Evaluation and Program Planning 34 (2011) 333–342

Contents lists available at ScienceDirect

Evaluation and Program Planning

journal homepage: www.elsevier.com/locate/evalprogplan

Targeting the worst-off for free health care: A process evaluation in Burkina Faso

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ARTICLE INFO

Article history:
Received 27 July 2010
Received in revised form 27 March 2011
Accepted 30 March 2011
Available online 9 April 2011

Keywords:
Exemption
Worst-off
Targeting
Process evaluation
Burkina Faso

ABSTRACT

Effective mechanisms to exempt the indigent from user fees at health care facilities are rare in Africa. A State-led intervention (2004–2005) and two action research projects (2007–2010) were implemented in a health district in Burkina Faso to exempt the indigent from user fees. This article presents the results of the process evaluation of these three interventions.

Individual and group interviews were organized with the key stakeholders (health staff, community members) to document the strengths and weaknesses of key components of the interventions (relevance and uptake of the intervention, worst-off selection and information, financial arrangements). Data was subjected to content analysis and thematic analysis.

The results show that all three intervention processes can be improved. Community-based targeting was better accepted by the stakeholders than was the State-led intervention. The strengths of the community-based approach were in clearly defining the selection criteria, informing the waiver beneficiaries, using a participative process and using endogenous funding. A weakness was that using endogenous funding led to restrictive selection by the community.

The community-based approach appears to be the most effective, but it needs to be improved and retested to generate more knowledge before scaling up.

1. Introduction

How best to select those indigents who should be exempted from healthcare services user fees in Africa? African decision-makers have been attempting to answer this question since 1980, when user fees for healthcare were generalized. In such a context, some people cannot use healthcare services due to lack of funds; this is particularly the case for the indigent, those with a "*sustained incapacity to pay for minimum health care*" (Stierle, Kaddar, Tchicaya, & Schmidt-Ehry, 1999). Thus, when user fees were decentralized to the local level in West Africa (the Bamako Initiative), it was envisioned that waiver measures would be created for the indigent (UNICEF, 1995). However, "*despite national policy guidance in all three countries* [Benin, Kenya, Zambia] *emphasising the importance of exemptions, no country had developed effective, formal mechanisms to protect the poorest from bearing the burden of fees*" (Gilson et al., 2000, p. 7). The same situation has been noted in Mali (Ridde & Girard, 2004), Senegal (Diallo, McKeown, & Wone, 1996) and Burkina Faso (Bicaba, Ouedraogo, Ki, & Zida, 2003; Ridde, 2008b). Today, decision-makers formulating national health insurance policies in Africa face exactly the same challenges of identifying the people who should be covered by insurance but lack the means to pay the premium (Aryeetey et al., 2010). In this article, we present the results of an evaluation of three processes for selecting indigents in Burkina Faso, in an effort to understand better how the persistent exclusion experienced by the worst-off, who are unable to pay for healthcare when they are ill, can be abated.

2. The challenges of indigent selection processes

There are at least three ways of identifying the indigent. In the first, people are identified individually, often on a financial basis (using means or proxy means testing). The second way targets categories of easily identifiable people or services, such as children under the age of five years, or deliveries. The third type of targeting

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doi:10.1016/j.evalprogplan.2011.03.007

is self-selection, when certain services are organized in such a way that only the worst-off avail themselves of them (Gwatkin, 2000; Hanson, Worrall, & Wiseman, 2007).

Waiver beneficiaries may be identified using processes that are primarily either administrative or community-based (Coady, Grosh, & Hoddinott, 2004; Conning & Kevane, 2002). Our literature review showed that the technocratic and directive process, in which program managers themselves decide on the identification criteria (Morestin, Grant, & Ridde, 2009), is the one most often used (76% of the experiences surveyed). However, the literature clearly demonstrates that no strategy for identifying the indigent is perfect (Coady et al., 2004). Some authors suggest that it is essential to experiment and to adapt identification processes to context and changing circumstances (Ashford, Gwatkin, & Yazbeck, 2006). The successes observed have more to do with the attention paid to the planning and implementation process (Gwatkin, 2000). Good execution has long been recognized as a factor in successful implementation (Pressman & Wildavsky, 1984) and this has been highlighted again by global health programs, because "*we face a formidable gap between innovations in health . . . and their delivery to communities in the developing world*" (Madon, Hofman, Kupfer, & Glass, 2007). We should add that there have been very few studies in Africa of indigent selection processes (Coady et al., 2004; Waelkens, 1999). Yet we know that these processes raise numerous challenges.

Identifying beneficiaries on an individual basis is often difficult in low-income countries, given the predominance of informal sector employment and the inadequate administrative capacity for managing such a system (Coady et al., 2004; Gwatkin, Wagstaff, & Yazbeck, 2005). Community-based identification may partly resolve this difficulty, while also reducing costs (Jacobs & Price, 2006), but it is not immune from arbitrary and political selection, when the process is taken over by members of the local elite (Conning & Kevane, 2002; Peters, El-Saharty, Siadat, Janovsky, & Vujicic, 2009). In addition, sometimes communities may not completely respect the criteria provided by the central authorities to guide the selection. Yet sometimes, involving communities in defining the selection criteria appears to be essential to the success of the process (Chinsinga, 2005), as is the political leadership to sustain it (Meng, Sun, & Hearst, 2002). Some experiences in Asia appear to favour community-based pre-identification of waiver beneficiaries (i.e., before they need to use health centre services) because this approach seems to be more effective for informing the beneficiaries and for selecting the worst-off rather than the poor (Ir, Decoster, Hardeman, Horemans, & Van Damme, 2008). With respect to funding, an absence of conflict of interest appears to be a necessary condition for effective targeting (Men & Meessen, 2008; Noirhomme & Thomé, 2006), because if waivers deplete the health centres' operating funds, the actors will tend to select the fewest number of beneficiaries, as was observed in Mauritania (Criel, Bâ, Kane, Noirhomme, & Waelkens, 2010).

Whatever the selection method, the operational challenges are numerous. There does not yet appear to be any consensus on how to resolve questions such as what process should be used to select the worst-off, who decides on this selection and on the basis of what criteria, how the beneficiaries will be informed, who will pay for these waivers, what services will be covered, how long the waiver will be valid, etc. (Gilson et al., 2001; Gilson, Russell, & Buse, 1995; Kivumbi & Kintu, 2002; Ridde, 2008a; Uzochukwu, Onwujekwe, & Eriksson, 2004; Waelkens, 1999).

3. Objectives of the process evaluations

This article looks at processes that directly target individuals. Since 1992, Burkina Faso's Ministry of Health has called for indigent selection processes to be tested, in order to obtain information to support decision-making in this matter (Ministère de la Santé, 1992). Indeed, as of yet, very little is known about the situation in Burkina Faso regarding the selection processes that should be set up. A recent review of targeting experiences at the national level showed a "*lack of implementation capacities—in particular, difficulties in identifying and reaching the poorest*" (World Bank, 2010). Many authors have demonstrated the need for further study of such waiver mechanisms (Gilson et al., 1995; Gwatkin, 2000). We therefore evaluated the processes of three strategies (described below) for indigent selection carried out in one of the country's health districts. The first was organized by the State authorities and the other two were conducted in the context of an action research project coordinated by the authors of this article.

Process evaluation is essential, as the conditions under which an intervention is implemented can determine its impacts (Chen, 2004). Of the various implementation evaluation approaches suggested by Patton (2008), the one of interest here is process evaluation, which is used to comprehend an intervention's internal dynamics and how its activities are organized, as well as its strengths and weaknesses. Our analytical approach is based on applying the theory of the three interventions (Chen, 2004) described below, taking into consideration how they are related to their context and to the dynamics of the social actors.

The overall objective of this process evaluation was to document the strengths and weaknesses of the three strategies (Table 2). More specifically, the aim of this evaluation was to understand: (i) the degree to which these strategies were accepted by stakeholders and considered relevant in the local context; (ii) how the stakeholders (health workers and beneficiaries) were informed about the waivers; (iii) how the beneficiaries were selected; (iv) the financial viability and funding mechanisms for the waivers; and (v) the evaluation approaches used.

4. Context and interventions

These interventions were carried out in the Ouargaye District, a rural district engaged in subsistence agriculture (260,000 inhabitants in 2006, 96% rural). In the Centre-East region, where this district is located, 55% of inhabitants were living below the poverty line in 2003, compared to 46% nationwide (INSD, 2007). The district has one district hospital (CMA) and 25 primary health centres (CSPS) that provide first-contact service. CSPSs are managed by nurse health-post managers (ICP). Each CSPS is overseen by a village health committee (COGES). In addition to user fees for curative consultations, profits are also generated from the sale of drugs in the EGD (essential generic drug) depots of the CSPSs. The COGESs use these profits to cover local operating costs and to provide incentive bonuses to governmental health staff and pay the salaries of the community-based managers of the EGD depots.

A State intervention and two action research projects were implemented between 2004 and 2007 in this district (Fig. 1), all with the same objective of selecting indigents to receive free care.

State-led policy (Intervention A). In 2004, in the context of the Poverty Reduction Policy (*Cadre stratégique de lutte contre la pauvreté* – CSLP), the Ministry of Health's Department of Health and of the Family (DSF) decided to provide free drugs to the worst-off. The DSF sent an official letter and a stock of essential drugs to all the ICPs. This directive stipulated clearly that these drugs were to be distributed free-of-charge to "indigents", but provided no indication of how indigents were to be selected nor what criteria should or could be used to identify eligible persons or families. It also made no mention of the period of time that these drugs were intended to cover, nor on what basis the needs had been calculated to determine the quantity delivered. The ICPs therefore were left to decide alone, according to their own perception of what indigence

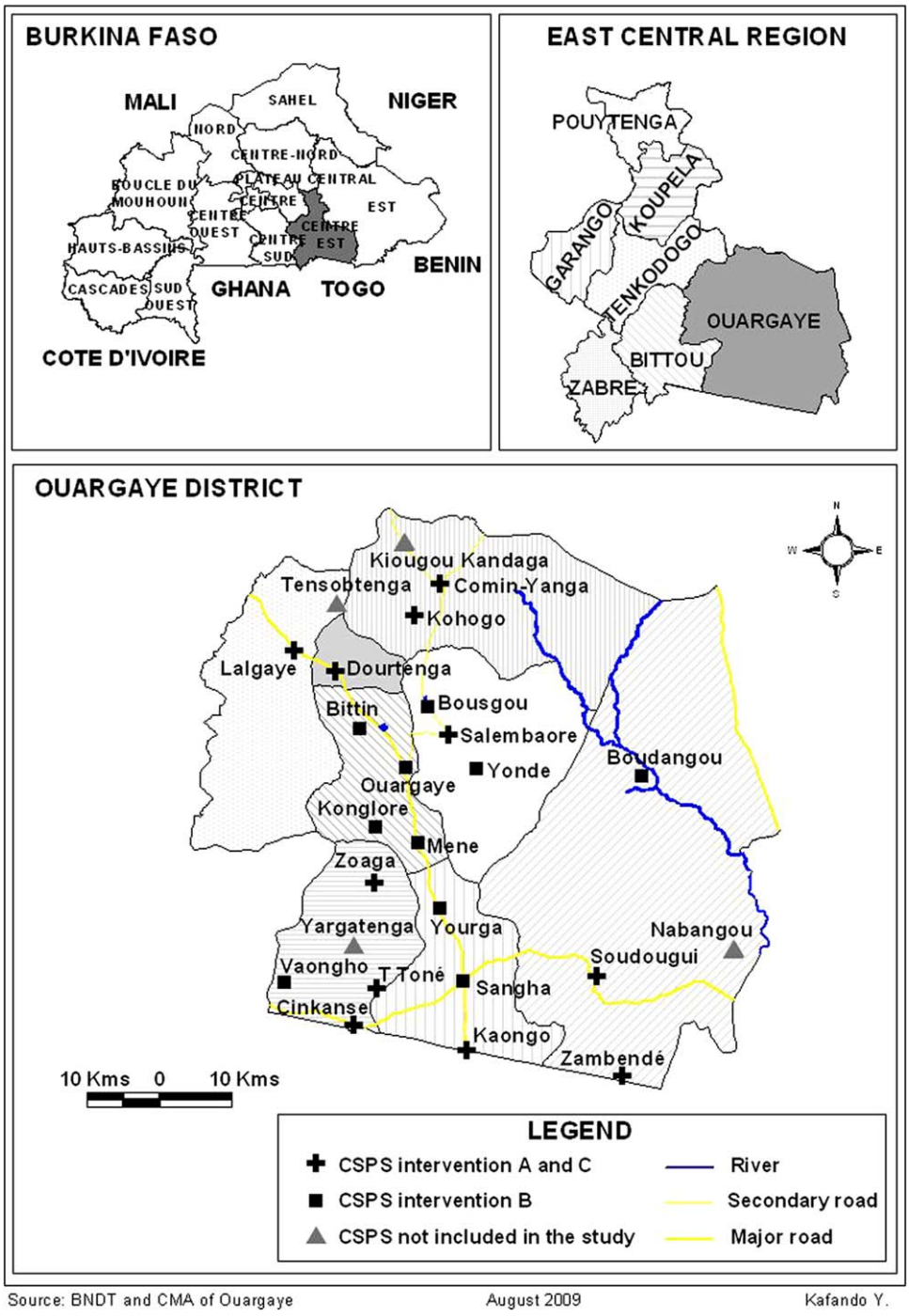

Fig. 1. Health district and Interventions.

was. Altogether, between May 2004 and September 2005, in all the CSPSs of the district, 2700 persons were officially declared indigent. However, we were only able to find the registration records in 11 CSPSs (50%), where a total of 297 indigents were treated over a period of two to 17 months, depending on the CSPS. Half the indigents selected were women (132/266), and the average cost of the free drugs supplied was 1200 F CFA. In contrast to the other two interventions, the researchers were not involved in this intervention, which was planned and implemented entirely by the Ministry of Health.

Community-based intervention led by researchers (B). In 2007, we undertook an action research project to try out a participative, community-based process for selecting indigents. Under the leadership of the health district, village selection committees (VSCs) were set up in 124 villages of 10 CSPSs (different from those evaluated in intervention A). To avoid influence by administrative officers, village chiefs and members of the COGESs, they were not allowed to be members of VSCs. The VSCs produced lists of indigents, whom they selected on the basis of a consensual definition chosen by ICPs and COGESs: "*someone who is extremely disadvantaged socially and economically, unable to look after himself (herself) and devoid of internal or external resources*" and without applying any pre-determined criteria. Based on this definition, they also decided to select individuals rather than families. It was possible for more than one member of the same household to be selected, or even all the members of a household. This list of

Table 1
List of 20 criteria for selection of indigents.

No.	Variables	Criteria				Points
Individual criteria						
1	Age	60 yrs and more	1	Less than 60 yrs	0	
2	Widower/widow	Yes	1	No	0	
3	Number of children living with you	0–2 children[a]	1	More than 2 children	0	
4	Have you engaged in an income-generating activity in the past seven days?	No	1	Yes		
5	Have you had any health problems lasting more than six months?	Yes	1	No	0	
6	Do you have any motor, visual or mental disability?	Yes	1	No	0	
7	Do you have problems lifting any weight (bicycle, water bucket, etc.)?	Yes	1	No	0	
8	How many meals do you eat each day?	1 meal	1	More than 1 meal	0	
9	Are you able to pay the fees for your healthcare services?	No	1	Yes	0	
10	Are you the head of household?	Yes	1	No	0	
Household criteria						
11	Is the head of household a woman?	Yes	1	No	0	
12	Is the ground of the yard natural?	Yes	1	No	0	
13	Is the roof of the house made of straw?	Yes	1	No	0	
14	Does your household have a storm lamp?	No	1	Yes	0	
15	Do you use harvest residue as fuel for cooking?	Yes	1	No	0	
16	Does your household have a radio?	No	1	Yes	0	
17	Does your household have a bicycle?	No	1	Yes	0	
18	Does your household have any draft animals?	No	1	Yes	0	
19	Does your household have a cart or plow?	No	1	Yes	0	
20	Does your household have any poultry?	No	1	Yes	0	
Total						

[a] In the local context, living with less that 3 children is a source of vulnerability.

indigent individuals was then validated by village chiefs, mayors and COGESs. The COGESs were the final decision-makers because, in order to respect the principles of the Bamako Initiative, it was decided by all the stakeholders that the waivers would be funded endogenously. In other words, they were funded by the profits accumulated by the COGES over the previous 20 years from drug sales and user fees. Each indigent person was contacted and received a waiver card with his or her photo on it. This card was validated by the Provincial Social Action Department. The 124 VSCs selected 566 persons. Of these, the 10 COGESs retained 269 persons, i.e., 2.81 per 1000 inhabitants. Half the indigents were women (134/269), and the average cost of the free drugs supplied was 1300 F CFA.

Criteria-based intervention led by researchers (C). This second intervention organized by the researchers in 2007 built upon Intervention B. It responded to a need frequently expressed by decision-makers and health workers for criteria to aid in the selection of indigents. Indeed, the Ministry of Health has issued no official list of criteria for this type of selection process. Intervention C was therefore less inductive than the community-based process and more standardized, due to the list of criteria. First, we conducted a quantitative survey of the 269 indigents of Intervention B to identify their specific characteristics and to compare them with the rest of the rural population of Burkina Faso (INSD, 2007). Based on these results, the researchers and local decision-makers came to a consensus on a list of 20 criteria for indigence (Table 1). An indigence score was established from the sum of the responses to all the criteria (1 if criterion is present; 0 otherwise). Criteria were equally weighed. Because 87% of the 269 indigents in Intervention B would have had a score higher than 10, it was decided to use this value as a threshold: any person scoring more than 10 points would be considered indigent. Then, health workers of the 11 CSPSs (different than those in Intervention B, see Fig. 1) were briefed on this selection process and trained in the use of these criteria, which they were instructed to apply to every patient who claimed not to be able to pay for care. The COGESs were informed of the study. Between June 2008 and December 2009, health workers applied the criteria to 72 possibly eligible persons, which represented 0.007% of the total number of visits. Of these, 33 persons (46%) were declared indigent, with an average score of 12.2 points.

5. Effectiveness of the interventions

While the focus of this article is on processes, here we summarize briefly the results related to effectiveness, details of which are available elsewhere (Ridde et al., 2010). Given the time lapse, the effectiveness of Intervention A was not evaluated. For the other two interventions (B and C), evaluation showed that the households in which the indigents lived appeared to be more vulnerable and poorer than the reference national rural households. Indigents selected by the management committees and the

Table 2
Comparison of the three interventions' characteristics.

	Intervention A	Intervention B	Intervention C
Time period covered	May 2004 to September 2005	November 2007 to date	June 2008 to September 2010
Services exempted	Drugs at CSPS	All services at CSPS and district hospital	All services at CSPS and district hospital
Criteria for selection	No criteria provided	Community-based definition of indigence	20 criteria (Table 1)
Selection of beneficiaries	Health workers at point of service	Community at village level (pre-identification)	Health workers at point of service (passive identification)
Information to the beneficiaries	At point of service	Individual distribution of cards	At point of service
Funding and compensation mechanisms	Ministry allocation of drugs No compensation	Cost-recovery schemes used to finance exemption (endogenous)	Cost-recovery schemes used to finance exemption (endogenous)

ICP were very comparable in terms of levels of vulnerability, but the former were more vulnerable socially. The majority of indigents proposed by the village committees who lived in extremely poor households were retained by the management committees. Only 0.36% of the population living below the poverty threshold and less than 1% of the extremely poor population were selected. The community-based process minimized inclusion biases, as the people selected were poorer and more vulnerable than the rest of the population. However, there were significant exclusion biases; the selection was very restrictive because the waivers had to be endogenously funded.

6. Materials and methods

This study is a qualitative evaluation of processes (Patton, 2008). All the people we interviewed were met either individually or in focus groups (see below). The topics covered in these interviews were their perceptions of the interventions' relevance and sustainability, the strengths and weaknesses of the selection of individuals, the definition and use of indigence criteria, the financial arrangements, and the procedures for informing the health workers and the beneficiaries of the waiver.

Data collection regarding the national policy (Intervention A) was carried out in January 2008 through interviews with the ICPs responsible for selecting indigents in 2004–2005. Of the 11 ICPs who had been present in 2004–2005 at the time of the intervention, we found six, whom we were able to interview in depth. Three were still in the district and three were elsewhere in the country. Because of the time lag between the intervention and the study, we did not consider that it would be useful to meet with any of the indigents who had received the free drugs.

Data collection for Intervention B was carried out in January 2008 and in January and June 2009. In all, seven interviews were carried out with health agents responsible for the health district (RDS: 5) and the research coordinator (CR: 2 encounters). Four focus groups were organized among all the ICPs (17 men) and all the COGES managers (17 men). Twelve focus groups were carried out among a sample of the VSCs of the 10 CSPSs. For each CSPS, three VSCs were chosen according to the number of indigents selected (maximum, minimum, average). Two to five members of each VSC participated in the focus groups. In all, the 12 focus groups included 158 VSC members, with nearly equal numbers of men and women (separated in the focus groups). In addition, 10 forums were organized among the VSCs and the COGESs. Representatives from 92 (74%) of the 124 CVSs travelled to participate in the forums. In all, these forums included 420 people, of whom 194 were women and 21 were COGES members.

Data collection for Intervention C was carried out in January and June 2009. Two focus groups were organized with all the ICPs (10) and all the COGES managers (9) of the 11 CSPSs. In addition, 24 individual interviews were conducted: eight health workers, eight COGES members, five selected indigents (ID), and three persons who were not declared indigent upon application of the list of 20 criteria. These people were met in five CSPSs chosen for their diversity with respect to the use of the criteria and the selection of indigents. The definition and use of these criteria were also the subject of debates with villagers during the 10 forums (Intervention B), because the list of criteria had been developed on the basis of their community-based selection processes.

All interviews (except two), focus groups and forums were audio-recorded. They were transcribed in their entirety into French and, where necessary, translated from Moore/Yana. Data production was subjected to content analysis and thematic analysis (Miles & Huberman, 1994). The themes retained for analysis dealt primarily with the key elements of the user fee waiver mechanisms as described above (see Section 3). The internal validity of the results was strengthened by triangulating the data sources and data collection methods. We presented the results to the interventions' stakeholders and two national scientific conferences to verify the appropriateness of our analyses. The study was approved by ethics committees in Burkina Faso and Canada.

7. Results

7.1. Intervention A

The persons we encountered agreed unanimously that the provision of drugs for the indigent was seen as very useful and perfectly appropriate.

However, the intervention suffered from "*insufficient communication*" (ICP 1). The ICPs received no directives on how to distribute the drugs. Some recalled that these were supposed to be for the indigent, others that they were simply to help out: "*that's what they told us, to help out like that, they didn't tell us to select the people*" (ICP 3). Although the Ministry's directive specified that the target public was indigents, the concept of indigence was never clarified.

The ICPs were therefore left to their own devices to distribute the drugs, "*to anyone whom, according to their own way of understanding, they perceived as being indigent*" (ICP 1). For some, this absence of criteria created a real problem, particularly in their relationships with certain patients who claimed the free drugs; others had no difficulties. The most commonly observed practice for selecting beneficiaries was a "*distribution on demand when someone comes and is unable to pay for the prescription*" (ICP 5). In general, then, the main criterion was an inability to pay among those who went to the CSPS. The drugs were not integrated into the EGD depot controlled by the community manager, but instead were kept in the examination room and managed only by the health workers.

Almost all the ICPs informed their COGES, hoping the latter would transmit the information in the villages, but most ICPs did nothing themselves to get closer to the villagers: "*actually, we didn't go out [to do] information sessions, to say that we had received drugs for the indigent*" (ICP 2). One reason often cited to justify this poor information was that the drug supply was too limited and there would not have been enough, if they had provoked too great a demand.

Some ICPs lamented the ephemeral character of this intervention, which they believed was externally funded: "*We would hope, in any case, that the government would make an effort again . . . with the partners so that this kind of stock doesn't dry up*" (ICP 5). They said that such stoppage could create relational problems with patients who would want free drugs after the stocks had run out, as had happened for other products in the past, such as iron supplements for pregnant women.

To our knowledge, the DSF did not carry out any evaluation of this intervention in the district. The fact that we were only able to find fewer than half the management registers shows that no monitoring system was organized, as all our respondents acknowledged, "*so much so that the management was very loose in certain areas*" (RDS 1). The relatively informal use of drugs intended *a priori* for indigents was thus not subjected to any thorough evaluation.

7.2. Intervention B

Most of the actors noted the relevance of this intervention because it allowed the worst-off to finally have access to care: "*we applaud this initiative because since the implementation of the Bamako Initiative, there was supposed to have been free access to care for indigents, but the problem remained*" (ICP M). Moreover, treating

indigents using endogenous funds is part of the "*COGES prerogatives*" (RDS 1) stipulated in the decree that created the COGES, even though this free access to care for indigents was never implemented. The intervention was a reminder of these prerogatives. The use of endogenous funds was also well accepted because of community solidarity.

The participative approach to defining and organizing the effective management of indigents was appreciated: "*There have been similar interventions that helped indigents but their process was not like this one, which is much more community-based*"(VSC Y). From the start, in their training sessions, the ICPs and the COGESs (as community members) were able to arrive at a consensual definition of indigence. Translating the definition into three languages was useful for the work with the VSCs. However, some VSCs noted that even before the selection of indigents occurred, "*people said that they didn't even want any of their relatives to be registered because it would dishonour the family*"(VSC S).

The selection of VSC members by the COGES was heterogeneous (by appointment, by vote), depending on each village's situation. The rule of parity and the lack of involvement by chiefs and local leaders were well respected, demonstrating the actors' commitment to community intervention. Many VSC members noted the importance of the presence of women—"*if we really want to know, it's the women who know who the indigents are, more than the men*" (VSC K)—even though that presence was sometimes only symbolic.

Most often, the VSCs selected indigents based on group consensus. Sometimes the votes were organized by "*the majority principle*" (VSC M). The processes used to develop the initial list were varied. Some VSCs visited people's homes to verify their indigent status, others did not, so as not to raise hopes or to stigmatize the family, because "*all the members of the committee know all the families*" (VSC V). The criteria most often used for selection were lack of social support, inability to work, lack of funds, and problems of access to water and food. While this was rare, some tried to select members of their families, and some VSCs were subjected to pressures: "*People approached us to tell us they had an indigent at home and asked us to register his name*" (VSC V).

Despite the fact that the COGESs managed the money from user fees, they knew nothing about the accounting nor the profits generated since the start of the Bamako Initiative. Given this lack of information, their selection of a very restricted number of indigents is explained, in part, by their fear of financially bankrupting the CSPS: "*They told us to limit the number because there will be no funding coming from outside*" (VSC S). Although this was not done everywhere, some COGESs, ICPs or RDSs influenced the selection by pressuring the VSCs about the financial viability of the CSPSs. Moreover, the COGESs only retained, on average, about 50% of the indigents selected by the VSCs. Some VSC members were very frustrated by these choices that the COGESs made without informing them. The great majority of VSCs expressed their dissatisfaction with their lists being validated by the COGESs, because they believed they knew the villages better. One year after the intervention, we presented to the COGESs and CVSs the state of the CSPSs' finances and showed them, in particular, that they had the capacity to cover six times more indigents than had been selected. At that moment, their understanding of the situation changed: "*We understood that providing free care to indigents could not shut down the CSPS*" (VSC Y). Thus, the next selection process should see more people selected: "*In my village there are still more indigents, we just wanted to limit the number, we were afraid to select because the charge would be assumed by the CSPS*" (VSC V).

7.3. Intervention C

This intervention was positively received by the health workers. They were happy to have criteria, which they had been wanting for a long time. Even so, we observed that the use of the list of criteria remained very minimal (0.10% of visits); "*There is a certain slackening in terms of its application*" (CR).

With few exceptions, the health workers did not question the appropriateness of the list of 20 criteria, even if some thought they were sometimes too restrictive (exclusion error). This list was also appreciated by the VSCs of Intervention B, because their selection of indigents formed the basis of these subsequent criteria. The VSC members unanimously thought these criteria appropriately represented the living conditions of indigents. However, in three CSPSs, they thought the criteria should be weighted. If the selection of indigents were to be repeated, the VSCs of the 10 CSPSs would be divided on which mechanism to use. Half of them proposed doing community-based selection again, but using the 20 criteria, in order to limit targeting errors and criticisms about their selections. Mainly, however, this would suppress the step of COGES validation, which they did not appreciate: "*With the list of 20 criteria, we would make our selection and no one could reduce it, it's clear and good*" (VCS Y). The other half of the VSCs suggested that the list of indigents produced by this community-based selection process using the 20 criteria be subsequently validated by the ICPs, which would increase consensus, minimize targeting errors and avoid conflict with the health workers.

However, the health workers' application of the criteria was the more sensitive issue. The four main reasons for low application mentioned by the health workers were:

(i) *Indigents' non-use of CSPSs*. Because the criteria are applied at the CSPS, only those who go to the CSPS can benefit from them; but indigents do not generally use the CSPSs.
(ii) *The unreliability of patients' declarations*. Most health workers expressed their reluctance to exempt patients based only on their declarations, whose veracity they considered to be sometimes questionable. Some preferred to confirm with a home visit, particularly by the COGES.
(iii) *Patients' difficulty with responding to questions*. Patients are not accustomed to the questions put to them relating to the criteria, leading to embarrassment and shyness, particularly since "*no one wants to always be receiving charity from others*" (ID 1).
(iv) *Household criteria that do not always reflect individual circumstances*. ICPs and COGES members thought some indigents might live in households that were not indigent, but they were marginalized by their families for multiple reasons, as confirmed by the VSC members. Also, a household's previously acquired possessions might no longer reflect on the conditions of poverty that prevail when the criteria are being applied. For these two reasons, some health workers suggested attributing more weight to individual criteria than to household criteria.

For some categories of persons that the ICPs habitually treat at no charge (prisoners, medical emergencies, social cases known in the village), they do not consider it useful to apply the criteria. Finally, it is interesting to observe that, in only one of the 11 CSPSs, the household criteria seem to be less well suited to the particular situation of this health area. This area, near Togo, is a very commercial border area where the living standard is higher than in the rest of the district.

When Intervention C was being planned, it included organizing an information campaign. However, the ICPs refused because they feared the ensuing demands would be too great. Nevertheless, the information sometimes circulated because "*Rumours now spread throughout the village whenever we treat someone in the CSPSs for free. So, others might come and humble themselves and claim indigence*" (ICP D). Along the same lines, the health workers (except in one case) did not inform patients of the use of criteria. They

wanted to apply the criteria secretly because they worried that the responses would not be truthful, or that the list would be made known in the villages. The patients we questioned confirmed that they did not know a list of criteria had been applied and that they were not informed of the results.

Regarding the implementation, both the ICPs and the COGESs think the latter should have been more involved. Indeed, they claim to know the villagers better than the ICPs and can participate in validating the selection carried out by the health workers. "*We know the people but the nurse, he does not. ... They can give false information to the nurses, but if the COGES is contacted, the COGES will clear things up for them and the work will go well*" (COGES S).

8. Discussion

8.1. Comparison of the three interventions

When it comes to targeting, there is clearly no perfect intervention (Coady et al., 2004), and each of the three interventions whose evaluation results we summarize in Table 3 can be improved.

Intervention A was not much appreciated because no definition was provided of the target public for the waivers, nor any selection criteria. Even though the Ministry of Health expressed a commitment, in 1992, to conduct operational research on indigent selection processes (Ministère de la Santé, 1992), nothing has yet been done, such that the failure of Intervention A is not surprising. It reflects what some researchers have documented in the region (Gilson et al., 2000; Leighton & Diop, 1995; Waelkens, 1999) and confirms the findings of a recent national evaluation in Burkina Faso that "*Implementation of national health subsidy/fee waiver program is impeded by the lack of clear targeting criteria and of explicit implementation mechanisms*" (World Bank, 2010). Intervention B was considered much better because it used a participative and relatively transparent process. It should, however, be adjusted because the COGESs' conflict of interest and their lack of knowledge about their own financial capacity resulted in a very small number of people being selected. One such experience in Mauritania was able to retain only 0.67% of the general population (Criel et al., 2010), while some in Asia, funded by outside funding agencies, selected more than 20% of the population (Noirhomme et al., 2007). Finally, Intervention C was praised by the health workers as providing them with specific criteria that they had been requesting for a long time. However, the application of these criteria presented some operational challenges, and very few people benefited from waivers because the existence of such an opportunity was largely unknown, as was shown also in Cambodia (Jacobs & Price, 2008).

In addition, it would be interesting to study the feasibility and implementation of a combination of these two methods (B and C), because knowledge on this subject in the African context is rare (Aryeetey et al., 2010). The comparative study carried out in Cambodia demonstrated the value of using a pre-identification system rather than a passive point-of-service identification system (Jacobs & Price, 2008). However, as have others (Criel et al., 2010; Gwatkin, 2000), the authors suggested that combining several methods might be a solution worth testing.

Some elements of these three interventions nevertheless merit closer examination.

8.2. Information, conflicts of interest and sustainability

Analysis of these three interventions' processes confirms the importance of providing information to all the stakeholders (Gilson et al., 1995). The African countries that are currently abolishing user fees for some population categories (e.g. women, children) are having the same experience in terms of information, as it appears not everyone is always informed of this new policy (Meessen et al., 2009; Ridde & Diarra, 2009). Moreover, in Intervention A, the ICPs lacked information on criteria for indigence, and in Intervention C, the population was not informed. The fact that the COGESs did not have information about their own financial capacity, even though this had been at the heart of the Bamako Initiative for 20 years, significantly limited their selection of indigents. Clearly, there is conflict of interest when the decision is taken to use endogenous funding (as requested by the Bamako Initiative), but better information would certainly have led to a more enlightened selection process. Some have also noted the importance of pre-identifying indigents rather than waiting for them to be identified at the point of service (Noirhomme et al., 2007). Indeed, we have shown elsewhere that the COGESs of Burkina Faso had very considerable financial resources that had been hoarded up for some time (Kafando & Ridde, 2010). In this case, considering the annual profit generated by the health centres, the COGESs would have been able to select six times as many people. In experiences of health equity funds, this conflict of interest barrier is removed because the waiver is paid by a third party (Noirhomme et al., 2007). However, health equity funds still present problems of sustainability and remain very rare in Africa (Noirhomme & Thomé, 2006).

8.3. Are criteria really required for selecting beneficiaries of the waiver?

Intervention B started on the principle that defining criteria for indigence can sometimes be counterproductive and time-consuming. Among 68 targeting experiences that we surveyed, only 30 provided indications about the processes used to define criteria for selecting beneficiaries of the waiver (Morestin et al., 2009). This sparsity can be explained by the complexity of such a process. Without criteria, Intervention B was still relatively well appreciated by the actors. Moreover, the specification of criteria in

Table 3
Comparison of the three interventions processes.

	Intervention A	Intervention B	Intervention C
Strengths	Response to a need	Response to a need Endogenous funding Information to the community Participative approach Involvement of women Information to the beneficiaries	Response to a need Endogenous funding Definition of explicit and appreciated criteria
Weaknesses	Beneficiaries not informed Low level of allocation No selection criteria No evaluation No sustainability	Interference by health workers and COGESs Overly restricted selection because of financial nervousness	Less utilization because of financial nervousness Some problems applying the criteria Lack of information to the population and to beneficiaries Other barriers to healthcare access

Intervention C did not appear to promote the selection of very many indigents. We might therefore wonder about the usefulness of defining criteria for indigence in rural areas where people know a great deal about each other (the urban situation is different (World Bank, 2010)). Studies should also be undertaken to understand the limitations of the unit of selection chosen in participative planning processes. As it happened, the decision was taken to select indigents at the individual rather than household level. This appears to have been justified in some cases by the fact that the communities knew that some people could be indigent even when living in a non-indigent household. However, it may also have been a self-rationing process aimed at limiting the number of people selected as indigents.

8.4. Administrative or community-based processes?

Studies have shown that administrative processes (carried out by civil servants) for selecting indigents in Africa do not really work (Bitrán & Giedion, 2003; Leighton & Diop, 1995). This is also true in Burkina Faso. An older study showed that only 25% of waivers granted in public health facilities were given to poor persons (Leighton & Diop, 1995). More recently, in three regional hospitals, only 32 women were exempted from fees, as indigents, between 1997 and 2002—i.e., 1.6% of caesarean cases (Bicaba et al., 2003). The situation of indigents under the national subsidy strategy led by the DSF since 2007 demonstrates the problems of administrative processes (World Bank, 2010). The present study confirms this situation, as the processes of Interventions A and C were not at all effective, and they were largely under the direction of public administration agents. Therefore, many insist that identifying the beneficiaries of waivers should be a matter left to local assessment, close to the communities and without heavy-handed and costly technicalities (Coady et al., 2004; Waelkens, 1999). The feasibility of such a community-based approach for identifying the poor in Burkina was also tested successfully in another district (Souares et al., 2010). In Tanzania, identification of the worst-off is left to the village chief and the villagers on the basis of food poverty. There are no other more explicit criteria, because the communities know who the most vulnerable persons are. These selections are then submitted to the village committee for validation and approval (Burns & Mantel, 2006). The community-based process therefore appears to be the preferable and more effective approach.

8.5. Need for more experimentation and scaling-up

Still, there is not yet sufficient evidence of the effectiveness of the community-based process, and this process also has certain limitations. The national policy context in Burkina Faso, characterized by a lack of political will around this issue, is also very different from that of Cambodia, for instance, where strong policy leadership was one of the factors in the successful expansion of health equity funds (Ir, Bigdeli, Meessen, & Van Damme, 2010). All of this confirms that there is no perfect solution (Coady et al., 2004). Several months after the community-based selection, some COGESs wanted to add more people's names to the list of indigents. However, in a healthcare system with a pyramidal structure, and in a hierarchical society (Ridde, 2008a), no COGES took the decision on its own to request authorization to give out additional cards to new indigents. The health authorities' lack of leadership and motivation with respect to this health intervention (which is added to many other interventions) helps to explain this (Haddad et al., 2009). Moreover, Interventions B and C are part of research projects that, according to a recent evaluation (Bicaba, Ouedraogo, & Biao, 2010), are not sufficiently integrated into the national system and may be perceived as being like all the other development projects that distribute a certain limited quantity of resources (Olivier de Sardan, 2005). One COGES member explained that the number of indigents selected could have been much greater "*if we had been told that this project came with sufficient money, there would have been so many indigents that we wouldn't even have been able to make all the photos.*" Aside from personal willingness, what interest do health workers have in exempting the worst-off? Neither the health authorities nor community leaders have actually made resources available on their own and outside of the research process, to update the list of indigents or to discuss the issue in greater depth. However, in recent months, there have been indications that nothing is set in stone.

The district medical officer has decided that each COGES must, in 2010, dedicate a minimum of 100,000 F CFA (150 Euros) to care for the indigent. Meanwhile, in its latest planning directives, the Ministry of Health has proposed for the first time, to our knowledge, that the COGESs use 200,000 F CFA for the indigent (Ministère de la Santé, 2009). In addition, two other districts in the country (Dori and Sebba, under the impetus of the NGO HELP) have learned of the existence of this experience and have decided to test it in four CSPSs. At the end of 2010, the community-based experience was scaled up to the two districts. Two neighbouring districts of Niger plan to carry out a community-based intervention after a study trip done in December 2009. We should also mention that Interventions B and C were presented in November 2009, April 2010 and October 2010 (see: http://www.medsp.umontreal.ca/vesa-tc/indigents.htm) to all the health authorities of the country's districts and health regions, as well as to central authorities at the Ministry of Health and other ministries, and to stakeholders involved in social protection in Burkina Faso. A policy brief was prepared and widely distributed to present these experiences. This may help in transferring the experiences and may even lead to a scaling-up.

9. Conclusions

In this experience, indigent coverage remained very low, particularly because of the use of endogenous funding; the effectiveness of the same process with exogenous funding has yet to be assessed. Thus, some might question the relevance of these targeting processes, when it might be more efficient to simply abolish user fees for everyone. First, not all African decision-makers are convinced of the appropriateness of that solution. It is therefore certainly urgent to persuade them and to explain the importance of supportive measures (Ridde, Meessen, & Kouanda, 2011). Then, some countries, such as Ghana and Mali, are still seeking solutions to exempt indigents from paying the national health insurance premium. The community process that we have described is still not very sensitive. However, the democratic nature of the process and its emphasis on local solidarity are effectiveness criteria that are worth testing on a wider scale. Finally, it may be that there is no single solution. To improve equity of access to care, perhaps the two methods need to be interwoven: abolish user fees for everyone, and identify indigents for whom specific measures should be taken over and above removing the financial barrier, which, although it is significant, is not the only barrier.

Our analysis of these three processes shows that the information available to the stakeholders and the funding for indigent coverage are two fundamental factors for effective mechanisms to exempt the indigent from user fees at health care facilities. Also, the community-based process appears to be the most suitable in that social context. Thus, the ICPs who were involved in Intervention C have now asked to reproduce Intervention B in their region. In September 2010, all the CSPSs of the district applied the community-based approach, and more than 1000 people

benefited from this latest round of selection. In 1992, the government of Burkina Faso made the commitment to conduct "*operational research on indigence*" and to take "*measures to provide care for the worst-off*" (Ministère de la Santé, 1992). To our knowledge, these are the first trials, along with that of the Nouna district (Souares et al., 2010), to be documented in Burkina Faso. The results show that the community-based process may be preferable to the administrative approach. At the same time, however, this community-based process, which requires some modification, will require further testing and evaluation, because "*many evidence-based innovations fail to produce results when transferred to community in the global south, largely because their implementation is untested, unsuitable or incomplete*" (Madon et al., 2007).

Competing interests

The authors declare they have no competing interests.

Authors' contributions

VR, SH, AB and MY wrote the research protocol. YK coordinate the interventions. MY coordinate the qualitative data collection with VR, YK and KK. MO organize the quantitative survey and do the primary analysis. MY and VR analyze the qualitative data. VR wrote the first draft. All authors read, improved and approved the final manuscript.

Acknowledgments

This paper describes a collaborative process and is therefore based on the work of many people. We would like to thank all our colleagues in the Region and District Health Team, head nurses, members of COGESs and CVSs, as well as the people in all the villages who took part in the process. Valéry Ridde is a *New Investigator* of the *Canadian Institute for Health Research* (CIHR). The research was made possible through funding from the International Development Research Centre (IDRC) and with support from the Global Health Research Initiative (GHRI), a collaborative research funding partnership of the Canadian Institutes of Health Research, the Canadian International Development Agency, Health Canada, the International Development Research Centre, and the Public Health Agency of Canada, see http://www.vesa-tc.umontreal.ca. Thanks to Donna Riley for translation and editing support and to the reviewers for their comments, which were helpful in improving the manuscript.

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