Decentralization and health resources transfer to local governments in Burkina Faso: A SWOT analysis among health care decision makers

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Abstract

**Background and Aims:** In line with the decentralization policy, in 2009, the central government of Burkina Faso issued a decree to transfer health resources to local governments for fulfilling their new responsibilities in health care provision. The first stage of this health care decentralization process involved the basic health care facilities, composed of primary health care facilities, maternities, dispensaries, maternal and child health centers, and essential drugs depots.

This study seeks to explore the strengths, weaknesses, opportunities, and threats (SWOT) associated with the health resources transfer in Burkina Faso, from the perspective of decision makers.

**Methods:** We used a qualitative research approach. We conducted 17 semistructured interviews with 17 representatives of key decision-making groups, in August to December 2017 in Burkina Faso. The participants included mayors of municipalities, health district managers, policy decision makers, and donors/partners. The data collected were subjected to a directed qualitative content analysis, and the SWOT framework was used to select themes and codes for the analysis.

**Results:** The most cited strength was the improvement of local governance, which also creates the opportunity for an enhanced partnership and decentralized cooperation. As expected, however, the limited financial capacity of local governments is an important weakness. Furthermore, misuse of financial resources threatens the resources transfer. Recommendations to improve decentralization and health resources transfer included effective enforcement of decentralization’s laws and policies, strengthening local governments’ capacities, adequate funding, and evaluation of the resources transfer process.

**Conclusions:** An analysis of the preconditions for a successful resources transfer is needed to provide guidance to policy.

**KEYWORDS**
Burkina Faso, decentralization, health resources transfer, local governments, SWOT analysis
1 | INTRODUCTION

In the health care sector, decentralization frequently involves the devolution of some administrative functions to local governments. These functions include, for example, management of health care personnel, hiring of staff, purchasing supplies and equipment, and purchasing and delivery of services. The experience with health care decentralization in Sub-Saharan Africa is rather mixed. Systematic reviews show important shortcomings in the decentralization process, the most important of which are the delay in the transfer of financial resources from the central state to local governments, the lack of formal coordination mechanism between health centers and local governments, the weak capacities of local governments to manage the health personnel, equipment and technical activities, the political interference with the health personnel recruitment process, and the intensive state intervention. However, good practices are also identified in countries where the government is able to make legislative and administrative changes to facilitate decentralization. The resulting achievements were the increased autonomy in the mobilization and allocation of financial resources from local sources, the enhancement of the accountability of health workers and reduction of bureaucratic procedures in decision making, a greater involvement of the grassroots community in the planning process, and the identification of their local priority needs. In this paper, we specifically focus on the experience with health care decentralization in Burkina Faso.

1.1 | Context of health care decentralization in Burkina Faso

Burkina Faso is divided into 13 regions, 45 provinces, 370 departments, and 351 local governments (communes). The regions correspond to the territorial breakdown of the health directorates. They are headed by governors, who are appointed by the central government and act as representatives of the Ministerial department in the regions. The governors assure the enforcement of laws at a regional level. The provinces are headed by the High Commissioners, who are also appointed by the central government and are representatives of the respective governor. They ensure the enforcement of laws at the provincial level. The departments are headed by the centrally appointed Prefects, who are representatives of the High Commissioners at the department level and ensure the enforcement of laws at that level. The communes (local governments) are run by elected mayors who are the head of the communal administration. They perform administrative, civil registrar, and police officer functions. The local governments are autonomous in terms of management and financing. Their budget comes mainly from local taxes, revenues from local services grants, subsidies from the central government, and intergovernmental transfers.

The local governments have no formal administrative or hierarchical relationship with the health directorates or their subdivisions, the health districts. The health directorates, health districts, and hospitals have a semiautonomous status in terms of management. They receive annual planning guidelines from the Ministry of Health and decide over their organization priorities. The financial and human resources are allocated to the health directorates, health districts, and hospitals by the central government on the basis of the needs that they express. The staff salary is also paid by the central government.

The health care system in Burkina Faso has witnessed significant policy and organizational changes over the past decades. In 1960-1979, the health care system in Burkina Faso was strongly centralized. It was based on the “all-state” model, in which the central government managed health care provision and funding. However, in 1980-1990, the concept of primary health care was introduced, to enhance community participation and ownership in health care management. One of the cornerstones of the primary health care policy was the adoption of the Bamako initiative in 1987, whose aim was the strengthening of the participation of different local stakeholders in the management of health care, through an increased decentralization of health resources. Against that background, Burkina Faso undertook, in 1992, a health system reform that reshaped the health system into two main areas, described below.

The first area is system administration, which is organized into three levels, namely, the central, regional, and peripheral (operational) levels. The central level consists of national and central directorates organized around the Ministry of Health. The role of these directorates is to develop national health policies and guidelines, to ensure their implementation, and to mobilize and allocate health resources. At the regional level, there are the 13 health directorates, and their main role is to ensure the implementation of national health policies and to supervise the 70 health districts. At the peripheral (operational) level, the health districts ensure an effective implementation of the national health policies and oversee the primary health care centers.

The second area is the provision of health care according to four levels. The first level is represented by primary health care centers, which provide communities with basic preventive and curative primary health care (essential package), and referrals to district hospitals. Their number was estimated at 1839 in 2017. They are run by the Chief Nurse, appointed by the District Medical Officer. The second level consists of the district hospitals. Their number was estimated at 45 in 2017. They are headed by the District Medical Officer, appointed by the central government. The third level is represented by regional hospitals, which provide specialized care and represent the point of referral of district hospitals. Their number is estimated at eight in 2017. They are managed by the Directors General appointed by the central government. The fourth level comprises six teaching hospitals, which provide tertiary care and represent the point of referral of regional hospitals. They are also run by the centrally appointed Directors General.

1.2 | Content of the health care decentralization policy in Burkina Faso

In 2007, a decree was adopted in Burkina Faso that provided a strategic framework for implementing decentralization (in French "Cadre..."
Stratégie pour la mise en œuvre de la Décentralisation”). An additional decree was issued in 2009, by the central government, to transfer health resources (both human and financial capital) to local governments for fulfilling their new responsibilities in health care provision.

The first stage of this health care decentralization process involved the basic health care facilities, composed of primary health care facilities, maternity units, dispensaries, maternal and child health centers, and essential drugs depots. Through an institutional agreement, local governments have been given the responsibility for the management of these health care facilities, procurement and supply of medical commodities, disease prevention, and sanitation.

The central government has kept its regulatory role, which includes defining the national health policy and orientation, setting norms and standards for the health infrastructure, equipment, health services functioning, and management. The government also oversees health facilities and allocates financial resources through grants and subsidies to local governments. Two main objectives underline the rationale of resources transfer to local governments in Burkina Faso: The first is to boost the grass-root development by enhancing the local governments capacities and ownership, and the second is to strengthen local democracy and governance.

The decentralization process is, however, not completed, since local governments have not yet taken over the entire management of resources transferred. Although the decree of 2009 to transfer health resources to local governments has brought clarity about the roles and responsibilities of the key players, there are concerns about some major issues, such as the adequacy of organizational and operational structures, as well as the match between needs and resources.

The implications of the decentralization and health resources transfer process in Burkina Faso have not yet been analyzed, and there are also no systematic evaluations of this reform. Given the overall lack of data on the topic, this study explores the strengths, weaknesses, opportunities, and threats (SWOT) associated with the health resources transfer in Burkina Faso from the perspective of decision makers. The study follows a qualitative approach. The opinions of key decision-maker groups are triangulated to determine the degree of consensus about the progress of this reform. The study provides evidence for health care decentralization in Burkina Faso, which can be of interest for other Sub-Saharan African countries where such reforms are underway or considered for implementation.

To structure the data collection and analysis, the SWOT framework was used. This framework comes from the area of management but has been already successfully applied in studies on health services as well. The objective of our analysis was to identify the strengths and weaknesses of the health care decentralization and health resources transfer in Burkina Faso, in addition to the opportunities and threats to which they are exposed. We also analyzed the degree of consensus between the participants in qualitative terms.

The guide (semistructured questionnaire) used in the interviews was developed in English and then translated into French to collect information on the following aspects: strengths, weaknesses, opportunities, and threats to decentralization and recommendations for improving the decentralization and process of resources transfer. To assure a common understanding among the participants, an explanation of the SWOT dimensions was given to them during the interviews. The guide was pretested before commencing data collection with five respondents (one district medical officer, one mayor, one policy maker, one country partner, and one head of primary health care center) who were not included in the group surveyed. The guide was slightly adjusted for the different groups (identification section). The different versions of the guide are provided in the Supporting Information.

A nonprobabilistic sampling method was applied to select participants from each group. Specifically, the participants were purposefully selected because of the involvement or participation of their organization in the decentralization process, as well as because of their management position. These selection criteria were applied to assure that only decision makers with relevant position or function were included in the study. Also, to assure the inclusion of diverse opinions, participants from both rural and urban areas were selected. Thus, the initial list included 25 potential participants, all from different institutions: five from municipalities (targeting mayors); seven from health districts and health centers (targeting health district managers); seven from health regions and regional councils (targeting policy decision makers at a regional level); four from national level decision makers organizations (targeting policy decision makers at a national level); and two from donor organizations (targeting donors).

An invitation was sent to the selected participants. The invitation explained the study objectives, scope, and methods.

All interviews were individual face-to-face interviews and took place at the participants’ office. Qualified interviewers were recruited and trained on the study methodology and interview skills, including protection of confidentiality, anonymity, and privacy of each participant. The interviewer made an appointment in advance with a participant to agree on the time and location. The average interview duration was 45 minutes. The main researcher supervised the data collection and checked the consistency of the data. The data were collected using edited transcription method on printed word sheets. The interviews were not recorded. At the end of each interview, the data collector summarized the key participant’s answers and discussed them with the participant to ensure that the participant’s views are well recorded.

2 MATERIALS AND METHODS

In this study, qualitative research methods were used to collect data among decision makers involved in the health care decentralization process. For this purpose, in-depth semistructured interviews with representatives of key decision-making groups were conducted in August to December 2017 in Burkina Faso. The targeted decision-making groups included (a) mayors of municipalities, (b) health district managers, (c) policy decision makers at a regional and national level, and (d) donors/partners.
The data analysis started 2 weeks after the end of the data collection in the field. The data collected underwent a directed qualitative content analysis. Thus, themes and codes were defined in advance on the basis of the SWOT framework. The analysis was performed by the main researcher, who was the single data coder. Intermediate and final results of the data analysis were discussed with the other two researchers involved, and in this way, unclarities were resolved.

Data were analyzed manually in five steps: reading the content, coding, displaying, data reduction, and interpretation. Specifically, the main researcher identified the common themes and ideas related to the SWOT dimensions: strengths, weaknesses, opportunities, and threats of health service decentralization in Burkina Faso. Information that reflected reality as expressed by participants was retained and organized in a MS Excel file for each theme. The responses were summarized in two steps: The first step was the aggregation of responses, and the second step consisted of disaggregation of responses according to participant groups.

Saturation was achieved within the groups of mayors, health district managers, and policy decision makers at a regional and national level. For the country donor's group, saturation was not achieved, i.e., while there were similarities between the two interviews with donors, there were also some new findings in the second interview. This suggested the need of an additional interview to confirm the saturation among donors, but we were unable to identify another donor involved in the health care decentralization. Nevertheless, we decided to include the results for donors because they offered a different perspective.

On the basis of the analysis, a SWOT matrix was designed to summarize the key findings and to identify the level of knowledge and consensus among the participants. The results are presented narratively and also supported with tables and quotations from the interviews. The subsequent interpretation of the results was used to outline recommendations for strengthening the decentralization implementation and improving the process of health resources transfer.

We present quotations from the interviews to show the level of consistency of data and findings, as well as similarities across the participant groups. The quotations also illustrate and clarify the major themes. We disregarded minor themes not directly related to the aim of our paper.

2.1 Ethical considerations

Ethical considerations were safeguarded throughout the study process. The research protocol was submitted for ethical approval, and such approval was granted by the ethical committee of a national health research institute, namely, "Institut de Recherches en Sciences de la Santé (IRSS), Centre National de la Recherche Scientifique et Technologique (CNRST), University of Ouagadougou (Burkina Faso)." All data were analyzed, reported, and stored in formats that do not allow identification of the individual participants. A verbal informed consent was obtained from each individual participating in the study and was registered by the interviewer. This involved informing the participant about the purpose for which the information is obtained and its use in a manner that can be understood by the participant.

3 RESULTS

In total, among 25 potential interviewees, 17 in-depth interviews were carried out, and eight persons contacted were unavailable (one mayor, two health district managers, three policy decision makers at a regional level, and two policy decision makers at a national level did not participate in the study).

Thus, the final participant list included the following:

- four mayors of municipalities, including two former mayors (two working in urban municipalities and two in a rural municipalities),
- five health district managers (two health district managers working in urban districts, one health district manager in a rural district, and two heads of primary care centers),
- four policy decision makers at a regional level (three health regional directors and one president of a regional council),
- two decentralization policy makers at a national level, and
- two representatives of country donors/partners.

The years of experience in their position range from 2 to 7 years, with an average of 4 years.

Various strengths, weaknesses, opportunities, and threats were suggested by the participants. Given the fairly large number of items suggested by the participants for each of these four categories, the five most-often-mentioned items in each category are briefly presented in the text. The full set of items is summarized in Table 1.

3.1 Strengths

The strengths that were suggested by most participants are the improvement of local governance (8/17), the declared political will of the central government (6/17), the improvement of communities' participation (5/17), the local partnership for resources mobilization (4/17), and the effective establishment of democracy (2/17).

On the improvement of local governance and the political will as strengths, a regional director of health (Ki13) declared:

_I think that decentralization is a development policy driven by the central government. The transfer of resources to local governments depends heavily on the will to implement the decentralization policies and laws._

One policy maker from the Ministry of Decentralization (Ki1) expressed the growing interest of citizens, as follows:

_With democracy, there is awareness-raising and citizens are taking an interest in public affairs._
A mayor (Ki9) highlighted this change, as follows:

Democracy has pushed the decentralization forward, and local elected administrative bodies and councils can play a great role in the grass-root development.

3.2 | Weaknesses

The top five weaknesses that impede the decentralization and health resources transfer process, according to participants, are the limited financial resources allocated to local governments (10/17), the weak capacities of the different stakeholders (9/17), the weak capacities of some local governments for the management of resources transferred (7/17), and misunderstanding about decentralization by the different stakeholders (3/17).

Inadequate funding does not facilitate the management of resources transferred by the central government, including the health resources, as stated by some participants. A mayor (Ki11) expresses his concern, as follows:

Financial resources are key to sustain the management of resources transferred. We are experiencing delays in funding allocation by the central government, and available funds are often not adequate.

To emphasize the funding issue, a health district manager (Ki6) stated:

The funding allocated by the central government to support the health resources transfer to local governments is not sufficient to cover the needs of health facilities.

Regarding local governments’ capacities, one health policy maker (Ki2) noted that:

Obviously some local governments have limited capacity to manage the resources transferred. The majority of some local governments’ council members, particularly in rural area, are illiterate and do not have knowledge about health issues and challenges. This makes the collaboration between the health districts and local governments difficult.
Some local governments recognize their limits. A member of a local government's council (Ki10) expressed this concern as follows:

“Our municipality does not have the required capacity to handle health issues. My background is as a school teacher and I am the focal point for education and health issues within our council. I think it would be advisable to appoint a health specialist to each local government.”

Other weaknesses were identified by the participants, among which was the misunderstanding of decentralization by the different stakeholders. Regarding this point, a decentralization decision maker said (Ki2):

“We noticed that the key actors have no control over their role in the decentralization process, which resulted very often in misunderstanding, crisis, and deadlocks within local government’s councils.”

One key weakness that was raised quite frequently by health service providers is the discrepancy between the territorial division of local governments and health sector. Both mayors and health district managers recognized that this creates difficulties for the management of health resources transferred. This lack of harmonization remains one of the biggest concerns. One head of a health center (Ki16) illustrated this point as follows:

“Before the resource transfer, we had easy access to the health district office, which was very close to the health center. Now, our health center is under the responsibility of the local government, the offices of which are located very far from the health center. Seeking, for instance, an authorization for an annual leave requires long travel time.”

### 3.3 | Opportunities

Participants identified a few opportunities that the decentralization and health resources transfer could create. The opportunities most often identified by the participants are the further enhancement of partnership and decentralized cooperation (5/17), the enabling international environment (4/17), the autonomy in local resources mobilization (3/17), the better functionality of decentralized services (2/17), and the country’s political stability (2/17).

On the matter of resource mobilization, a president of a regional council (Ki13) said:

“Decentralization allows local governments to collect taxes for generating local revenues to finance their development, given the limited resources and subsidies provided by the central government.”

A mayor (Ki12) suggested that the current environment enhances partnership and cooperation and noted that:

Decentralization gives an opportunity to establish twinning with other cities at a national and international level.

### 3.4 | Threats

The top five threats mentioned by participants are the misuse of financial resources (8/17), the risk of politicization (6/17), the weak implementation of decentralization laws and policies (5/17), the social and political crisis (4/17), and the resistance from the central government (3/17).

The misuse of funds and the politicization of decentralization are seen to result in political instability and crisis. One decision maker from the Ministry of Decentralization (Ki1) put it in this way:

“Politicization and corruption with misuse of resources cause frequent crisis, leading to council’s dissolution and a renewal of institutions and management teams that need to be trained and updated on the management of resources transferred.”

On the threats related to the decentralization laws and policies, a country partner (Ki14) said:

“Most of the crisis that we are observing within local governments’ councils is mainly due to a weak implementation of decentralization laws/policies, including their inconsistent follow up and misunderstanding among key stakeholders.”

About the resistance from the central government, a policy maker from the Ministry of Decentralization (Ki1) expressed the following opinion:

“There are some key actors from the central government who strongly think that the local governments are unable to manage the resources transferred. This lack of trust could explain the retention of resources at a central level, as well the recurrent delays observed in the implementation of decentralization laws and policies.”

On this point, a mayor (Ki11) expressed his disappointment as follows:

“We have the feeling that there is a permanent battle between the local governments and central government. We think it is the same country, and local governments should not be considered as separated entities or institutions.”

The resistance among health specialists takes the form of a lack of trust, as expressed by a health district manager (Ki8):

“Health is a very sensitive and specific field which has to be managed only by health specialists. I do not believe at all in local government capacities and readiness to handle health issues. The future will tell.”
| Affiliation of Participants | Strengths | Weaknesses | Opportunities | Threats |
|----------------------------|-----------|------------|---------------|---------|
| Health services providers  | • Political will of central government  
|                            | • Improvement of local governance  
|                            | • Enhanced local partnership for resources mobilization  
|                            | • Gradually strengthening of local governments' capacities  
|                            | • Improvement of communities' participation  
|                            | • Financial support from central government  
|                            | • Willingness of local governments to ensure the full management of resources and skills transferred | • Weak capacities of some local governments for the management of resources and skills transferred  
|                            | • Improved local governance  
|                            | • Limited financial resources allocated to local governments  
|                            | • Discrepancy between the territorial division of local governments and health map  
|                            | • Misunderstanding of decentralization by the different stakeholders  
|                            | • Weak coordination and communication between local governments and health districts  | • International/global trends towards decentralization  
|                            |                                            | • Political will  
|                            |                                            | • Enhanced partnership and decentralized cooperation  
|                            |                                            | • Increased need of transparency and democratic alternation  
|                            |                                            | • Country political stability  | • Risk of politicization  
|                            |                                            | • Misuse of resources  
|                            |                                            | • Social and political crisis  
|                            |                                            | • Weak capacities of some local governments for the management of resources transferred  
|                            |                                            | • Resistance from health specialists  
|                            |                                            | • Terrorism  |
| Local governments          | • Improvement of local governance  
|                            | • Political will of central government  
|                            | • Effective involvement of locally elected officials  
|                            | • Strengthening of collaboration with decentralized department's servants  
|                            | • Building of health infrastructure  
|                            | • The provision of staff by central government  
|                            | • Existence of local/communal development plan | • Limited financial resources allocated to local governments  
|                            |                                            | • Weak capacities of different stakeholders  
|                            |                                            | • Weak capacities of some local governments for the management of resources and skills transferred  
|                            |                                            | • Lack of agreement among stakeholders about the resources and skills transfer process  
|                            |                                            | • Partiality in resources and skill transfer by the central government  | • Enhanced partnership and decentralized cooperation  
|                            |                                            | • Enhanced local partnership for resources mobilization  
|                            |                                            | • Opportunity for health services improvement  
|                            |                                            | • Resources availability  | • Weak implementation of decentralization laws and policies  
|                            |                                            | • Misuse of financial resources  
|                            |                                            | • Lack of cooperation between some decentralized departments  
|                            |                                            | • Misuse of human resources  
|                            |                                            | • Risk of politicization  |
| Donors                     | • Improvement of local governance  
|                            | • Effective establishment of democracy  | • Weak ownership of decentralization process by the stakeholders  
|                            |                                            | • High politicization of the resources transfer process  | • Political and social crisis  |
The summary of participants’ responses is presented in Table 1, in the form of a SWOT matrix. The responses in each category are presented in decreasing order of frequency.

The disaggregation of the responses according to the participants’ affiliation is presented in Table 2. The table shows that while there are similar results across the decision makers in our study, there are also some differences.

Specifically, the comparison of the results across the decision makers groups indicate that the responses seem to be converging to a certain extent. Health services providers and local governments have identified as strengths the improvement of local governance and political will. The weaknesses proposed are related to the limited financial resources allocated to local governments and the weak capacities of some local governments for the management of resources transferred. The opportunity cited is the enhanced partnership and decentralized cooperation, while the threats are related to the risk of politicization and the misuse of financial resources. In addition to the improvement of local governance as a strength, the donors suggested the effective establishment of democracy. The best practices on decentralization from other countries were identified as opportunities that Burkina Faso could take advantage of, and finally, the political and social crisis was seen as a threat to decentralization and resources transfer.

Further analysis was done on the basis of mayors’ political affiliation, which is publicly known. Although the “mayor” group was rather small (two from the opposition and two from the governing party), we did a preliminary analysis to uncover whether their political affiliation could be related to their responses. The findings are presented in Table 3. This part of the analysis could be only performed for mayors because the political affiliation of the other participants was unclear since it was not asked for during the study.

The comparison of the results in Table 3 across the mayors’ groups shows that mayors with different affiliation have quite similar opinions on the SWOT aspects related to decentralization and health resources transfer. With regard to the strengths, the improvement of local governance was suggested by both groups, while the weaknesses identified by both groups are the limited financial capacities and weak capacities of some local governments. The opportunities suggested were related to the enhanced partnership and decentralized cooperation, and the threats have to do with the weak implementation of decentralization laws and the misuse of resources. Mayors from the governing party emphasized the strengths to the decentralization, while the opposition party often indicated the risk of politicization. Overall, the participants highlighted the highly political nature of the health care decentralization.

### 3.6 Ways to address the weaknesses and threats

The participants were also asked to suggest ways to address the weaknesses and threats in order to improve the decentralization and resources transfer. The main results are presented in Table 4.
TABLE 4  Suggestions to mitigate the weaknesses and threats to decentralization and health resources transfer in Burkina Faso according to the decision makers’ affiliation

| Affiliation of Participants | Ways to Improve Decentralization and Health Resources Transfer |
|----------------------------|---------------------------------------------------------------|
| Health services providers  | • Strengthen the capacities of different stakeholders (training, appointment of skilled personnel)  |
|                            | • Ensure an effective enforcement of laws and policies related to health resources transfer  |
|                            | • Allocate an adequate financing to primary health care facilities  |
|                            | • Review the current organization of the health system and appoint health specialist at the local government’s level  |
|                            | • Establish a technical coordination mechanism between the health districts and local governments with focus on awareness raising  |
|                            | • Set up a program or a budget at a district level to support the local government  |
|                            | • Conduct a regular annual review on health resources transfer  |
| Local governments          | • Ensure an effective enforcement of laws and policies related to decentralization  |
|                            | • Increase awareness of the different stakeholders including the politic leaders  |
|                            | • Train the different stakeholders involved  |
|                            | • Strengthen the capacities of local governments by appointing qualified personnel  |
|                            | • Allocate an adequate funding  |
|                            | • Appoint health specialists at a local government level  |
|                            | • Ensure the timeliness in health resources transfer  |
|                            | • Develop open collaboration between health districts and local governments  |
|                            | • Review the current laws and policies to enhance the stability of local governments’ board (avoid recurring crisis)  |
| Donors                     | • Ensure an effective enforcement of laws and policies related to decentralization  |
|                            | • Strengthen the capacities of local governments by appointing qualified personnel  |
|                            | • Conduct a review of the process of all the resources transfer (education, health, etc) from the central government to local governments  |

The results in Table 4 show that there are four main areas that would require focus according to the participants: (i) enforcement of decentralization laws and policies, (ii) capacity building with adequate staffing, (iii) adequate funding, and (iv) review of the resources transfer process.

Regarding the decentralization laws and policies, a regional director of health (Ki5) stated:

_The majority of issues that we experienced resulted from a partial or a lack of proper implementation of the texts governing the health resources transfer. The different laws adopted have to be properly implemented and monitored._

Along the same lines, a country partner (Ki15) stated:

_A proper implementation of laws and policies related to resources transfer, including a consistent follow up, will help to undermine the bottlenecks encountered._

Other key suggestions made by participants to improve the health resources transfer include the reorganization of the health system and awareness raising through a better collaboration between the health districts and local governments. With regard to health system organization, a regional health director (Ki4) noted:

_The current situation is a little ambiguous and makes the collaboration between health districts and local governments difficult. I think a review and a reorganization of the district health system towards a local government-focused will improve the delivery of health services._

This suggestion seems to be in agreement with the point of view of some local governments claiming an acceleration in the transfer of health resources. On this point, a mayor (Ki9) said:

_The health resources are not entirely transferred yet to local governments. For instance, the management of human resources remains under the control of the health district. There is a need to ensure a full transfer of health resources to local governments as stated in the decree issued by the central government._

4 | DISCUSSION

The aim of the study was to identify the SWOT related to decentralization and health resources transfer in Burkina Faso. The overall results of the study suggest that the participants are fairly knowledgeable of factors that can boost the health resources and skills transfer process, as well as those that could impede this process.

One of the key observations is the difference in participants’ understanding of the concepts of strength, weakness, opportunity, and threat. Some strengths are considered as opportunities and vice versa; some weaknesses are seen as threats and vice versa. This difference could be due to participants’ misunderstanding of the explanation given by the data collectors on the concept of strength, weakness, opportunity, and threats. However, it could also be a result of the perspective undertaken by the respondent. Strengths and weaknesses relate to factors internal to the health resources transfer, while opportunities and threats relate to the external environment (health care sector). Strengths and weaknesses may become opportunities and threats, respectively, when viewed externally. Other studies have also indicated this aspect of the SWOT analysis.  

The main strengths that may enhance decentralization and health resources transfer, from the participants’ point of view, are the political will and the strengthening of local governance. It is widely admitted that political will and support is key in the successful implementation of a national policy. According to Rondelli, the political commitment to decentralization is the sine-qua-non of strategy
A systematic review on municipal health services provision by local governments in Sub-Saharan African countries noted the highly political nature of the health resources allocation and skills transfer, characterized by continuous state intervention and politic interference. In fact, decision making of financial resource allocation, resources transfer, and the management of human resources remains under the control of the central or regional government.

With regard to the weaknesses, the participants pointed out the limited financial resources granted to local governments and the weak capacities of some local governments to manage general resources transferred and, particularly, health resources. These two main weaknesses raised by the participants have been identified in many studies on decentralization in Sub-Saharan African countries. These issues were also discussed in a report issued by the Minister of Decentralization of Burkina Faso.

Financial resources are key to support and sustain the management of resources transferred, as suggested by the participants. A policy review of the decentralization in Burkina Faso suggested that local governments’ budgets are extremely limited. For this reason, some decentralization actors in our study state that the central government does not give enough financial resources to local governments. Furthermore, when sufficient financial resources are given, some local governments are unable to spend them because of insufficient financial management capacities and the late disbursement of grants and subsidies by the central government.

Likewise, local governments have to possess sufficient capacities to properly manage these resources. On this point, the summary of a multicenter study conducted in West Africa on decentralization and resources transfer indicated that the main bottlenecks are the retention of financial resources and human resources at the central level and insufficient training of local stakeholders. Therefore, local governments do not have the required competencies and experiences to plan, implement, and evaluate development actions or initiatives at the local level. This tends to confirm the point of view of a mayor in our study about the permanent battle between the central government and local governments over the transfer of financial resources. This could be due to the opinions of some decision makers at the national level who strongly believe that the local governments do not have the required capacities, and therefore, the resources should be transferred progressively. This situation might be considered as a vicious circle, as “a snake biting its own tail.” However, a competence cannot be carried out without the required capacities, as confirmed by a study conducted on decentralization and health care prioritization process in Tanzania. This study suggested that the decentralization process needs to build greater technical and management capacity of the oversight institutions.

The main opportunities that were highlighted by the participants are the international/global trends towards decentralization, the increased need of transparency and democracy demanded by the citizens, and the autonomy in local resources mobilization. One key element that made an international context favorable to a country-wide policy is the support by donors and partners support. The decentralization reforms in Sub-Saharan Africa were largely supported by international institutions, such as the World Bank. In 1998, nearly 30% of the World Bank Projects implemented in the Africa region had a decentralization component. As suggested by participants, decentralization could take a great advantage of this enabling environment. Regarding transparency and citizens’ participation, decentralization provides an opportunity for the grassroots community to be involved in the planning process, as well as in the management of resources that were transferred to local governments such as primary health care facilities, primary schools, water, and sanitation. Also, decentralization plays a great role in resource mobilization, given that one of its outcomes is the increased ownership of citizens for their contribution to local resources mobilization to meet their needs and ensure a sustainable development. However, it is observed that apart from the urban local governments, the vast majority of local governments are underfunded and they rely solely on central government grants and subsidies. This might explain why the debate on resources transfer was focused on financial resources.

With regard to threats, the main issues identified by the participants are the risk of politicization and the misuse of financial resources. Given the politic nature of decentralization, the risk of politicization and misuse of funds is very likely if adequate control measures and mechanisms are not properly implemented. Various studies on decentralization found that political interference and political harassment of civilian servants are the factors militating against effective decentralization. Regarding financial resources, the findings of previous studies mainly indicate the lack of transparency in the allocation of resources, record-keeping, and auditing and lack of accountability of local governments in the management of resources provided. In Burkina Faso, newspapers have reported several cases of misuse of funds by local governments. This situation is mainly due to the weak enforcement of check-and-control mechanisms and the illiteracy rate of the local government councils’ members, which can reach up to 90% in some local governments. One important weakness or threat to decentralization, according to the view of the participants, is the resistance of the central government and health specialists. A decentralization policy review in Burkina Faso suggested that any social change creates resistance, particularly among the State’s officials. Often, the lack of understanding of decentralization’s policies and laws is stated in order to justify the officials’ refusal to collaborate with the decentralized bodies and councils. Such hostilities are related to a more general fear for reducing their power mainly over financial control and, therefore, their influence on people.

Finally, the participants suggested some recommendations to improve decentralization and health resources transfer. These suggestions were proposed to address the weaknesses and threats, as well to reinforce the strengths and opportunities. These included effective enforcement of decentralization’s laws and policies, strengthening of local governments’ capacities, adequate funding and review, and evaluation of the resources transfer process. Some of these recommendations were also provided by studies already conducted on decentralization and resources transfer. and this
raises the question of why the appropriate means to achieve the purpose of decentralization and resources transfer are not implemented.

An attempt to answering this question was suggested in a review on preconditions for successful implementation of decentralization in developing countries. This study argued that among the preconditions in implementing decentralization, there are two key factors. The first is the nature of the special implementation machinery that is put in place. Any agency that is meant to implement decentralization should have the authority, resources, and motivation. The World Bank suggests that the design of transfers is of critical importance to the success of decentralization. When local governments are expected to play a major role in delivering social services, the design of intergovernmental transfers is particularly important because the central government usually retains a strong interest in at least some of the outcomes. The second factor is the degree of acceptability or opposition it will generate at both the center and local levels.

Our study mainly identified factors that impede the decentralization process. These are the weaknesses and threats to the health care decentralization highlighted by the participants to this study. However, there are also other barriers to an effective health care decentralization suggested in the literature. Using the Walt and Gilson policy analysis framework, three additional factors, relevant for Burkina Faso, could be found in the literature in addition to the issues raised in the study. The first factor is related to policy content. As explained in Section 1, the health care decentralization policy in Burkina Faso is still not finalized, given the frequent political changes. This makes the decentralization implementation inconsistent and blurred for the different stakeholders. This also creates uncertainty about the next implementation phase. The second factor is related to the context within which the policy is formulated and executed. The resources transfer to local governments is part of the general decentralization policy, which has undergone several changes and reforms following the shifts of country leaders. This creates the impression that decentralization is just a slogan that can be interpreted more as a desire to seat the government’s power on popular support than as a true intent to share political power with the local levels of government. As a result, the stakeholders’ support might be weakened. The third factor refers to the actors involved in policy making. It is known that policy making, particularly in the field of decentralization, is still reserved for political elites who profit most of the expansion of their control through developing new local institutions or restructuring existing ones. Thus, a lack of knowledge on decentralization among other stakeholders might be a reason for them to avoid participation in the decentralization process.

4.1 Limitations of the study design

This is a qualitative study that aims to give an insight into the decentralization and health resources transfer to local governments in Burkina Faso. The sample was limited to 17 participants from 25 targeted institutions, which may not be representative of all institutions involved in the health care decentralization. Although representativeness is not an aspect of a qualitative study, like this one, we need to mention that our findings should only be seen as an indication of the impacts of decentralization and health resources transfer, rather than a representative picture for the entire country. This is especially true for the case of donors since the saturation in this group could not be confirmed. Also, the additional analysis for mayors’ political affiliation has no representative character. In addition, for our analysis, we applied the SWOT framework, which helped us to investigate the health care decentralization in Burkina Faso from different perspectives. The SWOT framework, however, limits the possibility to study the stakeholders’ involvement and their interactions, which necessitates a subsequent study to better understand the decentralization process in Burkina Faso.

5 CONCLUSION

From the results and their discussion, it can be concluded that the different decision makers, regardless of their professional affiliation and political affiliation (for mayors), appear to have a good knowledge of the decentralization process and are aware of the facilitating factors, as well as the bottlenecks to health resources transfer. Although progress has been made in the health resources transfer initiated in 2009, the key decision makers have identified weaknesses and threats that are impeding the process. These weaknesses and threats have been identified in previous studies in Burkina Faso as well as in some Sub-Saharan countries, as discussed above. To address these weaknesses and threats, it is necessary to assure the enforcement of decentralization’s policies and laws, and the strengthening of local government capacities, as well as their adequate funding and the regular review of resources transfer process. Furthermore, empirical studies on this topic are needed to provide evidence on the evaluation of the current decentralization phase, and the effective implementation of the subsequent phases.

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Investigation: Hilaire Zon
Methodology: Hilaire Zon, Milena Pavlova, Wim Groot
CONFLICTS OF INTEREST
The authors whose names are listed above certify that they have no conflicts of interests to report and are not affiliated with or involved in any organization or entity with any financial interest (such as honoraria; educational grants; participation in speakers’ bureaus; membership, employment, consultancies, stock ownership, or other equity interest; and expert testimony or patent-licensing arrangements), or nonfinancial interest (such as personal or professional relationships, affiliations, knowledge, or beliefs) in the subject matter or materials discussed in this manuscript.

TRANSPARENCY STATEMENT
The corresponding author affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of the article.

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