AfHEA

African Health Economics and Policy Association
Association Africaine d'Economie et de Politiques de Santé

Vers une couverture universelle des soins de santé en Afrique

2ème conférence de AfHEA

Toward universal health coverage in Africa

2nd conference of AfHEA

Hôtel Palm Beach, Saly - Sénégal
15 - 17 Mars 2011

[2011]

Toward universal health coverage in Africa

Palm Beach Hotel, Saly - Sénégal: 15th - 17th March 2011
AfHEA 2nd Conference – 2011

Programme and Abstract Book

Vers une couverture universelle des soins de santé

Hôtel Palm Beach, Saly, Sénégal : 15 – 17 Mars 2011
2ième Conférence de AfHEA – 2011

Livre du programme et résumés des présentations

The 2nd AfHEA Conference is co-sponsored by the Senegalese Ministry of Health
We gratefully acknowledge financial assistance for the conference received from:

La deuxième conférence de AfHEA est co-sponsorisée par le Ministère de la Santé et de la Prévention ; AfHEA est reconnaissante à toutes organisations qui ont donné un appui financier pour la réalisation de cette conférence :

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Second Conference of the African Health Economics and Policy Association (AfHEA)
"Toward universal health coverage in Africa"

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This publication was produce with the financial support of UNAIDS.
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Deuxième Conférence de l'Association Africaine d'Economie et de politique de la santé (AfHEA)
"Vers une couverture universelle des soins de santé"

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Cette publication a été réalisée grâce à l'appui financier de l'UNAIDS.
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10:00 Practical information
Reception of officials

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The detailed agenda

Monday 14 March 2011

Pre-conference session: Training on Measuring Equity and Financial Protection in Health (AfHEA/World Bank/CESAG)

17:00 - 20:00 : Pre-registration

Tuesday 15 March 2011

09:00	Registration
10:00	Participant seating, Practical information Reception of officials

Plenary 1	
10:00 12:00	**Main conference hall: Teranga Official opening ceremony**
12:00 12:30	BREAK / FAMILY PHOTO / POSTER PRESENTATIONS

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Wednesday 16 March 2011

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Thursday 17 March 2011

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Parallel session 1: Towards universal coverage I

PS 01/1
The Progressivity of the Ghanaian National Health Insurance Scheme and the Implications for Achieving Universal Coverage

Eugenia Amporfu; Kwame Nkrumah University of Science and Technology Kumasi, Ghana eamporfu@gmail.com

The Ghanaian National Health Insurance Scheme was introduced to provide access to adequate health care regardless of ability to pay. Even though currently voluntary it is intended to be mandatory in the future.

The ultimate goal of the Scheme then is to provide all residents with access to adequate health care at affordable cost. In other words, the Scheme intends to achieve universal coverage. An important factor for the achievement of universal coverage is that revenue collection be progressive. The purpose of the current study is to examine the progressivity of the Scheme. The Kakwani index method as well as graphical analysis was used.

The results showed that the revenue collection is regressive and the regressiveness does not vary with the revenue collecting agent. The Kakwani index was -0.124. Graphical analysis of the premium verses ability to pay showed that the contribution as a percentage of ability to pay falls with income, implying that the poor contribute a higher percentage of their income towards premium payment, hence confirming the regressive result produced by the Kakwani index.

The paper provides recommendations to improve the regressive system of revenue collection to help achieve universal coverage.

PS 01/2

Vers une couverture maladie universelle : Dix bonnes pratiques du Rwanda à prendre comme exemple dans certains pays en voies de développement

Laurent Musango[1], Ole Doetinchem[2], Diane Muhongerwa[3] et Hertilan Inyarubuga[4]

Le Rwanda a connu plusieurs réformes dans le domaine de la santé depuis les deux dernières décennies. L'une des réformes qui nous a fort intéressé est celui de l'Assurance maladie que nous avons analysé pour en tirés les bonnes pratiques « Leçons apprises ». Dans notre méthodologie d'analyse, nous nous sommes basés a l'expérience de terrains des auteurs et à la littérature disponible pour identifiés les bonnes pratiques qui peuvent être exploitable dans d'autres pays. Les éléments identifiés ont été soumis aux grilles d'évaluation de (Michael Q.Patton, 2001) » et de (David Hercot et all, 2010) pour leurs validations.

Dix bonnes pratiques ont été retenues comme leçons apprises à savoir : Le processus de sélection des indigents et leur prise en charge ; les mécanismes de mobilisation des ressources pour l'octroi des microcrédits susceptibles à faciliter les membres à adhérer aux mutuelles de santé ; la mise en place du cadre légal de fonctionnement des mutuelles de santé ; la décentralisation et la séparation des fonctions ; le renforcement des ressources humaines et la mise en place des organes de gestion ; le renforcement de l'ensemble de prestations offertes aux membres des mutuelles de santé ; la mobilisation des ressources financières additionnelles pour appuyer les initiatives mutualistes ; la sensibilisation de la communauté à l'adhésion aux mutuelles de santé ; la synergie entre les mutuelles de santé et les autres approches de financement de la santé pour améliorer la qualité de soins ainsi que le leadership politique et l'implication des autorités politico-administratives au processus de mutualisation du risque maladie.

Ces éléments ont été des facteurs importants qui ont favorisés la couverture universelle au Rwanda et nous estimons qu'ils doivent être soutenus et renforcés pour maintenir cette initiative qui facilité d'accès aux soins.

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[2] Organisation Mondiale de la Santé, Genève, Suisse

[3] Organisation Mondiale de la Santé, Kigali, Rwanda

[4] Ministère de la Santé, Kigali, Rwanda

PS 01/3

Moving toward universal coverage: the impact of different reform alternatives on equity in financing and utilization of health care in South Africa

John E. Ataguba[1] and Di McIntyre
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Universal health systems have been promoted more recently to replace fragmented financing options and improve access to health care in many countries. While there is general consensus on the desirability of universal coverage, how it can best be achieved in each country is an issue of major debate and ongoing research. In South Africa, the ruling party recently committed to establishing a universal health system. However, there are some concerns about the long-run feasibility and sustainability of the system. Recent studies have shown that the current health system is very inequitable, particularly in terms of delivery. These inequities and the need to redress them are at the heart of the proposed universal system. However, scientific evidence is needed to provide further insights into the equity implications of the proposed reform. This paper therefore attempts to examine the long-run (over a 15 year period) equity implications of the proposed health system reform. Because the proposed reforms are heavily contested by some stakeholders, the precise nature has not been finalised and so three alternative scenarios were simulated. The impact of these scenarios on the progressivity of health financing and the distribution of health care benefits were assessed. The three scenarios include:

- 'Universal coverage' or UC: A comprehensive package of services for all citizens funded by allocations from general tax revenue and a mandatory payroll health tax.
- 'Status quo' or SQ: Leaving the current system largely unchanged, with richer groups being covered by private insurance and the rest by taxfunded health services.

Social health insurance or 'SHI': Extending coverage by private health insurance to more formal sector workers and continuing to fund health services for others from general tax revenue.

The results show that in the long-run, there is considerable improvement in the extent of progressivity of health care financing. This is more so under the UC option than the SQ or SHI. Also there are improvements in the distribution of benefits from using health services under the UC option but not with the SQ.

These show that the choice of option may have different impacts not only related to the resource requirements but also on the distribution of gains.

PS 01/4

Removal of user fees for caesareans and under-fives in northern Sudan: a review of its implementation and effectiveness

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Objectives: In 2008, the Government of Sudan announced that it would provide free curative care for under-fives and caesareans. This policy was linked to the government's 2007 health sector strategy, which aims to achieve progress towards the Millennium Development Goals (MDGs), and aimed to increase and reduce disparities in access to care.
In 2010, the Federal Ministry of Health undertook a review of the policy. Its objective was to assess its implementation to date and to provide recommendations which would strengthen its future design, impact and sustainability, as well as its fit with other health financing strategies.
Design*:* The review took place from January to June of 2010 at national level and in five focal states (Red Sea, Kassala, Blue Nile, South Kordofan and Khartoum). Policy implementation was assessed using four research tools: key informant interviews; exit interviews; a facility survey; and analysis of facility finances and the cost of the package of care. 105 key informants were interviewed, purposively chosen at national, state and facility levels. Financial analysis was carried out in two hospitals and two health centres per state, and two national-level hospitals (22 facilities in total), while the facility survey covered 27 facilities (12 hospitals and 15 health centres). 450 exit interviews were carried out, focussing on carers of sick children and women who had recently delivered.
Results: Preliminary analysis suggests a number of key concerns about implementation to date. These include unclear specification of the exact target group and package of care; variable interpretation of the policy by different states; and unclear relationships between different free care initiatives, as well as between the national health insurance coverage and free care. Inadequate overall funding has also led to restricted application of the policy, with outpatients and primary care commonly being de-prioritised. This risks compounding the problem of under-utilisation and under-funding of primary care in general in Sudan. There is also concern about the high rate of elective caesareans, and whether the policy may encourage inappropriate medicalisation of deliveries.
Conclusions: This review contributes to the growing body of literature on the selective removal of user fees for priority services. It indicates the range of challenges to effective implementation, including strategic, financial, and organisational. Some of these are particular to the health financing system in Sudan, but many are shared, and indicate important lessons for improving access to and quality of care for women and children in Africa.

PS 01/5

Removal of user fees for maternal and child health services in South East Nigeria: Experiences of the community and Health care providers

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Objectives: To determine the experiences and the perceptions of the community and health care providers on the removal of user fees for maternal and child health services in Southeast Nigeria.

Methods: This was a cross sectional descriptive study carried out in Enugu state Southeast Nigeria. Pre tested interviewer administered questionnaire survey with 50 healthcare providers and 150 women of reproductive age were used to elicit information on the awareness, attitude, utilization and factors affecting utilization of maternal and child health services and willingness to continue use of this service.

Results: The findings revealed that among the women, there was a high level of awareness of the free maternal and child health services with antenatal and immunization services being the most utilized. Factors affecting utilization were lack of approval from spouse, inadequate skilled personnel, long waiting time and distance to the health facility. There was high willingness to continue use of maternal and child health services due to availability of drugs. Although the health workers were receptive of the free services, they opined that their workload had increased without any corresponding increase in their remuneration and that patients were making unnecessary visits to the health facilities and demand on drugs (moral hazard).

Conclusion/Policy implications: Removal of user fees for maternal and child health services have enhanced utilization of health services. However this has greatly increased the workload of health providers. There is need therefore for provision of adequate personnel and infrastructure to cater for this increase. In the interim there should be better remuneration of health workers to motivate them to continue providing health services despite the workload. There is also need to check the reported moral hazards that have been created by the removal of fees.

Acknowledgements We thank the all the participants in this study. We are also grateful to the Enugu state Ministry of Health for their support and to the College of Medicine, University of Nigeria Enugu-campus for providing the enabling environment to conduct this research.

PS 01/6
Which way to reduce or minimise Out of Pocket Expenses in Africa? Lessons in replacing user fees from Ghana and Uganda

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Majority of countries in the African Region rely heavily on private sources for financing health services. These high Out of Pocket (OOP) expenditures have increasingly been recognised by policy makers and experts as inefficient and inequitable, posing a particularly severe burden on the poorest and most vulnerable members of the population. Further impoverishment of households and incurring of catastrophic health expenditures as a result of paying for health services has been documented.

In recent years, efforts to replace user fees or OOPs at the point of service in Africa have taken two principal forms: abolition of user fees for access to certain priority health services (for all or targeted groups of the population), or implementation of health insurance systems designed to replace point of service payments with risk pooling mechanisms. Uganda represents the first kind and Ghana the second. Both systems, however, rely either totally or largely on tax funding.

We examine the experience of these two countries under their chosen strategies and ask to what extent they have succeeded in protecting their populations from the financial burden of illness as well as in attaining other critical health sector goals: equity, resource mobilisation (including sustainability) and quality (as measured by user satisfaction surveys.

The data sources for the analysis are Demographic and Health Surveys, other Household Surveys including Living Standards Surveys, undertaken since the policies came into effect. These are supplemented by the results of other relevant research and routine monitoring systems bearing on these themes.

Our study finds that, from the point of view of financial protection for populations, it might be more helpful to focus on removing or minimising the unacceptably high OOPs in Africa rather than on the interminable debate concerning the burden of user fees in health as such. In terms of the other health sector goals, there are advantages and challenges associated with each of the two principal methods by which the two case countries have gone about replacing high OOP spending. The extent to which each method contributes to the stated health goals depends on strong political leadership, the reform design, the resources committed to implementation, addressing system wide challenges alongside reform implementation and; stakeholder engagement and agreement/participation.

Parallel session 1: Covering those outside the formal employment sector I

PS 01/7
Efficiency, equity and feasibility of strategies to identify the poor: An application to premium exemptions under National Health Insurance in Ghana

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Objectives:
This paper outlines the potential strategies to identify the poor, and assesses their feasibility, efficiency and equity. Analyses are illustrated for the case of premium exemptions under National Health Insurance (NHI) in Ghana.

Methods:
A literature search in Medline search was performed to identify strategies to identify the poor. Models were developed including information on demography and poverty, and costs and errors of in- and exclusion of these strategies in two regions in Ghana.

Results:
Proxy means testing (PMT), participatory welfare ranking (PWR), and geographic targeting (GT) are potentially useful strategies to identify the poor, and vary in terms of their efficiency, equity and feasibility. Costs to exempt one poor individual range between US$11.63 and US$66.67, and strategies may exclude up to 25% of the poor. Feasibility of strategies is dependent on their aptness in rural/urban settings, and administrative capacity to implement. A decision framework summarizes the above information to guide policy making.

Conclusions:
We recommend PMT as an optimal strategy in relative low poverty incidence urbanized settings, PWR as an optimal strategy in relative low poverty incidence rural settings, and GT as an optimal strategy in high incidence poverty settings. This paper holds important lessons not only for NHI in Ghana but also for other countries implementing exemption policies.

PS 01/8

Scaling up Community Based Health Insurance Scheme: Nigerian Experience towards Universal Coverage

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In order to address the challenges of health care financing for universal financial protection in Nigeria, governments at all levels identified the need to support the scaling-up of risk pooling mechanisms in the health sector and the development and expansion of community based health insurance. The current scheme in Nigeria started with a mandatory health insurance through National Health Insurance Scheme which is the Government Agency with the primary responsibility of extending health insurance to all Nigerians. But this has only had a coverage of about 70% of Federal Civil Servants which translates to less than 3% of the entire population. It is therefore apparent that there is a need to provide sufficient financial risk protection to the rest of the uncovered population against the cost of health care. As a prerequisite for scaling up CBHIS, there is a need to conduct an inventory of all CBHIS and other social solidarity organization in the country. The objectives of the inventory study are to: analyze the strength and weaknesses of existing CBHI practices, identify other social solidarity organizations with similar characteristics with the CBHIS and examine the potentials and policy implications for transforming them into viable schemes.

The inventory covered CBHI, CSO and other social solidarity groups in the 36 states of Nigeria. The units of observation of the inventory included all micro health insurance schemes owned and managed by community members or local health care providers, state-and-community partnerships, and micro health insurance-and-microfinance partnerships in the country. Through random sampling, information was collected on 25 units of CSO and other social solidarity groups at each of the 774 Local Governments in the country.

The variables of interest included among others: socio-economic characteristics of the target population, benefit package, contribution policies, membership policies, risk management measures, contractual relationship with health care providers, organizational structure and administrative bodies, evolution of number of members, evolution of number of beneficiaries, performance in revenue collection, administrative and technical expenditures, support organizations and modes of interventions, strength and weaknesses.

Preliminary results from ongoing study show large numbers and wide coverage of social solidarity groups with high social capital content. This paper highlights the important stewardship role of governments in expanding widespread coverage to her teeming population. Further econometric analysis will reveal more interesting findings including factors essential for scaling up and sustainability of the schemes.

PS 01/9

Expérience du financement basé sur la performance dans le diocèse de Batouri au Cameroun : des défis pour le passage à l'échelle

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But : documenter l'expérience de payement basé sur la performance (FBP) dans les 4 centres de santé catholiques (CSC) diocèse de Batouri et tirer les leçons pour le passage à l'échelle préconisé au Cameroun.

Objectifs : (i) Décrire le système de FBP ; (ii) Evaluer les effets du FBP sur les indicateurs des CSC ; (iii) Identifier les goulots d'étranglement de cette stratégie pour l'accès universel des populations aux soins ; (iv) Proposer des pistes stratégiques pour l'amélioration du FBP et de l'accès des populations aux soins

Méthodes : Les 14 outputs inclus dans le FBP et produits de juin 2006 (date d'introduction du FBP) à juin 2010 par les 4 centres de santé ont été analysés et comparés à l'année 2004. Des entretiens avec des acteurs clés (nationaux et internationaux) de la mise en œuvre du PBF dans le diocèse de Batouri et des bénéficiaires (populations, membres des comités de gestion des centres de santé) ont été effectués.

Résultats : Quatorze indicateurs ont été inclus dans le paquet d'achat des soins. Une amélioration significative de la quantité et de la qualité des outputs produits par les centres de santé a été observée pour les soins curatifs, préventifs et promotionnels. Le taux d'utilisation en consultation curative a augmenté de 38% entre 2004 et 2007, puis de 2,7% entre 2007 et 2008 et a baissé de 4,5% entre 2008 et 2009. Les cas de femmes enceintes ayant suivies au moins 3 consultations prénatales (CPN), d'accouchements assistés, d'enfants complètement vaccinés, de moustiquaires ré-imprégnées et de personnes testées au VIH ont connu une augmentation significative entre 2004 et 2007. Par contre, une stabilisation des ces outputs a été observée à partir de 2009, soit 3 ans après la mise en œuvre du projet.
Les acteurs notent une gestion participative et efficiente des ressources. La sélectivité des indicateurs payés par le FBP et le faible coût d'achat de ces soins limitent le volume de financement alloué aux formations sanitaires. L'essentiel (70%) des recettes des CSC provient du recouvrement des coûts et les mécanismes de contrôle et de suivi génèrent les coûts de transaction élevés, et limitent l'accès des populations aux soins. La revue des outputs inclus dans le FBP et leurs coûts d'achat, et l'allègement des mécanismes de contrôle sont indispensables pour la réduction des paiements directs, le passage à l'échelle et le renforcement de l'accès des populations aux soins.

PS 01/10
Conditions conducive to the development of social health insurance in Africa, with particular reference to Nigeria

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Aim and objectives:
The aim is to identify the conditions conducive to the development of social health insurance in Africa. The objectives are to extend the framework developed by Carrin and James (2005) and apply this analysis to the National Health Insurance Scheme (NHIS) in Nigeria.

Methods:
Carrin and James (2005) have developed a framework for analysing the progress of social health insurance schemes against twelve process based indicators. We have extended this framework to incorporate the transitional role of community based health insurance (CBHI), the wider performance of the health care system and the importance of total health expenditure, and applied the analysis to Nigeria.

Key findings:
The performance of the NHIS in the core functions of revenue collection, pooling and purchasing has been poor. Population coverage is low. Small prepayment proportions and high out-of-pocket payments suggest that many people are still expending a major part of their income on health care. The arrangements for risk pooling are not adequately addressed, increasing the likelihood of pool fragmentation. The benefit packages do not appear to have been subject to analysis of cost effectiveness or explicit equity criteria. There are high administrative costs although competition among health maintenance organisations (HMOs) may drive them down in the long run. While some of these limitations are due to the design of the NHIS, they also reflect the limited number of successful CBHI schemes in the urban informal sector and among rural communities on which to build, slow progress towards a more stable political environment and competent administrative structure, competition from established private insurers, and Nigeria's low per capita income.

Carrin, G. and James, C. (2005) Key performance indicators for the implementation of social health insurance, Appl Health Econ Health Policy, 4(1), 15-22.

PS 01/11
How equitable is the Kenyan health system?

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Introduction: Achieving equity in health care remains an important goal of health systems worldwide. Many governments and international organizations aim at ensuring that both the rich and the poor benefit from health interventions and that spending on health care and other social services is pro-poor. Spending on health care and has been justified as an instrument for redistribution of welfare, especially in settings where the poor receive a larger share of benefits that is proportionate to their need for care. Unless services are well targeted to reach poor, universal coverage is unlikely to be achieved in many African countries. This study analyses the distribution of health care benefits among socio-economic groups in Kenya; shows how the distribution has changed over time, and identifies policy issues that should be addressed in order to ensure that the poorest population benefit from a universal health system.

Methods: Data from two nationally representative surveys conducted in 2003 and 2007 were used in the analysis (n=8,844 households). Benefit incidence analysis method was applied to estimate the share of benefits derived by different socio-economic status group. Data were analysed for both public and private health care services; and for both inpatient and outpatient care.

Results: For public healthcare services, primary health care services (dispensaries and health centres) benefited the poor more than the rich. Both outpatient and inpatient services at all hospital levels were pro-rich, although the gap between the rich and poor was wider for inpatient care and for the utilization of teaching and referral hospitals. Private health care services are pro-rich except for faith based facilities where primary level care is pro-poor. When total health care benefits (irrespective of level of care) are analysed, the richest 40% receive over 50% share of benefits for public and private sector. In general, the gap between the poor and the rich was narrower in 2007 than in 2003, suggesting that there was some improvement in targeting the poor between these two periods.

Conclusion: The Kenyan health system is highly inequitable. The Kenyan government should carefully reconsider mechanisms to address access barriers that prevent the poor from accessing health care services. Attention should particularly be given to hospital care level, since primary health services are already pro-poor. This is particularly important if the Kenyan health system is going to make any progress towards universal coverage.

PS 01/12

Equity of National Health Insurance in Ghana: who is enrolling, who is not and why?

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Objective:
The primary aim of our study is to evaluate equity in enrolment in the National Health Insurance Scheme (NHIS) in Ghana and whether NHIS is reaching the poor. Second, we assess the determinants of enrolment across socio-economic groups specifically looking at how different predisposing (age, sex, family size, health status), enabling (employment, education, income etc) and social factors (perceptions) affect household decision to enrol and remain in the NHIS. Third, we examine how policy options should vary for each group.

Methods:
We carried out a household survey among 3,301 households and 13,865 individuals. All households were classified into five socio-economic quintiles on the basis of consumption expenditure data. Equity in enrollment was assessed by comparing enrolment between these quintiles. The determinants of enrolling in and dropping out from NHIS were assessed using a multinomial logit model. We use PCA to evaluate respondent's perceptions relating to the three stakeholders of NHIS: providers, schemes and community attributes in the model.

Results:
We find evidence of inequity in enrollment in the NHIS and significant differences in determinants of current and previous enrollment across socio-economic quintiles. While the odds of enrolling and remaining in the scheme increase with positive perceptions on technical quality of care, NHIS benefits, NHIS convenience of administration and community health beliefs and attitudes, they decrease with negative perceptions of price of NHIS, provider attitudes and peer pressure.

Conclusions:
This paper demonstrates that the NHIS is not reaching the poor. Both current and previous enrolment is influenced by differences in perceptions and behaviour between the rich and poor. Policy makers need to recognize that extending enrolment will require recognition of all these complex factors as precursors to more effective interventions to stimulate enrolment.

PS 01/13
Demand for Care in South Africa: Insights into a National Health Insurance System

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Introduction and Objective:
The South African government is in the process of implementing a health sector reform that includes the establishment of a National Health Insurance (NHI) system. Key features of the proposed NHI system include mandatory contribution and freedom of choice in the utilisation of health services provided by both the public and private sectors. The objective of this study is to analyse trends in demand for public and private health care services with a view to identifying key factors that may facilitate or impede the successful implementation of a NHI with the above listed features.

Methods and Results:
The study uses three waves of samples of adult members of national household survey data (2002, 2006 and 2008 General Household Surveys) to analyse the choice people make between public and private providers when seeking health care. Multinomial logit models are used to estimate the choice of public, private care and a third option of deciding not to seek care with a formal health care provider; when an individual is ill or injured. The analysis controls for type of illness and geographic area. The results show that higher levels of education, membership of private medical schemes, and socio-economic status are all significantly associated with the preference for private health care over public health care. The reverse is the case for 'age'. An interesting outcome of the study is in recent times, socio-economic status as measured by an asset index no longer has an impact on the choice of whether to use a public or private provider. This suggests that there is no longer a pure income effect in decision making between the public and private sector. Following the theory on the demand for private health insurance, this indicates a reduction in substitutability between public and private sector health care services. Further analysis of quality indicators between the public and private sector service shows that the private sector in general has consistently maintained a much higher level of quality than the public sector. These results have far reaching implications for an NHI with the features described above.

Recommendations:
The study recommends that the quality gap between the public and private sector be reduced in order to efficiently allocate resources to both public and private sector providers under an NHI scenario. Under the current dispensation, implementing an NHI system will result in a disproportionately higher amount of resource flowing to the private sector and the potential for the worseneing of horizontal inequity.

PS 01/14

Benefit incidence of national health insurance scheme in the Southeast Nigeria: Implications for financial risk protection against health care costs

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Aim and objectives:
The study aimed at describing the health insurance arrangements, services covered, role of insurer, degree of cost sharing and population that was covered. The objectives of the study were to investigate the insurance benefits of the scheme among the members as well as the degree of risk protection provided by the scheme to its members.

Methods:
Data from the questionnaires were entered using Epi Info and later transferred to SPSS and STATA soft wares for analysis. There were cost computations to determine benefit incidence through utilization levels and net unit cost. The specific key data analyses for each of the objectives were done using cross-tabulations, non-parametric tests and multivariate analysis.

Findings:
The study showed the level of benefit provided by the scheme to beneficiaries. These resulted in a total of 435 outpatient visits of which 243 (55.86%) were covered by the NHIS. The remainder constitutes "out-of-plan" utilization. For those visits which were covered by insurance, the mean insurance benefit per visit was N2737.92 ($18.25), and the mean benefit per beneficiary was N1.80 ($0.01). Out of pocket expenditure on covered visit was N2174.00 ($14.49). For those who used non-insured services, the mean out-of-pocket expenditure per visit was N4344.23 ($28.96). A total of 62 admissions and 27 deliveries were reported in the 12 months prior to the study. 96.77% of the admissions and 92.59% deliveries were covered by the NHIS. For those hospitalizations that were covered by insurance, the mean insurance benefit per admission was N4519.40 ($30.13). Mean out-of-pocket expenditure per covered hospitalization was N23,276.01 ($155.17) , and for those who used non-insured services, the mean out-of-pocket expenditure was N39,143.40 ($260.96).For those deliveries that were covered by insurance, the mean insurance benefit per delivery was N25,869.05 ($172.46). Mean out-of-pocket expenditure per covered delivery was N19130.95 ($127.54), and for those who used non-insured services, the mean out-of-pocket expenditure was N24800 ($165.33).

Parallel session 2: Improved domestic public funding of health care

PS 02/1
Fonds d'achat de service de santé, une meilleure stratégie pour financer les programmes de santé

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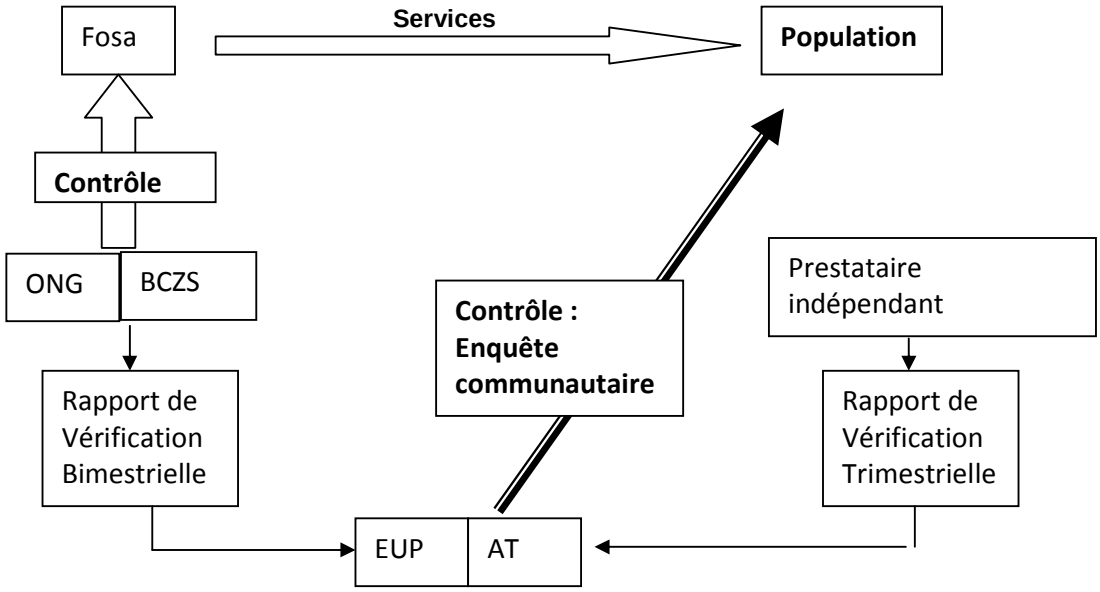
OBJET DE L'ETUDE/PROBLEMATIQUE.

Traditionnellement, le financement du secteur santé est alloué à l'offre de soins, dans l'idée que le subside au producteur va lui permettre de fournir des soins de qualité à un prix accessible au plus grand nombre. En réalité, le plus souvent, malgré la mise à disposition d'intrants en suffisance, l'accessibilité des formations sanitaires était très limitée. Le FASS peut contribuer à une amélioration de l'accessibilité et secondairement à une amélioration de la qualité de prestation par différents effets ; (1) en usant des critères d'éligibilité des Fosa et des prestations subventionnées, le FASS incite la Fosa à se conformer à ces critères, (2) à travers le paiement proportionnel aux prestations rendues, le FASS encourage l'effort supplémentaire et (3) sous condition d'un accompagnement technique adéquat, les recettes supplémentaires du FASS peuvent mener à un renforcement de la capacité technique des Fosa et une amélioration de la qualité perçue. Ce mécanisme décentralise la gestion financière, le choix de l'allocation des ressources étant réalisé par les organes de gestion de la Fosa. Cette approche complète l'approche traditionnelle de l'allocation centralisée des ressources qui à elle seule reste inefficiente.

FASS poursuit les objectifs suivant :

- Améliorer/accroitre la performance de la fourniture de soins des Fosa
- Rationaliser/augmenter le financement du système de santé
- Améliorer l'accessibilité financière des usagers qui reçoivent des services préventifs gratuits et curatifs moyennant le paiement d'un ticket modérateur.

1. Méthodes/description du programme.



2. Résultats obtenus/leçons tirées

Figure n°1 : Evolution du taux d'utilisation curati f de service de santé.

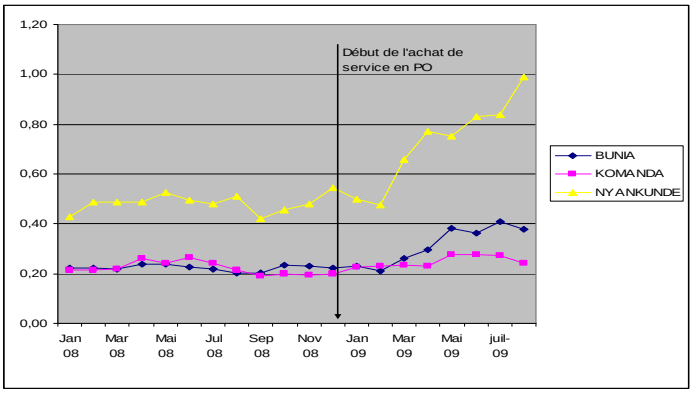
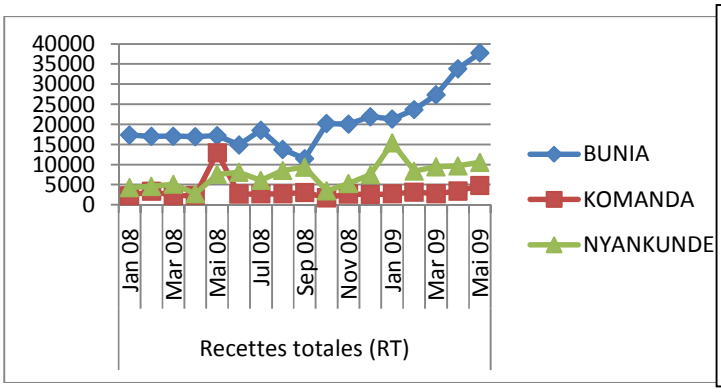


Figure n°2 : Evolution des Recettes totales des For mations sanitaires.



1. CONCLUSION/PROCHAINES ETAPES.

- Une nouvelle expérience à développer avec d'autres partenaires
- Un outil de financement efficace pour améliorer le programme de santé
- Mener des études scientifiques pour documenter ces nouvelles expériences

PS 02/2

Examining incidence of catastrophic health expenditures on different healthcare services in Nigeria

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Objective: There is paucity of existing information of socio-economic and other differences in catastrophic health spending in Nigeria and in many sub-Saharan African countries. The specific objective was to determine the level of catastrophic healthcare payments and their distribution across socioeconomic groups and use the findings to inform policy and implementation of interventions that will improve decrease the incidence of catastrophic health spending.

Methods: The study took place in 2 purposively selected Local Government Areas (LGA) (1 rural and 1 urban) in each of Enugu and Anambra states. Data was collected using pre-tested and structured interviewer-administered questionnaires administered in a household survey to 4873 households. A one-month expenditure recall period was used in the survey. A number of different indicators and threshold levels were explored for determining the incidence of catastrophic health expenditures. Three scenarios were explored for determining incidence of catastrophic health expenditures and these were: monthly household health expenditure/ monthly non-food expenditure (>40%, >10% and >5%); OOPS/monthly non-food expenditure (>40% and >5%); in-patient department stays (IPD) and out-patient department visits (OPD) in public facilities /monthly non-food expenditure (>40% and >5%). Due to the high incidence of poverty in Nigeria, a definitive catastrophic threshold of 5% of non-food expenditures should ideally be used in Nigeria. However, the threshold of 40% was used in order for the results to be comparable to international literature for the main interpretation of catastrophic spending. A definitive threshold of 40% of non-food expenditure was used in order for the results to be comparable to international literature for the main interpretation of catastrophic spending. Principal components analysis (PCA) was used to create a socio-economic status (SES) index using information of the households' ownership of some assets, together with the weekly household cost of food. The index was used to divide the households into SES quintiles respectively. Concentration indices were computed for all SES differences. Note: 120 Naira = US$1.00

Results: The average household expenditures per month 2353.8 Naira for combined OPD and IPD services. The average monthly household expenditure on OPD was 1809.0 Naira, whilst it was 609.6 Naira for IPD. Higher expenditures were incurred by urbanites, residents of Anambra state and the better-off SES groups. The overall

incidence of catastrophic expenditures for the different scenarios were 26.7%, 47.7 %, and 57.1% for monthly household health expenditure as a proportion of total non-food expenditures at >40%, >10% and >5% threshold levels. The poorer SES quintiles and rural dwellers incurred more catastrophic health expenditures.

Conclusion: There was lack of financial risk protection for healthcare in the study area and it was the worse-off people (the poorest SES and rural dwellers) that experienced the highest burden of health expenditure. Policy makers and programme managers in the two states should institute health reform mechanisms for developing, implementing and scaling-up financial risk protection mechanisms in the two states.

PS 02/3
Health care financing in Cameroon: Trends analysis and overview of main challenges?

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Aim: To analyze the evolution of health system financing in Cameroon in order to provide avenues for improving universal access to health care.
Objectives: the objectives are to:

- Describe the trends of health system financing indicators from 1995 to 2008;
- Analyze the perception of key informants of the national health system on strengths and weaknesses of the health care financing, and ways to move forward;
- Propose avenues for improving financial access to health care to all;

Method: The reference generic framework for health financing was used to analyze data from 1995 to 2008 of the national health account, finance laws, WHO online database. Nominal disbursements in FCFA were converted in $US using OECD exchange rate. Adjustments were made using GDP deflator for the GDP and consumption price index for other health expenditure (constant 2005). In addition, we used semi-structured questionnaire to conduct interview of some key informants at central (5), regional (10) and district (40) levels of the health system.

Results: From 1995 to 2008, health expenditure increased by 159% in real terms, passing from almost 444 million $US constant 2005 to more than 1.150 billion $US constant 2005. As GDP share, these expenses remain constant around 4.5%. Private expenditure varies between 75-87% of total health disbursement. Out-of-pocket payments constitute almost the totality of these private spending, and contribute for at least 94% every year since 1996. For each extra dollar per capita spent in health, there is 9 times more increase in private expenditure compared to public expenditure. Regarding public health expenditure per capita, the progress is very slight and marginal, and lies between 4 to 7 $US constant 2005. Up to 2006, the budget consumption rate of the Ministry of Public Health remained low (less than 60%). Poor budget allocation and corruption are the most important bottlenecks reported by stakeholders as main causes of the high out-of-pocket payment and the low efficiency and effectiveness of the spending.

Conclusion: Health financing system in Cameroon is highly inefficient leading to poor protection of the poor. Therefore, catastrophic health expenditures and iatrogenic poverty is more likely to occur. The consequence is the exclusion of the poor from access to health care. The main challenges are the set-up and extension of a viable prepayment mechanism, the reduction of out-of-pocket payment and the equitable allocation of resources.

PS 02/4

Modelling the resource requirements and possible funding mechanisms for universal health coverage: A case study of South Africa

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A key concern of policy-makers when moving towards a universal health system is whether or not it will be affordable and sustainable for the country and how the necessary funding will be generated. This paper presents the results of modelling the resource requirements and funding sources for a universal health system in South Africa and of alternative health financing reforms.

The model projecting resource requirements comprises 3 main variables:

- Population, disaggregated by age and sex to account for different health service utilisation by young children, the elderly and women of childbearing age.
- Utilisation rates for each age, sex group for different categories of health services (e.g. clinics, district hospital outpatient and inpatient, etc.).
- Unit costs of each category of health services.

Various assumptions were made about changes in each of these variables over a 15 year period, based on the best available data. Extensive sensitivity analyses were undertaken to assess the impact of changes in assumptions about these variables.

A model was developed for each of three scenarios (based on current policy debates):

- 'Universal coverage': A comprehensive package of services for all citizens funded by allocations from general tax revenue and a mandatory payroll health tax.
- 'Status quo': Leaving the current system largely unchanged, with richer groups being covered by private insurance and the rest by tax-funded health services.
- Social health insurance or 'SHI': Extending coverage by private health insurance to more formal sector workers and continuing to fund health services for others from general tax revenue.

Given the high burden of HIV/AIDS in South Africa, a separate Markov model was used to estimate the resource requirements of a universal antiretroviral treatment (ART) program. Revenue was estimated from information on the number of formal sector workers, current income tax revenue, predicted GDP growth and through assuming a constant government expenditure to GDP ratio.

Results indicate that universal coverage would not change the overall level of health care expenditure as a percentage of GDP, but there would be a relative shift of funding from private insurance to public funding. The SHI scenario would result in dramatic increases in spending on health care as a percentage of GDP. The status quo scenario results in a small increase in health care spending relative to GDP, but with increasing divergence in resourcing between those covered by private insurance and those reliant on tax-funded services.

Parallel session 2: Financing issues: specific groups or services

PS 02/5

Overcoming Financial Obstacles to Reproductive Health Care: Experiences with Free Care and Health Insurance

A Policy Brief of the Ministerial Leadership Initiative for Global Health (MLI)
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Aim and Objectives: Developing countries face significant challenges in implementing health financing reforms including scarce resources, a large informal sector and lackluster political support. As countries try to build cohesive financing strategies in response to these challenges, they face tradeoffs between targeting short-term improvements in key indicators and sustaining larger systemic goals. While a variety of tools are being employed to reduce the financial burden on households for health care, two of the most prominent are the expansion of free services policies and the expansion of health insurance.

This work aims to examine recent experience with such initiatives and their relative strengths and weaknesses and to establish a context for exchange and ongoing cross-learning between countries as these financing strategies evolve and progress.

Methods: This paper explores the reproductive health financing experiences of 5 MLI countries (Ethiopia, Mali, Nepal, Senegal and Sierra Leone) in addition to highlighting models from Ghana and Rwanda. It draw lessons from the literature about how and when to use such policy tools, alone or in conjunction with other tools, to reduce financial barriers to reproductive health (RH) care and to build a sustainable national health financing strategy.

Key Findings: The paper asserts that although reproductive health financing is only one component of an overall health financing strategy, focusing on vulnerable populations like women and children can help build momentum for a national health financing dialogue, which can help lay the groundwork for movement toward universal coverage. Additionally, vertical financing programs can provide important positive and negative lessons for any potential scale up of financing policies. For example, the initial results of a free C-section initiative in Mali indicate that the program required a more effective public communication strategy and complementary measures to ease transportation barriers in order to achieve its objectives. These findings should not only influence future iterations of the C-section initiative, but can be applied more broadly to policy formulation across the health sector. Similarly, when the Government of Senegal laid out its roadmap for achieving universal coverage, it drew heavily on the implementation challenges affecting its free reproductive healthcare initiatives.

Although vertical reforms are not always the best financing option, the many reproductive health financing reforms that have already been implemented provide a rich geography of experience that this work analyzes and mines to better navigate the path toward universal health coverage.

PS 02/6
Funding and the access to maternal and child health in Tanzania

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Background:
One of the major challenges facing Tanzania and similar poor developing countries is shortage of finances needed to facilitate health services including maternal and child health to achieve Millennium goal number 4 & 5. 75% of under than five children in Tanzania are vulnerable of pneumonia, diarrhea, measles, fever and malnutrition and reproductive women are vulnerable of HIV/AIDS, malaria and reproductive disorders. These two groups needs cover about 40% of country's population and it gets less than 15% annual budget allocation from Comprehensive Council Health Plan (CCHP). To reduce burden of these diseases from mother and child, the fund allocated to this group has to reflect the size of burden over time to improve survivals.

Method:
We did an analysis of council health plans and expenditures for years 2007/08, 2008/09 and 2009/10 on proportional of fund allocated for maternal and under five child health by using 2007/08 base year. Planned and expenditures data was gathered from 3 districts, Kilombero, Ulanga and Rufiji. The data was grouped in form of source of fund, allocation and expenditure category.

Results:
Between 2007/08 and 2009/10 there was an increase in funding allocated for maternal and under five children health services in the districts. In Ulanga funds allocated to facilitate maternal health rose by 945% and child health by 70% between 2007/08 and 2009/10 of which 35% was government funded and 65% was donor's funded. In Kilombero funds allocated to facilitate maternal rose by 209% and child health by 179% between 2007/08 and 2009/10 of which 85% was government funded and 15% was donor's funded. And in Rufiji funds allocated to facilitate maternal rose by 45% and child health by 165% between 2007/08 and 2009/10 of which 59% was government funded and 41% was donor's funded.

Conclusion:
For improved maternal and under five children health services particularly in rural areas well financed maternal and child health services will result into reduction of maternal and under five child mortality. With massive effort from government to achieve universal coverage on improved maternal and under five health services, governments and donor's fund contributes in facilitating it.

PS 02/7
Out-Of-Pocket spendings on TB and HIV infections in Middle-Belt, Nigeria

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The production resources of the rural households in Nigeria appear to be fast depleting as a result of human immunodeficiency virus (HIV) and tuberculosis (TB) coinfection. To investigate this, 500 patients comprising 250 males and 250 females (mean age = 37.9 $\pm$15.9 years) seeking medical attention in health-care institutions in Middle Belt, Nigeria, were screened for TB and HIV infections. The out-of-pocket spending as a result of the ill-health in these persons was also investigated. The rates of infections were as follows: TB (26.6%, 133), HIV (15.8%, 79), and TB/HIV co-infection (5.2%, 26). The infections had no preference for either sex and were same in males as in females (t_{TB} = -1.112, t_{HIV} = 1.103; $p>0.05$). For example, 28.8% of males and 24.4% of females were positive for the acid-fast-bacillus (AFB+) indicating probable TB infection; and 14.0% of males and 17.6% of females HIV positive. The infections showed age and occupational predilections: those within the 20-29 year age group had the highest rate of TB (42.4%, n=125) and HIV (20.0%, n=125) infections. In addition, students seemed to be afflicted with tuberculosis more than any other occupational group (38.8%, n=103; F=3.292, $p<0.05$). A larger proportion of the persons infected with TB, HIV, or both infections reported that they had spent a lot of money (>US $ 33.33) on the disease(s), and most of them claimed that they were receiving assistance in both cash and kind from parents and relations rather than from spouses (for those are married)($p<0.05$). Most of the infected persons reported that they stopped work, many of them for as long as one year, as a result of ill-health. Interventions to boost the economic base of the rural inhabitants will go a long way to alleviate the sufferings of HIV and tuberculosis patients in rural Nigeria.

Keywords: human immunodeficiency virus, tuberculosis coinfection, rural Nigeria, Middle-Belt Nigeria

PS 02/8
Inequities in child delivery by skilled health providers in Namibia: A decomposition analysis

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Background

In Namibia, significant inequities are seen in delivery by skilled providers despite high service coverage (>80%). The health system, an important social determinant of health in its own right, is also influenced by the other social determinants. It is thus imperative to identify the determinants of inequities in delivery by skilled providers in order to design multi-sectoral, evidence-based policies and interventions.

Objective

To identify the social determinants of inequities in child delivery by skilled health providers in Namibia and propose appropriate evidence-based policy recommendations.

Methods

The conceptual framework of the study is based on the framework of the WHO Commission on Social Determinants of Health. Data from Namibia Demographic and Health Survey of 2006-2007 was analyzed using a decomposable concentration index in order to assess the degree of inequity and identify the determinants of the inequities. Analysis was done using STATA 10 statistical software and MS Excel.

Results

The concentration index of delivery by skilled health providers indicates statistically significant inequities in favour of the relatively wealthier segment of the population. The rate of delivery by skilled providers is higher in urban areas, educated mothers, and those with insurance coverage. Furthermore, significant regional variations are observed – 63% of deliveries attended to by skilled health providers in the Kunene Region as opposed to 91% in the Hardap Region. The decomposition analysis shows that wealth (as measured by asset indices), education of the mother, residence in urban areas and insurance coverage explain most of the inequities in delivery by skilled health providers.

Conclusion

In Namibia addressing inequities in child delivery by skilled health providers and consequently reversing the upward trend of the maternal mortality ratio to achieve the target of MDG 5 requires a multi-sectoral action on the social determinants of access to delivery services.

Parallel session 2: Purchasing of services (benefit packages, provider payment mechanisms) I

PS 02/9
The implications of service level agreements on access and utilisation of child and reproductive health care Services at CHAM institutions in Malawi

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Health and health care provision are among the largest problems in Malawi, but the public health sector is inadequate and under-funded, leading to an acute shortage of skilled personnel, essential medicines, medical equipment and other medical supplies. These factors among others are thought to have impinged access and utilisation of health care service by people from low income communities and contributed to the higher maternal death rate, a decline in primary health care coverage and a drop of life expectancy at birth from 46 years in 1996 to 37.5 years in 2003.

To minimise the problem of accessing and utilising health care services as outlined above, the Malawi government in 2002 embarked on an innovative financing mechanism called the Service Level Agreement (SLA) with Christian Health Association of Malawi (CHAM) institutions that are located in low income communities. Since the inception of the SLA in 2002, there have been reports from district health officers and CHAM institutions on their functioning. The reports suggest that the success of SLA in improving access and utilisation of child and maternal health care services is varied. This implies that the flow of funds from government to CHAM institutions through SLA may not have significantly improved access and utilisation as envisaged.

The research aims were to evaluate the implications of service level agreements on access and utilisation of healthcare services at CHAM institutions. The rationale was that the information gathered through the project could inform policy decision on scaling up of SLA's to include all conditions under the Malawi Essential Health Package (EHP) and also extend SLA to other private health care providers who operate in low income communities.

The study employed qualitative and quantitative methodologies within a case study design supplemented by other qualitative and quantitative research designs to ensure that most of the data required to answer the research questions was captured. Data was collected through focus group discussions and survey questionnaires that were administered at 18 CHAM health centres and 7 hospitals from the southern region of Malawi. The respondents among others were Ministry of health officials and CHAM institution Managers.

The findings of the research are that SLA between the Ministry of health and CHAM institutions have the potential to improve access and utilisation of health care services. However, there is need for the Ministry of Health and CHAM institutions to address outstanding capacity and policy issues that are derailing SLA's.

PS 02/10

Splitting functions in a local health system: early lessons from Bubanza and Ngozi projects in Burundi

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In recent years, consensus has grown regarding the importance of well functioning health systems to achieve good health results. In particular, some researchers argue that it is the actual institutional arrangements of the health systems and the incentives they set that present some drawbacks. Therefore, the focus should be shifted to these institutional arrangements and further attention should be given to the issue of the 'separation of functions' (to whom are entrusted the different functions of a health system?).

From this starting point, this study analyzes the institutional (re)arrangements of two projects in Bubanza and Ngozi provinces of Burundi, both presenting a Performance-based Financing (PBF) component. The objective of the study is to shed some light over how the separation of functions was established in the schemes (by modifying which institutions and to which degree) and the effects of this reorganization on the performance of the system.

From a methodological standpoint, this study is a comparison of case studies that uses secondary data and qualitative primary data (direct observation and key informant interviews). In order to rigorously compare the schemes, a theoretical framework is applied (Meessen 2009), which draws from the field of institutional economics. This framework establishes a series of linkages between key variables, connecting institutional arrangements to the performance of a health system. It builds a pathway from the institutional re-organization, the modification in property rights, and the enforcement mechanisms to the incentives set and the outcomes they bring by as they interact with the intrinsic motivation.

The paper looks at each of these links in turn for the two projects and provides an explication for the variation in performance and the challenges faced. It also highlights practical lessons on what works and what does not work in the attempt of 'separating functions'. In particular, two issues emerge. The underlying philosophy of the project (co-management/partnership vs. establishment of an independent agency) has a critical influence on the possibility of realizing an effective separation of functions at provincial level, with consequences on the performance of the system. Secondly, some clear directions emerge for the entrusting of the provision and purchasing of services to separate entities, and for creating a strong enforcement mechanism in the form of strict verification procedures assigned to an independent agency to avoid potential conflicts of interest. However, some grey areas remain open for discussion and research, for example in relation to the "coaching" and supporting role, especially in contexts where capacities are low, and to the institutional composition of the purchaser agency (external NGO vs. semipublic entity).

PS 02/11

Pour une médecine de proximité : renouveler la participation communautaire?

Les comités de santé dans le cadre du financement basé sur la performance au Burundi.

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Le Financement Basé sur la Performance (FBP) reçoit actuellement une attention croissante de la part du grand public et du monde de la santé. Sur le terrain, ce système basé sur les incitations rencontre d'autres stratégies de renforcement des formations sanitaires dont la « participation communautaire », une idée aujourd'hui largement acceptée de (co-)gestion des structures sanitaires par la population via des Comité de Santé (CoSa). En comparant CoSa et Associations Locales (AsLo) à base communautaire contractées dans le système de FBF, notre objectif est de documenter les différents modes de transmission de la « voix de la population », soit les manières par lesquelles les consommateurs de soins de santé vont exprimer leurs préférences et peser sur les orientations de l'institution centre de santé afin de s'assurer de services plus accessibles et plus adaptés à tous.

Les résultats discutés proviennent essentiellement d'une enquête (questionnaires et groupes focaux) menée pour le compte de l'ONG CORDAID dans près de 104 centres de santé situés dans 6 provinces du Burundi entre octobre 2009 et février 2010. Notre grille d'analyse, de type nouvelle économie des institutions (droits de propriété et de décision), a également recours aux outils d'évaluation de la participation communautaire (travaux de S.B. Rifkin & al.).

Les deux systèmes comparés apparaissent essentiellement différents et tous deux perfectibles. Nous argumentons en faveur de leur complémentarité et montrons comment, dans une optique d'efficience et de redevabilité des formations sanitaires, FBP et participation communautaire sont interdépendants. Notre étude montre aussi comment certains CoSa ont pu développer, soit de manière spontanée soit encouragés par des ONG, des systèmes originaux favorisant un accès universel aux soins de santé. Nous émettons des propositions pour renforcer ces initiatives qui assurent plus de confiance entre soignants et soignés. Enfin, nous apportons une série de recommandations visant à l'amélioration du système de FBP et de participation communautaire dans le cadre burundais. Il s'agit notamment de la clarification des rôles des différents agents, de la place du bénévolat et des incitations non-financières et de la différenciation des fins et moyens (qui repose le débat structure habilitante contre structure instrumentalisée).

PS 02/12

The challenges and milestones of the use of artemisinin-based combination therapy for treating malaria among under-five children in ibadan, Nigeria

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INTRODUCTION: The adoption and promotion of Artemisinin-based Combination Therapy (ACT) in Nigeria is influenced by the increasing prevalence of Chloroquine resistant malaria. However, little is known about the adoption and perceptions of nursing mothers regarding ACT. The study therefore assessed the perceptions and pattern of use of ACT among mothers of under-five children in Ibarapa Central Local Government Area, Oyo State.

METHODOLOGY: The study was a cross sectional survey involving the use of a 5-stage random sampling technique to select 720 participants from households. A validated questionnaire with a 6-point knowledge scale was used for data collection. Descriptive and Chi-square statistics were used to analyze the data using Epidemiology Package Information software.

RESULTS: The participants' mean age was 29±5.3 years. Their levels of education were as follows: No formal education (26.0%), Primary (50.7%), Secondary (18.2%) and Higher Institution (4.9%). Thirty percent (30%) of participants had ever heard of ACT and their main sources of information include health facility (69.0%), Physician (11.0%), Nurses (11.0%) and Pharmacy (4.0%). Participants mean knowledge score relating to ACT related drugs was 1.2±2.0. Out of the maximum of 6 points, the mean scores based on their level of education were as follow: no formal education (0.8±1.7), primary (1.2±2.0), secondary (1.5±2.2) and polytechnic (1.5±2.2), $p<0.05$. Twenty-seven percent of participants had ever used ACT drugs, while 10.0% are current users of coartem which is the most popularly used (24.2%) among the ACT drugs. The level of education of the current users were as follows: no formal education (17.1%), primary (49.7%), secondary (22.5%), higher institutions (10.7%), $p<0.05$. Majority (90.6%) obtained the drugs from government hospitals where they are distributed free to under five children. These participants were of the opinion that the ACT drugs are not expensive. Only 27.0% of the participants were of the view that ACT was more effective than Chloroquine while 80% of the current users share the same opinion. Fifty –nine percent (59%) of the current users which represents 18.0% of the total participants stated that the drugs were readily available, while 78.0% of the current users could correctly state how they are used for treating under five children. Seventy-five percent of the current users are of the opinion that ACT drugs have lesser side effects compared to chloroquine. Nonetheless, Chloroquine was still the first line drug of choice for treating children

with uncomplicated malaria among majority (59.0%) of the current users of coartem in the home management of malaria. The reasons adduced for this included the following: Ready availability (30.2%), they are commonly prescribed by doctors and other health workers (27.8%), chloroquine taste suits my children (17.0%) and chloroquine is very cheap (12.4%).

CONCLUSION: Despite the positive attitude of the population that are aware of ACT and its effectiveness, the awareness and accessibility as well as its use for the management of malaria in under five children are still low among nursing mothers. Advocacy, social marketing and subsidization of ACT drugs especially in the private sector are needed to address the problem.

PS 02/13

Health sector Reforms in Uganda: How well does the Health Sub-district (HSD) meet Women's Health Concerns

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Abstract:

In Uganda, the LG Act (1997) regulates the decentralization and devolution of functions, powers and services to sub-national governments and establishes the District Health Services. The Act aimed at good governance and democratic participation in and control of decision making by the people. The National Health Policy (NHP) establishes the Health Sub-District (HSD – Village Health Team (VHT) to Health Centre IV (HC IV) for quality care closer people, identification of local priorities, and involvement in management of health services plus responsiveness to local needs. HSD model was envisioned to mainstream women's health concerns including; ANCs, FP, STIs including HIV -VCT), early childhood development (ECD), bringing men on board etc. The 2006 UDHS reveals that a very poor health outcome suggestive of the country's diminished chances of meeting the heath MDGs.

The study aimed to establish whether the HSD model is responsive towards women's health concerns; whether there are structures that help to address women's health concerns and whether there any strategies/policies to specifically address women's health concerns. The study covered Health workers, local leaders, women (young, HIV+, pregnant, community), TBAs, men in community, women leaders in Kampala and Mukono Districts. Focus group Discussions (FGDs) and Key Informant Interviews were conducted and the Content Analysis was used to elicit conclusions.

The study found that most of the services are offered per fixed schedule and free of charge in public facilities and the co-opted facilities charge (e.g FBOs in the HSD). Mostly services are for HIV/AIDs including rations. Drug stock outs, distance, late coming and limited hours of work in some facilities, poverty, time, attitude of health workers, culture/religion are the problems. Private clinics are the solution since in most cases there are no drugs except for HIV cases and disparities in benefits between Project and other staff are de-motivating. It also revealed that the Local Council I (LCI) structure had disappeared in most areas of recent and no VHTs were in place. Sub county health teams are not well functional and Traditional Birth Attendants (TBA) exist but not well facilitated although the Community recognises and respects them. There are strong HIV+ groups "Friends" with Savings and Credit associations (SACCOs) exist for economic reasons with no emphasis on health. There is no accountability systems as VHTs and LCs have collapsed. Therefore, Uganda faces poor and non responsive service delivery under the HSD model characterised by disappearance of the Local council structure and no clear strategies to address the health concerns of women in Uganda.

PS 02/14
Examining household treatment seeking, costs of illness and payment mechanisms in southeast Nigeria

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Introduction: The impact of healthcare expenditures on households can be substantial and can increase their poverty level. This study examined how households of different SES and geographic regions pay for health services their health seeking behavior and the costs of illness six communities in southeast Nigeria. The recommendations are hoped to help implementation of policies that will lessen the impact of health payments on the poor.

Methods: The study took place in Anambra and Enugu states southeast Nigeria. The study was conducted in three (3) communities in each state making up six (6) communities in total. These were two urban, two semi-urban and two rural communities. Data was collected from 3000 households (500 from each community) through questionnaire sampling. Tabulations and bivariate analysis were the data analytical tools. The data was examined for links between socio-economic status (SES) and geographic location. The SES index was used to divide the households into quartiles and chi-square analysis was used to determine the statistical significance of the differentiation of the dependent variables.

Results: Malaria was the illness that most people suffered from one month prior to the interview. The major sources of treatment were patent medicine dealers, followed by private and then public hospitals. Only a few people sought care from health centres in all the communities. Out of pocket (OOP) was the main method of payment and health insurance was rarely used. The average cost of transportation was 86 Naira and the total cost of treatment was 2819.9 Naira out of which drug costs alone contributed more than 90%.

Conclusion: The study showed that there are high levels of health expenditures at the household level and risk protection mechanisms are almost non-existent. There is thus the need for governments to have in place appropriate mechanisms to protect households against the financial burden of direct health care payments. User charges in health facilities should be minimized or abolished, and if they should exist appropriate and effective waivers and exemptions targeted at the poor should be put in place.

PS 02/15

Reducing maternal deaths: Is "Access" a convincing explanation for why many women choose to deliver at home?

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Introduction:
Each year nearly 600,000 women die from pregnancy- or childbirth-related complications. Research has shown that one of the most important factors for a safe delivery is the presence of a skilled health profession at birth. Presently, less than two thirds (62%) of women in developing countries receive assistance from a skilled health worker when giving birth (WHO 2008). As a practical matter, increasing the proportion of births attended by a skilled health professional means increasing the number of deliveries that take place in a health facility (or conversely, reducing the number of deliveries that take place at home).

Aim:
In this exploratory study we examine some of the reasons why women choose to deliver outside a health facility.

Methods:
Our data comes from a survey of about 2,500 women across four states in Nigeria. Nigeria is of particular interest because of the high maternal mortality ratio - estimates range from 545 per 100,000 live births (NDHS 2008) to more than 1000 per 100,000 births (UNICEF 2007) - but also because of the wide within-country variation. In this survey, women with children under 5 were asked where their last delivery took place. Women who reported giving birth outside a health facility were then asked follow-up questions about why they did not deliver at a health facility.

Results:
Nearly 80 percent of the women in our sample reported giving birth at home. Only 4 percent of births in a health facility did not have a health professional in attendance compared to 92 percent for home deliveries. Only 2 percent of women cited quality concerns as a reason for not delivering at a health facility. 13 percent of women cited distance and problems with transportation. More than double that number (28 percent) simply did not think it was necessary to give birth in a facility. We found that education, and receiving antenatal care during pregnancy were strongly associated with delivery at a facility. These results raise doubts about access as a major explanation for the low rates of facility deliveries and suggest that women may be making rational choices given the information in their information sets, about the relative costs and benefits of delivering at home vs. at a health facility.

PS 03/1
Quel avenir pour la couverture sanitaire universelle au Sénégal ? Une analyse des principales réformes

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Malgré les nombreux programmes de subventions et d'exemption développés par le Ministère de la Santé et de la Prévention (MSP) du Sénégal, la problématique de l'accessibilité aux soins de santé reste encore posée.

Le risque maladie n'est pas garanti dans le cadre du Code de sécurité sociale (loi 73.37 du 31 juillet 1973). Il n'est pris en compte que dans les dispositions du code du travail issues de la loi n° 75-50 du 3 avril 1975 relative aux institutions de prévoyance sociale. Ainsi, seul près de 20% de la population du Sénégal bénéficie d'une couverture maladie à travers divers régimes dont celui des agents de l'État en activité et retraités, les programmes d'exemption et d'assistance, les Institutions de Prévoyance Maladie (IPM), les assurances privées et les mutuelles de santé.

Par ailleurs, on note que la part des dépenses budgétaires allouée à la santé est de 10,4% en 2007. Les objectifs d'Abuja fixe la proportion à 15% du budget annuel.

La question cruciale est dès lors de savoir comment garantir un accès financier aux soins de santé à toutes les populations. L'on apprend que l'extension de l'assurance maladie a besoin d'être soutenue par une forte volonté politique et un leadership à plusieurs niveaux permettant de mobiliser durablement les moyens nécessaires et de coordonner les efforts, comme le montre le processus développé au Ghana et au Rwanda.

Au Sénégal, le MSP a initié une réflexion participative et multisectorielle, ayant abouti à une série d'étapes : (i) l'élaboration de la Stratégie Nationale d'Extension de la Couverture du Risque Maladie ; (ii) l'élaboration d'une feuille de route ; (iii) la signature de l'arrêté interministériel mettant en place le comité national de pilotage et les commissions techniques y afférent.

Cette présentation se propose de poser un regard sur un certain nombre de défis et notamment l'arrangement institutionnel adéquat pour gérer ce système. Elle visite l'impact de son statut, ses compétences et ses mécanismes de fonctionnement dans la perspective de création d'un système fort, avec une fonction de régulation efficace et une grande capacité de mobilisation, d'alignement et de coordination des différents partenaire d'appui au développement d'une couverture sanitaire universelle. Ce sont là toute une batterie de préalables qui permettront à la couverture sanitaire universelle au Sénégal, loin d'être une utopie d'être une réalité !

PS 03/2

Is universal health coverage an option for developing countries to bridge health inequalities?

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Health inequality has received considerable attention among health scientists and economists. Within country evidences have shown that the poor and vulnerable bear a greater burden of ill-health. Comprehensive cross-country analysis of the extent of socio-economic health related inequality is scarce. With increasing emphasis on universal coverage following the 58th round of the World Health Assembly, it is important to see what the poor and developing countries stand to gain moving toward universal coverage. Key questions to ask include: will universal coverage help reduce existing health inequalities across countries? What else do we need in addition to universal coverage to redress health related inequalities? In going about these, we acknowledge the importance of a combination of factors linked to social determinants of health. This paper conducts a cross-country analysis to examine the extent of socio-economic related health inequalities, understand the political economy of insurance coverage in selected African countries, and in light of these explores the importance of universal coverage in redressing health inequalities.

Data is drawn from a newly available World Bank database. It includes health system variables (e.g. health worker density), public health variables (e.g. immunization coverage) and population health variables (e.g. infant mortality rate). Socioeconomic status of a country is measured using per capita GNP. The latest year for which reasonably large data points are available is used for each condition. Concentration curves, indices, and statistical dominance tests are used to assess the extent of cross-country inequality. Selected published materials are also drawn upon.

Results show that in general, there is a strong and significant correlation between the burden of ill-health, deprivation and per capita income across countries. Insurance coverage in countries is driven by different factors including political motives, agitation from the public, keeping up with international trends, and also by economically powerful stakeholders.

A well targeted and initiated universal coverage system is important and is also likely to redress the health inequality across countries. While universal health coverage is based mainly on the health sector, we argue that it is important to bear in mind that reductions in health inequalities can be achieved through a combination of strategies that include the wider sphere of social determinants of health. To achieve universal coverage, the preparedness of the public sector and public support are very important. Therefore, an integrated approach that draws on the potential gains of universal coverage, health systems restructuring, public, and public sector support is likely to redress existing inequalities across countries.

PS 03/3
Assurance Maladie Universelle au Gabon : un atout pour le bien être de la population.

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La reforme du système de financement de la Santé au Gabon a mis en place une Caisse Nationale d'Assurance maladie et de Garantie Sociale (CNAMGS) en 2007 qui a comme mission d'assurer la couverture des risques liés à la maladie et à la maternité de ses assurés. Les sources de financement de cette caisse proviennent des cotisations sociales ; de la Redevance obligatoire à l'Assurance Maladie ; de la subvention de l'Etat ; des dons, legs et autres recettes générées par les activités propres de la caisse. Dans la mise en œuvre de cette réforme, le pays a opté pour une adhésion progressive à ce système, en commençant par les gabonais économiquement faible et les indigents en 2008 et 2009, suivi des agents du secteur public en 2010 et enfin le secteur privé et parapublic en 2011.

Ce projet d'assurance maladie universelle est un système mixte qui combine deux mécanismes de financement, à savoir, l'utilisation des fonds prélevés au niveau des taxes et impôts et ceux résultant des contributions émanent des salariés, des travailleurs indépendants, des entreprises et de l'État. Les sources de financement de la CNAMGS sont différentes par catégories des populations. Les catégories des populations considérées sont les agents du secteur public, les salariés du secteur privé et parapublic, les travailleurs indépendants, les pensionnés et les gabonais économiquement faibles.

Les cotisations des agents du secteur public et agents du secteur privé et parapublic sont constituées par 6,6% du salaire imposable de chaque agent, dont 2,5% payé par l'employé lui-même et 4,1% par l'employeur. Les retraités cotisent à hauteur de 1,5%. La couverture des soins est assurée à 80% par le tiers payent et 20% par le bénéficiaire sous forme du ticket modérateur. Les prestations de santé des Gabonais économiquement faibles, des refugiés, des élèves et étudiants non couverts au titre d'ayants droits sont financées par le Fonds de garantie sociale qui est alimenté par un impôt indirect dénommé Redevance Obligatoire à l'Assurance Maladie (ROAM). A ce jour, le secteur concerné est la téléphonie mobile (Libertis, Moov, Zain et Azur) qui reverse à l'Etat 10% de leur chiffre d'affaires, hors taxe pour financer la CNAMGS. Une autre source de financement relative aux impôts est celle de tous les transferts d'argent à l'étranger, hors zone CEMAC (Western Union, Money gram, etc) qui reverse aussi à l'Etat 1,5% de leur chiffre d'affaires, hors taxe pour financer aussi la CNAMGS. Les fonds collectés pour la CNAMGS en 2009 sont estimés à 24,975 milliards de FCFA, dont 16,20 Milliards de FCFA provenant de la ROAM, 7, 015 Milliards de FCFA au titre de la dotation budgétaire des prestations familiales des gabonais économiquement faibles et 2,760 Milliards de FCFA pour le fonctionnement et l'investissement.

Les prestations couvertes par l'assurance maladie sont décrites par types des services. Notamment les soins externes ou ambulatoires, les hospitalisations, les produits pharmaceutiques, les appareillages et les évacuations sanitaires à l'étranger. Toutes les catégories des populations ont accès aux mêmes paquets d'activités.

L'assurance maladie Universelle par le biais de CNAMGS au Gabon est une nouvelle expérience innovante et prometteuse. Cette expérience tient sa spécificité sur la source des revenus de l'assurance qui provient en partie aux taxes des opérateurs des téléphonies mobiles et aux transactions financières pour financés les soins des Gabonais économiquement faibles. L'autres innovation est celle du choix d'adhésion progressive pour tendre vers une couverture universelle, le Gabon a pris l'option de commencer par les plus vulnérables pour passer ensuite aux agents du secteur public, aux salariés du secteur privé et parapublic et les travailleurs indépendants en dernier. Ceci est une innovation parce que la plus part des pays commencent par les salariés du secteur public et parapublic.

Cependant, cette stratégie innovante n'est pas sans risque, parce qu'il y a des préalables. Les opportunités de réorienter cette initiative dans des pistes plus rassurants en tenants compte des recommandations formulées sont encore exploitable pour que cette expérience innovante du Gabon contribue au bien être de sa population.

Parallel session 3: User fees - removal and exemptions II

PS 03/4
Removing user fees in health services in low-income countries: a framework for evaluation and action

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Key words: *User Fees, Health Policy, Methods, Health Care Reform*

Removing user fees has been put forward as a quick win for improving access to health for the most vulnerable in most African countries, but at the same time experts have called for careful action when engaging in such a reform. While several authors have stressed the fact that many interventions fail because of poor formulation or implementation, there is little guidance in the scientific literature on how to enhance the probability of achieving policy goals with such a health care financing reform in low-income countries.

This paper presents the framework adopted for the multi-country review of user fee removal in six sub-Saharan African countries. Aiming to develop operational guidance for health planners, the framework builds on the Walt and Gilson health policy analysis triangle. The process and the actors are analysed by testing a list of 'good practices' that might be expected in a health financing policy reform, against the reality. The other elements of the framework- namely the context, the content and the effects- are dealt with in a more descriptive way.

Our framework and approach to this analysis offers new ideas about how to analyse policy reform in ways that offer support for the managers of financing policy change. First, it combines concern for policy design with the processes of policy change, and is focussed on supporting the implementation of financing policies in ways that increase the likelihood that their goals will be achieved. Second, it allows for explicit and transparent review of experience against a set of clearly established hypotheses, allowing their further refinement and development.

This paper has been submitted for publication to health policy and planning within a supplement on user fees to be published within the coming 6 month.

Presenting these findings to the participants would provide us feedback on the usefulness of the method we suggest to help countries remove user fees when they decide to.

PS 03/5

L'achat des services et la réduction de la barrière financière dans le Kassai-Occidental : REPUBLIQUE DEMOCRATIQUE DU CONGO

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Le but de l'achat des services est d'améliorer l'état de santé de la population du Kasaï Occidental par l'offre des soins de qualité à un prix accessible.

Il permet que les usagers reçoivent des services préventifs gratuits et curatifs moyennant paiement d'un ticket modérateur forfaitaire établi en fonction des revenus moyens de la population.

Les objectifs de l'achat de service sont :

- Accessibilité financière
  - Diminution des tarifs des soins payés par la population
- Performance du système de santé
  - Quantité : amélioration de l'utilisation
  - Qualité : amélioration de la qualité
- Autonomie de la formation sanitaire
  - Esprit d'entreprise
  - Participation communautaire
- Efficience des financements

L'achat des services de santé est un système de tiers payant qui prend en charge une partie du tarif normalement facturé au patient, tandis que la partie résiduelle reste à la charge du patient.

Pris dans ce sens il est un instrument d'allègement de la barrière financière des ménages aux services de santé essentiels et permet de mettre en place les mécanismes de financements durables pour assurer une continuité dans le financement de la fonction de prestation en complément aux différents systèmes de financement communautaire et public.

Cette expérience menée dans la province du Kasaï Occidental depuis 2007 montre le progrès accompli dans l'amélioration de la performance dans le système de santé tant du côté de la prestation que de la population.

Les premiers résultats démontrent un impact sur l'utilisation des services par les communautés, la baisse des tarifs des soins couplée à une augmentation des recettes des formations ainsi qu'une amélioration de la qualité des soins offerts à la population.

PS 03/6

Is free health care truly free and equitable? Using DHS, NHA AND BIA to analyse the effectiveness and equity dimensions of health financing policy in post conflict Liberia and Sierra Leone

S T Varpillah, Tesfaye Dereje, Chris Atim

Making access to quality health care more affordable and equitable to their populations are among the key reasons given by policy makers for abolishing user fees at the point of service. Liberia and Sierra Leone are two post conflict West African countries that have decided in recent years that user fees constitute an unfair burden on the poor and vulnerable in their populations, and decided therefore to do away with them for key or priority health services.

However, there has been no analysis so far of the effectiveness and equity impact of these policies. The paper intends to assess these dimensions of policy implementation in the two countries by examining the distribution of public health care spending across households in different quintiles of the population as well as the financial burden on individuals from health spending following policy implementation. The main sources of data are DHS, NHA and benefit incidence analyses in the two countries.

The findings show that in Liberia, the policy simply led to official user fees being replaced by unofficial user fees, often more pernicious for the poor due to lack of transparency and accountability in charges coupled with lack of resources to tackle chronic supply side problems such as availability of drugs and skilled personnel at facilities. The benefit incidence study shows most of the benefits of public subsidies continue to be captured by the higher quintiles, while NHA data show continuing high levels of OOPs by the poor. In Sierra Leone, the policy change is more recent, but initial concerted action to address foreseeable problems appears to have paid off with many more people reporting to facilities than before. However, while drug supplies appear to have improved in the short term, steps taken to address other supply side problems, especially HRH issues, have not led to the desired results, in the short term. Despite salary increases of up to four times their previous levels, a recent survey showed that absenteeism rates remain very high and many staff are simply collecting the new salaries but refusing to report to their new posts. The results of the benefit incidence and NHA studies for Sierra Leone after the policy are expected later and will inform the discussion on equity implications and financial burden.

The study shows that the success of the policy goals of abolishing user fees require significant accompanying measures and careful prior preparation, especially on the supply side, to address foreseeable health system impacts.

PS 03/7

Financement de la santé au Mali : Cas des gratuités dans le cadre de quatorze programmes de santé, année 2007-2008

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Objectif

- Identifier les types de prestation gratuite en rapport avec 14 programmes
- Déterminer le nombre et le pourcentage de personne ayant bénéficié de la gratuité par programme et par type de soins.
- Mesurer l'impact de la gratuité des soins sur l'utilisation des services de santé avec 14 programmes de la direction nationale de la santé (DNS).

Méthodologie

Nous avons procédé à une étude rétrospective transversale s'étendant sur une année (du 01 janvier au 31 décembre 2007). Elle s'est déroulée à la direction nationale de la santé. Elle comporte des divisions, sections et structure déconcentrées représentées par des programmes.

Résultats

Ce travail nous a permis d'identifier :
Les différents systèmes de financement de la santé tel que les subventions et les exemptions ; les assurances maladies volontaires
Les types de gratuité

- La gratuité qui s'applique à toute la population :
- La gratuité qui s'applique à une population particulière :

Le nombre de personne prise en charge gratuitement par programme :

Conclusion

Au terme de notre étude la couverture (mesurée par le taux de fréquentation) de ces services gratuits est de 70% pour 100 habitants.

Mots clés : gratuité, soins curatif et préventif, utilisation des services, couverture universelle en soins financement de santé.

Parallel session 3: Covering those outside the formal employment sector II

PS 03/8
The Impact of Micro-Health Insurance on the Access to Health Care Services among the Informal Sector Employee in Nigeria

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Health care insurance was formally launched in Nigeria in 2005 as a mechanism of catering of funding health care. The scheme which was designed along three streams of programmes vis: Formal Sector Programme (FSP), Informal Sector Programme (ISP) and Vulnerable Groups Programme (VSP) was currently catered for only formal sector employee. This paper analyze whether or not micro-health insurance scheme can be used to increase access to health care and utilization of health care services by the informal sector employee using the example of Lagos State Mutual health plan and Hygeia Community Health Plan.

A binary probit model is employ to estimate the determinants of participation in micro-health insurance and logit/log-linear model is used to measure the impact of micro-health insurance on access to health care services and utilization of health care services in Nigeria. The results shows that participation in micro-health insurance is dependent on household characteristics, coverage of illness, perception about future health care expenditure, age, number of children in the family, knowledge about health insurance, confidence in government policy and that household income and price of health care services have a negligible effect on participation in micro-health insurance scheme. Regarding access to health care services and utilization of health care services, the results shows that members of the scheme have easy and increased access to health care services and this increased their utilization of modern health care services since they don't have to pay out of pocket during the illness.

It is therefore concluded that micro-health insurance scheme can increase access to health care services and utilization of modern health care services by the informal sector employee and the poor provided people have confidence in the government programme and credible and effective provider are available. The policy implication of this is that government can covered the informal sector employee and the poor through micro-health insurance scheme if it is well organized and adequate publications and orientation are done to instill people confidence in the programme.

KEY WORDS: Micro-Health Insurance, Access to Health Care Services, Informal Sector Employee

PS 03/9

A Stepwise Approach from Community-Based Health Insurance to Universal Coverage in Low Income Countries

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Objectives:

The World Health Assembly of 2005 called for all health systems to move towards universal coverage. Many high-income countries, as well as some middle-income countries, have achieved this goal by introducing tax-based financing or/and social health insurance schemes. Although these schemes exist in low-income countries, the beneficiaries (breadth) and/or service coverage (depth) are rather limited. Majority of population have to rely on out-of-pocket payment mechanism for their healthcare utilization, and many of them fall below the poverty due to illness. Realizing the feasibility issue of introducing tax-based or social health schemes, community-based health insurance (CBHI) has been introduced/re-introduced to the low-income countries as an alternative financing mechanism for the poor in the past two decades. However, many low-income countries are still facing tremendous challenges for sustaining and scaling up of CBHI in their countries. People are still very skeptical about its role in reaching toward universal coverage. The purpose of this study is to explore the potential pathways by which CBHI can lead towards the universal coverage and to identify the major challenges of CBHI development faced by low-income countries.

Methodology:

Systematic literature review process has been adopted in this paper as the method for data collection and data analysis. Electronic databases as well as relevant international organizations' web pages have been the sources of information. The retrieved literatures have been analyzed from the aspects of the stages of CBHI development, the characteristics in each stages, and the key challenges and possible stragegies towards universal coverage.

Key findings:

Based on the existing evolution of CBHI development, the pathways from CBHI to universal coverage have been classified into three stages, the stages of generic model, enhanced model, and nationwide model. The key characteristics of each model have been laid out and critically reviewed. The key mechanisms for the transition from CBHI to universal coverage have been summarized, analyzed, and discussed as well based on the issues of the government engagement in community-based financing, fund pooling at higher level with professional management and risk equalization mechanism, and the introduction of strategic service purchasing. Based on the systematic review and analysis, this study suggests that although CBHI may have deficiency in terms of efficiency, effectiveness, and equity in financing and services delivery, it might be the most feasible approach toward the goal of universal coverage in low-income countries in short- and/or mid-terms.

PS 03/10

Projet d'amélioration de l'accessibilité financière aux traitements des infections opportunistes et des bilans biomédicaux des PV VIH au Sénégal (*Phase pilote à Kaolack et Ziguinchor)*

Initiative du Ministère de la santé appuyé des partenaires Abt et FHI\ USAID ; présenté par ***Christian Konan YAO,*** *point focale du projet.*

La prévalence du VIH/SIDA est relativement faible au Sénégal (autour de 1%). Cette situation résulte d'une réponse précoce qui a permis d'accumuler plusieurs acquis dans le cadre de la prise en charge des PV VIH dont la gratuité des traitements ARV,… La réponse au VIH/SIDA est toujours, cependant, confrontée à plusieurs défis… En effet, les volets « prise en charge des IO et des bilan médicaux» et « prise en charge socioéconomique » restent à ce jour en deçà des attentes des PVVIH du fait de l'absence de politiques et pratiques systématiques à leur encontre. En effet, les coûts de la prise en charge des IO et des bilans biomédicaux sont supportés directement par les PV VIH et réduisent leurs capacités à faire face à leurs besoins primaires (alimentation, éducation des enfants, transport pour observer leur traitement et autres besoins essentiels) …

Le but du schéma est d'augmenter la capacité d'auto-prise en charge et de responsabilisation des PV VIH dans le cadre de leur prise en charge médicale et psychosociale. Le schéma vise les objectifs spécifiques suivants :

- réduire les dépenses privées directes des PV VIH associées à la prise en charge des infections opportunistes et du suivi biomédical ;
- assurer l'accès au crédit aux PV VIH pour le financement d'activités génératrices de revenus (AGR);
- renforcer les capacités des acteurs impliqués dans le schéma de prise en charge des PV VIH ; et
- mettre en place des partenariats effectifs au niveau local pour soutenir la pérennité du schéma de prise en charge des PV VIH.

La stratégie d'intervention est basée sur deux piliers: (i) la subvention de la demande des soins des PV VIH pour améliorer l'accès aux soins à travers les mutuelles de santé et (ii) la facilitation de l'accès au crédit pour appuyer les activités génératrices et l'augmentation de revenus des PV VIH par le système de financement décentralisé.

La stratégie d'intervention est soutenue par deux mécanismes d'appui dont un fonds de garanties sociales (FGS) et des activités de renforcement des capacités. Pour réduire les risques associés à la couverture des soins par les mutuelles de santé et des prêts aux PV VIH par les institutions de microfinance, un fonds de garanties sociales est mis en place. Pour améliorer leurs capacités entrepreneuriales et leurs capacités de gestion et de suivi, un ensemble d'activités de renforcement des capacités est mis en place au bénéfice des acteurs.

Le projet envisage l'expérimentation à une petite échelle d'un schéma de prise en charge socioéconomique des PV VIH afin d'appuyer l'élaboration d'une politique de prise en charge socioéconomique des personnes vivant avec le VIH en particulier et partant des groupes vulnérables en général.

PS 03/11
Willingness to Pay for Voluntary Health Insurance in Tanzania

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The Community Health Fund (CHF) and Tiba kwa Kadi (TIKA) are voluntary insurance schemes costing between Tsh 5,000 - 15,000 per annum per household for care in primary public facilities. These schemes cover less than 5% of the population due to limited awareness, affordability of the premium and the limited benefit package. This study measured willingness to pay (WTP) for the CHF/TIKA among the uninsured and willingness to cross-subsidize the poor.

1,955 uninsured household heads were interviewed. The contingent valuation method was used to elicit willingness to pay for insurance in 2 urban councils and 4 rural districts. Two scenarios were presented: the CHF/TIKA as currently designed; and an expanded scheme covering inpatient care and transport. Respondents were asked if they would be willing to pay the current premium (Tsh 5,000). Those who said "no" were asked if they would pay less. The open-ended question format was used to elicit maximum willingness-to-pay. Households were ranked into five wealth groups (based on ownership of assets and housing characteristics) from poorest to least poor. We estimated the proportion of households WTP in rural and urban areas and across wealth groups.

In rural areas, 72.35% of respondents were willing to join the CHF and pay the current premium. Of those who were not willing to join at Tsh 5,000, 82% would join if the premium were lower. Their average willingness to pay was Tsh 2,260. 79.36% would join if the benefit package included inpatient care and transport. However, only 17.31% of these were willing to pay more than Tsh 5,000. In urban areas, 93% were willing to join at the current premium of Tsh 5,000. Of those who were not willing to join, 65.21% would join if the premium were lower. Their average WTP was Tsh 2,400. 38.66% of people in urban areas and 46.58% in rural areas were willing to pay an average of Tsh 16,600 and Tsh 7,950 per year respectively to finance the health care costs of the poor. Despite their willingness to pay respondents expressed concern about how the funds would be used, and about quality of care.

Communities need to be sensitized about the existence of the CHF/TIKA to encourage enrollment. An expanded benefit package would further increase enrollment However, few people would be willing to pay more than the current premium. Alternative sources of funding would be required to subsidize the scheme.

Keywords willingness to pay; contingent valuation; premium
Note (2008): USD $ 1 = Tsh 1,178.

PS 03/12
Catastrophic health expenditures at variable thresholds levels

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Objective: Using uniform thresholds and a set of variable threshold levels, this study examined the incidence of catastrophe amongst households of different socio-economic status (SES) quintiles classified using household consumption expenditure.

Methods: A household diary was used to collect data on expenditure on illness and a wide variety of goods and services on weekly basis from 1128 households over a one month period. Catastrophic health expenditure was examined based on uniform threshold levels of non-food expenditure, and a novel set of variable threshold levels in which the levels for various SES groups were weighted by the ratio of household expenditure on food.

Findings: A total of 167 households (14.8%) experienced catastrophe at a non-food expenditure threshold level of 40%, the highest proportion (22.6%) being amongst the poorest households. At levels of 20% and 10% of non-food consumption expenditure, the proportion of households experiencing catastrophe was 27.4% and 40.2%. For the first set of variable scenarios, the thresholds for the poorest and richest households were 5% and 29.6% and levels of catastrophe were 44.7% and 12.0% respectively. In the second scenario, the thresholds were 6.8% and 40%, and the corresponding levels of catastrophe were 7.6% and 42.5% respectively.

Conclusions: High levels of catastrophic expenditure exist amongst households in the south-east region of Nigeria. Use of variable thresholds to measure catastrophe led to higher overall and disaggregated levels of catastrophe. It is argued that such a variable measure is more appropriate in a low income setting with high levels of poverty.

PS 03/13
Reassessing catastrophic health care payments with a developing country application

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INTRODUCTION:

Health financing reforms have recently received attention in both developed and developing countries. The need for universal coverage to protect the poor and the vulnerable are central in the argument and is emphasized. In 2005 the World Health organization (WHO), in its World Health Assembly (WHA), encouraged countries to move towards achieving universal coverage. However, direct out-of-pocket (OOP) payments remain substantial more so in developing countries. Such OOP payments could be catastrophic to households. Direct health care payments deemed catastrophic are understood to involve expenditures above some given proportion of household resources (e.g. total or non-food expenditure). However, there still exists a lack of consensus in the literature as to what that proportion should be. Some define payments as catastrophic when they consume more than 10% of the person's annual household income or 50% or more of their non-food expenditure. Catastrophe has also been defined as payments exceeding 40% of household *capacity to pay*. Such payments are more likely to be common among lower income groups. This paper argues that there is need to define fairer indices of catastrophic payment that explicitly recognize diminishing marginal utility of income as reflected in some principle of vertical equity. As advancement in methodology, a modified measure of catastrophic payment is developed and empirically applied.

METHODS:

The paper, therefore, while arguing against a uniform threshold that has been used to traditionally define and assess the extent of catastrophe, proposes the use of *rankdependent weights* to vary thresholds across individuals on the income ladder. This is implemented using a single '*ethical'* parameter in such a way that those at the upper end of the income distribution face a higher threshold compared to those at the lower end of the distribution. These are applied to a data set from a developing country (Nigeria) where out-of-pocket payments form a substantial part of total health care financing. The National Living Standard Survey (2003/2004) is used for the analysis.

FINDINGS:

The revised methodology shows that catastrophic headcount (positive gap) obtained using a fixed threshold – weighted or not by the concentration index – is lower (higher) than that predicted by the rank-dependent threshold. This is the case where the poor make more out-of-pocket and catastrophic payments.

CONCLUSION:

In conclusion, therefore, a fixed threshold value will likely lead to lower catastrophic headcounts compared with a threshold which varies across the entire distribution by reducing the thresholds for the poor.

PS 03/14

Determinants of making catastrophic health expenditures and the role of Health Insurance

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Rationale:

Out-of-pocket (OOP) payments are one of the main sources of health financing in Tanzania. OOPs are concerning when they exceed a certain proportion of income, and become catastrophic, as they can push a household into poverty. Over recent years a number of health insurance schemes have been put in place to provide financial protection to households. Some of the schemes cover outpatient and inpatient care (the NHIF and SHIB for the formal sector) and others only cover outpatient care in public facilities (CHF for the informal sector). However, little is known about the effectiveness of insurance in reducing OOPs, and reducing the occurrence of catastrophic health expenditures.

Methodology:

We conducted a household survey in mid 2008 with 2,224 households and 12,204 individuals from six districts rural and urban; capturing out of pocket expenses for the last outpatient visit and inpatient admission recall periods was one month for outpatient and 12 months inpatient, among insured 1018 (8%) and uninsured 11,175(92%) . We obtained OOPs for medical expenditures within the facility, drugs purchased outside the facility, and transport costs. Payments were said to be catastrophic health payments if they represented 10% or more of monthly household consumption expenditure. We used the logit regression model to assess the determinants of making catastrophic health expenditures.

Results:

The proportion of people making catastrophic payments for outpatient was 26%(408), while for inpatient was 65%(254). The proportion of insured people that made catastrophic payments for outpatient was 12%(106), and non insured was 29%(191), and the proportion of insured people that made catastrophic payments for inpatient services was 52% (99) while for non-insured 66%(134).

All types of health insurance decreased the probability of incurring catastrophic health payments both for outpatient care by 14%, 19% and 22% for the NHIF, CHF and SHIB respectively, But for inpatient most of the schemes did not reduce the likelihood of making a catastrophic payment.

Households with High monthly consumption expenditure and many children were also less likely to incur catastrophic expenditures for outpatient care. Households with many children were more likely to incur catastrophic expenditures for inpatient care.

Policy recommendation:

Expanding insurance coverage is essential because it provides some protection in reducing the risk of incurring catastrophic health payments especially for outpatient. Increasing the benefit package of services and increasing the number of accredited facilities is important.

PS 03/15

Supranational Subsidies and Affordability of Essential Medicines in Low-Income Countries: the Case of Artemisinin-Based Combination Therapies in Nigeria

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Problem Statement: The Board of the Global Fund for AIDS, TB and Malaria (GFATM) in April 2008 initiated the Affordable Medicines Facility – Malaria (AMFm) as a global financing mechanism to facilitate the provision of affordable ACTs in malaria endemic countries through public and private distribution channels in individual countries. A select group of LICs including Nigeria was therefore chosen to implement a subsidy program that aims to reduce the price of ACTs from between 6-10 US dollars to between 20-50 cents per treatment episode. Unfortunately, the institutional factors within these countries seem to be making the realization of this goal difficult.

Objectives: The objective of this study is therefore to investigate how regulatory institutions and internal markets in Nigeria could be impeding the achievement of the objectives of AMFm.

Design: The study is essentially a case study that analyzes the effects of regulation and internal market processes on affordability of ACTs in south-east Nigeria. The study uses interviews with market operators and regulatory agencies to generate the data required for the analysis.

Setting: This study was conducted in two states in south-east Nigeria. It was based on interviews with national drug regulatory agency, and importers and distributors of ACTs and other anti-malarials, as well as other end-users of the medicine.

Study Population: The study population was the hub of drug importers, distributors and patent medicine sellers in Anambra and Enugu states in south-east Nigeria.

Policy: The policy evaluated was whether the supra-national subsidy on ACT was achieving the desired objective and the factors that may be frustrating the realization of these objectives of making ACTs affordable**.**

Results: The main results from the study is that regulation and the behavior of market agents and other macroeconomic factors are making it impossible to realize the objective of affordable ACTs in Nigeria, and other low-income countries. Prices are escalated through heavy mark-ups to compensate for the high cost of doing business.

Conclusion: The study concludes that global initiatives to lower the prices of essential medicines in LICs need to be complemented by pharmaceutical market and other institutional reforms in LICs if the populations of these countries are to benefit from international health financing initiatives.

Parallel session 4: Purchasing of services (benefit packages, provider payment mechanisms) II

PS 04/1
Why performance-based contracting failed in Uganda: evaluating the implementation, context and complexity of health system interventions

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Performance-based contracting (PBC) has been promoted as an instrument for improving effectiveness and accountability for development results and outcomes. The Development Research Group (DRG) of the World Bank and Ugandan Ministry of Health (MoH) instituted a randomised experiment to generate evidence of PBC effectiveness among non-profit health providers in five districts of Uganda. This study sought to compare the learning that could be achieved using the approach of 'realistic evaluation' relative to that using the more orthodox approach favoured by the DRG.

Prospective in-depth interviews were conducted among participants in the PBC pilot at the hospital, district and national level. Participant observation of critical implementation activities in the pilot provided additional sources of data. Complexity and expectancy theories were used to aid the building of plausible explanations of data.

The findings show that the design and implementation of the PBC encountered multiple context-related constraints that produced complex behavioural adaptations by participants. These adaptations intervened in the expected causal pathway. We show that experimental evaluation approaches can themselves intervene in results. For example, by allocating a high-powered incentive (financial bonus) to the "treatment group" to motivate higher service outputs, the experiment also created negative motivation among participants in the "control group". This situation had the potential to produce an artificially larger "effect size" with misleading policy implications.
This research has four implications (1) randomized experiments for interventions in health systems may be unwise and can mislead: 'gold standard' research must involve much greater attention to the processes in between intervention and outcome (2) adaptations in implementation arrangements create a gap between the *de facto* reality and the *de jure* intentions of intervention that cannot be understood by orthodox evaluation approaches; (3) structures to monitor harmful effects of experiments on health systems should be instituted to uphold the "do no harm" principle and (4) the complexity of health systems requires a strong theoretical basis for designing, implementing and evaluating observed actions and behaviours.

PS 04/2
Renforcement des districts sanitaires en RDC : analyse comparative de deux approches

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Le système de santé de la République Démocratique du Congo doit faire face à des défis majeurs en matière d'organisation et de financement des services et assurer un usage plus efficient de l'aide internationale.
Plus de 30 ans après Alma Ata, les effets et l'impact des politiques mises en œuvre avec d'importants appuis financiers, ne sont pas à la hauteur des espérances et des moyens mobilisés.
On constate actuellement que deux approches de financement du système de santé sont sujettes à des polémiques :

- Le modèle "historique" relevant de la tradition classique de l'organisation des services publics (cas du district sanitaire de Kasongo) c.à.d. l'Etat est employeur, propriétaire, fournisseur des intrants, financeur, veillant aux règles et procédures ; mettant ainsi plus l'accent sur le manque de ressources, de planification et de vision dans la secteur de la santé d'où l'aide des partenaires sous forme d'apports financiers, matériels et humains ((assistant technique ou « coopérant »).
- Le modèle émergeant (cas du district sanitaire de Katana), s'il ne rejette pas toutes les propositions de la première approche, se pose aussi comme une alternative. Ici on achète des résultats de manière à stimuler l'initiative et l'esprit d'entreprise et de concurrence des prestataires (financement basé sur la performance-PBF).

Partant des districts sanitaires ayant intégrés ces approches, une analyse comparative a été réalisée pour dégager les fondements sous-jacents à ces deux approches et leurs contenus respectifs, identifier leurs convergences et leurs divergences, comprendre les facteurs pouvant contribuer à une meilleure performance pour chaque modèle, contribuer à la qualité du débat, qui est très vif entre les tenants des approches, en le rendant plus structuré et moins idéologique ; et arriver à une meilleure formulation de la politique nationale.

Il en ressort que ces approches convergent en de nombreux points tels que : la promotion des soins de santé primaires, les grandes finalités par rapport au système de santé, les particularités du contexte d'intervention, la recherche de la couverture effective de la population par les services de santé de qualité. Par contre, elles divergent pour ce qui est: de leurs axes stratégiques sous-jacents (financement des résultats >< financement des inputs), du respect de la séparation des fonctions, des hypothèses comportementales du personnel (recours à un commandement hiérarchique efficace avec un système de sanction>< autonomie de gestion).
Ainsi, des recommandations pour améliorer l'efficacité et l'efficience de l'aide au système de santé congolais ont été formulées.

PS 04/3

The impact of National Health Insurance on the behavior of providers and patients in two districts of Ghana

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AIM AND OBJECTIVES

User fees are reported to be barriers to health seeking and can lead to the impoverishment of individuals and households through catastrophic payments for health care. The current debate therefore emphasises the need to replace user fees with prepayment and risk pooling schemes. It is against this backdrop that social/mandatory health insurance is increasingly been advocated by the WHO and other international development organisations as a health financing mechanism to better deal with health risks in low income countries particularly. Social health insurance is seen as a tool that helps mobilise resources for health, pool risk, prevent impoverishment and provide more equitable access to health services for the vulnerable. Hence, Ghana implemented the National Health Insurance Scheme (NHIS). The aim of the study was to explore the impact of the NHIS on the behaviour of providers and patients. Specifically, the study examined the effect of the reimbursement system of the NHIS on the behaviour of providers, and the interactions between providers' behaviour and that of patients.

METHODS

The study took place in Bolgatanga (urban) and Builsa (rural) districts in Ghana. Data was collected through exit interviews (N=200) with insured and uninsured patients, in-depth interviews (N=15) with providers and insurance managers, and focus group discussions (N=8) with community members.

KEY FINDINGS

The NHIS is operative, promoting access for the insured and mobilising revenue for health care providers. Both the insured and uninsured were satisfied with the care provided. But delay in reimbursement was the core problem leading to some providers preferring clients who make instant payments. Some insured reported verbal abuse, long waiting times, not being physically examined and discrimination in favour of the affluent. Few of the uninsured were utilising health facilities and visit only in critical conditions. This is attributed to the increased cost of health services in the era of the NHIS. Conclusion: The NHIS is beneficial, but there is an urgent need to streamline the reimbursement process. There is also the need for clear policy for identifying the core poor to be registered into the NHIS and to improve the capacity of health facilities and motivate staff for the provision of quality health care.

PS 04/4

Financement verticaux et Financement basé sur la performance dans trois pays d'Afrique Centrale : une opportunité manquée ?

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Le financement basé sur la performance est au centre des processus de réforme dans de nombreux pays d'afrique sub-saharienne. En Afrique Centrale, le dispositif de financement le plus fréquent vise à financer les structures de santé sur base de leur performance (quantité et qualité des services de santé produits).

A travers l'analyse de trois systèmes de financement basés sur la performance (Rwanda, Burundi et RDC), nous démontrons que ces systèmes utilisent les mêmes indicateurs que les programmes verticaux et financent directement des activités traditionnellement financées par ces programmes: PEV, Santé de la reproduction, Malaria, VIH-SIDA, Tuberculose, Trypanosomiase. Nous analysons également la proportion du financement PBF allouée à chaque maladie dans chaque pays. Nous montrons donc le lien direct entre le PBF et les programmes verticaux.

Dans un deuxième temps, nous procédons à une revue du financement des systèmes PBF dans la région. Etonnamment, les dispositifs PBF ne sont que très peu financé par les programmes verticaux, en particulier les programmes financés par le Global Fund, à l'exception du VIH au Rwanda et au Burundi. Or, à l'image du Planning familial au Rwanda ou du PEV en RDC, ces programmes bénéficient des résultats des systèmes PBF. A ce titre, ils adoptent un comportement de passager clandestin.

Nous estimons que les programmes verticaux, et à travers eux, les acteurs du financements liés aux maladies de la pauvreté devraient considérer le PBF comme une opportunité, soutenir leur développement et développer des synergies. Nous estimons que le système de financement est encore erronément perçu comme un outil de primes à la performance, et non pas une modification du mode de financement du système de santé.

PS 04/5

Waiting for chloroquine: A community's understanding of changes in 1st-line treatment for uncomplicated malaria, and the need for effective policy communication

Vincent Okungu

Background: Changing 1st-line treatment policy for uncomplicated malaria is a complex and sensitive undertaking that requires effective communication with the beneficiaries. How the treatment policy is communicated determines the way beneficiaries respond to the newly introduced drug. Effective communication empowers communities with accurate information that dispels negative attitudes against health interventions and helps in the uptake of new treatment policies.

Objectives: The study had two main objectives: (1) to explore community understanding of policy changes on 1st-line treatment for uncomplicated malaria in Kenya; (2) to evaluate the potential role of communication strategies in influencing community responses to the changes in the 1st-line treatment.

Methods: Multiple data collection methods were used including: document reviews, individual in-depth interviews (n=29), and focus group discussions (n=14).

Results: There was very limited knowledge in the study community about policy changes in 1st-line treatment for uncomplicated malaria in Kenya. The lack of knowledge was accompanied by negative perceptions about changing 1st-line treatments generally, and artemether-lumefantrine (AL) in particular. The reasons for the low awareness and negative attitudes towards the policy changes included: inappropriate communication channels that were inaccessible to the primary audience; confusion created by the media and commercial drugs; exclusion of some key actors from the policy communication process, and lack of resources to educate the public on drug changes. Other reasons included lack of responsiveness by primary health care providers to the policy change, and reluctance by the community to adapt to the use of AL (Coartem).

Conclusions and policy recommendations: There is low usage of AL in the study area. The findings suggest that effective treatment may not be achieved if beneficiaries are poorly informed about new treatment policies. This is also likely to complicate quality treatment in a universal coverage system, especially if the lack of information is coupled by distrust against health interventions. There is need to invest in appropriate and sustained information, education and communication channels.

PS 04/6

Rôle des ressources humaines : Quelles incitations pour une meilleure motivation des professionnels de la santé ? Cas du Burkina Faso

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Introduction : Le rôle prépondérant des ressources humaines dans l'amélioration de l'état de santé des populations n'est plus a démontrée, mais son efficience est confrontée à une crise se traduisant par un manque criard de personnel ainsi qu'une faiblesse des performances en particulier dans les pays pauvres et le Burkina Faso n'est pas en marge[5].
Malgré les réformes entreprises, l'un des problèmes majeurs reste la motivation des professionnels de la santé. L'objectif de notre étude fut d'identifier les principaux facteurs de motivation des professionnels de santé au Burkina Faso.

Matériel et Méthodes : Des entretiens (73) et des questionnaires (325) ont été administrés auprès des professionnels de la santé de 17 structures en zone rurale et urbaine du Burkina Faso.
Une grille d'analyse a été conçue pour les données qualitatives et les données quantitatives ont été analysées à l'aide du logiciel Stata.

Résultats : Les résultats obtenus montrent que le salaire et les conditions de travail sont les principaux facteurs de motivations, (coté par une moyenne respective de 8/10 et 6,8/10 par les enquêtés). De plus une amélioration des conditions de vie et de travail, notamment en zone rurale, une réorganisation et une meilleure transparence pour les conditions d'accès aux formations, la reconnaissance du travail effectué, de meilleures opportunités dans la construction de la carrière sont des solutions pour une meilleure motivation des professionnels de la santé au Burkina Faso.

Conclusions : De notre étude il ressort que des stratégies pour des incitations financières mais surtout pour celles non financières doivent être mise en place pour une meilleure motivation des professionnels de la santé. Cela permettra entre autre, une meilleure efficacité dans l'administration des soins aux populations.

[5] 2èmes Etats Généraux de la santé Burkina Faso, Février 2010

PS 04/7

Accessibilité des services de santé en Afrique de l'Ouest : le cas de la Côte d'Ivoire

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L'accès aux services de santé renvoie de façon générale à la compatibilité entre le coût et la qualité des prestations sanitaires, d'une part, et le pouvoir d'achat des populations, d'autre part. Dans cet article, nous étudions les conditions d'accès des populations, notamment les plus démunies, aux soins de santé. Cette étude a pour objet, l'identification des obstacles qui contraignent l'accès aux soins de santé qualifiés à l'ensemble de la population et, la proposition de solutions permettant de les surmonter, pour assurer aux populations, notamment les plus démunies de meilleures conditions de vie. Nous nous appuyons à cet effet sur les résultats de l'Enquête Intégrée de Base pour l'Évaluation de la Pauvreté en Côte d'Ivoire (EIBEP, 2002-2003), réalisée par le Gouvernement ivoirien et la Banque mondiale. Nous montrons qu'en dépit d'une nette amélioration de l'offre de santé faisant suite à l'application de l'*initiative de Bamako* (1987) et l'essor croissant des mutuelles d'assurance, de nombreux obstacles persistent : L'offre des services de santé éprouve des difficultés à induire la demande en Côte d'Ivoire, conformément à la littérature relative à l'économie de la santé. Une première raison est le dysfonctionnement du système de santé national. La seconde raison qu'on peut avancer est la mauvaise gouvernance des hôpitaux et le manque de clarté de leur statut. Les structures hospitalières nationales sont en effet partagées entre les services publics et le parapublic. Quant à l'engagement les autorités publiques, il reste imprécis. La politique de promotion de l'autonomie financière des hôpitaux par les autorités publiques est de ce fait en net contraste avec la main mise de l'État sur la direction de ces hôpitaux. A coté de cela, il faut dénoncer la mauvaise qualité des prestations, clientélisme dans les centres de soins, etc. Le desserrement de ces étaux permettra de pallier l'essoufflement de la politique de santé en place et d'inscrire les réformes dans la continuité. Un engagement soutenu de l'État est suggéré pour consolider les infrastructures hospitalières et favoriser un bon fonctionnement du système de santé national.

Mots clés : santé, financement, micro-assurance, population, Etat

PS 04/8

Cost-effectiveness of insulin monotherapy versus oral blood glucose lowering agents in type 2 diabetes patients in six sub-Saharan countries: Long-term simulations based on a DiabCare Middle Africa 2008 study

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OBJECTIVE:
Non-communicable diseases, such as diabetes, are becoming increasingly prevalent in Sub-Saharan Africa. This is increasing both the direct and indirect costs associated with its treatment, management and complications. In this study we assessed differences in long-term economic and clinical outcomes relevant to type 2, insulin naïve diabetes patients, in the Sub-Saharan Africa setting between patients treated with oral blood glucose lowering agents (OGLA) and monotherapy with premix human biphasic insulin (Mixtard®30).
METHODS:
A validated computer simulation model of type 2 diabetes (the CORE Diabetes Model) was used to make projections of long-term clinical and economic outcomes. Base case cohort characteristics were based on DiabCare data (mean age 56.87 years, 37.8% male, duration of diabetes 7 years, HbA1c 7.99%). Current treatment refers to OGLAs; 38.2% on one OGLA, 53.3% on two OGLAs and 8.5% on three or more OGLAs. Treatment effects assumed that insulin monotherapy reduced HbA1C levels by 1.2%, increased BMI by 1.45 and increased minor hypoglycaemic event rate (per 100 patient years) by 0.043. Costs of treatment and complications were from published sources and are reported in 2008 US dollar ($) values. Future clinical and economic outcomes were discounted at 7.0% per annum. Projections were made over a 50-year time horizon to capture the costs of long-term complications.
RESULTS:
Undiscounted life expectancy and quality-adjusted life expectancy increased with insulin monotherapy by 0.52 years and 0.30 Quality-Adjusted Life Years (QALYs) respectively. Total lifetime costs increased by $37 per person. The incremental cost-effectiveness ratio (ICER) was $282 per QALY gained for insulin monotherapy versus current treatment.
CONCLUSION:
Treatment of type 2 diabetes patients with insulin monotherapy increases discounted life expectancy and quality-adjusted life expectancy versus OGLA treatment. The Incremental Cost Effectiveness Ratio (ICER) for insulin monotherapy versus the current treatment is $282 per QALY gained, which is considered a cost effective intervention.

PS 04/9

Estimating the economic burden of malaria in Sub Saharan Africa: a multi-country study

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Objective: Malaria is a leading cause of sickness and death of children less than 5 years old in sub-Saharan Africa. If all goes well, general implementation of the first malaria vaccine is possible within 5 years or so, as a complement to other malaria interventions. The objective of this study is to refine and fill gaps in estimates of the economic toll of malaria on health systems and patients, as well as the most exposed socio-economic categories and indirect costs, in order to assist countries in weighing the role of various interventions including a malaria vaccine.

Methods: The PATH Malaria Vaccine Initiative, in collaboration with partners at John's Hopkins School of Public Health and ISSER (Ghana) developed a study protocol piloted in Ghana in 2009 and that is anticipated to be implemented in up to 6 countries including Burkina Faso, Uganda and Nigeria. The primary country selection criteria included lack of comprehensive data on malaria costs, diverse malaria endemicity, ongoing malaria vaccine trial, and country relative regional influence. The study builds upon WHO economic guidelines1, which has been field-tested in similar settings. Data will be collected on direct medical costs (e.g. medications and diagnostics), nonmedical direct costs (e.g. transportation) and indirect costs (lost household productivity). Key perspectives of the analysis will be societal, patient, and healthcare system. Total cost per case will be determined as follows, cases for which formal medical care is:

- Not sought (e.g. traditional healers, pharmacies, home care)
- Sought, through:
    - Household survey
    - clinical records and standardized costing approaches (healthcare resources used and their unit costs)

Cost per child and national annual costs to the health systems will be estimated by combining cost per case with epidemiological information on incidence in that age group.

Results: Results will be generalized to the whole country and across sub-regions through econometrics models. Finally, this information will be used by our partners at the Swiss Tropical and Public Health Institute to generate cost-effectiveness ratios of malaria vaccines in various settings.

Conclusion: Malaria represents an important share in households' health budgets in the African region. This multi-country study was designed to provide malaria programs, governments, partners and scientists with high-quality, comparable data on malaria's costs in order to strengthen programmatic decision-making in the future.

(1): "WHO Guidelines for estimating the economic burden of diarrhoeal disease with focus on assessing the impact of rotavirus diarrhea"
(2) ISSER: the Institute of Statistical, Social and Economic Research
(3): World Health Organization

PS 04/10

Dépenses de paludisme chez les enfants de moins de cinq ans au Burkina Faso : résultats préliminaires d'enquête auprès des ménages

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Le Burkina Faso est un pays en développement. Sa population est estimée à 15 224 780 habitants en 2009 dont 17% a moins de 5 ans[6]. Le paludisme est la première cause de consultation (44,5% en 2008). Le pays est hyper-endémique avec une transmission saisonnière sur l'ensemble du territoire. .

L'objectif global de notre étude était d'estimer les dépenses de soins de paludisme supportées par les ménages aussi bien au plan préventif que curatifs. Il s'agissait, plus spécifiquement, d'évaluer les coûts directs médicaux, les coûts directs non médicaux et les coûts indirects par épisode.

Pour atteindre ces objectifs, une étude transversale a été réalisée, en période hivernale de pic de paludisme (août-septembre 2010) dans le district sanitaire de Nanoro au Burkina Faso. Cette enquête à concerné 506 ménages ayant un enfant de moins de 5 ans. Le nombre d'enfants impliqués dans la présente étude était de 960.

Les résultats préliminaires montrent que les enfants qui ont consulté à la formation sanitaire de première ligne CSPS représentent 26,2% (n 465), et 23,1% des patients ont été déplacé au moyen d'une bicyclette. Une (28%) à deux (19,9%) personnes, principalement la mère de l'enfant, de profession agricole ont pris soin des enfants malades. Les dépenses directes totales des ménages pour les soins des enfants malades sont à 60,6% des ménages nulles. Par contre 30% ont utilisé leurs économies pour prendre en charge les dépenses de santé des enfants malades de paludisme.

Les dépenses directes médicales des ménages pour la prise en charges des enfants de moins de cinq ans malades de paludisme ont été réduites. Elles pourraient être imputées à la stratégie de prise en charge gratuite des cas de paludisme de cette cible au Burkina Faso.

[6] Institut national de la statistique et de la démographie (2008), *Recensement général de la population et de l'habitation (RGPH) de 2006 du Burkina Faso-Résultats définitifs*, Ouagadougou, 52 p.

PS 04/11

Costing the large-scale implementation of Intermittent Preventive Treatment of malaria in Children delivered through Community Health Workers in Senegal

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Background: In Senegal, recent evidence suggests that malaria is decreasing, further strengthening the need for robust cost and cost-effectiveness estimates of malaria interventions to ensure the most efficient use of scarce resources in a setting with many competing health needs. To date seasonal intermittent preventive treatment in children (IPTc) has been highly efficacious in preventing malaria in children under 10 years of age living in areas of seasonal malaria infection under randomized control trial conditions. The results presented here are based on a large-scale, 3 years implementation study in 4 districts in Senegal. In the final year of IPTc implementation, Vitamin A was also distributed alongside IPTc and the combined costs evaluated. In 2010, the World Health Organization identified the results of this economic study as a critical element in its upcoming formal policy decision on IPTc, and as the only economic evaluation of IPTc at scale, its results will be influential for malaria control strategies throughout the region.

Methods: 812 community health workers delivered IPTc door-to-door to approximately 185,000 children under 10 years old in 725 villages, under the direction of district medical health teams and nurses employed in government health facilities. Sulfadoxine-Pyrimethamine plus Amodiaquine was given by CHWs once a month for 3 consecutive months during the high transmission season from year 2008 to 2010. Implementation scale-up costs capture start-up costs in year one and the costs in subsequent years. Data was collected from both "top-down'' (using budget and centrally available data) and "bottom-up'' (using facility-based costs and extensive interviews on resource use). Costs reflect staff time, micro-planning, training, drugs, supplies and equipment, vehicles, delivering, sensitization, supervision and evaluation. Both financial and economic costs are presented from the provider perspective.

Findings: Preliminary results suggest that IPTc can be delivered at costs comparable to other malaria prevention interventions. The costs are lower than previous costings of IPTc due to economies of scale and scope. Findings also suggest that the incentives paid to CHWs were by no means the largest cost component associated with delivering IPTc.

Conclusions: IPTc can be delivered annually year on year at costs comparable to other malaria interventions. There is potential for costs to decrease further by integrating IPTc with other delivery programmes such as vitamin A delivery, to take advantage of economies of scope and to further strengthen the role of the existing network of CHWs.

PS 04/12
Analyse du processus de capitalisation régionale d'expériences d'exemption du paiement des soins en Afrique de l'Ouest

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Au rythme actuel, la plupart des pays d'Afrique subsaharienne n'atteindront pas les Objectifs de Développement du Millénaire dans le domaine de la santé. Lever l'obstacle de la barrière financière par la suppression du paiement au point de service est une stratégie en développement en Afrique de l'Ouest afin d'améliorer significativement l'accès aux soins de santé. Cependant, bien souvent, la décision est d'ordre politique. Les données probantes sur la mise en œuvre de ces politiques étant encore rares ou d'accès difficile, les techniciens sont souvent pris de cours dans son organisation, plus technique et complexe que l'on pense. Ainsi, l'Université de Montréal a planifié un projet régional visant à mettre au jour et à valoriser les connaissances tacites acquises par les responsables de ces projets ou politiques d'exemption du paiement des soins (*lay knowledge*). L'utilisation des connaissances ne se limite pas à celles des résultats (*findings use*), l'apprentissage se déroule aussi lors du processus (*process use*). Jugeant ce dernier tout aussi important que les résultats dans ce projet, le poster analyse le potentiel de succès du processus mise en œuvre.

La méthodologie repose sur une étude réflexive entreprise avec le cadre d'analyse SEPO (Succès/Echecs/Potentialités/Obstacles).

Le projet venant de démarrer, les résultats ne sont pas encore disponibles. L'analyse portera sur les principales composantes du processus telles que la dimension participative, l'approche par étape, la revue exploratoire concernant l'exercice de capitalisation, la synthèse des connaissances régionales relatives à l'exemption du paiement des soins, le choix des pays, des partenaires et des objets étudiés, l'accompagnement technique et méthodologique proposé par le projet, les examens critiques des politiques et des projets, le partage d'expérience, l'organisation des processus délibératifs, les stratégies nationales de dissémination des résultats, etc.

L'une des étapes préalables à la production de politiques publiques fondées sur des preuves (*Evidence Based Policy*) est la construction et le partage des connaissances. Celles-ci ne peuvent être limitées aux seules recherches scientifiques.

PS 03/13
Improving visibility of African Experts in the international literature. Way forward.

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African Researchers are still under represented in the international health literature over either African or global health issues. Innovative measures have to be taken to address this challenge. The Institute of Tropical Medicine of Antwerp, Belgium (ITM) launched a project since 2008 where we experimented various projects to improve visibility from Southern experts, particularly from low income countries and African countries in the international literature. The first move has been the development of a newsletter to allow knowledge sharing (http://www.itg.be/ihp) . But to increase the voice of experts from the South in the International debate further steps are necessary. Hence since 2010 we started a writers club where experts from developing countries with experts from developed countries share informally on important issues which from time to time should lead to the publication of a viewpoint (Agyepong 2010 in press). The capacity in making presentation, write academic papers and knowledge of the mechanisms to get a paper published have also been identified as crucial skills required to allow experts share information and publish papers in international journals. To improve these skills we launched the emerging voices essay competition on universal health care coverage and we provide support to publish paper when we think they have a chance to pass the selection process.

The session we propose is a presentation of this concept, coupled either to a presentation by the winner of our competition http://www.itg.be/colloq2010 and or by a brainstorming discussion on needs for African researchers to succeed in getting their research and opinions published. This session could be in the core programme or eventually organised as a side event.

PS 04/14

Contribution des ménages abidjanais au financement de services de santé de long terme.

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Les systèmes de financement communautaire ayant longtemps servi à pallier les insuffisances du mode de financement étatique de la santé rencontre aujourd'hui plusieurs obstacles tant dans leur mise en œuvre que dans leur fonctionnement. Si les individus ne parviennent pas à cotiser pour accéder aux soins de santé par leur adhésion, une fois dans le système de santé communautaire, ils désistent pour la simple raison qu'ils n'arrivent plus à honorer leurs engagements. Si rien n'est fait, ce sont, d'une part, les populations qui limiteront davantage leur accès aux soins, et d'autre part, ce sont les systèmes de financement communautaire qui mettront à mal leur pérennité. C'est pourquoi, l'une des manières de réduire ces différents risques, est de proposer un taux de cotisation qui serait proche du taux maximum que les populations sont prêtes à payer pour des soins de santé de long terme.

Ce papier tente de participer aux discussions sur les raisons pour lesquelles certains systèmes de financement communautaire de la santé sont, ou ne peuvent pas être pérennes ; de manière à trouver des éléments de réponse pour assurer leur performance.

L'objectif général de ce papier est de fournir des informations sur le consentement à payer des ménages abidjanais à adhérer aux systèmes de financement communautaire. De façon spécifique, il est question de: (i) Evaluer le consentement à payer des populations pour accéder à des soins de santé de long terme; (ii) Identifier les facteurs explicatifs de leurs dispositions à payer.

La méthode d'évaluation contingente a été utilisée à travers un questionnaire ouvert, pour évaluer le consentement à payer des ménages. Une régression Probit a permit d'obtenir les facteurs explicatifs du consentement à payer et une régression tronquée a permit d'obtenir les déterminants des dispositions à payer des ménages. Les estimations ont été réalisées avec le logiciel Stata dans sa version 9.1.

Les résultats de cette investigation révèlent que sur 464 ménages interrogés, 304 ménages ont consenti à adhérer au financement communautaire. Ces 304 ménages ont également consenti à payer pour bénéficier de soins de santé de long terme. Ils consentent à payer en moyenne 11 497 FCFA pour bénéficier des garanties qui leur seront offertes. Les facteurs explicatifs qui militent en faveur de ces deux décisions sont : l'âge, le statut matrimonial, le statut professionnel, le revenu, l'accessibilité géographique, le niveau d'étude supérieur et l'offre de soins de spécialité.

PS 04/15

Knowledge management for better health care financing policies: lessons from the African PBF Community of Practice

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Performance-Based Financing (PBF) is taking off in sub-Saharan Africa. The innovative character of the strategy raises major challenges in terms of knowledge management. In this presentation, we will first review the literature on knowledge management in the health sector and summarize the emerging consensus in terms of strategies for getting research into policy and practice. We will then present the community of practice strategy, an innovative model for generating, accumulating and sharing knowledge on health policies. We will present the experience of the African PBF Community of Practice, its organisation, its membership, its activities and its achievements so far. We will argue that one of the strengths of the strategy is to value professional knowledge acquired by experts involved in the design, implementation and evaluation of PBF strategies. It also tries to involve experts working at all the different levels of the knowledge-value chain (researchers, policy makers, frontline managers, technical assistants, consultants). Challenges and prospects will be identified.

[7] Members of the core group are : Olivier Basenya, Paulin Basinga, Nicolas de Borman, Christian Habineza, Jean Kagubare, Jean-Pierre Kashala, Laurent Musango, Floride Niyuhire, Louis Rusa, Claude Sekabaraga, Agnès Soucat and Frank van de Looij.

PS 05/1

The sudden removal of user fees: the perspective of a frontline manager in Burundi

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In May 2006, the President of Burundi announced the removal of user fees in all health centres and hospitals for children under 5 and women giving birth. As other studies describe, the policy was adopted extremely suddenly, without attention to its ultimate aims and on the operational dimension of its implementation.
This paper aims at analysing the impact of user fees exemptions, both on indicators and on the broader health system. However, while most of the existing literature describes how the policy was conceived and implemented from the eyes of the central level policy-makers, this study adopts a new perspective, that of the frontline manager of the Muramvya District Hospital, who witnessed the effects of the reform on a peripheral health structure. This point of view can effectively complement a central-level analysis performed by an external researcher, highlighting issues that could be otherwise overlooked.
From a methodological standpoint, the authors are clear about the question of 'positionality' of the researcher (Walt *et al.* 2008): indeed both authors are 'insiders', although to different extents. While they recognize the advantage of being 'insiders' and participant-observers, in terms of better understanding of the context, they are also aware of the intrinsic tension between their role in the policy implementation and in its evaluation –they are both players and referees. Notwithstanding this, they remain confident of being able to provide an interesting account that brings originality to the analysis, while at the same time being extremely rigorous.
This first-hand account of the introduction of the exemption policy highlights the challenges that the district and hospital teams faced. Main issues regarded the reduction of financial flows, which prevented the possibility of investments and caused frequent drugs stock-outs; the reduced quality of the services and the disruption of the referral system; the motivation of the health staff who saw the administrative workload increase (not necessarily because of increase in utilisation) and was faced to 'ethical dilemmas' caused by the imprecise targeting of the reform.
Undoubtedly, the removal of user fees for certain groups was an equitable and necessary measure in an extremely poor country such as Burundi. However, the suddenness of the decision and the lack of careful preparation had long-lasting, disrupting consequences on the entire health system. This analysis, performed from the unusual frontline perspective, clarifies the importance of a rigorous planning of any reform, as well as of involving peripheral actors. Peripheral actors usually have information available on the functioning of the system and the management of health facilities that can effectively guide the implementation of the reform.

PS 05/2
Les initiatives de gratuité au Cameroun : Quelle effectivité dans la prise en charge de la tuberculose ?

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Cette dernière décennie a été marquée dans nombre de pays dont le Cameroun, par des initiatives de gratuité et des mesures alternatives face aux difficultés posées par le système de paiement direct qui était jusque-là imposé aux malades ou aux usagers. Mais seulement, loin d'observer une gratuité totale à tous les soins et pour toutes les maladies, il s'est davantage agi des politiques de gratuité ciblées sur des catégories sociales précises (femmes, enfants, handicapés, indigents…) et sur des maladies bien « *élues* ». En contexte camerounais par exemple, dans les années 2004-2005, les autorités sanitaires ont présenté le VIH/Sida et la TB comme devant faire l'objet d'une attention particulière. L'accès aux Antirétroviraux et aux Antituberculeux a été déclaré officiellement gratuit pour tous les malades. Ces initiatives de gratuité des médicaments soutenues par les organismes internationaux (Banque mondiale, Fonds mondial…) font pourtant l'objet des débats particuliers et contradictoires auprès des acteurs. Elles soulèvent des enjeux socio-politiques pluriels. Des enquêtes de terrain menées au Cameroun, acteurs institutionnels, professionnels de santé et malades bénéficiaires, ne s'accordent pas toujours ni sur les principes des politiques de gratuité, ni sur leur dimension, leur valeur, leur perception, leur durabilité dans le temps, leur financement ou leur recouvrement. Pour le cas de la TB précisément, ces initiatives de gratuité, ont eu des effets pervers notoires. Les soignants ne manifestent plus un réel engouement pour un encadrement gratuit des malades ; les malades pour la plupart, pensent que « *ce qui est gratuit est sans importance ou sans valeur* ». Ces contradictions entrainent des reprises, rechutes et échecs thérapeutiques qui ne favorisent pas la rupture de la chaine de contamination de la maladie. La présente communication a pour objectif, de comprendre, de décrire et d'analyser les incidences que ces initiatives de gratuité ont eues dans l'organisation institutionnelle des soins contre la TB d'une part et sur les trajectoires thérapeutiques des malades tuberculeux d'autre part. Comment ces politiques de gratuité ont-t-elles été construites ou acquises sur le plan institutionnel ? Comment les professionnels de santé et les malades de la TB s'approprient-ils ces initiatives? Peut-on interroger la durabilité de ces politiques impulsées par les dynamiques exogènes ? Cette recherche entend apporter quelques éléments d'analyse à ces questions.

Mots clés : Initiatives de gratuité, effectivité, prise en charge, tuberculose, Cameroun.

PS 05/3

User fee reduction in Kenya: adherence to revised charges at primary care facilities and implications for quality of care

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Aims and objectives Following evidence that user fees present a barrier to accessing health services, especially for poor and vulnerable people, there has been increasing pressure for user fees to be reduced or abolished. In 2004, Kenya removed high and variable user fees for primary health facilities, replacing them with flat rate fees of KES 10 (approximately US$0.15) at dispensaries, and KES 20 (approximately US$O.30) at health centres. Kenyan based studies in 2005 and 2007 on the implementation and impact of this policy suggested that following an initially positive impact, adherence to user fee reduction has been variable but generally low. Although this has important negative implications for universal financial protection, reported reasons for failure to adhere included the need to maintain essential services, patient satisfaction and staff morale.

This study aims to present nationally representative data on user fees currently charged in government health centres and dispensaries, and to examine associations between fees charged and structural quality of care, staff motivation and patient satisfaction. This information will be essential in guiding future policy on user fee levels and the financing of primary health facilities more generally.

Methods Data are currently being collected from a randomly selected sample of 265 public health centres and dispensaries in 24 districts across all 8 provinces in Kenya. Data collection at each facility includes an interview with the facility in-charge, a self-administered questionnaire for the in-charge, record reviews, exit interviews with patients (3 per facility), and interviews with health facility committee members (2 per facility). These survey data are complemented by data from semi-structured interviews with health managers at district level.

Findings We present data on adherence to the national user fee reduction policy across all facilities, and on the contribution of user fees to total facility income. We will also describe structural quality of care, staff motivation and patient satisfaction with health facilities, and explore associations of these variables with adherence to user fee policy. Key outcomes will be compared across facility type and rural/urban location. Finally, we will discuss the implications of the findings for future financing policy in the country and elsewhere in the region. In particular we will highlight the implications for the roll out of a new direct facility funding initiative being implemented in Kenya over the next 2 years, which is intended to improve quality of care and facility utilisation, partly through improved adherence to user fee reduction.

Parallel session 5: Covering those outside the formal employment sector III

PS 05/4
Examining community-based health insurance (CBHI) financial risk protection in southeast Nigeria

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Objectives: To determine CBHI financial risk protection in two communities with varying success levels in implementing the scheme.

Methods: The study was undertaken in Anambra State, southeast Nigeria. Two communities (Igboukwu and Neni), one successful and one not successful were purposively selected from the 10 CBHI pilot communities for the study. The rural communities were chosen because most of the pilot schemes were conducted in rural setting and majority of the people live in rural area. CBHI scheme success was determined by enrolment data in the facility.

The study was cross sectional and data were elicited from head of households or their representative using a pre-tested interviewer-administered questionnaire. Sample size was determined, using a power of 80%, 95% confidence level and utilization rate of public health facilities of 20%, giving a sample size of 400 per community. The sample size was increased by 25% (i.e 500 per community) in order to control for non-response rate. Households were selected by simple random sampling from a sample frame of primary health care house numbering system. Data collected included socio-economic and demographic characteristics, as well as willingness to renew registration and to pay for others.

Results: The highest level of education and occupation of enrollees in the scheme in both communities were primary education and petty trading. 36.5% in Igboukwu and 32.8% in Neni had primary education while 50.3% in Igboukwu and 61.4% in Neni were petty traders. Enrolment level was 14.9% in Neni community and thus less successful compared with 48.4% in Igboukwu community. Most respondents who registered did so because they perceived that the scheme offered financial risk protection. Flat amounts of 100 naira (less than $1) were paid as registration fee/premium by all SES quartiles. There were no exemptions and no subsidies.

Conclusion: Contributions were regressive and although the average premiums were small but unaffordable to the very poor. Education level and occupation of enrollees expectedly indicate people in the lower socio-economic status. For sustainability and financial viability of CBHI, efforts need to be made to increase the number of enrollees, so as to increase the pool of funds and risk sharing. CBHI premiums should be supplemented by subsidies from government and donors funding in order to ensure equitable financial risk protection.

PS 05/5

Understanding the role of social capital in demand for community-based health insurance in Senegal

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Aims and objectives: Community-based health insurance (CBHI) has been proposed by health policy makers as a mechanism to remove financial barriers to health care in low-income countries. However, the evidence base on CBHI is limited and it is unclear whether CBHI schemes are sustainable in the long term. Although it is estimated that in West Africa there has been a rapid increase in the number of CBHI schemes, from 199 schemes in 2000 to 585 in 2003, levels of population coverage remain very low. To date, studies aiming to understand demand for CBHI have mainly focused on economic and health systems factors as explanatory variables. These studies have been unable to fully explain variations in demand for CBHI because, it is argued in this study, there has been insufficient consideration of social, political and cultural context.

This study aims to address this gap by exploring whether social capital can help explain demand for CBHI in Senegal, one of the first countries in Africa to introduce CBHI.

Methods: This mixed-methods study extends the scope of a handful of previous studies of social capital and CBHI by including a more comprehensive range of indicators. Stratified random samples of 620 CBHI scheme members, ex-members and non-members residing in the target population across three different CBHI schemes were surveyed. The household survey is complemented by 80 semi-structured interviews.

Key findings: Preliminary analyses of the survey data suggest that as expected household wealth is significantly associated with the likelihood of enrolment in CBHI schemes. However, other social, political and cultural factors are also significant (controlling for demographic factors, education and health status). These include enrolment in other associations, borrowing money, having privileged social relations (such as having godchildren or homonyms), trust and feeling of control of over local decision making.

The interviews shed further light on how solidarity, trust, intra and extra-community networks (for example membership of Sufi brotherhoods and agricultural collectives), vertical links with local power structures, identity (religion and ethnic group) and opinions about local developmental priorities affect people's decisions about joining and quitting CBHI.

The results suggest that CBHI schemes might be able to increase their membership by further drawing on existing local social structures and networks. With a more long-term view to moving towards universal coverage, these results suggest that schemes wishing to scale up beyond the local level, perhaps by merging with other CBHI schemes, should also consider drawing on meso or national level existing social structures to increase demand in the broader population.

PS 05/6

National Health Insurance in Ghana - a systematic appraisal of the impact of community perceptions on enrollment

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Objective:
This paper identifies, ranks and compares community perceptions as they relate to providers, insurance schemes and community attributes. Further, it explains how these perceptions affect household decisions to enroll and remain in the scheme.

Methods:
Using data from a household survey study sample of 3,301 households and 13,865 individuals we use Principal Component Analysis (PCA) to evaluate respondents perceptions. Percentages of maximum attainable scores were computed for each of cluster of factors to rank them according to their relative importance. A multinomial logistic regression was run to explain the effect of identified perception factors on enrollment.

Results:
This study reveals the impact of community perceptions on household decisions to enrol in NHIS. While respondents had positive perceptions on technical quality of care, benefits of NHIS, convenience of NHIS administration and community health beliefs and attitudes, they were negative about price of NHIS, provider attitudes and peer pressure. The uninsured were more negative than the insured about benefits, convenience and price of NHIS and these can be perceived as barriers. These findings are confirmed by the regression analysis.

Conclusions:
Policy makers need to recognize community perceptions as potential barriers to enrollment in their design of interventions to stimulate enrolment. While previous studies have focused on socio-economic and demographic characteristics in relation to insurance coverage and suggest policies such as exemptions and waivers, the role of perception factors suggests additional policies focusing on quality of care and especially those relating to the schemes.

PS 05/7

The effectiveness of financial and nonfinancial interventions in attracting nurses to remote areas of Tanzania: a contingent valuation study

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Many countries experience difficulties in attracting health workers to remote areas. This paper analyses (1) how strongly financial and nonfinancial incentives (housing and education) might affect nurses' willingness to work in remote areas of Tanzania, and (2) how strongly the level of financial incentives needed to attract health workers is affected by nurses' geographic origin and their intrinsic motivation. Contingent Valuation methodology was used to elicit the preferences over job locations for 362 nursing students. We created three main choice scenarios distinguished by their level of non-financial incentives for taking a remote job: (1) No non-financial incentives, (2) free housing, and (3) improved educational opportunities. In each scenario, the minimum wage premium needed to attract a nurse to a remote area was identified by presenting respondents with discrete choices between a centrally located and a remote job while the wage premium was gradually increased.

We calculated the share of nurses willing to work in remote areas at various levels of wage premiums in the respective scenarios. Finally we ran an interval regression model to identify the association between the nurses' reservation wage (i.e., the minimal wage needed to work in remote areas) and their geographic origin and intrinsic motivation. Without any interventions, 19% of nurses were willing to work in remote places. With provision of free housing, this share increased by 15 percentage points, while better education opportunities increased the share by 28 percentage points from the baseline. In order for a salary top up to have the same effect as provision of free housing, the top up needs to be between 80% and 100% of the base salary. Similarly, for salary top ups to have the same effect as provision of better education opportunities the top up should be between 120% and 140%.

Nurses with a very remote origin (i.e., origin more remote than the remote working place) had on average a 55% lower reservation wage than others, and those classified with high intrinsic motivation had on average a 30% lower reservation wage. Having children was not significantly associated with the reservation wage, while having dependants other than children was associated with an 18% increase in the reservation wage. Nurses in Tanzania respond to both financial and nonfinancial incentives. Specific educational interventions are more effective in attracting nurses to remote areas than housing. Substantial top ups are needed in order for salary to

have the same effect as alternative interventions In order for remote recruitment to be effective in reducing the need for incentives to attract nurses to remote areas, health workers need to be recruited from places that are more remote than the places supposed to be their work stations. The next steps should be to estimate costs in order to implement the most cost effective interventions for making nurses take up jobs in remote areas.

PS 05/8

Progressivity and determinants of out of pocket health care payments in Zambia

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Introduction: Universal health coverage has become an important goal for most health systems around the world. Achieving this goal requires that deliberate policies, including how to finance health services are introduced. Usually, in countries where universal coverage has been achieved, there has been a tendency of moving away from regressive financing mechanisms to more progressive ones. Out of pocket is one such financing mechanism which has been found to be regressive in most countries. Despite this, most African countries largely rely on out of pocket as a source of health financing. This has implications for attaining universal health coverage.

Objectives: To assess the progressivity and determinants of out of pocket health care payments in Zambia

Methods: Data are drawn from the 1998, 2004, and 2006 rounds of the Zambia Living Conditions Monitoring Survey (LCMS). Out of pocket expenses include costs of medicines, fees to medical personnel (e.g. Doctor / Health Assistant / Midwife / Nurse / Dentist, etc), payments to hospital/health centre/surgery as well fees to traditional healer. Socio-economic status was measured using per adult equivalence. Kakwani index (K_π), in addition to Lorenz and concentration curves were used to assess progressivity of payments. Statistical dominance was also performed. Logistic and Tobit regressions were used to assess the factors that predict payments out-of-pocket and the magnitude of payments respectively.

Findings: Results show that out of pocket payments were progressive in 1998 ($K_{\pi=}$ 0.0366) and 2006 ($K_{\pi=}$ 0.0171) and regressive in 2004 ($K_{\pi=}$ -0.0799). Dominance tests of Lorenz and concentration curves also significantly affirm the relative progressivity. Living in rural area was associated with less likelihood of incurring out of pocket payments but only in 2006. Larger households and those in high socio-economic categories were more likely to incur out of pocket payments and consequently larger amounts out of pocket compared to their counterparts.

Conclusion: There is need to cushion households from making out of pocket payments as this may be regressive. Also out-of-pocket payments may be progressive when the poor do not make payments as they cannot afford care. To mitigate these, alternative health financing mechanisms that are more progressive, guarantee access to care by all, and do not require health care users to pay at the point of use of health services should be introduced and promoted. This will reduce the incidence and the amount spent out of pocket by households.

PS 05/9

Costs of seeking health care: A barrier to Universal Coverage in DRC

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Aim and objectives

In DRC, around 80% of total health care expenditure is in the form of out-of-pocket expenditures at the point of service. The objective of this paper is to shed light on the extent to which the financial cost of accessing health services is a barrier to seeking care and, thus, to moving towards universal coverage of basic health care.

Methods

This paper uses a recently-available dataset that has not used yet been used for presentations at any conference. The dataset is drawn from a survey conducted in the district of Haut-Katanga (population: 1 million) in south-eastern Democratic Republic of Congo in Oct 2009. It includes information from all public, private and confessional health facilities in the district, a random sample of 1,060 households and more than 1,000 patient exit interviews. Using standard descriptive techniques, we (i) estimate the total cost of seeking care for different illness episodes, including user fees, diagnostic tests, medicine, informal payments and travel costs, (ii) estimate the degree of impoverishment that arises from this health expenditure and, (iii) explore how expenditure incurred in the utilization of private and confessional facilities differs from that incurred in the utilization of public facilities. We also use interviews with households to understand their perceptions of the relative importance of financial barriers versus other potential barriers to accessing care.

Key findings

Preliminary data analysis confirms our hypothesis of a high level of out-of-pocket expenditure on health care in this district. We also find that user fees are only a small part of total costs: transportation fees can be very high (but with much variation across the sample) and expenditure on medicine is substantial. There are also differences between public and private facilities. Thus, so far, our findings confirm that, in DRC, the high level of out-of-pocket expenditure by patients is a formidable obstacle to obtaining universal coverage. Achieving the sort of financial accessibility that is needed for universal coverage of services will need to address, but also go far beyond, user fee policies.

PS 05/10

Analyse Situationnelle sur la réforme des critères d'allocation des ressources dans le secteur de la santé au Sénégal

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Le But et objectif général : Dans un contexte international défavorable, le Sénégal est confronté à d'importantes tensions budgétaires qui exacerbent naturellement le climat social et l'exclusion des plus fragiles et cette situation accentue la concurrence entre les différents départements ministériels. L'heure est donc, plus que jamais à la bonne gouvernance et c'est au travers de la réforme des critères d'allocation, que le ministère de la santé se placera en situation de défendre son budget par rapport aux autres secteurs, en optimisant ses ressources dans les meilleures conditions.

Depuis la mise en place d'une politique de décentralisation principalement au bénéfice des collectivités territoriales, le système de santé publique au Sénégal est soutenu par des contributions émanant de toutes les strates socio-économiques du pays. En dépit des efforts consentis, l'analyse des différentes études réalisées et des indicateurs ne révèle pas une amélioration significative du système de santé dans son ensemble.

Le but de cette étude est d'améliorer l'efficacité de la dépense publique et optimiser le *«franc investi»*, telle est la volonté du ministère de la santé. L'objectif général est de fournir aux parties prenantes de la gestion stratégique du secteur de la santé une base d'information pour soutenir les débats de politique portant sur la réforme des mécanismes d'allocation des ressources.

Méthodologie : Nous avons mené une recherche qualitative qui a consisté d'une part à réaliser une analyse documentaire de la littérature disponible sur les politiques budgétaires, et d'autre part des entretiens approfondis avec deux groupes d'informateurs clés (les témoins privilégiés et les détenteurs d'enjeux). Une analyse des politiques budgétaires du secteur est faite et sur la période allant de 2006 à 2008 et les priorités sont avancées et exécutées pour une meilleure objectivité dans les conclusions de l'étude.

Principaux constats : Après l'analyse des mécanismes traditionnels et une revue des expériences nouvelles en matière d'allocation des ressources, des propositions sont avancées pour poser les nouvelles bases d'une réforme concertée. Nous préconisons que l'allocation des moyens dans les structures de santé ne soit pas uniquement liée aux critères démographiques (population de référence) et infrastructurels, si l'on veut corriger les disparités géographiques. Il est pertinent de mettre en place des mécanismes de discrimination positive proposant une allocation supplémentaire pour les localités défavorisées où le principal déterminant serait l'indice de pauvreté.

Trois scores sont calculés pour les critères d'allocation des ressources des structures porteurs d'objectifs: Démographique ; Pauvreté ; Plateau technique. Un score Total composite est également calculé pour chaque région administrative, basé sur des pourcentages suivants: Poids démographique (50%), Contribution à la pauvreté (30%), et Plateau technique (20%). L'étude a donné des moyens opérationnels permettant de transcrire les critères d'allocation des ressources proposés dans le budget.

Parallel session 5: Service access issues II

PS 05/11
Stratégie d'amélioration du financement des évacuations sanitaires, District Sanitaire de Kéita (Niger)

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Introduction : Depuis quelques années, certains pays africains dont le Niger ont adopté des politiques d'abolition du paiement direct en ciblant des catégories de personnes ou de services. Cette suppression du paiement s'opère au niveau de l'offre de service, elle ne prend pas en compte l'accessibilité géographique et financière pour les cas nécessitant une évacuation sanitaire du niveau primaire vers le niveau secondaire. Dans cet essai nous documentons une expérience pilote qui a porté sur l'importance de considérer la place des évacuations sanitaires dans les mécanismes d'exemption de l'accès aux soins des populations vulnérables.

Méthodes : - Mise en place de l' « approche centime additionnel » qui est un système de prépaiement pour financer les évacuations sanitaires. Il consiste à prélever un centime additionnel de 100 FCFA (15 centimes d'euro) sur chaque nouvelle consultation pour constituer un fonds pour financer les évacuations sanitaires.
- Un système de collecte de fonds qui va de pair avec le système d'évacuation a été organisé allant de la case de santé à l'hôpital de district. Le patient est pris en compte à partir du moment où il est en contact avec les services de santé.

Résultats : - un fonds d'évacuation sanitaire excédentaire fut constitué. 77% des fonds collectés proviennent des centimes additionnels des populations cibles de la gratuité.
- Un doublement des cas évacués qui est passé de 191 en 2008 à 460 en 2009. Une analyse approfondie montre que plus de 72% des évacués sont représentés par les populations cibles de la gratuité.

Conclusions : Dans cette approche, les ressources sont mises en commun par un mécanisme de prépaiement engendrant des subventions croisées : les moins malades qui à un moment donné consomment un type de service de santé participent au financement des évacuations des malades graves. Elle a permis d'agir sur la barrière géographique d'accès aux soins au niveau secondaire dont le coût estimé à 37 euros est parfois plus élevé que le coût de la prestation de soins. Ce montant, hors de la portée de la plupart de ces populations rurales, constitue des dépenses catastrophiques de santé. Cela a promu une forme d'équité, a permis d'éviter qu'un ménage ne se paupérise du fait de ses besoins de santé.
Pour conclure, le prépaiement, la mise en commun des ressources représentent une stratégie efficace de couverture du risque maladie et de prévention des effets appauvrissants de la mauvaise santé.

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PS 05/12

Re-consideration of the Demand and Supply side challenges facing community health insurance in promoting financial risk protection and access to health care in Tanzania

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Voluntary community health insurance is being promoted as a means of increasing access and financial protection in low-income countries among the informal sector. In Tanzania, a voluntary community health insurance scheme (the Community Health Fund: CHF) was introduced for the rural informal sector in 2001 due to the failure of the government to provide free health care to all its citizens through tax financing. The scheme provides its members with free care in primary and, in some cases, secondary level public facilities. Health facility governing committees were established to mobilize people to join the CHF. The aim of this paper is to explore the characteristics of members of the CHF and to explain the demand and supply factors influencing enrolment.

A survey was conducted in 2,234 households in seven district/councils (3 urban and 4 rural) in 2008, and data were weighted to be nationally representative. 18 focus group discussions were carried out in two rural and two urban districts with members of the CHF, non-scheme members, members of health facility committees and council health service boards designed to oversee the quality of health care in the district. Two in-depth interviews were carried out with doctors in charge of primary care facilities.

People from poor (with low or unstable income), large households where the household head had primary level education or no education and had poor perceived health status were more likely to enroll in the CHF. The main reasons for joining the CHF was financial protection, which was partly due to the high cost of services when paying out-of-pocket. However, enrolment rates in the districts visited were very low, due to supply and demand factors. Supply (availability) factors affecting people's willingness to join, included shortages of drugs, health workers, a lack of diagnostic equipment and poor quality of care at public primary facilities. Demand (acceptability) factors included the limited benefit package offered by the CHF and a lack of understanding of the concept of risk pooling. Affordability was an issue mainly in cases of repeated illness, multiple cases of sickness at same time; and inpatient admission.

Community health insurance has been effective in reaching poorer groups in Tanzania, however, the limited benefit package means that financial protection is incomplete, and access is limited to facilities with poor quality of care. To encourage enrolment, the benefit package should expand and better management and awareness rising will be critical.

Key words: community health insurance, financial risk protection and access to health care.

PS 05/13

Universal coverage and access barriers to use of health care in Ghana

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Introduction: Universal coverage is built around financial protection and access to needed care for all members of the society. The main focus in many countries including Ghana has been on financial cover. However removing financial barriers does not necessarily remove other access barriers to the use of health care services. The extent to which a population gains access to needed health care depends on a multiplicity of factors. Both community and health service factors affect access to health care services.

Objective: To explore health service and community factors that influence access to health care service in Ghana.

Methodology: The study was conducted in rural and urban communities in six districts in Ghana. Twenty six focus group discussions and twenty nine in depth interviews were conducted with community members and health care providers respectively. The study explored key barriers to accessing health care from the perspective of the community and the service provider.

Findings: Key access barriers found include economic factors such as direct and indirect costs to seeking health care. Many health facilities are located long distances away from the population they serve. Travel time and cost including waiting time deter many poor rural populations from seeking health care. Other factors include organizational factors such as availability of staff and equipment leading to frequent referrals which many poor people find difficult to adhere to. Unpredictability of opening hours in small rural facilities is a problem. Other issues include poor staff attitudes and lack of confidence in some health facilities in dealing with health needs of segments of the population deter use. Lack of awareness of entitlements and information on NHIS hinders access to health care.

Conclusion: Financial protection alone will not necessarily ensure access. Other factors such as geographical, organizational, socio cultural and informational factors need to be tackled concurrently to facilitate access to health care services.

PS 05/14
Utilization and predictors of health insurance coverage among the elderly in a rural setting, Kenya

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Background: Aging is a natural process that begins the day one is conceived. The elderly (≥ 60years) especially in developing countries are characterized by ill health and low health insurance coverage. In Kenya, the elderly mainly enjoy health insurance from the National Hospital Insurance Fund (NHIF) as it is the only insurance product tailor-made to cover persons of all ages. Broadly this study aimed to establish the health insurance coverage among the elderly in a rural setting of Kenya and determine its predictors.

Methods: This cross-sectional survey was a baseline of a quasi-experimental study, designed to recruit uninsured elderly persons to a comparative longitudinal cohort to elicit predictors of health insurance (HI) coverage. Two administrative locations were randomly selected and assigned as experimental and control sites. A structured questionnaire was administered to 1,104 sampled elderly persons. With the aid of SPSS computer software, data was analysed and chi square test and logic regression used to measure the association.

Results: The ever owned HI Coverage was 12.9%, with significant differences (p=0.018) between the experimental and control sites - 15.2% and 10.5% respectively. Current HI coverage was declared by 5.9%, similarly with significant differences (p=0.010) - 7.7% and 4.0% in the experimental and control respectively. The National Health Insurance Fund (public sector) was the main provider of the current HI cover (4.7%). A number of predictors were found to be associated with utilization of HI among the elderly. Lack of enough details on health insurance was the main reason for low coverage (49.8%) followed by expensive premiums (35.9%) and a feeling that a health cover was not necessary (4.9%).

Conclusions: HI coverage among the elderly in the rural setting is low. This is attributed to poor knowledge on the importance of the health cover. There is need to enhance sensitization for promotion and increased health insurance uptake among the elderly.

PS 06/1

Promoting universal access to health services in post-conflict situations: what role can large scale cash transfer programmes play for better outcomes?

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Making well-informed decisions about how best to achieve MDGs depends on the ability of public policy makers in accessing the best available evidence about what is known to work and what could be potential benefits, and ways to integrate solutions into complex and often under-resourced health systems. Conditional cash transfer programmes have been largely explored as a policy for improving the education and health outcomes of poor children in developing countries as well as a tool for long-term poverty alleviation; but needs to be appropriate to the context and both fiscally and politically affordable. In DRC, the crisis and conflicts of the past decades severely affected the health status of the population and degraded the health system. Consequently, efforts in reducing infant and under-five morbidity and mortality are seriously hampered by widespread poverty and economic deregulation.

The aim of this paper is to question the feasibility and affordability of cash transfer compared to 2 alternatives: an outreach health and nutrition programme with a behavioral change communication component and the elimination of basic health care user fees. The results show that children health outcomes may instead be driven by the equal distribution of quality services through outreach health and nutrition programmes (20% to real GDP) than a large scale health-oriented conditional cash transfer (25.9% to real GDP). A number of issues is outlined with regard to the country's socio-economic and political context : (i) health-oriented conditional cash transfer cannot operate in DRC due to supply-side constraints and lack of health supply strategy, logistics and engineering ; (ii) targeting is somewhat time consuming and irrelevant in such context with a headcount averaging 77% ; (iii) outcomes of a geographic focused cash transfer programme could be expected on improvement of nutritional status, but less on the rise of health demand and would be difficult to scale-up.

Key-words: cash transfer, health, universal access, child poverty, post-conflict, DRC.

PS 06/2

The Balanced Scorecard: A Tool for Developing the Health Sector Development Plan IV in Ethiopia

A Policy Brief of the Ministerial Leadership Initiative for Global Health (MLI)

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Aim and Objectives: Ethiopia is a large country in both land area and population, but one with a GDP per capita of only $317[11]. Given its weak infrastructure and dispersed population, Ethiopia has chosen to decentralize its health system. The Federal Ministry of Health (FMOH) provides overall strategic guidance and mobilizes and allocates resources nationally, but the nine Regional Health Bureaus manage and oversee health service delivery all the way down the system to the Health Extension Workers in the communities and the woredas. In order to improve the efficiency of its decentralized system, the FMOH has embraced business process re-engineering and has sought ways to make service providers more patient-focused.

One of the key tools the GOE has used to manage the performance of its health system from the central level to the periphery is the Balanced Scorecard (BSC). The BSC aims to enhance the performance of managers, teams, and individuals at all levels of the health system by tying an employee's day-to-day work to overall system performance and assisting them to act more effectively at their place in the system. This issue brief describes the experience of designing and implementing a BSC throughout the health sector and draws lessons for other seeking to improve health system performance.

Methods: This paper reviews Ethiopia's experience of designing and implementing the BSC and examines how the tool has influenced the development of Ethiopia's new Health Sector Development Plan IV (HSDPIV). It documents the experience of MLI and the FMOH from 2008-2010 during which a technical assistance program was implemented to build capacity of Ministry leaders and health personnel at all levels to apply the BSC, and a FMOH study tour to Botswana helped to refine Ethiopia's approach.

Key Findings: The BSC has been used as a guiding framework for the preparation of 5 year health sector strategic document plan (HSDPIV). Key strategic focus areas, strategic objectives, performance measures and initiatives were developed for the health sector in consultation with all stakeholders. Staff at all levels to providers in the field were trained in BSC methodology to build capacity for its use throughout the long term operations of the health system and to strategically gather performance and operations data for decision making.

Ethiopia's experience suggests that the BSC can be a powerful instrument in shaping health policy and management. After the implementation of BSC at every level of the sector, this tool will enable more effective management of all sector activities to ensure alignment of effort in meeting the mission and vision of the sector.

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PS 06/3

Characteristics and operation of health facility committees in Kenya's primary care facilities: implications for promoting universal access

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Aims and objectives: Community participation has re-emerged as a top priority in health service delivery in sub-Saharan Africa. It is promoted both as a right in itself, and for its potential to identify and address health service access barriers such as poor quality of care and inappropriate health service delivery. To date, initiatives to increase community involvement in public health facilities have focused on the establishment of Health Facility Committees (HFCs) which include community representatives. In Kenya, the role of HFCs will be expanded from late 2010 with the introduction of a national programme of direct facility funding (DFF) into health centre and dispensary bank accounts, which will be managed by HFCs.

This paper aims to present nationally representative data on HFCs in Kenya in advance of the introduction of DFF nationally, documenting their characteristics and operation, and patient awareness of their activities. In addition we will assess associations between these characteristics and factors affecting access such as user fee adherence, patient satisfaction, and structural quality of care.

Methods: Data are currently being collected from a nationally representative sample of 265 randomly selected public health centres and dispensaries in 24 districts across all 8 provinces in Kenya. Data collection at each facility includes an interview with the facility in-charge, a self-administered questionnaire for the in-charge, record reviews, exit interviews with patients (3 per facility), and interviews with health facility committee members (2 per facility). These survey data are complemented by data from semi-structured interviews with health managers at district level.

Findings: The few empirical studies in the region suggest that there can be significant challenges for HFCs in meeting their goals, including in processes of selection and training of members, in lack of clarity and ability to perform technical roles, in relations between health facility in-charges and other committee members, and in awareness of HFC roles among the broader community. We will present data on these issues across the country, and describe differences in key variables between rural and urban facilities, and between health centres and dispensaries. Any associations between the presence of an active HFC with facility adherence to user fee reduction policy, patient satisfaction, and structural quality of care will be described and discussed. In particular we will identify implications for ensuring the successful implementation of DFF and the associated expanded HFC role.

PS 06/4
Assessment of the role of the private sector in the health sector in Ghana

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Aims and objectives: Ghana has had a policy of working with both public and private actors in health since at least 2003 when it adopted a formal policy. However, much of the agenda of the 2003 policy remains unfulfilled. Since 2004 Ghana instituted its National health insurance scheme (NHIS) that reimburses services used by members at accredited health providers, whether public or private. The Assessment used a supply, demand, and market and policy success and failure framework to gather and analyze data to inform the debate around how to maximize the benefit to national health objectives of private participation.

Methods: The Assessment examined demand through the analysis of two rounds each of the Demographic and Health Survey (DHS) and the Ghana Living Standards Survey (GLSS), the conduct of patient exit interviews, and the conduct of population focus group discussions. The examination of supply comprised the collection of data from all private actors (more than 600) in seven geographic areas, five urban and two rural, and the conduct of focus group discussions with private actors. The Assessment also conducted dozens of key informant interviews of regulators, policy makers, professional association leaders, representatives of groupings of private actors, input suppliers, sources of financing (banks and microcredit institutions) and others. The analysis of these data allowed the Assessment to draw conclusions concerning market successes and failures and similar conclusions concerning institutional factors.

Key findings: The Assessment painted a more-complete picture of the role played by the private sector than ever before available in an African country. Private for-profit providers are concentrated in urban areas and not-for-profits fill gaps in public provision in rural areas. The development of NHIS has had a profound impact on the role of the private sector, but its potential role is even greater. Ghanaians of all geographic areas and socioeconomic groups make heavy use of private care—more than 50 percent of service use is private and more than 80 percent of the use of private sources is at for-profits. Private providers are sought for short waits, customer service, and assured supply of drugs and diagnostics. Public providers are sought for low prices and the availability of doctors. Private actors are weakly organized to represent their interests to policy makers. Government regulation is weak and under-funded and staffed. Lack of business management skills prevents a greater expansion of private initiative, complicating already difficult access to financial capital.

PS 06/5

Universal coverage through National Health Insurance in South Africa: Do quality gaps between the public and private sector matter?

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Introduction and Objectives:
A common perspective on the state of the South Africa health system is that it is unsustainable. With an increasingly costly private sector providing health services mostly to those who can afford to contribute to private health insurance (PHI), while the majority of South Africans depend on the public sector. The private sector accounts for about half of total health expenditure. In response to this 'lop-sided' financing of health care (amongst other reasons), the government has proposed a national health insurance (NHI) system. Some of the components of the proposed NHI system are: freedom of choice between the public and private sector and a mandatory NHI tax to raise additional finances for the public health sector. It is hoped that the NHI will draw resources from the private sector to the public sector and ultimately reduce the proportion of the population that purchase private health cover. The objective of the paper is to estimate the likely impact of the NHI on the demand for PHI within the context of a quality gap between the public and private sector.

Methods and Results:
Household survey data from 2005 and 2008 are used to model the impact of an NHI tax on the demand for PHI. The study constructs a probability distribution for membership to PHI along an income axis. This is the basis for estimating the number of PHI beneficiaries following a shock to household disposable income from an NHI tax. The analysis follows a conceptual framework developed from literature on the demand for PHI with freely available or low-cost public health care. The results show that the demand for PHI is income inelastic. For example, for an NHI tax of 5%, the demand for PHI reduces by 2.6%. This is consistent with the prediction of a large quality gap between the public and private sector. Also, the results are supported by the trend in the demand for PHI and real contribution rates for PHI.

Recommendations and Conclusion:
The results of the study show that improving the quality of care in the public sector is a more efficient and effective policy lever to influence the demand for PHI than income or price policy levers. In the introduction of an NHI, the quality of care in the public sector must be improved to a level such that public and private sector health care services are seen as substitutes. Failure to do so will see a sustained demand for PHI, and an ineffective NHI system.

PS 06/6
Universal Coverage: Reflections of a missed opportunity in Rivers State, Nigeria

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There appears to be consensus that the poor health outcomes of people in sub-Saharan Africa (SSA) can be hugely improved – if equitable access to a full range of personal and non-personal health services for all is made available. But poor policy formulation and implementation continue to prevent progress in achieving universal coverage.

The aim of this paper is to highlight the fact that among other factors, policy inconsistency still constitutes a major impediment to increasing access to essential health services in SSA. The paper reflects on the policy implementation of a social health protection programme in Rivers State, Nigeria that was bungled. It attempts to understand: what went wrong, and what measures should have been taken to safe guard the programme.

Using Rivers State, Nigeria (population, 5.1 million) as a single case study, the paper tells the story of how what would have become a model universal coverage was mismanaged by the very champions that initiated the programme – the Government of Rivers State, Nigeria. The main sources of data are: a personal account of the author who provided technical assistance and guidance to the programme from inception, as well as documents (reports, minutes of meetings, programme memorandum, draft bill etc) that were produced in the planning process.

The key findings are as follows: over-concentration of executive power in one person – the Governor of the State, determine what policies get implemented in relation to other options; the failure of the Government of Rivers State, Nigeria to implement the Rivers State Social Health Protection Programme, was not due to lack of political will as such, but a failure to understand the use of the right tools in public policy making; and policy making is political as well as technical, therefore bureaucrats who posses neither of these skills in a specialised area such as this stand little chance of making things happen.

Drawing from the above findings, the paper concludes that in order to effectively manage key actors in implementing universal coverage policies, a lot more effort needs to be put into understanding the specific context under which this has to take place.

PS 06/7

Is Rwanda replicable? Mali's quest to learn from Rwanda's health insurance success and adapt its approach in a national strategy to extend mutuelles de santé

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Aims and Objectives: Having launched social health insurance and a fund to cover the health costs of the most indigent in 2010, Mali now intends to cover the 80% of its population working in the informal and agricultural sectors as it aims for universal health coverage. MLI is assisting the government by sponsoring a process of learning from Africa's health insurance success stories, specifically, from Rwanda's experience.

Methods: MLI is a demand-driven initiative to support governments in policy reforms aimed at equitable financing for health. MLI is supporting the Malian government's efforts to extend social protection to the informal and agricultural sectors by sponsoring peer learning opportunities, leveraging and coordinating donor support, and mentoring a core group of government technicians, civil society, and elected leaders as they develop, validate, and operationalize a national strategy to scale up mutuelles de santé.
Notably, MLI sponsored a study tour to Rwanda involving a delegation of technicians, representatives of civil society, and elected leaders. The group benefited from site visits and intense discussions at different levels of the system (national and local) with mutuelle administrators, providers, and elected leaders. The study tour culminated in producing a policy brief for Mali's political leaders about how the Rwandan model can help Mali advance toward universal coverage.

Key findings: Studying the Rwandan story firsthand advanced Mali's thinking and profoundly affected the design of Mali's national strategy to scale up mutuelles, specifically in terms of the organizational schema for a national system, the importance of government cofinancing, as well as in the close linkage of mutuelles with health centers and with local government.
A major lesson learned was that political leadership and engagement in bringing health insurance to the population is fundamental to success. Linking expanding health insurance to quality improvement mechanisms – performance-based financing for public facilities – has also been key to Rwanda's success.
Having a multi-disciplinary delegation including political leaders resulted in a more complete understanding of the economic, policy and other factors associated with Rwanda's success. It also meant that the lessons learned have been better communicated in Mali to a broader spectrum of stakeholders, and at a higher political level. The success of Mali's strategy to extend mutuelles nationwide will depend largely on effective leadership. MLI, the World Bank, and USAID are supporting Mali in the development of an advocacy strategy aimed at key decision makers – political, technical, and religious – and at development partners to secure their essential engagement.

PS 06/8

Cost and cost-effectiveness of intermittent preventive treatment of malaria in infants with Sulfadoxine Pyrimethamine in Senegal

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Background: Intermittent Preventive Treatment in infants (IPTi) is a new promising intervention for malaria control in Sub Saharan Africa which can be delivered through the existing routine Expanded Programme on Immunization (EPI). Although the efficacy of IPTi is proven, there is limited economic evaluation data on scaling up IPTi using sulfadoxine pyrimethamine (SP) as a strategy for malaria control in Senegal

Methods: Implementation scale-up cost was calculated by estimating IPTi incremental costs in the start-up year and in subsequent years. Costs included were the financial costs of delivering IPTi to infants (drugs and equipment) and of programme activities. In recurrent years, because a survey in IPTi areas showed high acceptability and health care worker knowledge, programme costs included only IPTi administration and safety surveillance. To estimate IPTi cost-effectiveness (IPTi net cost per case of malaria averted, per death averted, per year of life saved, and per disability adjusted life years) we calculated the intervention's economic costs in recurrent years using a pooled efficacy analysis. A time and motion study was also conducted to assess staff time on IPTi delivery and the associated costs.

Results: Delivering IPTi-SP to 17,500 infants incurred $40,753 in financial costs for programme implementation. IPTi's incremental financial costs in the start-up year ($3.31 US/infant) were substantially higher than in recurrent years ($1.04 US/infant). In startup years, communication activities accounted for the most significant expenditure (30%) while half of the total programme resources is allocated to capacity building of professional staff. In routine implementation, programme costs were US$ 0.81 per infant, and patient costs (drugs and utensils) only $0.24 US/infant. The incremental time needed to administer IPTi during EPI was 2.19 min/child on average, representing 7% of the time spent by health workers in immunization clinics. The net cost per averted case of malaria was $22.11.The cost per death averted was $447, per life-year saved $23.84 and per DALY averted $25.39.

Conclusion: IPTi with SP through EPI can be scaled up successfully at a low cost. Using pooled efficacy results from previous IPTi trails we can see that it is a highly cost effective intervention in the study sites where malaria transmission was both high and perennial. But, the IPTi cost-effectiveness in the other areas in Senegal where malaria transmission is not high, worth assessing.

PS 06/9

Costs and Effects of a Multifaceted Intervention to Improve the Quality of Care of Children in District Hospitals in Kenya

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BACKGROUND: It is estimated that more than 9.7 million children die globally before they reach the age of five. In Kenya, the under five mortality rate was 74 per 1000 children in 2008. To improve care for seriously ill children, a multifaceted approach employing guidelines, training, supervision, feedback and facilitation was developed, for brevity called the Emergency Triage and Treatment Plus (ETAT+) strategy. We assessed the costs and efficiency of delivery of the ETAT+ strategy in district hospitals in Kenya.

METHODS: A cost-effectiveness analysis from the provider's perspective was conducted alongside a cluster randomized study that compared the delivery of ETAT+ in four district hospitals in Kenya to four control district hospitals receiving a partial version of the intervention between 2005 and 2009. Effectiveness of the intervention was measured using 14 process measures that capture improvements in quality of care and span the assessment, diagnosis and treatment on admission for diseases resulting in 60% of inpatient deaths in children under five. The economic cost of development, implementation and treatment of sick children in intervention and control hospitals was estimated through interviews with implementers of the intervention, accounting and clinical record reviews. An annual discount rate of 3% was used and one way sensitivity analyses were used to assess uncertainty. Incremental cost-effectiveness ratios (ICERs) were defined as the cost per percentage improvement in quality of care as measured from the 14 process measures in control and intervention hospitals.

FINDINGS: The cost per child admission was US$ 54.74 in intervention hospitals compared to US$ 31.06 in control hospitals, while quality of care as measured by the 14 process measures was 23.05% higher in intervention hospitals than in the control hospitals. These results suggest an additional cost of US$ 0.85 per child admitted to achieve a percentage improvement in quality of care.

INTERPRETATION: Our findings indicate that the delivery of ETAT+ as a multifaceted intervention yields significant improvements in quality of care of sick children but at a higher cost. Knowing what value decision makers place on quality improvement and their preferences for attributes of this and similar quality of care interventions would be useful in making decisions about their adoption explicit. Also of importance is assessing the costs of scaling up to assess the feasibility of implementation of ETAT+ on a national scale.

PS 06/10

Cost analysis of psychiatric hospital services in Nigeria; A case study of Federal Neuropsychiatric Hospital Enugu (FNHE), South-East Nigeria

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Introduction: Efficiency in the health care system depends on sound and evidence-based decisions which in turn rest on the availability of reliable data. Information on the cost of mental health services in Africa is very limited even though mental health disorders represent a significant public health concern in the region. The study estimated the total and average/unit costs of psychiatric hospital services (including inpatients, outpatients and emergency services) to guide policy and psychiatric hospital management efficiency in Nigeria.

Methods: The study was exploratory and analytical, examining 2008 data. Using ingredient approach, top-down methodology was combined with step-down approach to allocate resources (overhead and indirect costs) to the final cost centers. All costs associated with treatment of the psychiatric patients (including annualized costs of buildings, equipments and vehicles) were measured on aggregate basis as well as on per capita basis. Costs were calculated from the perspective of the healthcare facility, and converted to the US Dollars at the 2008 exchange rate

Findings: Personnel accounted for the highest input resource averaging 80% of the total hospital cost, reflecting the mix of capital and recurrent inputs. The unit cost of inpatient day ($56) was equivalent to 1.4 of the outpatient visit at $41, while the cost of an emergency visit was about two times the cost of an outpatient visit. The cost of one psychiatric inpatient admission averaged $3,675 for an average period of 66 days, including the costs of drugs and laboratory services. About 90 new outpatients could be treated for the cost of one inpatient admission. Levels of subsidization for inpatients were over 90% while ancillary services are not subsidized hence full cost recovery. Cost of drugs is about 4.4% of the total costs and each prescription averaged $7.48.

Conclusion: The cost findings reflect inefficiency and inadequacy of resource inputs, requiring improvement of hospital management to reduce cost and enhance efficiency. Hospital policy should address the aspects of improving technical efficiency, setting administrative and practise standards, and implementing preventive community-based mental health services. Adequate research is needed for effective comparisons and valid assessment of efficiency in psychiatric hospital services in Africa.

Parallel session 6: Session on health financing and universal coverage in Senegal

PS 06/11
La couverture du risque maladie au Sénégal

Mbaye Sene, CAFSP

L'accessibilité aux soins de santé est une priorité de nombreux pays en développement. En effet, les évolutions des systèmes de santé des pays en voie de développement, malgré les efforts réalisés en matière de couverture sanitaire et d'amélioration du fonctionnement, n'ont pas favorisé, comme cela aurait été souhaité, l'équité dans l'accès aux soins de santé.

Plusieurs réformes ont été initiées et ont permis une amélioration du fonctionnement des structures sanitaires en termes de disponibilité en médicaments et de leur viabilité financière. Malheureusement, ces réformes ont également eu un impact négatif sur l'accessibilité financière aux soins de santé dont les déterminants les plus importants sont : (i) la mise en œuvre du recouvrement des coûts suite à l'initiative de Bamako qui a créé une première barrière notamment pour les pauvres ; (ii) les réformes des statuts des structures sanitaires les incitant à faire de l'équilibre financier une priorité nécessitant une bonne politique de recouvrement des coûts.

Ces réformes ont été réalisées dans un contexte de bouleversement des équilibres macroéconomiques liés aux chocs endogènes et exogènes, qui aggravent la situation économique des plus pauvres. Une des conséquences majeures de la pauvreté, selon les différentes enquêtes ESAM réalisées au Sénégal, est relative à l'incapacité de travailler pendant la maladie et de payer les dépenses médicales des membres de la famille qui sont malades. Ces difficultés d'accès aux soins de santé ont amené le Ministère de la Santé et de la Prévention à développer des programmes et des projets facilitant l'accès aux soins de santé surtout pour les groupes vulnérables il s'agit notamment de : (i) la gratuité des accouchements et césariennes ; (ii) la gratuité des soins aux personnes âgées (carte Sésame); (iii) l'accès gratuit aux antirétroviraux (ARV) ; (iv) le traitement gratuit du paludisme grave chez les enfants et les femmes enceintes; (v) et enfin la subvention pour la prise en charge des indigents.

Ces différents programmes qui facilitent l'accès aux soins par une solvabilisation de la demande permettent également une amélioration de la santé financière des structures de santé de l'Etat mais ils concernent une proportion relativement faible de la population non solvable.

En dépit de toutes ces initiatives, la problématique de l'accessibilité aux soins de santé reste encore aujourd'hui posée du fait surtout de la faiblesse du pouvoir d'achat des populations en général à laquelle nous nous intéressons ici

A cinq ans de l'horizon 2015, le Sénégal est confronté à plusieurs défis relativement à la contribution du secteur de la santé à l'atteinte des OMD, dont l'amélioration de l'accès aux soins de santé et la réduction des risques d'appauvrissement associés aux dépenses liées à la maladie pour la majorité des ménages Sénégalais. Pour relever ces défis, le secteur de la santé doit engager des réformes profondes pour améliorer l'accessibilité aux soins de santé, et protéger les revenus des ménages dans la santé.

Les efforts en cours pour augmenter les ressources allouées au secteur de la santé à hauteur de 15% du budget de l'Etat à l'horizon 2015 vont sans nul doute contribuer à faire face au défi. Ces efforts devraient être combinés, cependant, avec des réformes majeures des mécanismes de financement et d'allocation des ressources dans le secteur pour accroître l'efficacité des dépenses publiques relativement à l'accessibilité aux services de santé et la protection des revenus des ménages dans la santé.
Appréciée en termes de nombre de personnes couvertes, on constate que seulement 2.252.2002 sénégalais soit 20,13% de la population totale bénéficient d'un système de couverture du risque maladie ***(Stratégie Nationale d'Extension de la Couverture du Risque Maladie, 2008).***

En termes de fardeau économique, en 2005, la Dépense Nationale de Santé est de 254,2 milliards de FCFA dont plus de 84 milliards de FCFA, soit 33% constitués principalement des apports des ménages.

C'est dans cette perspective, que l'extension de la protection sociale a été inscrite comme un axe prioritaire du deuxième document de stratégies de réduction de la pauvreté du Sénégal.

Depuis les réformes ayant instauré les régimes d'assurance maladie pour les employés du secteur formel et leurs ayant-droits au milieu des années 70, le Sénégal n'a pas engagé de réforme majeure pour étendre l'assurance maladie dans les secteurs informels et ruraux. Sur leur propre initiative, les organisations socioprofessionnelles et les organisations communautaires de base ont mis en place des mutuelles de santé en se fondant sur les valeurs de solidarité et d'entraide mutuelle ambiantes dans le pays.

Le Sénégal s'est doté en 2005 d'une Stratégie Nationale de Protection Sociale et de Gestion des Risques dont les principales orientations stratégiques sont intégrées comme un des axes stratégiques du Document de Stratégies de Réduction de la Pauvreté de 2006. En conséquence, le Ministère chargé de la santé a engagé depuis 2007, avec l'ensemble des ministères et des parties prenantes impliqués dans les différents systèmes d'assurance maladie, des réflexions sur la couverture du risque maladie des sénégalais. Ces réflexions ont abouti à l'élaboration d'une Stratégie Nationale d'Extension de la Couverture du Risque Maladie dont l'objectif est de porter le taux de couverture en assurance maladie de 20% à 50% en 2015.

La Stratégie d'Extension de la Couverture du Risque Maladie au Sénégal, comprend trois composantes : (i) la réforme des politiques de gratuité des soins pour les rendre plus pérennes, à travers la création d'un fonds national de solidarité santé ; (ii) la réforme des Institutions de Prévoyance Maladie (IPM) ; (iii) l'extension de la couverture du risque maladie à travers les mutuelles de santé.

Cette stratégie s'appuie sur le principe que l'accès aux soins de santé relève d'un droit dont l'exercice est garanti par la Constitution sénégalaise. Elle est sous-tendue par le développement progressif d'un système de protection contre la maladie des populations vulnérables et la promotion des mutuelles de santé communautaires qui sont, à l'état actuel du niveau de couverture et de l'ampleur des secteurs informels et ruraux, les seules à disposer de potentiels pour couvrir la majorité de la population sénégalaise.

Poster presentations

Poster Presentation

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PT 1

Financing incidence of out-of-pocket spending for healthcare in Nigeria

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Objectives: The aim of the study was to generate new knowledge about the burden of out-of-pocket spending (OOPS) to households, with inferences of the result towards coverage with increasing financial risk protection from healthcare expenditures. In practice, available data showed that direct out-of-pocket spending dominates household expenditure on health in Nigeria, and hence was chosen as the focus of the FIA.

Methods: The study took place in 2 purposively selected Local Government Areas (LGA) (1 rural and 1 urban) in each of Enugu and Anambra states. Interviewer-administered pre-tested structured questionnaires were used in household surveys to collect the necessary data. A one-month expenditure recall period for health expenditures was used in the household survey. Financing incidence analysis was assessed at the household level. Financing incidence was assessed based on socio-economic groups and rural-urban location of the households. Data was collected from 4873 households. The frequency distributions of the variables by socio-economic status (SES) and rural-urban location were computed and chi square ($Chi^{2)}$ test for trend analysis for statistical difference across the states were undertaken. Principal components analysis (PCA) was used to create a socio-economic status (SES) index using information of the households' ownership of some assets, together with the weekly household cost of food. The index was used to divide the households into SES quintiles. Concentration curves of OOPS was plotted with the Lorenz curve of total household expenditures to show the distribution of the burden of OOPS by SES compared with total household expenditure, and the Kakwani index was computed to examine the overall progressivity or regressivity of OOPS. Note: 120 Naira = US$1.00

Results: Health expenditures were mostly paid through out-of-pocket spending (OOPS) and the average monthly household OOPS was 2219.1 Naira. There was almost complete absence of health insurance. It was found that 3150 (98.8%) of payments were made using OOPS, 9(0.3%) using reimbursement by employers, 1 (0.03%) through private voluntary health insurance, 9 (0.3%) using instalment and 14 (0.44%) through 'others'. None was reportedly made using NHIS and CBHI. There were differential uses of the different payment mechanisms by different population

groups and the Kakwani index for financing incidence of OOPS was -0.18 showing that OOPS was regressive.

Conclusion: There was lack of financial risk protection for healthcare in the study area and the worse-off people that experienced the highest burden of health expenditure worst hit were the rural dwellers and most-poor people. OOPS still dominates as the payment mechanisms for healthcare, accounting for the very high level of catastrophic costs that were found in the study. Overall the distribution of OOPS was regressive, as measured by the Kakwani index. Hence, urgent steps should be taken by the government to institute and increase coverage of financial protection mechanisms such as the National Health Insurance Scheme in addition to possibly abolishing some of the user fees that led to the high incidence and burden of OOPS.

PT 2

Approaches to Development Partner Coordination in Five MLI Countries: An Issue Brief of the Ministerial Leadership Initiative for Global Health (MLI)

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Aim and Objectives: Development assistance is delivered by hundreds of separate development partners' (DPs) individually managed projects, each with various rules, procedures and demands on country-level administrators. Both DPs and country officials recognize the inefficiencies and unnecessary transaction costs involved in aid disbursement and are seeking solutions to mitigate the unintended consequences resulting from the mushrooming of development projects. The Sierra Leone Ministry of Health and Sanitation recognizes the urgent need for a stronger stance in donor and NGO coordination and is strengthening its Donor/NGO Liaison Unit through support from MLI. In order to inform these efforts, MLI documented the various DP coordination experiences of MLI countries. This issue brief aims to provide practical information for Sierra Leone and contribute to a broader understanding of the range of approaches health ministries (MoH) use to coordinate DP assistance.

Methods: This brief is based on a questionnaire administered to MoH staff in the five MLI countries. The questionnaire included both multiple choice and open-ended questions and was translated into French for the francophone respondents. The findings were compiled and analyzed by MLI staff and reviewed and validated by relevant MoH staff.

Key Findings: In the five MLI countries there has been a range of experiences with DP harmonization and alignment and variation in the structures developed to support these efforts. Nepal, Mali, and Ethiopia have IHP+ country compacts and Senegal and Sierra Leone are currently on the path of developing country compacts. Mali, Nepal and Senegal have Sector-wide Approaches.

In all five MLI countries, the DP coordination function is housed within established DP coordination units ("DPCUs") in MoH planning departments/units. The roles and responsibilities of DPCUs include participating in health sector planning activities, registering health NGOs, mapping and monitoring NGO and donor activities, tracking commitments and financial contributions of DPs, liaising with other ministries or national offices involved with coordinating development assistance, and to some extent, monitoring and evaluating the deliverables of DPs.

The most commonly reported challenges that DPCUs face are inadequate staffing and uneven technical skills of the personnel. Other challenges include insufficient support for field work, weak record keeping systems, and inadequate monitoring

and tracking of financial and other resources, in part due to a lack of routine reporting by DPs.

This review offers many potential lessons for Sierra Leone and beyond. To the extent that developing countries continue to rely on development assistance, strong coordination mechanisms will help ministries of health ensure that resources are used effectively and targeted toward national health priorities.

PT 3

Equity in Healthcare Financing in Nigeria: A flow of funds approach

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Background: Equity is one of the basic principles of health systems and features explicitly in the Nigerian health financing policy. Despite acclaimed commitment to the implementation of this policy through various pro-poor health programmes and interventions, the level of inequity in health status and access to basic health care interventions remain high.

Objective: This study presents an equity assessment of Nigeria's health financing system using data from the 2004 National Living Standard Survey NLSS) and the Nigerian National Health Accounts of 2003, 2004 and 2005.

Methods: The methodological framework rests on the flow of funds approach. The flow of Nigerian health care resources is analysed by tracing the flow of public and private health resources from individuals to financial intermediaries, and further to health care providers and functions. The structure of the flows for three years, 2003, 2004 and 2005 are analysed for inequities in healthcare financing. This is complemented with using quintile ratios and concentration curves/indices obtained from the NLSS data

Results

The results reveal that health financing incidence disproportionately rest on households with about 70% of the total expenditure on health is through out-of-pocket payments by households. Other major sources of financing health care are the government, and donors. Due to low share of government in total health care expenditure and the presence of user fees in many public facilities, households are prone to bear most of the expenses in the event of any health shock. The catastrophic consequences thus push some into poverty, and aggravate the poverty of others. Overall, the findings indicate that in most of the selected indicators there are pro-rich inequities. The non-poor states, receive most of the health spending in the country, whereas the poor who have a greater proportion of the disease burden spent less resources on health.

Conclusion

The flow of funds approach complements other existing analytic methods on equity in health financing and generates policy lessons. The paper therefore suggests that the country's health financing systems must be designed not only to allow people to access services when they are needed, but must also protect household, from financial catastrophe, by reducing OOP spending through risk pooling and prepayment schemes within the health system.

PT 4

Performance-Based Financing: The Forest, Not the Tree

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Performance-Based Financing (PBF) is generating a hot debate. Some suggest that this may be a donor fad with limited potential to improve service delivery. Our view is that most of the criticism is linked to viewing PBF solely as a provider payment mechanism, which aims at reaching a few targets. This is looking at the tree and missing the forest.

In this paper, we highlight how PBF can catalyze comprehensive reforms and help address structural problems of public health services, such as low responsiveness, inefficiency, and inequity. We argue that PBF may even contribute to profoundly transforming the public sectors of low-income countries Our argumentation combines empirical data from experiences in Central Africa and theoretical arguments. We conclude by identifying challenges for the emerging PBF movement in Africa.

PT 5

Public-Private partnership towards TB control: Incentives for retail pharmacies to distribute drugs in Hararé (Zimbabwe).

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INTRODUCTION:

It is globally recognized that public–private health partnerships (GHPs) have become an established mechanism of global health governance and could be effective in scaling up to improve coverage and strengthening of health services. There is increasing interest in public-private partnerships (PPPs) for the provision of tuberculosis (TB) treatment to improve TB service outcomes, however motivations for such partnerships and the nature of the incentives that are required to achieve a desirable outcome still remain a grey area in Zimbabwe. This study examines the incentives and willingness of for-profit retail pharmacists in participation in PPPs for the provision of TB treatment in Zimbabwe.

OBJECTIVES:

The objective of the study is to determine perceived adequate incentives (financial and non-financial) for retail pharmacies to merge with the Ministry of Health in provision of anti-TB drugs in Zimbabwe. The paper also seeks to establish the willingness to participate in PPP as well as the preferred mode of PPP.

METHOD:

A cross sectional descriptive study was conducted using a semi structured researcher administered questionnaire. The target group were retail pharmacists both employers and employees within Harare (Capital City). Pharmacists practicing in Council clinics were excluded in the study.

RESULTS:

The study found that of the pharmacists interviewed, none were distributing TB drugs at that moment despite higher proportions (74%) of willingness to do so. 54% prefer a type of partnership where the government funds the program while the private provide the service. The following are the amounts required by provider for the service provision. In terms of fee-for-service, the average amount per patient per visit was $3 ($1-$10) per visit. Some would require hourly rating of an average amount of $10.80 ($7-$20) per hour dedicated to the service. Others' monthly rates were an average of $300 ($100-$500) per month. Capitation was not an option as a provider payment mechanism. The top five non financial incentives were (a) the removal of or decrease in practicing license fees (77%), (b) given points to renew practicing license each year (81%), (c) provision of other drugs related to TB at subsidized prices e.g. pyridoxine, prednisolone and ARVs (86%) and (e) duty waivers on medicine importation. 65% of pharmacists interviewed would want to serve 20 patients or less while the others can go up to 100 patients. All interviewed pharmacists would prefer the ministry to deliver drugs to their pharmacies but however, 26% of them said they can go and collect the drugs if it's necessary.

CONCLUSION:

Retail Pharmacists are willing to participate in TB drug treatment however despite the perceived national responsibility, financial motivations are necessary to reduce opportunity costs on their side as well as quality of services offered. Non-financial motivations are also critical and should be considered in PPP of TB control. Generally for a partnership to be successful, in addition to sufficient motivation, a policy and legal framework is required above political and social commitment.

Key words: Incentives, distribution of TB drugs; TB control; PPP and TB control; private-public partnership

PT 6

Determinants of health care utilization among the elderly population in rural Ghana

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Aim: To describe health care utilization and identify factors that affect health care utilization among the elderly rural Ghanaians.

Objectives: To identified factors that influence health care utilization among the elderly population in Kassena-Nankana district in Ghana.

Methods: Secondary analysis was performed on cross-sectional interview data collected on 594 adults aged 50+ years for the WHO-INDEPTH Adult Health and Ageing Survey in Ghana between February and July 2007. Prevalence of health care and chronic conditions was determined and based on the behavioural model of health service utilization; predisposing, enabling and need-related factors were investigated by use of multivariate logistic regression analysis.

Results: Thirty one percent (31%) of the study participants reported to have utilized health care services in the last 3 years and 28% reported presence of at least one chronic disease. Arthritis was the most prevalent chronic condition (6.4%), followed by cataracts (4.3%), angina (3.9%) and depression (3.5%). Factors or conditions that were associated with health care utilization among the elderly in rural Ghana, included: Medical history of at least one chronic condition (OR = 2.36; 95% CI = 1.49 – 3.75; p<0.001), Poor perceived health status (OR = 2.00; 95% CI = 1.11 – 3.59; p = 0.021), Age (60 – 69 years) (OR = 1.68; 95% CI = 1.07 – 2.64; p = 0.025), severe cognitive impairment (OR = 1.26; 95% CI = 1.02 – 1.56; p = 0.032) and severe difficulty with picking up things in the last 30 days (OR = 0.76; 95% CI = 0.61 – 0.96; p = 0.021).

Conclusion: Presence of at least one chronic disease and poor perceived health status were the most pervasive determinants of health care utilization among the elderly in rural Ghana, outweighing age, cognitive impairment and difficulty with picking up things in the last 30 days. These factors could help policy makers, health systems and all stakeholders understand health needs of the elderly rural Ghanaians and consequently create conducive environment for universal provision of appropriate health services.

PT 7

Composition of pluralistic health systems: How much can we learn from household surveys? An exploration in Cambodia

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In spite of all efforts to build national health services, health systems of many low-income countries are today highly pluralistic. Households use a vast range of public and private health care providers, many of whom are not controlled by national health authorities. Experts have called on ministries of health to re-establish themselves as steward of the entire health system. Modern stewardship will require national and decentralised health authorities to have an overall view of their pluralistic health system, especially of the components outside the public sector. Little guidance has been provided so far on how to develop such a view. In this paper, we explore whether household surveys could be a source of information. We zoom in on Cambodia, a country with a highly pluralistic health system. We mainly use a cross-sectional household survey carried out in three rural health districts in 2007 (5,975 households). The study reveals that household surveys can provide useful insights for the national and local stewards for the organization of the health system. We argue that a whole research program on the composition of pluralistic health systems still needs to be developed. We identify some of its empirical challenges.

PT 8

Les soignants parallèles et l'offre des soins au Cameroun: Logiques, pratiques et perspectives

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Nombre d'africains se soignent dans les structures de soins informelles. Face aux coûts élevés et surtout aux pratiques déviantes (corruption, violence verbale, mépris, parrainage…) observées dans les hôpitaux dits de référence, les malades et les familles les moins favorisés ont progressivement opté pour les trajectoires sanitaires parallèles. Au Cameroun par exemple, ils fréquentent une pluralité de GIC santé ou de cabinets de soins, des pharmaciens de rue, des tradipraticiens, des naturopathes, des exorcistes et même des spécialistes de la médecine chinoise. Ces acteurs qui ont su capitaliser à leur profit la crise ou les faiblesses du système de santé public, sont désormais incontournables dans le champ sanitaire camerounais ou africain. Parler d'un « *Elan pour une couverture sanitaire universelle en Afrique* » exige aujourd'hui qu'on prenne ces soignants émergeants en compte. Même si leur légitimité institutionnelle reste à construire ou à conquérir, il faut cependant noter qu'ils ont déjà une légitimité sociale établie. Dans un contexte africain ou camerounais où les structures sanitaires orthodoxes ont « *renoncé* » à leurs responsabilités et sont devenues « *inaptes* » à porter secours, ces soignants parallèles ou « *du bas* » jouent le rôle de « *sapeurs pompiers* ». Ils exercent auprès des couches sociales moins nanties une action sanitaire certaine, acceptée, recherchée, réclamée et même défendue. Leurs conséquences négatives sont souvent désastreuses mais, tout compte fait, ils permettent à de nombreux individus de « *rester debout* ». Ils recrutent un nombre important de malades et sont de véritables lieux où l'on peut mesurer la qualité et l'accès des familles aux soins. La présente communication a pour objectif de comprendre, d'un point de vue socio-anthropologique, les pratiques et les logiques qui structurent la grande émergence des soignants parallèles dans l'espace sanitaire camerounais.

Mots clés : soignants parallèles, pratiques, conditions d'émergence, offre des soins.

PT 9

Health Status and Vulnerability to Poverty in Ghana

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Background: In many developing countries, policies aimed at improving the welfare of people through poverty reduction tend to target the current poor to the neglect of those who are not currently poor but vulnerable to future poverty. However, people who are not poor today might not necessarily remain in that position in the future. This study seeks to examine the level of vulnerability to poverty in Ghanaian households and the role of current health status on vulnerability to future poverty.

Method: The study uses cross section data from the Ghana Living Standards Survey 5 with a nationally representative sample of 8,687 households from all administrative regions in Ghana. The study employs a vulnerability estimation procedure suggested by Chaudhuri to model vulnerability estimates and to examine the effect of health status on expected future consumption and variations in future consumption. Vulnerability to poverty estimates are also examined against various household characteristics.

Results: Using an upper poverty line, the estimates of vulnerability show that about 56% of households in Ghana are vulnerable to poverty in the future and this is higher than the observed poverty level of about 28%. Households with sick members are vulnerable to poverty. Moreover, households with poor hygiene conditions are also vulnerable to future poverty. The vulnerability to poverty estimates were, however, sensitive to the poverty line used and varied with household characteristics.

Conclusion: The results imply that while policies directed towards poverty reduction need to take into account the vulnerability of current non-poor households to future poverty. Also, the sanitary conditions and health status of households need not be overlooked in poverty reduction strategies.

PT 10

Burden of abortion and other emergency obstetric care costs: risks faced by low income households in Burkina Faso

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RATIONALE: This study is part of an overall project which aims at investigating the relationship between reproductive health outcome and poverty in Burkina Faso and Gambia. Due to increasing interest in reducing maternal mortality and morbidity towards achieving MGD 5, efforts have been devoted into reducing financial barriers of maternity care in Burkina Faso through policy of subsidy. However, evidence on how far this policy protects households' especially low income households from catastrophe is still under-demonstrated for emergency obstetric care particularly for abortion and post-abortion care for which legal restrictions and stigma constitute serious hurdles in investigating costs burden to households.

OBJECTIVE: To assess the costs burden to households of emergency obstetric care especially abortion and post-abortion care.

METHOD: Participants in this study will be women having had severe obstetric emergency including abortion care. They will be recruited in hospitals and their consent will be asked to participate in the study. Semi-structured quantitative pilot-tested questionnaire will be developed and administered to women in theirs households for data collection. Questionnaire will cover socio-demographic and household composition as to overall characteristics as well as household possession of assets, conveniences, expenditures on goods and services and household income. Survey will collect also direct and indirect costs for emergency obstetric and abortion care, strategies developed by household to cope with costs as well as immediate emergency obstetric including post-abortion care costs.

RESULTS: Assessment of costs borne by households for emergency obstetric including abortion and post-abortion care enables the analysis of the affordability of maternity care. By evaluating the distribution of costs in relation with household's income, it is possible to appreciate the equity of the strategy of maternity care subsidy. This research will also shed the light on a topic which was under-investigated such as abortion care and theirs effects on household economy.

CONCLUSION; Evaluation of the costs and effects of emergency obstetric including abortion costs is essential in establishing equity in access and utilization of qualified obstetric care by poor people in Burkina Faso. While helping the government and policy makers in designing effective policy for obstetrical care, this study will also help communities in understanding and establishing actions that target low income women especially aborted women.

PT 11

Variations in Out of pocket payment among different Socio-economic groups in South east Nigeria

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Introduction:
Where out-of-pocket payment (OOP) serves as the major means of financing health care, the cost of health care might differentially influence health seeking behavior of households of different socio-economic status (SES) groups. This study examined the variations in health care seeking and incidence and level of OOP across households of various SES groups.

Methodology:
The study was carried out in south-east Nigeria. A pre-tested household diary was used to collect information from 1128 households over a period of one month. Household consumption expenditure data was used to disaggregate households into SES quintiles. The incidence of spending on health care and the reasons for not spending when the household should have done so were determined across SES quintiles. The levels of expenditure on healthcare and burden of OOPS were also compared across SES quintiles.

Results:
The poorest households had the least incidence of spending on health care. The most common reason amongst the poorest households for not spending on health care when they should have was the cost of health services while for the richest household, this was because the illness was not considered serious enough. Households in the richest quintile representing 19.7% of the entire population accounted for 50.6% of the total expenditure on health while those in the second quintile and the poorest quintile accounted for 9.9% and 6.4% of total health care expenditure respectively.

Conclusion:
There is a wide gap between what poor and rich households spend on health and with no financial protection mechanism, poor households might be forgoing needed health care. Policy makers need to be persuaded that a shift away from out-of-pocket payment for health care which is inequitable and inefficient is necessary and requires urgent attention.

PT 12

Connaissances, perceptions, attitudes et pratiques communautaires du paludisme parasitaire et anémie : évidences pour le suivi de l'impact des stratégies de surveillance

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Introduction

Disposer d'information adéquate sur la participation communautaire aux soins de santé primaires, la connaissance et perceptions communautaires sur la prévention et le traitement des maladies est un préalable fondamental pour le développement et la mise en œuvre de stratégies d'intervention efficaces. L'étude réalisée au niveau du poste de santé de Lamarame au centre du Sénégal visait à évaluer / apprécier les connaissances communautaires, les attitudes et pratiques sur le paludisme ainsi que la prévalence du paludisme parasitaire et de l'anémie chez les enfants de la localité. L'étude a été réalisée avant la mise en œuvre d'une recherche opérationnelle visant à identifier des mécanismes intégrés de surveillance du paludisme à base communautaire fondés sur l'utilisation des Test de Diagnostique Rapide (TDR), de combinaisons thérapeutiques d'arthemisine et de traitement intermittents préventifs chez les enfants (IPTc).

Méthodes

Une enquête ménage transversale a été réalisée dans 33 villages situés autour du poste de santé de Lamarame au centre du Sénégal. La méthode d'échantillonnage s'est basée sur l'utilisation d'une technique d'échantillonnage au hasard à 2 grappes; l'unité de base étant le ménage. Dans chaque ménage visité, les enfants de moins de 10 ans ont été examinés après consentement éclairé. Un échantillon de sang a été prélevé pour les frottis. Le taux d'hémoglobine a été mesuré par hémoculture. Les mamans ont été interviewées sur la base d'un questionnaire structuré et des focus group ont été organisés avec différentes composantes de la population.

Résultats

Au total 830 enfants ont été examinés et 350 mamans interviewées. La prévalence du paludisme parasitaire était de 1.5% [0.7-2.6]. Des anémies modérées et sévères sont respectivement de 53.4% [48.2-58.9] et de 12.5% [10-15.3]. Les participants à l'enquête ont démontré d'une bonne connaissance du paludisme y compris l'association piqure de moustique et paludisme (93.7%), la fièvre comme symptôme principal (97.4%) et ses potentielles fatales conséquences (96.8%). En ce qui concerne le recours aux traitements, 41,2% des répondants déclarent effectuer un recours aux soins dans un délai de 24h après l'apparition des premiers symptômes alors que 37.5% font recours à l'automédication avec les médicaments disponibles à domicile ou chez le boutiquier du village ; généralement du paracétamol. En matière de prévention, 90.2% des mamans considèrent la moustiquaire comme essentiel

pour la prévention du paludisme alors que peu connaissent l'IRS (0.29%) et l'IPTc (4.6%). La majorité des participants (84.6%) possèdent une moustiquaire.

Conclusion:
Malgré le bon niveau de connaissance du paludisme au niveau du poste de santé de Lamarame, il y a un besoin urgent à améliorer le comportement sanitaire. L'introduction d'un programme intégré de prévention et de gestion du paludisme pourrait contribuer à réduire de façon drastique la recrudescence du paludisme dans la zone. Toutefois, le succès d'une telle stratégie reste fortement dépendant de la conception et de la mise en œuvre d'un programme d'éducation communautaire.

PT 13
PT 13

Pré-financement communautaire de type mutualiste comme modèle d'accès aux soins de santé de qualité: représentation de la catégorie sociale Abbey du sud de la Côte d'Ivoire face à une telle initiative.

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La Côte d'Ivoire, après 20 ans de croissance, au cours desquelles, nous avons pu observer une amélioration des indicateurs nationaux de santé, a connu au début des années 80 une crise économique avec pour conséquence la mise en place d'une politique d'ajustement structurel, et la dévaluation du Franc CFA intervenue en 1994. Ces mesures ont imposé, entre autres, le désengagement de l'Etat et la réduction des dépenses publiques, réduisant ainsi le budget alloué au secteur sanitaire. A partir de cette époque l'Etat ne pouvait plus seul assuré le financement des soins de santé. La participation de la population à leurs frais de santé est devenue alors une nécessité. Tous les soins dans les hôpitaux et centre de santé sont devenu payant. Les recettes ainsi recouvrées constituent les ressources propres pour les établissements et complète le budget de l'Etat. Cette politique constitue un frein à l'accès aux soins pour les catégories sociales vulnérables et pauvres qui représentent la plus grande partie de la population ivoirienne. Ainsi la faible capacité des ménages d'avoir accès aux soins de santé moderne les amène à recourir à des solutions thérapeutiques tourmentées et de bien de drame. Face à la condition d'accès aux soins relativement dégradé le gouvernement ivoirien décida de créer en 2001 un régime d'assurance maladie connu sous le nom d'assurance maladie universelle (AMU) mais cela n'a pas encore fonctionné jusqu'à présent en raison, selon les pouvoirs publics, de la crise politico-militaire. Notre contribution s'inscrit dans cette recherche de solution d'accès aux soins à travers un projet de préfinancement de type mutualiste des soins. Nous nous sommes proposé d'étudier dans un contexte social et géographique précis : la société Abbey de la région de l'agneby au sud de la Côte d'Ivoire. L'accès aux soins de santé de qualité dans cette zone pose une véritable problématique pour les acteurs, en occurrence ceux qui sont reculé du chef lieu de région eu égard aux mauvais états des routes. C'est ainsi que l'on meurt vite des maladies facilement curables. Cependant, le préfinancement des soins suppose des implications psychologiques aux contours imprévisibles aux niveaux des agents sociaux. C'est sur cette base que l'étude questionne les modes de représentations des acteurs face à une initiative de pré financement collectif pour utilisation future des services de santé a la lumière du contexte de vie quotidienne dans lequel ils s'insère.

Mots clés : représentation sociale, Pré-financement, acteur, société, maladie

PT 14

Phase pilote de la campagne Nationale de distribution de moustiquaires imprégnées d'insecticide à longue durée d'action pour une couverture universelle en Côte d'Ivoire.

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Dans le cadre de la lutte contre le paludisme, le Ministère de la Santé et de l'Hygiène Publique à travers le Programme Nationale de Lutte contre le Paludisme met en œuvre un projet de passage à échelle des interventions de lutte contre le paludisme en Côte d'Ivoire. Ce projet prévoit une campagne nationale de distribution gratuite de moustiquaires imprégnées d'insecticide à longue durée d'action (MILDA) aux ménages de Côte d'Ivoire. En prélude à cette intervention une phase pilote a été réalisée en juillet 2010.

But : Amener 80% de la population de la zone pilote à l'utilisation de la MILDA.
Objectifs spécifiques:

- Réaliser une distribution pilote de MILDA
- Tirer des leçons pour la mise à échelle des interventions.

Méthodologie : Deux districts sanitaires ont été choisis sur les 83 districts selon les critères ci après : situation géographique nord et sud du pays, les populations des deux districts sont sensiblement les mêmes, ces deux districts avaient bénéficié d'une distribution antérieure de moustiquaires en campagne chez les enfants de 0 à 5 ans.
Trois étapes principales composent cette phase. Une micro planification, un dénombrement des ménages et une distribution. Le dénombrement permet d'attribuer un bracelet au chef de ménage récencé, Ce bracelet donne droit à une ou deux moustiquaires selon qu'il existe une moustiquaire dans le ménage ou pas. Ces trois étapes ont été soutenues par un plaidoyer auprès des autorités et une formation des acteurs.

Principaux constats : A l'issu de cette phase, on peut retenir que :
Le nombre de ménages dénombrés est supérieur au nombre de ménage planifiées (14 703 à SIKENSI) Cette différence peut être attribuée à la définition opérationnelle du ménage qui tient compte du cas spécifique des ménages polygames
Dans le district de Sikensi les résultats partiels montent une couverture en moustiquaires 80%
Dans le district de Tengrela tous les ménages dénombrés ont été couverts (16 264);
Un dénombrement correct des ménages permet de satisfaire la cible et d'évoluer vers une couverture universelle. On note par ailleurs un engouement pour l'acquisition de la MILDA du fait de la gratuité, cependant il est indispensable d'intensifier la communication sur la MILDA en vue d'encourager son utilisation : en effet une évaluation rapide de quelques ménages a permis de noter que l'installation des MILDA n'est pas effective 24 heures après la réception de celles-ci.

PT 15

Formation des médecins à la chirurgie essentielle pour l'offre de soins obstétricaux et chirurgicaux d'urgence : stratégie pour un meilleur accès aux soins versus tremplin pour une meilleure position professionnelle

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De nombreux pays en développement font face à un manque de personnel qualifié pour offrir des soins en « chirurgie de sauvetage » aux populations vivant dans les zones les plus reculées. Pour parer à ce manque, des stratégies de formation de « personnel de substitution », en attendant la formation de médecins spécialistes, ont été initiées dans ces pays, comme au Burkina Faso depuis 1992. La stratégie de formation des médecins généralistes à la chirurgie essentielle semble très attrayante et apparaît comme une option viable pour offrir des soins obstétricaux et chirurgicaux d'urgence dans les hôpitaux périphériques de districts. Cependant, une récente évaluation a montré que les médecins généralistes formés à la chirurgie essentielle sont très mobiles donnant un taux d'abandon élevé.

Une évaluation pluridisciplinaire de cette stratégie a été menée en 2007-2008, avec un volet qualitatif qui avait pour objectif d'explorer les perceptions des barrières à son plein essor au Burkina.

Méthodologie : Des entretiens individuels approfondis ont été menés auprès de 126 informateurs de divers profiles (médecins formés à la chirurgie essentielle, médecins spécialistes, autorités sanitaires, partenaires financiers, femmes césarisées), aux moyens de guides d'entretien spécifiés. L'analyse et l'interprétation ont consisté en une triangulation des résultats, obtenus selon un dépouillement thématique manuel du verbatim issu de la retranscription des interviews.

Résultats : Les barrières révélées étaient relatives aux facteurs inhibiteurs de la pratique réelle de la chirurgie après la formation ; qui s'avéraient donc démotivant pour la poursuite de la pratique. Ces facteurs inhibiteurs et démotivant étaient : les taches administratives (34% des césariennes sont effectuées par les infirmiers spécialisés en chirurgie), les conditions matérielles insuffisantes de travail, la courte durée de la formation, et le manque de supervision. Les obstacles à la poursuite de la pratique sont le caractère « *non diplômant* » de la formation, avec pour conséquence le manque de retombée financière, et le mode de sélection imposant des candidats. Cependant, cette formation est un critère sine qua non d'accès au poste de médecin chef de district. Une fois formé, l'apprenant accède rapidement à un poste de responsabilité qui ne lui permet plus d'exercer pleinement ses acquis professionnels. La stratégie se retrouve ainsi au prise entre une alternative adaptée pour un meilleur accès aux soins obstétricaux et chirurgicaux d'urgence et ; un tremplin ou levier pour se faire une meilleure situation socioprofessionnelle.

En conséquence les décideurs devront lever les barrières identifiées pour une optimisation de la stratégie et ainsi améliorer l'accès aux soins de qualité des populations.

PT 16

Barriers to the use of needed care for children: Lessons towards universal health insurance.

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The success or failure of existing health policy could be used to predict potential barriers to the effectiveness of any proposed mechanisms for improving access to the health delivery system in a country. Currently, a variety of competing proposals are being deliberated in South Africa to provide more universal health insurance coverage to the population. Most of these plans provide some mechanism for reducing the financial burden of care. They are in essence, attempting to reduce the proportion of a family's or individual's total economic resources that must be spent for medical care and facilitate health care use when needed. A similar underlying motivation made the government of South Africa to make health care for children under five to be free. However, overtime a good number of children has had no opportunity to seek care even though they were ill and needed to have a contact with the available and supposedly financial burden free health care system. Therefore, this study taking an inference from the policy of free child health care to the proposed universal coverage will try to identify household and community factors associated with the decision not to seek needed care for children under-five in South Africa.

Making use of the South Africa General Household Survey (GHS) available from 2002 to 2008 to form a longitudinal data base, analytical and empirical evidence to answer the above question as well as identify the trend overtime with regards to the non-utilization of healthcare among children that needed care can be carried out. The GHS is an annual survey conducted by Statistics South Africa since 2002. The survey captures information on the living conditions of South African households which allows for evaluation of various government programmes. Areas covered by the survey are education, health, labour market, household access to services and household assets and facilities.[12]

Recognizing that decisions are taken on behalf of the child in the household and that free health care policy was suppose to reduce financial barrier, we thus expect our trend and estimate analysis to reveal interesting issues on the value of simultaneously considering economic and non-economic barriers to obtaining services even though universal coverage may be introduced.

[12] South Africa Statistics, Various years

PT 17
Economic Aspects of Sickle Cell Disease (SCD) in Africa: A Research Agenda

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Background:
Sickle Cell Disease (SCD) is the most common genetic disorder in the world. Despite recent improvement in the treatment and care of this condition, a high mortality and morbidity remain the hallmark of the disease, especially in Africa. An estimated 85% of children with SCD are born in Africa and 50% to 98% of them die in childhood. As infant and children mortality decreases due to a better control of infectious diseases, the influence of SCD on those rates might increase leading to a negative impact on overall rate. Unfortunately, little is known on the economic aspects of SCD in Africa. This dire lack of information calls for coordinated efforts to improve our knowledge on this disease through appropriate research.

Objective
The objective of this abstract is to present the work currently in progress among APHRC and other collaborators and the future direction of research

Methodology
Currently, two exploratory studies are being conducted in collaboration with researchers and health care professionals from Kenya and Togo. The first one concerns the economic aspects of SCD clinic in rural Kenya where a SCD clinic, a district hospital and universal infant screening are linked to a Health and Demographic Surveillance System (HDSS). The strength of this study is that it is based on population longitudinal data from 2003. The setting includes an integrated and systematic data collection on health care, its utilization, and the cost of the program. Its weakness resides in the small sample size and the fact that it concerns only children.

On the contrary, the second study concerns SCD in adults in a hospital setting in Togo. This study involves the largest cohort of adults with SCD in the country. Its strength lies in the sizable number of adults currently treated and their wide age range: 18 years to older than 70 years. This study provides also an insight into the near future where SCD will not be thought of as a childhood disease. Its weakness resides in the fact that the sample is not representative of the general population of adults with SCD.

Future Research
A multi-sites project on epidemiology, economic and social aspects of SCD including HDSS sites within the INDEPTH network is planned. This project will be interested in the incidence at birth and prevalence of SCD in the population, as well as the cost-effectiveness of different treatments and newborn/infant screening. It will also seek to investigate the impact of SCD on demographic and socio-economic outcomes, and calculate the burden of the disease. In addition, it will provide a software model of cost of care depending of variable parameters.