A community-based targeting approach to exempt the worst-off from user fees in Burkina Faso

V Ridde,[1,2] M Yaogo,[3,4] Y Kafando,[5] O Sanfo,[6] N Coulibaly,[6] P A Nitiema,[6] A Bicaba[5]

[1] Research Centre of the University of Montreal Hospital Centre (CRCHUM), Canada; [2] Department of Social and Preventive Medicine, University of Montréal, Canada; [3] Groupe de recherche, d'Expertise et de Formation en Santé pour le développement (GREFSaD), Burkina Faso; [4] Université Catholique de l'Afrique de l'Ouest-Unité Universitaire de Bobo-Dioulasso, Burkina Faso; [5] Société d'étude et de recherche en santé publique (SERSAP), Burkina Faso; [6] Ministère de la santé, Burkina Faso

Correspondence to: Dr V Ridde, CRCHUM, International Health Unit, 3875 rue Saint-Urbain, Montréal, Québec, CANADA (H2W 1V1); valery.ridde@umontreal.ca

Accepted 31 July 2009
Published Online First 19 August 2009

ABSTRACT

Background: To contend with the risk of exclusion created by user fees, those implementing the Bamako Initiative (BI) were asked to organise exemption schemes for the indigent. But those exemption schemes were never put in place in Africa due to difficulties identifying the indigent. An action research was implemented to test the hypothesis that a community-based process for selecting beneficiaries of user-fee exemptions in an African environment of BI organisation is feasible.
Methods: This study was carried out in 10 primary health centres (CSPS) in Burkina Faso. Village selection committees (VSC) made lists of those worst-off, and the lists were validated by village chiefs, mayors, and health committees (COGES). A process evaluation was implemented using documentation analysis, accounting calculation, focus groups and in-depth interviews.
Results: The 124 VSCs selected 566 persons. The 10 COGESs retained 269 persons (48%), ie 2.81 per 1000 inhabitants. Except for one CSPS, the annual profits from the user fee schemes could support on average six times more indigents than the mean number selected by the VSCs.
Conclusions: In the rural African context, villagers are capable of selecting those who should be exempted from user fees according to their own perspective. Thanks to the BI, health centres have a certain financial capacity to take care of the indigent. In a community-based targeting approach using endogenous resources generated from BI profits, local perceptions of the health centres' financial viability, coupled with the hierarchical social context, led to a very restrictive selection of candidates for exemption.

Participants at the International Conference on Primary Care Services and Healthcare Systems in Africa held April 28–30, 2008, in Ouagadougou (Burkina Faso) reaffirmed, as did the recent WHO Commission on Social Determinants of Health,[1 2] the need for solutions to improve equity of access to care. In West Africa, user fees have been implemented using a community-based, decentralised approach in accordance with the principles of the Bamako Initiative (BI) of 1987.[3] To contend with the risk of exclusion created by user fees, those implementing the BI were asked to respect principle #7, that is, to organise exemption schemes to help those unable to pay.[4] However, 20 years later, it is obvious that in Burkina Faso,[5] as elsewhere in Africa,[6] this type of system was never put in place. One reason most often mentioned to justify this inaction is the difficulty of identifying who is to be exempted.[5 7 8] However, evidence on this subject is quite rare, especially in Africa.[9] To the author's knowledge, there has been no documented experience of any exemption mechanism within the context of BI in Africa, whereas most countries have exemption systems that are supervised by the public administration. However, only four of sub-Saharan Africa's 34 countries have a clear national policy, with precise criteria, to support exemption measures.[10] Exemption systems organised by central administrations do not really work.[11] For example, in three regional hospitals in Burkina Faso, only 32 women were exempted from fees, as indigents, between 1997 and 2002, ie 1.6% of Caesarean cases.[12] Therefore, many insist that identifying the beneficiaries of exemptions should be a matter left to local assessment, close to the communities and without heavy-handed and costly technicalities.[10 13] However, little is known about such community-based schemes,[10 14] and African experiences are rare.[9 13] A review of 122 social programmes (not only in health) that use targeting techniques revealed that only 14 used a community-based method.[13] Thus, this study presents the results of an action research the objective of which was to test the hypothesis that a community-based process for selecting beneficiaries of user-fee exemptions in an African environment of BI organisation is feasible. In this study, the criterion for effectiveness is the capacity for members of the community to implement a selection process. Clearly, before considering the effectiveness of the targeting (exclusion or inclusion error), there must first be a process in place. No scientific evidence was found of the implementation of such processes in the BI context. Before providing evidence that the intervention made a difference in access to health care for identified individuals, which is the final goal of all exemption schemes, research must show that the process is feasible, as this has never been documented in the literature.

CONTEXT AND INTERVENTION

Burkina Faso, ranked next-to-last in the 2007 Human Development Index, launched the BI in 1993. The organisation of public health care follows a classical pyramidal model. First-contact service is composed of primary health centres (CSPS) managed by a village health committee (COGES). Medicines are sold in the EGD (essential generic drug) depots of the CSPSs and the profits are managed by the COGESs. The COGESs use the profits for local operating costs, incentive bonuses to governmental health staff, and salaries for community managers of the EGD depots. The Social Action Ministry is responsible for the official exemption mechanism in Burkina Faso and for delivering the indigence cards. However, the bureaucrats do not have the means to do surveys

to decide on the selection of recipients, and the services, which are often unknown to the population, are only available in urban settings. This study was carried out in the Ouargaye District (260 000 inhabitants in 2006, 96% rural), a rural district engaged in subsistence agriculture. In the Centre-East region, where this district is located, 55.2% of inhabitants were living below the poverty line in 2003, compared to 46.4% nationwide. The rate of measles vaccination is 65% for the district, as opposed to 71.1% nationwide. This action research was carried out in 10 of the district's 25 CSPSs (figure 1). The action consisted of asking the communities to select the indigents who could receive total exemption from payment, to be financed from the BI profits. The definition of the content of the action and the choice of the 10 CSPSs were made by the research and district teams based on three criteria: ethics (not to inflict any financial risk during a pilot project); sustainability (using endogenous funds); and appropriateness (functional COGESs, an action that was participative and adapted to the context).

Planning

In 2003, the authors conducted a study aimed at understanding why exemption measures had not been implemented in Burkina Faso. One conclusion of that study was the need for action research to study community exemption mechanisms.[5] The action research approach is, in fact, often recommended to introduce such social change, including in Africa.[15 16] Thus, in a first step, the authors (VR) took advantage of a workshop led by the Canadian Coalition for Global Health Research in July 2004

Figure 1 Map of the Intervention District.

in Canada to develop, with a researcher (AN) from Burkina Faso, the broad lines of this action research. In a second step, two workshops at the national and local levels (led by the Public Health Association of Burkina, AB, and the Regional Director of Health, NC) were organised in Burkina Faso in March 2005. These workshops made it possible to develop the protocol for the action research in a participatory manner with various national and local stakeholders. Then a graduate student (a Burkinabé physician) carried out a feasibility study in August 2005, which suggested, in particular, that the communities' selections be validated by the village chiefs. In a fourth step, the co-investigators met in November 2005 to finalise the protocol and verify again the interest among decision-makers for such a process. The Minister of Health supported this study because he had been asking since 1992 for it to be organised.[17]

Content and implementation process

Implementation of the action followed several steps:

- i) *Information*: All the administrative authorities of the district headquarters were informed, then a tour of the 10 CSPSs was organised to inform the local and traditional authorities, as well as the COGES members and the health personnel.
- ii) *Training*: Because implementation activities are carried out by researchers in conjunction with the members of the District Health Team (DHT; SO), they were trained in order to implement the action. Then, the health personnel and two people from each COGES were also trained. After a presentation on the study, a workshop involving DHT members, researchers, community member (COGES) and health staff allowed for consensus to be reached on a definition of the indigents who were to be selected in the villages: "someone who is extremely disadvantaged socially and economically, unable to look after himself (herself) and devoid of internal or external resources." The term "indigent" was translated into the local languages on a consensual basis.
- iii) *Creation of village selection committees (VSC)*: VSCs made up of seven members were set up in each of the 124 villages located in the health areas of the 10 CSPSs. The membership, as designated by the COGESs after the training, had to respect a gender balance. To avoid any local elite capture, the members could not be administrative officers, village chiefs or members of the COGESs.
- iv) *Selection of indigents*: All the VSCs met several times. They made lists of the persons they considered to be indigent based only on the definition and without any predetermined criteria. The selection unit was individuals. The process of selection was left under the decision of the members. The majority used their own knowledge of the population, combined sometimes with field visits to households. In accordance with the local context, this list was validated by the traditional chief of the village, the mayor, and finally the COGES, which had the final word.
- v) *Distribution of cards*: Each indigent received individually an exemption card with his or her photo. This card was validated by the Provincial Social Action Department.

METHODS

The objective of this study is to describe and analyse the process of implementing the intervention. Through analysis, it was possible to identify the key characteristics of the intervention, ie its duration, the cost, the organisation of committees, the profiles of those selected as indigents, the financial capacity of the health centres, and finally, the perceptions of stakeholders. Reports and documents from the research project were analysed. Financial capacity was calculated using a method previously used by researchers in the same country.[7 18] In each CSPS, the accounting records of the EGD depots were analysed from the expense books (purchase of EGDs, operating expenditures, etc), receipt books (sales of EGDs, user fees, grants, etc), and cash records (cash in the bank and in the safe), as well as the inventory records of drug stocks. Sums accumulated since the start of the BI correspond to the treasury status. Annual profits correspond to revenues (Expenditures + [initial EGD stock –final EGD stock]). A qualitative study was undertaken to analyse the perception of stakeholders concerning the process by means of five focus group discussions (FGD) with male members of VCSs from the 10 CSPSs (n = 43), five FGDs with female members of VCSs (n = 31), one FGD with head nurses of nine CSPSs (n = 9), one FGD with managers of eight COGESs (n = 8), and three individual interviews with the coordinator of the action research and two members of the DHT. All the discussions and interviews were translated where necessary, recorded and then transcribed using word processing software. The data were analysed using content analysis.

RESULTS

Duration and cost

The selection of indigents by the VSCs and their validation took 45 days. The whole process took 4 months. Some expenses were assumed by the DHT (photocopies, printing, transport). The amount spent on the action (excluding the salary of the district-based research coordinator) was 1 500 000 F CFA (2300 €) paid by the research project.

Composition of the VCSs

Of the members of the 124 VCSs, less than 2% were members of the COGESs or religious leaders. Women made up 44% of the members, but only 15% of the VSCs had more than three women among the seven members.

Selection of indigents

The 124 VSCs selected 566 persons. The 10 COGESs retained 269 persons (48%), ie 2.81 per 1000 inhabitants (table 1). Less than 5% of the VSCs selected more than 10 persons, and 15% of them did not select any. Half the indigents were women (134/269) and 63% of the indigents were more than 50 years old.

Financial capacity of the EGD depots

Savings achieved since the launching of the BI (table 2, column b) make it possible theoretically to support between 290 and 4400 indigents per year in the coming years, depending on the CSPS (hypothesis based on one primary health care consultation per year per person). Except for one CSPS, the annual profits (column d) could support 24–560 indigents per year. The mean number of indigents selected by the VSCs represent on average 17% of the financial capacity. Health centres are thus able to support more than six times the number of indigents selected in the intervention (table 2, column f).

Stakeholders perceptions

The action was well received by the stakeholders. They considered that it was beneficial for the worst-off, according to their own ("emic") criteria. It was a useful incentive for making the COGESs' legal responsibility towards the indigent a concrete reality. One criterion for the effectiveness of this action was the fact that it was community-based and participative, because, as one VSC member remarked, "there have been other interventions

Table 1 Indigents selected per CSPS

CSPS	Total population (a)	Total number of villages per VSC	Number of indigents selected by the VSCs (b)	Rate of selection (‰) (b/a)	Number of indigents retained by the COGESs (c)	Rate of validation COGES/CVS (%) (c/b)	Final selection rate (‰) (c/a)
Bittin	5294	7	26	4.91	7	26.92	1.32
Boudangou	6686	7	43	6.43	12	27.91	1.79
Bousgou	5714	12	42	7.35	3	07.14	0.53
Konglоré	2461	5	6	2.44	0	00.00	0.00
Méné	11905	13	43	3.61	43	100.00	3.61
Ouargaye	13393	14	110	8.21	69	62.73	5.15
Sangha	19361	15	96	4.96	26	27.08	1.34
Vaongho	3825	8	20	5.23	16	80.00	4.18
Yondé	13223	24	104	7.87	64	61.54	4.84
Yourga	13991	19	76	5.43	29	38.16	2.07
Total	95853	124	566	5.87	269	47.53	2.81

that helped the indigent, but their approach was not like this one, which is much more community-centred." It was also accepted because it respected the social context by requiring validation of the lists and by choosing as VCS members people who were very involved in the community. In the VCSs, the selection process was consensual. However, the fact that the COGESs only retained half the indigents can be explained according to members of COGES essentially by their fear of using up their accumulated funds and the fact that they do not really know the status of their financial situation. Some COGESs expressed a lack of confidence in the selection carried out by the VCSs and felt they were not rigorous enough in their selection. Some challenges still need to be addressed: ensuring the continuity of the exemption in the health pyramid; having more time and resources for creating the VSCs, providing better information to the COGESs about their financial margins of manoeuvre so that an informed decision can be taken on the number of indigents, and avoiding the risk of social stigmatisation.

DISCUSSION

The first limitation of this study was that it was still not possible to assess the effectiveness of the targeting. The criterion of effectiveness presented at the beginning of this study was focused on the community's capacity to actually implement the process. The present study thus demonstrated that this was possible. Further research will be required to verify whether the targeting was effective in selecting the worst-off (inclusion or exclusion error) and enabling them to use health care services. Nevertheless, it can be said that it was effective from the point of view of the VSC members who selected the persons they considered to be indigent, but not as much from the perspective of the researchers and health professionals, who expected a larger number of people to be selected. To use the terminology of anthropology,[19] this study revealed the "emic" effectiveness more than the "etic" effectiveness of the intervention. The second limitation is that the estimate of the financial capacity to support the indigent is based on a hypothesis of only one visit per year and does not take into account possible fees for more costly treatments, particularly in hospital. That being said, support to the indigent is considered, in the real intervention, as covering all fees, including cases transferred to hospitals. The third limitation, associated with the preceding one, is that this intervention only partly improves the affordability of health services, without acting upon availability and acceptability.[20]

Table 2 Financial capacity of EGD depots to support indigents, per CSPS

CSPS	Number of indigents retained by the COGES (a)	Funds available at 1 March 2007 (F CFA) (b)	Number of indigents that could be supported (c = b/1500 F)	Financial capacity to provide support (a/c)	Accounting benefits in F CFA (1/03/07 to 28/02/08) (d)	Number of indigents that could be supported per year (e = d/1500 F)	Financial capacity per year vs number of indigents retained (f = e/a)
Bittin	7	942905	629	1%	835318	557	80
Boudangou	12	1017735	678	2%	357309	238	20
Bousgou	3	1580630	1054	0%	128697	86	29
Konglоré	0	429585	286	0%	69461	46	NA
Méné	43	3378315	2252	2%	160742	107	2
Ouargaye	69	2963574	1976	3%	NA	NA	NA
Sangha	26	1651554	1101	2%	−6711	−4	NA
Vaongho	16	6593065	4395	0%	276506	184	12
Yondé	64	2823926	1883	3%	547403	365	6
Yourga	29	942905	629	5%	36184	24	1
Total (10 heath centres)	269	22324194	14883	2%	2404909	1603	6
Mean per health centre	27	2232419	1488		267212	178	

EGD, essential generic drugs.
b, Money in the bank + money in the safe (treasurer) + cash on hand (EDG manager).
d, Revenues – (Expenditures + [initial EGD stock –final EGD stock]).
NA, data not available.
655 F CFA = 1 Euro
Average cost per outpatient consultation = 1500 F CFA (hypothesis of one visit per year per person).

The exemption reduces only direct costs for the indigent, but they are sometimes also the furthest away (geographically and socially) from health centres and often disempowered. The intervention showed, for example, that the selected indigents also asked for food to take their medications, which were now free. Such an intervention, just in the health care sector, cannot pretend to reduce poverty or the social inequalities of health. Nevertheless, the authors believe this experience of targeting could now be useful to other public services (food security, education, etc) in distributing aid targeted to the worst-off that could complement this access to health care services. However, there remains a serious need for producing data on this subject in Africa, as such studies are still too rare. In fact, an analysis of publications on targeting programs between 1985 and 2003 shows that less than 10% of those programmes were implemented in sub-Saharan African countries.[13]

To the authors' knowledge, this is the first study on community-based exemption schemes in the context of the BI in Africa. The study offers good news and bad news. The good news is that it is feasible to implement principle #7 of the BI (as a process) and to adapt it to the context. The selection of individuals perceived as indigent by the community using a community-based process was not very costly and was appreciated by the stakeholders. With respect to gender, the importance assigned to including women in the preparation phase and the directive to ensure an equitable distribution of VSC members contributed most definitely to a gender-balanced selection of indigents, which testifies to the feasibility of gender-balanced interventions called for in this context.[21]

The bad news is the stringency of the final verdicts of the communities in selecting indigents—only 3/1000, or 6/1000 if retaining the numbers selected by the VSCs. In Cambodia, in a very different context, a community-based targeting approach retained 16% of the population to receive exemptions, knowing that the funding was external.[22] In the same region, it appears that pre-identification by the community would be more effective for selecting the worst-off (very poor) than the poor.[23] In Burkina, this restrictive selection can be attributed to social and technical reasons. Socially, because their vision of social justice (equity) is more egalitarian than Rawlsian (and its "maximin" principle: the maximum for those who have the minimum), people are more apt to seek social peace and consensus.[5 24 25] The selection of indigents was made on the basis of a double burden, economic (lack of financial means) and social (lack of support) because the situation is that of a country ranked next-to-last in the Human Development Index. In a context of widespread poverty, it is extreme poverty that makes the difference for the population. The region's social organisation is very hierarchical and to be labelled "indigent" can sometimes "dishonour the family", the authors were told. This social hypothesis had been advanced in a study of three pilot projects in Africa.[9] Technically, the (equitable) utilisation of endogenous resources generated by BI user fees is not promoted,[7] and therefore that idea definitely hindered the selection of indigents. The COGESs were in conflict of interest, as no third-party purchaser was involved. The effectiveness of the Cambodian experiences can be explained, in part, by significant funding that went beyond the local contributive capacity (table 2) and was mostly exogenous in origin.[9 22]

Conclusion

This experience teaches us that in the African context of the BI, decision-makers who want to increase service utilisation among the worst-off should definitely consider two possible solutions, because there is still insufficient data[9 26] and experience[27]. First, although endogenous resources may be limited, they do exist (thanks to the BI) and communities can select individuals whom they consider indigent ("emic" effectiveness). Also, the State could legally require (and even enforce, by accompanying measures) that a minimum number of indigents be selected on the basis of a percentage of annual profits. The present research showed, in fact, that the health centres had the capacity to take on six times more indigent persons than the committees selected. Exclusion error could be reduced by increasing the number of beneficiaries. Second, a community-based targeting approach should be tested where support for the worst-off could be funded by a third-party purchaser like the Health Equity Funds.[22 28] Further studies need to be undertaken, particularly in Africa, to evaluate the effectiveness of such mechanisms in selecting the worst-off and improving their access to care.

What is already known on this subject

- User fees exemption schemes must be implemented to help those unable to pay.
- Exemption systems organised by central administrations do not really work.
- Little is known about community-based exemption schemes in Africa.

What this study adds

- The selection of indigent people using a community-based process in Burkina Faso was feasible, not very costly and appreciated by the stakeholders.
- Health centres had the capacity to take on six times more indigent people than the community selected.
- The selection was very restrictive (only 3/1000) for social (vision of social justice and extreme poverty) and technical reasons (utilisation of endogenous resources and conflict of interest).

Policy implications

- African States could require that a minimum number of indigents be selected by the community on the basis of a percentage of annual profits thanks to user fees schemes.
- Community-based targeting approaches should be tested where support for the worst-off could be funded by a third-party purchaser.

Acknowledgements: This study describes a collaborative process and is therefore based on the work of many people. We would like to thank the *Association Burkinabé de Santé Publique* and all our colleagues in the DHT, head nurses, members of COGESs and CVSs, as well as the people in all the villages who took part in the process. The feasibility study carried out by Dr Yonaba was especially helpful. Critical readings of a preliminary draft of this text by Bruno Meessen, Fabienne Richard and Béatrice Nikiema helped clarify the arguments presented. Thanks to Donna Riley for translation and editing support. The research was accepted by the ethics committees in Burkina Faso and Canada.

Funding: This action research was made possible through funding from the International Development Research Centre (IDRC) in Canada. Valéry Ridde currently holds a research fellowship from the *Fonds de Recherche en Santé du Québec* (FRSQ).

Competing interests: None.

Ethics approval: Canada and Burkina Faso ethics committees.

Provenance and peer review: Not commissioned; externally peer reviewed.

REFERENCES

1. **Gilson L,** Doherty J, Loewenson R, *et al*. *Challenging inequity through health systems. Final report Knowledge Network on Health Systems*. WHO Commission on the Social Determinants of Health. Equinet. CHP. LSHTM 2007:49.
2. **WHO**. *Closing the gap in a generation Health equity through action on the social determinants of health*. Commission on Social Determinants of Health FINAL REPORT. Geneva: World Health Organization, 2008:247.
3. **Mc Pake B,** Hanson K, Mills A. *Implementing the Bamako Initiative in Africa, a review and five case studies*: London School of Hygiene and Tropical Medicine PHP Department Publication 1992.
4. **UNICEF**. *The Bamako Initiative: rebuilding health systems*. New York: UNICEF- The Bamako Initiative Management Unit, 1995:20.
5. **Ridde V.** ''The problem of the worst-off is dealt with after all other issues'': The equity and health policy implementation gap in Burkina Faso. *Soc Sci Med* 2008;**66**:1368–78.
6. **Gilson L,** Kalyalya D, Kuchler F, *et al*. The equity impacts of community financing activities in three African countries. *Int J Health Plann Manage* 2000;**15**:291–317.
7. **Ridde V.** Fees-for-services, cost recovery, and equity in a district of Burkina Faso operating the Bamako Initiative. *Bull World Health Org* 2003;**81**:532–8.
8. **Gilson L,** Kalyalya D, Kuchler F, *et al*. Strategies for promoting equity: experience with community financing in three African countries. *Health Policy* 2001;**58**:37–67.
9. **Noirhomme M,** Thomé J-M. Les fonds d'équité, une stratégie pour améliorer l'accès aux soins des plus pauvres en Afrique? In: Dussault G, Fournier P, Letourmy A, eds. *L'Assurance maladie en Afrique francophone: Améliorer l'accès aux soins et lutter contre la pauvreté*. Washington: Banque mondiale, 2006:431–54.
10. **Waelkens M-P.** *Exemptions for cost recovery systems in sub-Saharan Africa: A review of policies and practices*. London: A dissertation submitted to the Division of International Health, Liverpool School of Tropical Medicine, 1999.
11. **Bitran R,** Giedion U. *Waivers and exemptions for health services in developing countries*. Final draft. World Bank 2002:89.
12. **Bicaba A,** Ouedraogo J, Ki S, *et al*. *Accès aux urgences chirurgicales et équité*. Ouagadougou: ABSP, CRDI, UdM, 2003:109.
13. **Coady D,** Grosh M, Hoddinott J. *Targeting of Transferts in Developing Countries: Review of Lessons and Experience*. Washington: World Bank, IFPRI, 2004.
14. **Conning J,** Kevane M. Community Based Targeting Mechanisms for Social Safety Nets: A Critical Review. *World Dev* 2002;**30**:375–94.
15. **Reason P,** Bradbury H, eds. *Handbook of Action Research. Participative Inquiry and Practice*. London-Thousand Oaks-New Delhi: Sage Publications, 2001.
16. **Scott V,** Stern R, Sanders D, *et al*. Research to action to address inequities: the experience of the Cape Town Equity Gauge. *Int J Equity Health* 2008;**7**:6.
17. **Ministère de la Santé**. *Document national sur le renforcement des soins de santé primaires au Burkina Faso; projet de démarrage de l'Initiative de Bamako*. Ouagadougou: Comité préparatoire de l'Initiative de Bamako, 1992:73.
18. **Galland B,** Fontaine D, Rasidy K. *Évaluer la viabilité des centres de santé. Fascicule 1: Guide méthodologique* ReMeD, AFVP, CIDR, Medicus Mundi France, Coopération Française 1997.
19. **Olivier de Sardan J-P.** *La rigueur du qualitatif. Les contraintes empiriques de l'interprétation socio-anthropologique*. Louvain-la-Neuve: Academia Bruylant, 2008.
20. **Thiede M,** Akweongo P, McIntyre D. Exploring the dimensions of access. In: McIntyre D, Mooney G, eds. *The economics of health equity*. Cambridge: Cambridge University Press, 2007:103–23.
21. **Nikièma B,** Haddad S, Potvin L. Women bargaining to seek healthcare: norms, domestic practives, and implications in rural Burkina Faso. *World Development* 2008;**36**:608–24.
22. **Noirhomme M,** Meessen B, Griffiths F, *et al*. Improving access to hospital care for the poor: comparative analysis of four health equity funds in Cambodia. *Health Policy Plan* 2007;**22**:246–62.
23. **Ir P,** Decoster K, Hardeman W, *et al*. Challenges in identifying the poor: An assessment of household eligibility for Health Equity Fund after four years of pre-identification in Oddar Meanchey, Cambodia. In: Meessen B, Pei X, Criel B, *et al.*, eds. *Health and Social Protection: experiences from Cambodia, China and Lao PDR*. Anvers: Studies in Health Services Organisation & Policy, 23 2008:385–407.
24. **Ridde V.** Equity and health policy in Africa: using concept mapping in Moore (Burkina Faso). *BMC Health Serv Res* 2008;**8**:90.
25. **Yaogo M.** La mobilisation physique et financière dans le cadre du développement local: exemples pris dans les provinces du Bazéga, du Boulgou et du Zoundweogo. *Ouagadougou, ACE/RECIT, Etude n 3 [wwwace-recitorg/rapport_ace/Etude0003pdf]* 2004.
26. **Lagarde M,** Palmer N. *Evidence from systematic reviews to inform decision making regarding financing mechanisms that improve access to health services for poor people*. Geneva: The Alliance for Health Policy and Systems Research, 2006:67.
27. **Meessen B,** Pei X, Criel B, *et al.*, eds. *Health and Social Protection: experiences from Cambodia, China and Lao PDR*. Anvers: Studies in Health Services Organisation & Policy, 2008:23.
28. **Bigdeli M,** Annear PL. Barriers to access and the purchasing function of health equity funds: lessons from Cambodia. *Bull World Health Org* 2009;**87**:560–4.