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Influence of Political Guidelines and National Health Strategies on Resource Mobilisation for Integrated Community Care in Burkina Faso

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Abstract

Background: High infant mortality and inadequate access to care have led Burkina Faso to offer integrated community care for childhood illnesses (iCCM) for many years. Studies show that uptake is low and infant and child mortality remains high. The aim of the study is to analyse the influence of policies and strategies on the implementation of community-based management of childhood illnesses.

Methods: A mixed methods cross sectional study was conducted in Burkina Faso in the health districts of Boussouma and Bousséé. Data was collected from February to March 2023 using interviews of 29 people and administered questionnaires to 42 health workers. Descriptive statistics and thematic analysis was used respectively for quantitative and qualitative analysis. Nvivo 14 was used for qualitative analysis.

Results: Overall, 29 people from various structures and 42 health workers took part in this study. The iCCM is well described and integrated into strategic documents and several activities are planned by stakeholders. Despite this strategic commitment, geographical coverage is still insufficient, according to our respondents. Financial resources and especially health products are not enough to meet needs.

Conclusions: There is effective ownership of policy orientations and guidelines, but only partial. Vigorous action is needed on governance and funding alignment. The study identified the level of institutionalisation of iCCM and the efforts needed to improve coverage, particularly in terms of funding for drugs and equipment by government.

Keywords: community, integrated community care, governance, health policy, community health worker, district

1. Introduction

Health systems are facing a shortage of human resources and poor access to basic health care for the population (Baynes et al., 2017; WHO, 2016, 2021). In sub-Saharan Africa, the impact of war and other crises is exacerbating this shortage. In Burkina Faso, the security crisis has led to difficulties in accessing health centres due to attacks by armed terrorist groups, which has affected the provision of health care: 19.5% of health facilities have been closed, including 124 that have been looted, depriving some 3.8 million people of access to healthcare (CLUSTER SANTE/CORUS Burkina Faso:, 2024). In response, the World Health Organisation (WHO) and most development partners have been advocating the construction of rural health systems since the 1970s. Various consultations have recommended that care should be delivered as close to the community as

possible (Van Olmen et al., 2012). Primary health care was launched at the Alma Ata conference in 1978 (WHO, 1978), and adopted by Burkina Faso in 1979, which placed particular emphasis on the development of community health services(Ministère de la santé, 2019b). The ultimate objective of PHC was to effectively combat infant mortality (LeBan et al., 2021; Perveen et al., 2022; WHO, 2).

The national strategic health guidelines set out in the National Health Development Plans (PNDS) drawn up in 2011 and 2021 therefore emphasised the development of community health(Ministère de la santé, 2011, 2022) and promoted preventive care and, above all, community-based curative treatment, including the integrated management of uncomplicated cases in the community. These choices were motivated above all by the desire to eliminate the difficulties of geographical access to healthcare (average distance of 6.1 km)(Ministry of Health BF, 2023b) and the financial costs weighing on households (2021-2030) (Ministère de la santé, 2019b). The Integrated Management of Childhood Illness (IMCI) strategy has been shown by several studies to be an effective response to these concerns, and has been included by the WHO and UNICEF in the international agenda leading to its widespread adoption in developing countries (CORE GROUP, 2009; Unicef, 2016; WHO, 2; World Health Organization, 2018).

These institutions therefore recommended the use of human resources from communities whose capacities have been strengthened to meet these challenges in order to ensure community-based management of childhood illnesses, the most deadly of which were malaria, diarrhoea, measles, acute respiratory infections and malnutrition. The strategy promotes sixteen basic family practices, including community-based therapeutic services (CORE GROUP, 2009; Malou Adom et al., 2019).

The political decision to operationalise community care was well taken, however, and should have facilitated the scaling up and use of community care and thus improved access to care for rural communities. The community health worker profile(Ministère de la santé, 2014) was subsequently adopted and community care was declared free of charge (Matt et al., 2020; Ministère de la santé, 2018, 2019b; Ministry of Health BF, 2023a).

Following its adoption and application, a number of shortcomings have been identified by previous studies. According to Seck et al. in 2011, there are many shortcomings in the implementation of this iCCM, particularly in terms of motivating stakeholders and the availability of healthcare products. Baya et al. in 2015 and Druetz came to the conclusion that the studies they carried out in Burkina Faso showed that use was inadequate (Baya, et al., 2015; Druetz et al., 2015; Siri & Sanogo, 2020).

However, these studies rarely assessed the capacity of these players to reduce problems of equity of access to healthcare in line with the country's commitments.

The aim of our study was to analyse the influence of national health policies, directives and strategies on the mobilisation of resources for effective coverage of communities by iCCM in Burkina Faso, by means of the following research questions in the context of work carried out in Burkina Faso: i) are the operational planning and types of intervention of the players aligned with the orientations, strategies and directives for community-based management of childhood illnesses integrated into the national health development strategies? ii) has the adoption of these orientations and strategies led to better coverage of community needs?

2. Methods

2.1 Research Design

We conducted a cross-sectional mixed-methods study which allowed us to go beyond the descriptive and analyse some results by means of perceptions. The data was collected prospectively from 20 February to 30 March 2023.

This study was conducted based on conceptual model adapted from the health systems dynamics framework (Figure 1). This conceptual model is adapted from the Olman et al. health system dynamics framework (Figure 1) (Olmen et al., 2012). The Olman et al. framework describes the interrelationships between the resources needed to deliver services and the leadership and governance aspects that influence this process and ultimately determine the outcomes that can be achieved.

This framework is therefore well suited to our study, which aims to assess the influence of policy orientations and national strategies on iCCM in Burkina Faso.

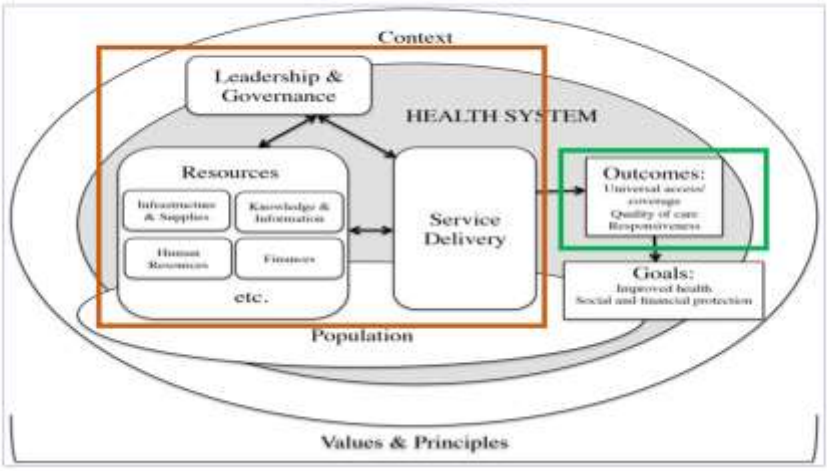

Figure 1. Conceptual framework adapted from the health systems dynamics framework (Olman *et al*., 2012)

2.2 Setting

The study was carried out in to health districts of Burkina Faso (Boussouma and Bouss é). Bouss é health district is located in the Central Plateau region). It has 33 health facilities and covers 199,999 people. The district of Boussouma is located in the Centre-North region), has 29 health facilities and it covers 239,894 people (10). These districts were chosen because they offered the security safest conditions for data collection. We chose a rural district in a region that benefited from specific support for the implementation of iCCM before the introduction of national free community care in 2018 (Boussouma) and a rural district that was not covered by iCCM, before the adoption of national free community care (Bouss é).

2.3 Participant and Sampling

This study involved Table 1: i) Ministry of Health public agents and managers (at central, regional, district team and health facility levels); ii) agents and managers of Ministry of Health partner institutions (United Nations agencies, civil society including non-governmental organisations (NGOs), associations and institutions working with health districts) listed in the districts' annual action plans as partners in the implementation of community activities.

Table 1. Participants by categories and roles

Stakeholder categories	Stakeholders	Roles	Number
Heads of local authorities	Head of town councils	Local governance, Advocacy, guidance and decision-making, implementation monitoring, funding	**3**
Health Ministry central level staff	Community health directors Staff from the department responsible for community health	Community health governance, Policy development and giving planning guidelines, monitoring and mobilisation of financial resources	**5**
Health regions and districts staff	Regional managers and members of district staff	Coordination health system at regional and district level, advocacy, planning and monitoring, mobilisation of financial resources	**11**
United Nations agencies staff	National and regional programme officers	Advocacy, participation in the development of strategies, in the planning and monitoring, mobilisation of international financial resources	**4**
Civil society (NGOs and associations) members	Associations/NGO managers and staff;	Advocacy, participation in the development of strategies, in the planning and monitoring, mobilisation of financial resources	**6**

Sampling for the qualitative part of the study was purposive. Participants were included on the basis of their role in implementing iCCM and their willingness to answer our questions according to quotas by level of the health system (central, regional, district and civil society). The size of the sample of twenty-nine people to be interviewed and the number of responses by category are shown in Table 1. For the quantitative part, we decided to include all health centre managers whose health areas covered villages randomly selected from an exhaustive list of villages in the two health districts (Bousséand Boussouma). A total of forty-two managers were to be interviewed. Participation was free and voluntary, after the participant had been informed of the purpose of the study and of confidentiality measures.

2.4 Data Collection

Data were collected using semi-directive interview grids for the qualitative phase. The interviews were conducted face-to-face or by e-mail for people who had been in charge of community health and were outside Burkina Faso. The pre-mentioned themes in the interview guides were the: i) the inclusion of iCCM in policy and strategy documents (policies, directives, strategic plans, etc, ii) the integration of iCCM-related policy and strategy guidelines into operational planning, iii) the influence of these policy and strategy guidelines on financial access (implementation of free community health care), iv) the geographical coverage of iCCM, v) changes in health care access disparities, vi) the perceived adequacy of resources to needs and vii) measures to strengthen the implementation of iCCM.

With the participant's consent, data were recorded using a dictaphone and sometimes on paper.

In the quantitative part of the study, participants were interviewed using a questionnaire. The variables studied were i) presence of skilled CHWs, ii) treatment of diarrhoea, pneumonia and malaria with iCCM drugs and iii) performance of the malaria rapid diagnostic test.

2.5 Data Analysis

The qualitative data collected was transcribed into Word, coded and the discourse related to the themes was retained. Quotes were analysed inductively using NVivo14 software.

The quantitative data were entered into Excel and then exported to SPSS version 25 for a descriptive analysis that gave different proportions according to the variables under study.

2.6 Ethical Issues/Statement

This study was authorised by the National Health Research Ethics Committee within the Ministry of Health and

Public Hygiene of Burkina Faso. Oral consent was requested, and participation was free and voluntary. The data collected were compiled in an electronic file secured by a code.

3. Results

A total of 71 participants were included in the study. Twenty-nine people participated in the semi-structured interviews, according to the proportions shown in the following Table 1. We also administered the questionnaire to 42 of the managers or team members of the health facilities. Among this health facility managers surveyed, 69.7% had been in their position for at least 2 years (mean length of service: 3.46 years); 9/42 (21.4) were women and the mean age of respondents was 40.5 years (33; 54).

Political orientations and guidelines relating to iCCM and their integration into operational plans

Several strategic documents guide operational planning in Burkina Faso, and the iCCM is clearly mentioned in some of them, such as the health sector policy, where strategic objective 1 and expected impact 1 state that:

> "*These community health interventions are integrated into political programmes and reforms. Particularly in the current security context, community approaches are essential to the health system resilience*" (Administrative Manager_E24).

Another one added:

> "*Community health is integrated into development programmes and political reforms such as free healthcare and the delegation of tasks*" (Administrative Manager_E22).

Integration of iCCM into the intervention strategies of partner structures in the health system

Table 2 summarises the statements made by the partners. These results show that the majority of stakeholders have incorporated iCCM into their projects and programmes. Partner organisations have made it a priority in their support to the health system. They stated that they use community-based health workers, the harmonised profile adopted by the Ministry of Health and made operational in 2017.

Commitment and effective focus on priorities should increase the resources available to implement the strategy. However, respondents' views suggest that budget elements are not well aligned with these planning orientations. This makes it difficult to effectively allocate synergistic resources for the development of this iCCM. One of our respondents said that "*funding costs are not taken into account very much*" (Administrative Manager_E5). And the quotes presented in Table 2 reveal a lack of various resources (notably financial and health products).

Table 2. Intervention, Stakeholders and the gaps in resources mentioned by the respondents in relation to iCCM in the health districts of Boussouma and Bouss é

Respondents	Scope of intervention	Stakeholders in the process	Identified gaps (Insufficient resources identified by our respondents)
Partner_P7	- Community healthcare: management of malaria, diarrhoea and pneumonia; - Nutrition care: infant and young child feeding, food distribution, supervision of community-based health workers, technical and material support for centres; - Monitoring malnutrition recovery et health facilities;	Community-based health workers supervised by ministry of health, health workers from health facilities/health districts and regional health departments, and NGOs volunteers;	**- Human resources**: health staff insufficient for supervising community-based health workers; Community-based health workers not enough of them for the tasks: relative to locality **- Inputs and equipment:** Health product insufficient, Diagnostic inputs, drugs, especially Amoxicillin dispersible are insufficient;
Partner_P6	- Nutrition: a raising awareness of good nutritional practices for pregnant and breastfeeding women and behaviour changes communication Infant and young child feeding (community dialogue, GASPA); - Community health with training, nutrition and health supply distribution, provision of homecare kits (malaria test, disinfection products, masks, etc.); - Strengthening the health system: medico-technical	Community health workers, volunteer (as community leaders such as village committee chairpersons, traditional and religious leaders, village state official members) Health workers ;	**- Human resources**: Community-based health workers was not enough; **-Financial resources**: Weaknesses in the pooling of partners' resources for iCCM, luck of government financial support

	materials in 10 health facilities, - Rehabilitation of ten health facilities ;		
Partner_P3	- Activities organised on the use of long-lasting impregnated mosquito nets by communities, nutrition (6-59 months) and vaccination promoting;	Associations, NGOs, Community Health Workers;	- **Human resources**: Community health workers and others community volunteers not enough - **Inputs and equipment**: Great problem was the drug and other inputs, those was not sufficient;
Partner P1	-Communication for: raising awareness of malaria and diarrhoea treatment for children under five; vaccination awareness campaign, including in insecure areas; - Data management: data collection on - data collection to support free health care monitoring;	Associations and NGOs to support monitoring coordinators, health workers and community leaders	- **Human resources**: Skilled workers (midwives and nurses) not enough to supervise CBHWs: it is essential to increase the number of CBHWs to 3/village Health workers and community leaders supervised by health district staff Consider large urban areas Others: involve OBC associations and local NGO coordinators Coordination is not better and many lack monitoring - **Inputs and equipment**: medicines and consumables insufficient: Too many gaps in areas with security challenges
Partner_P5	Health, nutrition and WASH, , , vaccination with delegation of immunisation tasks;	Community health workers, Mothers as leaders, Village state officials, volunteers, Vaccination champions	- **Human resources:** Community health workers are not enough - **Inputs and equipment**: Incoming drugs, including medicines (amoxicillin, ORS zinc, artemisinin-based combination therapies, etc.) are not sufficiently registered;
Partner_P2	Support for the health district in the integrated community for malaria care (mobilisation, training; provision of equipment such as hand-washing facilities, etc.). Monitoring the malaria treatment for free of charge;	Community relays for the "Husbands' School" project, Community-based health workers, communication and child protection units;	- **Human resources**: Care staff are insufficient: (Nurses) CBHWs: health facilities need to improve their workforce Others: health facilities need psychologists assistance in insecurity areas **-Inputs and equipment:** Care inputs in insufficient quantities **-Financial resources**: Many drop out due to motivations;
Partner_P9	Community iCCM: care for newborn babies at home, vaccination, promotion of birth registration	Health workers and community leaders, as well as a number of operational stakeholders, particularly state and NGOs	- **Human resources**: Traditional staff (CHWs, nurses) and community-based health workers (CBHWs), with a target workforce of around 370 people for the two health districts lack of programmed resources for iCCM by the government (especially for inputs)
Partner_P4	iCCM; Nutrition	Leaders, community-based health workers	- **Human resources**: Community health workers **-Inputs and equipment**: need support with registers, timers, weighing scales, medicines
Partner_P8	Technical support and inputs Health product for iCCM management in emergency areas	Community health workers, health district and facilities staff, national coordination structures	- **Human resources**: Community health workers to be recruited by the State

Level of application of iCCM guidance

In this section, we have analysed the improvements made to the community care system by these policies and guidelines in terms of the geographical coverage estimated by the players and the adequacy of resources in relation to needs.

Level of coverage

In In the Boussouma health district, a district staff member told us that all the villages that were more than 5 km away and needed to implement the full iCCM package had two CHWs. In contrast, in the Bousséhealth district, a district official estimated that more than half of the villages in the district were not covered by iCCM. This variation in implementation is confirmed by a national official:

> "*In terms of regions, we have 7/13, or 54%. However, in terms of districts, this figure is plummeting. It means that not all districts in a given region offer iCCM. In the regions covered, the three diseases concerned are uncomplicated malaria, diarrhoea and cough in children under 5*" (Administrative Manager_E24).

A programme manager from the community health department told us that "*we have gone from 5 regions to 7, with an extension underway to cover all the other regions*" (Administrative Manager_E6).

Matching needs and resources (human, material and health products, financial) for iCCM implementation

Availability of human resources

Respondents identified three types of problem: human resources (insufficient number of CHAs), material resources and drugs used for treatment, and financial resources (Table 2). There were 8/42 (21.4%) health facility managers who did not have relays trained in the use of iCCM drugs (Table 3).

Table 3. Illustration of input availability as reported by health centre staff

Episodes of drug shortages for iCCM (malaria, diarrhoea, pneumonia)? (n=42)

	Frequency	Percentage
No	33	78.6
Yes	9	21.4
Total	42	100.0

Some respondents congratulated the government for recruiting and deploying CHWs and for motivating them, but noted that there were delays in payment, which affected the quality of their work. One of our respondents said:

> *"A profile for CBHWs has been developed and revised, including the packages to be implemented and their remuneration. However, due to motivation problems and drug shortages, these CBHWs are being diverted from their intended duties and activities in some health facilities. "* (Partners_P5).
>
> *"The contribution of government resources to community health is substantial. The provision of supervisory staff for CHWs and the financial incentives used in community health are proof that the state is investing (...). I also salute the political commitment of the government, which is sparing no effort to honour its commitment despite the difficulties (...). So, I agree with the remuneration of community relays. However, the strong involvement of local authorities is essential to ensure the sustainability of this initiative"* (Partners_P4).
>
> *"They are successfully carrying out their tasks despite low motivation. The remuneration of CHWs must be improved and a CHW post should be created"* (Partners_P5); "*there are too many unpaid bills in the health facilities*" (Partners_P3).

Besides the problems of managing these CBHWs, one respondent said that the population is not sufficiently covered by the services provided by CBHWs.

"*The contribution of CBHWs to case management remains low at national level (less than 15%*" (Administrative Manager_E24).

Availability and access to health products

To enhance the availability and accessibility of these community services, the Burkinabe government has decided to extend free child health care to the community component. "*It was decided that community services would be free from 2018 on a pilot basis*" (Partners_P9).

However, difficulties in implementing free community healthcare were reported by some of our respondents.

One of the main challenges noted was the lack of health products used to implement iCCM and the lack of financial resources (Table 2). This has been confirmed by health workers who have faced shortages of products needed to implement iCCM in (9/42) 21% of cases (Table 4).

According to another person at regional level, support differs depending on the relationship. "*The regions have different technical and financial"* (Partners_E24).

> "*Free healthcare at community level has been implemented in some regions, but not enough in others. This is linked to the difficulty of providing free healthcare at health facility level (shortages, non-renewal of medicines and poor mastery of the strategy by some health workers)*" (Partnaers_P9).

Respondents were unanimous on the fact that the resources provided by the state and local authorities were insufficient (Table 2) and that the contribution of partners to the health product seemed to be predominant. "*As the State does not manage the inputs, it is the region with the most partners that will do best*" (Administrative Manager_E24). The contribution of local authorities (Municipalities) in terms of inputs is considered to be almost non-existent.

Availability of financial resources

Staff at all levels are dissatisfied with the level of resources mobilised to support iCCM. "*There is not enough mobilisation of financial resources*" (Administrative Manager_E11). And we were told that "*as far as partner investment is concerned, these are occasional actions*" (Administrative Manager_E15).

"*The mobilisation of resources has always been insufficient for successful implementation*" (Administrative Manager_E21).

Another respondent commented:

> "*As regards resource mobilisation, advocacy has been successful. However, the management of resources for community components often raises questions and slows down the momentum of technical and financial partners*" (Administrative Manager_E24).

In addition to all these shortcomings in the implementation of the state's commitment to ensure equitable access to health care through iCCM, the majority of respondents noted the absence of a regular and functional legal framework to ensure proper accountability to communities and to encourage endogenous contributions.

4. Discussion

In several strategic documents and operational plans. Full stakeholder alignment does not appear to have been achieved, resulting in insufficient financial resources to ensure adequate geographical coverage. These findings differ from those of Rivera et *al*. (Rivera et al., 2017), whose work showed a robust implementation of the iCCM in Nicaragua with good resource availability.

The implementation of iCCM was guided by policy guidelines and strategies adopted by the country, based on UNICEF and WHO framework documents, which set out the conditions for implementation to achieve economic benefits and save lives (WHO, 2017, 2; World Health Organization, 2018).

Leadership and Governance

The adoption of the iCCM follows the appropriation of community initiatives by the Government of Burkina Faso and its partners since 1979 with primary health care (5, 19), which laid the foundation for most community health interventions.

The various Community Health Strategies (2008 and 2018) (Ministère de la santé, 2018, 2019b) and Burkina Faso's Sectoral Health Policy (2018-2027) (Ministry of Health BF, 2018) have directed the health system towards institutionalising community-based health workers to meet the growing need for care closer to communities. This has been achieved by recruiting, training and motivating the 17,000 CHWs recruited in 2016 to effectively implement the package of community activities (Ministère de la santé, 2014, 2022; Ministry of Health BF, 2023a). This strategic option is clearly visible in national health development strategies and implemented in national health planning guidelines (Ministère de la santé, 2011, 2018, 2019a, 2022; Ministry of

Health BF, 2011, 2018). It is fully consistent with the solutions proposed by WHO (WHO, 2017, 2021; World Health Organization, 2018). This is an option that has been pursued by several sub-Saharan African countries for more than a decade, with varying degrees of success (Baynes et al., 2017; Burke et al., 2021; Geta et al., 2024; LeBan et al., 2021; White et al., 2018). WHO's efforts to develop national community health worker programmes (WHO, 2017) and the recent World Health Assembly resolutions on community-based primary health care (WHO, 2022) as a participatory and inclusive approach to universal health coverage aim to help countries fill the human resource gaps that are difficult to fill in most of sub-Saharan Africa (DUPONCHEL, 2004; Perveen et al., 2022; WHO, 2016).

The national planning guidelines for 2024 directed operational structures to ensure the development of community health services (Ministry of Health BF, 2023c). As a result, iCCM was well integrated into the annual action plans of the Boussouma and Bousse health districts. This policy orientation and the resulting strategies are fully in line with the main orientations and milestones of the international agenda over the past five years.

The existence of political and strategic guidelines has made it possible to include iCCM among the priority health interventions in Burkina Faso, but above all to harmonise the profile of the community health worker responsible for this curative care, in line with WHO guidelines, which recommend better structured health worker programmes and the provision of incentives to ensure a certain availability of these community human resources in the provision of care to hard-to-reach communities (World Health Organization, 2018).

The government's adoption of free community care as a complement to free health care is undoubtedly one of the major effects of this policy orientation. These national policies and guidelines have not really solved the main problems faced by the health system in developing iCCM, in terms of the major shortcomings listed in Table 2, such as the shortage of medicines and consumables already mentioned in previous studies (Geta et al., 2024; Ridde et al., 2013; Seck & Valéa, 2011).

In Burkina Faso, the iCCM has been well institutionalised in a dynamic driven by UN agencies, but with very clear actions taken in recent years to strengthen governance and improve availability of resources by good funding strategies through more synergetic funding, but with the share of the budget of the Ministry of Health being indexed to this front-line care in order to reduce mortality.

iCCM coverage according to stakeholders

The strategic choices made by the country and the system in place should gradually lead to full coverage of communities by the iCCM to fill the gaps in coverage of health facilities (Ministère de la santé, 2018, 2019b; Ouédraogo et al., 2023).

However, our results show that there are significant geographical disparities in the implementation of the iCCM package. More than a decade later, and after major reforms such as the harmonisation of the profile and motivation of the CHWs and the introduction of planning guidelines incorporating the iCCM, our results show that the problems identified by Seck et *al*. (Ridde et al., 2013) in relation to the lack of synergy in funding and the shortage of health products persist.

Resources and matching

Shortages of CHWs, drugs and health equipment were confirmed by health workers. In 19% of cases, they reported having no trained CHWs. This is a major shortcoming given the model that Burkina Faso has developed to ensure that communities benefit from iCCM through these CHWs.

Drug stock-outs have been highlighted by a mapping of community interventions carried out by the Ministry of Health and its partners (USAID et al., 2021), which also shows a low level of mobilisation of funds for the acquisition of the inputs needed to provide community-based services(Ministère de la santé, 2019c). The availability of medicines, according to our results, depends on the target intervention areas of the partners, indicating a lack of strategic leadership to guide the actions of the partners with a view to good synergy.

These results show that the level of funding for iCCM is not optimal and that the state lacks funding in certain key areas, such as the health products needed to implement the curative care package for community health workers.

The estimated cost of adequately covering the country with community-based interventions in 2018 is USD 177.7 million. The needs of iCCM dominate this total cost, amounting to at least USD 8.6 million, according to the scenarios in the Community Health Investment File. Resource mobilisation has likely been affected by the COVID-19 pandemic (Anyanwu & Salami, 2021) and the security crisis, which has worsened since 2017

(Ministry of Health, 2019c). This mobilisation has been insufficient, and gaps in medicines and other resources have also been identified in other countries, such as the Democratic Republic of Congo (Programme Intégré de Santé Maternelle et Néonatale (MCHIP) & USAID, 2012). The extension of free health care to communities in 2018 (Matt et al., 2020) has unfortunately not solved the problem of making financial resources available.

Including iCCM in the results-based purchasing system, focusing on the performance of health districts in implementing iCCM, and effectively operationalising free community care by targeting partner funding to this component will make it possible to improve the availability of health commodities (Godt & Centre de recherches pour le developpement international (Canada), 2017; WHO, 2017, 2022).

Furthermore, the literature review showed that the mapping of health sector resources in 2022 did not include iCCM as a specific intervention. This does not provide a clear picture of resource mobilisation for iCCM and makes it difficult to develop sound strategic projections(Naimoli et al., 2015). Future mapping should better segment community health to better inform strategic decisions.

Insufficient accountability and involvement of local authorities and decentralisation implementation structures. A contractual arrangement with the structures responsible for decentralisation and better operation of the community diagnosis and reporting frameworks will facilitate endogenous contributions and the mobilisation of local resources(Ministère de la santé, 2018, 2022; Naimoli et al., 2015). Greater decentralisation and community involvement in the management of CBWs is therefore necessary, and could bring real ownership and financial support for the strategy from the communities, rather than confining them to their recruitment role (Perveen et al., 2022). During the course of this study, we were not able to carry out an in-depth economic evaluation to better guide the mobilisation of resources to fund the various components of iCCM implementation. In addition, the confidentiality of the information and the reluctance of some of the interviewees prevented us from obtaining financial data on the funding shares of the partners supporting the iCCM. Another limitation is that we were not able to interview the beneficiaries and the perceptions of the ACSFs were not taken into account and will be the subject of future studies. Finally, desirability bias cannot be ruled out, as respondents to the qualitative component were selected on the basis of their level of involvement in the implementation of the iCCM.

5. Conclusion

More Improving access to health care for all is a challenge for Burkina Faso.

Our study has shown that iCCM has been taken into account in planning guidelines and translated into operational plans. However, our results show that these policy orientations and guidelines are not sufficient to influence partners and the state itself in budget modelling.

Despite the commitment of the government and the stakeholders involved in the implementation of the strategy, major shortcomings have been identified. Geographical coverage is still inadequate and gaps in access to care persist. Insufficient resources have been mobilised to meet the needs required for full implementation of iCCM. The application of decentralisation was found to be inadequate, resulting in low levels of community involvement. The involvement of municipalities and civil society organisations, beyond the recruitment processes, will extend the influence of policy guidelines and directives to funding aspects through a more perfect alignment of actors, as advocated by the 'one plan, one budget and one report' approach.

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Authors' Contributions

1. Hamed Sidwaya Ouedraogo: Conceptualization, Acquisition of data, Analysis and interpretation of data, Drafting of the manuscript, Critical revision of the manuscript for important intellectual content, Statistical analysis, Obtaining funding, Administrative, technical, or material support, Supervision.

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