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What Factors Influence Health Policy Entrepreneurs in West Africa?

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ABSTRACT

This paper investigates the agenda-setting criteria used by policy entrepreneurs directly involved in the implementation of user-fee abolition or reduction policies for maternal care services in Africa. The study uses an experimental technique, best-worst scaling (BWS), to identify the criteria that drive their decision making. Results suggest that political commitment and impact on health are identified as the most important criteria, while international pressure and donor money are ranked as the least important. Respondents confirm that a strong leadership role is required at the governmental level in order to effect policy change, but attribute relatively little importance in decision making for increasing equity of health care among population groups or for the ability of the health system capacity to carry out new policy.

INTRODUCTION

In West Africa, women have had to pay for antenatal care consultations and deliveries in health centres since the 1980s — a system known as user fees. This mode of financing imposes a financial barrier for poor households to obtain necessary health care (Nanda, 2002). Evidence has shown that delivery in a health centre with qualified staff reduces maternal and infant mortality (De Brouwere and Van Lerberghe, 2001). Hence, different agencies of the United Nations and the African Union (AU) have joined forces to call for the abolition of user fees for delivery (AU, 2010; The Global Campaign for the Health Millennium Development Goals [MDGs], 2009: 59).

Since the 1990s, there has been a wave of public policies promoting user-fee abolition for antenatal care and delivery in multiple East and Southern African countries (Gilson and McIntyre, 2005). In West Africa, such policies, in particular for delivery, are relatively recent (Ridde and Morestin, 2011). For instance, in Mali, Benin and Senegal, women are not required to pay for C-sections. In Burkina Faso, the government decreased the fees for delivery rather than abolish them completely, so women must pay 20 percent of the total cost. Recent research reveals that these policies often represent an efficient means of increasing service utilization but that there are barriers to their effective implementation (Meessen et al., 2011). The political decision to reduce or eliminate user fees is usually taken rapidly, leaving little time for planning the implementation. Since these decisions are politically driven, there has been inadequate involvement of service providers (as implementers) in policy design (Agyepong and Nagai, 2011; Olivier de Sardan and Ridde, 2012; Walker and Gilson, 2004).

Published evidence has thus far provided limited information about what factors lead decision makers to design and implement user-fee abolition policies. Retrospective qualitative studies are useful in identifying the processes leading to a decision (Olivier de Sardan and Ridde, 2012); however, these studies suffer from obvious methodological limitations, given the challenges encountered when reconstructing events in the past. Ideally, since African countries operate in a context of scarce resources and are unable to abolish user fees for all health care services, well-defined criteria should guide policy decisions on user-fee abolition. This study assesses

the criteria policy entrepreneurs regard as most and least important in guiding their decisions on user-fee abolition or reduction (Kingdon, 1995). It focusses exclusively on maternal care, an area where user fees have mostly been abolished for this set of services.

METHODS

Theoretical Approach

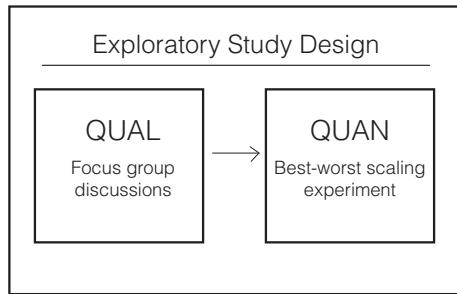
The technique of BWS was implemented to investigate the importance of different criteria guiding the decision to abolish user fees in maternal care. This is a methodological approach rooted in health economics that gives the participants a set of choices to rank as best and worst (Flynn et al., 2007). The underlying theory is the recognition that there are unmeasured influences on choices, such as those that were not ranked as best and worst. BWS is rooted in the same random utility framework that underpins other stated preference methods, such as discrete choice experiments (DCEs)¹ and ranking studies, and in some respects, it represents a compromise between the two. More information is obtained with BWS than with a DCE, but the respondents for this study were not required to provide a full ranking of all of the choice options. Proponents of BWS argue that it is an easier cognitive task for the participant, but still provides reliable and valid answers for the researcher. In addition, it is argued that traditional DCEs are not suitable to estimate the importance of attributes by comparing utility (impact) estimates. Therefore, BWS is deemed to be more appropriate when policy makers are interested in comparing the absolute impact of attributes in the experiment, or in this case, the degree to which certain factors motivate health care decision making (*ibid.*).

Since its first appearance in 1992, BWS has gained popularity in health economics and it has been used to investigate a plethora of issues, ranging from eliciting public views on health care reform in Australia to estimating population-level values (scoring) for quality of life instruments (Louviere and Flynn, 2010; Coast, Smith and Lorgelly, 2008). To the authors' knowledge, this method has never been used to explore health and health care issues in low- and middle-income countries (LMICs); this study, therefore, is the first to do so. In this BWS, participants in West Africa were asked to identify what criteria they valued as most and least important when deciding on user-fee abolition or reduction. The criteria emerged from an exploratory sequential mixed-methods design, entailing both a qualitative and quantitative phase (see figure 1) (Pluye, 2012).

“
RESULTS SUGGEST THAT POLITICAL COMMITMENT AND IMPACT ON HEALTH WERE IDENTIFIED AS THE MOST IMPORTANT CRITERIA, WHILE INTERNATIONAL PRESSURE AND DONOR MONEY WERE RANKED AS THE LEAST IMPORTANT
”

¹ A DCE is a choice-based, attribute-driven experimental technique for eliciting stated preferences for service delivery and policy interventions. In a DCE, services or interventions are described by their attributes, which are defined according to a set of dimensions called attribute levels. The attributes and their levels are combined using experimental designs to produce hypothetical choice sets. By making choices across sets, respondents reveal the value they attach to a specific attribute of a given service or intervention.

Figure 1: Exploratory Sequential Mixed-methods Design



Source: Authors.

The Qualitative Phase

“
IT BECAME APPARENT THAT SATURATION AND REDUNDANCY HAD NOT BEEN REACHED IN TERMS OF IDENTIFYING POTENTIALLY IMPORTANT CRITERIA USED TO DECIDE THE POLICIES
”

The qualitative phase of this research identified the criteria to be used in the BWS. Initially, two focus group discussions (FGDs) were conducted among policy entrepreneurs ($n=17$). For the purpose of this study, Kingdon's definition of policy entrepreneur as those who influence the policy agenda is used. Participants were selected from those who attended a relevant regional policy meeting held in Ouagadougou in May 2011, which also served as the venue for the discussions. Participants came from nine countries — Benin, Burkina Faso, Cameroon, Guinea, Ivory Coast, Mali, Niger, Senegal and Togo. They were all officials of their respective health ministries or those directly involved in the design or implementation of user-fee abolition policies. Data was collected using a semi-structured interview that included two initial open-ended questions to elicit any criteria used to decide user-fee abolition or reduction policies, followed by a series of more specific questions that explored relevant issues that had been identified by the authors through reading the literature or direct field experience. Respondents were also asked to explain why a given criteria was considered important in guiding decision making for user-fee abolition or reduction.

When the FGDs were transcribed and analyzed, using in vivo coding,² it became apparent that saturation and redundancy had not been reached in terms of identifying potentially important criteria used to decide the policies. Two additional FGDs, using the same interview guide, were conducted in October 2011 with respondents from a second regional policy meeting. Participants in the first additional FGD ($n=8$) were from Benin, Burkina Faso, Côte d'Ivoire, Guinea, Niger, Senegal and Togo, all employed by their respective ministries of health and involved in the implementation of the policy. Participants of the second additional FGD ($n=9$) were from Burkina Faso and involved at a regional or local level in the policy. Analysis of the four FGDs led to the identification and definition of 11 key criteria. An annotated literature review was then carried out to verify that the criteria identified as relevant to the decision-making process matched those identified in the literature. This process confirmed the relevance of the 11 criteria identified through the four FGDs. Table 1 shows the criteria, their operational definition and relevant quotations from the FGDs.

Table 1: Criteria Identified in FGDs

Criteria	Definition	Focus Group Quotations
International pressure	Pressure from the international community to achieve specific population health targets and/or to abolish/reduce user fees	"It should be noted that the politicians know the international context has a huge influence on national politics even if it is an indirect influence."
Donor money	Funds are available from bilateral and multilateral partners to support interventions in maternal care and/or to abolish/reduce user fees	"The financial support from partners highly contributes to decisions on gratuity policy."
Political commitment	National government and/or national politicians are committed to abolish user fees for maternal health care services	"Politicians must judge each action's usefulness in terms of getting re-elected." "Political will is required for improvements in reproductive health."
Financial sustainability	Funds are available, either from internal or external sources, to sustain user-fee abolition/reduction in the long term	"If we fund the policy from non-sustainable resources, it will fail at some point. But if we base it on renewable and accessible resources without need for a lot of work, it can be very durable." "It is necessary that policies are funded for sufficient time to have adequate and long lasting results."
Equity	Ensuring access to services free of charge based on need and not on ability to pay or geographical location	"Since we don't have an unlimited budget we have to provide care where it is most needed by those who have little or no money for health care."
Increase in service utilization	Increase service utilization by lifting the financial barrier	"As services are not being used to their maximum potential, question is will making the service available without cost result in increased utilization?"
Institutional capacity	User-fee abolition/reduction can be implemented within the institutional set-up of the existing system and foreseen changes in the demand for services can be managed adequately	"As a first step we must analyze the current status of health facilities in the community: do we have the required institutions, facilities for the public and health care providers with the capacity for new projects?"
Quality of care	The quality of the services on offer can be maintained, and/or improved, even after user fees are abolished/reduced	"We have to evaluate the project cost in terms of personnel and equipment because if abolishing costs leads to an increase in usage, there will be increased investment required in human resources, drugs and equipment."
Impact on health	Evidence is available to demonstrate the positive impact of abolishing/reducing user fees on population health	"We face women whose own life and the life of the child are at risk when they give birth. These conditions may play a major role in changing policy to provide care without user fees."
Cost effectiveness	Evidence is available to demonstrate that the intervention is cost effective	"We have to use the minimum resources required to reach the maximum effectiveness. We can benefit from studying what has worked in other places and adopting the most effective and efficient policies and methods."
Burden of disease	Evidence is available on large disease burden induced by the condition associated with the service for which user fees are abolished/reduced	"We need to know the health problem importance. It should be based on scientific report from different hospitals for the degree and frequency of some diseases and child mortality rates."

Source: authors.

“
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”

The Quantitative Phase

Based on these 11 criteria, a BWS was developed and included in a structured questionnaire for maternal health policy entrepreneurs. The BWS included all criteria identified in the FGDs, irrespective of the relative importance attributed to them by the respondents. The questionnaire was divided into four sections. The first section included the actual BWS. The second asked participants to indicate whether the 11 criteria were relevant or not relevant when deciding on abolition or reduction policies. This section was included in the questionnaire as a source of data validation, allowing the authors to check for the consistency of the BWS answers. The third section asked participants to indicate which criteria guided the decision-making process on user-fee abolition or reduction in their own country. The fourth collected information on the respondents' socio-demographic background. Respondents were provided with a separate list of the 11 criteria and their relevant definitions.

A balanced incomplete block design (BIBD)³ was used to randomly distribute the combinations of the 11 criteria into comparable sets. Half the sample was presented with 11 sets of five criteria and half the sample with 11 sets of six criteria, producing two separate BIBDs. It is important to note that the BIBDs complemented each other, each criterion appearing only once per column and per row, allowing control of the order. For each set, participants were asked to identify the criteria that they deemed to be the most and least important in guiding policy decisions.

The original questionnaire was developed in English, translated into French and then re-translated into English by the authors. A pilot study of both versions was conducted to verify that questions could be easily understood and that the BWS was feasible. The pilot indicated that the questionnaire was adequate, but that the definitions of some of the criteria needed to be refined, and definitions were defined accordingly.

Respondents were recruited during a regional policy meeting held in Bamako in November 2011. A total of 45 policy entrepreneurs, including politicians, technicians and researchers working on relevant policy consultancy, attended the meeting to discuss financial accessibility to maternal care services.⁴

Analysis was based on assigning the most valued principles a 1 and the least valued principles -1. Each item appeared a maximum of six times in each block. Preferences were analyzed over a cardinal utility scale bounded by -6 and +6 so that each respondent's preference about a particular criterion was determined by subtracting the number of times a criterion was chosen as least important from the number of times it was chosen as most

³ A BIBD is an experimental design, used in many disciplines, including economics. It represents a set of choice options (in this case, decision-making criteria), which together with a family of subsets (all the decision-making criteria included in each set of interviews) are chosen to satisfy a set of properties that are deemed useful for a particular application. In experimental economics, BIBD allows for an efficient estimation of utility values.

⁴ For details on the workshop, see www.hha-online.org/hso/financing/subpillar/workshop-benefits-package-maternal-health-fee-exemptions.

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“ ”

important over the six (or five) subsets in which it appeared. The individual scores were averaged to provide a crude aggregate measure of level of importance for each criterion. The analysis proceeded in steps and was conducted using Stata 12 software. First compiled were simple descriptive summary statistics of both the utility scores and the information collected in tasks two to four of the questionnaire. Then two separate regression models were carried out in order to calculate subjective utility scores for the 11 criteria.

The authors obtained subjective priority scores through two models. In the first log-linear regression model, the dependent variable was defined as the natural logarithm (to control for skewness of the data) of the overall score by criterion as most and least valued:

$$\ln(f) = \text{cnst} + \beta_1 \text{ burden of disease} + \beta_2 \text{ cost effectiveness} + \\ \beta_3 \text{ donor money} + \beta_4 \text{ equity} + \beta_5 \text{ financial sustainability} + \beta_6 \text{ impact} \\ \text{on health} + \beta_7 \text{ increase in service utilization} + \beta_8 \text{ international} \\ \text{pressure} + \beta_9 \text{ institutional capacity} + \beta_{10} \text{ political commitment} + \\ \beta_{11} \text{ quality of care}$$

In the second-ordered logit model, observations were clustered by the participant and scenario, controlling for possible correlation. Clustering accounts for the fact that observations within a participant and a scenario are not independent from one another. The dependent variable in the multilevel-ordered logit regression model was created by coding the criteria chosen the most times as equal to one, the criteria chosen the least as equal to three and all remaining criteria (neither selected as most important or least important) as intermediate in rank (or equal to two). The model was run with all 11 criteria being entered in the model as independent dummy variables and with "international pressure" acting as reference category.

RESULTS

A total of 45 individuals were invited to participate, but only 38 provided complete responses to the questionnaire. Seventy-six percent of the respondents were men, with an average age of 43. Four of the African representatives came from Benin, seven from Burkina Faso, one from Cameroon, one from Ghana, two from Kenya, six from Mali, five from Morocco, three from Niger, two from Nigeria and three from Senegal. There were also three participants from outside Africa (United States, France and the United Kingdom). Respondents were highly educated: 50 percent held a Ph.D. and 39 percent held master's degrees. Twenty-two respondents held a non-academic position and 16 held academic positions as lecturers or researchers. Only seven (18 percent) had more than 16 years professional experience in the field, while the majority (50 percent) had less than five years. Each questionnaire included 11 scenarios for BWS and a total of 418 observations were obtained.

The total "most," "least" and "most-least" scores are shown in table 2. The "most-least" score is the difference between the number of times that a criterion was chosen as "most" minus the number of times a criterion was chosen as "least." The average individual scores are also calculated for

“ **RESPONDENTS
WERE HIGHLY
EDUCATED: 50
PERCENT HELD
A PH.D. AND
39 PERCENT
HELD MASTER'S
DEGREES** ”

“
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 CONFIDENCE
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 SUSTAINABILITY,
 WHILE THE
 SMALLEST WITH
 QUALITY OF CARE**
 ”

each criterion. The criteria with higher positive values are deemed to be more important than those with lower, negative scores. These initial results suggest that political commitment and impact on health are the most important criteria, followed by burden of disease and increase in service utilization. International pressure and donor money were considered the least important criteria.

Table 2: Results of the BWS

Criteria	Total Counts (number of respondents x number of scenarios)	Total Most Important (total number of mentions across counts; % of total)	Total Least Important (total number of mentions across counts; % of total)	Most-Least	Mean Individual Score	Confidence Interval (95%)
Political commitment	418	69 (16.5)	9 (2.2)	60	1.579	[1.409 to 1.748]
Impact on health	418	66 (15.8)	9 (2.2)	57	1.500	[1.304 to 1.696]
Burden of disease	418	48 (11.5)	11 (2.6)	37	0.974	[0.792 to 1.155]
Increase in service utilization	418	54 (12.9)	18 (4.3)	36	0.947	[0.803 to 1.093]
Financial sustainability	418	52 (12.4)	18 (4.3)	34	0.895	[0.693 to 1.097]
Equity	418	49 (11.7)	21 (5.0)	28	0.737	[0.551 to 0.922]
Quality of care	418	31 (7.4)	16 (3.8)	15	0.395	[0.254 to 0.535]
Cost effectiveness	418	23 (5.5)	36 (8.6)	-13	-0.342	[-0.498 to -0.185]
Institutional capacity	418	13 (3.1)	52 (12.4)	-39	-1.026	[-1.194 to -0.859]
Donor money	418	8 (1.90)	105 (25.1)	-97	-2.556	[-2.743 to -2.362]
International pressure	418	5 (1.2)	123 (29.4)	-118	-3.105	[-3.304 to -2.907]

Source: Authors

To assess individual differences, the authors calculated standard errors (SE) and confidence intervals across individual scores. The results show a large amount of variability in subjective priorities within the sample. The widest confidence interval was associated with financial sustainability, while the smallest with quality of care.⁵

These initial results were further tested with two statistical models: log-linear regression analysis and clustered-ordered logit model. The coefficients estimated for all 11 criteria were statistically significant except for quality of care in the first regression model, and donor money and

⁵ Further research should investigate if priorities are associated with particular socio-demographic characteristics of respondents, as this was not possible with the limited sample size of this analysis.

political commitment in the clustered-ordered logit model. The absolute size of the coefficients reflects the relative importance of the different criteria that is reflected in their ranking (see table 3). In both regression analyses, international pressure and donor money were least important, while political commitment and impact on health were selected as most important.

Table 3: Results of Regression Analysis and Clustered-ordered Logit Models

Criteria	Regression Analysis*			Cluster-ordered Logit**			
	Estimated Coefficient	SE	Rank	Estimated Coefficient	SE	Confidence Interval (95%)	Rank
Political commitment	0.94	0.13	1	-2.82	0.25	[-3.30 to -2.33]	1
Impact on health	0.92	0.13	2	-2.69	0.25	[-3.18 to -2.20]	2
Equity	0.37	0.13	5	-2.64	0.31	[-3.24 to -2.04]	3
Increase service utilization	0.47	0.13	3	-2.55	0.27	[-3.08 to -2.02]	4
Financial sustainability	0.46	0.13	4	-2.49	0.27	[-3.01 to -1.96]	5
Quality of care	0.26	0.13	6	-2.2	0.25	[-2.70 to -1.71]	6
Burden of disease	3.28	0.04	7	-2.14	0.24	[-2.61 to -1.68]	7
Cost effectiveness	-0.30	0.13	8	-1.28	0.26	[-1.78 to -0.78]	8
Institutional capacity	-0.76	0.13	9	-1.12	0.26	[-1.63 to -0.62]	9
Donor money	-1.36	0.13	10	-0.21	0.24	[-0.69 to 0.27]	10
International pressure***	-1.68	0.13	11				11

Source: Authors.

* The natural logarithm of the answer.

** Analysis was clustered by individual and scenario.

*** Reference category for multilevel-ordered logit; the remaining variables coded as dummy variables.

In the validation section of the survey (see table 4), participants were asked to identify the criteria they thought relevant, those criteria not relevant at all and those criteria that were actually used in their countries when deciding on user-fee abolition or reduction. There was no evident link between the criteria identified as theoretically important and those actually used.

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Table 4: Relevancy of Criteria Used in Decisions on User-fee Abolition/Reduction in Maternal Care (n=38)

Criteria	Relevant (%)	Not Relevant (%)	Actually Used (%)
Political commitment	81.6	2.6	65.8
Impact on health	78.9	10.5	55.3
Burden of disease	68.4	10.5	52.6
Increase in service utilization	63.2	5.7	50.0
Financial sustainability	71.0	7.9	21.0
Equity	84.2	13.2	26.3
Quality of care	78.9	7.9	21.0
Cost effectiveness	68.4	10.5	13.2
Institutional capacity	55.3	7.9	13.2
Donor money	13.2	60.5	23.7
International pressure	13.2	71.0	36.8

Source: Authors.

It is interesting to note that only a very small proportion of individuals (13 percent) indicated that donor money and international pressure should be considered, while the majority questioned why these two criteria were even suggested (<70 percent). The majority of participants (65.8 percent) reported that political commitment guided decision making in their country. It ought to be noted that institutional capacity was not considered at all important in the BWS or in the validation part of the survey.

DISCUSSION

This is the first study undertaken to identify the agenda-setting criteria guiding policy decisions of African policy entrepreneur on user-fee abolition for maternal care services. It is also the first study adopting BWS in an LMIC. Field experience revealed that when presented with 11 criteria, the participants easily understood the BWS. The BWS application is currently being tested using an Internet platform, as a means of reaching a larger number of respondents at a lower cost.

Due to the small number of respondents, the authors are cautious about the interpretation and drawing generalized conclusions from the study results. Those participating in the workshop in Bamako are not representatives of all policy entrepreneurs in West Africa. Moreover, it is important to acknowledge that the majority of respondents were not actual decision makers in their countries; in many cases, ministers and presidents, rather than officials, make decisions. Thus, this study reflects primarily the policy-making criteria valued by the policy entrepreneurs to decision makers, rather than by the decision makers themselves. Nevertheless, the authors know that the policy-making process in Africa and elsewhere is not linear (Grindle and Thomas, 1991; Ridde, 2009) and is heavily influenced by experts and technical advisers (Wu, Howlett and Fritzen, 2010). Therefore, understanding the viewpoint of maternal health policy entrepreneurs on the criteria that should and do influence user-fee abolition policies represents a relevant concern.

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This study confirms historical findings from empirical studies in many African countries that national political commitment is at the core of the decision to abolish maternal health fees (Meessen et al., 2011; Olivier de Sardan and Ridde, 2012). This has been the case in South Africa, one of the first countries to abolish user fees for maternal care in 1994 (Gilson and McIntyre, 2005), and in Mali and Niger in the early 2000s when these policies were presented as “gifts” to the general population (Olivier de Sardan and Ridde, 2012). In February 2012, Côte d’Ivoire abolished user fees for women in spite of skepticism by experts that enforcement efforts and accompanying measures in the country are not yet up for the challenge.

Participants confirmed that political commitment to abolish user fees was behind policy changes in their country. The concern remains as to whether the respondents were able to differentiate the set of choices provided in the survey from the actual policy process in their own country; this is a limitation of the BWS method. Since almost every country in Africa has taken steps towards user-fee abolition, it would have been difficult to recruit participants who have not been influenced by recent decisions in their own country.

The BWS results, however, appeared consistent with reality in two ways. First, data reflected the fact that abolition policies in the vast majority of countries had been taken by politicians without consulting technical advisers and donors (Meessen et al., 2011; Olivier de Sardan and Ridde, 2012; Ridde and Morestin, 2011). Second, the participants rejected the suggestion that donors influence their work. This confirmed findings from a recent empirical review, observing that “all reforms benefit from strong ownership at governmental level...[and] the role of donors was quite limited,” and reaffirmed that most initiatives were financed through national budgets (Meessen et al., 2011). Qualitative studies carried out in the participants’ respective countries could determine if the results using the BWS stem from discussions in development policy research or if it represented empirical reality (Olivier de Sardan, 2005). For example, in Burkina Faso and Niger, the World Bank played a facilitation role, if nothing else (Olivier de Sardan and Ridde, 2012; Ridde et al., 2011). The lack of importance attributed to the influence of donors could indicate that because they had not taken part in the initial decision-making process, many international aid agencies waited for political authorities to take the lead on such matters. The World Bank (2007), for example, has stated that it “stands ready to support countries that want to remove user fees from public facilities,” and Denmark has stated that it “will support national initiatives to ensure universal coverage and to make primary health care free for children and pregnant women at the point of service” (Ministry of Foreign Affairs of Denmark, 2009). One has to wonder if this discourse advanced by donors is not normative in itself (that is, discourse without action), as long as their actual influence on the decision making remains limited.

Unexpectedly, respondents attributed little importance to the role of institutional health system capacity in guiding policy decisions on user-fee abolition. This reflected a general attitude of considering the implementation of policy as something that would follow from a political decision — “if the political decisions are taken, the implementation will follow” — in accordance

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with the theories of rational choice in political sciences. This finding is worrisome, as it is well established that the implementation of such policies frequently faces serious difficulties caused by deficient preparation, lack of funding and a health system that is not always able to respond to the increase in demand induced by user-fee abolition (Meessen et al., 2011; Ridde, Robert and Meessen, 2012). As a consequence, policies do at times fail due to lack of preparation and this provides an opportunity to those who oppose user-fee abolition to criticize the policy itself, even though its ability to improve access to care has long been scientifically proven (Evans, Barer and Stoddart, 1993). Thus, politicians are faced with a dilemma: abolishing user fees for vulnerable population groups pleases their voters, but insufficient preparation for adequate implementation can alienate those voters and provide ammunition for the politicians’ critics, not to mention fail to meet the maternal health needs of their populations.

Finally, impact on health was ranked at the top of the list, while equity was surprisingly not ranked as high. The first may be due to the fact that the achievement of the MDGs has driven much of the development of national policies in the last 10 years. If this was actually the case, it would suggest that the absence of any international pressure was reflected as a normative discourse by the participants. These policies have been viewed as a quick impact model by governments and donors alike, leading to the policy being put in place before adequate preparation has been made (Richard et al., 2011). The equity ranking also reflects current policies that are, for the most part, aligned with the MDGs to target vulnerable groups, such as women, but not to take into consideration existing inequities within these groups (Vandemoortele, 2011). The abolition of user fees is one of the few public policies geared toward guaranteeing that the poorest women and those living the farthest away from health centres also benefit from reforms (De Allegri et al., 2012; Fournier et al., 2011; Ridde et al., 2012a; 2012b). Most public policies try to improve the health of the general population without taking into consideration health inequities among different segments of the population, in spite of the fact that such consideration should constitute a primary goal of any public health intervention (World Health Organization [WHO], 2008a: 247). During the International Conference on Primary Health Care and Health Systems in Africa, held in Ouagadougou in April 2008, the importance of improving equity in health care was reinforced (WHO, 2008b). In order to achieve a paradigm shift and a “third wave health research” (Ostlin et al., 2011), qualitative studies should be pursued to understand why these policy makers have not considered to a greater extent the question of equity as an influential factor for policy decision making.

CONCLUSION

Abolishing user fees at point of service for vulnerable populations is one solution for improving access to care and moving toward universal coverage (“The Struggle,” 2012). This is important in maternal health since delivery in a health centre with qualified staff reduces maternal and infant mortality and many people cannot afford to pay for health care. This study’s participants, mainly policy entrepreneurs, expressed that political commitment and the desire to improve the general health status of the

population are the most important criteria guiding the development of user-fee abolition policies. Nevertheless, the findings suggest that for political commitment to become a reality, two strategies have to be set in place: first, equity considerations have to mediate the policy implementation to counteract existing inequities within population subgroups; second, policy decisions have to be accompanied by adequate implementing measures and receive the necessary funding.

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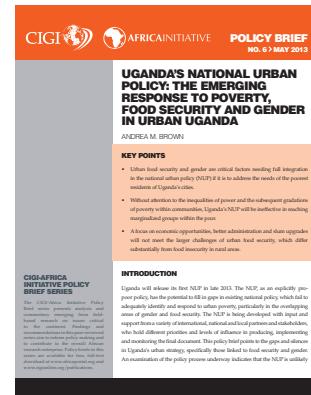
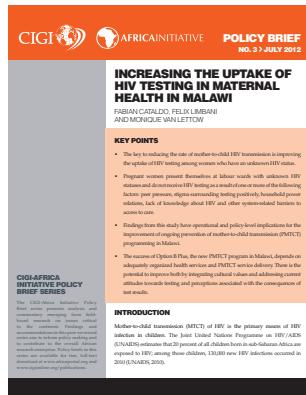
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