## COUNTRY FACTSHEET: BURKINA FASO 2020

Strategic Purchasing for Primary Health Care (SP4PHC) is a multi-country project implemented by ThinkWell with support from the Bill & Melinda Gates Foundation. Its purpose is to improve how governments pay providers for primary health care (PHC) services, with a focus on family planning (FP) and maternal, newborn, and child health (MNCH). The project is implementing programs of work in Burkina Faso, Indonesia, Kenya, the Philippines, and Uganda. We developed factsheets for each of the five countries that serve as a data reference for the strategies we chose within each.

### Demographic & Socioeconomic Characteristics

<table>
<thead>
<tr>
<th>Indicator (2019)</th>
<th>Burkina Faso</th>
<th>Kenya</th>
<th>Uganda</th>
<th>Sub-Saharan Africa</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total population (million)</strong></td>
<td>19.7</td>
<td>52.6</td>
<td>42.7</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Population growth (annual %)</strong></td>
<td>2.9</td>
<td>2.3</td>
<td>3.3</td>
<td>2.7</td>
</tr>
<tr>
<td><strong>Urban population (% of total population)</strong></td>
<td>29.4</td>
<td>27.5</td>
<td>24.4</td>
<td>40.7</td>
</tr>
<tr>
<td><strong>Poverty headcount ratio at $1.90 a day (% of population)</strong></td>
<td>43.7 (2016)</td>
<td>36.8 (2015)</td>
<td>41.7 (2016)</td>
<td>42.3 (2015)</td>
</tr>
<tr>
<td><strong>Human Development Index Rank (out of 189)</strong></td>
<td>182</td>
<td>147</td>
<td>159</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Source: World Bank 2019
Modern contraceptive prevalence (mCPR) amongst all women in Burkina Faso is low (26.9%) and 26.7% of married women have an unmet need for contraception. Government health facilities are the major source for modern contraception, providing services to 74% of users in the country. The proportion of users choosing long acting and permanent methods is high by global standards, and only slightly less common (48.9%) than the use of short acting contraception methods (51.1%).

Trends in mCPR (all women), unmet need (married/in-union women), and total fertility rate (all women), comparing Burkina Faso and Sub-Saharan Africa (2012-2018)

Source: CIA World Factbook

Source: Track20 2020 (mCPR and unmet need for FP), World Bank 2020 (total fertility rate)
Family planning methods used by Burkinabe women (% of all women of reproductive age, 2018)

- **Implant (44.0%)**
- **Injectable (31.9%)**
- **Condom (male) (5.9%)**
- **Pill (12.7%)**
- **Intrauterine device (IUD) (4.6%)**
- **Sterilization (female) (0.3%)**
- **Other modern methods (0.6%)**
- **Contraceptive (male) (5.9%)**

Source: Burkina Faso DHS 2010

Source of family planning methods by provider type (2010)

Source: Burkina Faso DHS 2010
Despite some improvements in the coverage of key interventions, Burkina Faso did not reach the Millennium Development Goals (MDGs) 4 and 5 for maternal and child health, and the country continues to face a high rate of maternal and child mortality. There are significant differences between urban and rural women and across wealth quintiles. The public sector plays the primary role in delivering MNCH services to women. Most women deliver in public facilities, but significant disparities exist between wealth quintiles.


Source: World Bank 2019

Trends in antenatal care (ANC), skilled birth attendance, facility deliveries, C-Sections, and MMR (1998-2015)

Source: WHO 2019 (C-section, delivery in health facility, ANC +4); World Bank 2019 (skilled birth attendant, MMR)
Proportion of all deliveries by facility type (2010)

- Public facility (65.6%)
- Private facility (1.1%)
- Home (33.3%)

Source: Burkina Faso DHS 2010

Proportion of all deliveries by place of delivery and wealth quintiles (2010)

Source: Burkina Faso DHS 2010
Maternal and newborn health indicators by residence (2010)

Source: Burkina Faso DHS 2010
The government’s share of current health spending is higher than the average across sub-Saharan Africa and has been increasing over the past two decades. Out-of-pocket (OOP) expenditure as a share of current health spending has also fluctuated considerably over the last two decades and is much lower than the average OOP for sub-Saharan Africa and low-income countries. This is, in part, reflecting government and donor efforts to subsidize health services.

<table>
<thead>
<tr>
<th>Health Financing Indicators (2017)</th>
<th>Burkina Faso</th>
<th>Sub-Saharan Africa</th>
<th>Low Income Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current health expenditure per capita in US$</td>
<td>44.4</td>
<td>121.5</td>
<td>32.9</td>
</tr>
<tr>
<td>Domestic general government health expenditure as % of current health expenditure (%)</td>
<td>43.3</td>
<td>36.1</td>
<td>21.0</td>
</tr>
<tr>
<td>External expenditure as % of current health expenditure (%)</td>
<td>17.9</td>
<td>11.2</td>
<td>22.2</td>
</tr>
<tr>
<td>OOP expenditure as % of current health expenditure (%)</td>
<td>31.6</td>
<td>35.3</td>
<td>51.5</td>
</tr>
<tr>
<td>Current PHC expenditure as % of current health expenditure (%)</td>
<td>69.0</td>
<td>65.0 (2016)</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Source: Global Health Expenditure Database 2017; Primary Health Care Performance Initiative 2018

Trends in OOP expenditure as a percentage of current health expenditure, comparing Burkina Faso, Sub-Saharan Africa and Low-Income Countries (2000-2016)

Source: World Bank 2020
Proportion of current health expenditure (2017)

Private health expenditure (38.8%)*

Government health expenditure (43.3%)

External health expenditure (17.9%)

Proportion of current health expenditure (2017)

Government health expenditure by health area (2017)

Governance, health system, and financing administration (11%)

Primary health care (42%)

Other (47) **

*Private health expenditure is primarily comprised of out-of-pocket payments. Private health insurance makes up a very small percentage of Burkina Faso’s current health expenditure.

**Other includes expenditure areas by the government for NCDs, curative care, medical goods, rehabilitative care, long term care, and ancillary services.

Source: Global Health Expenditure Database 2019; Primary Health Care Performance Initiative 2018
The table below provides key details about the main purchasers of health services in Burkina Faso.

<table>
<thead>
<tr>
<th>PURCHASER ATTRIBUTES</th>
<th>Supply-side financing/line item budgeting</th>
<th>Gratuité</th>
<th>Community Based Health Insurance</th>
<th>World Bank Performance-Based Financing (PBF)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sources of revenue (e.g. taxes, contribution)</td>
<td>Local Tax, Transfer from National Government, Grant, &amp; Loan</td>
<td>Local Tax, Transfer from National Government, Grant, &amp; Loan</td>
<td>Member premiums</td>
<td>World Bank grant</td>
</tr>
<tr>
<td>Population Covered</td>
<td>General Public</td>
<td>No membership required. Services target women of reproductive age and children under 5</td>
<td>Membership required. This covers approximately 5% of the population</td>
<td>PBF currently covers 19 of 73 districts, with a plan to scale to 37</td>
</tr>
<tr>
<td>Benefits/services covered (PHC, hospitalization, inpatient, outpatient)</td>
<td>The central government pays for salaries, commodities, services and other facility costs through input-based financing</td>
<td>Services for children under 5, ANC, deliveries, c-sections, postnatal care, and FP services (to be scaled nationwide in 2020)</td>
<td>Curative care, ambulatory, care, hospitalization included across schemes. In theory, government subsidized free services are meant to be excluded from the benefits packages</td>
<td>Payments are based on quality of the following services: Services for FP services, ANC, deliveries, c-sections, PNC, and children under 5</td>
</tr>
<tr>
<td>Types of facilities included (referral hospitals, health centers, health posts, etc)</td>
<td>All public sector health facilities</td>
<td>All public sector health facilities and a small number of private sector health facilities</td>
<td>Mainly public sector primary health care centers and medical centers (Centre de santé et de promotion social [CSPS] and centre médicaux [CM]). Patients can be referred to participating district hospitals (Centre médical avec antenne chirurgicale [CMA])</td>
<td>Primarily public and private primary health care centers and medical centers (CSPS and CM)</td>
</tr>
<tr>
<td>Provider payment methods (with FP and MNH specifics)</td>
<td>Input-based financing for salaries and commodities; user fees support services and facility operating costs</td>
<td>Equivalent fee-for-service (FFS) payments are made to facilities by the central government on a quarterly basis. Funds are prepositioned at the facilities, and subsequent payments are adjusted based on service reports. Facilities can use these funds for drugs, consumables, and operations costs. The Ministry of Health (MoH) recently approved a transition to case-based payments</td>
<td>FFS</td>
<td>Quality-focused PBF</td>
</tr>
</tbody>
</table>
User fee removal for maternal, newborn, and child health services

In June 2016, the Government of Burkina Faso adopted a user fee replacement scheme – known as the Gratuité scheme – for maternity and child health services. The Gratuité scheme uses government funds to replace OOP payments, allowing contracted facilities to provide a defined package of MNCH services free of charge. The Government of Burkina Faso bears the full cost of the services covered by the Gratuité. In 2017 and 2018, the cost of the scheme accounted for approximately 15% ($50 million USD) of the government health expenditure ($320 million USD). FP services are not currently included in the Gratuité package, but after a successful pilot in two districts, the government plans to scale provision of free FP services nationally in 2020.

The introduction of the Gratuité in 2016 increased the utilization of services for children under 5 and reduced OOP expenditure as a proportion of current health expenditure but has had less of an impact on deliveries and c-sections in public facilities. In 2018 and 2019, claims made by facilities under the Gratuité scheme have exceeded funds budgeted by the MoH, leading to underpayment. An accumulation of debts within the primary care system has had knock-on effects on drug procurement and supply management and has led to concerns about the financial viability of the Gratuité scheme.
MNCH service cost trends for Gratuite in public sector health facilities (2016-2019)

Source: Technical Secretariat for Universal Health Coverage data from e-gratuité and reports, February 2020


Source: Technical Secretariat for Universal Health Coverage data from e-gratuité and reports, February 2020
Progression of service use for children under 5 in public sector health facilities (2012-2018)

Source: Institut national de la statistique et de la démographie 2019

Gratuité implemented June 2016

Progression of deliveries in all public sector health facilities (2013-2018)

Source: Institut national de la statistique et de la démographie 2019
Progression of c-sections in all public sector health facilities (2013-2018)

Source: Institut national de la statistique et de la démographie 2019

Progression of total costs paid through OOP payments as a percentage of current health expenditure (2012-2017)

Source: Institut national de la statistique et de la démographie 2019
District debts to central medical stores versus Gratuité payments (2016-2019)

Note: Gap means the difference between payment and claim.
Source: Technical Secretariat for Universal Health Coverage data from e-gratuité and reports, February 2020

Recommended citation