

Report from West Africa

**IS THE BAMAKO INITIATIVE STILL RELEVANT
FOR WEST AFRICAN HEALTH SYSTEMS?**

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Faced with the difficulty of implementing primary health care services as proposed at Alma-Ata, UNICEF and the World Health Organization launched a new public health policy in 1987, the Bamako Initiative, to improve access to health care by revitalizing primary health care. The key principle was to decentralize retention of user fees to the local level in health centers managed by a committee of community representatives. Initially, measures were envisioned to exempt the worst-off who were unable to pay; however, these measures were never applied. Today, with most funding agencies in favor of abolishing user fees and some African countries already starting to do so, the relevance of this public policy is being reconsidered for West African countries.

In July 2005 at Gleneagles, the G8 members called for exempting primary health care from user fees. Two year later, in June 2007, Dr. Margaret Chan, director-general of the World Health Organization (WHO), stated clearly that, “if you want to reduce poverty, it makes sense to help governments abolish user fees” (1). These statements heralded a turnaround in health policies and health system financing mechanisms in Africa. In fact, after more than 20 years of imposition of user fees (2), the evidence in terms of inequity of access and financing of health services is dramatic (3–5). Those who cannot pay have been purely and simply excluded from access to care for the past 20 years. This is why some Southern and Eastern African countries (South Africa, Uganda, Madagascar) decided to abolish these fees. Because of these experiences, the World Bank, the U.K. Department for International Development, and the WHO Commission on the Social Determinants of Health now favor suppression of user

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Box 1

Bamako Initiative Principles

1. *National commitment* to the development of universally accessible essential health services
2. *Essential drug policies* compatible with, and complementary to, the rational development of primary health care
3. *Substantial decentralization to the district level* of the health ministry's decision-making
4. Decentralized management of community resources, with funds collected at the local facilities remaining under *community control*
5. *Community financing* of health services, usually in the form of payment for consultation, treatment or drugs, which remains consistent throughout the different levels of the health care system
6. Substantial *government financial support* for primary health care, preserving and, wherever possible, increasing the proportion of the national budget dedicated to basic health services
7. Measures to ensure that the poorest people benefit from primary health care, through fee *exemptions or subsidies*, for which criteria should be established in consultation with the community
8. Clearly defined *intermediate objectives* and agreement on *indicators* to measure them

Source: UNICEF (9; emphasis in original).

fees (6–8). Still, the West African countries, having organized a system of user fees under a decentralized community-based model based on Bamako Initiative principles (Box 1) (9), continue to resist the abolition of user fees.

Within this context favoring the abolition of user fees, after 20 years of promoting them internationally, my goal in this opinion article is to analyze the resistance to abolishing user fees, a policy instrument that has become embedded in what is still very much current public policy in West Africa: the Bamako Initiative (BI).

THE BAMAKO INITIATIVE FOR UNIVERSAL ACCESSIBILITY TO PRIMARY HEALTH CARE

Faced with the harmful effects of African countries' economic problems (and debt load) on health care, and the difficulty of implementing primary health care (PHC), UNICEF formulated the Bamako Initiative in 1987, which was accepted reluctantly by the WHO. In 1987, therefore, the PHC policy was adopted

by African health ministers, with the stated objective of “universal accessibility to PHC” (10). At that time, reduced government financing of health care systems created a situation in which passing costs along to users, as promoted by the BI, appeared logical. The BI created the illusion that when support from outside funding agencies ended (expected to occur in 1993), community-managed health centers (an idealized vision of traditional societies’ community solidarity; 11)—or even African governments—would become financially autonomous (12). This is why some warned (e.g., 13) that governments’ enthusiasm for the BI was most certainly based on the fact that the initiative evaded questions of responsibility, particularly that of the state and of health ministers. States could envision reducing their contributions to the health sector—a source of concern to the BI’s detractors (14). Although community mechanisms had existed in Africa before (Pikine, Kassongo, Pahou, etc.), what was new was the desire to generalize micro-experiences based on an initiative that was exogenous and largely driven by international organizations and by central services of the state.

Even if many actors in West Africa today still do not attribute their actions to the BI, they are nevertheless implementing those principles (see Box 1)—principles recalled when the countries concerned, along with the WHO and UNICEF, carried out a review of the BI in the African region, in Bamako in March 1999.

Technically, the BI was translated through the endowment of an initial stock of generic essential drugs, given to a dispensary under a village management committee. These drugs were sold to patients, with a profit margin that was conserved locally. This margin, added to user fees for consultations, was to be used to replenish drug stocks and improve health care access and quality. In contrast to revenues from user fees centralized at the state level, the BI introduced decentralization. Funds were retained and used locally by a community-based committee. The BI was intended to promote equity by extending PHC, but implementation was something else.

THE IMPLEMENTATION GAP AND REVISIONISM

As with many public policies in the low- and middle-income countries, even though the Bamako Initiative was adopted in an African capital, it was largely exogenous in origin and driven by international organizations, notably UNICEF and the WHO. Beyond the aim of universal accessibility to PHC, the initiative was supposed to organize community self-financing, while ensuring measures by which the worst-off could access services (see Principle 7, Box 1). In many countries, it was suggested that 10 percent of profits be used to provide free care to indigents. Following the policy’s launch in 1987, nongovernmental organizations and academics raised the alarm about this implementation gap and its negative consequences for equity in access and financing of services (14–16). Despite these concerns, stakeholders were attracted to the BI’s effectiveness, even to the detriment of equity. Box 2 summarizes the findings from an analysis of articles published between 1995 and 2004 on 17 African countries (17).

Box 2

Bamako Initiative Results

Indicators of effectiveness

- Increase in activities and rates of immunization
- Increase in antenatal utilization rate
- Increase in geographic access to essential generic drugs, but some stock shortages
- No clear picture (positives and negatives) of general consultation rates
- Low level of cost recovery
- Low community participation

Indicators of equity

- Regional disparity in terms of geographic access to health centers and drugs
- Worst-off less likely than the others to use health services
- Absence or ineffectiveness of exemption schemes
- Worst-off perceive the quality of health care lower than the others
- No participation in decisions among women and the worst-off
- Tendency toward hoarding and no utilization of cost recovery to increase access for the worst-off
- Drug prices and user fees never calculated according to capacity to pay

Source: Ridde (17).

Today, 30 years after Alma-Ata and 20 years after the BI, the worst-off still do not have access to care. Problems of equity were raised again by African authorities at the April 2008 International Conference on Primary Health Care and Health Systems in Africa, at Ouagadougou (Burkina Faso). Use of generic essential drugs has lowered costs for those who can pay, but nothing has changed for those who cannot. This observation has been documented in various African countries: Kenya, Benin, Zambia, Burkina Faso, and Nigeria (18–20); “all countries simply failed to recognise and tackle the specific needs of the poorest” (18, p. 54). Yet the BI’s equitability was clearly specified by UNICEF at its inception (21), and again in 2008 (22). It is beyond the scope of this article to explain the complex factors underlying this implementation gap (for Burkina Faso and Benin, see 19, 23). The focus here is on user fees and the absence of equity, and I offer here a few possible explanations for the implementation gap from this perspective.

The fundamental explanation is that the BI was poorly interpreted and implemented (19). The most flagrant example is that equity for the worst-off was neglected. In the field, Principle 7 (fee exemption) was omitted by health staff, nongovernmental organizations, experts, donors, and decision-makers. This is not

surprising given that, at the policy's introduction, its UNICEF promoters (now at the World Bank) revisited the vision of equity and affirmed that the BI "was not set initially at reaching the poorest groups but at restoring access to affordable quality care to the majority of the rural population" (24, p. 28). Regarding access to care for the worst-off, the person responsible for the BI at UNICEF at that time said: "there is still the problem of those who refuse to seek treatment because they cannot afford the expense" (21, p. 267). It seems that, in those days, willingness and capacity to pay were still being confused. Fifteen years later, this same person would like to see, finally, this problem of access for the poor resolved (25). UNICEF's discourse has also changed (26), and the true nature of the stress imposed by the BI on communities, or rather on the sick who must pay user fees, is now acknowledged. Contrary to the statements of James Grant (director of UNICEF) in 1987 (27), we no longer speak of cost recovery to render essential drugs available, but rather of shared operating costs. This goes further in lifting the community's financial burden and helps break the link that the BI (re)created between a tangible product (drugs) and user fees. Community involvement was more financial than political. Community management committees never actually worked. Ten years of experience in Mali revealed the absence of democracy in these committees (28). Health professionals remain powerful and patients still have not come into their own in Africa (29, 30). Thus, the WHO acknowledges that "in certain West African countries, the term 'community involvement' is synonymous in the field with 'user fee'" (31, p. 135), whose consequences for the worst-off are well known (3, 5). This is finally being acknowledged as a problem that must be resolved. In 1999, members of the Bamako Initiative Working Group expressed the hope that "the issue of equity and how to reach those without it should become a priority in the future" (32, p. 14). In 2003, former BI promoters suggested that "more needs to be done, tested and experimented to better include the poor" (24). In 2008, UNICEF asserted that the BI's challenge is "to protect the poorest" (22). But what if the solution were to abolish user fees?

TO RETAIN OR REMOVE USER FEES IN THE CONTEXT OF THE BAMAKO INITIATIVE?

Little progress toward equity has been made in the context of the Bamako Initiative over the past 20 years. Thus, in a February 2008 letter, Oxfam and Save the Children deplored UNICEF's continued support for the BI and user fees and its criticism of policies to abolish user fees. Yet, in 2005, UNICEF joined with other international agencies to support such abolition under certain circumstance (33), as the World Bank has said (8). This is the heart of today's debate: to retain or remove user fees (34). Some countries of Southern Africa and East Africa have chosen to abolish these fees. These have mostly been political decisions taken against the advice of donors. Evidence is growing of the positive effects on service utilization (4, 35). At the same time, however, these experiences

demonstrate the importance of carefully preparing, accompanying, and improving the parallel supply (3, 36). Also, there is still not enough evidence to assert that the poorest really benefit and that households' catastrophic health expenditures are reduced (37–39). West African countries with BI-based health systems are slow to abolish payments. It was only in 2005 that Senegal tested (then stopped) free services for childbirth deliveries. In 2007, Mali abolished fees for caesarian deliveries, and Niger, for consultations for children under age 5 and antenatal consultations. High-level decision-makers that I met in West Africa are wary of abolishing fees; they wonder whether this international tide will turn when fashions change. In Burkina Faso, most of them expressed their worries during a national workshop in June 2008 (40). If the international community is not consistent in supporting abolition, how will states pursue this policy? At the same time, few African countries respect the Abuja Declaration's call to allocate 15 percent of budgets to health. Local management committees told for 20 years that their fellow citizens should pay are now confused. The millions of CFA francs they have saved will melt away as health centers' operating costs continue. Meanwhile, these committee members, health officers, and international experts have done nothing tangible to apply Principle 7 of the BI, despite the millions that have been hoarded (41).

ABOLISHING THE BAMAKO INITIATIVE AND THE USER FEES

If abolition of payment is generalized and funding is ensured (still to be verified with both donors and African governments), the Bamako Initiative principles, including decentralized user fees managed by locally based committees, are likely to disappear. The BI will no longer be relevant. Community-based health insurance, after being promoted unsuccessfully for 15 years (5), will probably follow suit. Administrative exemption schemes do not work, as they are too complex and inefficient (42). Evidence on community-based exemption schemes is rare, especially in Africa (43). In 2007, I led a research team that attempted to carry out such an experiment in the context of the BI in Burkina Faso. In 124 villages, ad hoc committees selected 566 persons whom they thought should be exempted as indigents. This exemption was to be covered by the profits engendered by the BI and managed by the health center committees. These community-based committees were very strict and retained only 269 exempted persons. Thus, we were only able to distribute indigents' cards to 2.81 inhabitants per 1,000 (44). In Cambodia, in a very different context with a sustainability problem, a community-based targeting approach funded by exogenous funds selected 16 percent of the population for exemptions (45).

Given the ineffectiveness of these alternatives, the solution might just be to abolish user fees for everyone. With the abolition of user fees, health system utilization will increase in the short term and stabilize after a few months. This is

Box 3

Lessons Learned on the Abolition of User Fees in Africa

- Ensure leadership and political will
- Prepare and plan the intervention carefully
- Inform all health staff, stakeholders, and the population
- Have sufficient resources to maintain the quality of services and the benefits of the health workers
- Organize a simple and consistent administrative system
- Have measures in place to control any abuses
- Install a monitoring and evaluation system

the most expected outcome, as observed in South Africa, Uganda, and Niger (46). Nevertheless, to avoid an implementation and outcome gap, abolition should not be carried out haphazardly and must absolutely take into account the many lessons learned from other African experiences (Box 3) (47–49).

If a country as economically disadvantaged as Senegal or Mali has gone this route successfully, there is no reason, scientifically or technically, that the other West African countries could not do so as well. Still, vigilance will be required to ensure that this measure, which is a priori equitable, does not produce unanticipated inequitable effects. It will be important to ensure that this doesn't favor the less poor (which would have the perverse effect of increasing inequities) and that savings for households are significant (user fees relate only to direct health care expenses). The Global Ministerial Forum on Research for Health, held in Bamako in November 2008, was a not-to-be-missed opportunity for establishing dialog. Implementing an alternative financing model to user fees can only succeed if all stakeholders are engaged. The limitations of uniform and exogenous solutions have been sufficiently demonstrated. The delays experienced in West African countries could be turned to their advantage, to the extent that these countries can use lessons from the other countries to improve the effectiveness of this equitable policy.

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