The user fees exemption piloted in the Sahel region of Burkina Faso reinforces the resilience of vulnerable populations

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The user fees exemption piloted in the Sahel region has had a very positive impact on both service utilization and healthcare system efficiency, while maintaining the quality of care. It has also helped to improve the health of women and children, reduce household health expenditures, and strengthen communities. This social transfer strategy in healthcare is a political option that can be mobilized by the Global Alliance for Resilience Initiative – Sahel and West Africa (AGIR - Sahel), the key alliance currently being launched which is aimed at reinforcing the resilience of the Sahel's vulnerable populations.

INTRODUCTION

Crises such as soaring food prices, droughts, floods, epidemics, etc., are increasingly frequent for the populations of the Sahel. Global acute malnutrition there routinely surpasses emergency thresholds, and mortality rates are among the highest in the world [1]. This grim health and nutritional situation is characterized by service utilization that is far below what is needed [2].

In 2007, in the Sahel region of Burkina Faso, three out of four women still gave birth at home, and more than half of children under the age of five years had not been to a health centre [3]! Because of this, in 2008, the Sahel Regional Health Department (DRS) and the NGO HELP (funded by ECHO) conducted a trial of user fees exemptions for children under five and for pregnant and nursing women in two of the region's four health districts (DS) (see Table). The project involved putting in place a third-party payer system and support measures. A scientific partnership was established with the University of Montreal (CRCHUM) to evaluate this intervention [4]. This policy brief summarizes the results of this research to show the value of this strategy in reinforcing the resilience of vulnerable populations.

Table. Total beneficiaries of the project (from September 2008 to December 2012)

TARGET GROUP	NUMBER
Children under age 5	970 820
Pregnant women	231 675
Deliveries	83 658
Nursing women	188 510

METHOD

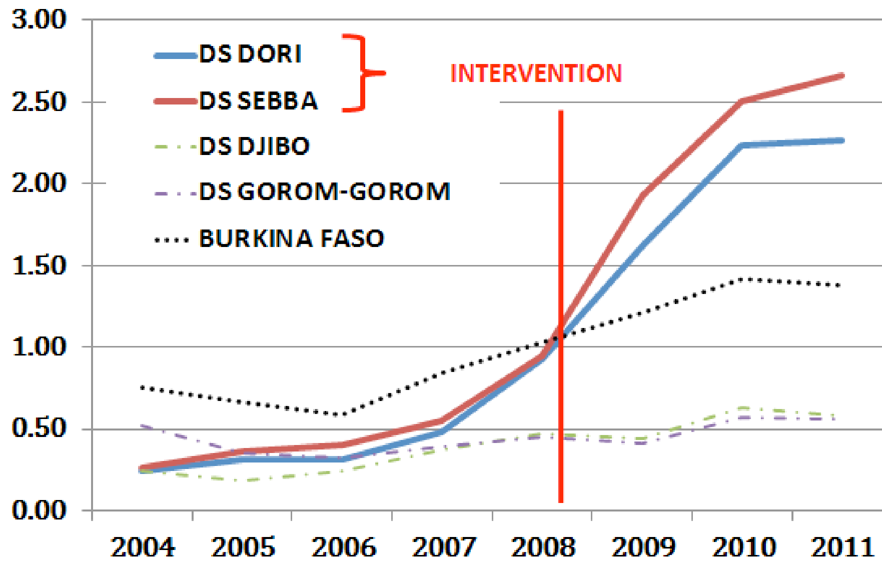
In developing its methodological approach, the independent research team took into account the constraints of natural experimentation, of time and of resources. Some 15 studies were undertaken, with quantitative and qualitative data collected from individuals, households, villages, health centres and districts.

RESULTS

The impacts on service utilization were substantial

The impacts on service utilization were immediate, substantial and sustained (Figures 1 and 2).

Figure 1. Evolution of healthcare service utilization (contacts/inhabitant/year) in children under five years of age in the four districts of the Sahel region and in Burkina Faso from 2004 to 2011

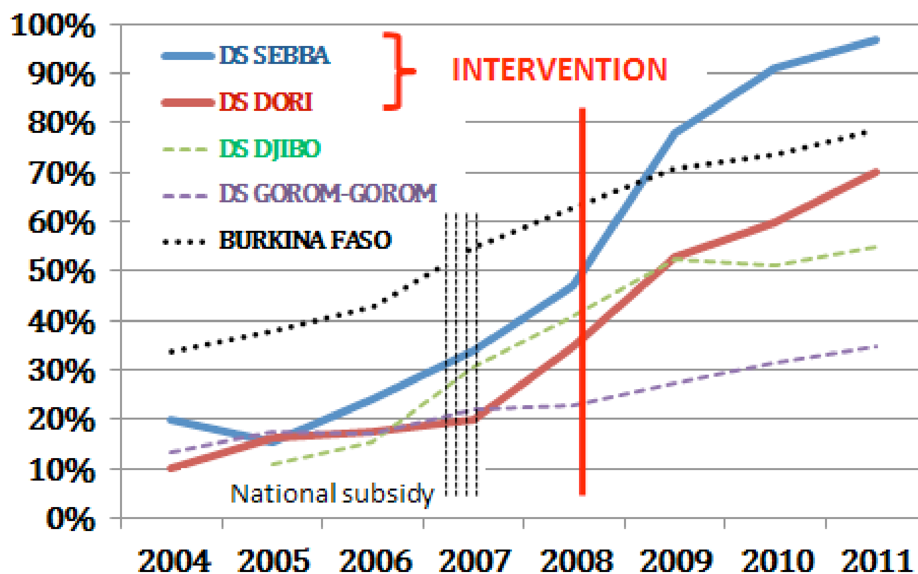


Source: MS/SG/DEP Burkina Faso (2005 to 2012). Statistical annual reports for healthcare, 2004 to 2011.

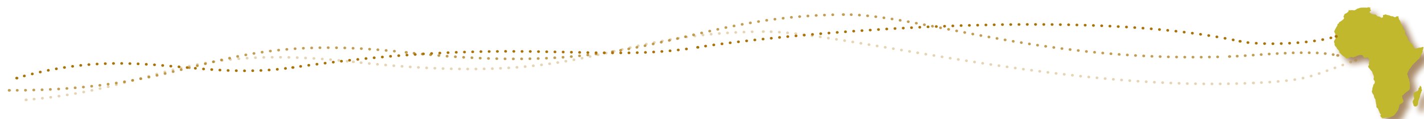
The greatest increase in the use of healthcare was for seriously ill children [5]. In addition, after only one year of the intervention (2009), 80% of sick children used a health centre, whereas prior to that, when user fees were charged, the proportion was only 30% [5]. The proportion of early consultations (within the first three days of illness) went from less than 50% to around 80% for all children, whether poor or not, even for those living more than 10 km from a health centre [5].

With respect to deliveries, the national subsidy introduced in 2007 that allowed women to deliver in health and social promotion centres (CSPS) for 900 francs CFA (1.37€) [6] improved the rate of assisted deliveries (Figure 2). However, the user fees exemption improved it still further [6].

Figure 2. Evolution in the rate of assisted deliveries in healthcare facilities in the four districts of the Sahel Region and in Burkina Faso from 2004 to 2011



Source : MS/SG/DEP Burkina Faso (2005 to 2012). Statistical annual reports for healthcare, 2004 to 2011.



The existing levels of health personnel are sufficient

In 2010, the workloads of the health workers in one of the two intervention districts were compared to those in the neighbouring district where there was no intervention [7]. In both districts, the health workers' self-reported average time spent on activities was greater than the average times observed. As well, there were no differences between observed average times for free and paid services. For example, the average time for curative consultations was 12 minutes in the CSPSs of the experimentation district, as compared to nine minutes in the CSPSs of the comparison district, where services continued to be paid. In the end, there were enough health workers to handle the increased service utilization and respond to population needs.

The quality of medical prescriptions was maintained

A quantitative study with control groups (pre-/post- and with/without intervention) showed that the intervention did not incite prescribing professionals i) to deviate from the quality norms of the World Health Organization (WHO) and the Ministry of Health, ii) to use antibiotics and injections inappropriately, or iii) to prescribe more drugs than before [8]. For example, the average number of drugs per prescription for children under the age of five went from 2.26 before the intervention to 2.19 after it (WHO and national norms: <2). Another quantitative study showed women's perceptions of the quality of deliveries to be equally positive whether those deliveries were free or paid [9]. The steady increase in the use of services by children under the age of five in districts where healthcare has been free since 2008 suggests that mothers' perceptions of these services are equally positive.

The increase in service utilization benefited everyone

Studies on equity of access to services [10] showed not only that the user fees exemption benefited the poorest children and those living far from health centres, but also that they were treated sooner. For example, poor children who were seriously ill and lived less than five kilometres from a health centre benefited twice as much from free services as those who were less poor.

Making services free would lower Burkina Faso's infant-child mortality rate by 16%

Burkina Faso's progress toward MDG 4, aimed at reducing infant-child mortality, has been very slow [1]. If the intervention carried out in the Sahel were scaled up to the entire country, its results after only one year suggest that it could save the lives of 18,982 children [CI 95%: 5,670; 28,340] (Lives Saved Tool method) [11]. Currently, just over 100,000 children under the age of five die each year in Burkina Faso [1]. This number of children's lives saved would correspond to a potential 16% reduction in the infant-child mortality rate. Given the sustainability of the intervention's effects, the estimated impacts on the number of lives saved after three years of the intervention would no doubt be even more impressive.

The user fees exemption helped reduce healthcare expenditures and strengthened communities

The user fees exemption strengthened CSPS management committees and empowered women [12]. It also served to develop people's confidence in modern healthcare services. As well, it helped significantly reduce household health expenditures [13]. For example, the total direct cost for a delivery (including transportation) went from an average of 1,787 F CFA before the intervention to only 816 F CFA a year later. For children under the age of five, the average expenditure for a consultation and medicines went from 4,181 F CFA before to 1,337 F CFA one year after the intervention.

Healthcare subsidization, social transfer, and resilience of vulnerable populations

Despite the enormous potential of user fees exemption, the option of making deliveries and healthcare for children under five "free" is still being fiercely debated in Burkina Faso's health sector. Nevertheless, targeted exemption from user fees is enshrined in the national social protection policy developed by the government in 2012. This divide regarding the elimination of user fees is found in the health and social sectors of certain technical and financial partners. Professionals in the social sector are interested in user fees exemption because the subsidization of healthcare for vulnerable populations in a context of poverty is considered a **social transfer** program (Box 1). Indeed, the results presented in this policy brief show that subsidizing healthcare reinforces the **resilience** of populations (Box 2). The reason for taking into account the resilience of individuals and of populations is that we can begin by targeting those who are most vulnerable and have the most urgent needs. This would include the poor populations of the Sahel as well as children under five and women who are pregnant or nursing.

Box 1. Definition of "social transfer" [14]

Transfer of non-contributory resources (in cash or kind) financed by public, direct, recurrent, and dependable funds, to poor or vulnerable individuals or households, aimed at reducing their food shortages, protecting them from crises (particularly economic and climatic) and, in some cases, strengthening their productive capacity.

Box 2. Definition of "resilience" [15]

The capacity of vulnerable households, families and systems to face uncertainty and the risk of shocks, to withstand and respond effectively to shocks, as well as to recover and adapt in a sustainable manner.

CONCLUSION

We are very pleased to see that health (with nutrition) has been selected as one of the four strategic pillars of the important AGIR-Sahel program currently being launched [15]. Now the challenge facing the Sahel countries and their partners is to see that this approach is successfully and sustainably incorporated into the various policies involved. Healthcare subsidization for vulnerable populations—a social transfer of proven effectiveness—is an option that can be mobilized rapidly. It offers an immediate opportunity to embed the consideration of resilience into health policies and to facilitate the link between humanitarian assistance and long-term development.

This note and other documents on the financial accessibility of healthcare services in West Africa are available on the websites of the NGO HELP **(www.help-ev.de)** *and the University of Montreal* **(http://www.medsp.umontreal.ca/vesa-tc/ressrc.htm)**.

The authors would like to thank Jan Eijkenaar (technical assistant, Résilience & AGIR-Sahel, in the Directorate-General for Humanitarian Aid and Civil Protection of the European Commission - ECHO) for his critical reading of a first version of this document.

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