birthing, the strategies health workers employed to provide quality care; and what they experienced as obstacles to the provision of quality birth care.

Methods

Study site

The study was conducted in the Banfora and Mangodara health districts in the South-western part of Burkina Faso with an estimated population of around 500 000 inhabitants. Situated in West-Africa, Burkina Faso is among the world's poorest countries, ranking 181th of 187 on the Human Development Index 2011 [23]. In the study area, cotton production, subsistence farming and animal husbandry remain the main economic activities. With annual rainfalls of over 900 mm, the region of Banfora is amongst the most fertile and the least poor in the country [24]. Literacy is low in the region, 80 % of the adult population in the two health districts is

considered illiterate. The main spoken language is Dioula; French is the official language, but is only spoken by those who have attended school.

The annual number of expected deliveries in the study area was 24 500 in 2011 [25]. At the time of the study, Banfora and Mangodara health districts had 39 primary health centres, usually with one dispensary and one maternity unit. Primary health centres referred women with obstetric emergencies to the regional referral hospital in Banfora town. The driving time from the health centres participating in the study to the regional hospital varied from five to 150 minutes. Not all health centres had access to an ambulance; some had to rely on private transportation.

Data collection

The fieldwork lasted from September 2011 to January 2012 and the data collection took place in four primary health centres in the Banfora region, combining participatory observations and in-depth interviews.

As we assumed that working conditions would differ between urban and rural areas and depending on the monthly number of births, one urban, one semi-urban and two rural facilities were chosen. The number of health workers in the health centres varied from two to 12. The number of births per month varied from three to 100. The infrastructure of the health centres also varied substantially. Some had electricity and running water, while in others health workers had to rely on their personal torches as the only light source and on water from wells situated up to one kilometre from the health centre.

The two rural health centres were relatively large units situated approximately 65 km from the Banfora regional referral hospital. No smaller rural health centres were chosen due to practical concerns such as availability of housing and transport during data collection.

The first author, at the time a third-year medical student, carried out the participatory observations, both day and night for 12 weeks; three weeks in each of the four primary maternity units. The researcher was present at the health centres from two to eight hours every day, and during 14 night shifts. During this period, more than 30 deliveries were observed, 21 deliveries during daytime and 13 at night. The observations were non-structured; the researcher followed the health workers at work, asking questions and helping out with small tasks like getting the necessary drugs and equipment ready for the health workers. She did not work autonomously, nor did she provide direct patient care. Observations and reflections were noted daily in a field diary, providing information about health worker-patient interactions; health workers' practices related to routine care such as pre- and postnatal consultations, reception and follow-up of women through first, second and third stage of labour as well as providers' perspectives about working conditions, access to and quality of care.

In addition, the first author conducted 12 in-depth interviews with health workers providing obstetric care. Health workers were purposively selected for in-depth interviews on the basis of informal conversations and caregiving during observations in the health facilities, as well as their levels of experience and training, to represent different views. Two of the interviewees did not work in the study health centres, but were selected to represent the view of health workers in small rural health centres where, for practical reasons, observations could not be carried out. The 12 interviewees were two registered midwives, three registered nurses, one enrolled midwife, four auxiliary midwives, and two outreach health workers. Three of the interviewees were male. The recruitment of participants was ended at the point of data saturation when little new information emerged from the interviews. In addition, two medical doctors in the health district management team were interviewed about policy implementation at the centre level. The interviews included open-ended questions about access to facility pregnancy and birth care, the quality of care provided, working conditions, and health worker performance. All co-authors contributed to the making of the interview guide, which was piloted for its suitability in facilities not participating in the study, the interview guides were modified in the course of data collection based on observational data. The interviews were conducted in French in a separate room at the interviewees' workplace, and lasted from 45 to 90 minutes. The interviews were recorded and transcribed verbatim.

Data analysis

After initial analysis during fieldwork, interview transcripts and field notes were analysed thematically. NVivo 9 software was used to code and organize the data (http://www.qsrinternational.com). Firstly, after being familiarized with the datasets, initial codes were generated. These codes were grouped into categories and subsequently into themes. For instance, having a single blood pressure measurement device at the maternity ward was coded as *shortage of equipment*. This code was grouped with other codes to form the category *insufficient infrastructure as a barrier to routine care*. This, and others were then again grouped into the theme *Barriers to quality routine maternal and new-born care*. The combination of participant observations and interviews allowed for methodological triangulation, cross-checking the observational and interview data during analysis for improved validity [26].

Ethical considerations

The study was approved by the national health research ethics committee of the Ministry of Health, Ouagadougou, Burkina Faso (Comité d'éthique pour la Recherche en Santé, CERS, No2011-9-57). Administrative clearance was granted by the regional health authorities in Banfora. Written informed consent was obtained from all interviewees. Verbal consent to participate at the care provision was granted by health workers for all observations. Health workers were asked to inform and ask all women in labour to consent to the researcher's presence. To ensure the informants' confidentiality, they are only referred to by their level of training throughout this paper.

Results

We will firstly examine health workers' perceptions about access to facility births and safe birthing. To explore health workers' perceptions of the effectiveness of the healthcare provided, we will secondly explore aspects limiting quality of routine care, and thirdly the management of birth complications within primary health facilities.

Access to facility births

Health facility as the only place to give birth

During IDIs and observations, health workers presented the health centre as the only safe and responsible place to give birth, and accused women not giving birth at the health centre of not being interested in 'the best for their infants', thus raising issues of responsibility. Some health workers claimed that home deliveries caused birth complications by the use of herbs and traditional medicine. Health workers reported that women and families arriving for vaccination after a home delivery were shameful, feared being scolded by health workers, and presented their excuses. Health workers emphasized that fundamental birth care such as the clean cutting of the cord, the timely detection of complications and the prevention of post partum haemorrhages by the routine administration of oxytocin during the third stage of labour could only be offered during facility births.

Reasons to give birth at home

Distance from the health centre was presented as the only acceptable reason to give birth at home. According to health workers, many women simply did not arrive in time, although some health workers suspected that this was due to the fact that women waited too long after the onset of labour to travel to the health centre.

> 'The women like to blame the home births on the distance. We cannot argue against that. Some say it was late at night. Others say that the child arrived while they were preparing to go to the health centre. There are also some that give birth on the way to the health centre, who would like to come, but give birth on the way to the health centre. Well, but sometimes I think that these women do not get up early enough.'
>
> Auxiliary midwife, IDI

Ignorance was perceived as the main driver for home births. According to health workers, it was more widespread for illiterate women or women living far away from the health centre to not yet understand the benefits of giving birth at a health centre. There was a general conception among health workers that informing the population at the health centre and in the communities to 'make them understand' the benefits of giving birth at the health centre was an important strategy for improving attendance rates.

Cost was not considered an issue since the introduction of the policy of subsidies for emergency maternal and neonatal care. All interviewees stated that the cost of a health centre birth was 900 FCFA (1.40 €), and that the population, with some few exceptions, were aware of the reduced price. Women coming to the primary maternity unit with complications after home births were observed not to benefit from the subsidy, but had to pay for the equipment and services provided. During interviews, health workers expressed how this policy was appropriate and justified considering the aim of increasing facility birth. They saw the reduced cost of facility delivery as an incentive that would make women give birth at the health facility, and informed women about it during antenatal care. In some health centres women giving birth at home were reported to receive emergency care for post-partum complication at reduced costs if she accessed care at health facility within 24 hours after birth. Otherwise she had to pay for the care provided. A health worker explained the practice in his health centre:

> 'Anyhow, the EmONC-policy does not cover that. When they [women with complications after home birth] arrive, we prescribe everything and they pay at the drug store.'
>
> *Auxiliary midwife, IDI*

Another important obstacle for facility birth, as perceived by health workers, was the limited privacy for women giving birth at the health centre. According to the interviewees, women tended to seek birth care at a late stage of labour to avoid neighbours from keeping track on the time spent at the maternity ward. According to health personnel, it was a sign of pride, especially in polygamous households, for a woman to endure the

suffering and not seek help until the cutting of the cord. Additionally, at the health centre, neighbours would come to enquire about the progress of labour and get to know if the woman took a long time giving birth. Through the windows, neighbours and other patients could also hear the patients' screams.

Perspectives on patient-provider interactions

Health workers expressed uncertainty when asked whether women were satisfied with the services offered at the health centre. They reported how women sometimes would give health workers blessings or small gifts to show satisfaction with the services provided. Otherwise, health workers found it difficult to know how women felt, as they did not show their dissatisfaction. How patients were received at the health centre was put forward as key to patient satisfaction, and as an area where health workers could improve their performance.

> 'A patient, when she is received in a good way, she is already satisfied, she is already cured. But if you receive her badly, no matter what you do for her, it is nothing.'
>
> Nurse, IDI

According to the study participants, the reception provided depended on the person on duty, which also was perceived to affect the attendance rate. It was seen as important to have good relations with local women and encourage them to come to the health centre to give birth. Some health workers emphasised the importance of being able to speak to the women in their local language to gain their trust. In many health centres women were reported to send relatives to see which health worker was on call before deciding the place of birth.

> 'They come because, often the women chose a person. When it is the auxiliary midwife, the women come to confide. We had one auxiliary midwife here, she had been here for long, over five years. She was part of the village. The women came to give birth with her. When she was here and was on call, the women came. When other staff members were here, they went elsewhere… Often, they sent someone, asking who was on call before coming.'
>
> Outreach health worker, IDI

The delivery of routine maternal and new-born care

Health workers in primary maternity units

Health centres (CSPS) were commonly divided into a dispensary and a maternity unit in two different buildings. Larger rural maternity units as well as urban ones were most commonly headed by a midwife. Other birth attendants observed to work independently with outpatient consultation and birth care in the maternity wards were nurses, auxiliary midwives and outreach health workers. Midwives were recruited after they completed 13 years of school, and received a three-year training. Auxiliary midwives and outreach health workers were recruited after they completed primary school and attended a two-year training. Whereas midwives and auxiliary midwives' curricula focused on maternal health care, outreach health workers curricula was reported by health workers to focus more on vaccination programmes and public health education. Some reported not having conducted a delivery before they were on duty alone and had to get assistance from the traditional birth attendant (TBA) in the village:

> 'This was my first delivery in my first post. The woman arrived, she was my neighbour. She arrived, I did not know anything. Luckily for me, my luck was that it was 23.40 at night. I went to the village, where there was a traditional midwife. I looked for her, and she came. We did, she showed me how I should attend a birth. We attended the birth, and after that I have being attending births. I have not had any problem.'
>
> *Outreach health worker, IDI*

Even though the expressed goal of the health district management during interviews was to have midwives in every health centre, this was not yet observed to be the case in small health centres where auxiliary midwives and outreach health workers constituted the majority of the maternity unit work force. Nurses typically worked in the dispensary unit during daytime, but assisted births when they were on call. Midwives and medical doctors did not, however, consider auxiliary midwifes and outreach health workers as able to ensure quality care at birth. One midwife characterized the auxiliary midwives curriculum as learning how to 'to pull out and put down babies', and argued that the auxiliary midwives curricula did not include the detection and management of birth complications. Members of the health authorities emphasized the need for continuous training for the large group of health workers working in the maternity units, but said that they did not have the capacity to supervise newly educated health workers. A medical doctor in the local health authorities explained:

> 'Because the number of students in the schools, they are too many. The training capacities are not adapted to the number of students and that is what we see in the field. We ask ourselves where these

people have been trained. But, what is done is done. They say you have got trained health workers, you have to do the best out of it.'

Medical Doctor, IDI

Limited compliance with clinical guidelines

In the maternity wards, several established standards of care as referred to by health workers during interviews were observed not to be followed. The researcher observed, with few exceptions, no skin-to-skin contact with babies after birth, limited surveillance during and after birth, and no hand washing between patients and procedures. These, and other national standards were communicated through the antenatal care booklet and posters produced by the Ministry of Health and displayed in the health centres. During interviews, non-compliance with clinical guidelines for routine maternal and new-born care was often mentioned, and explained by health workers by lack of time, inadequate infrastructures and everyday realities.

Health workers expressed that surveillance during labour competed with the delivery of routine care such as antenatal consultations, family planning consultations, immunization of infants and postnatal consultations as well as the surveillance of other women in labour. During nights, when routine care was not provided, health workers felt incapable of following the progress of labour with a partograph since they would be too exhausted for their routine tasks the following morning. Typically, at night, health workers were observed to ask the woman's relatives to wake them up when delivery was approaching.

'You see, she [the health worker] had five women in labour at once. Honestly, could she follow the process of labour correctly with partographs? It is difficult. One person assisting at five births cannot deliver quality birth care. You do whatever you manage.'

Midwife, IDI

In several health centres, health workers claimed that there were not enough beds, adequate lighting or toilet facilities for patients, which made post partum surveillance during the designated 72 hours difficult. Due to lack in health centre infrastructure, health workers therefore chose to let women return home shortly after birth; this was observed even one hour after delivery. During birth, the lack of running water, especially in rural units, was said to limit hand washing as well as the cleaning of equipment and the delivery room between patients. Some health centres were observed to be out of stock of several diagnostic tests, and were not able to provide urine tests to detect proteinuria (a sign of pre-eclampsia) and rapid HIV-tests during antenatal care. The researcher also observed a lack of smaller equipment, such as blood pressure measurement devices, scissors and foetoscopes, which also made the assurance of routine care difficult for health workers. In the urban health centre in the example below, blood pressure was only measured routinely during antenatal visits due to lack of equipment:

'We have a huge problem with equipment. We have only one blood pressure measurement device here [maternity ward], as you have seen. One needs it for the family planning, one needs it for the antenatal consultation, one needs it to look after the women after birth and one needs it in the delivery room. It is complicated.'

Midwife, IDI

The antenatal care booklet indicated when a pregnant woman was having a high-risk delivery, and should be referred to the regional hospital in Banfora to give birth. There were different clinical indications for referral such as previous caesarean section, age, parity and blood pressure. Many women were reported not to follow the health workers' advice due to financial constraints, and opted for a health centre delivery rather than going to the regional hospital. Primary health workers found some of the guidelines, such as age under 18 years at first delivery, as out of touch with local realities, and consequently were observed not to follow them.

'Primipara younger than 18 years, they said should be referred. But if we should take that into account I am not sure if we would have any births at the health centre level. It is not sure. Because the majority of our primipara they are 16 years old, 17 years old.'

Auxiliary midwife, IDI

Management of birth complications

Health workers found that birth complications such as postpartum bleedings, fresh stillbirths and delayed progress of labour were common, and related it to the women's hard manual work in the fields until the time of delivery. From certain villages, health workers reported, women would only come to the health centre in case of a complication. Several health workers stated that a proportion of stillbirths and neonatal deaths were caused by the behaviour of women; either they got pregnant too often, or they refused to push when the foetus was showing sign of distress during labour. During

interviews, health workers described how they would threaten the women with evacuations, caesarean sections, the possible death of the baby or with episiotomy by approaching scissors to the perineum in order to make the woman push and thus save the baby.

> 'The women here are capricious, they refuse to push. Even when the amniotic liquid is coloured they refuse. I say push, or you will lose your baby. Or I tell them that they would have to go to Banfora [regional hospital]. Sometimes I even go to the consultation room to get the reference card. When I show them the reference card, they say to themselves that they do not want to go to Banfora, and they push better.'
>
> Auxiliary midwife, IDI

Referral as first choice for health workers

All interviewees agreed on the fact that complicated deliveries should not be managed at the health centre level, but referred to the regional hospital in Banfora. At the health centre there was only a limited possibility to manage complications due to lack of competences and equipment. In many cases, families were reported to be unwilling to refer the woman because of the costs implied with the evacuation and the uncertain reception at the regional hospital. During observations outside the urban area of Banfora, the woman's family was perceived to be responsible for finding a car or renting a minibus, and for paying the costs of the referral. Although health workers reported to be able to convince the family to go in most cases, some families decided to stay at the health centre against the health workers' advice as exemplified below:

> 'If you tell them they have to go to Banfora [regional hospital], some ask you to try to manage the situation here. I got the opportunity to ask a man why. He told me that he had accompanied his brother's wife to Banfora, and after what he saw there, he preferred that his wife stayed here. We said no. It was a prolapse of the umbilical cord alive with heartbeats and a cephalic presentation, which we are instructed to refer. The husband said no, if the woman survives and only the child dies, it will not be a problem. That he prefers to stay at the health centre and that the woman gives birth, losing the child rather than going to Banfora. At that time, we did not have an ambulance. If he found the money to go to Banfora, the woman could still lose the baby on the way to Banfora. … They did not leave. The following day she gave birth to a fresh stillborn. When they were leaving, the husband kneeled, and thanked us. The woman also thanked us.'
>
> Auxiliary midwife, IDI

Delayed detection and transport

Health workers felt insecure about their own training and their ability to detect and handle obstetric emergencies when these occurred. One midwife heading a rural maternity unit claimed that the auxiliary midwives' limited ability to examine the pelvis had several times lead to delayed identification of women in need for a caesarean section, with the consequence of foetal death. During observations of birth care, the partograph was not used a single time by health workers to monitor labour, regardless of level of training. Limited surveillance and knowledge about birth complications contributed to a delayed evacuation according to this auxiliary midwife working in a rural centre:

> 'Sometimes, the woman arrives early in labour, but only afterwards you figure out that there is a complication. For example, once I received a woman here. She arrived around 1 am at night. She stayed until 1 pm, then I discovered that she was bleeding, even though she had not yet given birth. So, I called the chief nurse. He told me that the woman had signs of uterine rupture. We referred her. Unfortunately for us, she had a uterine rupture before arriving to Banfora. She arrived early, but we did not manage to detect the complication early enough.'
>
> Auxiliary midwife, IDI

When having detected an emergency and a need for referral, the transport options were observed to vary a lot between health workers working in urban or rural health centres. Referrals in urban and semi urban areas were according to health authorities as well as health workers provided free of charge by the fire brigade (Sapeurs-Pompiers) with little waiting time. The rural health centres' ambulances were observed to be in bad shape, and often did not function at all. Alternative means of transport were sought. Health workers conveyed that they advised women to leave on motorcycle or by bus. If the woman's life was at risk, health workers stated that it was possible to call the regional hospital and get them to send an ambulance. The auxiliary midwife's account of the woman with the uterine rupture continues:

> 'The departure time causes problem. At that time the ambulance was out of order. We had to call Banfora [regional hospital], and then we had to wait.'
>
> Auxiliary midwife, IDI

Health workers felt that they had limited abilities to manage complications while waiting for emergency

transport. Even though they knew that it was not recommended, several health workers felt that they had no other options but pushing on the woman's stomach with all their weight or giving oxytocin injections in cases of delayed labour. Such practices were also several times observed in the health facilities. Several interviewees reported how they felt disempowered, as they were forced to wait for emergency transport without being able to help the woman in any way, as exemplified in the same case as above:

> 'We called the regional hospital, and they sent us an ambulance for her. We had to wait, we could not do anything. We saw that she was in danger, but couldn't do anything. So we waited for the ambulance until 8 pm, for seven hours. We had no ambulance, what could we do?'
>
> Auxiliary midwife, *IDI*

Discussion

Disempowerment of health workers

In resource poor settings, where comprehensive emergency obstetric and neonatal care is inaccessible, primary care is used as a strategy to provide birth care to all [8]. One of the main roles of primary care at birth is to detect and refer complications when these occur. The accounts of birth care providers in rural Burkina Faso reveal how health workers' ability to assure timely detection and management of birth complications is severely limited. It has previously been documented that few of the primary health centres in Burkina Faso are capable of assuring BEmONC functions, especially assisted vaginal deliveries and removal of retained products [20]. In this study, health workers reported that women prefer staying in primary centres rather than being referred to the regional hospital for fear of unmanageable out-of-pocket costs. To prevent maternal and new-born morbidity and mortality and limit the number of referrals, all BEmONC services need to be provided at the health centre level.

Even though emergency transportation should be provided free of charge according to the subsidy policy, this was not the case in the study area. Access to emergency transport has also been a concern in other regions [22]. The combination of limited possibilities to manage complications at the health centre and little or no access to emergency transport made health workers into disempowered bystanders when life-threatening emergencies occurred. We argue that the despair of health workers faced with obstetric emergencies made them resort to alternative and potentially harmful strategies.

Missed opportunities in the process of care

Clinical care

Previous studies have shown that users' of institutional deliveries in Burkina Faso evaluate the clinical care provided as of good quality [22, 27], but patients have a limited ability to evaluate technical performance, and great discrepancies between reported and observed birth care have been shown [18]. Health workers in this study reported severe technical weaknesses in the surveillance of women in labour, routine hygiene and the management of complications. There was a continuous lack of material supplies, staffing and competences of staff within the health centres. These findings are not new nor unique for Burkina Faso [7, 28, 29], and are in line with the findings reported from the QUALMAT study conducted in the North-western part of the country [20, 30].

Health workers perceived several clinical standards and protocols available in the health centres as not relevant for their particular contexts, but as something you would do in an 'ideal world'. This is in line with previous findings from Burkinabè primary health centres [30]. This non-compliance with set guidelines could be interpreted as a 'know-do' gap, but it may be more fruitful to discuss health workers' ability to follow basic quality-promoting guidelines within a health system that is severely constrained in terms of both material and human resources. It has been shown that frontline health workers in Burkina Faso have limited access to clinical practice guidelines for maternal health, and that these are found to be of limited use [31]. Successful implementation of clinical guidelines depends on the guidelines themselves, their implementation as well as health worker, patient and environmental characteristics [32]. In a setting where health worker competences are seen as limited, there is an even larger need for clinical practical guidelines that are adapted to local realities.

It is important to note that certain aspects of substandard clinical care were not directly explained by insufficient infrastructure. Interventions that did not require additional costs such as skin-to-skin contact after birth to avoid hypothermia and early initiation of breastfeeding were not being routinely practiced in the health centres. Such low- or no-cost interventions constitute missed low-hanging fruits to substantially improve new-born health [18, 33]. In the study setting, we believe that the limited training of auxiliary midwives and outreach health workers practicing in the maternity units contribute to a limited knowledge of the importance of such interventions. In resource-poor settings such as the study area, there is a particular need for continuous training of health workers with a focus on interventions that do not require additional cost, time or resources.

Inter-personal care

Although health workers acknowledged that access to facility birth care depended on geographical factors, inter-personal care and structure of facilities, the health centre was presented as the only responsible place for a woman to give birth. Women who give birth at home were seen as less invested in the well-being of their babies. Similar attitudes among health personnel have been described elsewhere [34]. Such attitudes could be linked to the practice of blaming women for poor pregnancy outcomes [30]. These findings resonate with Douglas' writings about risk and blame. According to her, risk is inevitably moral, and every poor outcome chargeable to someone's account. This implies a 'combination of moralistic condemning the victim and an opportunistic condemning [of] the victim's incompetence' [35].

The blaming of women for poor pregnancy outcomes can also be seen as a way for health workers to justify the mistreatment of women reported in this paper. Threats of poor outcomes for women and their babies, lack of confidentiality, neglect of women in labour, unwelcoming and poorly trained health workers, are all part of the larger problem of the mistreatment of women during labour [36]. It is evident that a health system deprived of resources may contribute to health worker behaviour, but it also seems reasonable to suggest that health workers utilize coercive methods deliberately to gain compliance from women, as reported from South-Africa [37].

Being blamed and mistreated for not using the services as prescribed by health workers, has implications for the utilisation of services and the overall trust in the health system [38]. The practice of sending a family member to find out who is on call, indicates that patients place their trust in individual health workers rather than in the health care institution, in this case the government health centre and its referral system [39]. In this setting, the high turnover of health workers may partly explain the problem of trust and may represent a barrier to the accessibility of care. Keeping health personnel in rural areas is a challenge for most countries' health systems [40]. Although not explored in our findings, gifts of satisfaction to health workers have elsewhere been linked to the expectation of better treatment in the future, and thus interpreted as an element of bribery [41]. The practice of gift giving implies an additional cost for women and their families and is thus perceived as a threat to equal access to facility care. At the same time, such informal payments constitute an important source of income for health workers in low resource settings, and contribute to the retention of health workers [42]. In Burkina Faso, it has been shown that it is particularly hard to keep female health workers in rural areas because of lack of basic infrastructure such as water, electricity and schooling opportunities for their children [30].

Methodological concerns

This study reports from four health centres in a rural part of Burkina Faso. Although substandard quality of care in primary health facilities in Burkina Faso previously has been documented [18, 19], the emphasis on frontline health workers' and managers' perspectives provides additional insight into the dynamics within primary health facilities providing birth care. Through observations and interviews with providers, we gained knowledge of providers' perspectives on accessibility of services and the three components of health care effectiveness: the structure of care, the process of care and the outcomes of the care provided [9], and how these dimensions interact. This paper explored only providers' perspectives; when users' perspectives are presented, they are only seen through the lens of the providers of care.

As a young female student, the observer was perceived as a subordinate to the staff and was accepted in the ward, which facilitated participatory observation. However, social desirability bias may have influenced study participants both to describe and to perform best practices in the researcher's presence. With no prior clinical experience from her home university and not having completed courses in obstetrics or paediatrics, she was only able to assess the health workers' performance based on limited theoretical knowledge and nationally established guidelines as communicated to local health workers and was not able to provide advice on patient care. As the researcher experienced and developed an understanding of the practical constraints to the provision of quality care experienced by health workers, such as lack of water, electricity, referral possibilities and necessary drugs, her presence at the health centres may positively have influenced the interpretation of health worker actions in the findings. Staying for several weeks in each health centre, the health workers may have forgotten the observer's role as a researcher and disclosed issues that they may not have revealed during formal interviews.

The observer did not understand the local language. This was a limitation when observing the patient/provider interaction and when the interaction between health workers took place in Dioula. When needed, the researcher asked health workers to explain to her in French what was happening.

The findings are limited to four health centres in the Banfora area and cannot be generalised beyond these study sites. However, the health centres in the study are subjected to the same health policy and the same health system culture and resource scarcity as health centres in

other parts of Burkina Faso. Furthermore the services are provided in a socio-economic context with high levels of poverty and illiteracy which are not much different from other rural areas in the country. There is therefore reason to believe that the findings are relevant also in other rural health care settings in Burkina Faso.

Conclusion

Quality of care as defined by Campbell et al. [9], which comprises both access to and effectiveness of the clinical and interpersonal care provided, was seriously compromised in the health centres in Banfora. The combination of limited abilities to manage birth complications and limited possibilities to refer women in need contributed to health worker disempowerment. Health workers tended to place the responsibility for poor quality of care on infrastructural limitations and to blame poor pregnancy outcomes on patient behaviour, while observation data also identified missed opportunities throughout the process of care that would not demand additional resources to address. There is an urgency to address the mistreatment of women during labour and to provide health workers with the necessary training both in midwifery skills and in respectful care. Basic infrastructure and the possibility to refer women to higher level of care are prerequisites to prevent and handle maternal and newborn complications. Implementation research is needed to guide action on how to ensure that low cost life-saving interventions such as skin-to-skin-contact after birth and early initiation of breastfeeding are employed at all levels of care.

Abbreviations

BEmONC: Basic Emergency Obstetric and Neonatal Care; CSPS: Centre de Santé et de Promotion Sociale (Primary health centre); HIV: Human Immunodeficiency Virus; IDI: In-depth Interview

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Availability of data and materials

The data will not be made available in order to protect the participants' identity.

Authors' contributions

AM participated in the design of the study, conducted observations, in-depth interviews and analysis and drafted the manuscript. AHD participated in the design of the study, the data collection and helped to draft the manuscript. TT participated in the design of the study and critically revised the manuscript. KMM participated in formulating the research questions, the data analysis and helped to draft the manuscript. All authors read and approved the final manuscript.

Competing interests

The authors declare that they have no competing interests.

Consent for publication

Not applicable.

Ethics approval and consent to participate

The study was approved by the national health research ethics committee of the Ministry of Health, Ouagadougou, Burkina Faso (Comité d'éthique pour la Recherche en Santé, CERS, No2011-9-57). Written informed consent was obtained from all interviewees. Verbal consent to participate at the care provision was granted by health workers for all observations. Health workers were asked to inform and ask all women in labour to consent to the researcher's presence.

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RESEARCH ARTICLE

Reflections on the Unintended Consequences of the Promotion of Institutional Pregnancy and Birth Care in Burkina Faso

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Abstract

The policy of institutional delivery has been the cornerstone of actions aimed at monitoring and achieving MDG 5. Efforts to increase institutional births have been implemented worldwide within different cultural and health systems settings. This paper explores how communities in rural Burkina Faso perceive the promotion and delivery of facility pregnancy and birth care, and how this promotion influences health-seeking behaviour. A qualitative study was conducted in South-Western Burkina Faso between September 2011 and January 2012. A total of 21 in-depth interviews and 8 focus group discussions with women who had given birth recently and community members were conducted. The data were analyzed using qualitative content analysis and interpreted through Merton's concept of unintended consequences of purposive social action. The study found that community members experienced a strong pressure to give birth in a health facility and perceived health workers to define institutional birth as the only acceptable option. Women and their families experienced verbal, economic and administrative sanctions if they did not attend services and adhered to health worker recommendations, and reported that they felt incapable of questioning health workers' knowledge and practices. Women who for social and economic reasons had limited access to health facilities found that the sanctions came with increased cost for health services, led to social stigma and acted as additional barriers to seek skilled care at birth. The study demonstrates how the global and national policy of skilled pregnancy and birth care can occur in unintentional ways in local settings. The promotion of institutional care during pregnancy and at birth in the study area compromised health system trust and equal access to care. The pressure to use facility care and the sanctions experienced by women not complying may further marginalize women with poor access to facility care and contribute to worsened health outcomes.

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Background

Despite a steady decline over the past few decades, maternal mortality continues to be a global health concern: an estimated 303, 000 women died from pregnancy-related complications in 2015, the majority living in resource poor settings [1]. The Millennium Development Goals (MDGs) sought to address and channel support for women's health through MDG 5, aiming to reduce the burden of maternal deaths by three-quarters by 2015 compared to the 1990 figures [2]. Because measuring maternal mortality is difficult, the proportion of women giving birth with skilled health personnel has been used as an indicator for progress towards MDG 5 [3].

The policy of institutional delivery aims to provide every woman with skilled attendance at birth, and has become the cornerstone of actions aimed at monitoring and achieving MDG 5 [4,5]. Giving birth in health facilities is generally accepted to equate with skilled attendance, and be the most effective measure to reduce maternal and early neonatal mortality [4,6]. Identifying and implementing feasible strategies to increase the proportion of women giving birth in a health facility remains a major concern for researchers and policymakers on the global, national and local levels. The strategies to improve the access to and utilization of facility delivery services include distance and costs, but also improved user satisfaction as a result of enhanced quality of care within the facilities [6,7].

Efforts to increase institutional births have been implemented worldwide, and constitute a global social action that aims to reduce maternal deaths. The focus on institutional birth care has been criticized for its unintended impacts on policies and practices at global, national and local levels [8,9]. Merton's classic paper "The unanticipated consequences of purposive social action" provides a framework to guide our understanding and analysis of some unexpected effects of MDG 5 [10]. Unintended implications of the institutional birthing policy can be divided into consequences for actors, such as the health system, patients and their families, and also for communities as a whole, since social actions have the potential to influence social structures and cultures [11]. Among the unwanted effects on the global level is the narrowing from a broad agenda of sexual and reproductive health rights to the number of institutional births [8]. Nationally, this goal has been criticized for obscuring the quality of care provided when women give birth in health facilities. At local levels, the pressure to meet performance indicators and report increased numbers of institutional deliveries has pushed health workers to report incorrect data and led to efforts to convince women to use the services 'correctly' [9,12].

In the wake of MDG 5, the research agenda has focused on how to increase the number of facility births, but has to a lesser degree explored users' experiences and perceptions of the promotion of the institutional birthing policies: How are these institutional care policies promoted to users and how do communities experience this promotion? Furthermore, what are the potential implications for women who do not comply with the norm of institutional care? This paper explores how communities in rural Burkina Faso perceive the promotion and delivery of facility pregnancy and birth care, and how this promotion is perceived to influence healthcare-seeking behaviour.

Subjects and Methods

Study setting

Situated in West Africa, Burkina Faso is among the world's poorest countries and has a high burden of maternal deaths, with an estimated maternal mortality ratio of 400 per 100 000 live births in 2013 [13]. In Burkina Faso births with skilled attendants take place in health facilities

with few exceptions. Hence, the promotion of facility care has been the core effort aiming to reduce maternal mortality. A primary objective in the Ministry of Health's (MoH) strategic plan to reduce maternal mortality is to increase the proportion of women giving birth with skilled assistance from 50 to 80% between 2006 and 2015 [14]. Among the factors that limit the utilization of facility care during pregnancy and at birth in Burkina Faso are distance to the health facility, financial constraints, and women's limited decision-making power [15–17]. In this context, a subsidiary policy for pregnancy and birth care has been implemented since 2006 to reduce financial barriers to facility care [14,18]. Poor quality of care in primary health facilities has also been proposed as an explanation of frequent home births, nevertheless users' assessment of care remains largely favourable [19–22].

The study was conducted in two health districts in the South-Western part of Burkina Faso, Banfora and Mangodara. The annual number of expected deliveries for these health districts in 2011 was 24 500 for a population of approximately 500 000 [23]. The proportion of deliveries taking place with a skilled attendant was 67% in Banfora and 59% in Mangodara [23]. At the time of the study, the area had 39 primary health centres (*Centres de santé et de promotion sociale*, *CSPS*) and one regional referral hospital in Banfora town. In the study area, subsistence farming is prevalent and maternal literacy remains very low. A cohort study among pregnant women in the area indicated that 83% had never attended school [24]. The main spoken language is Dioula.

Data collection

The data collection lasted from September 2011 to January 2012, as part of a study on the quality of facility birth care in four health centres in the Banfora region. Assuming that facility care would differ between urban and rural areas and also taking into consideration the monthly number of births, one urban, one semi-urban and two rural facilities were purposively selected to achieve maximum diversity. According to health district data, the health centres had an assisted delivery rate varying from 48 to 77% [25,26]. The health centres varied in size, and had from 2–12 health workers with different levels of training. Their infrastructure also varied substantially; some had electricity and running water, while others relied on torches as the only source of light; and water was provided from wells situated up to one kilometre from the health centre.

A total of 21 in-depth interviews (IDIs) and 8 focus group discussions (FGDs) with women who recently experienced childbirth, their partners and community members were conducted, Table 1. A research assistant trained in sociology and fluent in Dioula and French recruited the participants in the IDIs and FGDs. She was assisted by community health workers in semi-urban and rural communities in the areas covered by the four health centres. Participants were purposively selected for the interviews, on the basis that they or their partner had given birth within the last three months. The age of the interviewees ranged from 18 to 42 years, they had none to 13 living children, and lived from one to 20 km from their local health centre. A good

Table 1. Overview of IDIs and FDGs.

In-depth Interviews: (A total of 21)	13 women with a recent health centre birth
	5 women with a recent home birth
	3 partners
Focus group discussions: (A total of 8)	4 groups with female participants
	3 groups with male participants
	1 mixed-sex group

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majority relied on subsistence farming, and only a handful had attended school. The recruitment of informants ended at the point of data saturation.

Both IDIs and FGDs were conducted in Dioula; AM conducted the IDIs with the research assistant as an interpreter, while the research assistant facilitated the FGDs in Dioula with AM as an observer. The IDIs took place in the interviewees' home, while the FGDs took place outdoor in a public place in the community where the participants lived. Both IDIs and FGDs lasted between 45 and 90 minutes.

The interview guides included open-ended questions about practices during pregnancy and childbirth, the place of birthing and the personal, as well as community perceptions on the care provided in the health centres, S1–S3 Interview Guides. The co-authors contributed to the development of the interview guides, which were translated from French to Dioula by a certified Dioula translator. Both IDIs and FGDs were recorded and transcribed verbatim in Dioula before translation into French.

Data analysis

During fieldwork, AM carefully read the transcripts and discussed the meaning of the verbatim transcripts and the culturally embedded expressions with the research assistant. After data collection, the transcripts were examined by drawing upon qualitative content analysis [27]. After familiarization with the dataset, initial codes were identified in the interviews. These codes were grouped into categories and subsequently into themes. For example, the quote 'If you don't do the weighing [attend antenatal care (ANC)] she [health worker] will say "Why haven't you come to be weighed [attended ANC]. It's when your child is sick you're coming" She growls like that. She will care for you, but she will disrespect you while caring for you.' will be grouped into the category *imposing a sanction by use of verbal reprimands* and consequently into the theme *sanctions for not using the pregnancy and childbirth services as prescribed*.

Ethical approval

Ethical clearance was provided by the national health research ethics committee of the Ministry of Health, Burkina Faso (Ref 2011-9-57, Comité d'éthique pour la Recherche en Santé, Ministère de la Santé, Ouagadougou, Burkina Faso). The Banfora regional health directorate Chief and the Heads of Banfora and Magodara health districts provided administrative authorisations. As a great majority of the study participants were illiterate, the research assistant would read a written consent form in Dioula before signed or thumb-printed informed consent was obtained from all interviewees. When names have been used, these were changed to preserve anonymity.

Findings

During analysis, three main themes emerged: 1) The health centre as the only place to give birth, 2) Sanctions towards women not using the pregnancy and childbirth services as prescribed, and 3) Communities as incapable of questioning health worker practices.

'There is only one place to give birth'

When enquiring about possible places to give birth, participants started out by only mentioning the nearby health centre, and underlined the fact that it was the only place a woman could give birth in the area. This also applied for women having had a recent home birth, and for women that would prefer to give birth at home for their future pregnancies. Study participants

stated that the authorities, health workers and community members discouraged home births. Many stated that all pregnant women had an obligation to give birth at the health centre.

> 'We shouldn't give birth at home. A pregnant woman has to go to the health centre. For all my pregnancies I have been weighed four times [attended ANC] and given birth at the health centre.'
>
> Woman, IDI 8

According to participants, the nature of births had changed, with more complications, and a greater need for assistance nowadays. Home births were described as a result of not being able to deliver at the health centre for the following reasons: the labour was short, it was far to nearest facility, there was no access to transportation, and no money to pay for the hospitalization fees and medical prescriptions. Over time, facility births had become more available and common: giving birth at home was associated with the practices of older generations, regarded now as out of date. Many also mentioned how the reduced costs of facility births over the last few years facilitated access to care. Even though ANC was supposed to be free of charge and the price of a health centre delivery was officially 900 FCFA (1.4€) according to a newly implemented subsidiary policy, participants typically would report that they were charged 200 FCFA (0.3€) per ANC and 2000 FCFA (3€) for a facility delivery.

> 'Before there were some people doing deliveries at home, but now the authorities have told us that if your wife is pregnant, you should do everything to bring her to the health centre to give birth.'
>
> Man, FGD 2

Home births were associated with complications and participants linked home births to higher risks for both mothers and new-borns. This was explained by delayed detection and treatment of potential complications at home, but also by home births in themselves leading to complications. The participants stated that if the birth was not normal or complications occurred, help could only be sought at the health centre, where you could be referred to the regional referral hospital if necessary.

'They impose sanctions on you'

Health workers were reported to enforce the use of pregnancy and childbirth services by the use of different sanctions. These varied from health centre to health centre, and AM perceived them as local incentives rather than strategies implemented at the health district level. According to participants, health workers emphasized the importance of women going for four antenatal care visits and coming at an early stage of labour to reduce the risk of birth complications. Health workers enforced the prescribed use of the pregnancy and childbirth services at the health centre through verbal reprimands as well as economic and administrative sanctions. Although informants generally seemed dissatisfied with these sanctions, a number of women recently having facility births thought they were well justified.

The fear of verbal reprimands motivated the use of facility care since not complying with the recommended antenatal care visits during pregnancy would lead to verbal abuse. In addition to potential health benefits, it was seen as important to follow health personnel's recommendations to receive good treatment and avoid verbal reprimands. Women giving birth at home expressed how the woman, her husband and other family members accompanying her would be reprimanded when arriving at the health centre after a home birth or without having

attended antenatal consultations. This was perceived as a burden in addition to not receiving facility care:

> 'There are no advantages of giving birth at home. It is caused by the distance. If you go to the health centre [after a home birth] they bother you, they insult you. It is like your baby is a problem for them.'
>
> Woman, FGD 3

Our informants reported that they experienced being blamed for poor health outcomes since the health workers tended to explain birth complication in terms of patient or community behaviour:

> 'They tell us that our wives have to be weighed [attend ANC]. That we refuse our wives to leave home to go and get weighed [attend ANC]. That's why, they say, when our wives give birth, the births get complicated. But the health centre is far. That is why [our wives don't attend ANC].'
>
> Man, FGD 4

Participants described economic sanctions against patients that did not comply with recommendations. Several reported that women who came to the health centre after home births were asked to pay more than women who gave birth there. This was either done by charging the services directly at a higher price, by prescribing medications or costly additional exams.

Another example concerns emergency transportation. Some participants, especially males, perceived that health workers would be more inclined to refer women to the regional hospital if they had not adhered to the recommended antenatal care in pregnancy. This led to substantially higher costs, and was seen as a punishment in some cases. Although participants perceived costly additional tests/examinations, prescriptions and referral to the regional hospital as sanctions, our data does not allow us to argue that the interventions represented an expression of health workers' sanctioning unwanted behaviour rather than ordering medically justified interventions. However it does point to a problem of distrust in health workers. In addition, patients not complying with the antenatal care recommendations did not benefit from the free evacuation policy in case of complications:

> 'If the woman has been weighed [attended ANC] and gives birth to a premature and she has to be transferred to Banfora [regional hospital] it will not be a problem. The health centre will pay [the ambulance] . . . If she hasn't been weighed [attended ANC], and she gives birth to a premature at home and you bring them to the health centre. To be transferred to Banfora [regional hospital] they will charge you 15 000 francs [22.5€].'
>
> Male, FGD 4

Administrative sanctions were also put forward as a reason to give birth at the health centre, especially for the obtainment of birth certificates. These are essential for future health care, schooling and identification documents. Several participants stated that not giving birth at the health centre or not having the antenatal care booklet would make it impossible to get the child's birth certificate.

Economic, administrative and verbal sanctions were in some cases perceived to prevent women from seeking services, even when they were in need of facility care. The use of services as prescribed was regarded as an insurance in order to receive respectful and reasonably priced

treatment if complications occurred during childbirth or the mother or child were to fall sick afterwards.

> 'If a husband did not have the money to pay for the weighing [ANC], and the woman goes to the health centre to give birth, the health workers will growl at her because she did not attend the antenatal consultations. They will neglect her. If somebody sees that, they will not go to the health centre to give birth, but rather give birth at home.'
> Male, FGD 2

The non-use of services due to fear of sanctions was exemplified by the particular case of Aïcha, a young single woman. While the reasons she did not attend the antenatal consultations were unclear, she wished to give birth at the health centre. Her father's fear of being disrespected by health workers was reported as the obstacle for a health centre delivery:

> 'But if you don't drink water [attend ANC] you cannot give birth at the health centre. That's why'. . .

> 'You cannot go because of the lack of respect. I was told to go, but my father said no since I hadn't gone to drink water [attend ANC]. He did not want us to go, as it would cause him disrespect at the health centre.'
> Woman, IDI 16

'If I say that you're not doing a good job. . . will you care for me?'

Communities valued the services provided in health centres, but felt unable to evaluate them. When asked directly how they appreciated the services provided, participants were positive, although some were reluctant to evaluate the care that they received. Participants did not consider themselves competent enough, and that it was not the patient's role to evaluate the services, considering the superior knowledge and training of health workers. During ANCs, birth complications were said to be prevented by early detection and treatment of malposition of the baby as well as sickness of the mother and foetus. During birth, the advantages were related to detecting complications, the possibility of receiving injections to make the labour shorter and less painful and clean cutting of the cord. Access to neonatal vaccines was also one of the benefits mentioned in receiving care at the health centre.

> 'If you go there [the health centre], they give you a needle to give birth quickly. But at home you don't have that. That's why we want to go [to the health centre].'
> Woman, IDI 9

For communities situated far away from a health facility, having a health centre closer to their village was presented as the only way to increase use of facility care. Some expressed frustration that antenatal consultations were only available in the morning, thus making it difficult to attend. Using the childbirth services demanded effort from women and their families; having to walk for several hours and being away from home for more than 12 hours were commonly reported. Sometimes these efforts did not result in care at the health centre:

> 'Since we live far from the health centre, when we arrive for the consultation [ANC], they tell us that we arrive too late. They don't want to work. They say that the sun is high and when the sun is high the bleedings don't stop. They don't do the weighing [ANC], and you

return home. Another day, you go to the health centre again, and they refuse you once more. They will not wait for you. They bother us with that. We get tired.'
Woman, FGD 3

Common concerns regarding the care provided at the health centres were the waiting time for the antenatal consultation, and the availability of water, lighting and medications. A minority of the participants were clearly dissatisfied with the pregnancy and birth care provided at the health centre. One concern was confidentiality: giving birth at the health centre would lead to the community knowing how long the delivery lasted -having a quick delivery was seen as a sign of pride in the area. Others raised the issue of disrespectful treatment by health staff and that some health workers would say that the women smelt badly, made fun of their suffering or neglected the women by simply leaving them to themselves during birth.

'I gave birth at the health centre. They did not care for me. . . When I arrived at the health centre I found the health worker. He said it was the time of birth. He gave me a bed, then he closed the door and left. I did not know where he was. I gave birth alone.'
Woman, FGD 1

To avoid such disrespectful care at the health centres, different measures were taken by communities. In one village, family members were sent out to see which health workers were on call before going to the health centre for care. Another example was how women chose to give birth at home, then brought the baby to the health centre immediately afterwards saying that the delivery was quick. While the two previous examples illustrate strategies and agency to influence the care received, one father explained how conflicts with health workers over costs after home births led him to not bring his wives at all to the local health centre. When asked about other possible ways to influence the care received at the health centres, some participants stated that they feared complaints directed at health workers would have negative consequences for their future treatment at the health centre.

'If I say that you're not doing a good job, and if I'm the only one? to say so, the day I come for help, will you accept to care for me?'
Woman, IDI 10

Discussion

The study findings illustrate how facility based pregnancy and birth care was the dominant discourse, how the use of childbirth services was perceived to be enforced through the use of sanctions, and how community members, to a large extent, remained incapable of questioning facility-based practices. We will now proceed to the discussion, starting with examining MDG 5 on maternal mortality reduction as a global social action. Second, we will explore how the experience of sanctions at the health facilities has negative consequences for trust in the health system. Third, we will argue that the pressure to use facility pregnancy and birth care contributes to the further marginalization of women with poor access to facility care.

Promotion of institutional care as a global social action

Global policies articulate with national and local policies and practices in Burkina Faso, where the MoH has as an expressed ambition to 'Contribute to the achievement of the MDGs by accelerating the reduction of maternal and neonatal mortality' [14]. The country has

implemented the strategy to have a skilled provider attend 80% of all births, with the aim of reducing maternal mortality. In the study area, attending at least four antenatal care consultations and having a facility birth were heavily promoted by health workers. These services were described as essential by users, and are both used as indicators for the progress towards MDG 5 [3]. These will probably also measure progress towards the newly adopted Sustainable Development Goals (SDGs), although the list of indicators has not yet been approved.

Merton's concept 'imperious immediacy of interest' can help us unpack the effects of the promotion of facility pregnancy and birth care reported in this study [10]. The urgency of addressing preventable maternal deaths on global, national and local levels constitutes an immediacy of interest. Policymakers' and health workers' preoccupation with increasing the number of institutional births to reduce maternal mortality may divert attention away from other consequences of the policy and its implementation. The aim of increasing the number of women who give birth in a health facility and the methods employed to achieve this goal seem rational when seen in isolation. However, actions to increase institutional births may diverge from other important principles in public health, and with local values in the communities in which they are implemented, such as health system trust and equity. As the discussion proceeds, we will explore the unintended consequences of the promotion of institutional pregnancy and birth care by examining the values and interests affected in a rural Burkinabè context.

Unintended consequences for health system trust

Sanctions against women not using the health services as expected by health workers constitute a distortion of the global and national institutional birthing policy. It has already been reported how the demand for improving performance indicators in the field of maternal health makes health workers use persuasive and coercive strategies to increase facility care [12,28,29]. We propose that health workers' reported eagerness to increase the utilization of pregnancy and childbirth services is an expression of the pressure put on the entire Burkinabè health system to 'Contribute to the achievement of the MDGs' [14], and that the fear of sanctions plays an important role when women decide to seek facility care. The use of sanctions raises normative questions about the role of and inherent values in health systems. Use of facility pregnancy and birth care seems to have become an imperative rather than an offer, and health workers are seen by communities as enforcers of an unwritten law of institutional care. Users feel that they are left with no choice but to comply with health workers' recommendations to receive proper care and avoid sanctions.

Home births remained prevalent in the study area although institutional care emerged as the only acceptable option. According to government data Burkina Faso had an estimated home birth rate of approximately 25% in 2010, which might mean that home births are not solely the result of constraints, but also of preferences for traditional practices and/or dissatisfaction with treatment in health facilities [17, 23, 30]. A recent study from Zambia illustrates how difficult it is for communities to challenge the official norm of institutional care by saying that they prefer home births [31]. Women's reported satisfaction with, and preference for, facility pregnancy and birth care during interviews could be understood as an expression of the dominant discourse on institutional births, political correctness or passivity [32,33]. However, their expressed preference for facility care may also be associated with a belief in health facility as the safest place to give birth in medical terms and thus preferable, despite concerns about staff attitudes.

The asymmetric distribution of power between the poor illiterate women and the more educated healthcare providers may create norms of passivity, where users of birthing services do

not declare their dissatisfaction, even in cases of negative experiences [34]. In the few cases where community members contested sanctions or expressed discontent with the services, they feared conflicts with local health workers. Community members are largely dependent on the services provided by the local health centre, and they stand to lose their only access to health care if they challenge the local power structure [35]. Our findings suggest that the sanctions experienced by women and their families may work to increase institutional delivery among women with easy access to health services, but may also undermine health systems trust and further worsen access among already marginalised pregnant women.

Social suffering as an unintended policy implication

Actions that could be aimed to increase the use of services might become, in this context, obstacles to service utilisation for women with already poor access to care. Although the sanctions may have been locally implemented to increase the use of pregnancy and childbirth services, their complexity may nevertheless have the opposite effect. Aïcha reported not giving birth at the health centre due to the fear of verbal sanctions. Her baby died within hours after a home delivery lasting for more than a day. Although the cause of her baby's death, and her reasons for not seeking care remain complex, Aïcha's story raises questions of whether the practices aimed to increase the use of facility services and reduce maternal and newborn mortality exclude, rather than include, women in need. Maternal deaths are largely influenced by social context and young, rural, illiterate single mothers are at significantly higher risk of poor pregnancy outcomes [36,37]. Excluding already marginalized women constitutes an unforeseen and unwanted effect of the institutional birthing policy, where actions to increase the numbers of women receiving care in facilities conflicts with the principle of promoting health equity. This resonates with Merton's concern that the 'imperious immediacy of interest' may in unintended ways defeat the attainment of other fundamental values within communities and institutions [10]. We will, through Aïcha's story, now discuss how the pressure to institutionalize births may contribute to social suffering.

The social suffering framework helps us explore how political, economic, and institutional power influences access to care, and how these types of power impact policies and actions implemented to increase institutional births in the study area [11]. The framework takes particular regard to the poor and marginalized groups, which are, by historical and social disparities placed at the back of the line for high quality care [38]. We argue that sanctions may worsen health outcomes for the already marginalized in the name of improved maternal health. Due to existing power structures between mothers and providers, communities are unable to influence the use of sanctions; their only way to prevent bad treatment and/or economic sanctions is to withdraw from the health system. This is exemplified by Aïcha, as well as by the other women who choose to arrive just after delivery or not attend the childbirth services if certain health workers were on call. The fear of economic sanctions may even prevent communities from seeking care in case of emergencies. The use of sanctions will, in this way, lead to poorer access to health care for the women and infants in question, and worsen rather than improve their health outcomes. The pressure to institutionalize care may thus exacerbate health problems for women with limited access to facility care.

The sanctions described in our study may lead to worsened social outcomes for communities that already have poor access to services. For many rural women, like the participants not reaching the ANC clinic by foot before closing time, the non-use of facility services does not represent an intended choice. Rural women often cannot influence the factors constraining them from using the services as prescribed by health workers, namely distance to the health centre, financial constraints and limited decision making power within the household [39].

The perceived use of sanctions by health workers was not accompanied by any efforts to overcome access barriers, and could reflect an overestimation of women's agency. Furthermore, it implies blaming women for their poor health outcomes. Such practices of placing the 'responsibility' for ill health on the individual influences community perceptions about the 'right place' to receive care [40]. Economic sanctions, as practiced in the study settings, could further impoverish families not accessing care for various reasons. Imposing sanctions on women for factors they are unable to influence adds an unintended double burden with social stigma and/or increased financial constraints to the burden of not accessing health care.

For the study participants, frontline health workers are represented as the implementers of an institutional care policy with serious unwanted effects such as the sanctioning of women with poor access to care. However, it is important to keep in mind that the health workers in question operate within a health system of severe constraints under the pressure of a strong international discourse on institutional births. As Kleinman pointed out, the potential for harm lies latent in institutional structures, such as health systems, that are authorized to implement social actions. Even though the separate health centres remain the sites where unwanted effects are operationalized, it is the responsibility of policymakers both on a global and a national level to propose actions to reduce the unintentional harmful impacts of policy [11].

Methodological concerns

This study reports from four health centres in a rural part of Burkina Faso. Although the centres were purposively selected based on their diversity in terms of location, size and assisted birth coverage, one cannot rule out that there might be systematic differences between the study health centres and other health centres in the two districts. However, we do believe that the findings are also relevant in other primary health care settings in Burkina Faso.

AM, collected the data for this paper as part of her doctoral study, in each of the four primary maternity units. She did not provide patient care, but her and the research assistant's participation in clinic activities at the health centres might have contributed to her being perceived as a health centre representative, which may have biased participants' responses. The interpretation of the findings may have been influenced by AM's position as a European medical student, coming from a very different health system and culture in which patient rights, user involvement and choice are basic values. While throughout the research process AM tried to 'bracket' these values and remain open to the local conditions for health worker-patient interaction, her background and values may have made her particularly attentive to the adverse effects of the strong discourse on institutional delivery, and to the pressure to which individual women were exposed.

Conclusion

This paper documents that women in rural Burkina Faso and their families experience a substantial pressure from health workers to secure health facility childbirth. We suggest that the use of health facility at birth has been transformed from a recommendation to an obligation since women are negatively sanctioned if they do not comply. We argue that this is a perversion of the goal to provide skilled attendance at birth, and that it moves responsibility to use health facility at birth from the health system to the individual woman with limited power to overcome access barriers. Our study indicates that the implementation of the policy of skilled attendance at birth in Burkina Faso may undermine the trust in the health system and may counteract the overall goal to reduce maternal mortality for certain groups. However, the current study's exploratory approach does not allow us to draw conclusions on the prevalence of these negative impacts. The findings call for an increased research focus on, and policies to

address, the unintended local consequences of the preoccupation with institutional births as we enter the SDG era.

Supporting Information

S1 Interview Guide. Interview guide: Women with a recent facility birth.
(DOCX)

S2 Interview Guide. Interview guide: Women with a recent home birth.
(DOCX)

S3 Interview Guide. Interview guide: Focus Group Discussion.
(DOCX)

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Author Contributions

Conceived and designed the experiments: AM AHD TT KMM. Performed the experiments: AM AHD. Analyzed the data: AM ALR KMM. Wrote the paper: AM AHD ALR TT KMM.

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Policy, paperwork and 'postographs': Global indicators and maternity care documentation in rural Burkina Faso

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ABSTRACT

Targets and indicators set at the global level are powerful tools that govern health systems in low-income countries. Skilled birth attendance at a health facility is an important indicator for monitoring maternal mortality reduction worldwide. This paper examines how health workers negotiate policy implementation through the translation of clinical care into registries and reports. It does so by analysing the links between the global policy of institutional births and the role of documentation in the provision of birth care in primary health centres in Burkina Faso. Observations of health workers' practices in four primary maternity units (one urban, one semi-urban and two rural) conducted over a 12-week period in 2011–2012 are analysed alongside 14 in-depth interviews with midwives and other health workers. The findings uncover the magnitude of reporting demands that health workers experience and the pressure placed on them to provide the 'right' results, in line with global policy objectives. The paper describes the way in which they document inaccurate accounts, for example by completing the labour surveillance tool partograph after birth, thus transforming it into a 'postograph', to adhere to the expectations of health district officers. We argue that the drive for the 'right' numbers might encourage inaccurate reporting practices and it can feed into policies that are incapable of addressing the realities experienced by frontline health workers and patients. The focus on producing indicators of good care can divert attention from actual care, with profound implications for accountability at the health centre level.

1. Introduction

Despite decades of international attention, maternal mortality remains a major problem, especially in Sub-Saharan Africa. More than 300,000 women died from pregnancy-related complications in 2015, most of them living in low-income settings (Alkema et al., 2016). The majority of maternal deaths are avoidable because the direct causes of maternal deaths, and the medical interventions to prevent and treat these are well known (Ronsmans and Graham, 2006). Ensuring that all women have access to safe abortions as well as quality care at and around the time they give birth are essential for reducing maternal morbidity and mortality (Campbell et al., 2016). Because maternal mortality is inherently difficult to estimate in countries without reliable civil registration systems, skilled birth attendance has become an important proxy indicator for maternal mortality (Storeng and Béhague, 2017; Wendland, 2016). Skilled birth attendance is assured by a healthcare provider with midwifery skills who is trained in the management of normal deliveries and the detection and management of complications during birth, and who has the ability to refer to a higher level of care when needed (World Health Organisation, 2004). In most countries, women giving birth in healthcare institutions are considered to be provided with skilled attendance, although this is based on the sometimes questionable assumption of sufficiently trainined health workers and well-functioning referral systems (Campbell et al., 2016).

Since the launch of the Safe Motherhood Initiative in 1987, the global community has fostered a number of initiatives, policies and goals. Over the past decades, global efforts to reduce maternal mortality have been channelled through the Millennium Development Goal

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(MDG) 5 (2000–2015) and, after 2015, through the Sustainable Development Goal (SDG) 3.1, targeting maternal mortality reduction. These global initiatives have mobilised attention and funds. At the same time, they have narrowed the field of reproductive health and influenced national health system through a myopic focus on averting maternal *mortality* – rather than improving maternal *health* – in policies and interventions (Austveg, 2011; Roalkvam and McNeill, 2016; Storeng and Béhague, 2014).

Policies promoted in the field of maternal healthcare are often highly standardised, and they constitute what Olivier de Sardan et al. (2017) refer to as travelling models to be realised in the same format in many countries. The policy texts are presented as culturally neutral and they are expected to be implemented by frontline workers in healthcare institutions with great geographical, economic, political and cultural diversity (Blystad et al., 2010; Olivier de Sardan et al., 2017; Smith, 2001).

Global policy targets are powerful, and they can alter and incentivise nation states, health systems and women giving birth in several ways (Danielsen, 2017; Oni-Orisan, 2016; Roalkvam and McNeill, 2016; Storeng and Béhague, 2014). The global policy level is multifaceted with possible policy dynamics between various actors at different levels; it is far from being a permanent entity with well-defined actors, beneficiaries, mandates and ways of working (Ferguson and Gupta, 2002). The way in which policies formulated in the so-called global sphere are translated into country-level programmes is determined by the power of global actors and national governments. A country's degree of discretionary power over policy adoption is reliant upon its level of donor dependency, the functioning of its civil society and the availability of healthcare expertise (Sandberg and Justice, 2013).

In many settings, the successful implementation of policies addressing maternal mortality becomes a prerequisite for the nature of external financing and governance of weak health systems (Oni-Orisan, 2016; Storeng and Béhague, 2014). Development assistance partners tend to influence priority setting at all stages of the policy process including in the development of national and lower level policies, and in the monitoring and evaluation of their implementation where key indicators are used to measure the success or failure of policies and programmes (Khan et al., 2018). In a context where maternal mortality constitutes an important measure of social development and women's status, skilled attendance at birth also becomes an indicator of the success of the state vis-à-vis the international community, and it is often used to compare the performance of countries and regions (Oni-Orisan, 2016). These measurements can be helpful in monitoring progress, and policymakers and governments alike view them as a tool to stimulate improvements in maternal healthcare and, thereby, justify donors' investments (Storeng and Béhague, 2017).

The attention to targets might influence health workers' practices and sense of accountability within health systems (Coutinho et al., 2000). Strong performance accountability, which Brinkerhoff (2004, p. 374) defines as 'demonstrating and accounting for performance in view of agreed-upon performance targets', can modify the internal accountability between health workers and their superiors (George, 2009). Performance accountability can also modify the external accountability between health workers and women in need of birth care (Roalkvam and McNeill, 2016).

Health centres, as primary health care units constitute the interface between global technical norms around birth care, patients' practices and understandings, and health workers' actions influenced by professional and organisational factors (Jaffré and Suh, 2016). Frontline health workers provide services to the population within the framework of government policy, but with the ability to mould these policies through their discretion over which services are offered, how they are offered and the benefits and sanctions allocated to patients (Lipsky, 1980; Suh, 2014). As civil servants at the lowest level of government, and in direct contact with the general population, Lipsky (1980) refers to them as 'street-level bureaucrats'. Implementation and adherence to policy by front line health workers is negotiated through written registries and reports (Hull, 2012). One example of this is how Burkinabè health workers complete the partograph intended for labour surveillance after birth, thus transforming it into a 'postograph', to demonstrate bureaucratic compliance (Ridde et al., 2017). Therefore, an analysis of health workers' actions and inaction with regard to documentation practices is key to understanding policy implementation, especially in resource-deprived areas (Erasmus, 2014; Kaler and Watkins, 2001; Walker and Gilson, 2004).

The articulations between standardised policies, local healthcare systems and local health workers at the point of service delivery remain poorly understood (Olivier de Sardan et al., 2017). By examining the interfaces between policy and practice (Jaffré and Suh, 2016), this study aims to shed light on the links between the global policy of skilled birth attendance and the provision of birth care in health care facilities. The study is set in primary health centres in rural Burkina Faso, which struggle with high levels of maternal mortality and a donor-dependent healthcare system. We argue that the magnitude of reporting linked with global policies is burdensome and time consuming for health workers, and can compromise quality of care. In addition, the pressure to achieve measurable progress at the health centre level encourages inaccurate reporting practices among health workers. On an aggregate level this produces incorrect statistics on skilled attendance, which in turn feeds into inaccurate policies that do not serve the interests of women in need of pregnancy and birth care.

2. Methods

2.1. Study setting

Burkina Faso, a former French colony situated landlocked in West Africa, is among the world's poorest countries. It was ranked 183 out of 187 on the 2012 Human Development Index with over 40% of its population living below the poverty line (United Nations Development Programme, 2011). Maternal mortality remains high; in 2013 the estimated maternal mortality ratio was 400 per 100 000 live births (Kassebaum et al., 2013). In 2014, the health expenditure per capita was 82 international USD, which corresponds to 5% of the gross domestic product (GDP) (Word Health Organization, 2018). About one-fourth of the country's national health budget in 2009 was financed by external donors and channelled through the Programme d'Appui du Développement Sanitaire (Ministère de la Santé).

The Burkinabè healthcare system consists of four levels of health facilities in which the health centre (Centre de Santé et de Promotion Sociale) is the most basic unit responsible for the provision of preventive and curative primary healthcare services (Ministère de la Santé, 2011). Other facilities include district, regional and university hospitals. At the time of the current study 13 regional health directorates, divided into 67 health districts organised the country's 1443 primary health centres. Official health data is compiled in monthly reports developed at the health facilities consolidated into tri-annual reports by health districts and regional health directorates (Direction Générale de l'Informaion et des Statistiques Sanitaires, 2012). In accordance with the decentralised structure of the Burkinabè healthcare system, annual action plans are developed at every level (facility, district, region) based on the data reported. National level policies, such as the ten-year National Sanitary Development Plan and the Plan to Accelerate the Reduction of Maternal and Neonatal Mortality, are integrated into these action plans.

Facility-based or institutional delivery care has been the core national strategy to reduce maternal mortality in line with the MDG 5 target. To achieve this aim, the Ministry of Health set an ambitious goal of increasing the proportion of women giving birth with skilled attendance from 50% to 80% between 2006 and 2015 and to provide Basic Emergency Obstetric and Neonatal Care (BEmONC) in 80% of the

country's primary care facilities (Ministère de la Santé, 2006a). At the same time, the government implemented a policy to subsidise user fees for pregnancy and delivery (Ministère de la Santé, 2006b; Ridde et al., 2011) to reduce financial barriers and protect healthcare users against catastrophic healthcare expenditures (Storeng et al., 2008). Despite the country's policies to increase attendance, Burkinabè health centres and hospitals continue to be characterised by low quality birth care with a continuous lack of material resources and skilled staff (Duysburgh et al., 2013; Kouanda et al., 2016; Melberg et al., 2016a).

The current study was an exploratory follow-up to a breastfeeding promotion trial conducted in the health districts of Banfora and Mangodara, which revealed high levels of perinatal mortality with no significant difference in mortality between facility births and home births (Diallo et al., 2010). The study therefore set out to explore the quality of institutional birth care in health centres in the trial area (Melberg et al., 2016a). Documentation of care was not an initial study objective, but emerged as a crucial part of the everyday work of the birth care providers already after the first weeks of observation and interviews. As the fieldwork proceeded, the ways in which health workers' practices were negotiated through written texts, such as patient charts and reports, was gradually given more attention during the observations, in informal conversations with health workers and in formal interviews.

The districts of Banfora and Mangodara are located in the Cascades region in the southwestern part of Burkina Faso and are two of the more economically well-off and fertile districts in the country (Institut national de la statistique et de la démographie, 2010). Like elsewhere in Burkina Faso, cotton production, subsistence farming and animal husbandry constitute the main economic activities. The town of Banfora is the centre of the country's sugar cane industry, and in 2006 its population was approximately 75,000. Literacy in the study districts is low and in 2008 83% of pregnant women have never attended school (Diallo et al., 2011). Although the official language is French, the main spoken language is Dioula.

In 2011 the combined population of these two study districts was approximately 500,000 and the annual number of expected deliveries was 24,500 (Diréction Générale de l'Information et des Statistiques Sanitaires, 2012). The 39 primary health centres in the two districts were served by one regional hospital in the city of Banfora. In 2011, about 67% of the deliveries in both districts were institutional deliveries in comparison to the national average of 78% (Diréction Générale de l'Information et des Statistiques Sanitaires, 2012). According to official Ministry of Health data, the reported maternal deaths of the Cascades region (comprised of the three health districts Banfora, Mangodara and Sindou) was 182 per 100 000 live births compared to the national average of 128 per 100 000 live births. In the health district of Banfora, like the country as a whole, 27% of the population resided more than 10 km from the nearest health centre; in contrast, in the health district of Mangodara, over 60% of the population resided over 10 km from the nearest health centre.

2.2. A study of four health centres

Qualitative data were collected from September 2011 to January 2012 in four primary health centres in the Banfora and Mangodara health districts. Considering the difference between urban and rural health centres and the monthly number of births, one urban, one semi-urban and two rural facilities were purposively selected to achieve maximum diversity. According to health district data, the selected health centres had between 250 and 1500 births per year, and an assisted delivery rate varying from 48% to 77%. The health centres varied in size and in level of infrastructure. They had from 2 to 12 health workers, and half of the centres had electricity and running water. Three of the health centres were situated in the Banfora health district. The two rural health centres were relatively large units situated approximately 65 km from the city of Banfora. No smaller rural health centres were chosen due to practical concerns, such as the availability of housing and transport for the researchers during the data collection process.

The first author who was a third-year medical student at the time the data was collected, conducted the observations, for three weeks in each of the four primary maternity units. This resulted in a total of 12 weeks of observations. She was present at the health centres every day, and also attended14 night shifts. The observations were non-structured; the researcher followed the healthcare providers at work, asking questions and helping out with small tasks, such a getting the necessary drugs and equipment ready. The first author's young age and background as a medical student seemed to facilitate her role as an observer in the health centres which involved being present in the ward and asking questions, but not providing direct patient care. The researcher recorded the observations and reflections in a field diary on a daily basis. In all the four study health centres she went through the available antenatal care-, birth- and referral registries for the past 5 years focusing on what was documented, the completeness of the information provided and, and how well-kept the registries were.

The observations were supplemented by 10 in-depth interviews with birth care providers in the four study health centres. Two to three providers were purposely selected in each study site on the basis of observed clinical- and documentation practices and their levels of experience and training. In addition two interviews were conducted with providers recruited from small rural health centres where, for practical reasons, observations could not be carried out. The altogether twelve interviewees all provided pregnancy and birth care, and included two registered midwives, three registered nurses, one enrolled midwife, four auxiliary midwives and two outreach health workers. In addition two medical doctors who were members of the health districts' management teams, were interviewed. The semi-structured interview guide explored issues, such as quality of care, working conditions and the role of documentation [insert link to online file A]. The interview guide was piloted for its suitability in healthcare facilities that were not part of the study, and it was modified based on the themes that emerged during data collection. All of the interviews were conducted in French in a separate room at the interviewees' workplace and lasted from 45 to 90 min. They were recorded with the informants' consent, and then transcribed verbatim.

2.3. Data analysis

During fieldwork, regular reading of the field notes and the interview transcripts allowed a preliminary analysis that informed further data collection. The analysis continued after the data collection was completed, when the transcripts were examined by drawing upon qualitative content analysis (Graneheim and Lundman, 2004). After re-familiarisation with the entire dataset, initial codes were identified in the interviews. These codes were first grouped into categories and then into themes. During the writing process, the themes were repeatedly assessed and refined by going back to the original dataset. Finally, the themes were narrated and representative quotes were identified.

2.4. Ethical considerations

The study was approved by the National Health Research Ethics Committee of the Ministry of Health, Ouagadougou, Burkina Faso (Comité d'Ethique pour la Recherche en Santé) and the Regional Committe of Medical and Health Research Ethics of Western Norway. Written informed consent was obtained from all of the interviewees. The health workers gave their verbal consent to the observations and to participating in the care practices, and they were asked to inform all their patients about the observations and ask for their consent to allow the researcher to be present.

3. Results

3.1. The magnitude of reporting

Health workers in southwestern Burkina Faso spent a vast proportion of their time and assigned a great deal of importance to documentation and reporting. After every patient consultation which normally took a few minutes, the workers spent at least the same amount of time documenting the care they provided in paper registries and forms. The time health workers spent on documenting their care necessarily diverted time away from actual care practices. In all the four health centres in this study, two health workers conducted the antenatal consultations. While one of them consulted and examined the woman, the other would sit at the desk and manually filling out the woman's antenatal card, the antenatal care registry, the registry of immunisation and the HIV-testing registry. Many of the forms requested that the same or very similar information be documented repeatedly, such as blood pressure, weight, fundal height and HIV status. Similarly, during or after every delivery, at least five registries were completed: the antenatal card, the antenatal registry, the birth registry, the partograph and the subsidy reimbursement cards.

In addition to the information registered during and after patient interactions, the health workers summarised the number of visits and the services provided in monthly paper-based reports that were submitted to the health district. The monthly report (Rapports Mensuels d'Acitivités) of the maternity ward was written by the head midwife or an auxiliary midwife, and later integrated into the health centre report by the chief nurse. The production of these reports required detailed information about the services provided. The monthly report provided information about the total number of births, the number of assisted home births, the number of non-assisted home births, the number of normal facility births, the number of complicated facility births, the number of twins and triplets born, the number of stillborn babies for each of the categories above, the number of children born weighing less than 2500 g, the number of premature babies born, the number of obstetrical interventions, the number of women referred before, during or after birth, the number of maternal deaths and their causes, the number of stillborn babies and the associated causes and the number of hospitalisation days in the maternity after birth and for other causes. Antenatal care, postnatal care, family planning activities, immunizations and other well-baby clinic activities were also summarised with a number of indicators. The production of the reports was time-consuming as the maternity head collected the information by manually going through different registries, such as the immunisation registry, the antenatal care registry, the birth registry, the abortion registry, the family planning registry, the referral registry and the well-baby registry. In two of the larger centres, the midwives in charge of the maternity ward were observed to withdraw completely from clinical care to their offices for two to 3 day at the end of the month to write the reports.

To a large extent the health workers described the documentation of care as something imposed on them by the local health district management, and they often expressed frustration about the time spent on paperwork. The antenatal card which follows every pregnant woman through antenatal care, delivery and the child's first five years of life, was always actively used to obtain information about the mother and child's medical history, growth and past immunizations. With the exception of this card, health workers did not view the written materials as useful to their everyday practice. Rather, they saw documentation as something that took time away from actual care provision. Many health workers perceived that members of the local health authorities were more focused on their reports than securing the best possible patient care. After a field supervisory visit from the local health administration, a rural health worker expressed her frustration about being given another form to fill out during the antenatal consultation:

> We already have four forms to fill out during the antenatal consultation. Every time they [the supervisory team from the health district] come, they give us new forms … They [health district supervisors] do not care about the sick; all they want to do is to be able to write their reports. (Auxiliary midwife)

Health workers stated that in many cases they were unable to carry out the tasks the health district expected of them due to lack of time, resources and training. As one midwife noted, in a health centre with only one device to measure blood pressure it was simply impossible to take the blood pressure of the women in antenatal care, the women in labour and the women in family planning clinic at the same time. In rural health centres which typically have one or two births per night, several midwives argued was that it was impossible to ensure timely surveillance of women in labour during the night *and* get enough sleep to be able to staff the outpatient clinic the following morning. One midwife explicitly stated that pressure from the local health administration's to increase antenatal care attendance compromised the quality of the care she could provide:

> If a health worker says that his capacity is 20 antenatal consultations per day, you should ensure that it is 20 antenatal consultations of good quality. But you don't come yelling at him so that he should do 40 per day. If he achieves 40 antenatal consultations per day that means that the quality is ruined.

3.2. Reporting the 'right' results

Registries and reports, and more specifically the number and coverage of different services provided at the health centres, was an important part of the health district's evaluation of the health centres. Some services, such as the number of women receiving more than two antenatal care consultations and the number of deliveries at the local health centre, were particularly important indicators that were used to evaluate a facility's performance. Local health workers often referred to these numbers when talking about their place of work. One nurse said: 'The antenatal care visit rate is very good here. Last month, we had 245 antenatal care visits. We [the health centre personnel] are very pleased with this number'. Biannual supervision was also an important element of the evaluation of the health centre. In the days preceding the supervision visit at one of the health centres in the study, all the health workers participated in careful preparations: the buildings and courtyard were cleaned, registries were revised and expired medications and HIV tests were hidden. On the day of the supervision, all the health workers were present (which was rarely the case). Prior to the arrival of the district team, the head nurse instructed the health workers to tell the supervisors that antenatal care and family planning were provided every day, not two days a week as was the case. The supervisory team consisted of four district level officials, and the 5-h supervision visit consisted of going through and checking different registries, discussing the trends in the past month's attendance rates and brief direct observations during antenatal care provision.

Information in the reports constituted a way to assess and compare the performance of different health centres and health workers. At the health district, whiteboards were used to display the different health centres' performance rates on specific indicators, such as the completion of the monthly reports and the antenatal care and facility delivery coverage rates. The frontline health workers stated how they felt responsible to report 'good' results to the health district managers, and they were eager to explain and justify 'bad' results during informal conversations. In one health centre for example the health workers were convinced that the population covered by the health centre was overestimated. This led to a lower coverage of institutional births and other services, and to the wrong impression that the health workers at this health centre did not do a good enough job motivating women to use institutional pregnancy and birth care. Health workers hesitated to

report more negative results as exemplified by the reporting of out-of-stock medications at the health centre's pharmacy. As one nurse noted:

> There is a form in our reports where we write out of stock. We cannot write out of stock more than one week …. We cannot [do so] in order to not have any problem with the pharmacist (at the health district).

The health workers paid less attention to the services and outcomes that were less closely monitored by the health district. One example was the registrations of deaths that occurred at the health centre. While a maternal death was to be reported within 24 h, stillborn babies were simply registered in the birth registry and included in the monthly report. Abortions and neonatal deaths were not systematically registered. Responding to a question about the registration of the recent death at a health centre of a 6-h-old new-born, the auxiliary midwife on duty answered that the death should not be registered because 'he is not a stillborn'. Services were also prioritised differently. Supervisors paid less attention to postnatal care, and this was reflected in the practices of health workers. With the exception of one health centre, women were not given an appointment for the postnatal consultation seven days postpartum due to work overload. As one nurse explained:

> Honestly we don't do that [postnatal consultation seven days after birth] here. We should do it, but we don't. We give her an appointment directly on the 45th day. If she has a problem before the 45th day we tell her to come back.

3.3. Documenting preferred accounts

Throughout the observations, a wide discrepancy appeared between the care that was *reported* and the care that was actually *provided* in the health centres. For example, during antenatal care, laboratory tests that were never performed, such as urine and HIV tests were accounted for in writing. Another example pertains to the registration of births that occurred before a woman arrived at the health facility. In three out of four facilities, these births were registered as facility births. When a woman arrived during the night with her recently delivered baby, the midwife on call documented it as if she had observed the baby's vital signs the ten first minutes following the delivery. She noted: 'I have to put something, so I put an Apgar score of 8 (out of 10)'.

Likewise, the partograph which is a central tool in labour surveillance in low resource settings, was never used to monitor labour during data collection. Instead health workers routinely filled the partographs out after delivery including measures that they never actually performed, such as cervical dilatation, maternal blood pressure and foetal heart rate from hour to hour. In recognition of this distortion of the partograph's intended use, the health workers sometimes referred to the tool as the 'postograph'. They saw such after-the-fact data fabrication as being necessary because the detection of a missing partograph during supervisions would lead to being reprimanded by the supervisors. One auxiliary midwife said:

> 'They [district supervisors] ask us to show up the partograph, and we give it to them'.

Health centre workers repeatedly acknowledged that the monthly reports did not reflect the actual care provided on the ground. Indeed, a nurse described the making of the monthly report as 'going to the laboratory to make up numbers'. Although the health workers participated in data fabrication, some of the study informants were uncomfortable with sending inaccurate data in the monthly reports to the health districts. As an outreach health worker put it:

> 'You have to lie and it is not good. You only put some lines, you lie on the partograph, and then you send it in. It is not good.'

Some of the health workers even claimed that health district managers actively encouraged the practice of manufacturing 'postographs' . An auxiliary midwife stated that during the biannual supervision, partographs that were clearly falsified were identified due to inconsistencies, and that the health district team members told the health workers to 'cheat well if they had to cheat'.

The health workers also saw patient files as a way to demonstrate their professional competence. In one health centre, women who only came to antenatal consultation once and did not plan to come back for subsequent consultations were simply not registered, and women who had received previous consultations elsewhere were registered as if the consultations had taken place at the health centre in question. When asked to explain this practice, an auxiliary midwife stated that having a woman with only one antenatal consultation in the registry during supervisions would indicate that the health worker in question had not advised her properly:

> If they [health district managers] see that the woman has only had one antenatal consultation here before delivery, they will mark us poorly. That's why we have to rewrite everything in the registry. Or if the woman has only one antenatal consultation here and then she is lost to follow-up, they [health district managers] will say that we have done a bad job. (Auxiliary midwife)

Patient files were also at the centre of audits conducted by the health district after maternal deaths. These audits were described as a way for district managers to blame the local health workers for the deaths, and as one outreach health worker stated:

> 'They [team from the local health authorities] come, they rummage through everything to know if it's you or if it's God that killed her'.

During informal conversations some of the study's informants argued that the fear of blame lead to underreporting of maternal deaths, especially deaths that occur while transporting the woman to a higher-level care facility. When asked about the consequences of maternal deaths for local health workers, they referred several times to a maternal death that occurred in a primary health centre in the city of Bobo-Dioulasso at the beginning of the fieldwork. In this highly publicised case, a 26-year-old woman died alone in the health centre delivery room while giving birth to her seventh child. She allegedly died after falling from the birthing table in the delivery room in which she had been locked alone while the health workers on call was sleeping in a nearby building. The tragedy led to public protest and to members of the community setting fire to the health centre buildings (Barry, 2011). In all four study sites the case was discussed extensively, from the initial reports of the community setting fire to the health centre, to the criminal conviction and imprisonment of one auxiliary midwife and one outreach health worker for involuntary homicide. As a protection against any accusation of substandard care in the case of a maternal death, clinicians and health district managers perceived a correctly completed partograph as a proof of 'good care' at the health centre. After a complicated delivery that ended with the woman being sent in an ambulance to the regional hospital with a post-partum bleeding, a midwife filled out a partograph retrospectively and entered many details about measures that had not been taken during delivery. When asked about this in an interview some days later, she explained:

> 'It is to protect ourselves. Because even what they say, when it heats up, you manage to show up your partograph. That can prove that you have followed the woman a bit. Even if it's a postograph'.

4. Discussion

The study findings illustrate how the completion of registries and reports consume valuable clinician time, how the focus on health centre numerical performance introduces inaccuracies (and sometimes deceptions) into the evidence base from which policymakers ostensibly make decisions. Written records serve as sites for silent negotiation over how policies are translated into practice. While reporting practices

serve the production of a success story about the institutionalisation of birth care, they also serve to protect the health workers against accusations from district-level supervisors of poor working morale or clinical malpractice.

The findings can be situated within the broader move towards accountability and measurement in global health in general and more specifically in the field of maternal health (Storeng and Béhague, 2017). While global policy indicators are presented as objective, comparable facts, they are neither neutral nor apolitical (Adams, 2016; Erikson, 2015). The inclusion of maternal health among the Millennium Development Goals mobilised attention and funding to the field of maternal health (Shiffman and Smith, 2007). At the same time, it has narrowed conceptualisations of maternal health, often equating it with the number of women giving birth in health facilities and separating it from the broader reproductive health and rights agenda and the actual care provided in facilities (Austveg, 2011; Melberg et al., 2016a; Storeng and Béhague, 2017; Chattopadhyay et al., 2017). Documentation of care plays a decisive role because it acts as a mediator between normative policies and clinical practice (Hull, 2012; Jaffré and Suh, 2016). While documentation is often seen as a way to formalise and standardise care, it also creates possibilities for manipulation from health workers (Hull, 2012).

4.1. The translation of care

Documentation of care is necessary to provide quality healthcare, and health information systems need to balance administrative and clinical needs (Karsh et al., 2010). Clinicians often spend a large part of their working time on documentation in both high- and low-income settings (Hadley and Roques, 2007; Woolhandler and Himmelstein, 2014), but we argue that this is more critical in a setting where resources are scarce. As George (2009, p.221) reported from India, health worker demoralisation arises when the realities at local health centre are 'superseded by mathematical coherence and internal validity of the reporting forms'. Reports are passed from one level to another, and supervision becomes an empty ritual of number checking. In the process the health system goals that the reports are designed to accelerate, are lost. In a multi-country study of HIV clinics, Heimer and Gazley (2012) illustrated how material scarcity makes it difficult for clinicians and monitoring staff to focus on deep compliance rather than bureaucratic or superficial compliance. Hence, it is challenging to transcend the regulatory ritualism of supervisions.

Policy adherence and achievement of targets are dependent on how health workers translate clinical practice into registries and reports. In Burkina Faso, as in many Sub-Saharan settings, there are great discrepancies between programme ideals, established clinical norms and standards of care and the experiences of health workers and patients (Jaffré and Suh, 2016; Olivier de Sardan et al., 2017). In line with other findings from West Africa, we suggest that the production of 'post-ographs' was not only due to lack of knowledge or time. It was also linked to the fact that the partographs were required by the health district and when used during birth, they had the potential to reveal mistakes for which the health workers could be held responsible (Jaffré, 2012; Olivier de Sardan et al., 2017).

We argue that the routine documentation practices of birth care providers are not arbitrary. Rather, they are part of what Olivier de Sardan (2015) refers to as practical norms, 'the latent regulations of the practices of civil servants when these do not follow official regulations' (p. 3). These norms regulate the health workers' responses to policies or travelling models in the field of maternal health care. Even though the widespread discrepancies between the provided and reported care are well known to frontline health workers, officials and experts, the discrepancies are seldom reflected in official reports, policies and guidelines or in the public health literature (Olivier de Sardan et al., 2017). As observed in clinical studies in Sub-Saharan Africa and in the context of performance-based financing in Burkina Faso, data fabrication acts as a tool to manage everyday challenges, and it is a response to high demands, difficult working conditions and unsupportive supervision (Kingori and Gerrets, 2016; Turcotte-Tremblay et al., 2017). This fabrication creates parallel realities, as 'the maternities spoken of in the world of public health are largely fictitious, paper maternities, far removed from the realities experienced by the parturients. Travelling models address these paper maternities, and are built on their image' (Olivier de Sardan et al., 2017, p. 80). The implications are profound. The pressure to implement policies to improve maternal health care reinforces inaccurate reporting practices in health centres, which in turn can result in policies that are incapable of addressing the realities of the practices that occur at these same health centres.

4.2. Powerful policy indicators

In most resource-deprived areas, maternal mortality rates are estimates that reflect a wide range of uncertainty, but they are nonetheless used as an objective comparison across different economic and cultural settings (Storeng and Béhague, 2017; Wendland, 2016). The global-level accountability pressures and the accountability pressures operating on health workers are not necessarily the same. As the goal of skilled attendance filters down from the global and national policy level to local health centres, it influences everyday practices because health workers at all levels are evaluated based on the numbers they report (Danielsen, 2017; Kvernflaten, 2013; Mishra, 2014; Roalkvam and McNeill, 2016). The reporting of successful policy implementation serves as proof of return on donor investments (Storeng and Béhague, 2014), and it facilitates different actors' access to political and economic power (Oni-Orisan, 2016). For example, in rural Malawi, village leaders and the community as a whole worked to increase institutional deliveries and to position themselves for future development investments by producing the right results in line with MDG 5 (Danielsen, 2017).

Policy achievements can be seen as being embodied in health workers' actions through documents and guidelines regarding institutional birth care (Flynn, 2002). Targets are pivotal in self-regulatory practice. By counting the number of consultations and births, health workers adhere to the expected policy aims and they find (sometimes creative) ways of going from 'where they are' to 'where they should be' (Rose and Miller, 1992, p. 187). As reported from in India, registries are simultaneously technologies of self-discipline and enablers of the surveillance, control and discipline of health workers from above (Ferguson and Gupta, 2002). Although primary health workers are situated at the bottom of hierarchical healthcare systems, they have the power to allocate benefits and sanctions to patients that do and do not comply with the goals of institutional birth care (Lipsky, 1980; Melberg et al., 2016b; Chattopadhyay et al., 2017; Wendland, 2018).

4.3. Reversed accountability

Targets might also influence accountability relationships between health systems and communities. Primary health workers in Burkina Faso strive to provide quality pregnancy and birth care, despite health worker shortages, lack of infrastructure, training and the ability to refer patients, when needed (Duysburgh et al., 2013; Melberg et al., 2016a). Documentation and reporting are seen as diverting the health workers' time and focus from the provision of care. This resonates with Hull's (2012) description of accountability contradictions in South Africa, where the documentation of clinical care was prioritised over, and became a substitute for care itself. Medical records lost their clinical usefulness and were transformed into sole 'physical marker [s] of professional capability and institutional accountability' (Hull, 2012, p. 621). As Roalkvam and McNeill (2016) argued regarding policies to increase skilled attendance in India, the encompassing focus on performance accountability and measures of achievements in health centre reports expressed in terms of the numbers of women giving birth at

facilities, moves upwards from health facilities and creates a reversed accountability. Health system actors at all levels, from frontline health workers to Ministry of Health officials, become accountable to global agencies and development assistance partners rather than to women in need of pregnancy and birth care. Or, as an auxiliary midwife in our study put it: 'They do not care about the sick; all they want to do is to be able to write their reports.'

4.4. Study limitations

Some limitations of this study should be noted. The study was not initially designed to explore the topic of documentation practices, and it would have benefitted from an increased focus on the consumption of data at the district level and on the interactions between the health centres and the health district officials. The study findings represent little divergence in the health workers' perspectives on the burden of reporting demands, although the strategies employed to meet these demands varied from health centre to health centre. Our presentation of how national, regional and district level policies are developed in Burkina Faso is based on official reports and may not capture the often opaque processes of how policies are negotiated and adopted by the actors situated at different levels.

Lastly, although the findings produced in this small qualitative study are not generalizable in a statistical sense, we argue that they are highly relevant also to other similar contexts within Burkina Faso. The health centres in the study are subjected to the same health policy, the same health system culture and resource scarcity as health centres in other parts of the country.

5. Conclusion

By examining frontline birth care providers' documentation practices in a rural area of Burkina Faso, this study has documented how health workers placed great emphasis on their reporting practices and the amount of time used on completing the required reports. Health workers felt pressured to provide the 'right' results, and they resolved to document inaccurate data or 'preferred accounts' of the maternity care they provided. We argue that such practices misinform policymakers at all levels, and they can feed into policies incapable of addressing the realities experienced by frontline health workers and patients in these health centres. The reporting practices portrayed here can be situated within the broader move towards accountability and measurability in global health, where targets and indicators act as powerful tools that govern healthcare systems. Although indicators are necessary for healthcare policy and planning, we need to address the uncritical pressure on health workers to produce the 'right' numbers, as this could direct health workers' accountability upwards to district health managers and ultimately to global agencies and donors rather than to the women they are tasked with providing care for.

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Appendix A. Supplementary data

Supplementary data related to this article can be found at https://doi.org/10.1016/j.socscimed.2018.09.001

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REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK vest	Anna Stephansen	55978496	26.01.2018	2017/2500/REK vest
			Deres dato: 05.12.2017	

Vår referanse må oppgis ved alle henvendelser

Thorkild Tylleskar
Årstadveien 21

2017/2500 Dekning og kvalitet av fødselshelsetjenester i Burkina Faso

Forskningsansvarlig: University of Bergen, Centre Muraz
Prosjektleder: Thorkild Tylleskar

Vi viser til søknad om forhåndsgodkjenning av ovennevnte forskningsprosjekt. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK vest) i møtet 10.01.2018. Vurderingen er gjort med hjemmel i helseforskningsloven (hfl.) § 10.

Prosjektomtale
Dette prosjektet er en oppfølging av et intervensjonsprosjekt i 2005-08 i Burkina Faso for å stimulere til amming. Det ble i dette prosjektet påvist en svært høy perinatal dødelighet (8%). Det ble ikke påvist bedre resultat for fødsler som forgikk i offentlige fødestuer i forhold til hjemmefødsel. Det ble besluttet å følge opp med det aktuelle prosjektet for å kartlegge kvaliteten på svangerskaps- og fødselsomsorgen for å kunne foreslå kvalitetsforbedrende tiltak.

Vurdering
Ettergodkjenning
Veilederen til helseforskningsloven sier følgende om ettergodkjenning "Ettersom helseforskningsloven § 9 stiller krav om godkjenning før igangsettelse av et forskningsprosjekt, skal REK normalt ikke kunne godkjenne et forskningsprosjekt etter det er igangsatt. Det kan imidlertid tenkes grunner for at det ikke er søkt om godkjenning før et prosjekt er satt i gang. [...] Etter departementets oppfatning må REK derfor i særskilte tilfeller kunne vurdere et prosjekt selv om det er igangsatt når søknaden kommer" (2010, s. 38).

Saksgangen i REK vest
Dette prosjektet er en oppfølging av et intervensjonsprosjekt i 2005-08 i Burkina Faso for å stimulere til amming. Det første intervensjonsprosjektet ble søkt godkjent av REK vest i 2005, men ble i utgangspunktet ikke vurdert siden det den gang ikke var krav om at prosjekter som ble gjennomført utenfor Norge skulle ha REK-godkjenning også i Norge. Det ble imidlertid gitt en veiledning fra REK vest.

Det aktuelle prosjektet ble gjennomført i 2011/2012. Da prosjektet skulle gjennomføres var helseforskningsloven trådt i kraft (2009) med krav om at det skal gis REK godkjenning også i Norge. REK vest mener at det klart skulle vært søkt om forhåndsgodkjenning av dette prosjektet i 2010/2011.

Vurdering fra REK nord
Prosjektgruppen fikk en evaluering av et mer omfattende prosjekt i 2010 av REK nord. Konklusjonen var at fra og med den nye helseforskningslovens ikrafttredelse av 2009, så skal denne typen prosjekter ikke lenger godkjennes av norsk komité. Det er forståelig at prosjektgruppen hadde dette på minnet i tiden etter. REK

vest betrakter vedtak fra REK nord som formildende omstendighet i saken om ettergodkjenning av dette prosjektet.

Det er imidlertid underlig at prosjektleder ikke fikk med seg endring i REK vest sin rutine før 2010. For også prosjektleder har fått to prosjekter klarert i 2007. Et doktorgradsprosjekt for Elin Hestvik i Uganda (REK vest ref. 217.07) og et doktorgradsprosjekt for Eli Fjeld i Tanzania (REK vest ref. 109.07). I vurderingen av prosjektet i Uganda er også de lokale myndigheters egen vurdering tillagt vekt i REK vest sin avgjørelse for å endelig godkjenne prosjektet. Dermed er det en tydelig endring i REK vest sin behandling av slike søknader på det tidspunkt. REK vest presiserer at vurdering fra REK nord i sak 2010/184 strider med tolkning av helseforskningsloven § 3 om lovens geografiske virkeområde som har vært praktisert i REK vest. Hovedforskningsansvarlig som er utenfor Norge er ikke alltid avgjørende for REK vest sin tolkning av hfl. § 3.

Godkjenning fra lokale myndigheter
Prosjektet ble godkjent av den nasjonale forskningsetiske komiteen for helse i Burkina Faso. REK vest merker seg at denne komiteen skal være velfungerende.

Forsvarlighet
REK vest vurderer det slik at observasjonsstudien er gjennomført på en etisk forsvarlig måte.
I studien observerte man praksis under svangerskap og fødsel i lokale klinikker og spørreskjema/intervjuer både helsearbeidere, lokale ledere(community members) og kvinner som har født (også hjemme) og eventuelt deres partner.

REK vest har imidlertid diskutert fremgangsmåten for å innhente samtykke fra en del av deltakerne som ble observert der muntlig samtykke '...ble forsøkt innhentet...'. I prosjektsøknaden punkt 3.3. side 10-11 beskrives det at deltagende observasjon, som en etnografisk metode, ikke krever innhenting av samtykke fra alle. Dette mener komiteen ikke kan aksepteres. Som regel skal samtykke innhentes fra alle deltakere i et forskningsprosjekt som dette. Det er videre beskrevet kompenserende tiltak blant annet at prosjektet legger opp til at samtykke ble innhentet i ettertid.

REK vest vurderer det slik at i dette tilfellet er det rimelig og tilstrekkelig å innhente samtykke i etterkant av en gjennomført observasjon. REK vest forutsetter i sin vurdering at alle kvinner har samtykket til bruk av observasjonsdata i studien senest i etterkant av prosjektet.

Vedtak
REK vest godkjenner søknad om ettergodkjenning

Sluttmelding og søknad om prosjektendring
Prosjektleder skal sende sluttmelding til REK vest på eget skjema senest 31.08.2020, jf. hfl. § 12. Prosjektleder skal sende søknad om prosjektendring til REK vest dersom det skal gjøres vesentlige endringer i forhold til de opplysninger som er gitt i søknaden, jf. hfl. § 11.

Klageadgang
Du kan klage på komiteens vedtak, jf. forvaltningsloven § 28 flg. Klagen sendes til REK vest. Klagefristen er tre uker fra du mottar dette brevet. Dersom vedtaket opprettholdes av REK vest, sendes klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag for endelig vurdering.

Med vennlig hilsen

Marit Grønning
dr.med.
Avdelingsdirektør, professor

Anna Stephansen
sekretariatsleder

Kopi til:post@uib.no; hamadial@yahoo.fr

MINISTERE DE LA SANTE

MINISTERE DE LA RECHERCHE
SCIENTIFIQUE ET DE L'INNOVATION

COMITE D'ETHIQUE POUR
LA RECHERCHE EN SANTE

BURKINA FASO
Unité - Progrès - Justice

DELIBERATION N° 2011-9-57

1. TITRE DE LA RECHERCHE

«Etude pilote de la couverture et de la qualité des soins obstétricaux et périnataux dans le district sanitaire de Banfora, Burkina Faso »

2. REFERENCE DU PROTOCOLE

Version 1. Août 2011

3. DOCUMENTATION

Protocole de recherche

4. REFERENCE DU DEMANDEUR

Investigateurs principaux :
- Dr. Hama DIALLO, Centre MURAZ,
- Pr. Thorkild Tyllescar, University of Bergen

Co-investigateurs principaux:
- Dr. Nicolas MEDA, Centre MURAZ,
- Pr. Karen Marie Moland, University of Bergen

5. SITES DE LA RECHERCHE

District sanitaire de Banfora (départements de Banfora, Sidéradougou et Soubakénédougou)

6. DATE DE LA DELIBERATION

07 septembre 2011

07 septembre 2011

7. ELEMENTS EXAMINES

- Conception scientifique et conduite de la recherche ;
- Soins et protection des participants à la recherche ;
- Protection de la confidentialité des données du participant à la recherche ;
- Processus de consentement éclairé ;
- Budget de la recherche.

8. OBSERVATIONS

- joindre le budget de l'étude,
- reformuler, au niveau du paragraphe 3 de la page 5, l'objectif général comme suit : « *Evaluer la qualité actuelle des soins obstétricaux et périnataux fournis dans les CSPS du District sanitaire de Banfora en vue* **de la réduction de** la mortalité maternelle... ».

9. AVIS DU COMITE

Avis favorable

10. RESERVES

Néant

11. RECOMMANDATIONS

Prendre en compte les observations

Ouagadougou, le 07 septembre 2011

Le Rapporteur

Scholastique TRAORE

Le Président

Pr. Jean Baptiste NIKIEMA
Chevalier de l'Ordre national

Annexes

Fiches d'information des participants

Fiche d'information du participant
(Personnel de santé des CSPS)

Ce formulaire de consentement éclairé est destiné au personnel des CSPS du District Sanitaire de Banfora invité à participer au projet de recherche sur «L'étude pilote de la couverture et de la qualité des soins obstétricaux et périnataux dans le District sanitaire de Banfora, Burkina Faso».

Ce formulaire est composé de deux parties:
- Une fiche d'information des participants à la recherche
- Une page de signature pour le consentement éclairé de participation

Vous allez recevoir une copie de la page de signature.

Le Centre MURAZ (un service qui fait de la recherche en santé, basé à Bobo-Dioulasso et qui appartient au Ministère de la Santé du Burkina Faso), en collaboration avec l'Université de Bergen (situé en Norvège) et le District sanitaire de Banfora mène une étude sur les soins pour les femmes et les bébés lors de l'accouchement et durant les 6 semaines qui le suivent.

Dans votre région (Banfora), il y a des femmes et des bébés qui meurent pendant ou après l'accouchement. L'étude que nous voulons mener vise à trouver des stratégies pour éviter ces décès. Nous croyons que vous pouvez nous aider en décrivant les soins fournis lors de l'accouchement dans cette région.

Nous allons vous poser des questions sur votre travail quotidien en rapport avec les soins pendant la grossesse, l'accouchement et le premier mois après celui-ci, sur ce que vous voyez en travaillant dans ce CSPS et sur ce que vous en pensez. Au cas où il y a des questions qui vous semblent indiscrètes, vous n'êtes pas obligés d'y répondre. Si vous n'avez pas bien compris aussi une question, nous pouvons la reprendre et l'expliciter davantage.

L'interview (une causerie) prendra environ 1h, et nous pouvons l'effectuer quand et où vous voudrez en tenant compte de vos occupations. Pour ne pas oublier ce que vous nous direz, l'interview va être enregistrée sur un magnétophone mais personne d'autre ne pourra réécouter ce que vous avez dit hormis moi-même et mes superviseurs. Et jamais, nous ne citerons dans une publication votre nom en disant que c'est vous nommément qui avez dit ceci ou cela. Les données de cette étude sont confidentielles, c'est-à-dire que personne ne sortira dire ce que vous nous direz.

Il est important que vous sachiez que votre participation à cette étude est strictement volontaire. Personne ne sera fâché contre vous si vous décidez de ne pas y participer. De même, si vous changez d'avis, vous pouvez retirer votre consentement et sortir de l'étude.

Si vous voulez aller réfléchir et discuter avec votre famille ou des amis avant de vous décider à participer à l'étude, vous pouvez aussi le faire et revenir nous voir dans les 3 prochains jours.

Cette étude a reçu l'approbation du Comité d'éthique de recherche en santé du Ministère de la santé du Burkina Faso.

Maintenant nous avons fini de vous expliquer le travail que nous voulons faire, vous pouvez poser toutes questions que vous souhaitez. Si vous êtes d'accord pour participer à l'étude, nous allons vous donner la page de signature du consentement afin de marquer votre accord.

Nous vous remercions beaucoup.

Fiche d'information du participant

(Femme accouchée récente)

Ce formulaire de consentement éclairé est destiné aux femmes accouchées récentes ayant (ou non) utilisé les services de maternité du CSPS du village et invitées à participer au projet de recherche sur «L'étude pilote de la couverture et de la qualité des soins obstétricaux et périnataux dans le District sanitaire de Banfora, Burkina Faso».

Ce formulaire est composé de deux parties:

- Une fiche d'information des participantes à la recherche
- Une page de signature pour le consentement éclairé de participation

Vous allez recevoir une copie de la page de signature.

Le Centre Muraz (un service qui travaille pour comprendre les problèmes de santé des gens et qui se trouve à Bobo-Dioulasso, Ministère de la Santé), en collaboration avec l'Université de Bergen (situé en Norvège) et le district sanitaire de Banfora, mène une étude sur les soins pour les femmes et les bébés lors de l'accouchement et dans les 6 semaines qui le suivent.

Dans votre région (Banfora), il y a des femmes et des bébés qui meurent pendant ou après l'accouchement. L'étude que nous voulons mener vise à trouver des stratégies pour éviter ces décès. Nous croyons que vous pouvez nous aider en décrivant les soins fournis lors de votre accouchement si vous avez accouché au CSPS ou de nous expliquer les conditions de votre accouchement et les raisons qui vous ont amené à accouché à la maison (si accouchement à domicile).

Nous allons donc causer avec vous (interview) et vous poser plusieurs questions qui concernent les soins que vous avez reçus lors de votre dernier accouchement, les problèmes que vous avez rencontrés, les raisons qui vous ont amené à accouchement à domicile, la façon dont le choix du lieu d'accouchement est fait et comment on peut faire pour amener beaucoup de femmes à accoucher au CSPS. Au cas où il y a des questions qui vous semblent indiscrètes, vous n'êtes pas obligées d'y répondre. Se vous n'avez pas bien compris une des questions nous pouvons la répéter et l'expliciter davantage pour vous.

La causerie va durer environ 1h et nous pouvons l'effectuer quand et où vous voudrez à l'écart des gens si vous le souhaitez. Pour ne pas oublier ce que vous nous direz, l'interview va être enregistrée sur un magnétophone mais personne d'autre ne pourra réécouter ce que vous avez dit hormis moi-même et mes patrons. Jamais nous n'allons sortir pour dire ce que vous nous avez dit car les informations de cette étude sont confidentielles et tous nos agents sont tenus à respecter cela.

Si vous voulez aller réfléchir et discuter avec votre mari, les autres membres de la famille ou des amis avant de vous décider à participer à l'étude, vous pouvez aussi le faire et revenir nous voir dans les 3 prochains jours.

Il est important que vous sachiez que votre participation à cette étude est strictement volontaire. Que vous participiez ou non, vous serez soignées et examinées par les agents du CSPS comme auparavant. Personne ne sera fâché contre vous si vous décidez de ne pas y

participer. De même, si vous changez d'avis, vous pouvez retirer votre accord et sortir de l'étude.

Cette étude a reçu l'approbation du Comité d'éthique de recherche en santé du Ministère de la santé du Burkina Faso.

Maintenant nous avons fini, vous pouvez poser toutes questions que vous souhaitez. Si vous êtes d'accord pour participer à l'étude, nous allons vous donner la page de signature du consentement afin de marquer votre accord.

Nous vous remercions beaucoup.

Fiche d'information du participant

(Membres de la communauté)

Ce formulaire de consentement éclairé est destiné aux membres de la communauté (leaders, membres du CoGes du CSPS, représentantes des associations féminines) dans les villages abritant les CSPS d'étude et qui sont invités à participer aux focus groupes dans le cadre du projet de recherche sur «L'étude pilote de la couverture et de la qualité des soins obstétricaux et périnataux dans le District sanitaire de Banfora, Burkina Faso».

Ce formulaire est composé de deux parties:

- Une fiche d'information des participants à la recherche
- Une page de signature pour le consentement éclairé de participation

Chaque participant aux discussions des focus groupes va recevoir une copie de la page de signature.

Le Centre Muraz (un service qui travaille pour comprendre les problèmes de santé des gens et qui se trouve à Bobo-Dioulasso, Ministère de la Santé), en collaboration avec l'Université de Bergen (situé en Norvège) et le district sanitaire de Banfora, mène une étude sur les soins pour les femmes et les bébés lors de l'accouchement et dans les 6 semaines qui le suivent.

Dans votre région (Banfora), il y a des femmes et des bébés qui meurent pendant ou après l'accouchement. L'étude que nous voulons mener vise à trouver des stratégies pour éviter ces décès. Nous croyons que vous pouvez nous aider en décrivant les soins fournis lors de l'accouchement des femmes au CSPS ou de nous expliquer les conditions de l'accouchement et les raisons pour lesquelles certaines femmes accouchent à domicile.

Nous vous invitons donc à participer à une causerie en groupe (focus groupe) au cours de laquelle 7-8 autres personnes du même sexe de votre village discuteront des problèmes de santé des femmes notamment lors de l'accouchement, des coutumes et pratiques en matière de choix du lieu d'accouchement, quelles sont les acteurs clés et les détenteurs du pouvoir sur ce sujet, quelle appréciation faites-vous des soins donnés au niveau du CSPS et comment penser vous qu'on puisse améliorer les choses pour que plus de femmes viennent accoucher au CSPS. Cette discussion sera dirigée par un membre de notre équipe.

La causerie en groupe durera environ 1-2h, et nous allons l'effectuer en un lieu du village à une date et à une heure qui vous seront précisées ultérieurement, mais en tenant compte de votre agenda et de celui des autres participants.

Lors de cette causerie de groupe, nous allons enregistrer les discussions sur un magnétophone afin de ne pas oublier ce qui nous a été dit. Toutefois, personne d'autre hormis moi-même et mes patrons, ne pourra réécouter ce qui s'est dit. Jamais nous n'allons sortir pour dire ce que vous nous avez dit car les informations de cette étude sont confidentielles et tous nos agents sont tenus de respecter cela.

Vous êtes invités à participer à l'étude parce-que vous êtes un des notables du village, ou que vous faites partir des membres du comité de gestion du CSPS ou que vous êtes la

représentante d'une association de femmes dans votre village. Si vous voulez aller réfléchir et discuter avec votre famille ou des amis avant de vous décider à participer à l'étude, vous pouvez aussi le faire et revenir nous voir dans les 3 prochains jours.

Il est important que vous sachiez que votre participation à cette étude est strictement volontaire. Que vous participiez ou non, vous serez soignées et examinées par les agents du CSPS comme auparavant. Personne ne sera fâché contre vous si vous décidez de ne pas y participer. De même, si vous changez d'avis, vous pouvez retirer votre accord et sortir de l'étude.

Cette étude a reçu l'approbation du Comité d'éthique de recherche en santé du Ministère de la santé du Burkina Faso.

Maintenant nous avons fini, vous pouvez poser toutes questions que vous souhaitez. Si vous êtes d'accord pour participer à l'étude, nous allons vous donner la page de signature du consentement afin de marquer votre accord.

Nous vous remercions beaucoup.

Formulaire de consentement éclairé

Etude pilote de la couverture et de la qualité des soins obstétricaux et périnataux dans le District sanitaire de Banfora, Burkina Faso

CONSENTEMENT ECLAIRE DE PARTICIPATION

(Page de signature)

Je soussigné,

Nom et Prénom du participant ……

Village/CSPS de ……

Accepte par la présente ma participation volontaire à l'étude intitulée « Etude pilote de la couverture et de la qualité des soins obstétricaux et périnataux dans le District Sanitaire de Banfora, Burkina Faso".

J'ai bien pris connaissance des objectifs de l'étude et les conditions de sa réalisation m'ont été clairement indiquées par le Dr Hama DIALLO (Investigateur principal de l'étude, Médecin-épidémiologiste au Centre MURAZ, Tél 20970102) ou son représentant. Je reconnais la possibilité qui m'est réservée de refuser ma participation à l'étude ou de la retirer à tout moment quelle qu'en soit la raison et sans avoir à le justifier.
Les données de cette étude resteront strictement confidentielles. Je n'autorise leur consultation que par des personnes qui collaborent à l'étude, désignées par l'investigateur principal, et les autorités sanitaires du Burkina Faso.

Fait à ……., le ……..…../……../2011

Signature ou empreinte digitale du participant :……..

Nom et prénoms du témoin (si participant illettré): ……

Signature du témoin …….

Nom et prénom du PI ou son représentant:….....

Date et signature du PI ou de son représentant: ……

Fiche d'interview de femmes accouchées récentes

Interview avec des femmes du village ayant récemment accouché (au CSPS)

Données sociodémographiques de base :

Nom de la femme:……
Village de résidence :…….
Age (années): /_____/ Gestité:/____/ Parité : /_____/
Nombre d'enfants actuellement vivants : /____/
Nombre d'enfant nés vivants et décédés : /_____/
Nombre d'avortements spontanés ou de mort-nés : /____/
Age du 1er enfant vivant (ans et mois) : /_____/
Age du dernier enfant vivant (ans et mois) : /_____/
Statut matrimonial : /_____/
Votre mari a-t-il d'autres épouses ? oui /____/ non /____/ Si oui combien ?/____/
Quel est votre niveau d'instruction le plus élevé ?: /_____/
Avez-vous été alphabétisée dans une langue quelconque ?
Si oui pendant combien de temps (mois) : /____/ et dans quelle langue ?:…….
Date de votre dernier accouchement (vérifier dans le carnet CPN si elle avait accouché au CSPS ; sinon se contenter de mm/yyyy): /____/_____/_____/

Pendant votre grossesse avez-vous parlé du lieu d'accouchement avec un membre de la famille?

- Quel membre de la famille a initié cette conversation?
- Y a-t-il eu un accord sur le lieu de votre accouchement?
- En cas de désaccord sur le lieu prévu pour l'accouchement, quel membre de la famille a pris la décision finale sur le lieu d'accouchement?

En considérant le lieu d'accouchement, la tarification de celui-ci dans un CSPS était-elle connue?

- Comment l'avez-vous su ?
- Le prix, était-il déterminant pour le choix que vous avez fait?
- Aviez-vous fait des économies en prévision de votre accouchement?

Avez-vous effectué au moins une consultation prénatale (CPN) pendant cette grossesse?

- Si oui, combien de fois? Si non, pourquoi pas?
- Les CPN étaient-elles dans le même CSPS que pour l'accouchement?
- Etiez -vous contente des soins qui vous ont été offerts lors de cette CPN?
- Si non, pourquoi?

Où étiez-vous lorsque les douleurs du ventre pour l'accouchement (travail) ont commencé?

- Quand avez-vous senti les premières contractions utérines?
- Qui était avec vous à ce moment là?
- Votre mari/ votre père, était-il à vos côtés?

Quand avez-vous fait la décision de vous rendre au CSPS?

- A quel moment du travail était-ce?
- Vers quelle heure (matin, après-midi, soir, nuit)?

Comment êtes-vous arrivée au CSPS?
- Avec quel moyen de transport?
- Avez-vous eu des problèmes pour trouver un moyen de transport?
- Combien de temps a-t-il fallu entre la prise de décision et votre arrivée au CSPS?
- Est-ce que quelqu'un vous a accompagné?
- Combien avez-vous payé pour le transport?

En arrivant au CSPS, a-t-il fallu attendre pour recevoir les premiers soins?
- Combien de temps environ avez-vous attendu?
- Qui s'est occupé de vous pendant l'attente?
- Ce temps d'attente, est-il acceptable pour vous?

En cas d'évacuation vers l'hôpital de Banfora:
- Qui a pris cette décision?
- Quel moyen de transport a été utilisé?
- Avez-vous eu des problèmes pour trouver le moyen de transport?
- Combien de temps a-t-il fallu entre la prise de décision et votre arrivée au CHR de Banfora?
- Est-ce que quelqu'un vous a accompagné?
- Combien avez-vous payé pour le transport?

Les soins reçus au CSPS, les jugez-vous adéquats pour vous et votre bébé?
- Y-a-t-il eu trop d'interventions?
- Y-a-t-il eu trop peu d'interventions?
- Qu'est-ce qui manquait selon vous?

Lors des examens, le personnel de soins s'est-il montré discret?
- Les examens ont-ils été faits dans une salle isolée ?
- Le personnel a-t-il posé des questions indiscrètes (intimes) dans la salle d'attente?
- Etiez-vous certaine que ce que vous disiez au personnel ne se saurait pas dans tout le village?

Le personnel a-t-il donné suffisamment d'informations?
- A-t-il expliqué les examens qui ont vous été faits ainsi qu'à votre enfant?
- L'information a-t-elle également été donnée à vos accompagnants ?

Avez-vous eu l'opportunité de poser des questions au personnel de soins?
- Sur les choix de traitement?

Comment trouvez-vous l'état du CSPS?
- L'état du bâtiment?
- Le matériel était-il disponible et fonctionnel?
- Les médicaments étaient-il disponibles dans le dépôt MEG du CSPS?

Lors de l'accouchement, vous et votre bébé, avez-vous bien été suivis par le personnel de soins?
- Pouviez-vous toujours joindre (contacter) le personnel en cas d'urgence?
- Etes-vous suivi(e)s principalement par la même personne?
- Sinon, combien se sont occupés de vous?

- Est-ce que vous vous êtes trouvée seule (sans personnel) lors de l'expulsion du placenta (troisième stade du travail)?

Les soins obtenus, étaient-ils en accord avec vos normes religieuses et culturelles?

Pouvez-vous me décrire le personnel du CSPS qui vous a assisté à l'accouchement?
- Caractéristiques: sexe, âge,?

- Comment était leur comportement (respectueux)?
- Etaient-ils compatissants?

Comment ont été traités les gens qui vous ont accompagné?
- Ont-ils reçu suffisamment d'information?
- Le personnel a-t-il demandé de l'argent avant que les soins soient effectués?
- Vos accompagnants ont-ils été admis dans la salle d'accouchement?

En tout, combien avez payé pour cet accouchement?
- Les médicaments, le kit d'accouchement, le transport, la nourriture, le coût pour les personnes qui vous ont accompagné...
- Est-ce que ces coûts ont posé des soucis pour vous/votre famille?
- Comment avez-vous fait pour payé ce montant (économies, ventes, prêts) ?

Quelle est votre impression générale sur les soins obstétricaux offerts dans le CSPS?
- Y-retournerez-vous pour un prochain accouchement?
- Est-ce que vous allez recommander l'accouchement dans ce CSPS aux autres femmes?

Avez-vous quelque chose d'autre que vous voulez ajouter?

Nous vous remercions beaucoup pour votre contribution !

Interview avec des femmes du village ayant récemment accouché (à domicile)

Données sociodémographiques de base :

Nom de la femme:……
Village de résidence :…….
Age (années): /_____/ Gestité:/____/ Parité : /_____/
Nombre d'enfants actuellement vivants : /____/
Nombre d'enfant nés vivants et décédés : /_____/
Nombre d'avortements spontanés ou de mort-nés : /____/
Age du 1er enfant vivant (ans et mois) : /_____/
Age du dernier enfant vivant (ans et mois) : /_____/
Statut matrimonial : /_____/
Votre mari a-t-il d'autres épouses ? oui /____/ non /____/ Si oui combien ?/____/
Quel est votre niveau d'instruction le plus élevé ?: /_____/
Avez-vous été alphabétisée dans une langue quelconque ?
Si oui pendant combien de temps (mois) : /____/ et dans quelle langue ?:……
Date de votre dernier accouchement (vérifier dans le carnet CPN si elle avait accouché au CSPS ; sinon se contenter de mm/yyyy): /____/_____/_____/

Pouvez-vous me décrire les avantages et les inconvénients d'un accouchement à domicile ?

- Pour la mère ?
- Pour le bébé ?
- Pour la famille?

Pouvez-vous me décrire les avantages et les inconvénients d'un accouchement au CSPS ?

- Pour la mère ?
- Pour le bébé ?
- Pour la famille?

Au cas de complications de l'accouchement à domicile, quelles mesures peuvent être prises pour sauver la vie de la mère et son bébé ?

- Qu'est-ce qui peut être fait au sein du village ?
- Qu'est-ce qui peut être fait au CSPS ?
- Qu'est-ce qui peut être fait au CMA/ CHR de Banfora?

Pendant votre grossesse avez-vous parlé du lieu d'accouchement avec un membre de la famille?

- Quel membre de la famille a initié cette conversation?
- Y a-t-il eu un accord sur le lieu de votre accouchement?
- En cas de désaccord sur le lieu prévu pour l'accouchement, quel membre de la famille a pris la décision finale sur le lieu d'accouchement?

En considérant le lieu d'accouchement, la tarification de celui-ci dans un CSPS était-elle connue?

- Comment l'avez-vous su ?

- Le prix, était-il déterminant pour le choix que vous avez fait?
- Aviez-vous fait des économies en prévision de votre accouchement?

Avez-vous effectué au moins une consultation prénatale (CPN) pendant cette grossesse?
- Si oui, combien de fois? Si non, pourquoi pas?
- Les CPN étaient-elles dans le même CSPS que pour l'accouchement?
- Etiez-vous contente des soins qui vous ont été offerts lors de cette CPN?
- Si non, pourquoi?

Où étiez-vous lorsque les douleurs du ventre pour l'accouchement (travail) ont commencé?
- Quand avez-vous senti les premières contractions utérines?
- Qui était avec vous à ce moment là?
- Votre mari/ votre père, était-il à vos côtés?

Pouvez-vous me décrire le déroulement de votre travail ?
- Où étiez-vous ?
- Le travail, a-t-il pris beaucoup de temps ?
- Après l'accouchement, le bébé, était-il en bonne santé ?

Pouvez-vous me décrire les gens qui vous ont assisté à l'accouchement?
- Caractéristiques: sexe, âge?
- Comment était leur comportement (respectueux)?
- Etaient-ils compatissants?

En tout, combien avez payé pour cet accouchement?
- A l'accoucheuse villageoise ?
- A la matrone ?
- Quels autres payements avez-vous fait et combien cela a-t-il coûté ?
- Est-ce que ces coûts ont posé des soucis pour vous/votre famille?
- Comment avez-vous fait pour payer ce montant (économies, ventes, prêts) ?

Quelle est votre impression générale sur les soins obstétricaux dispensés au CSPS (si vous y avez déjà accouché la-bas)?
- Resterez-vous à domicile pour un prochain accouchement?
- Pour quelles raisons recommanderez-vous l'accouchement à domicile à d'autres femmes?

Avez-vous quelque chose d'autre que vous voulez ajouter?

Nous vous remercions beaucoup pour votre contribution !

Fiche d'entretien avec le personnel de santé

Interview avec le personnel du CSPS

But:
Identifier les obstacles aux pratiques obstétricales essentielles au sein CSPS.

Objectifs:

1) Identifier les obstacles à la disponibilité, à la qualité et à l'utilisation des soins obstétricaux dans le CSPS.

2) Décrire la perception de ces obstacles par le personnel du CSPS.

Introduction

Données sociodémographiques de base

Date de l'interview : /_____/_____/2011
Nom du CSPS:……
Nom du participant à l'étude:…….
Sexe participant: /_____/
Qualification professionnelle de l'agent: ……..
Niveau d'études le plus élevé :…….
Ancienneté dans l'exercice professionnel de santé (années) ……
Durée d'exercice dans l'actuel CSPS (années):

Description du contexte général des soins au CSPS

Pouvez-vous me décrire, en général, les pratiques essentielles lors de l'accouchement pour assurer la santé du bébé?

- Comment peut-on évaluer le déroulement du travail chez une parturiente?
- Si le déroulement du travail n'est pas satisfaisant, quelles mesures faut-il prendre à votre avis?

Pouvez-vous me décrire, en général, les pratiques essentielles après l'accouchement pour garantir la santé du nouveau-né?

- Si le nouveau-né s'étouffe ou ne respire pas/plus, qu'est-ce qu'il faut faire?
- Comment faut-il faire les soins du cordon?

Pouvez-vous m'indiquer les soins postnataux essentiels?

- Combien de temps les femmes restent au CSPS après l'accouchement ?
- Les femmes, reviennent-elles au CSPS pour une consultation postnatale ?
- Le personnel du CSPS, rend t-il une visite à domicile aux accouchées récentes (<7 jours)?

D'après vous, quel pourcentage de femmes enceintes de votre région vient au CSPS pour l'accouchement?

- Quelles sont les raisons pour lesquelles les femmes viennent pour l'accouchement?

- Quelles sont les raisons pour lesquelles les femmes ne viennent pas pour l'accouchement?
- Quel(s) membre(s) de la famille décident du lieu d'accouchement de la femme?
- Dans les villages, quelle réputation a selon vous ce CSPS ?
- Selon vous, les femmes ayant accouché dans ce CSPS, sont-elles contentes des soins reçus?

Dans votre travail dans ce CSPS, à quelles sortes de complications obstétricales faites-vous face le plus souvent?

- Ces complications sont-elles courantes? Rencontrez-vous ces complications fréquemment?
- Dans quelles conditions les parturientes arrivent-elles ici?
- D'après vous, pourquoi est-ce que les parturientes arrivent dans de telles conditions?
- Pour la plupart des mères, quelle est la distance moyenne pour se rendre jusqu'au CSPS?
- Combien de temps faut-il pour faire ce trajet (à pied, en mobylette ou avec d'autres moyens de transport)?
- La tarification des soins, contribue-t-elle au fait que les femmes n'arrivent pas dès le début du travail
- Y-a-t il du personnel au CSPS 24h sur 24, 7 jours sur 7? Quel type de personnel?
- Quel membre du personnel prend la garde de nuit au CSPS/à la maternité?
- Qu'est-ce qui se passe lorsqu'une femme présentant des complications obstétricales arrive au CSPS?
- Les médicaments utilisés pour le traitement des complications obstétricales, sont-ils toujours disponibles au CSPS (dépôt MEG)?

Si une parturiente a besoin d'être évacuée jusqu'au CMA le plus proche ou au CHR de Banfora, qu'est-ce qui se passe?

- Qui est responsable du transport?
- Le coût de l'évacuation, est-il un obstacle au déroulement de celle-ci?
- Lors d'une évacuation, quel est le rôle du personnel du CSPS?
- Dans les cas où l'évacuation n'a pas lieu, quelles peuvent en être les raisons?
- Dans les cas où l'évacuation n'a pas lieu, qu'est-ce qui se passe habituellement?

<u>Barrières dans le CSPS</u>

Vous m'avez décrit les soins nécessaires pour assurer la santé du nouveau-né, pendant, et après l'accouchement. Etes-vous capable de fournir ces soins essentiels au sein de ce CSPS?

- Avez-vous le temps de fournir ces soins?
- Les soins du nouveau-né sont-ils prioritaires dans le CSPS?
- Le matériel nécessaire est il disponible et fonctionnel?
- Savez-vous comment utiliser le matériel?
- Avez-vous le droit d'utiliser ce matériel?
- La patiente et/ou sa famille s'opposent-elles aux pratiques essentielles décrites auparavant?

Est-ce qu'il y a des choses dans le fonctionnement du CSPS qui limitent l'utilisation par les femmes des soins offerts ?

- Le coût, pose-t-il un problème pour la mère et sa famille?

- Les soins offerts sont-ils acceptables pour la mère/sa famille/la communauté?
- Est-ce que le temps d'attente pourrait être une des raisons pour lesquelles les femmes ne viennent pas?
- Est-ce que le manque de ressources matérielles puisse faire que les femmes ne viennent pas?
- Quelles sont les autres raisons de faible fréquentation du CSPS par les parturientes selon vous ?

Quelles mesures peuvent-être prises pour mieux soigner les femmes venant avec des complications obstétricales urgentes?

Quels problèmes rencontrez-vous en soignant les femmes avec des complications obstétricales urgentes?
Quelles sont les raisons pour lesquelles une parturiente peut être amenée à patienter avant de recevoir des soins dans le CSPS?

Comment faire face aux barrières d'une plus grande fréquentation du CSPS?

Récapitulatif des problèmes rencontrés au CSPS par le modérateur:

Comment faut- il aborder ces problèmes ?
- Qu'est t-il possible de faire au sein même du CSPS?
- Quel membre du personnel du CSPS serait le mieux qualifié pour introduire (ou initier) de tels changements?
- D'après vous, qu'est-ce que le Ministère de la Santé peut y faire?

Avez-vous quelque chose d'autre que vous voulez ajouter?

Nous vous remercions infiniment pour votre contribution !

Guide d'entretien pour les focus groupes avec les leaders communautaires

Guide d'entretien pour les discussions en focus groupe

Lorsqu'une femme est enceinte, y-a-il une discussion sur le lieu d'accouchement?

Dans cette région est-ce qu'il y a des préparations pour l'accouchement qui se font pendant la grossesse (transport, économies)?

En cas de désaccord sur le lieu prévu pour l'accouchement, quel membre de la famille prend la décision finale sur le lieu d'accouchement?

Quelles sont les raisons pour lesquelles les femmes accouchent parfois à domicile?

Que font les accoucheuses villageoises pour assister les femmes lors de l'accouchement?

Que font les agents du CSPS pour assister les femmes lors de l'accouchement?

Dans cette région, arrive-t-il que les maris sont absents lorsque le travail commence?

Dans cette région, quelles sortes de complications obstétricales rencontre t-on à l'accouchement?

D'après vous, quelle complication est la plus grave?

Si une femme de votre village présent une complication lors de l'accouchement, que peut-elle/sa famille faire?

Est-ce que les femmes enceintes et/ou leurs familles font des prévisions pour les cas où une complication surviendrait?

Après l'accouchement, est-ce que la femme est libre de sortir de chez elle comme elle veut?

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