USER FEES EXEMPTION: ONE STEP ON THE PATH TOWARD UNIVERSAL ACCESS TO HEALTHCARE

Pilot experiences in Burkina Faso
In 2009, the President of the European Commission, with the leaders of all the United Nations agencies and numerous Presidents of African and European countries, called for the abolition of user fees at the point of service for pregnant women and children under the age of five years. Indeed, access to care, a key determinant in the fight against malnutrition, is very much limited by peoples’ financial capacities. However, even though we know today that user fees abolition is a solution that should be implemented without delay in order to save lives, political leaders require more evidence before generalizing this practice. The data presented in this report are therefore timely and will be useful to leaders as they decide on the most effective and equitable policy options to improve the standard of health of their citizens. The partnership between NGOs and researchers supported by the European Commission, and particularly by its Humanitarian Aid service (ECHO), has produced evidence of the value of subsidizing healthcare user fees for vulnerable populations. The investment made by Burkina Faso over recent years to subsidize deliveries and certain preventive services is reinforced by these experiences conducted with the Ministry of Health in several districts of the country. The data analyses also make it possible to quantify the overall financial implications of such an approach; this knowledge will be indispensable to the government and to funding agencies as they develop sustainable financing solutions. At this crucial time, as Burkina Faso is strengthening its social protection policy and planning for the introduction of national health insurance, this report highlights the importance of considering user fees exemption as a solution to address the needs of the most vulnerable populations. This is certainly an essential milestone in the transition toward universal access to healthcare services.

Amos Tincani
Ambassador, Chief of the European Union Delegation to Burkina Faso

SUMMARY

The World Health Organization has cautioned countries that they must “resist the temptation to rely on user fees”. In other words, healthcare funding should not depend on what patients pay when they use services. This is why more and more countries have decided to abolish user fees, a move that has greatly increased the utilization of services among vulnerable populations. At the same time, however, these experiences have revealed the challenges presented by their implementation.

In Burkina Faso, in 2008, three regional health departments supported by the non-governmental organizations (NGOs) HELP and Terre des hommes decided to subsidize at 100% user fees for services to children under the age of five years and pregnant women in four health districts. This was the first time that user fees exemption was implemented for such large population groups. Also, the Regional Health Department of Sahel and the NGO HELP established a scientific partnership with the University of Montreal (CRCHUM) to produce, share and disseminate data on these interventions. The objective of this report is to share with a relatively informed public the key results of studies undertaken since July 2008.

Documentation of the interventions was based on a multilevel methodological approach using mixed methods and combining impact analysis with cost and process analysis.

The results demonstrate that interventions aimed at user fees exemption and third-party subsidies, such as those implemented here:

- satisfy, in an immediate and sustained way, health needs that were not previously covered by the healthcare system;
- benefit all population categories without reinforcing inequities in access to healthcare services;
- guarantee an affordable cost for the State and the preservation of the quality of care provided to users;
- respect the principles of the Bamako Initiative by reinforcing equity, community participation and cost recovery.

Lifting the financial barrier by exempting patients from user fees and organizing third-party reimbursement of fees is an option that merits serious consideration in order to achieve the objectives of Burkina Faso’s National Health Policy. This option was proposed by African decision-makers at the African Union Summit in July 2010. Moreover, as demonstrated in Ghana, exemption from user fees at the point of service can be seen as the perfect starting point for the organization of national health insurance. The data in the present report should be useful for decision-makers as they formulate the National Health Development Plan for 2011–2020.
# Table of Contents

1 Introduction and Background 8

2 Interventions in Burkina Faso 10
   2.1 Health situation and ECHO strategy 10
   2.2 Pilot projects of user fees exemption 10
   2.3 Scientific partnership 14

3 Outcomes Generated by the Interventions 15
   3.1 Overall increase in service utilization 15
   3.2 Significant increase among children under the age of five years 16
   3.3 Continued upward trend in deliveries 17
   3.4 Increase in service utilization benefiting disadvantaged groups 19
   3.5 Preservation of the quality of drug prescriptions 23
   3.6 Strengthening the financial capacities of the COGESs 24
   3.7 Poor coverage of indigents but few inclusion errors 25

4 Implementation Analysis 28
   4.1 Validity of the strategy and appropriateness of the beneficiary populations 28
   4.2 Information satisfactory but coverage still imperfect 28
   4.3 Strengths and weaknesses of the subsidy system 29
   4.4 Reasonable turnaround times for reimbursement 29
   4.5 Positive outcomes expected and negatively perceived outcomes 30
   4.6 Key lessons from the process 30

5 Direct Cost of the Subsidy to CSPS 32

6 Sharing and Disseminating the Knowledge Produced 34
   6.1 Knowledge syntheses for decision-makers 34
   6.2 Extending the strategy to other regions 34
   6.3 Close collaboration with RHD and DMO partners 35
   6.4 Early access to key results for the Ministry of Health 35
   6.5 Discussion and dissemination at the national and international levels 35

7 Conclusion 37

8 Studies Carried Out Between 2008 and 2010 39

9 References 40
TABLES
Table 1: Some indicators of the current situation in Burkina Faso 10
Table 2: Information on the pilot projects 12
Table 3: Relevant indicators for the eight districts studied 15
Table 4: Impact of the intervention on the use of services by children under 5 years of age in Dori and Sebba 17
Table 5: Impacts of the intervention on rates of assisted deliveries in the Djibo, Dori and Sebba health districts 19
Table 6: Evolution of the average monthly number of acts in 11 CSPSs in the Dori district 20
Table 7: Summary of multiplier effects in the Dori and Sebba districts 22
Table 8: Evolution of prescription indicators before and after the intervention 23
Table 9: Summary of the impacts of the intervention on prescription indicators 24
Table 10: Evolution of the average cash assets (F CFA) of the COGESs in the four intervention districts 25
Table 11: Categories of actors and numbers of people encountered in the process study 28
Table 12: Key results of the study of reimbursements for the final quarter of 2008 (T4) and first quarter of 2009 (T1) 29
Table 13: Summary of actual costs and hypotheses regarding scaling up 33

FIGURES
Figure 1: Evolution of the utilization rate for curative services in Burkina Faso since 1979 9
Figure 2: Simplified conceptual framework for maternal and neonatal mortality and morbidity 11
Figure 3: Locations of user fees exemption pilot projects in Burkina Faso 11
Figure 4: Third-party payer system in the projects studied 12
Figure 5: Intervention logic of the HELP user fees exemption project 13
Figure 6: Average monthly number of consultations by children under 5 years of age per CSPS since 2004 in the two groups of districts studied 16
Figure 7: Average monthly number of consultations for children under 5 years of age and of adults by CSPS since 2007 in the two groups of districts studied 16
Figure 8: Average monthly number of assisted deliveries per CSPS since 2004 in the three groups of districts studied 18
Figure 9: Average monthly number of assisted deliveries by CSPS since 2004 in the four districts of the Sahel region 18
Figure 10: Proportion (%) of early consultations in relation to total consultations, before and after the intervention 21
Figure 11: Proportion (%) of consultations by amounts spent before the intervention and one year later 21
Figure 12: Proportion (%) of deliveries in the CSPSs before the intervention and one year later 22
Figure 13: Evolution of the average number of molecules per prescription before and after the intervention 23
Figure 14: Distribution of income for the four groups of persons studied in relation to the thresholds of poverty and extreme poverty 26
Figure 15: Evolution of the average cash assets of the COGESs in the Dori and Sebba districts and average monthly reimbursement amounts (F CFA) 30

BOXES
Box 1: Exemption from user fees or free care? 8
Box 2: “Maternal health is a right” 9
Box 3: Long-term and short-term impact 15
Box 4: Data collection methodology for household survey 20
Box 5: The impacts of user fees exemption according to one woman 30
Box 6: Some occasions at which research results were shared 35
Box 7: Comment by Roger Sie Hien, Deputy at the National Assembly of Burkina Faso following his participation in the national discussion workshop on experiences (Ouagadougou, March 2010) 36
Box 8: Key lessons from these pilot projects on user fees exemption subsidies 38
### ACRONYMS AND ABBREVIATIONS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired immuno-deficiency syndrome</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretrovirals</td>
</tr>
<tr>
<td>BI</td>
<td>Bamako Initiative</td>
</tr>
<tr>
<td>BMH</td>
<td>Boucle du Mouhoun</td>
</tr>
<tr>
<td>CAMEG</td>
<td>Central purchasing agency for essential generic drugs</td>
</tr>
<tr>
<td>CISSE</td>
<td>Centre d’information sanitaire et de surveillance épidémiologique (Centre for Health Information and Epidemiological Surveillance)</td>
</tr>
<tr>
<td>COGES</td>
<td>CSPS management committee</td>
</tr>
<tr>
<td>CRCHUM</td>
<td>Research Centre of the University of Montreal Hospital Centre</td>
</tr>
<tr>
<td>CSI</td>
<td>Indigent selection committee</td>
</tr>
<tr>
<td>CSPS</td>
<td>Health and social services centre</td>
</tr>
<tr>
<td>DMEG</td>
<td>Essential generic drugs depot</td>
</tr>
<tr>
<td>DMO</td>
<td>District medical officer</td>
</tr>
<tr>
<td>DRD</td>
<td>District distribution depot</td>
</tr>
<tr>
<td>ECHO</td>
<td>Humanitarian Aid service of the European Commission</td>
</tr>
<tr>
<td>EG</td>
<td>Essential generic drugs</td>
</tr>
<tr>
<td>HD</td>
<td>Health district</td>
</tr>
<tr>
<td>HELP</td>
<td>HELP - Hilfe zur Selbsthilfe e.V. (NGO)</td>
</tr>
<tr>
<td>HP</td>
<td>Health post</td>
</tr>
<tr>
<td>LN</td>
<td>Licensed nurse</td>
</tr>
<tr>
<td>IGB</td>
<td>Institut géographique du Burkina (Burkina Geographical Institute)</td>
</tr>
<tr>
<td>INSD</td>
<td>Institut national de la statistique et de la démographie (National Institute of Statistics and Demography)</td>
</tr>
<tr>
<td>MDM</td>
<td>Médecins du monde (NGO)</td>
</tr>
<tr>
<td>MSF-OCB</td>
<td>Médecins sans frontière – Operational Centre Brussels (NGO)</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
</tr>
<tr>
<td>PNDS</td>
<td>Plan national de développement sanitaire (National Health Development Plan)</td>
</tr>
<tr>
<td>RHD</td>
<td>Regional health department</td>
</tr>
<tr>
<td>RGPH</td>
<td>Recensement général de la population et de l’habitation (General population and habitat census)</td>
</tr>
<tr>
<td>SERSAP</td>
<td>Société d’études et de recherche en santé publique (Society for Studies and Research in Public Health)</td>
</tr>
<tr>
<td>SNIS</td>
<td>Système national d’information sanitaire (National Health Information System)</td>
</tr>
<tr>
<td>SONU</td>
<td>Emergency obstetric and neonatal services</td>
</tr>
<tr>
<td>SQN</td>
<td>State qualified nurse</td>
</tr>
<tr>
<td>SRI</td>
<td>Severe respiratory infection</td>
</tr>
<tr>
<td>Tdh</td>
<td>Terre des hommes (NGO, Lausanne, Switzerland)</td>
</tr>
<tr>
<td>TG</td>
<td>Target group</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>ZD</td>
<td>Zone de dénombrement (census tract)</td>
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</tbody>
</table>
“The patient will not go to sell his death at the health centre.” These words spoken by Mariam Ouedraogo, who lives in a village in Burkina Faso, describe the experience of most people who cannot receive proper care because they lack money. In Burkina Faso, 80% of poor households must go into debt to cover their health expenses. Yet the World Health Organization (WHO) cautions that we must “resist the temptation to rely on user fees.” In other words, healthcare system funding should not depend on what patients pay when they use services. Indeed, we know that the worst-off, like Mariam Ouedraogo, do not have the capacity to pay and therefore cannot benefit from the so-called modern healthcare system. Yet, since 1993, when the Bamako Initiative (BI) was organized across the entire territory, user fees have become generalized. Patients were required to pay health centres directly for their medications. Shortly thereafter, patients were also asked to pay for services, such as curative consultations. However, studies showed that introducing this direct payment had the effect of reducing service utilization. This was why the promoters of the BI and the government had hoped to organize user fees exemptions for the worst-off (Box 1), but these were never actually implemented in Burkina Faso, as they were elsewhere in the region.

Even though the healthcare system is only one of the determinants of population health, it is important to acknowledge that it helps to save lives. Indeed, we know that 80% of maternal deaths and 40% to 70% of newborn deaths could be avoided if patients’ rights to access to services were respected (Box 2).

Health services utilization has remained low (fewer than 0.6 new curative consultations per year per inhabitant) for years in Burkina Faso (Figure 1) compared to the “standard” of one consultation often stated by WHO. However, a clear improvement has been observed since 2002.

Box 1: Exemption from user fees or free care?

Words matter. It is not unusual for the term “exemption from user fees” to be confused with the concept of “free care”. In this report, we are not using the term “free care”, since it leads to confusion and often provokes discussions that are more ideological than rigorous. The issue described here is that of exempting the patient from user fees at the point of service. We cannot call it free care because: i) patients have other expenses to cover before and after coming to the point of service; and ii) this exemption creates expenses for the health system that must be covered. Thus, we prefer to speak in terms of an exemption from user fees for patients that is subsidized by a third-party (Figure 4).

Box 2: “Maternal health is a right”

The preamble to the Constitution of Burkina Faso refers to the Universal Declaration of Human Rights and reasserts the country’s commitment to international treaties and to the African Charter on Human and Peoples’ Rights. Articles 1 and 26 of the Constitution confer on every person the right to life and the right to health. The obligation on states to progressively realize the right to the highest attainable standard of health is enshrined in various international and regional instruments to which Burkina Faso is a party including the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Convention on the Rights of the Child (CRC) and the Protocol to the African Charter on Human and People’s Rights on the Rights of Women in Africa (the Maputo Protocol), Preventable cases of maternal mortality are recognized as a violation of the right to life, as enshrined in the International Covenant on Civil and Political Rights (ICCPR). Moreover, the CEDAW Committee has insisted that women must absolutely have access to healthcare services, and in particular, those related to family planning, pregnancy and delivery. In November 2008, the African Commission on Human and Peoples’ Rights adopted a resolution to address maternal mortality. This resolution acknowledged that preventable maternal mortality in Africa is a violation of women’s rights to life, dignity and equality. It called on African governments to address, individually and collectively, the issue of maternal mortality. According to the terms of these various treaties, the State has the immediate obligation to ensure that the right to health becomes a reality and that it is exercised, without the least discrimination, by allowing women “to have access to a full range of health services of good quality and at an affordable cost.” (ICESCR)

– Amnesty International
This is why more and more countries are moving to abolish user fees. Most African experiences have shown that this strategy has greatly increased the utilization of services among vulnerable populations. At the same time, however, these experiences have shown the challenges presented by the implementation of such reform. In some countries, pressures were introduced into healthcare systems that were sometimes already fragile. Also, there is still a lot to learn about the subsidy strategy. Given its recent implementation, studies on this topic have only just begun and are rare in francophone African countries.

The objective of this report is therefore to share with a relatively informed public the preliminary results of studies carried out since July 2008 to produce evidence from pilot projects of user fees exemption in Burkina Faso. It also contains a note of several pages destined for a wider audience. Participants in the February 2010 Estates General on Health called for the organization of strategies to promote healthcare services utilization. It is our hope that the data in the present document will be useful to decision-makers in formulating the 2011–2020 National Health Development Plan.
2 INTERVENTIONS IN BURKINA FASO

2.1. Health situation and ECHO strategy
UNICEF estimates that 600,000 children under the age of five years die every year in the Sahel countries, more than half from malnutrition. The rates of maternal mortality, infant mortality and mortality among children under the age of five years are also among the highest in the world. Like its neighbours, Burkina Faso will not achieve most of the Millennium Development Goals (Table 1).

Given this situation, the objective of the Humanitarian aid service of the European Commission (ECHO) in the region is to reduce severe malnutrition and mortality among the most vulnerable populations, particularly children under the age of five years and pregnant or nursing women.

Since 2007, the amount accumulated in ECHO’s various global plans for the Sahel countries has reached 120 million Euros. Its strategy is based on three axes:

1) better knowledge (nutritional surveys, studies on the basic socio-economic conditions of the means of sustenance, etc.);
2) promotion of policies and nutritional treatments that are effective, innovative and reproducible in other contexts;
3) relevant and effective advocacy among donors and governments for appropriate and long-term policies and interventions.

2.2. Pilot projects of user fees exemption
Some of the partners funded by ECHO have set their sights on improving access to the healthcare system, considered to be a major determinant of malnutrition (Figure 2). To achieve this, they are using an innovative strategy: eliminating user fees at the point of service. Some partners are reinforcing national policies, in cases where the countries have already adopted this type of strategy (e.g. HELP and MDM in Niger and MSF-OcB in Mali), while others are implementing pilot projects aimed, ultimately, at influencing decision-making at the national level in favour of this solution (e.g. HELP in Niger in 2006 and HELP and Tdh in Burkina Faso since 2008).

<table>
<thead>
<tr>
<th>Total population (millions), 2008</th>
<th>15’234</th>
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<tbody>
<tr>
<td>Population living on less than $1 (PPP) per day (%), 2000 - 2007</td>
<td>56,5</td>
</tr>
<tr>
<td>Public expenditure on health per inhabitant ($US), 2007</td>
<td>16</td>
</tr>
<tr>
<td>Life expectancy at birth, 2008</td>
<td>51</td>
</tr>
<tr>
<td>Children under 5 years old presenting a weight deficit (%), 2000 - 2009</td>
<td>37,4</td>
</tr>
<tr>
<td>Mortality rate for children under 5 years old (per 1,000 live births), 2008</td>
<td>169</td>
</tr>
<tr>
<td>Births attended by qualified health personnel (%), 2000 - 2008</td>
<td>54</td>
</tr>
<tr>
<td>Maternal mortality rate (per 100,000 live births), 2000 - 2009</td>
<td>307</td>
</tr>
<tr>
<td>Maternal mortality rate (per 100,000 live births), 2005</td>
<td>700 [390-1’000]</td>
</tr>
<tr>
<td>Mortality rate due to a specific cause (per 100,000 inhabitants): Malaria, 2006</td>
<td>178</td>
</tr>
</tbody>
</table>

*Estimate reported by the countries. **Inter-agency estimate

Source: WHO

Table 1. Some indicators of the current situation in Burkina Faso
In Burkina Faso, despite Objective 2 (to increase health services utilization) of its National Health Development Plan (PNDS) for 2001–2010, utilization rates for health services remain dismally low (Figure 1). Thus, in September and October 2008, three regional health departments (RHD) supported by the non-governmental organizations (NGO) HELP and Terre des hommes (Tdh) decided to subsidize at 100% user fees for services to children under the age of five years and pregnant women in four health districts (Figure 3, Tables 2 and 3).

Figure 2. Simplified conceptual framework for maternal and neonatal mortality and morbidity

Inadequate nutrition
Insufficient access to food
Unhealthy environment & inadequate health services
Inadequate healthcare practices for mothers and newborns
Limited access to maternity services (including EmOC)

Illnesses
Infections
Obstetrical risks
Congenital factors

Insufficient and/or inadequate knowledge, discriminatory attitudes limiting households to existing resources

Quantity and quality of resources (human, economic and organizational) in place for maternal health and how they are controlled

Political, economic, cultural, religious and social systems, including the woman’s condition limiting recourse to potential resources

Potential resources

Inadequate healthcare practices for mothers and newborns
Limited access to maternity services (including EmOC)

Fundamental causes (Society)
Underlying causes (Household/Community/District)
Direct Causes
Impacts

Source: Adapted from UNICEF

In Burkina Faso, despite Objective 2 (to increase health services utilization) of its National Health Development Plan (PNDS) for 2001–2010, utilization rates for health services remain dismally low (Figure 1). Thus, in September and October 2008, three regional health departments (RHD) supported by the non-governmental organizations (NGO) HELP and Terre des hommes (Tdh) decided to subsidize at 100% user fees for services to children under the age of five years and pregnant women in four health districts (Figure 3, Tables 2 and 3).

Figure 3. Locations of user fees exemption pilot projects in Burkina Faso

Source: IGB 2001
This subsidy program is fully integrated into the healthcare system and acts as a third-party payer (Figure 4). The populations benefiting from the subsidy are exempted from user fees in all of the districts’ public health centres. The health workers document all related fees (consultations, pharmaceutical products, examinations, analyses, etc.). At the end of each period the health centre managers report this information to the district team, which, after validation, requests reimbursement from the project partner. After the requests are processed and some verifications, primarily related to accounting, are completed, the NGO reimburses the health centre management committees (COGES).

The projects are not limited to reimbursing the costs of care. They include a range of activities along with the subsidies, aimed especially at strengthening the quality of care: training for health workers, technical and material support to health centres, providing information to the population, etc. (Figure 5).
Figure 5. Intervention logic of the HELP user fees exemption project

MODIFYING CONTEXTUAL FACTORS: RHD and DHO leadership; availability and motivation of the health workers and COGES members; gender; cultural factors; health, social, economic and political situations...

Financial support (100% subsidy of services to children < 5 ans, pregnant and nursing women, and indigents, supplementary SONU subsidy, emergency transport subsidy)

Material support (equipment, materials, etc.)

Technical support (training, follow-up, supervision, equipment, renovations, etc.)

Reimbursement of user fees (TC)

Improvement of service quality

Rationalization of prescriptions

Improvement of medico-technical platform

Improvement of service quality

Improvement of the financial situation

Strengthening the capacities of COGES

Women’s empowerment / healthcare system-latent period for healthcare consultations by TGs

Number of emergency evacuations AND wait times for management of urgent evacuations

Public trust in the healthcare system

Assisted deliveries and caesareans

Assisted deliveries and caesareans

Use of informal healthcare system

Use of informal healthcare system

Public trust in the healthcare system

Use of formal healthcare system / empowerment / empowerment of women's system

The healthcare system in poverty

Targeting, rollout, etc.

Healthy lifestyle, nutrition, etc.

Involvement in the community development capacity

Information to leaders

Public trust in the healthcare system

Assisted deliveries and caesareans

Assisted deliveries and caesareans

Use of informal healthcare system

Use of informal healthcare system
2.3. Scientific partnership

Despite Objective 6 of the 2001–2010 PNDS (to improve financial accessibility to healthcare services for the population), user fees have been the rule in Burkina Faso since the end of the 1980s. Systems to exempt the indigent from user fees have never really worked.\textsuperscript{5, 6} Aside from a few conventional exemptions in recent years (tuberculosis, leprosy, etc.), exemptions for other services have been few and far between (preventive care for pregnant women and infants; syringes, iron, chloroquine and health booklets; patients with meningitis; victims of severe malaria, etc.).\textsuperscript{18} In 2008, AIDS patients were still required to pay for ARVs (1,500 F CFA), and deliveries and emergency obstetric and neonatal care were only subsidized at 80% or 60%.\textsuperscript{19}

The HELP project (September 2008) thus represented the first time since the Bamako Initiative that user fees were exempted for such large population groups. Given the experimental nature of such an initiative, the Sahel DHR and HELP established a scientific partnership with the University of Montreal (CRCHUM) aimed at producing, sharing and disseminating the evidence gathered from the project.

Documentation of the interventions by the CRCHUM researchers was based on a multilevel strategy\textsuperscript{ab} that used mixed methods and combined impact analysis with cost and process analysis.

The October 2008 launch of the Tdh project and the interest expressed by other ECHO partners (Action Against Hunger, Save the Children Canada, and the Belgian and Burkinabè Red Cross agencies) led to the creation of a working group, the extension of the knowledge production, sharing and dissemination strategy, and the hiring of a national firm specialized in public health (SERSAP) for part of the inter-project studies.

\textsuperscript{b} Using concomitantly data on individuals, households, communities and health centres.
3 OUTCOMES GENERATED BY THE INTERVENTIONS

The impact analysis focuses on changes generated in the short term (Box 3) with respect to service utilization (including equity in utilization and funding), the quality of medical prescriptions, and the financial viability of the COGESs of the health and social services centres (CSPS).

3.1. Overall increase in service utilization

From an analysis of long-term trends (since 2004), we can more easily see the immediate changes by comparing health services utilization before and after the intervention. Also, by comparing districts that implemented subsidy projects against some that did not, i.e., comparison districts, it is possible to confirm that, in the absence of interventions and some contextual differences (Table 3), utilization did not follow the same trends. This involves comparing data from before and after the intervention as well as with and without user fees exemption projects. Thus, we analyzed the available service utilization data from eight districts using district-level data from the national health information system (SNIS), the patient registers of a sample of CSPSs in two Sahel districts (Dori – with intervention, and Djibo – without intervention), and a before-and-after survey of 2,200 households in the districts of Dori and Sebba.

First, using the SNIS, we studied the utilization data in relation to the CSPSs’ monthly revenues. The four intervention districts were paired with four comparison districts (Table 3).

Table 3. Relevant indicators for the eight districts studied

<table>
<thead>
<tr>
<th>Subsidy</th>
<th>Comparison</th>
<th>Subsidy</th>
<th>Comparison</th>
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<tbody>
<tr>
<td>Dori</td>
<td>Sebba</td>
<td>Djibo</td>
<td>Gorom-Gorom</td>
</tr>
<tr>
<td>Sahel</td>
<td>Nord</td>
<td>BMH</td>
<td>Nord</td>
</tr>
<tr>
<td>Number of inhabitants</td>
<td>283 672</td>
<td>176 532</td>
<td>358 389</td>
</tr>
<tr>
<td>Number of CSPSs</td>
<td>17</td>
<td>11</td>
<td>24</td>
</tr>
<tr>
<td>Mean nb. of inhabitants/CSPS</td>
<td>16 687</td>
<td>16 048</td>
<td>14 933</td>
</tr>
<tr>
<td>Number of nurses (SQN, LN)</td>
<td>61</td>
<td>40</td>
<td>68</td>
</tr>
<tr>
<td>Mean nb. of inhabitants/nurse</td>
<td>4650</td>
<td>4413</td>
<td>5270</td>
</tr>
<tr>
<td>Main ethnic groups</td>
<td>Peulh (78%)</td>
<td>Peulh (80%)</td>
<td>Peulh (47%)</td>
</tr>
</tbody>
</table>

Sources: DEP Yearbook 2008; RGPH 1996

* These data were smoothed with three-month moving averages to reduce the less significant variations.
3.2. Significant increase among children under the age of five years

Because the districts launched their user fees exemption projects in different months (September or October 2008), the data for children under the age of five years were aligned to begin in month M, as presented on the horizontal axis in the figures.

Figure 6 shows a long-standing mild upward trend in utilization since 2004, with comparable seasonal variation in the two groups of districts. When the exemption (vertical yellow bar) was implemented in the intervention districts (blue curve), the increase was observed starting in the first month; it was immediate. The dotted line shows that the increase was unanticipated. The increase in the month preceding the exemption was at very much the same level as in the previous year, which notably corresponds to the epidemic season for malaria. Also, the level of consultations remained well under that of preceding years and that of the comparison districts, following the same seasonal variation. The higher level of consultations continued into December 2009 until the malaria season had passed. On the other hand, the trend in the comparison districts (red curve) was unchanged.

This increase for children under the age of five years did not occur to the detriment of adults (Figure 7), since in the districts with exemptions (blue curves) the long-standing mild upward continued. In the comparison districts (red curves) the level of utilization remained steady.

This figure also shows the extent to which user fees exemptions make it possible for more children to be treated during the malaria season, which bodes well for reducing child mortality.

Using statistical analyses, we can better quantify these visually observed impacts. On one hand, these analyses allow us to take into consideration (and control for) certain factors that might interfere in the results and are not easily detected graphically. On the other hand, thanks to data from the most recent census conducted by the Institut National de la Statistique et de la Démographie (INSD), we have information on the socio-economic status of households and of reference populations to calculate the rates of consultation. Using a statistical model, we can thereby estimate the utilization rate expected without the intervention and compare it with the intervention in the Dori and Sebba districts (HELP project).
Regardless of the season studied (normal attendance or seasonal increase), the impact of the intervention is high (Table 4).

The impact estimates combine the immediate effect of the intervention and its effect on the trend up to the time indicated. The “with” rates are model predictions for the observed situation. The “without” rates represent what would have been the rates without the intervention effect (everything else going on as observed before the intervention and as concurrently observed in the control district).

For example, in Sebba, 12 months after the start of the intervention (August 2009), the rate of utilization for curative services among children under five years of age was 2.04 times greater with the intervention (at 2.80 instead of 1.37 consultations per child per year) when we take into account all the variables available that could intervene in this effect. The effect in the Dori district is similar.

### 3.3. Continued upward trend in deliveries

For deliveries, the situation is more complex to study because between January and April 2007 the health districts launched the national subsidy for deliveries (SONU) announced by the government (blue vertical arrow, Figure 8). Thus, between this period and the beginning of the exemption projects (yellow vertical bar), women officially had to pay 900 F CFA for a normal delivery. For a better understanding of the trends, we added data from four other districts of the country (blue curve)—one from the capital Ouagadougou and three from the Centre-East region.

Figure 8 shows that the eight districts that only implemented the State subsidy (including the four comparison districts, green curve) had a long-standing upward trend before the national subsidy, although the trend started later in the four comparison districts. This trend continued after the SONU national policy was implemented and pregnant women had to pay 900 F CFA.

The four districts (red curve) that implemented the “full subsidy” (which paid the 900 F CFA for the women and provided complementary measures related to the exemption projects) had the same long-standing upward trend, which did not change

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Table 4. Impact of the intervention on the use of services by children under 5 years of age in Dori and Sebba

<table>
<thead>
<tr>
<th>District</th>
<th>Time</th>
<th>Scenario</th>
<th>Rate*</th>
<th>Impact</th>
<th>p-value</th>
<th>95% CI**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dori</td>
<td>February 2009</td>
<td>with HELP</td>
<td>1,50</td>
<td>1,65</td>
<td>&lt;0,0000</td>
<td>1,39</td>
</tr>
<tr>
<td></td>
<td>(normal attendance)</td>
<td>without HELP</td>
<td>0,91</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>August 2009</td>
<td>with HELP</td>
<td>2,35</td>
<td>1,85</td>
<td>&lt;0,0000</td>
<td>1,54</td>
</tr>
<tr>
<td></td>
<td>(seasonal increase)</td>
<td>without HELP</td>
<td>1,27</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sebba</td>
<td>February 2009</td>
<td>with HELP</td>
<td>1,74</td>
<td>1,81</td>
<td>&lt;0,0000</td>
<td>1,41</td>
</tr>
<tr>
<td></td>
<td>(normal attendance)</td>
<td>without HELP</td>
<td>0,96</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>August 2009</td>
<td>with HELP</td>
<td>2,80</td>
<td>2,04</td>
<td>&lt;0,0000</td>
<td>1,53</td>
</tr>
<tr>
<td></td>
<td>(seasonal increase)</td>
<td>without HELP</td>
<td>1,37</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Annualized utilization rate. **CI = confidence interval

Source: Heinmüller & al. 22

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* The confidence intervals for these combined effect estimates are obtained from estimable functions, available with the estimate statement in SAS PROC GLIMMIX.
* Controlled for pre-existing level and trend, contemporaneous development without intervention (IV) in the CSPSs of a control district (Djibo), immediate effect and change in trend subsequent to the start of the IV, average household economic status and its interaction with the IV, months of the year, districts and the differences in the average reactions of their CSPSs to the IV, non-measured influences of the CSPSs on their base rates, pre-existing trends and immediate reactions to the IV (random effects), as well as for serial autocorrelation (preceding month’s rate), negative binomial regression and adaptive Gaussian quadrature (SAS 9.2 PROC GLIMMIX).
after the national subsidy policy. Several months before the elimination of the 900 F CFA payment, the trend showed a stronger increase, which also continued after the interventions.

The distances between the three groups of districts are especially noteworthy. As time passed, the districts with full subsidy for deliveries tended to catch up with and then surpass the absolute level of utilization in the four districts without intervention. In other words, the four districts with intervention, which had done 2.5 times fewer deliveries than the four others in 2004, had now, with the full subsidy, attained the same level as those others.

Beyond these analyses regarding the two interventions, in looking at the four districts of the Sahel health region (HELP intervention), we observe contrasting trends. Figure 9 shows that the two districts without intervention appeared to have reached a plateau in maternity services utilization, whereas in the districts of Dori (blue curve) and Sebba (red curve), where women no longer pay the 900 F CFA, the upward trend continued, most markedly in Sebba (the red triangles represent the start of the SONU subsidy).

As described earlier for the children, statistical analyses were carried out using the SNIS and INSD data on delivery rates in the two districts with the HELP intervention and in a third, comparison district, Djibo. The analysis is more complex, given that the HELP intervention was added to the State subsidy. The statistical model we used allowed us to confirm the visual analyses with respect to the very small and statistically non-significant impact of the HELP intervention on the rates of assisted deliveries in the CSPSs (Table 5). Eighteen months after its introduction, the delivery subsidy organized by the State (user fees of 900 F CFA) had already had a definite impact (varying between 131% and 150%) on the rates of deliveries in the three districts. In Djibo, for example, the statistical model predicted a delivery rate of 28% if the State subsidy had not been implemented vs. 37% with that subsidy in place. On the other hand, 12 months after the HELP intervention, no statistically significant overall impact was observed (on top of what was to be expected from the long-standing trend and State subsidy). The changes already

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1 Ibid.
observed from reducing user fees to 900 F CFA for deliveries were maintained and the trends were not disrupted by the elimination of the 900 F CFA fees. However, this observation is true for all of the female population; we will see later the HELP intervention’s positive impacts on equity, since it attracted many more women coming from a distance and greatly reduced healthcare expenses.

### Table 5. Impacts of the intervention on rates of assisted deliveries in the Djibo, Dori and Sebba health districts

<table>
<thead>
<tr>
<th>District</th>
<th>Time</th>
<th>Scenario</th>
<th>Ratio*</th>
<th>Impact</th>
<th>p-value</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Djibo</strong></td>
<td>August 2008 (1½ years of SONU)</td>
<td>with SONU</td>
<td>37%</td>
<td>SONU</td>
<td>1,31</td>
<td>&lt;0,0134</td>
</tr>
<tr>
<td></td>
<td></td>
<td>without SONU</td>
<td>28%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>August 2009 (2½ years of SONU, no HELP)</td>
<td>with SONU</td>
<td>55%</td>
<td>SONU</td>
<td>1,39</td>
<td>&lt;0,0529</td>
</tr>
<tr>
<td></td>
<td></td>
<td>without SONU</td>
<td>39%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dori</strong></td>
<td>August 2008 (1½ years of SONU, before HELP)</td>
<td>with SONU</td>
<td>38%</td>
<td>SONU</td>
<td>1,50</td>
<td>&lt;0,0022</td>
</tr>
<tr>
<td></td>
<td></td>
<td>without SONU</td>
<td>26%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>August 2009 (2½ years of SONU, 1 year of HELP)</td>
<td>SONU + HELP</td>
<td>53%</td>
<td>HELP</td>
<td>1,06</td>
<td>&lt;0,6609</td>
</tr>
<tr>
<td></td>
<td></td>
<td>without HELP, with SONU</td>
<td>50%</td>
<td>SONU</td>
<td>1,74</td>
<td>&lt;0,0099</td>
</tr>
<tr>
<td></td>
<td></td>
<td>without SONU</td>
<td>29%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sebba</strong></td>
<td>August 2008 (1½ years of SONU, before HELP)</td>
<td>with SONU</td>
<td>47%</td>
<td>SONU</td>
<td>1,40</td>
<td>&lt;0,0290</td>
</tr>
<tr>
<td></td>
<td></td>
<td>without SONU</td>
<td>34%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>August 2009 (2½ years of SONU, 1 year of HELP)</td>
<td>SONU +HELP</td>
<td>83%</td>
<td>HELP</td>
<td>1,04</td>
<td>&lt;0,8023</td>
</tr>
<tr>
<td></td>
<td></td>
<td>without HELP, with SONU</td>
<td>80%</td>
<td>SONU</td>
<td>1,56</td>
<td>&lt;0,0739</td>
</tr>
<tr>
<td></td>
<td></td>
<td>without SONU</td>
<td>51%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*= Annualized rate of deliveries in the CSPS predicted per 100 expected births

Source: Heinmüller & al. 22

### 3.4 Increase in service utilization benefiting disadvantaged groups

Analysis of data from the CSPS patient registers and from the before-and-after household survey shows the distribution of the impacts among the population subgroups affected by the HELP intervention in the Sahel Region.

#### 3.4.1. Service utilization and CSPS patient registers

The registers are the primary source underlying the SNIS data. The health workers fill a line for every outpatient consultation and two pages for every delivery assisted in the health facility. The registers provide information on the distance between the patients’ residence and the CSPS, which is not available in the SNIS at the district team level. We selected a representative sample of 11 CSPSs in the Dori district for the period 2004–2009. Using multilevel regression, we controlled for the long-term trend, seasonal effects and individual variations by CSPS.
Table 6 presents the average monthly number of acts per CSPS, comparing a hypothetical situation of no HELP intervention (“without”, all else assumed to be equal or equally continuing) with the actually observed situation in which there was an intervention (“with”). This comparison was calculated at 12 months after the intervention’s start for children and 11 months for pregnant women.

Table 6. Evolution of the average monthly number of acts in 11 CSPSs in the Dori district

<table>
<thead>
<tr>
<th>Distance / CSPS</th>
<th>Children under the age of 5</th>
<th>Pregnant women ≤ 19 years</th>
<th>Pregnant women ≥ 20 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>From 0 to 4 km</td>
<td>More than 5 km</td>
<td>From 0 to 4 km</td>
</tr>
<tr>
<td>With intervention</td>
<td>64</td>
<td>96</td>
<td>0,6</td>
</tr>
<tr>
<td>Without intervention</td>
<td>121</td>
<td>151</td>
<td>2,6</td>
</tr>
<tr>
<td>Multiplying factor</td>
<td>1,9</td>
<td>1,6</td>
<td>4,3</td>
</tr>
</tbody>
</table>

The results show that even people living more than 5 kilometres away from the CSPSs benefited from the intervention. In the case of deliveries, for which the HELP intervention was added to the State subsidy (SONU) launched at the beginning of 2007, it was the women living far from the CSPSs who benefited most.

3.4.2. Household panel survey

The before-and-after survey was conducted in 2,200 households in the Dori and Sebba districts where HELP operates. This survey provided preliminary population results (preliminary because still under analysis) on the effects of the subsidy (Box 4).

Statistical analysis shows that when households’ distance from the CSPSs (0–9 km, 10 km and more) and their socio-economic status (within versus above the median annual household expenditures) were taken into account, the chances that a child under the age of five years would use CSPS services were, on average, more than four times greater (multilevel odds ratio, p < 0.0001, n = 616 episodes of illness) one year after the start of the intervention. A similar improvement was seen in the percentage of early consultations (in relation to total consultations), i.e., within the first three days of an illness, the crucial time during which a child’s life can be saved (multilevel odds ratio 3.7; p = 0.0003). Figure 10 illustrates this improvement for both those living near the CSPS and those at a distance.

Box 4. Data collection methodology for household survey

To obtain data that would allow us to see beyond impacts observed in the health centres, we surveyed households directly, which provided population data. This was the only way to verify whether the user fees exemption actually benefited populations in accordance with their health needs and their level of poverty (equity indicators). We organized a panel survey, in which the same households were surveyed in July/August 2008, before the intervention, and again one year later, in July/August 2009. The sampling methodology was based on the EPI methodology (used in vaccination surveys) that we improved upon and adapted to local conditions and the requirements for statistical power. In a first step, 75 census tracts (ZD) were selected by a random draw that rendered their selection probability proportional to their size. Then, in a second step, households were selected using a specially adapted methodology: each ZD was divided into quadrants, in each of which a direction for household selection was chosen using a table of random numbers. Finally, we used a random draw approach to select households in order to better account for the population’s socio-economic and cultural heterogeneity.

Source: Heinmüller R. & al. 20

a Controlled for distance and household socio-economic status (N = 172 episodes of illness with CSPS visits)
The HELP intervention was also very effective in reducing households’ spending related to illness. The distribution of spending changed completely (Figure 11). Before the intervention, most households’ healthcare-related spending fell within the range of 1,000 to 1,500 F CFA. One year later, the majority of households stated they had spent nothing for their children’s care. The effect was the same whether households lived near or far from the CSPS. The multilevel odds ratio for the change from 2008 to 2009 in the proportion of people who declared having paid nothing was very significant (odds ratio 24, p < 0.0001).

The increase in assisted deliveries since the start of the HELP intervention that supplemented the State subsidy (begun in 2007) was also very clear (p = 0.0164) for all household categories (Figure 12). This increase bodes well for a reduction in maternal mortality, since experts in the field consider this an essential first step in saving women’s lives. However, this after-versus-before result of the household survey must not be interpreted as a HELP effect, because the pre-existing upward trend seen in the SNIS and register data explains most of the overall increase (see Figures 8 and 9). Nevertheless, the larger improvement factor for women residing far from the CSPS, seen in the register and survey results, can be ascribed to the HELP intervention.

Figure 11. Proportion (%) of consultations by amounts spent before the intervention and one year later

Figure 10. Proportion (%) of early consultations in relation to total consultations, before and after the intervention

* N = 256 episodes with visits to a CSPS

Source: Heinmüller R. & al

* Controlled for distance and household socio-economic status (N = 548 deliveries)
The change in the distribution of payment for deliveries is similar to that observed in expenses for children, whether the women lived less than or more than 5 kilometres from the maternity units (n = 172 deliveries). The multilevel odds ratio for the increase in the proportion of persons who declared having not paid anything is very significant (odds ratio 472 [logit factor 6.2; p < 0.0001]). Thus, the supplementary subsidy provided by HELP was equally effective.

This effectiveness was confirmed by another survey conducted in June/July 2010. Among the women who had delivered during the 60 days of the survey in the Dori and Sebba districts (n = 301 and 299 respectively), nearly all reported that they had paid nothing for delivery fees. On the other hand, women (n = 270) who delivered in the district of Djibo, where there is no HELP intervention, reported having spent 905 F CFA for these fees. However, it should be noted that medical fees are only one part of the total spending by women for deliveries, since the average total expenses (i.e., transport, food, etc.) in these three districts are roughly 3,900 F CFA.

Table 7 summarizes the changes observed in the household survey in terms of percent ratios and odds ratios (to facilitate comparison with results from other countries). These numbers confirm that all categories of the population affected have benefited from the user fees exemption, whether they live near or far from the CSPSs, and regardless of whether their financial status lies above or below the median household income.
3.5. Preservation of the quality of drug prescriptions

There is no point in abolishing user fees for patients if the quality of the care they receive subsequently deteriorates. We therefore verified whether the quality of services had been preserved with the user fees exemption in the Sahel region (HELP intervention). However, quality of care is a complex subject with many dimensions\textsuperscript{26}. Therefore, within the scope of available time and resources, we focused our analysis on the quality of drug prescriptions for children under the age of five years.

The study was conducted in the same sample of the nine CSPSs of the Dori district previously selected for process evaluation. We studied the evolution of four indicators for the quality of drug prescriptions, as defined by WHO\textsuperscript{27}, by comparing the 12 months (September 2007–August 2008) before the start of the user fees exemption project with the 12 months after (September 2008–August 2009). The data were collected from the registers of the CSPSs in a sample of 14,956 prescriptions related to severe respiratory infections (SRI) and malaria. The results for all these prescriptions are presented in Table 8.

Table 8. Evolution of prescription indicators before and after the intervention

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Before</th>
<th>After</th>
<th>WHO standards/National protocol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orders that respect the therapeutic and diagnostic guide</td>
<td>60%</td>
<td>80%</td>
<td>≈100%</td>
</tr>
<tr>
<td>Orders with an inappropriate prescription for antibiotics</td>
<td>9,4%</td>
<td>6,2%</td>
<td>≈0%</td>
</tr>
<tr>
<td>Orders with at least one injectable product</td>
<td>8%</td>
<td>9%</td>
<td>&lt; 17%</td>
</tr>
<tr>
<td>Average number of molecules per prescription</td>
<td>2,5</td>
<td>2,5</td>
<td>&lt; 2</td>
</tr>
</tbody>
</table>

Source: Atchessi N. & al\textsuperscript{28}

Beyond the before-and-after comparison, which shows no deterioration in the quality of drug prescriptions, it is important to understand whether the trends for these indicators have changed. In terms of the number of molecules per prescription, Figure 13 shows that, with respect to all the orders, the way of prescribing does not seem to have changed over time.

Figure 13. Evolution of the average number of molecules per prescription before and after the intervention

| Source: Atchessi N. & al\textsuperscript{28} |

Multivariable analysis (logistic/Poisson regression) provides in-depth information on the intervention’s effects on the quality of prescriptions by distinguishing between those for SRIs and those for malaria. In addition, we distinguished between prescriptions
related to only one of these two diagnoses and those for combined diagnoses (such as malaria accompanied by diarrhea). Thus, Table 9 shows that the three significant changes are positive with respect to drug prescriptions, which is even more interesting given that no statistically significant change was observed in all the other indicators.

From this analysis, we can conclude that the level of quality of the prescriptions (as recorded in the patient registers and thus without examining the quality of the diagnosis) was maintained and even improved for some indicators. These outcomes were made possible by the absence of user fees for patients and by appropriate training and supervision.

3.6. Strengthening the financial capacities of the COGESs

The approach adopted by the NGOs in the four districts exempted the target groups from user fees and at the same time organized the reimbursement of services provided without fees by the health centres (see the Intervention section). Clearly it is unacceptable for these interventions to be carried out at the expense of the health centres, and particularly for them to undermine the financial capacity of the COGESs, as seems to have happened in Niger, where delays for reimbursement are very long.29 Indeed, it has long been known that the COGESs, which manage the health centres’ medication depots (DMEG) and cover certain operating expenses, have solid financial capacities.3, 30 Since the launch of the Bamako Initiative, the COGESs have amassed relatively important sums. Thus, we carried out an accounting and financial analysis of all the COGESs (n = 72) of the four health districts to assess the impacts of the user fees exemption on their financial positions. The data came from accounting information available from the COGESs, such as expense and receipts ledgers, EGD stock forms, cash records, bank books, etc. The analyses were done using a methodology previously tested in Burkina Faso.3

The cash assets corresponded to the resources available in the bank and in the COGESs’ cash boxes. In other words, they represented the total amounts that the COGESs had saved since the start of the cost-recovery system. This is the most significant indicator of the COGESs’ financial capacity. Here we are less interested in the absolute value of the assets and more interested in their evolution1. The study showed a steady increase in the level of cash assets since 2006, except in the Sebba district (Table 10). The increase in assets was, however, greatest in the last period (P.3), when the State’s SONU subsidy co-existed with the subsidies for groups targeted by

---

1 This is because a lower absolute value may be due to a significant past investment made to improve the quality of the health facilities, as was the case in the Sebba health district.
exemption projects, as opposed to period 2 (P.2), when the only subsidy was for SONU. The decline in the Sebba district can be explained by significant investments that were made in these periods, particularly in the fleet of motorbikes for outreach activities.

This being said, there was considerable variation among the COGESs of the four districts in terms of their cash assets levels. The COGES with the fewest resources over the three periods had cash assets of 21,000 F CFA, whereas the one with the most resources had 8,600,000 F CFA.

All the COGESs in these districts had maintained a level of cost-recovery above 100% over the three periods studied, except for one period in Sebba. Thus, at the district level, the rates ranged from 90% to 116%.

Because there is a lack of reliable data from the start of the interventions\(^1\), certain information could not be compared before and after the user fees exemptions. However, we believe it is useful to present these data because they provide information on possible solutions to make the healthcare system more equitable. Before the user fees exemption projects, 58% of the COGESs’ spending was on EGD purchases and 10% on the salaries of support staff. During the same period, EGDs were sold to patients at a margin of 39% to 56%. In other words, a medication bought for 100 F CFA from the district distribution depot would be sold to patients for 139 to 156 F CFA. Fees for services (not including the sales of EGDs) represented 4% to 8% of the total revenues, depending on the district. Health workers’ commissions on the prices of acts varied between 17% and 39% before the State SONU subsidy, depending on the district, and between 19% and 51% in the presence of this subsidy before the start of the interventions studied.

### 3.7. Poor coverage of indigents but few inclusion errors

Since 1992, the Ministry of Health has been promising to carry out operational research to define the criteria for indigent selection.\(^2\) Meanwhile, as this has not yet materialized, four COGESs of the Sebba and Dori districts, referring to an experience conducted in the Ouargaye district\(^3\), and with the support of the HELP project, tested a community-based and participative approach to the selection of indigents. The principle was that indigents should be exempted from user fees and that this exemption should be covered endogenously, that is, from the funds set aside by the COGESs. Starting from the idea that, in villages, people all know each other, selection committees were set up in the 51 villages of the four CSPSs involved. These committees (CSI) selected the people they considered to be indigent based on a consensual definition: someone who is extremely disadvantaged socially and economically, unable to look after himself (herself) and devoid of internal or external resources. The list of indigents was then validated by the local authorities and the COGESs. Of the 656 indigents selected by the village committees, 147 (22%) were retained by the COGESs, and of these, 69% were more than 50 years old. These persons were then given user fees exemption cards signed by the Prefect and the Ministry of Social Action.

\(^1\) This is due to the fact that revenues coming largely from NGO reimbursements are not disaggregated by the COGES, as was done before the subsidy.

<table>
<thead>
<tr>
<th>District</th>
<th>Start P. 1 (before SONU)</th>
<th>Start P. 2 (SONU)</th>
<th>Evolution P.2 vs. P.1</th>
<th>Start P. 3 (SONU + Subsidy)</th>
<th>Evolution P.3 vs. P.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>DORI</td>
<td>1,461,000</td>
<td>1,565,000</td>
<td>7,12%</td>
<td>1,802,000</td>
<td>15,14%</td>
</tr>
<tr>
<td>SEBBA</td>
<td>2,111,000</td>
<td>1,951,000</td>
<td>-7,58%</td>
<td>1,373,000</td>
<td>-29,63%</td>
</tr>
<tr>
<td>SEGUENEGA</td>
<td>1,909,000</td>
<td>2,013,000</td>
<td>5,45%</td>
<td>2,459,000</td>
<td>22,16%</td>
</tr>
<tr>
<td>TOUGAN</td>
<td>499,000</td>
<td>556,000</td>
<td>11,42%</td>
<td>754,000</td>
<td>35,61%</td>
</tr>
</tbody>
</table>

Source: Queuille & al.\(^2\)
An evaluation of the effectiveness of this targeting process was conducted to verify that the COGESs had not selected non-indigents (minimizing inclusion biases) and had retained enough indigents (minimizing exclusion biases). The study compared the indigents selected by the COGESs with: i) the indigents selected by the CSIs but not retained by the COGESs; ii) a sample of users from the four CSPSs; and iii) the rural households of Burkina Faso. Two criteria were used to assess potential eligibility for indigent status—the poverty threshold (82,672 F CFA in 2003, adjusted for 2009) and the extreme poverty threshold (41,153 F CFA in 2003, adjusted for 2009) calculated by the INSD of Burkina Faso.34

The distribution of income (Figure 14) shows that the indigents selected by the village indigent selection committees (CSI, green curve) and the COGESs (red curve) lived in households that were poorer than the rural households of Burkina Faso (dark blue curve). They were also poorer than the users of the CSPSs (light blue curve). Nearly 60% of the indigents selected by the COGESs lived in poor households, whereas this proportion was 44% for Burkina Faso’s population as a whole. Likewise, 15% of the indigents selected by the COGESs lived in extreme poverty, as opposed to 9% of the country’s population.

Thus, the communities were able to select people who were, on the whole, poorer than the rest of the population. The COGESs were also able to minimize inclusion bias, since only 0.12% of the people they selected were not poor and 0.15% not extremely poor. However, the coverage was very low, as only 0.21% of the poor living in the catchment areas of the four CSPSs were selected and only 0.28% of the extremely poor. This very restrictive selection was almost identical to the experiences in the Ouargaye district of Burkina Faso and in Mauritania.36 Indeed, we would have expected to see a minimum of 9% of indigents (the extremely poor at the country level according to the INSD) to a maximum of 20% (as projected by the Ministry of Health in

![Figure 14. Distribution of income for the four groups of persons studied in relation to the thresholds of poverty and extreme poverty](image-url)
its SONU subsidy policy\textsuperscript{19}). One explanation for this severely restricted selection may certainly be found in the fact that, to ensure the sustainability of the process, these indigents’ fees were covered by the COGESs rather than by the State or by the NGO HELP.

We should add that a survey conducted nine months after the cards were distributed showed that 67\% of the indigents found their cards to be beneficial.\textsuperscript{37} Of the 76 indigents (59\%) who reported having had an episode of illness since receiving their card, 40 (53\%) had gone to a CSPS, for a total of 71 consultations, or 1.7 per indigent. As with other categories of persons exempted from user fees (see above), once the financial barrier at the point of service was lifted, there remained other determinants of health services utilization.
4 IMPLEMENTATION ANALYSIS

A process evaluation was undertaken after less than a year of intervention in the Dori and Sebba districts in order to draw lessons from the implementation of the user fees exemption.

The pre-evaluation phase was devoted to developing the logic of the intervention, the processes to be studied (presented in grey in Figure 5) and the evaluation questions, all done with the participation of the project’s key actors.

Within the framework of this process evaluation, the population studied consisted of 29 health centres. Six methods of data collection were used: i) documentary review (n = 20 health centres); ii) individual interviews (n = 69); iii) group interviews (n = 27); iv) observations (n = 15 health centres); v) questionnaires (n = 56); and vi) multiple case studies on reimbursement turnaround times (n = 10 health centres). The interviews involved three categories of actors (Table 11).

### Table 11. Categories of actors and numbers of people encountered in the process study

<table>
<thead>
<tr>
<th>Health authorities/local</th>
<th>Health workers, DMEG managers &amp; NGO agents</th>
<th>Population and users</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual interviews</td>
<td>6</td>
<td>39</td>
<td>31</td>
</tr>
<tr>
<td>Group interviews</td>
<td>2 (14)</td>
<td>8 (136)</td>
<td>18 (154)</td>
</tr>
<tr>
<td>Questionnaire</td>
<td>0</td>
<td>56</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total (persons)</strong></td>
<td><strong>20</strong></td>
<td><strong>231</strong></td>
<td><strong>185</strong></td>
</tr>
</tbody>
</table>

Source: Queuille & al. 17

4.1. Validity of the strategy and appropriateness of the beneficiary populations

The actors we encountered recognized the validity of the project’s strategy. They considered that it helped improve equity of access to services—“despite distances, women give birth in CSPSs”, one woman said (FG 6)—and they felt the choice of groups of beneficiary populations was appropriate, since “the target of HELP is the person who gives life”, as one COGES member said. Many also appreciated the socio-economic impact (fewer catastrophic health expenses), as this made it possible to “help women more while also reducing expenses for the men.” While health workers generally reported that they were committed and motivated, some worried about abuse by certain users and seemed attached to the idea of user fees. Our questionnaire survey showed that 66% (n = 56) of them were completely/moderately in agreement with the idea that patients did not value services for which they did not have to pay. Neither the health workers nor the COGESs believed the subsidy would be taken up by the government.

4.2. Information satisfactory but coverage still imperfect

Information was transmitted from the regional health authorities to the communities through the usual hierarchical channels, with a particular effort made at the community level. “There was a town crier who passed along information on every market day”, one man said (FG2). Except for nursing women (problems with eligibility criteria), the health workers and COGESs knew the target groups well and understood the subsidy’s reimbursement mechanisms. They reported being satisfied with the information received. Despite the massive influx of beneficiaries in the health centres at the start
of the project, the level of information transmitted to users remained insufficient: “I only learned the day before yesterday that medications were free. If I go again, I will pass the news along to others”, said one user we encountered (EI 1.4).

4.3. Strengths and weaknesses of the subsidy system
The involvement of the COGESs, the actual existence of a reimbursement system, and the project’s capacity for adaptation were the key strengths of the subsidy system, according to those we consulted. The slow reimbursement process, the pressures on cash assets, on EGD stocks and on individual treatment records, the insufficient consultation with and training of health workers at the start of the intervention, the heavier workload engendered by the subsidy and the lack of incentives for health workers (according to them) were its weaknesses. The COGES have added user fees, sometimes, for products and/or services that should normally have been free: “If the medication is in the depot, the treatment is free; otherwise, you have to go out and buy your medications elsewhere,” one woman said (fG 9). But not everything was free since, as one woman told us, “you have to pay to use the toilets, or when you want to wash a piece of clothing” (FG 2). In addition, while the COGESs were pleased with the project’s close monitoring of the subsidy (supervision, auditing, etc.), some of the health workers complained about it. This was confirmed in the survey on the quality of drug prescriptions (see above).

4.4. Reasonable turnaround times for reimbursement
The long turnaround times for reimbursement, considered to be the subsidy system’s main weakness, were the subject of a multiple case study. The results showed that, after the system’s implementation phase, the average turnaround time for reimbursement in the first quarter of 2009 (33 days) should be assessed positively (Table 12). Indeed, given the reimbursement cycle, it cannot reasonably be less than 30 days. The problem lies elsewhere. The reimbursement system requires that the COGESs pre-fund the exemption. When the amounts advanced by the COGESs approach or even surpass their cash assets, the pressures mount and may lead to disruptions in cash flow, EGD stock shortages, etc. In the Dori and Sebba districts, at the start of the user fees exemption project (August 31, 2008), the average cash assets of the COGESs were 1.6 million F CFA. After seven months of user fees exemptions (March 31, 2009), they were 800,000 F CFA, reduced by exactly the average monthly amount of reimbursements due at this stage of the project (Figure 15). Since the average monthly amounts of reimbursement continued to increase, they ultimately exceeded the financial capacities of the COGESs.

Table 12. Key results of the study of reimbursements for the final quarter of 2008 (T4) and first quarter of 2009 (T1)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2008 (T4)</th>
<th>2009 (T1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average monthly amount of reimbursements</td>
<td>544 523 XOF</td>
<td>720 534 XOF</td>
</tr>
<tr>
<td>Period A average (days) [see Figure 4]</td>
<td>20</td>
<td>16</td>
</tr>
<tr>
<td>Period B average (days) [see Figure 4]</td>
<td>15</td>
<td>11</td>
</tr>
<tr>
<td>Period C average (days) [see Figure 4]</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>Average total turnaround time (days)</td>
<td>46</td>
<td>33</td>
</tr>
</tbody>
</table>

Source: Queuille & al. 38

* These data are taken from an accounting and financial analysis of the COGESs covering the period from six months prior to the start of the SONU subsidy to six months after the launch of the exemption projects (see above). The reimbursements studied only started with the user fees exemption subsidy project (September 2008).
4.5. Positive outcomes expected and negatively perceived outcomes
The first changes perceived as positive were the increase in service utilization, including by the poor (Box 5), the reduced latency period before consultation, the facilitation of health evacuations, the strengthening of the COGESs, and the improvements in quality of care and in cost-recovery. The main changes that were perceived as negative were the deterioration of conditions in reception and service, the discontent of non-target groups, the “pretend-patients”, the new constraints on the patient-provider relationship (according to health workers), health workers’ heavier workloads and burn-outs reported by some of them.

4.6. Key lessons from the process
This process evaluation shows how important it is to focus on adjusting the supply when dealing with an intervention that transforms the relationship between healthcare demand and supply.

The subsidy strategy can reinforce the three pillars of the Bamako Initiative (equity of access to care, community participation and cost-recovery). The principle of a third-party payer is easily enough integrated into the existing system, as compared with the problems encountered by exemption strategies based on providing free inputs, as was done in Mali, for example.39

As in South Africa or Niger13, health workers were not sufficiently involved and heard. They asked for more planning and support, particularly with respect to the organization of work, medication supplies, and consideration of each context’s specific needs.
The multiple case study on reimbursement turnaround times showed the need for pre-funding to complement reimbursement in the subsidy system studied.

In addition, moving from reimbursement of actual costs to fixed-rate reimbursement would help to shorten reimbursement turnaround times and lessen the administrative workload of health workers. The district management teams could be strengthened to be able to conduct audits of the registers and of users in the community.
5 DIRECT COST OF THE SUBSIDY TO CSPS

In the context of these pilot projects, we were able to estimate the direct cost to NGOs of reimbursing the CSPSs for subsidized consultations. This estimate has many limitations, since it does not take into account all the costs associated with a consultation. Staff salaries and building maintenance, for example, are not taken into account; nor are the costs of supervisions carried out by project officers that help to maintain a high standard of prescription quality (see above).

For example, a study done in 20 CSPSs of the Nouna district in 2003 showed that the average cost of a curative consultation (children and adults) was roughly 1,600 F CFA and the cost of a delivery, roughly 2,800 F CFA, when all costs at the CSPS level were considered. Nevertheless, the present study provides a rough idea of the amount of subsidy that should be transferred to the CSPSs, all else being equal. That is to say, this amount reflects the cost at a given time of the exemption’s impact on utilization, which was after approximately one year of the pilot projects’ implementation. We have followed exactly the same methodological approach used by the government in 2005 when planning the SONU subsidy policy to establish the amount of the payment to be transferred to the CSPSs. We will return later to the amount of this payment.

Thus, the data show that the average cost to CSPSs of the inputs (medications and consumables) and the act for a curative consultation for a child under the age of five years is roughly 1,000 F CFA. While the four districts involved have not yet reached an optimal level of utilization, a longer experience (since 2007) in a neighbouring district of Mali, where another NGO (MSF-OCB) subsidizes consultations for these children, can serve as a reference. In this district (Kangaba), after four years of user fees exemption, the annual rate of utilization of curative services among children went from 0.27 to 3.6. Thus, if we use as a starting hypothesis three new curative consultations per year per child in Burkina Faso, given the number of these children in Burkina Faso in 2010 (~ 3 million), the funding required is 8.8 billion F CFA per year. According to the budget in the 2009 Funding Act, this amount corresponds to 16% of the budget of the Ministry of Health, and 2% of the country’s total budget.

With regard to deliveries in the CSPSs, an evaluation has shown that the amount of the payment granted by the State was underestimated. A study of the real costs engendered by these deliveries in the Ouargaye district showed the average cost to be 2,600 F CFA (including inputs, acts and hospitalization costs). Thus, we start from the hypothesis that the reimbursement amount should be 3,000 F CFA for normal deliveries and 7,000 F CFA for dystocic deliveries (necessitating episiotomy or other interventions). It has been estimated that 80% of the deliveries nation-wide are normal and 20% are dystocic. The second part of our hypothesis is a 100% rate of assisted deliveries by qualified personnel (~ 730,000 deliveries expected). Based on this double hypothesis, the funding required would be 2.8 billion F CFA per year. This estimate is close to the estimate projected by the government (2.4 billion F CFA) in its SONU subsidy policy. This shows that the financial investment required to exempt women fully from user fees for deliveries would be minimal. According to the budget in the 2009 Funding Act, this amount corresponds to 3.8% of the budget of the Ministry of Health and 0.5% of the government’s total budget.

1 Hypothesis advanced by Alexandre Dumont (2009), an expert in maternal health in West Africa.
These estimates (Table 13) therefore provide a useful starting point for reflection on scaling up, although they would definitely need to be considered low estimates, since the organizational costs of scaling up (taking into account all the support measures and management costs that it would entail) remain to be calculated; other studies that have been carried out in Burkina Faso should also be taken into consideration. A more detailed study is currently being implemented as part of the HELP project, and those results should be available at the end of 2010.

Table 13. Summary of actual costs and hypotheses regarding scaling up

<table>
<thead>
<tr>
<th></th>
<th>Children under 5 years</th>
<th>Deliveries</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F CFA</td>
<td>$ US</td>
</tr>
<tr>
<td><strong>Average direct cost of one act</strong></td>
<td>1,000</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total annual cost (millions)</strong></td>
<td>8,800</td>
<td>17,5</td>
</tr>
<tr>
<td><strong>% of Ministry of Health budget</strong></td>
<td>16</td>
<td></td>
</tr>
<tr>
<td><strong>% of total government budget</strong></td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

* $1 US = 500 F CFA

Sources: HELP/Tdh data, 2009 Funding Act.
6 SHARING AND DISSEMINATING THE KNOWLEDGE PRODUCED

The studies whose results have been presented in the preceding sections were planned and executed in such a way as to promote utilization of the evidence produced. Using a multilevel design helped to strengthen the internal validity of the results. The same is true for the use of qualitative and quantitative data and the process evaluation carried out concurrently with the impact evaluation. The health authorities (the RHDs and DMOs involved), who were concerned about the production of the results, got involved in the process. The methodological design took into account the needs of decision-makers and the timing of decisions while maintaining all the scientific rigour required to produce solid evidence. The various stakeholders were interested in the research activities (training, action-research, etc.) but also, and primarily, were involved in activities to validate, share and disseminate the knowledge produced. Thus, in the following sections we describe the main activities carried out to share and disseminate the knowledge produced over these past two years.

6.1. Knowledge syntheses for decision-makers
This work began with the production of four policy briefs on topics related to financial access to healthcare:

- the abolition of user fees for health services in Africa
- the criteria and processes for identifying the poor as beneficiaries of programs
- improving access to healthcare for the poorest by means of health equity funds
- how the poor can be better integrated into health insurance programs in Africa

These policy briefs were prepared by experts based on systematic reviews of the scientific literature. The preliminary versions were given to leaders in the healthcare sector, both in government and outside of government, at the central and peripheral levels, in Burkina Faso and elsewhere, for critical reading and feedback. The final versions are available in English and French. Hard copies of these briefs have been widely distributed at meetings, workshops, seminars and conferences held in Burkina Faso and the subregion, and can be downloaded from the Internet.

6.2. Extending the strategy to other regions
The project of the NGO Terre des hommes, launched shortly after the HELP project, is active in two other regions of the country. It thus provided an opportunity to strengthen

http://www.vesa-tc.umontreal.ca/ressrc.htm
the validity of the knowledge produced from the HELP experience. Starting in October 2008, the two NGOs created a working group on user fees exemptions for vulnerable populations; they were subsequently joined by other ECHO partners (Action Against Hunger, Save the Children Canada, and the Belgian and Burkinabé Red Cross agencies). This working group has helped to extend the strategy for producing, sharing and disseminating knowledge to various projects: project visits, inter-project studies, sharing experiences on different topics including particularly the RHD and DMO partners, joint knowledge sharing and dissemination activities, etc.

6.3. Close collaboration with RHD and DMO partners
As explained earlier, the RHD and DMO partners in these projects are stakeholders in the research strategy and in the strategy for sharing and disseminating results. All the preliminary results of the studies undertaken in the context of the HELP project were very productively shared and discussed with all the actors in the project at the provincial and regional levels before being disseminated nationally and internationally (sharing of preliminary reports, provincial workshops for sharing/restoration of results, etc.) After one year of intervention, the first major results were discussed and formulated by the RHDs, DMOs and CISSE of the Boucle du Mouhoun, East, North and Sahel regions, all partners in two groups preparing for the 20th annual conference of RHDs and DMOs (of special note was the participation of the Ministry of Health’s Department of Studies and Planning, in the person of the PNDS Technical Secretary). Subsequently, and most often, the research results were presented by the RHDs and DMOs in charge of these pilot projects, whether in Burkina Faso or outside the country (see below).

6.4. Early access to key results for the Ministry of Health
The Health Directorate has been following with interest the experiences described in this report. It was important that the key results be shared first with the national health authorities. This was done by the RHDs and DMOs at the 20th annual conference of RHDs and DMOs held October 12 and 13, 2009 (see above). This conference, whose theme was “Improving the financial accessibility of populations to healthcare services,” was presided by the Minister of Health. Besides the Minister, other decision-makers were also there to receive the latest knowledge: the Inspector-General of Health Services, the Minister’s Chief of Cabinet, executive directors, directors at the central government level, RHDs, DMOs and technical and financial partners. Thus, Burkina Faso’s key decision-makers had very early access to the various results of the studies carried out by the CRCHUM researchers and their colleagues in Burkina Faso.

6.5. Discussion and dissemination at the national and international levels
As the different studies progressed, the knowledge produced was regularly presented in different contexts at the national and international levels (Box 6).

Box 6. Some occasions at which research results were shared

- 2nd Journées Scientifiques du Centre de Recherche en Santé de Nouna (December 2009 – Burkina Faso): oral communications (3) and poster (1)
- 2nd Estates General on Health (February 2010 – Burkina Faso)
- Round Table on Social Protection in Burkina Faso (April 2010): oral communication
- Workshop of the Observatoire de la gratuité in Mali (April 2010): oral communication
- 15th Journées des Sciences de la Santé de Bobo-Dioulasso (May 2010 – Burkina Faso): oral communications (3) and poster (1)
- 20th IUHPE World Conference on Health Promotion (July 2010 – Switzerland): symposium on free healthcare in West Africa
In March 2010, a national workshop was held to discuss experiences related to user fees subsidies for vulnerable populations in Burkina Faso. Its aim was to present and discuss the latest key results of the different studies carried out by the CRCHUM and the Société d’Étude et de Recherches en Santé Publique (SERSAP). At this workshop, analyses of national user fees exemption policies and health insurance were presented by DSFs for Burkina Faso, and by national representatives from neighbouring countries (Benin, Ghana, Mali and Niger). The 80 participants represented all the actors involved in health policies (politicians, government leaders – primarily from the Ministry of Health, international agencies, the scientific community, civil society and the media).

Box 7: Comment by Roger Sie HIEN, Deputy at the National Assembly of Burkina Faso following his participation in the national discussion workshop on experiences (Ouagadougou, March 2010)

The right to health is a fundamental right that is universally recognized. Because health is a pre-condition for the enjoyment of the other rights, it is the duty of the public authorities to take measures to make the healthcare system more accessible.

It is therefore important that such experiences be carried out in collaboration with health authorities and that the results be discussed with all the actors involved, as was done in the discussion workshop on the experiences of user fees exemptions for vulnerable populations held in March 2010 at Ouagadougou.

The work on sharing and disseminating the knowledge emerging from these user fees exemption experiences continues. The present report is part of this effort. The research results will notably be presented in November 2010 at the First Global Symposium on Health System Research organized by WHO on the theme of universal healthcare coverage.
7 CONCLUSION

It is now recognized that the goal of reducing maternal and child mortality is not beyond the reach of African governments. Indeed, the interventions that would support this reduction, whether by saving the lives of mothers or of children, are widely known. Burkina Faso has made much progress in this area in recent decades, but the current mortality rates are still much too high for the country to be able to achieve the Millennium Development Goals by 2015. At the recent African Union Summit (Kampala, July 2010), African decision-makers reconfirmed their commitment to a campaign to accelerate the reduction of maternal mortality in Africa. In particular, they advocated the use of “exemption from user fees for pregnant women and children under the age of five years.” This intention on the part of African decision-makers follows the call by United Nations agencies and several heads of state in Africa and elsewhere for the same measure.

In addition, it is aligned with the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa (April 2008), which is aimed at bringing equity back into the heart of health systems.

Lifting the financial barrier by means of user fees exemptions for patients and organizing for third-party reimbursement of these fees is a strategy that is being increasingly recommended, particularly by the WHO Commission on the Social Determinants of Health. This strategy may, eventually, lead into universal access to healthcare services, such as Ghana has been experiencing since 2003, since user fees exemption there preceded and was subsequently integrated into national health insurance. However, this exemption is a complex intervention that requires skilled leadership. Also, there is still very little evidence on user fees exemption in West Africa. For these reasons, the data presented in this report are doubly essential.

On one hand, these data show that user fees exemption with third-party subsidies is a winning strategy for access to the healthcare system in the Burkina Faso context. Some of the lessons learned were highlighted by these pilot projects (Box 8) and reinforced what was already known about these interventions. The many studies (see Section 8) carried out in these pilot projects funded by ECHO and implemented with the regional health departments and the health district management teams have shown that the combination of user fees exemption and third-party subsidies:

- Satisfies, in an immediate and sustained way, health needs that were not previously covered by the healthcare system;
- Benefits all categories of the population without reinforcing inequities of access to healthcare services;
- Guarantees an affordable cost to the State and the preservation of the quality of care provided to users;
- Respects the principles of the Bamako Initiative by strengthening equity, community participation and cost recovery.

These results show user fees exemption to be a very relevant option for achieving the objectives of the National Health Policy. However, since the studies are currently in progress, there are still a certain number of results to produce, such as a more detailed calculation of the cost of scaling up and an analysis of the social impacts of such a strategy.

On the other hand, this evidence will most certainly be useful to Burkina Faso’s decision-makers. Indeed, while it has long been acknowledged that public policies need to be based on scientific evidence, this process has not always been easy.
The information provided in this report will enable Burkina Faso to step into the lead ahead of other countries in French-speaking West Africa in terms of evidence on user fees exemption. Thus, decision-makers now have enough data to be able to take informed decisions on this strategy for subsidizing the demand for healthcare. This report comes at exactly the right moment to provide tangible proof of the relevance of user fees exemption, but also of the challenges involved in its implementation, and to support its potential inclusion in the 2001–2020 National Health Development Plan. Following upon the presidential intention, reported by Amnesty International, to lift all financial barriers to access to obstetric care (February 2010), participants at the 2nd Estates General on Health (February 2010) expressed the desire to extend this strategy.

Box 8: Key lessons from these pilot projects on user fees exemption subsidies

- Involve health workers and community leaders as early as possible in defining the operating modalities
- Integrate the subsidy into the system in place, particularly by involving the COGES
- Ensure the information is widely disseminated, particularly at the community level, and especially among “isolated” populations
- Exempt categories of persons from payment for all services, rather than for certain specific services
- Organize a community process for identifying the indigent
- Reimbursre acts rather than provide free inputs
- Pre-fund health centres at the start of the subsidy for the projected amount of services and products to be provided without fees
- Ensure rigorous control of actual-cost reimbursements
- Plan for an eventual fixed-rate reimbursement system
- Audit the veracity of the acts for which reimbursement is claimed, by going into the community
- Ensure that the entire medication supply chain is sufficiently prepared to deal with the expected increase in attendance at the health centres
- Provide ongoing training and regular supervision of health workers

This report provides a great deal of evidence that decision-makers can use in pursuing the quest for universal access to healthcare, a principle that is enshrined in the country’s Constitution. An active commitment to provide substantial support to this effort will most certainly be required from technical and financial partners. User fees exemption at the point of service and its sustained funding are two solutions worth implementing on a national scale to supplement and reinforce the planned organization of national health insurance.
Impact studies related to healthcare services


Impact studies related to population


Process studies


Studies related to costs


All of these studies were conducted under the direction of Valéry Ridde.

The research centers GREFSaD/AFRICSané and SERSAP were involved in some of these studies. Others who contributed significantly to these studies are: Agagliate T., Bado J., Da B., Dadjouari M., Gnagnou S., Kafando Y., Karama H., Karambiri A., Korgo P., Marcellin N., Nikiema L., Nizie M., Ouedraogo M., Rauland K., Sawadogo B., Sedogo S., Seini É., Sogli P., Traore M., Yameogo P., Zagre A., Zio A., Zonon N. and Zoungrana Y.


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