Strategies for promoting equity: experience with community financing in three African countries

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Abstract

Although the need for a pro-poor health reform agenda in low and middle income countries is increasingly clear, implementing such policy change is always difficult. This paper seeks to contribute to thinking about how to take forward such an agenda by reflection on the community financing activities of the UNICEF/WHO Bamako Initiative. It presents findings from a three-country study, undertaken in Benin, Kenya and Zambia in 1994/95, which was initiated in order to better understand the nature of the equity impact of community financing activities as well as the factors underlying this impact. The sustained relative affordability gains achieved in Benin emphasise the importance of ensuring that financing change is used as a policy lever for strengthening health service management in support of quality of care improvements. All countries, however, failed in protecting the most poor from the burden of payment, benefiting this group preferentially and ensuring that their views were heard in decision-making. Tackling these problems requires, amongst other things, an appropriate balance between central and local-level decision-making as well as the creation of local decision-making structures which have representation from civil society.
groups that can voice the needs of the most poor. Leadership, strategy and tactics are also always important in securing any kind of equity gain—such as establishing equity goals to drive implementation. In the experiences examined, the dominance of the goal of financial sustainability contributed to their equity failures. Further research is required to understand what equity goals communities themselves would prefer to guide financing policy. © 2001 Elsevier Science Ireland Ltd. All rights reserved.

**Keywords:** User fees; Community financing; Affordability; Participation; Equity; Policy analysis; Implementation; Evaluation; Benin; Kenya; Zambia; Africa

### 1. Introduction

The need for a pro-poor health reform agenda in low and middle income countries has become increasingly evident in the face of inequities in access and payment for care [1] and disrespectful treatment of patients [2]. The World Health Organisation (WHO) has, therefore, combined fairness in financial contributions and responsiveness to the legitimate expectations of the population with improving the level and distribution of health as the criteria it is promoting for assessing health system performance [3]. Implementing pro-poor health reform is, however, always difficult as it has to confront the challenges associated with any politically controversial policy change [4–6].

This paper seeks to contribute to thinking about pro-poor reform by reflection on an earlier phase of health policy change, the UNICEF/WHO Bamako Initiative (BI). Building on previous experiences of community financing, local-level co-operative action associated with material or financial support for health care activities [7], the BI sought to accelerate and strengthen the implementation of primary health care, with the goal of achieving universal accessibility to these services. Its three main strategies were: decentralised decision-making including the involvement of community members in managing primary health care activities; user-financing of health services under community control; and the provision of essential drugs within the framework of a national drugs policy [8,9]. From its inception the BI was caught up in a wider debate about the potential equity impact of any form of user financing, given its potential to undermine the access to health care of lower socio-economic groups [10–14].

The investigation reported here was initiated in the mid-1990s to add to the available empirical evidence about the equity impacts of community financing and BI activities. They investigated both the perceived and demonstrated impacts on equity of such activities, as well as the mechanisms and processes through which these impacts were obtained. The studies’ focus on understanding how and why any perceived and demonstrated changes in equity came about, or what obstacles there were to securing such impact, is unusual in the health care financing literature. However, such investigation is important both in better understanding the nature of the equity impacts and in generating policy-relevant findings. Experience suggests that understanding the factors influencing the pattern and nature of public policy change is essential in determining how to better achieve policy goals in the future.
Policy-makers and managers seeking to learn lessons from existing experiences are, therefore ‘...demanding information on what is being done elsewhere, what works, what does not work, why, whether it can be imported, adapted, and how’ ([21] p. 18).

The study was undertaken in Benin, Zambia and Kenya in 1995–96 [22–25]. The Benin BI programme adopted the ‘classical’ BI approach [26] as its main health reform strategy, seeking to improve the quality of care available at existing primary care facilities, staffed by trained primary care health workers, and to develop the financial sustainability of services offered within them. The package of interventions included the introduction of charges to fund improved drug supplies and support the provision of immunisation services, the formation of local committees, combining community representatives and health staff, to participate in decision-making about drug control, revenue collection and revenue use and clinical training and enhanced supervision. The Kenyan BI programme, in contrast, was implemented in parallel to other changes within the health system, and sought rather to extend primary care coverage beyond the existing facility network by establishing new community pharmacies in areas otherwise not served by government health facilities. The pharmacies were staffed by community members who received a short period of basic training to allow them to offer simple curative and preventive care. They were also associated with a wider network of community health workers (CHWs) based in the villages served by the pharmacy who had health education and preventive care roles. The pharmacies stocked and sold both a limited range of drugs and bed nets, for use in protecting against malaria transmission, and were managed by community committees established with the support of the local leaders. Finally, the pharmacies were also intended to be the focus for the wider community development action, particularly income generating activities, needed to combat ill health and poverty. The very different experience of the third country, Zambia, involved, in 1994/5, an almost exclusive focus on decentralisation to district management teams and boards as the main reform strategy for improving the efficiency and equity of the health care system. The introduction of user fees in the early 1990s was, therefore, only of secondary importance in its overall reform programme. Zambia was, nonetheless, included in this study because its different experiences were expected to provide interesting comparisons with the other countries’ activities.

The full evaluation of the equity impacts of these community financing activities is presented in a sister paper [27]. It was rooted in consideration of three equity principles: payment on the basis of ability to pay; equal opportunity of use for equal need; and effective representation of all community interests in decision-making [22,28]. Whilst the first two principles are commonly associated with distributive justice concerns, that is the distribution of the outcomes of decision-making, the third reflects a concern for procedural justice—the respectful treatment of all groups in decision-making [29–31]. The equity successes of the Benin and Kenyan BI programmes resulted from the relative affordability gains associated with reducing the cost of accessing care by, respectively, improving existing services and bringing new services closer to people’s homes. In Kenya, however, these gains were
undermined by two factors. First, the limited range of services provided through the BI programme meant that people still had to access more distant services for many health problems. And, second, the provision of even this basic set of services was not sustained over time (as evidenced by the drug supply problems experienced in pharmacies towards the end of the study period). Yet in these relative affordability gains went hand in hand with absolute affordability problems, as the most poor received little protection from, and struggled to cope with, the burden of fee payment. Absolute affordability problems were, moreover, evident in both countries as neither established effective exemption mechanisms and so the poorest groups were unfairly burdened with paying for care. These problems were seen most clearly in Zambia where the introduction of user fees without concurrent quality improvements or effective exemption practices led to declining utilisation levels, as large proportions of the population experienced reduced access to health care (although these levels may have stabilised over time [32]). Finally, the voice and needs of the poorest within communities were largely ignored within decision-making practices in each country, a failing in terms of the third equity principle used in the study.

This paper seeks specifically to identify the factors that explain this pattern of equity impacts within and across countries, and to draw policy-relevant conclusions from this analysis. Section 2, first, describes the framework used in the analysis. Attention is then given to the three key sets of factors identified as shaping the country experiences: the leadership given to policy development and implementation (Section 3); the contribution of policy design in sustaining relative affordability gains (Section 4); and the interacting problems of policy design and process that failed the poorest within communities (Section 5). Finally, policy relevant conclusions are outlined (Section 6).

2. The analytical framework

Cross-country analysis of experience in developing and implementing health policies is recognised as important in informing broad questions of policy direction as well as implementation strategies [21,33,34]. The analytical framework used both within each country study and in reflecting on the three different experiences is summarised in Fig. 1.

In stage 1 the impact of the community financing schemes on equity was assessed against the study’s three guiding principles of equity using available utilisation data, investigations of the experiences of different population groups, especially the poorest, in accessing care and in decision-making, and assessment of the design of the schemes of focus (details presented in [27]).

In stage 2 (the focus of this paper) the factors influencing the equity impacts of the community financing activities in each country, and across countries, was investigated by combining a grounded approach to data analysis with the application of a broad lens through which to filter experience. This lens built on the policy analysis approach of Walt and Gilson [20] and highlighted four broad groups of factors as having potential influence over impacts:
1. contextual factors: the socio-economic context of implementation, the previous condition and financing patterns of the health system, socio-cultural traditions and practices of decision-making;
2. the design of each scheme: its objectives, the nature and level of fees, practices regarding the retention and use of revenue, the existence and nature of an exemption scheme, the structures and practices of community involvement in decision-making;

Fig. 1. Analytical framework of the study.
3. the particular processes used in initiating and implementing the schemes: the speed and manner of implementation, and the relative inputs of technicians, service providers and community members in design and implementation;
4. the actors affecting decision-making at all levels of the system (groups within communities, community leaders, service providers, health managers and external donors): their interests, concerns and roles in the activities.

The methods used to gather the data used in this analysis are outlined in Table 1 (see also [22,27]). Document reviews and semi-structured interviews with key informants (policy-makers, programme managers, donor agency representatives) in each country allowed initial analysis of the policy environment and aspects of the process of policy development and implementation. More detailed data on implementation practices were drawn from the two rounds of community inquiry conducted within study sites, that is the commune, within which the primary care facility is located, in Benin; villages served by a BI pharmacy/CHW network in Kenya and districts in Zambia. The first round of these inquiries involved a rapid appraisal of purposively selected sites, in which information about the history and performance of the site was gathered by record review and semi-structured interviews with health workers/managers and a small number of community representatives. In the second round of site visits a wider range of structured interview and qualitative data collection approaches were used in a purposively selected sub-set of the initial sample of sites (see Table 1). Community respondents’ (including the poorest in Benin and Kenya) views about their experiences of the services and decision-making processes were identified.

As only a limited number of sites were investigated in each country it is clearly important to be careful in generalising from the study findings. However, investigating the complexity of implementation experience is at least equally as important in informing future policy development as identifying common patterns across a large number of sites. An understanding of how and why equity has been promoted or undermined can, moreover, be better generated by small-scale, intensive case study evaluations than by large-scale, extensive assessments [35]. Qualitative methods are particularly relevant within such an approach: ‘Quantitative methods can identify ‘how’ individuals behave in certain circumstances, while qualitative methods… are better equipped to answer the diagnostic question of ‘why’’ ([36], p. 445).

3. The importance of leadership in effective policy design and implementation

The overall success of the Benin BI activities, evident in the restoration of services in previously ineffective rural facilities, contrasted with the poorly sustained BI pharmacies in Kenya and the equity losses consequent on reduced utilisation in Zambia. What explains these different experiences?

The first explanation lies in the three countries’ differing processes of policy development and implementation. Although actors played critical roles in each case, in Benin they demonstrated an ability to shape and mould the interactions between themselves and the other three sets of factors influencing policy change.
<table>
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<tr>
<th>Policy review</th>
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<th>Kenya</th>
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<td>Document reviews and key informant interviews (in Zambia, key members of the research team had also been involved in financing debates)</td>
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<td>Rapid appraisal</td>
<td>One commune randomly selected from each of 18 purposively selected sous-prefectures, to provide a sample representative of each of the country’s six departments and to cover all of the ‘partner’ institutions involved in supporting the primary care network (international bilateral &amp; multilateral organisations, and NGOs); semi-structured interviews with four purposively sampled health professionals and six randomly selected members of the community per site commune visit lasted 2-3 days</td>
<td>Two districts purposively selected because among first to develop BI schemes (so longer experience) and areas of most poor health status; 12 sites purposively selected: six from each district located in different agro-ecological potential zones (reflective of socio-economic status), ten government-sponsored sites of different ages (five from each district) and two NGO sites (one from each district); conducted three focus group discussions with village/pharmacy committee, CHWs and TBAs (traditional birth attendants), using interview guide; semi-structured interviews with chairman, treasurer and pharmacist in each site; collected available health service statistics and revenue data; site visit lasted 1-2 days</td>
<td>Eight districts purposively selected, each from a different province (of which there are nine); districts included fairly even balance of rural and urban areas, areas of different socio-economic status; in one district services run by mission; in six districts, visits included collection of available data on utilisation patterns, and semi-structured interviews with district managers, local government managers and health care providers; for remaining two districts, data on utilisation and staff perceptions collected from parallel study; in each district looked specifically at experiences of hospital located in it and sample of two to four health centres or clinics; 34 facilities of focus: ten hospitals (all levels, three church run); nine urban clinics (eight council run); 14 rural health centres (two mission run); district visits lasted 2 days</td>
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*Table 1: Summary of methods used by phase of study and country*
Table 1 (Continued)

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<th>Benin</th>
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<td><strong>Detailed case studies</strong></td>
<td>Seven sites purposively selected from initial 18, five ‘typical’ (i.e. said they were implementing national BI principles) and two atypical (i.e. said they were not implementing national BI principles), on grounds of ease of access to information, quality of information collected, focus on needs of poor; self-administered questionnaires completed by three purposively selected health workers; conducted interviews with ten poor households, 20 randomly selected service users, and undertook four focus group discussions (members of the commune committee, women, young people and village notables)</td>
<td>Seven sites purposively selected from initial 12, including sites from both districts and the two NGO sites, on grounds of level of function and ease of access to information; two household surveys across all sites: (a) random sample of 30 households per site (210 in total) (b) 87 ‘poorest’ households; Participatory rapid appraisal techniques applied including wealth ranking, social mapping, transects in community where pharmacy located in four sites; first round of focus group discussions with community representatives in all sites and second round in government sites only with village health committees; collection of additional health service statistics and other data</td>
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* From a total of 67 rural sous-prefectures (districts).
* NGO, non-governmental organisation.
* From a total of 52 in the two districts of focus; there were 237 sites across the country in 1994.
* The Comite de Gestion de Commune (COGEC).
* This round of focus group discussions was specifically undertaken to review site experiences following the withdrawal of UNICEF support for the BI programme.
and, in particular, to create mutually reinforcing interactions in support of, and through, implementation (Fig. 2). In Kenya and Zambia, however, leading actors failed to build such interactions and so either did not or could not take action to offset obstacles and opposition.

3.1. Leadership and vision in Benin

The design of the Benin BI programme was rooted in a context characterised by poor economic performance and a deteriorating health system. The government budget allocation for health fell by more than half between 1987 and 1990, leaving total government health expenditure per capita at just under US$2 [37]. Rural health centres frequently lacked drugs and other supplies and health staff were poorly motivated. Patients using their services had to purchase drugs from distant private pharmacies and few, if any, preventive or other services were provided to the surrounding population.

The Benin BI programme sought, therefore, to build demonstrable improvements in the quality of curative primary care and in the coverage of immunisation services. It built both on the country’s diverse range of community financing experiences and on a government decision to allow a district management board, composed of representatives of all sectors, to generate funds locally and decide on their use, rather than returning them to the central government. The WHO/UNICEF Bamako declaration of 1987 then acted as a catalyst for the development of a coherent framework within which to extend a similar financing approach to all government health facilities. The first steps were to establish the legal framework for the activities and to strengthen drug procurement and supply.

Equally important was the early government action to forge ‘alliances’ [38] with international agencies and non-governmental organisations (NGOs) in support of BI activities. The Benin UNICEF country office (BCO) was, for example, a key external partner for the Ministry of Health and supported the first steps in management training for community committee members through its expanded programme of immunisation (EPI). Subsequent support for BI activities was provided through the World Bank’s project for the development of health services
(1990), whilst bilateral donors and NGOs supporting financing activities in different parts of the country funded drugs, equipment, renovation, training, supervision, and the development of tools such as clinical pathways for diagnosis. Although government sought to promote some degree of coherence between these external partners’ activities, it also provided an environment in which they were encouraged to experiment and to feed back new design and management ideas into the BI programme. The relatively gradual growth in the numbers of BI-supported health centres (increasing from 44 in 1988 to 250 in 1992 [39]) also enabled lessons from experience to be fed back into the programme.

In addition, both the programme’s design and the manner of its implementation generated wider support for it. The commitment and enthusiasm of local-level health workers was, for example, partly promoted through the provision of direct benefits (such as a financial incentive for each fully immunised child) as well as through overall service improvements. These improvements in turn promoted community support of the programme, as did their direct involvement in decision-making; and with local-level ownership and enthusiasm came the continued support of government and external donors.

Overall, therefore, a virtuous cycle of policy change was founded on an alliance between a range of actors. They either shared the common vision underlying the scheme design or were persuaded of its relevance through successful implementation. At a technical level, Knippenberg et al. [40] identify three strategies as particularly important to the development of the Benin BI activities: analysis of best practices, applying lessons learnt from earlier national and international experiences; translation of best practices into a coherent set of operational strategies and management systems through experimentation; adaptation of the strategies through a bottom-up approach involving community participation, peer support, networking and regular monitoring. But, finally, the leadership of the Ministry of Health was critical in sustaining the implementation process over time as ‘sustainability depends on the internal capacity to manage the process of change’ ([38] p. 24).

3.2. Actor failure in Kenya

The development of the Kenyan BI programme was, like that of Benin, rooted in the earlier community financing experiments of NGOs whilst the harambee tradition, a form of community financing for local development activities, provided evidence on the potential role of community-based charges [41]. Again as in Benin, Kenya initially extended its BI activities through a fairly gradual increase in numbers of BI-supported pharmacies, to try and ensure that the increase in sites could be adequately supported. Policy guidelines were also developed to support this expansion, and were allowed to evolve as new lessons and approaches were developed. The initial successes of the programme only bred further support for the programme, as parliamentarians saw advantages for their own constituents at an early stage and began pressing for the faster development and spread of the approach. The number of BI pharmacies, thus, rose from one in 1989, to three in 1990, to 84 in 1992 and to 237 (including NGO-supported sites) in 1994.
However, the Kenyan BI programme, unlike its Benin counterpart, was not adequately rooted in the context of its development. The programme sought specifically to extend primary health care coverage to previously under-served areas on the flawed understanding that the most critical factor undermining the effectiveness of the Kenyan primary care network in the late 1980s was poor coverage [42]. Yet by the late 1980s this network suffered as much from quality weaknesses as from poor coverage [41,43], due to the biased allocation of health system resources towards urban areas and growing balance of payment problems [44]. Weaknesses in the drug supply and distribution system thus bedevilled the existing primary care network and, ultimately, the BI pharmacies. At the same time, the programme failed to build on wider international experience with CHW programmes [45] and so suffered similar problems—such as communities’ poor perceptions of the low level of care offered by CHWs, CHW attrition and a failure to provide support to CHWs through the broader health system.

The Kenyan Ministry of Health, like its counterpart in Benin, played an important role in the programme’s initiation. Its delegation attended the 1987 WHO/UNICEF Bamako conference and officials working with the Ministry of Health’s national primary health care unit were subsequently involved in shaping BI activities, including developing training programmes and supervision manuals. However, the Kenyan UNICEF Country Office (KCO), to which a key member of the Ministry of Health Bamako delegation moved shortly after 1987, remained the stronger partner. Together with a few bilateral agencies, the KCO funded all the costs associated with pharmacy-based activities, even including the non-salary costs of the officials working within the national primary health care unit, as well as being the sole distributor of drugs and bed nets to pharmacies. The significant dependence of BI activities on UNICEF support explains why they were severely disrupted by the suspension of this support in 1995/96 during a period of reorganisation within the UNICEF.

It also suggests that, in practice, the UNICEF KCO drove the development of the BI programme. Thus, it was the KCO officials who were primarily responsible for the frequent introduction of new ideas, such as changes to the service package, into the BI programme. It was also the KCO that refused to consider basing drug procurement systems on the existing national Essential Drugs Programme (EDP) and instead sought to establish an alternative distribution approach using NGOs. However, as these innovations were generally based on ‘what might be good to do’ rather than resulting from reflection on experience or the changing context, they were often flawed. The decision to ignore the EDP, for example, partly reflected the economic and management difficulties faced by this programme but supporting NGOs distributors was equally problematic and did not survive the withdrawal of UNICEF’s financial support. This failure to establish sustainable drug supplies was a critical weakness of the BI programme.

At the same time, Minister of Health policy-makers were responsible for isolating the BI programme from the wider developments that could have supported it by following the common pattern of establishing parallel management structures based on donor funding directed at specific purposes [46]. Run from the central primary
health care unit as a vertical programme and only weakly tied to the existing health facility network, there were few links between BI pharmacies and nearby primary care facilities. These facilities simply had no funds for, and no interest in, the activity. At a national level the programme was never given government recurrent budget support and was kept separate from the management of the broader cost-sharing programme that developed over the 1990s. As the first level primary care facility remained free, the failure to link up the two systems of charging not only created the potential for perverse incentives over utilisation patterns [47] but also prevented BI activities from being strengthened through the cost-sharing programme.

Ultimately, therefore, its two central actors, the UNICEF KCO and the Ministry of Health undermined the Kenyan BI programme. The design of the programme, its evolution over time and the support it received were simply not adequate to allow effective implementation. The imaginative approaches developed within it remained experiments that were not sustained in the face of changing circumstances.

3.3. The contradictions of implementation strategies in Zambia

The Zambian experience was clearly very different from that of the other two countries because financing reforms took second place to decentralisation, and so were both given less consideration by policy-makers and also subjected to other policy changes. Initiated after the election of the first democratic government in 1991, the decentralisation programme was intended to address the critical weaknesses of the health system by strengthening management and quality.

By 1995, the time of this study, the reforms had primarily focused on the appointment of district health management teams (DHMTs), as well as training and systems development to strengthen their capacity to manage the budgets allocated to them. Despite the importance of community participation in decision-making, less consideration had been given to the appointment and support of district health boards (to be a governance structure working with management teams), area boards (to act as a link between the population and district boards) or neighbourhood health committees (to act as a forum for community-based decision-making, with representation on health facility management committees). Few of these bodies were functioning in the districts visited in this study. Following the guidance of the 1992 National Health Policy and Strategies document [48] fees had been introduced in some facilities, but the extent and level of fees varied considerably between districts as did revenue retention and use practices.

A major review of the nature and consequences of the Zambian reform implementation strategy undertaken in 1996 identified the strong leadership and pragmatism of the reformers as being fundamental to the achievements in district development that had by then been secured [49]. Yet at the same time, it suggested that the incremental nature of the strategy and delays in tackling ‘difficult-to-win’ problems, such as the development of a national drug policy, resulted in a piecemeal package of reforms and generated uncertainty that undermined imple-
mentation (Section 4). In particular it suggested that there had been an ‘apparent ambivalence… to the whole issue of financing, which contrasts sharply with the clarity and sureness of touch which has characterised many other aspects of the reform process’ ([49], pp. 23–24). Comparison of the Benin and Zambia experiences emphasises this point. Whilst an incremental process was adopted in both countries, in Benin this was rooted in a clearly specified policy design as well as implementation and monitoring procedures that allowed experience to be reviewed and fed back into policy development. In contrast, the purpose and design of financing reform in Zambia was unclear and the general lack of monitoring precluded lessons being learnt from the process of reform [49,50]. Tackling such problems requires stronger leadership and vision in the development of financing policy change.

4. Strengthening management through fee introduction: the contribution of policy design to equity gains

The second explanation for the differing equity impacts of the three countries’ BI activities lies in seven key differences in the design of the financing activities investigated in the three countries (Table 2).

1. The Benin BI programme was rooted in an enabling legal and policy framework. New legislation permitted the sale of drugs within health facilities, the retention of revenue by the collecting facilities and decision-making on revenue use by community management committees. The overall policy framework complemented legal change and guided the coherent development of BI activities in different areas of the country—for example, specifying practice concerning fee levels and revenue use (point 2) and the tasks and functions of community decision-making committees (point 6).

Although similar actions were taken in Kenya and Zambia, they did not provide such clear guidance for implementation in either country. A policy framework [51] was only established in Kenya after 5 years of experience, whilst its adaptation over time simply generated uncertainty around key aspects of practice. Not surprisingly there was considerable variation across Kenyan sites in fee-setting practices and levels (point 2), the implementation of income generating activities and the extent of community consultation (Section 5). Zambian fee-related practices also varied between districts (point 2), largely because, as the health managers and providers interviewed in this study indicated, the various circulars and verbal official announcements supposed to guide implementation were commonly perceived as confusing.

2. In Benin fee levels for curative care (in the form of a drug rather than a consultation fee), antenatal care and deliveries were established by national managers and community committees were not allowed to adjust them. The prices were based on the cost of drugs used for complete treatment with a mark-up, varying by 20–300% between treatment types. This mark-up generated sufficient revenue to cross-subsidise immunisation outreach activities (which were free of charge) and curative care for children, and to cover the costs of drug supplies and staff
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<tr>
<th>Design element</th>
<th>Benin</th>
<th>Kenya</th>
<th>Zambia</th>
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<tr>
<td>1. Legal and policy framework</td>
<td>A clear framework promoted coherent development across country</td>
<td>No legal framework; guidelines developed late and remained flexible, generating uncertainty</td>
<td>Inadequate legal framework and confusing guidance</td>
</tr>
<tr>
<td>2. Fee design and fee setting practices</td>
<td>Nationally set fee levels ensured adequate revenue generated to allow expected cross-subsidisation of other activities</td>
<td>Weak national guidelines adapted by VHCs on basis of broad assessment of local circumstances</td>
<td>No national guidance and so DHMTs made own decisions on unclear grounds</td>
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<tr>
<td>3. Funding sources supporting service provision</td>
<td>Government and donor support provided to primary care facilities to complement local revenue generation</td>
<td>Total reliance on donor funding despite local revenue generation</td>
<td>Significant reliance on donor funds within health system as a whole, and so at district level</td>
</tr>
<tr>
<td>4. Strengthening drug availability</td>
<td>Deliberate parallel action taken to improve drug availability</td>
<td>No action to improve drug supply; few drugs available in basic package of care offered in pharmacies</td>
<td>No action to improve drug supply</td>
</tr>
<tr>
<td>5. Strengthening clinical skills</td>
<td>In-service training and supervision deliberately strengthened</td>
<td>Little action</td>
<td>Little action</td>
</tr>
<tr>
<td>6. Supporting local management structures</td>
<td>Community committees given clear guidelines, specific training and regular supervision</td>
<td>VHC guidelines applied flexibly in practice and key roles undermined</td>
<td>DHMTs trained but given weak guidance on roles</td>
</tr>
<tr>
<td>7. Strengthening information systems</td>
<td>Clinic information system strengthened and used in monitoring activities</td>
<td>Steps to develop community-based information system weak and not sustained</td>
<td>Focus only on district financial information system</td>
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*a* VHC, village health committee.  
*b* DHMT, district health management team.
incentives. In practice, the revenue generated through community contributions covered, on average, nearly 30% of total recurrent costs of the primary care facility [52].

Fee design and fee-setting practice were quite different in Kenya and Zambia. The rule of thumb established by central managers to guide drug and bed net fee levels in Kenya (two to three times the purchase price) was not based on careful analysis of revenue needs, and village health committees (VHCs) were anyway allowed to adapt national guidelines on the basis of local circumstances. Price levels varied, on average, by 400% across drug items between the BI sites assessed. The lack of a guiding policy framework in Zambia was similarly reflected in the considerable variability in health centre price levels between districts: rising from 200–300% for outpatient fees between rural health centres to 400–500% in outpatient fees between urban health centres. The revenues generated were barely adequate to re-supply drugs and nets in Kenya and made negligible contributions to total operating costs in Zambia.

3. Within the Benin BI programme’s funding package government and donor support complemented the revenue generated by fees [52]. Government contributions, representing about one half of total facility recurrent costs, fully covered the costs of salaries and partially covered the costs of supervision, whilst donor contributions, representing less than one-quarter of total facility recurrent costs, supported the cost of transport, training, cold chain requirements and building renovation and maintenance. At the same time, some steps had been taken by the mid-1990s to reduce reliance on donor funding. For example, external funding for fuel for immunisation outreach services was being gradually withdrawn as health facilities began to cover these costs fully from their own revenue surpluses [40].

In contrast, the Kenyan BI programme’s almost total reliance on external funding led to the severe disruption of its activities when the UNICEF KCO withdrew its support in 1995/96. Whilst the Zambian health system’s reliance on donor funding [53] made it similarly vulnerable to changing donor priorities, donors were broadly in support of the reform programme at the time of this study.

4. The Benin BI programme’s efforts to tackle low quality within primary care facilities was supported by improving drug availability through parallel action to promote essential drug lists and use international tendering procedures.

In direct contrast, no steps had been taken by the time of this study to develop an effective drug procurement and supply system in support of BI pharmacies in Kenya or the wider health system in Zambia. The weaknesses of the Zambian system meant that fees were introduced without any concomitant improvement in drug availability at health facilities. As a drug, rather than consultation, fee was levied, patients complained that they effectively had to pay twice, once for consultation in the public facility and a second time in purchasing drugs from other sources [54]. Perhaps not surprisingly, the initial evidence suggested that utilisation levels fell considerably after fees were introduced—for example, by 40–100% in selected clinics in Lusaka Urban District [22,55]. In Kenya, focus group discussions with VHCs held after UNICEF had stopped supplying drugs and nets to pharmacies indicated that pharmacies were then experiencing major problems in drug
availability and had turned to local, private sources, despite concerns about the quality of their supplies. In practice, therefore, the access gains achieved by locating pharmacies in previously under-served areas were undermined by the failure to develop a secure, local, drug procurement system. In addition, as the benefit package offered through the programme included only first aid care, and little access to referral services, community members still had to use other sources of care for some, particularly more serious, conditions, with the consequent cost implications. In the household surveys undertaken within this study, the limited range of drugs was the most frequently identified community criticism of the BI activities.

5. Within the Benin BI programme, various actions were taken to strengthen the clinical skills of primary care staff. They were given in-service training to promote rational prescribing of drugs, the use of clinical pathways (such as flowcharts) in diagnosis and risk screening in the provision of care to pregnant women. Efforts were made to strengthen supervision practices, including the development of a tool to help facility staff and supervisors monitor coverage and identify and address the obstacles to improved coverage. Fee revenue was also partly channelled into supporting regular supervision, through a flat-rate levy of 2500CFA on all health centres paid to the local Direction Departmentale de la Santé (i.e. regional health office). As a result, nearly all (99%) of the health staff interviewed in this study indicated that their health centre received financial, material and technical support from higher levels (although another study identified weaknesses in supervision practices [40]).

In contrast, clinical skills’ development was weak in both Kenya and Zambia. Indeed, at the time of this study, the Zambian health reforms explicitly focussed on the development of management rather than clinical skills. In Kenya, data collected from household surveys in case study sites indicated that the limited skills of CHWs was the second most frequently identified community criticism of the BI pharmacies. Subsequent in-service training rarely followed the short-period of initial training given to CHWs, and little supervision was provided. Pharmacy staff at only one out of the 12 sites visited in this study indicated that they had received support from the neighbouring health facility whilst national supervision was, again, ultimately undermined by the lack of secure funding for BI activities.

6. Local management structures were developed in Benin by clearly defining the tasks and functions of community committees, and providing relevant training for their members. The Comité de Gestion de Commune (COGEC) was given responsibility for managing drugs (receiving drugs, stock control, being informed on drug orders made by staff), managing funds (banking money and keeping one of the two keys to the facility safe), employing and paying local workers such as drug dispensers, and deciding on how to use money. Clear guidelines, training and supervision also promoted common practices across communes: thus, 74% of the health workers interviewed in this study indicated that revenue use in their facility followed policy guidance.

Although guidelines were established to guide the establishment and functioning of VHCs in Kenya [51], the establishment, size, composition and activities of the committees varied considerably between sites. Their revenue management function
was anyway undermined by UNICEF’s continued provision of financial support and drug and bed net supply. Rather than being used to support BI activities the revenue generated by fees largely remained in bank accounts, earning interest but losing value, and sometimes being misused. In Zambia although community committees had not been established at the time of this study, district management teams had been strengthened using an on-the-job training approach, rooted in plan development and performance monitoring. However, as already noted, the guidance district managers received on fee-related issues was often confusing. At the time of this study no attempts had been made to develop the management skills of health facility staff or community committees.

7. The management information system was strengthened in Benin by linking it to local decision-making concerning health care provision, resource management, supervision of quality of care and monitoring coverage, drug use and cost recovery [38]. Steps were taken to involve both health staff and community members in simplifying the system, so increasing their understanding of the information available. This also promoted transparency at a local level.

Similar efforts to strengthen the Zambian district financial information system, through a process involving district management staff, were not, however, extended to other relevant management information or to the health facility and community level. A local-level information system developed to record basic community statistics (such as births, deaths, pit latrines constructed etc.) within the Kenyan BI sites, the ‘chalk and board’ system, was simply not sustained after the withdrawal of UNICEF support.

Overall, this cross-country comparison of design issues emphasises that the Benin BI’s promotion of relative affordability gains was not simply a function of levying fees. Rather, as Knippenberg et al. ([40], p. 42) comment, ‘while the cost sharing mechanism initially seemed revolutionary at the national and international levels, the linkage with strengthened clinic management, staff quality and morale, drug supply and relations with the community as a whole were visibly more important factors in revitalising’ the health centres. The management change associated with fee introduction was, ultimately, the key to improving the service quality and coverage of primary care facilities in Benin, whilst management weaknesses undermined the Kenyan and Zambian financing activities.

5. Failing the poorest: the interacting problems of policy design and process

Despite its other successes, the Benin BI programme shared a common equity problem with the financing activities examined in Kenya and Zambia: all three failed to protect and benefit preferentially the poorest within communities.

A critical factor underlying this equity problem was the failure to establish the protection of the poorest as a clear goal of the activities. The Benin BI programme sought, rather, to improve quality of care, and the Kenyan programme, to support both improved access to drugs at community level and health-promoting community development actions. Whilst the Zambian reforms sought broadly to improve
equitable access to cost-effective health care, fees were introduced with the specific
goals of creating community ownership of the health system and raising revenue.
Given these goals, the subsequent design and implementation of the relevant
financing activities in all countries simply failed to recognise and tackle the specific
needs of the poorest. For example, neither Benin nor Kenya took action to offset
differences in revenue generating capacities between communities of 200% annually
(Benin) and 900% monthly (Kenya). Although not fully investigated, there were
signs that more wealthy communities generated higher levels of revenue, and
benefited from greater service improvements, than less wealthy communities [27,38].
Zambian action to implement a resource re-allocation mechanism between districts
may, however, provide lessons for other countries on this issue [55].

The three design problems promoting intra-community inequities are highlighted
in Table 3, together with the key factors explaining them. However, for each issue
and in each country there were important features of context that influenced
practice concerning the poorest, and that cannot easily be off-set by actions within
the health sector alone. The health needs of the poorest and their ability to
contribute to local decision-making clearly require much broader action if the
socio-economic and socio-political roots of these problems are to be effectively
addressed.

5.1. Ignoring financial barriers

A critical gap in the design of all the schemes of focus was the lack of an effective
means to protect the poorest from the burden of payment. Zambia was the only
country in which guidance on who to exempt was established by the central
Ministry of Health. In Benin and Kenya the decision of whether or not to protect
the poorest groups from payment, and how, was left to the local-level management
committee on the grounds that it could best make case-by-case exemption judg-
ments. Yet in all countries the weak guidance on who to exempt and how to
provide for the poorest groups’ needs was commonly identified by interviewees in
these studies as a reason why exemptions or reduced prices were usually not
offered.

Exemption practice in all countries was, however, primarily undermined by the
conflict between financial sustainability and protection of the poor. Even in
Zambia, where revenue generation was not an explicit goal of the fee system,
providers interviewed in this study complained that if the exemptions of policy were
applied fully it would prevent revenue generation. In Benin the need to recover
costs in order to maintain the quality of services was the most important reason
given by service users for why protection was not offered to the poorest, and was
also one of the reasons given by health staff. ‘More and more, social assistance and
the desire to help the sick who are targeted by the health services is undermined by
profit’ (focus group discussion, young people). The pre-eminence of financial
sustainability was almost inevitable given the programme’s insistence on generating
revenue to promote service improvements. The training and supervision offered to
primary care workers and community members stressed their responsibility to raise
### Table 3
**Explaining intra-community equity losses across countries**

<table>
<thead>
<tr>
<th>Equity losses</th>
<th>Explanatory factors</th>
<th>Design/actors</th>
<th>Process/actors</th>
</tr>
</thead>
<tbody>
<tr>
<td>No protection for poorest</td>
<td>Beneﬁting majority poor is the established and accepted equity goal; communities may not wish to implement protection for poorest (prices affordable, danger of leakage to non-poor); weak management capacity</td>
<td>Primary goal of ﬁnancial sustainability; unclear or no guidance on who to exempt; vague or weak exemption mechanism; no other mechanism to tackle ﬁnancial barriers; poor have no voice (see below)</td>
<td>Top-down and inconsistent implementation process undermines authority of local actors to offer protection; limited training and supervision to develop relevant management capacity</td>
</tr>
<tr>
<td>Limited beneﬁt strategies</td>
<td>Community demand/preference for curative care; low cash incomes limits revenue generation possible; weak management capacity</td>
<td>Limited health promotion beneﬁt packages; curative care dominance; limited curative care package (Kenya); target group primarily deﬁned in disease terms (at risk); limited inter-sectoral collaboration; poor have no voice (see below)</td>
<td>Top-down and inconsistent implementation process undermines authority of local actors to widen beneﬁt package; training and supervision to develop relevant management capacity; limited consultation within community</td>
</tr>
<tr>
<td>Not listening to the poorest</td>
<td>Characteristics of poorest; socio-cultural realities of local communities</td>
<td>‘Community participation’ seen as strategy of implementation not objective in its own right; formal guidance that promoted exclusion of poorest; no mechanisms to promote inclusion of poorest</td>
<td>Socio-cultural realities dominate practice of implementation; implementation through local structures promotes exclusion of poorest; top-down implementation undermines local ownership and decision-making by local structures</td>
</tr>
</tbody>
</table>
revenue and so both groups expressed a concern about the need to avoid making a loss and to ‘balance the books’. ‘We do not see any sense of equity in the decisions taken about the health centre. Perhaps the health workers and the COGEC members have not been sensitised to this issue’ (focus group discussion, village leaders). Similar practices in Kenya may also have influenced decision-making despite external support for the provision of drug and bed net supplies.

Given the dominance of financial sustainability, it is perhaps not surprising that little consideration was generally given to other possible strategies for addressing the financial barriers faced by the poorest. Yet in three Kenyan sites, VHCs had been encouraged by the DHMT to consider imaginative ways of addressing the issue, such as an approved list of those entitled to exemptions and a special bank account to cover the costs of care for the poorest. Some NGOs in Kenya and Benin had also developed broader protection strategies. In one Kenyan site, a community solidarity fund (which was set up and funded separately from the health care fee system) was used to pay for the health care provided to the indigent. And in Benin, the poor were protected through mechanisms such as reduced prices and a pharmacy providing free drugs to the poor.

The failure to develop such innovative protection strategies in most communities may itself reflect the limited authority given to local decision-makers within the BI programmes. In both Benin and Kenya the composition and tasks of community committees were determined within fairly limited parameters by higher levels. In Benin, for example, they were neither allowed to determine price levels nor given much freedom in terms of revenue use. There was, in effect, limited management flexibility to respond to the financial needs of the poor, as highlighted in discussions with COGEC members.

“…the COGEC has regulations to respect, which considerably limit its field of action. Drugs must be disbursed at a small cost, we have no authority to distribute them freely and the stocks must be replaced.”

“…the COGEC is ruled by regulations which deprive it of its autonomy.”

Although Zambian providers were given authority to offer specified exemptions, the guidelines were implemented differentially between districts because of a failure effectively to communicate them either to health staff or the community at large. Indeed, guidance on exemptions was only provided after fees had been introduced and been negatively received by the population. Thus, staff at one rural health centre indicated that no official communication had been received about exempting under fives or the elderly and so ‘being just a rumour [they] did not exempt the two from paying’. Many others complained that policy was changed often and that the changes only came as verbal pronouncements. In 1994 the Deputy Minister of Health had even announced that nothing should be considered official until written notification had been received from the permanent secretary, given the number of verbal pronouncements being made from the central level.
Ultimately, the voice and views of the poorest were often simply not heard or considered in decision-making on price structures and levels. In Benin, for example, price levels were largely thought to be acceptable by the general population. Yet whilst only 1% of the community-level key informants felt that prices should be related to socio-economic status, 62% of those interviewed from the poorest group said they would like to obtain exemptions and 87% said current price structures deterred some people from accessing services.

5.2. Inadequate development of pro-poor benefit strategies

The importance of benefit strategies to equity gains is shown, for example, in the contrast between the relative affordability gains of fees with quality improvements in Benin and in the decline of utilisation rates that appeared to be associated with the introduction of fees without quality improvements in Zambia. The contrasting experiences of Benin and Kenya also suggest that the nature of benefit strategies influence the extent to which the poorest preferentially benefit from health care. The broader health promotion and development strategies pursued in Kenya had the potential to generate equity gains by cross-subsidising the spread of benefits within communities beyond the group of health care users. Although the cross-subsidisation of immunisation services in Benin did generate some similar gains for the health vulnerable groups of mothers and children, the dominant focus on curative care channelled most benefits only to those using these services. Yet financial barriers continued to constrain access to these benefits by at least some of the poorest [38,56].

The potential benefits of the broader Kenyan benefit strategy were, moreover undermined by the limited development of such activities. In practice, only four sites initiated income-generating activities (IGA) and of these, only one site supported activities through an IGA that spread benefits widely within the community (the construction of a road and a school). In other sites the IGAs generated benefits for only a limited group, sometimes as incentives to CHWs. Even relative affordability gains were constrained in Kenya by the limited package of care provided, as it required continued use of more expensive and more distant health providers especially for more serious, and potentially expensive, conditions. These weaknesses of the Kenyan BI programme reflected four main factors:

1. The programme adopted a curative care ‘entry point’ in initiating its activities, with the intention of building broader primary health care activities over time. However, the pharmacies came to be seen by the community almost solely as places that sold drugs and bed nets, perhaps reinforcing a general preference for curative services and undermining the intended role of the BI programme in health promotion.

2. It is always difficult to raise revenue at primary care level: price setting has to balance the potential impact on demand with the generation of funds [12]. In practice, the revenue generated within BI sites was barely adequate to re-supply drugs and bed nets and no site visited in this study had generated enough revenue to give CHWs incentives for providing preventive services, or broader development activities.
3. To offer broader benefit strategies it is necessary that local management committees are trained in a wider range of skills and better supported, than in more narrowly focused approaches. Yet the skills and training needed to support the diverse range of IGAs initiated were simply not available within the BI programme, and would have required inter-sectoral collaboration.

4. Community members expressed strong concern that decision-making around IGAs, in particular, was in the hands of the VHC and/or CHWs rather than the whole community in four out of the ten government-supported BI sites visited in this study.

“We find ourselves at a crossroads now because there is nothing we can ask the VHC about this project because we were not part and parcel of its inception.”

“We cannot comment on the IGAs because even at present none of us knows the number of bags of maize which were brought to be sold.”

IGAs may, therefore, have become simply a way of generating benefits for a small elite rather than promoting health and development activities of benefit to the wider community.

5.3. Not listening to the voice of the poorest

The failure to hear the voice of the poorest reflected a broader problem: there were signs in all three countries that the community at large, let alone the poorest, did not feel involved in decision-making. In some Kenyan BI sites, activities were initiated by a specific group or person (such as pre-selected CHWs or the chief) and this influenced the wider community’s perception of who ‘owned’ the BI pharmacy. Even when elections were undertaken without the overt influence of the local administration, the chief’s real influence would be understood by the community and he, or an assistant chief, might be present at the baraza (chief’s assembly). The very fact that the baraza was seen as a key instrument in initiating BI activities underlined the potential for the chiefs to manipulate the activities to their own ends. In one case, a chief took control of the dairy cattle owned by the BI for ‘safe keeping’ and then declared the animal his, in spite of opposition from community members. In contrast, there were other instances when the district BI co-ordinator (a DHMT member) directly involved himself in local decision-making concerning the appointment of office bearers and price levels. Whilst perhaps undertaken to promote ‘good practice’, this may also have undermined local ownership. Not surprisingly, community members often thought that ‘the project’ belonged to the VHC, the BI co-ordinator, the Minister of Health or UNICEF. Similarly in Zambia, although cost sharing was introduced ostensibly with the aim of promoting partnership, few community members felt they could participate in decision-making or influence practice. One analysis of the Zambian experience expressed concern that decision-making had been taken over by some health staff and so had discouraged the community [49].
As noted, in all three countries key aspects of implementation remained effectively controlled by higher levels and so precluded opportunities to listen to the poorest. All community-based key informants interviewed in Benin, therefore, stated that the health authorities set prices. In Kenya, the revenue generated largely remained stored in bank accounts whilst community bodies awaited instructions on when and how to use them. Only when UNICEF deliveries of bed nets and drugs failed to arrive did communities begin to think they could use the revenue they had collected. In Zambia, although decisions concerning price levels, exemptions and revenue generation were being taken at district level, there were also signs that the district sometimes blocked decision-making by lower levels on these issues. Thus, in six out of eight districts visited in this study, facilities were required to bank fee revenue at the district level—leading to some confusion about how the revenues could be used and who could decide on their use. The lack of clear guidance only exacerbated the issue: guidelines requiring that a proportion of revenue be retained for use by individual facilities were drafted and verbally communicated to district managers, but never signed and given official status.

The policy guidance implemented through these top-down practices sometimes directly excluded the poorest. Thus, in Kenya, VHC members and CHWs had to be literate and the selection of both groups had to occur through the baraza. Yet 78% of the poorest households surveyed in case study sites had not attended a baraza in the previous year, compared to 43% of those surveyed in the initial survey.

“The vulnerable members do not get an opportunity to be a CHW or join a VHC because… that selection is one only for the fittest members in society.”

“The poor do not take part in the decisions regarding exemptions because they do not take part in meetings.”

Clearly, however, the diverse range of personal and material factors that characterised the poorest in all countries [27] are likely themselves to have had a marginalising effect on their role in the community. The extreme poverty from which the poorest suffer inevitably places an enormous burden of survival on them and may simply prevent them from engaging in any voluntary activity. Women may be most excluded from decision-making because of deep-rooted beliefs about the traditional roles of men and women and so, despite policy guidance, the VHC chairperson was a man in all Kenyan BI sites visited.

Perhaps the tendency towards top-down implementation approaches was inevitable in all countries. The problems were defined as technical in nature, the technicians played a dominant role in generating solutions, the traditional decision-making practices of most communities and public sectors were hierarchical and external, international agencies played a strong role in supporting these activities. Certainly, despite stated intentions, an appropriate balance between central level control and local decision-making seems never to have been achieved. Some decisions, such as who to exempt, were left to the community in apparent reflection
of the international view that this was the most effective way of identifying and addressing some community needs. However, this approach ignores the clear pressures to focus on other priorities at the expense of the poorest, as well as the socio-cultural and political realities of communities. In addition, the practice of implementing change in all three countries gave only limited roles to these local decision-making structures and consistently excluded both direct and indirect consideration of the voice of the poorest. Only in sites supported by NGOs, where special mechanisms had been established to address the needs of the poorest and the parent organisation had taken responsibility for providing funding, were these mechanisms implemented effectively. Overall, therefore, the community decision-making bodies created to strengthen accountability by giving a ‘voice’ to the community often did not appear to serve the interests of the poorest.

6. Conclusions and recommendations: meeting the needs of the poor and the poorest

6.1. Strategy is always important

The three-country studies all illustrate the critical importance of leadership and strategy to the effective implementation of policy change. Managing such change requires both political skills, to develop and mobilise support, and technical skills, to inform and guide the reform process [57–59]. The careful design of reforms can aid implementation by reducing the potential for confusion or conflict by stating clear goals, outlining simple technical features and establishing clear implementation steps. Within a clear guiding framework, incremental approaches then allow capacity for implementation to be developed, give implementors the flexibility to learn from experience and enable support for change to be developed.

The continual adaptation of reforms in pursuit of goals is also only possible if there are sound procedures for monitoring and evaluating experience [57,58,60]. For pro-poor policies it is particularly important to monitor the impact of policy on the poorest. Dis-aggregated data are essential for this task. For example, it must be possible to identify and compare the utilisation of different population groups as well as to track changes in utilisation over time. This study has also highlighted the usefulness of looking at various aspects of equity, and the interaction between them, as well as the need to understand why and how change is brought about—not only what change is achieved.

6.2. Sustaining the potential equity gains of community financing schemes

The country experiences reviewed here also suggest that the key factor in sustaining the potential relative affordability gains of community financing activities is to use the introduction of fees as a policy lever for strengthening management. The key, interacting steps required to ensure these gains include:
establishing a clear design that includes local retention of most revenue and cross-subsidisation of a limited range of preventive services;
- ensuring that parallel action is taken to support implementation-in particular, reforms to improve drug availability and to support decentralised decision-making;
- providing clear and detailed guidance on pricing practice and revenue use;
- providing management and clinical training and supervision for health facility staff, possibly supported by a financial contribution from each facility;
- encouraging health facility staff to monitor local health facility performance;
- involving local community structures in decision-making with appropriate guidance and support;
- generating in-country support for change through incentives and sustained improvements;
- maintaining government financial support for at least the salaries of staff and using donor funds as flexibly as possible to support the overall approach;
- adopting a gradual but progressive implementation process.

6.3. Seeking to meet the needs of the poorest

However, the experience of all three countries highlights the difficulty of establishing effective exemption mechanisms to protect the poorest from payment, especially within systems seeking to promote financial sustainability.

An alternative approach, proposed by respondents in both Benin and Kenya, is to establish a separate 'community solidarity fund' which can fund the use of care by the poorest, alleviating the tension between financial sustainability and concern for their needs:

“To better care for the impoverished and vulnerable, the political authorities must count the indigent. The state must, moreover, give the health centre a special drug supply to care for the impoverished and vulnerable who don’t have support.” (Benin focus group discussion, young people)

A first step would be to develop mechanisms for determining who should be given support. Drawing on the 1992 Zambian experience of drought relief procedures, Booth et al. ([54]; see also [61]) suggest that local, democratically elected committees could be strengthened by NGOs in assessing each household within the catchment area of health centres and determining which should be exempted. The approach has some similarities to that of the Thai low income card scheme which brings local leaders and health workers together to determine on the basis of a nationally-determined income threshold who within a community should be allocated a card entitling them to free care. Over 15 years of implementation experience has shown that such an approach can be implemented relatively effectively [62]. de Kadt and Tasca [63], similarly, propose a geographic targeting approach based on
identifying vulnerable groups by living conditions, rather than income, through a process that uses both available technical information, such as health statistics, and the knowledge of the local population. They suggest that health interventions, and inter-sectoral action, should then be directed to these target populations in response to their worse access to care or experience of a particular health problem.

Although there are no easy options in meeting the needs of the poorest, the experiences examined here suggest that the following actions are always important to consider:

- maintaining government and donor support within an overall financial plan for the health sector, so that the full burden of financing, and especially the burden of financing necessary support, is not left to communities;
- the creation of local decision-making structures which try to take into consideration the needs of the poorest by specifically seeking representation from civil society groups such as churches and NGOs, women and others, and by procedures which allow broader views to be heard (e.g. community-wide meetings, specific attempts to hear the needs of the poorest);
- developing broad approaches to targeting which involve local people working within central guidelines, and which are managed and funded separately from the local revenue generation mechanism;
- developing benefit packages broader than curative care to ensure the wide dispersion of benefits within the community (recognising the particular importance of strong local-level administrative capacity);
- a package of training and supervision which strengthens local management practices and emphasises the importance of addressing the needs of the poorest;
- a monitoring approach, perhaps building on a targeting mechanism, which allows changes in the situation of the poorest to be identified and fed back into health service planning and local decision-making;
- an appropriate balance between local and central decision-making.

The last issue is possibly one of the most critical and is also emphasised by wider decentralisation experience [64]. Rather than simply leaving protection of the poorest to communities, governments need to provide financial assistance, guidance and appropriate support to communities in this task and in promoting inter-community equity. By themselves community financing schemes can do little for the poorest, instead much broader action, backed by political support, is required.

6.4. The continuing debate

Ultimately, however, the nature of the equity goal established to guide any health programme’s development will influence the equity gains it actually promotes. Whose views and values should underlie the selection of this goal? Some argue that the concern for the poorest groups is imposed on African cultures by external agents [65]. Carrin, thus, ([66], p. 186) suggests that:

“…equity does not normally seem to be perceived as a priority at the outset of a community financing scheme. One of the reasons is that feelings of interfamily
solidarity may be rather weak so that the population may resist the implementa-
tion of certain equity rules in a financing scheme… Greater equity should be kept
as a long-run goal. Schemes are invited to monitor equity and to move gradually
towards this goal.’

However, during focus group discussions undertaken in these studies community
members expressed concern for the poorest as well as the broad community, and
recognised the difficulties faced by the poorest in accessing fee-paying care:

“Equity requires equality of rights for all at the health centre with, nonetheless,
some priority for the worst sufferers and the children.” (Benin)

“The poor should be chosen as leaders of the project as well so that they can
speak on behalf of other poor colleagues about their requirements.” (Kenya)

“Equity in health care means that everyone, whether they are rich or poor and
whatever ethnic group they come from should have access to health care when
they need it… Equity is not possible because every intervention has its own price
and those who have no money dare not even come to the health centre.” (Benin).

Although an inadequate analysis, these community voices may be suggesting that
strategies to promote equity must achieve gains for the majority poor and the
minority poorest. Further research on understanding how communities perceive
equity and how to achieve it would be an important foundation for future policy
development.

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