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**Health
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and
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Project**

**REDSO WORKSHOP ON
HEALTH FINANCING AND SUSTAINABILITY
IN WEST AND CENTRAL AFRICA**

**Saly Portudal, Senegal
February 14-18, 1994**

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**Regional and Economic Development Services Office
for West and Central Africa
and
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ABSTRACT

The Regional Economic Development Services Office for West and Central Africa (REDSO/WCA) of the U.S. Agency for International Development, with technical support from the Health Financing and Sustainability (HFS) Project, sponsored a regional conference on the themes of health care financing and sustainability in Saly Portudal, Senegal, from February 14-18, 1994. Presentations, case studies and discussions covered a broad range of policy issues which included cost recovery, means testing, user fees, hospital autonomy, the role of the private for-profit health sector, the impact of the recent FCFA devaluation on the health sector, new topics for applied research, and non-project assistance. This report serves as a summary of the proceedings, with emphasis on the participants' findings, recommendations, and proposals.

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ACRONYMS

AGBEF	Association Guinéenne du Bien-Etre familial/Guinean Association for the Well Being of the Family
AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute respiratory infections
BI	Bamako Initiative
CCCD	Combatting Communicable Childhood Diseases
CHW/VHW	Community Health Worker/Village Health Worker
CREDESA/SSP	Centre Régional pour le Développement et la Santé/Soins de Santé primaire
DDM	Data for Decision-Making Project
EPI	Expanded Program for Immunization
FCFA	Franc Communauté Financière Africaine (monetary unit tied to the French franc and used throughout the former French colonies in Africa) Approximately US 1\$=285 CFA until devaluation in February 1994 when \$1 US = 570 CFA
HFS	Health Financing and Sustainability Project
HMO	Health maintenance organization (managed care provider)
HHRAA	Health and Human Resources Analysis for Africa
IEC	Information, education, and communication programs
IPRES	Institut de Prévoyance Sociale (Social Welfare Institute)
KAP	Knowledge, attitudes, and practice
MCH	Maternal/Child health
MOH	Ministry of Health
NPA	Non-project assistance
ORT	Oral rehydration therapy
PID	Project Identification Document
PHC	Primary health care
PP	Project Paper
REDSO/WCA	Regional Economic Development Services Office/West Central Africa
SENECI	Sénégalaise d'Etudes de Conseils et d'Interventions
STD	Sexually transmitted disease
UNICEF	United Nations International Children's Fund
URC	University Research Corporation
USAID	United States Agency for International Development
WHO	World Health Organization

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The organizers of the Health Financing and Sustainability workshop, sponsored by USAID's Regional Economic Development Services Office/West Central Africa (REDSO/WCA), wish to express appreciation to all of the workshop participants for the enthusiasm, experience, insights, and commitment that they brought to the proceedings and discussions. In particular, we would like to thank those participants who presented formally their own country's experience in the area of health financing. These presentations helped to ensure the relevance of discussions, as well as facilitate comparison of country experiences. The countries represented at the workshop include the following:

Benin, Burkina Faso, Cameroon, the Central African Republic, Chad, Guinea-Conakry, Ivory Coast, Mali, Niger, Senegal, and Togo.

We also wish to thank the Senegalese Ministry of Health and the USAID Mission in Dakar who served as country hosts for the workshop; USAID/Africa Bureau; USAID country Missions from the WCA region; and donor representatives from UNICEF, The World Bank, and France. Special appreciation is extended to the Senegalese firm, Sénégalaise d'Etudes de Conseils et d'Interventions (SENECI) for their tremendous contribution in coordinating all logistical and administrative details over the months leading up to the conference and during its actual implementation. Without their valuable support, the workshop could have never taken place.

The workshop was planned and conducted in collaboration with staff from REDSO/WCA—Katherine Jones-Patron and Bineta Ba; staff and consultants from SENEKI—Mary Friedel, Moustapha Kane, Fabala Ndiaye Ba, Hélène Sourang Diakhaté, Théodule Koffi, Omar Seck; and staff and consultants from the HFS Project—Marty Makinen, Ricardo Bitran, Nena Terrell, Denise Lionetti, James Setzer, Eckard Kleinau, and Barbara Stevens.

EXECUTIVE SUMMARY

The U.S. Agency for International Development, Regional Economic Development Services Office for West and Central Africa (REDSO/WCA), with technical support from the Health Financing and Sustainability (HFS) Project, sponsored a regional conference on the themes of health care financing and sustainability in Saly Portudal, Senegal, south of Dakar, from February 14-18, 1994. USAID/Dakar Mission Director Julius Coles and Assane Diop, Senegalese Minister of Health and Social Action, made opening remarks. They both stated their eagerness to institute far-reaching health policy reforms in Senegal based on ongoing public and private sector efficiency studies conducted by HFS for the Mission.

More than fifty participants representing Ministries of Health, USAID Missions, and USAID-funded projects in eleven West-Central African countries attended along with donor representatives from UNICEF, The World Bank, and France. Representatives from USAID's Africa Bureau Program on Health and Human Resources Analysis for Africa (HHRAA), the Basic Support for Institutionalizing Child Survival (BASICS) Project, supported by the Office of Health Research and Development arm (R&D/Health), introduced the work of these initiatives. HHRAA and BASICS representatives also worked with participants in special sessions on ideas for collaboration in their respective areas, for example, applied research and dissemination, and service delivery for child survival.

Presentations, case studies and discussions covered policy issues which included cost recovery, means testing, and user fees, hospital autonomy, the role of the private for-profit health sector, the impact of the recent FCFA devaluation on the health sector, new topics for applied research, and non-project assistance. The current role and potential for private sector services in health reform strategies emerged as an important theme to explore and develop in future workshops.

Participants collaborated with workshop facilitators to draw the following conclusions and recommendations:

- ▲ Users have demonstrated their willingness to share, according to their ability, with government the financial burden of health care.
- ▲ All governments should adopt the policy of stocking and providing essential drugs, based on the list formulated by the World Health Organization (WHO). Further, the availability of drugs is a key factor for the success of service and financial sustainability.
- ▲ The retention of user fees at the local level promotes efficient use of resources and provides incentives to health workers for improved performance.
- ▲ A successful cost recovery policy is also contingent on the implementation of management training and systems.
- ▲ The burden of health care costs must be shared by governments, their people, and donors, to ultimately attain sustainability.

- ▲ It is important to protect the poor in both rural and urban areas where cost recovery policies operate to ensure their access to care.
- ▲ The private sector should have a growing role in the provision and financing of health services to supplement limited public resources.
- ▲ Efforts to increase efficiency and reduce the costs of service delivery do not and should not require a reduction in quality or availability of services.
- ▲ It is imperative to reallocate resources for and within the health sector and to grant hospitals managerial and fiscal autonomy.

Priorities for applied research were ranked according to votes by participants. The HHRAA team presented a list of topics that had been formulated and ranked by a consultative panel in Washington. The following five headed the participants' list:

- ▲ Means testing mechanisms to identify and protect the poor;
- ▲ Hospital autonomy;
- ▲ Factors influencing preference or use of different sources of health care;
- ▲ Services and charges made by traditional healers (choice factors); and
- ▲ Insurance schemes.

Hospital autonomy emerged as the only topic which overlapped with the Washington list of top priorities for applied research.

The workshop was concluded by Mr. Alioune Mbaye of the Senegalese Ministry of Health, who lauded USAID's leadership in promoting and providing support for health policy reform in his country and recognized the Agency's role as foremost among all the donors in this sector.

1.0 INTRODUCTION

The purpose of this report is to provide highlights of the workshop on health financing and sustainability, held February 14-18, 1994 in Saly Portudal, Senegal, under the auspices of the Senegalese Ministry of Health and Social Action and sponsored by the U.S. Agency for International Development's Regional Economic Development Services Office for West and Central Africa. USAID's Health Financing and Sustainability (HFS) Project provided technical support for the design and facilitation of the workshop program and contracted Sénégalaise d'Etudes de Conseils et d'Interventions (SENECI), based in Dakar, to provide logistical and administrative support.

The present report is intended to serve as an overall record of the proceedings, with emphasis on the participants' findings, recommendations, and proposals. In this way, the report provides both a record participants can use for follow-up and a summary of the workshop's approaches and conclusions.

Officials, including medical doctors and economists, from eleven Ministries of Health in francophone African countries, managers of USAID-funded projects, representatives of The World Bank, UNICEF and French Development Assistance, USAID's Africa Bureau/HHRAA, REDSO/WCA, and country Missions participated in the workshop. (See the list of participants in the appendix.)

1.1 BACKGROUND AND PURPOSE OF THE WORKSHOP

Health financing and related sustainability issues are of increasing importance to Ministries of Health (MOH) in developing countries, as they confront declining donor support, shrinking MOH budgets, and unpredictable and erratic economic environments. In response to these challenges, the U.S. Agency for International Development (USAID) has provided assistance to African countries to assess these problems with the aim of identifying alternative strategies for financing and delivering practical and appropriate health services. In fact, USAID Missions are now required to include a section on sustainability in Project Identification Documents (PIDs) and Project Papers (PP). Additionally, non-project assistance (NPA) funds, utilized to finance health recurrent costs, often require adoption of policies favoring health cost recovery as conditions precedent to disbursement of funds. Given this emphasis on health program sustainability issues and the need to better address these issues in designing and implementing health programs and projects, a cable was sent in 1993 by REDSO/WCA to all Missions proposing a workshop on Health Financing and Sustainability. Responses received to the cable were overwhelmingly positive. Then, during a Combatting Communicable Childhood Diseases (CCCD) conference workshop on health care financing and sustainability held in Dakar in March 1993, responses to a questionnaire distributed to workshop participants reflected further support for the proposed workshop.

For this reason, in early 1993, Bineta Ba, Health Economist with REDSO/WCA, approached HFS to request assistance with the organization and implementation of a workshop that would provide a forum for representatives of WCA Missions and host government officials to discuss their concerns with regard to health financing and sustainability. It was agreed that the findings of applied research conducted by HFS on cost recovery, quality of care, efficiency within the public and private sectors, particularly in the West-Central African region, would be presented at the workshop. Further, the workshop would build on earlier studies of sustainability issues related to regional health programs, supported by REDSO/WCA,

notably a study commissioned by REDSO/WCA and completed by the University Research Corporation (URC) in 1990 entitled, "Cost Recovery for Child Survival Programs: Recommendations to Build Sustainable West African Health Projects". Although the findings from this study had been discussed informally with WCA Missions and host governments, no forum had ever been organized for formal dissemination of results or the design of follow-up activities.

1.2 OBJECTIVES OF THE WORKSHOP

Several objectives were established for the workshop, as listed below:

- ▲ provide technical updates and lessons learned from health financing policy initiatives in West and Central Africa over the past decade;
- ▲ improve capabilities to assess health financing strategies and needs to design assistance for sustainable health services;
- ▲ assess financing strategies and implementation activities;
- ▲ exchange country experiences; and
- ▲ identify health financing policy research priorities.

2.0 SUMMARY OF PROCEEDINGS: INTRODUCTION OF THEMES AND ISSUES: DAY ONE

Monday, February 14, 1994

- ▲ Opening Address by Julius Coles, Director, USAID/Dakar
- ▲ Address by Assane Diop, Minister of Health, Senegal

Sustainability

- ▲ Presentations, general overview of workshop, expectations of participants
- ▲ Health financing policies and strategies in sub-Saharan Africa, 1960-93
- ▲ West-Central Africa: present situation and health financing plan
- ▲ General discussion and synthesis
- ▲ Development of viable health projects in West Africa/Recommendations

Sustainability Strategies

- ▲ Definition, scope and objectives of sustainability
- ▲ Current perspectives on sustainability strategies: Round Table with representatives of The World Bank, USAID/Washington, USAID/Chad, and USAID/REDSO
- ▲ General Discussion

2.1 OPENING REMARKS OF SENEGALESE MINISTER OF HEALTH

Director of USAID, Representatives of REDSO/WCA, Representatives of the HFS Project, Ladies, Gentlemen, Representatives of bilateral and multilateral donor organizations, Honored Guests, Participants,

The workshop-seminar that brings us together this morning, has cardinal importance for our nations. In fact, our countries have endured, for two decades, an economic and financial recession that has effected the reduction of resources allocated to the health sector. In addition, in January 1994, the par value of the CFA franc was reduced to mitigate against the worsening of our economic situation.

With respect to my own country, Senegal, the Ministry of Health and Social Action's share of the budget, compared to the overall State budget, has dropped from 7.8 percent during 1973-74, to 5.0 percent during 1988-89, and risen slightly to the current level of 6.0 percent, in compliance with the

Head of State's decision to increase each year the budget allocated to health to reach the goal of 9 percent set by the World Health Organization (WHO).

In spite of these important contributions that are nevertheless inadequate for the health challenges we confront, our States would benefit from other financing alternatives. This is why, in Senegal, the State has solicited the support of donors, international organizations, bilateral and multilateral cooperating agencies, the participation of users, local authorities, and has encouraged private initiatives for better health coverage of the population.

Thus, the volume of financing mobilized through international aid has been estimated, on a yearly basis, to equal 8.1 billion 1989-90 FCFA, to which must be added the aid designated for non-governmental organizations whose contributions were estimated to be 100 million FCFA during the same period. The contributions of households (IPRES fees, health welfare institutions, health insurance, voluntary organizations, HMOs, etc.) were estimated, during 1989-90, to be 17.9 billion FCFA directly allocated to health expenses of which 63 percent was injected into the private sector. The financial contribution of local governments to health expenses was as much as 843 million FCFA during 1989-90, of which 47 percent went just to Dakar.

As you can see, the funds mobilized for financing the health sector in Senegal are extremely significant. These efforts notwithstanding, this sector confronts many difficulties linked to legal, administrative, and budgetary constraints, that prevent a better financing strategy from taking root. Acknowledging these fundamental problems, the Government of Senegal has made health financing a priority and adopted a national health policy whose implementation has resulted in many favorable developments, notably for vulnerable groups such as mothers and children.

While certain accomplishments have been made and continue to be made, there is still much lacking. This is why the Government of Senegal has found it necessary to conduct in-depth research to better understand health financing problems.

Ladies and Gentlemen, the last decade of this century and the century to follow will witness a radical transformation in health systems, economic growth, and population growth that will be factors shaping the demand for health care. I therefore invite you to focus your attention and activities here on:

- ▲ updating what is known;
- ▲ exchanging country experiences;
- ▲ reinforcing expertise in the areas of design and execution of sustainable health programs and projects;
- ▲ examining thoroughly research issues in health financing policy.

I know that I can count on this regional gathering of eminent authorities from Central and West Africa to carry out this critically essential work. The outcome of your work sessions should be to propose ways and means to adopt better financing strategies. As you know, it is clear that health financing is the foundation for the sustainability of health programs. Keep in mind that, to be applicable, any proposal or recommendation must gain the approval of the population and users concerned.

Ladies and Gentlemen, I would like to conclude by extending, on behalf of the Head of State, the Prime Minister and the entire Government, our appreciation to the U.S. Agency for International Development for their technical and financial assistance and the interest that they continue to take in the performance of our health system.

My appreciation also is extended to the HFS Project/Abt Associates and REDSO/Abidjan, to all donors, international organizations and agencies for bilateral and multilateral cooperation who, on a daily basis, support our respective States.

Wishing you much success with your work, let the seminar-workshop on Health Financing and Sustainability in our region begin,

Thank you for your kind attention.

*Assane Diop
Minister of Health
Republic of Senegal*

2.2 REMARKS BY USAID MISSION DIRECTOR

His Excellency, the Minister of Health, Representatives of REDSO/WCA, Representatives of governmental and international organizations, Ladies and Gentlemen, Participants,

On behalf of USAID, I would like to welcome you to this important seminar. USAID attaches great importance to improving the health status of people around the world and finances a number of health projects, notably in Africa. Your seminar that brings together participants from West and Central African countries, provides a framework for broad coordination, an exchange of ideas and experience among specialists from various horizons sharing the same concern: that of finding more appropriate ways and means to ensure the sustainability of health projects financed by governments and donors that are intended to benefit the residents of West and Central African countries.

In fact, to ensure the sustainability of health projects, it is necessary to find formula and mechanisms that provide efficient health services of good quality at reasonable costs, accessible to populations with low incomes. To do this, it is important to involve these same segments of the population, not only through their financial participation, but also in all levels of the decision-making process and execution of health programs.

It is clear, Mr. Minister, Ladies and Gentlemen, that the problem of sustainability of health projects cannot be managed without the populations concerned. It is up to you, the participants in this seminar, to ponder together all aspects and implications of this participation with a view to proposing solutions to governments and donors. As far as I am concerned, USAID expects a great deal from this seminar to contribute to the sustainability of health projects that the Agency finances in various countries.

I wish you much success with your work and thank you for your kind attention.

*Julius Coles
Director, USAID/Dakar*

2.3 OVERVIEW OF REGIONAL HEALTH FINANCING AND SUSTAINABILITY POLICIES AND ISSUES

2.3.1 History and Strategy

To depict the evolution of health financing and sustainability in Africa over the past thirty years, Marty Makinen, Technical Director of the HFS Project, presented an overview of the historical development of the health sector during this period, followed by a discussion of solutions proposed to problems confronted by the health sector in Africa.

The 1960s and 1970s were a period marked by the expansion of infrastructure. In spite of slow economic growth, the number of medical and health center staff increased rapidly. During this period, it was the State that made services available and financed the health sector. In the beginning of the 1980s, the development of infrastructure slowed down and government resources diminished. Moreover, the resources allocated for personnel began to limit resources devoted to supplies. Ministries of health retained their old policies, for example, to guarantee employment for graduates of medical and nursing schools, insuring an overabundance of medical personnel. Gradually as these new tendencies developed, the health sector became increasingly inefficient.

The 1980s and early 1990s were characterized by numerous problems affecting the already overburdened African health sector, the most serious of which was the beginning of the AIDS pandemic. This is when ministries of health realized that reforms in the organization and financing of African health systems were required to find a solution to these problems. Cost recovery programs, attempts at hospital autonomy, and the development of the private sector are only some of the new approaches that were adopted.

2.3.2 Current status and issues to address

Bineta Ba, Economist, USAID/REDSO/WCA, introduced her discussion of the current status of health financing and sustainability efforts in the region by highlighting problems identified in the evaluations of three USAID-funded projects in Niger, Burkina Faso, and Mali. Such problems pertain to:

- ▲ Low quality of care;
- ▲ Lack of monitoring of activities;
- ▲ Irregularities in the provision of medicines; and
- ▲ Typically low rates of participation in health programs by the populations of these countries.

USAID's regional office in Abidjan has noted that these problems reflect the:

- ▲ Need for training health personnel;
- ▲ Absence of a coherent drug policy, a fact often linked to constraints in national budgets for health; and
- ▲ Lack of clearly defined project objectives.

Ms. Ba explained that no reference is made, either in her presentation or the report which it summarized, to the traditional sector which is, of course, an integral part of the private sector. Unfortunately, there are no statistical data permitting the measurement of impact exerted by the traditional sector in these countries.

In the area of health insurance in countries in West and Central Africa, there have been some developments since 1990. The first study touching on this subject, prepared in 1989, described the pilot project in Boulgou Province, Burkina Faso (*See Section 4.7 of this report*). This study pointed to the tremendous underdevelopment of health insurance programs in our countries. In almost all countries in the region, efforts are being made to consider community financing, especially in Senegal, where this is very developed.

Suggested points for discussion included whether or not governments should be asked to increase their budgetary allocations to this sector. Ms. Ba offered her opinion that it is up to individual countries to examine their capacities in this regard according to the WHO recommended budget of 9 percent. There is also concern with the efficient use of resources. The study of efficiency in the health sector in Senegal, by Ricardo Bitran and others, documents some of these problems, such as the low productivity of health personnel (*See Section 3.3 of this report*). Rates of cost recovery ranging from 5 to 12 percent have been noted for different countries. Should prices be increased? Should such experiments be expanded? What about problems of equity?

Regarding the Bamako Initiative (BI), Ms. Ba indicated that the above problems would not exist, if the eight BI principles were respected, namely:

1. National commitment to universal PHC, with emphasis on priority MCH problems.
2. Incorporation of universal PHC policies within long-term national plans and budgets.
3. Government commitment to continued and increasing financial support to MCH/PHC, maintaining budget integrity.
4. Decentralization of central health ministry management of PHC to district and community levels.
5. National commitment to ensure equity of access to MCH/PHC for the poorest sectors of the population, through measures such as fee exemptions, subsidies, additional budgetary provisions and links to income-generating activities.
6. Policy provision for community participation in the management and financing of MCH/PHC.
7. Commitment to the local management of community resources with a proportion of funds generated at the local level remaining in the community.
8. Policies promoting essential drugs and the rational use of drugs.

As regards insurance, experiments at the community level should be encouraged, as well as more thought given to national insurance systems with the formal sector. It is important also to consider the operational research that must accompany any strategies to be developed.

2.3.3 Some lessons learned for project implementation

Eckhard Kleinau, HFS Consultant and Director of Program Evaluation and Information Systems on the BASICS Project, presented a summary of findings from an extensive study entitled, "Cost Recovery for Child Survival Programs: Recommendations to Build Sustainable West African Health Projects," that he co-authored in 1990 with Donald Shepard, Wayne Stinson, and Ron Vogel. This study presented the evaluations of various donor-sponsored child survival projects in West and Central Africa, as completed by the four authors from December 1989 to August 1990. The evaluation team prepared health financing profiles for 20 countries based on a review of more than 80 project documents developed by bilateral and international organizations. (Profiles of various countries are available as a computerized annotated bibliography, "AskFINE".) Based on the experience of these countries with the sustainability of child survival activities, a detailed document with strategies and recommendations was developed for USAID's regional office in Abidjan. The recommendations pertain to six areas where major deficiencies were noted in child survival programs, as indicated below:

- ▲ Country Selection. The sustainability of child survival programs should be an important criterion in the selection of countries to benefit from USAID's assistance.
- ▲ Project Design. The goals, objectives, and actions supporting sustainability should be clarified when the project is designed. The objectives of cost recovery should be adapted to the economic potential of a country and should be *realistic*.
- ▲ Project Management. In coordination with other donor organizations, USAID should develop innovative approaches to integrate child survival and primary health care, in order to make better use of resources that are becoming increasingly scarce. Efforts should be made to develop efficient service delivery and a more decentralized system through efficient mechanisms of local control and management information systems.
- ▲ Social Financing. Through an intensive on-going dialogue among USAID representatives, ministers of finance, planning and health, it is important to reinforce the social responsibility for and financial commitment to child survival, in both the public and private sectors. Maximum use should be made of available epidemiological and demographic data to plan national strategies and policies.
- ▲ User Fees. USAID should encourage child survival programs with a view to implementing cost recovery possibilities through user fees, health insurance, cross-subsidies, and other mechanisms. Further study is warranted of the private sector services where fees and quality of service are perceived to be relatively high.
- ▲ Operational Research. In search of ways to mobilize revenue and enhance administrative efficiency, USAID should support operational research that would assist institutions providing child survival services by:
 - ▲ determining the costs of individual services;
 - ▲ setting schedules for user fees;

- △ testing discriminatory and exoneration policies;
- △ examining possibilities for risk-sharing plans;
- △ assuring the quality of services; and
- △ designing and carrying out pilot projects.

2.4 STRATEGIES FOR SUSTAINABILITY

2.4.1 How to define and set objectives for sustainability

James Setzer, HFS Consultant and Program Coordinator, Center for International Health, Emory University School of Public Health, proposed a definition for the concept of sustainability and how it related to health financing policy in general. He went beyond the conventional definition of sustainability as strictly an issue of adequacy of financial resources, by pointing to related issues such as quality, equity, and cost-effectiveness. For many individual countries, the history, situation, and possible and actual solutions may differ.

Assured financing: In its narrowest sense, sustainability may be thought of as having enough funds to continue an activity that produces benefits, like the provision of health services.

Source of funding: Funds may originate with a variety of sources, including government tax revenues and borrowing, consumers, employers, private entrepreneurs, NGOs, PVOs, and external donors. To the extent that funds from the latter are relied upon, is sustainability achieved? In fact, references to sustainability often imply the survival of projects or activities after donors cease funding.

Management system: Some projects fail not due to the inadequacy of available funds but due to the lack of a sustainable management system which may require training, the right tools, or appropriate equipment.

Quality: If the services are of poor quality, then potential benefits are not realized. How can a sustainability strategy ensure that quality is attained, and maintained? What types of services might one be talking about in terms of consumer perceptions of quality (availability of drugs) as well as technical quality (treatment protocols)?

Equity and Access: How equitable is the distribution of resources and types of services across the population, among higher income and lower income areas, urban and rural. Is there fair physical and financial access to services across areas?

Cost-effectiveness: Getting the most output from limited available funds, which ties into several points made previously.

Political viability of policies and programs: Whether policies enjoy broad political and popular support, or whether they are likely to be changed by new governments.

2.4.2 Donor Perspectives on Sustainability

In a Round Table format representatives of The World Bank, USAID/Washington, USAID/REDSO, and USAID/Chad offered their perspectives on sustainability.

Mr. Alassane Diawara, Operations Officer with The World Bank's office in Dakar, initiated the discussion with a summary of the two latest reports that The World Bank has prepared on the health sector, to illustrate certain new orientations for the Bank in health activities. The first is the 1993 *World Development Report (WDR)* (World Bank 1993). The second is *Better Health in Africa* (World Bank 1994).

It is the opinion of the authors of both reports that to bring about sustainable health policies, more aid to African countries should focus on economic growth. Economic growth enhances the living conditions of populations and their revenue, because with increasing frequency significant proportions of the populations participate in the financing of health services. The second observation is that education levels must be raised. It is very important to pursue education policies in low-income countries, particularly targeting girls, given the important role that they play in family health and nutrition.

The two reports also cite efforts that governments have made over the past decade, for example, to encourage household participation in the financing of health services. Household participation in health financing has generated resources for the health sector, in spite of the demand for services that this stimulates. There are certain problems which could slow down the participation of households in health financing and jeopardize efforts at sustainability concerning the inequitable access to health by certain segments of the population, and inappropriate expenditures relative to priority needs. The WDR proposes certain corrective measures such as an increasingly important role to be played by government in reducing the cost of care. It is suggested that the State supervise appropriate allocations of resources, particularly by investing more in *preventive* care.

In the area of institutional reform, four components emerge:

- ▲ Encouraging decentralization policies which play an increasingly important role in the management of health systems with many benefits, for example, more equitable coverage for all segments of the population, and increased involvement of local authorities in financing health, and motivation factors;
- ▲ Autonomy of certain structures such as hospitals, to permit more judicious management of resources, including subcontracting certain functions that are often integrated into hospital operations (for example, food service and maintenance);
- ▲ Development of incentives by the government to attract the private sector in its broadest sense, which would diversify the provision of health services, encourage competition offering a choice to the patient of where to seek care.
- ▲ Information systems to inform populations about the cost of prescriptions and care which ultimately would permit better assessments to be made of cost/efficiency trade-offs.

Case studies from various countries have showed that the State models itself as a function of programs suggested by donors more often than the other way around. There are few cases where governments have sought to formulate a coherent policy with programs that could eventually be supported by donors.

Anita Mackie, Health Officer with USAID/Chad, noted a lack of specificity on the part of presenters and participants regarding the concept of "sustainability". At what level are we referring to sustainability? If one speaks of decentralization, sustainability is more important at the level of the population and village health associations. There are many aspects of sustainability that pose problems for families in villages. There is another level that should be part of sustainability, the government and ministry of health. Dr. Mackie allowed that this lack of precision during discussions was very important to consider because there are many ministries of health that are in the process of developing decentralized authority.

Abraham Bekele, Health Economist USAID/HHRAA Project, explained that the Human Resources Division in the Africa Bureau is defining a health policy for Africa and elaborating plans for research and analysis activities regarding financing and sustainability in the private sector. USAID has chosen four broad areas for development:

- ▲ Economic growth;
- ▲ Health and population;
- ▲ Environment; and
- ▲ Democracy.

There is great concern in USAID now with the linkages among environment, health, and population and the relationship of these linkages to sustainability. For example, focus is placed on female education, because to ensure the sustainability of health, it is necessary for women to receive health education. As far as health itself is concerned, HHRAA is stressing the development of the private sector. There is much evidence to suggest that the government will never be able to satisfy all the health needs of a population. Therefore, it is absolutely essential to establish collaboration between the public and private sectors. Regarding the private sector, there are three areas of focus for research activities:

- ▲ Definition of the private sector and the services it provides;
- ▲ Ways to use the private sector to promote the public health agenda; and
- ▲ Possibilities for collaboration between the public and private sectors.

Ultimately, health financing is only a means to the end of sustainable health services for the improved health status of a population.

3.0 SUMMARY OF PROCEEDINGS: KEY ISSUES OF HEALTH FINANCING AND SUSTAINABILITY: DAY TWO

Key Issues of Health Financing and Sustainability, Part I

- ▲ Priority research and problems of health financing and sustainability in Africa
 - ▲ Role of collaboration between private and public sectors in providing health care in Africa
 - ▲ Efficiency in the private and public sectors: research in Senegal
 - ▲ Reform in the hospital sector
 - ▲ Experience of Cameroon in the area of primary health care and hospital reform
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3.1 HEALTH AND HUMAN RESOURCES ANALYSIS FOR AFRICA (HHRAA) PROJECT

Alex Ross, Health Policy Analyst, USAID/Africa Bureau, described the work of the Health and Human Resources Analysis for Africa (HHRAA) Project. The primary goals of HHRAA are the improvement of health and nutrition, increasing rates of literacy and training for the population, and stabilizing the fertility rate. Secondary goals are to increase the efficiency and sustainability of health, food, education, and family planning systems. The objective of the project is to promote research, analyses, and information dissemination to support the development of better strategies, policies, and programs in the areas of health, food, and education. Studies supported by the HHRAA Project typically pass through various stages of development, as indicated below:

- ▲ Identification of primary issues
- ▲ Development of strategic conceptual frameworks
- ▲ Selection of priority issues

Examples of illustrative strategic frameworks for the HHRAA Project are listed below:

- ▲ Financing and sustainability of health care
- ▲ Contribution of non-governmental health service delivery to national health goals
- ▲ Family planning and population
- ▲ Child Survival: medical management of the sick child, and changes in behavior

- ▲ AIDS, STDs and tuberculosis
- ▲ Malaria and emerging diseases
- ▲ Development of (public health) human resources
- ▲ Nutrition and food for children, and
- ▲ Dissemination of information and results, primarily to decision-makers.

To aid HHRAA in setting its priorities, workshop participants were requested to rank specific research/analysis and dissemination topics for later discussion. (*See Section 6.2 of this report*)

3.2 PRIVATE AND PUBLIC SECTOR COLLABORATION ON DELIVERY OF HEALTH SERVICES

Abraham Bekele, Economist, and Hugh Waters, of the HHRAA-sponsored Support for Analysis and Research in Africa (SARA) Project managed by the Academy for Educational Development (AED), spoke about the role of collaboration between public and private sectors in the delivery of health care in Africa. Owing to population growth, the problem of AIDS and other diseases, such as malaria and tuberculosis, and the simultaneously diminishing resources available to the health sector, it is very clear that one can no longer depend only on government resources to support the health sector. Diseases like AIDS are capable of absorbing many more resources than are currently available. For example, if African states want to care for all AIDS cases, they risk dedicating from 40 to 60 percent of all their resources to this task alone.

In all African countries people are now talking about cost recovery, making users pay, planning medical services, the sale of medicines. Yet evidence suggests that the impact of fees on total revenue is limited because of the poverty levels of the majority of the population. Nevertheless, the contribution of the community and users is essential, given the very limited government resources. The results of some research suggests that revenue and quality of care can be increased through planning more carefully for and efficient use of resources. Whereas it has been thought that planning diminishes demand, recent findings suggest that this is not necessarily the case.

Another way of increasing resources is to encourage the development of health insurance. HHRAA's concern is to find ways of covering the greatest portion of the population and providing necessary care. There are movements underway to decentralize health services, yet it is not known exactly what effect this will have on the delivery of health services. It is not obvious that decentralization enhances efficiency. There is also hospital autonomy to consider. Hospitals consume large amounts of resources, and the curative care they provide can also be made available through the private sector. WHO is currently examining hospital autonomy. Dr. Bekele asked the participants for their views on the appropriateness of devoting more resources to the private sector and away from hospitals. He also asked for ways that human resources could be developed so that they can provide care in the most efficient manner possible.

3.3 EFFICIENCY IN THE PUBLIC SECTOR: RESULTS OF RESEARCH IN SENEGAL

Ricardo Bitran, Applied Research Director, HFS Project, presented the findings of a study of efficiency in the public health sector in Senegal. In 1989, the government of Senegal adopted a sectoral reform package known as National Health Policy. In an attempt to aid the reform process, this presentation seeks to provide information about costs, financing, and efficiency of public health services. A second study on efficiency in the private sector will be conducted for comparison.

Among the principal findings of this study were:

- ▲ Inadequate information management systems
- ▲ Low utilization and coverage
- ▲ High personnel expenses and low productivity of personnel
- ▲ Shortages of basic drugs and medical supplies
- ▲ Poor quality of care due to lack of protocols and inappropriate practices, and perceptions of patients and staff
- ▲ Inappropriate referral patterns
- ▲ Low pricing for curative care
- ▲ Low rates of cost recovery

In regard to cost, Dr. Bitran analyzed the expenditure patterns and cost structure of hospitals, health centers, health posts, and health huts. Drawing from the accumulated data, he concludes that, on a per inhabitant basis, health centers are the most expensive type of facility, followed by hospitals, health posts, and health huts, respectively.

To properly assess financing, an analysis was conducted of sources and uses of funds to assess recurrent cost financing in government health facilities. This inquiry revealed that hospitals were highly dependent on government support to finance their operations. For example, in FY 1991 the government paid for 84 percent of hospital recurrent costs. User fees paid for 5 percent of total personnel expenditures, 22 percent of the cost of pharmaceuticals, and 8 percent of other recurrent costs. Similar data are available for health centers and health posts.

As a measure of efficiency, personnel productivity was found to be low. Staff productivity of health posts was found to be higher than that of health centers. The difference in productivity between centers and posts was most striking in Dakar. For doctors, nurses, and medical technicians who work in health centers, the lowest levels of productivity were found in Dakar.

Lastly, the study addresses the issue of quality of care. Most notably, the lack of selected drugs, poor communication among medical staff, and failure on the part of staff to complete standard tests, questions, and exams reflect the fact that overall quality of care is poor. In analyzing the differences among health care providers in terms of appropriateness of treatment, the study found that health posts were the best and that health centers and hospitals were the worst.

Findings from this study bear the following implications for policy:

- ▲ Fund local development of information management systems and training in their use
- ▲ Improve quality to stimulate use of preventive and curative public services

- ▲ Decentralize management and redistribute staff and facilities for efficient use of resources. Reduce staff and/or close facilities where necessary.
- ▲ Adopt and enforce an essential drugs policy. Allow competition for importation and distribution of drugs.
- ▲ Routinely monitor and train medical personnel. Adopt national standards for diagnosis and treatment.
- ▲ Assure supplies of medicine and availability of personnel to improve public perceptions of quality.
- ▲ Improve the quality of primary care facilities to discourage non-essential referrals. Adopt higher referral fees.
- ▲ Slightly increase user fees for curative services parallel to quality improvements. Authority to set prices should be transferred from the central to the regional or community level. Reduce high fees for preventive services.

3.4 HOSPITAL FINANCING REFORM

Marty Makinen, HFS Technical Director, examined how tertiary hospitals in Africa, through finance reform, could reduce spending, free resources, and improve quality of care. This presentation was composed of five components:

- ▲ History of hospitals in Africa. The hospital orientation in Africa is in part a legacy from the colonial period, when colonial governments focused their health sector attention on providing services to expatriate populations in the cities. Hospitals in Africa are the government health facilities that are most likely to charge fees; they are used by the most influential population groups, and employ the most influential doctors.
- ▲ Importance of hospital finance reform. The deterioration of quality of care and resource mismanagement has led to a near crisis situation in many hospitals. Owing to the practical and symbolic status of hospitals, addressing the issue of hospital finance reform has become increasingly urgent.
- ▲ Impact of autonomy on African hospitals. In response to such problems, hospitals have begun to experiment with a new form of management—autonomy. Autonomous hospitals move management control away from the government and into the hands of a board of directors. Reform efforts in Egypt, Kenya, and Niger have led to the establishment of a number of autonomous hospitals. For now, these hospitals are charging fees, renovating their physical plant, and instituting quality improvements.
- ▲ What is known about government hospitals in developing countries. the movement toward autonomy has been strengthened by recent studies concerning the role of government hospitals in developing countries. Specifically, Dr. Makinen summarized the findings of a comprehensive review by Howard Barnum and Joseph Kutzin (1990) that examines resource use, costs, and financing.
- ▲ What is needed to institute autonomous hospital management and financing. If autonomy is to be successful, there needs to be a well-documented and evaluated testing of autonomous efforts, along with an increased understanding of the management concept

at all levels. Mechanisms to limit subsidies and develop complementary financial risk-sharing mechanisms, for example insurance, must also be developed.

3.5 PRIMARY HEALTH CARE AND HOSPITAL REFORM: LESSONS FROM CAMEROON

Bihina Laurentine, Assistant Director of Budget and Equipment, Ministry of Public Health, Cameroon, summarized her country's experience with primary health care, hospital reform, and cost recovery. Since 1989, Cameroon has been involved in important primary health care reforms based on community participation.

In light of the State's inability to cover all health expenses, problems were exacerbated by the elevated growth rate of the population. Currently only 5 percent of the national budget is allocated for health services, of which 80 percent is designated for salaries. In response to this situation financial support for health services in various provinces has been mobilized from three sources: the State, bilateral and multilateral cooperation (and NGOs), and community participation. The community is involved in cost recovery in the following four areas: the sale of essential drugs; payment for medical-surgical acts; gifts and donations (equipment and supplies); and human resource investments for maintenance and upkeep of health facilities. For initial donations of essential drugs, the support of international agencies was critical. Revenue generated through the sale of drugs is used to restock essential drugs in health facilities and medical supplies/equipment, as well as other expenses required for supervision and training.

Four years ago, in 1990, the institutionalization of management reforms began in the health sector, which aim at simplification and sharing of responsibilities with the community through health committees. A law passed in 1993 accords specific responsibilities to the community for monitoring the activities of health facilities. Each province holds responsibility for the management of costs recovered through the sale of essential drugs, and for the following fiscal year, each health facility can establish a plan to use revenue collected through certain operations. Fifty percent of revenue collected by health facilities is held in reserve for this purpose until the end of the fiscal year when actual amounts expended in certain budgetary line items can be reviewed. This process encourages budgetary planning based on actual expenses.

Many positive results of the reforms implemented in Cameroon can be cited. The utilization rates at health centers and hospitals have been increased by reorienting primary health care to include EPI, family planning, ORS, and others. In addition, health planning efforts have been encouraged to permit more judicious use of available resources. The quality of health personnel has been improved through training programs and bonuses.

Current obstacles are political, administrative, and financial in nature. Cooperation among administrative bodies in different sectors is difficult and inevitably results in delays implementing particular reforms. The relative shortage of personnel able to monitor, promote, and enforce reforms remains a problem. It would seem that regulatory guidelines should be issued that permit cost recovery to be generalized in all regions of the country in a uniform fashion.

4.0 SUMMARY OF PROCEEDINGS: KEY ISSUES FOR HEALTH FINANCING AND SUSTAINABILITY: DAY THREE

Key Issues of Health Financing and Sustainability, Part II

- ▲ Role of service providers in the private sector
 - ▲ Impact of User Fees in Niger
 - ▲ CREDEBSA/SSP in Benin and community financing of health care
 - ▲ Impact and Results of the Bamako Initiative
 - ▲ Experience with the Bamako Initiative in Guinea Conakry
 - ▲ Impact of User Fees in Mali
 - ▲ Boulgou Pilot Project in Burkina Faso: An experiment in health insurance
-

4.1 ROLE OF PRIVATE SECTOR HEALTH CARE

Marty Mäkinen, HFS Technical Director, presented suggestions for a more active role by the private sector in health care delivery. The tremendous difficulties faced by governments in developing countries, for example, high cost of curative care, unfulfilled health needs of rural and poor populations, chronic shortages of medicines, supervision, and maintenance of public health facilities) preclude their being able to provide all needed health care. Traditionally, the private sector is involved in curative care, particularly in urban areas, health insurance, the pharmaceuticals, and health care for employees and their families. Additional roles that could be envisaged for the private sector include the following:

- ▲ Under contract, provide inputs to the public sector, such as pharmaceutical, transport, laundry, or food services.
- ▲ Provide preventive services through HMOs with incentives for good health status, rather than for treatment of an existing illness.
- ▲ Deliver health services to poor and rural populations through governmental reimbursement systems, for example, coupons distributed to indigents.

One difficulty concerns where to divide roles and responsibilities between the two sectors, taking into account the advantages and disadvantages of each, the importance of different criteria, and each sector's current and projected capacities to perform. Once these determinations are made, the government should take all necessary action to bring about the desired solutions in terms of a legal framework, and develop systems for follow-up and evaluation in order to make any necessary modifications.

It would appear that the theoretical advantages for increased involvement of the private sector outweigh the disadvantages, but decisions obviously must be based on local conditions. Complementary

interventions by the public and private sectors could overcome many disadvantages, but the government's ability to carry out these interventions must be assessed. A health sector dominated by either the public or private sector will not solve all existing problems, but the private sector is often under-exploited. The increased involvement of the private sector would offer several advantages:

- ▲ Greater quantity of resources available to the health sector
- ▲ Reallocation of public sector resources to public health activities and to services for disadvantaged groups;
- ▲ Enhanced range in quality of care, especially in terms that the patient is able to appreciate.

Dr. Makinen concluded by stressing the benefits that could follow from a careful examination of possible ways to increase participation by the private health sector, a solution that has been adopted by most industrialized countries.

4.2 IMPACT OF COST RECOVERY: RESULTS FROM NIGER

As more countries experiment with cost recovery programs, there has been a growing debate over the effect that fees for service programs have on various aspects of health services. In light of this debate, Ricardo Bitran, HFS Applied Research Director, presented findings of HFS applied research on cost recovery pilot tests in Niger on the actual impact that user fee programs have had on access, equity, and quality of services. The impetus for conducting the cost recovery pilot tests in Niger stemmed from the shortage of medicines in public health centers and the government's lack of financial resources. Three arrondissements in Niger participated in the pilot tests, Boboye—where payment was indirect, with a head tax of FCFA 200, Say—where payment was direct, and Illela—the control, where no costs were recovered.

Raising fees through cost recovery programs can affect access by health care consumers in varying ways and lead to a wide range of outcomes. An examination of two of these possible outcomes demonstrates the effect that fees have on financial access to health care and show how fees affect geographic access. For example, charging user fees restricts utilization rates of all populations, especially the poor. However, it should be noted that quality improvements as a result of user fees can offset the effects of raising the price of services. In Niger, utilization rates went up and the poor demonstrated a willingness to pay for improvements in quality. Thus, the effects that user fees have on equity considerations are varied and complex. Although the poor are more sensitive to increases in the price of health care, cost recovery programs can incorporate means testing, thereby increasing the potential for greater equality.

The evidence regarding impact of user fees on quality of services provided seems to be less ambivalent, as cost recovery programs demonstrate an array of quality improvements. More broadly, cost recovery forces health care providers to be more efficient by forcing them to pay closer attention to costs, quality of care, and patient satisfaction. The raising of fees presents many positive and negative elements. Policymakers will be forced to weigh the costs and benefits and decide among varying cost recovery

program options. If further reform efforts are to be successful, these possible outcomes of implementing a fee-for-service program must be better understood.

4.3 COMMUNITY FINANCING OF HEALTH CARE IN BENIN

Félicien Hounye, physician and researcher with the Regional Center for Development and Health, presented an overview of Benin's experience with community financing of health care.

The Regional Center for Development and Health (Centre Régional pour le Développement et la Santé, CREDESA) has played a major role in the area of health financing in Benin. From 1983-89 CREDESA implemented a community financing system in two rural communities. Health care was made available to each village. Each village was given access to a visiting health nurse, an emergency health aid, and a mid-wife. CREDESA has now jumped up to the level of district in setting up community participation systems. CREDESA has now put into place service delivery with costs compatible to the socio-economic level of the population. CREDESA has implemented community health services based on the findings of research on essential drugs, inspired by the BI.

Community financing of health services in Benin has been guided by the BI. Community financing efforts have begun in two communes of Paodiablokité. The experiment benefitted from numerous visits by representatives of UNICEF, WHO, and Bineta Ba of USAID/REDSO. The EPI program now covers half of the health centers in Benin; this experiment was conducted with support from UNICEF which provided first packets of essential medicines.

Currently in Benin, community financing covers 90 percent of health facilities and is supported by many donors. Systems exist where communities take care of one-third of total operating expenses, the government takes care of another third, through salaries, and donors handle the break-down of local costs to replace medicines and equipment. Concern with the issue of sustainability led to combining community financing and health care with development activities, because there are always poor people who cannot pay even what are considered to be very low prices. A structure called the Community Bank, supported by Catholics (ESCATOUEL in Benin) functions very well and enables people of Benin to have a reserve of funds managed by SAVE the Children which is directed toward supplies for acceptable living which, in turn, is directed towards health care. These mechanisms assure coverage is guaranteed for more than half of the population.

The BI introduced training in areas of accounting, management, immunizations, and areas where health staff had not received formal instruction previously. All these elements were considered beyond the scope of work of health staff and, as such, required certain incentives for health workers to assume new responsibilities. To motivate health workers, each child targeted was to be completely immunized. For this the Health Team in the commune charged FCFA 20 each semester. Each completely immunized woman who delivered in health facility also paid 20 FCFA, and each new curative care consultation brought to the health team 50 FCFA each semester. As a result, the benefits exceeded the projected capacity for provision of care. there were some drops in immunization coverage but never below pre-cost recovery levels.

In fact, cost recovery has advanced to the point where health agents can cover their salaries from revenues. This caused problems with community health agents who considered themselves to be equally involved in cost recovery efforts but drew no salary. Dr. Hounye closed asking to hear recommendations from participants as to how this could be avoided.

4.4 BAMAKO INITIATIVE IMPACT IN THE REGION

Rudolph Knippenberg, UNICEF representative, began his presentation by asserting that the FCFA devaluation could be a fatal blow to efforts at revitalization/reinforcement of health systems in the FCFA region. The first negative effects are linked to inflation which provokes:

- ▲ A reduction in the purchasing power of households, which diminishes financial accessibility to health services, for example, travel costs, medicines, and increased expenses for adequate food;
- ▲ A mechanical increase in the cost of medicine, management tools, immunizations, equipment and fuel for the functioning of health centers;
- ▲ Other effects originating from certain inadequate measures taken such as stock-outs, diminution of community participation, neglect of preventive care in favor of curative care.

General recommendations for health policy reform and implementation reported by Knippenberg and based on experiences of the Bamako Initiative in diverse settings include:

1. Avoid actions taken in two stages which consist, first, in furnishing massive supplies of medicines without establishing a cost recovery scheme for medicines, and secondly, anticipating minimum community management/control. Such a disassociation between availability of medicines and the functioning of the health system risks seriously compromising preventive care, the quality of care, and the credibility of the system.
2. The adoption of national essential and generic drug policies is an indispensable condition to reinforce/streamline health systems and develop community health, and thus to assure coverage with a minimum package of services, including EPI.
3. When setting fees for care, it is important not to disassociate the payment of medicines from the total cost incurred by the sick person. For example, in Mali and Senegal, BI programs are put into practice by closely linking the cost of medicines and consultations at health centers.
4. Regarding the private sector, the acceptance of essential drugs with generic names must be encouraged, but without state subsidies and with free pricing.
5. To serve BI community health structures, the mobilization of donors must be an opportunity for development or structural reform of central purchasing of essential drugs, notably through the participation of consumers in management/administration councils.

6. A revision of health financing systems in the FCFA region is needed, with a redefinition of the role of each partner in the co-financing, financing and pricing mechanisms. This revision must take into account, budgetary pressures, the capacity for households to pay for health care and also the capacity of governments to finance recurrent costs through revenues. This revision would enlist donor contributions for medicines, immunizations, management tools and equipment to free up government and community funds in order to improve the quality of care, the motivation of peripheral health agents and communities (through affordable prices).

Moreover, this revision will promote the sustainability of revitalized and reinforced health systems, by assuring responsibility in the medium and long term of costs to replace equipment by donors in the framework of projects by The World Bank or other donors. Finally, this revision should balance out the negative and positive effects of subsidies in the short term and over several years, on the one hand assure the strengthening of quality health systems, the motivation and utilization of communities, and on the other hand the financial and managerial autonomy of these systems.

4.5 BAMAKO INITIATIVE EXPERIENCE IN GUINEA

Lamarana Diallo, Demographer and Coordinator of National Programs, Guinean Association for Family Welfare (Association Guinéenne pour le Bien-Etre familial/AGBEF), and Dr. Lamine Touré, National Director of Health Care Establishments, presented Guinea's experience with the Bamako Initiative. It was explained that the word "district," which has different applications for particular countries, would be used in the sense of a WHO district, that is, an administrative unit within a health system having two tiers: a grouping of health centers that are centered around a referral structure.

The health center in Guinea delivers preventive and curative care, but provides no hospitalization. Guinea's experience with the BI began in 1986, that is, a few years before the actual initiative. The minister of health organized an evaluation of the health system that consisted of an inventory of all human, material, and financial resources; interaction with communities to learn what they thought of healthcare, and an analysis of the health situation, including an evaluation of the EPI which had been functioning in Guinea for seven years. Observations made during the evaluation were overwhelming. Infrastructure and equipment were poor. There was a total lack of medicines in all health centers; management capacity was very weak, returns from training were mediocre, health personnel had not been recycled for ten years. In 1987 the minister of health, in collaboration with two organizations, developed a health action plan and a national program of primary health care. The phrase, "Bamako Initiative" is used very little in Guinea.

The Guinean primary health program selected health centers as the focal point for multiple reasons. In addition to the goals of accessibility, availability, and coverage the financing objectives were two-fold:

- ▲ The sick person will cost the health center less than half of one dollar;
- ▲ The sick person pays at most one dollar for care.

Various strategies were developed, first for the integration of services, streamlining services (that is, behavior and size of staff), development of a diagnostic-treatment protocol, the introduction of essential

medicines and management procedures. Communities had responsibility to provide infrastructure and non-technical material; the State provided personnel and technical material, as well as medicines.

The cost recovery strategy aimed at certain costs, particularly medicines and local operations. A coefficient multiplier of 2.5 was chosen, that is, medicines are sold at 2.5 times their purchase price. An upper limit of 2,000 F (two Guinean francs buy one FCFA) was set for each treatment. Health center budgets were split into two categories: costs without which the health center cannot fill its mandate, and "accessory" costs. On average, medicines represent 40 percent of expenses; management tools, 10 percent; fuel, 10 percent; and incentive bonuses, 11 percent. The number of health centers has grown from 90 in 1988 to 283 in 1994, which theoretically corresponds to an 80 percent coverage rate for the population. A commensurate increase is noted in national immunization coverage, from 1 percent in 1986 to 55 percent in 1994. The program in Guinea is characterized by the harmonization of interventions (that is, external, non-governmental and multi- or bilateral). From the start, a very specific plan was designed, and the program implemented was the same across geographic areas, with regular monitoring and supervision.

Despite the impression that may have been created by this presentation, problems have been encountered, such as deficient health centers. Eighty percent of health centers can recover their operating costs, but 20 percent are incapable of handling their minimum operations. The second problem is how to take care of indigents; no viable solution has been found. A third problem is the progressive increase in the cost of medicines. Another problem is the motivation of certain personnel. In spite of these problems, for which solutions continue to be explored, the goal for the end of 1995 is total coverage of the population by health centers. A national supply system for medicines has been developed, the central pharmacy of Guinea. Efforts are also underway to establish a balance between health centers and hospitals.

4.6 IMPACT OF USER FEES IN MALI

Salif Coulibaly, Director of Planning and Statistics, Ministry of Health, Solidarity, and the Aged, explained that Mali, like other countries in the region, has encountered problems in financing health services linked to the general economy and the socio-political upsets that the country has experienced. However, following implementation of policies based on the BI principles, commendable results have been achieved.

Demand for health care has continued to increase, as a result of the elevated growth rate of the population and the stagnation of resources. The analysis of the financing of health services in Mali demonstrates a progressive and alarming diminution of the national health budget: in 1980, the budget was at 8 percent, in 1991; the budget fell to 4 percent, with a slight rise to 5.2 percent in 1992, before stabilizing around 6 percent in 1993.

National hospitals and central administration consume the majority of resources allocated to the health sector. The consequences are prolonged stock-outs of essential medicines and surgical-medical supplies, the inadequacy of diagnostic and treatment protocols, but also frequent break-downs of health vehicles and lack of motivation among personnel.

While the BI strategy was adopted in 1987, it was nearly 1990 before plans were finally operational. It was then interrupted in 1991 by social unrest in Mali which really changed the system. Political events constitute a factor often overlooked in health sector policy, because all experiments that were attempted before the political upheavals were stopped, and it was necessary to return effectively to square one. Although Mali had many experiences with cost recovery before 1991, it was only after this date that one streamlined and capitalized on this prior experience.

The new system is characterized by community participation with the objective of mobilizing the whole population to promote health. Regular supplies of essential medicines and the revitalization of health services have been brought about through a minimum range of care available at health facilities consistent with the health pyramid.

The experience of Mali highlights the positive impact of establishing a pricing structure and the sale of medicines. First, there was an increase in the basic resources devoted to health care, as well as mobilization of supplemental funds, regular functioning of health structures (which was not the case before the BI), improvement of working conditions for health personnel, regular renewals in the stock of medicines and other supplies, a better allocation of resources through the national savings account, and revitalization of health facilities to make available a basic package of care.

Mr. Coulibaly expressed agreement with Mr. Knippenberg on the matter of setting individual rates that are compatible with the population's purchasing power, because too much is expected of the population. It has been proven over time that populations are always ready to pay, but there is an over-solicitation that frequently discourages their effort to participate. In Mali, fee schedules are used to increase the clientele and demand for health care. There is also a high degree of satisfaction with the quality of care.

Mali's experience would suggest that without effective decentralization of activities and management of health services so that populations are integrated into the process of taking charge, there can be no sustainability. Mali has a social tradition of self-help which has assisted with the identification of indigents in the communities, yet it has not always been an easy matter to find appropriate ways to exempt them from payment. In closing, Mr. Coulibaly cited the need for applied research on the creation of HMOs, health insurance and social security systems.

4.7 LESSONS LEARNED FROM THE BOULGOU PILOT PROJECT IN BURKINA FASO

Abraham Bekele, USAID/Africa Bureau; Bineta Ba, REDSO/WCA; Issouf M. Ibrango, Division of Studies and Planning, Burkina Faso Ministry of Health; Brahim Bassane, Provincial Health Director, Tenkodogo (Boulgou); and Perle Combarry, Health Financing Project Task Manager, USAID/Ouagadougou; composed the panel that presented the Boulgou Cost Recovery Pilot Project on conducted in Burkina Faso from 1988-91. Following many changes in its health programs over the past few decades—all of which were basically unsatisfactory — Burkina Faso adopted the principles of the BI.

The lack of success associated with considerable efforts to reduce the size of health personnel, increase the governmental health budget, and persistent difficulties in financing health services prompted Burkina to consider pilot tests. A pilot test intended to increase community financing with technical and

financial support from The World Bank and USAID/Ouagadougou was begun in 1988 in the medical zone of Garango, in the province of Boulgou. The principal players in this study were the community, community health agents, and a research team that directed the study. In the basic communities, health units were created where there were health facilities. An inter-departmental health committee, which constituted a key element of the study, to ensure the solidarity of the communities involved. The purpose of the pilot study was to test possibilities for partial cost recovery for health care with the base of community self-financing. There were three specific objectives:

- ▲ Organize various echelons of health systems to permit the delivery of integrated health care to the population;
- ▲ Devise a fee schedule that is accessible for the general population and populations at risk;
- ▲ Develop a financial management system that can function at the local level, permitting the retention and utilization of funds collected for health services.

The main goal was to demonstrate whether or not recovery was possible, and find a practical field for study so that the rest of the country should adopt the BI and to draft regulatory texts. At the time of the project evaluation in 1991, the rate of cost recovery for the zone was a total of 44 percent which included revenue from services and from pharmaceutical depots. Thus, an operational system of cost recovery, with community participation, was put in place. The longer the system continues, the more likely it is to be sustainable, attracting more people take an interest in it.

After three years, community structures exist to manage financing resources and social mobilization programs for health education. Algorithms are used for diagnostic and therapeutic treatments, as well as streamlining of procedures to deliver prescriptions. A functional supervisory structure has been developed. Burkinabés have now gained competency to continue the study. One problem encountered is the unavailability of essential medicines; another concerns fee retention at the local level.

Lessons learned from the Boulgou pilot test for cost recovery include the following:

- ▲ Research can be done with a minimum of human and financial resources.
- ▲ Review financial legislation.
- ▲ Limit the cost of bank operations incurred by local authorities.
- ▲ Develop a security system.
- ▲ Give members of management communities incentives.
- ▲ Establish a systematic supply channel for essential medicines.

5.0 SUMMARY OF PROCEEDINGS: STRATEGY DESIGN FOR SUSTAINABILITY: DAY FOUR

Strategy Design for Sustainability

- ▲ Means testing for cost recovery of health services in developing countries
- ▲ Round Table on non-project assistance (NPA) and related experience, with representatives of REDSO/WCA, The World Bank, HFS, and a country representative
- ▲ Work in groups to exchange ideas on the design of lasting reforms in the health sector

Case Studies on Sustainability

- ▲ Introduction to case studies and guidance for work in small groups
 - ▲ Work in small groups on child survival, family planning and AIDS/HIV projects in Senegal, Niger, and Guinea-Conakry
-

5.1 MEANS TESTING IN COST RECOVERY FOR HEALTH SERVICES

The growing number of developing countries contemplating or implementing cost recovery policies has prompted much debate, particularly over the equity of cost recovery programs. A central question in this debate is, "Does cost recovery restrict the access of poor people to health services?"

Exploring answers to some of the questions related to means-testing, Marty Makinen, HFS Technical Director, highlighted three tasks:

- ▲ Defining key terms and concepts used in discussions of means-testing. In its most basic sense, means-testing involves the classification of specific individuals or households as eligible or ineligible for benefits, according to established income-related criteria. Sample key terms, which are often used, are defined below:

Coverage refers to the percentage of the target population receiving benefits.

Undercoverage refers to the percentage of the target population not receiving benefits, either because of targeting errors or because of insufficient program resources.

Incidence is the percentage of program benefits going to members of the target population.

Leakage is the percentage of program benefits going to people outside the target group.

- ▲ Taking stock of the progress and problems means-testing programs have faced in developing countries. Over 50 surveys of different targeting projects in developing countries have been completed in conjunction with the HFS project. Data collected in countries like Senegal, Zimbabwe, and Kenya, have provided policy-makers and administrators with a wealth of information on current means-testing programs. For example, in Senegal, where the concept of cost recovery was introduced in 1986, there is roughly a 50 percent leakage rate (meaning that half of the exemptions are given to people who do not deserve them).

- ▲ Providing conclusions and recommendations that will inform the debate, stimulate discussion, and guide future policy decisions involving means-testing programs. Given these shared problems, there are a number of actions that developing countries can take to strengthen their means-testing and, moreover, their cost recovery programs, for example, establishing clear, formal criteria with little discretion for administrators would reduce leakage. In addition, requiring that exemptions be reviewed periodically and routine measures be taken to verify information, would dramatically improve targeting procedures. Hence, means-testing can prove to be a very effective vehicle for cost recovery and, in turn, improved quality of care. However, until significant steps are taken to improve the administration of these programs, none of the benefits will be realized.

5.2 DONOR POLICIES FOR NON-PROJECT ASSISTANCE

The representative from The World Bank's office in Dakar, Mr. Diawara, explained that usage of the term "non-project" in The Bank context usually implies budgetary support for anything touching adjustment, and not conditionalities.

Bineta Ba, Economist, REDSO/WCA, explained that non-project assistance started up in 1986 and its principal objective is to assure the sustainability of projects. Because the commitment of government is required, it is expected that there will be continuity in policy after USAID leaves a particular country. In 1992 there was an evaluation of non-project assistance in Niger and Nigeria that studied factors influencing the success or failure of this mode of assistance.

The political climate is an important factor. A second factor is the mix of the institutions involved. For example, in a MOH a common problem is the lack of continuity of decision-makers. USAID's role is to follow the financial execution of reforms and offer guidance to the nationals implementing NPA programs. It is necessary therefore that USAID involve itself in NPA to assist governments in carrying it out. There is a heavy burden of financial management of NPA, and governments must prepare carefully before funds are released. Experience has shown that it is more difficult to fill conditions precedent in social sectors, like health, than in agriculture, for example. Finally,

it is important to look at the impact of structural adjustment programs on the health sector. These are briefly some of the points that emerged from the evaluation.

Oumarou Kane, Health Specialist, USAID/Niamey commented that, in general terms, NPA approach is a more flexible approach to assistance than the project. There are many drawbacks as experienced in Niger. Sectoral reform, including health, depends on external factors that are not always controllable by the ministry of health. Policy reform is a two-step process that entails policy formulation and then implementation; the latter does not always follow from the former.

James Setzer, HFS consultant, raised a key question: How can we encourage policy reforms that accompany technical reforms in the implementation of activities? A consensus can be reached on the agenda for policy reform that best supports the needs of the health sector. Once the agenda is defined, however, it must be examined in terms of previously existing conditions. Occasionally, health reform that permits the realization of objectives that emanate directly from the health sector; this is not always the case, however. NPA tries to define an agenda for policy reform based on previously existing conditions. NPA also aims at supporting progress made in increments through subsidies. Sometimes the subsidies are tied to accomplishing certain ends, sometimes they take the form of a budgetary allocation.

In the case of Kenya, where money went to the MOH budget, the only condition precedent to be met was that there had to be new financing and not simply budgetary reallocation. In Niger, there was a process in effect through which financial aid was programmed by the MOH when funds were released. The advantage to this type of assistance is that it makes it possible to target, identify, and openly focus the attention of everyone concerned on obstacles to policy reform. In the framework of projects, one can become overwhelmed with technical activities; in spite of this, it is sometimes necessary to support project activities. Further, subsidies can buffer against the negative financial impact of certain reforms. In the case of Togo, it is clear that if the Togolese Government agreed to reduce import taxes on medicines, this would be at a cost to the National Treasury. However, with financial aid from NPA programs, in very little time, they can justify this loss of revenue because it will be offset by the funds received from donors.

Another advantage offered by NPA is that it keeps certain policy issues open to national discussion. In Niger, a national conference was held to discuss questions related to the financing of the health sector. While it is reasonably straightforward to propose reforms, their implementation or impact is less certain. The concern is therefore to link reform with impact to ensure that the reforms produce the desired results. In the framework of policy reform, it is necessary to obtain the support of all institutions involved; that is, it is necessary to obtain the backing of all players in the policy arena, not only those in the health sector. Often certain fundamental reforms that are sought fall outside of the health sector. It is critical to employ all political mechanisms available for discussions and negotiations that must take place.

5.3 WORKING GROUP CASE STUDIES ON SUSTAINABILITY FACTORS FOR CHILD SURVIVAL, FAMILY PLANNING, AND AIDS/HIV PROJECTS IN SENEGAL, NIGER, AND GUINEA-CONAKRY

Working groups were organized to explore sustainability factors for child survival, family planning, and AIDS/HIV projects in Senegal, Niger, and Guinea.

Fatimata Sy, USAID/Dakar, spoke about the Senegal Child Survival and Family Planning Project. The principal objective of the project is to strengthen birth spacing, specifically through awareness and use of modern contraceptives. There are two areas of intervention:

Institutional support. Decentralization is encouraged through a process conceived and defined as part of the national health policy signed in 1989 by the GOS. Decentralization is operationalized with technical and financial support of donors, for example, there is a plan to reactivate a decentralization follow-up committee, so that a decentralized management process may be put into effect. Committee members represent all central services of the MOH. Donors with specialization in health planning and programs provide directives necessary to begin the decentralization process in 45 health districts spread over Senegal. The follow-up committee is intended to provide TA, monitoring of activities, quality control, periodic evaluation, and annual updates of health development plans. Efforts are focused on strengthening the management capabilities, through training activities, at different levels of health system, that is, central, regional, and district.

MCH and EPI Programs. In Senegal a big effort has been made in the area of planning, so national MCH programs now exist. Within MCH and EPI, three specific interventions are targeted: support for the national family planning program, national program for diarrheal disease, and the national nutrition program, which includes breast-feeding. EPI, pre-natal, and post-natal consultations are supported through training, supervision, and equipment donations. With respect to family planning, support will be provided in certain areas consistent with the national program intended to improve the quality of and access to services. Pilot activities will be tested and enlarged while the project is ongoing, social marketing activities, community distribution of contraceptives and condoms. To increase the demand for family planning, IEC activities will be developed, technical manuals prepared, and mass-media possibilities will be considered. Information and education will be made available to community leaders through programs modeled after RAPID presentations.

Lamarana Diallo, AGBEF, spoke about the MCH project in Guinea Conakry. Since 1986, the Ministry of Public Health and Social Affairs has had a program for EPI, primary health care, and essential drugs. AGBEF has also put in place certain related structures including clinical models. Donors such as UNDP and The World Bank provide financial support, while IPPF and USAID supports AGBEF through the American NGO, Population Services International (PSI). Hence there is no direct intervention of donors on the project in Guinea. It is important to note that Guinea adopted a population policy that advocates an increase in contraceptive prevalence from the current level of 5 percent to 25 percent in 2010.

At a seminar gathering representatives of donor organizations, the MOH, and local NGOs, initial plans were discussed to develop a framework for a national program and agreement was reached on certain principles. It is important that donors respect the principles that countries adopt. In addition to the actual delivery of family planning services, the environment in which they are delivered is very important. For example, complementary activities include social marketing of condoms, including family planning in the package of basic primary health care, the fight against AIDS, institutional support to AGBEF, and support for the demographic and health survey (DHS). This integrated program will be applied in two regions, covering 15 out of 33 *préfectures* (precincts), and 64 health centers. Fifty health centers have already been reached. The integration of the program will not be carried out at random.

The GOG has set respect for community management as a cardinal rule. At each health center, receipts generated through the sale of contraceptives are recorded so that at the time of supervision visits, these amounts can be monitored. Eventually it will be possible to tell which family planning activities assume priority. It has been agreed that training will be made available for health personnel in management, contraceptive technology, and IEC. A determination will be made concerning which areas of family planning can be integrated into the existing primary health care package. Currently under study is the fee schedule to be applied. Consultations through AGBEF are free, but any client asking for contraceptives must pay 1000 F. This fee entitles the client to an appointment card, a card for their individual file, and three months of contraceptives. For the time being 600F is asked for pills. IUDs cost 1000 F.

Mr. Diallo underscored the importance of reviewing the volume of receipts accumulated through cost recovery. Close attention is being paid to this, because at health centers such receipts must cover costs for IEC, and the purchase of management tools. In this way, health centers will be assured of sustainability.

A new design for a project in Niger for integrated MCH and family planning services was discussed. It is expected that the project will begin in 1995 and run until 2001 or 2002. Institutional and administrative reforms and health policy will be addressed. The goal of the project will be to encourage improvements in the health status of the general population and to assist with the application of an appropriate health policy according to public resources and the growth rate of the population. A second objective of the project will be to enhance the quality, accessibility, and development of MCH and family planning programs through decentralization of health activities and collaboration with the private sector. The quality of health personnel will be improved through training programs. Village health teams will be used to monitor the integration of health and MCH/FP activities. Within the MOH, an effort will be made to strengthen capacities for IEC strategy design. Planning and management capabilities will also be reinforced, at the central and local levels.

6.0 CONCLUSIONS AND RECOMMENDATIONS: DAY FIVE

Conclusions and Follow-up

- ▲ Impact of the devaluation of the CFA franc on the health sector
 - ▲ Results of research priorities survey
 - ▲ Workshop Summary Statements: Lessons Learned
-

6.1 IMPACT OF THE FCFA DEVALUATION ON THE HEALTH SECTOR

HFS Technical Director, Marty Makinen gave a presentation on the recent devaluation of the CFA franc which highlighted certain consequences that could be anticipated for the health sector. Workshop participants were concerned about the troubling effects that the currency devaluation would have on them and their countries.

Some of the factors which prompted the devaluation include:

- ▲ Drop in revenue per inhabitant of FCFA countries of 40 percent between 1986 and 1992, compared to an increase of 4.5 percent during this same period elsewhere in Africa;
- ▲ Government revenues dependent on international commerce;
- ▲ Salaries of a civil servant which were 6-10 times the gross national product per capita, and two times the gross national product per person in France, the USA, or Morocco;
- ▲ Deterioration in the terms of trade;
- ▲ Strengthening of the French franc since 1985;
- ▲ Loss of competitiveness (for example, Senegalese tuna, palm oil in Ivory Coast); and
- ▲ Effects of structural adjustment (for example, reductions in the number and salaries of civil servants and reduced investments);
- ▲ Shifts in trade balances with France characterized by a 12 percent drop in exports to France between 1970-90, and a commensurate drop of 13 percent in imports from France;
- ▲ European Monetary Union's view that monetary cooperation needed to be rethought.

The general consequences of the devaluation can be expected to include increases in the cost and quantity of imported goods, fiscal revenue, and inflation (estimated between 40-70 percent), in addition

to a supplemental injection of funds from the International Monetary Fund (IMF) and The World Bank. For the health sector, the following consequences can be anticipated:

- ▲ a rise in imported pharmaceutical products to 90 percent;
- ▲ supplemental need estimated by The World Bank;
 - △ \$US 30 million;
 - △ 225 (new) FCFA per person;
 - △ 0.2 percent income/person (US200);
 - △ 0.75 percent income/person for those who do not have one quarter of the average income.
- ▲ need for adjustment in the medium term;
- ▲ private sector:
 - △ no price control;
 - △ no double discount.
- ▲ increased utilization of public health facilities;
- ▲ capacity to pay for health care in the long term:
 - △ increase in rural areas;
 - △ drop in urban areas.
- ▲ increase in costs of:
 - △ supervision;
 - △ advanced strategy;
 - △ evacuations;
 - △ cold chain (continuous refrigeration for vaccines and drugs).
- ▲ budgetary pressure.

Certain measures and factors that can attenuate the impact of the devaluation:

- ▲ competitive purchasing;
- ▲ timely assistance from donors;
- ▲ reduction in taxes and import margins;
- ▲ new capital for buying back imported medicines;
- ▲ savings from projects financed by donors; and
- ▲ strong possibilities to pay salaries.

6.2 PRIORITIES FOR APPLIED RESEARCH: RESULTS OF THE SURVEY OF PARTICIPANTS

Hugh Waters, HHRAA Consultant, presented the results of the research priorities survey distributed to workshop participants. He reiterated the usefulness of these findings for the HHRAA work program. The table below provides rankings for 19 proposed research topics. The final column compares the rankings at the workshop to those of a HHRAA consultative group in Washington in January 1994.

Proposed Research Topics for the HHRAA Project: A Comparison of Prioritization Rankings by Participants in the February 1994 REDSO Workshop for West and Central Africa with those of Participants in the January 1994 Consultative Group Meeting in Washington

RANK Saly	SCORE Saly	TOPIC	RANK WASH.
1	128	Poor segments of the population: how to identify them? How to ensure that the poor will have access to reference facilities?	—
2	120	Cross country study of hospital autonomy, including effects on MOH budget allocation, quality, efficiency.	1
3	110	Study of the factors (financial, sociological, cultural, traditional) influencing consumer preferences for different sources of care (modern vs. traditional, self- care, private, etc.).	8 tie
4	107	Traditional healers: what are the factors determining the demand for the services of the healers? What are the costs relative to the modern sector?	—
5	104	Test operational approaches for health insurance; evaluate different insurance schemes.	15
6	102	Research on public and private expenditures on health (national health accounts approach).	11
7	99	Case studies on implementation of the package of basic/cost effective services and experiences with decentralization.	8 tie
8	85	What are the political factors and processes influencing resource allocation, what are constraints to efficient allocation?	14
9	82	Study of the efficiency, equity and quality implications of different types of decentralization.	2

RANK Saly	SCORE Saly	TOPIC	RANK WASH.
10	80	Evaluation of the efficiency and effectiveness of different traditional solidarity, insurance and risk-sharing systems.	—
11	73	Case studies of means testing/exemption systems.	6 tie
12	65	Study of NGO experience with improving efficiency, pricing of services, quality and means testing.	6 tie
13	60	What are the revenue, equity and efficiency effects of various resource mobilization schemes?	4
14	58	Cross-country study of methods of implementing health financing measures — not just the "what" but also the "how".	13
15	57	How to encourage the pharmaceutical sector to promote public health objectives (social marketing)?	-
16	40	Designing incentives for health workers and health systems managers for application of technically efficient use of resources.	3
17	36	Evaluation of training and capacity building efforts, including methods, short vs. long term.	12
18	34	Case studies of institutional development in different countries (including multidisciplinary team in Niger); successes and failures. Case studies of natural experiments in institution building.	5
19	28	KAP studies of consumers concerning the basic package of services; influence on health status and personal behavior.	10

6.3 WORKSHOP SUMMARY STATEMENTS

Laurentine Bihina, Accounting Inspector and Assistant Director of the Budget, Cameroonian Ministry of Public Health, presented a synthesis of workshop findings on behalf of all the participants.

An international workshop on health financing and sustainability in Africa was held from February 14-18, 1994, at the Savana Hotel in Saly Portudal, Senegal. This workshop brought together participants from Benin, Burkina Faso, Cameroon, the Central African Republic, Chad, Guinea Conakry, Ivory Coast, Mali, Niger, Senegal, and Togo.

The technical framework was developed by the following research institutes:

REDSO/USAID/Abidjan; HFS Project/USA; The World Bank; UNICEF; HHRAA Project/USAID/W; SENECEI/Senegal

The principle objective of the workshop was to find the appropriate ways and means to ensure the sustainability of health financing projects supported by governments and international donors for the benefit of African populations. To this end, the workshop defined specific objectives as listed below:

1. To update what is known about the state of the art of health financing;
2. To exchange country experiences;
3. To strengthen expertise in the development of lasting health programs and projects; and
4. To provide in-depth knowledge of research issues related to health financing policies.

During working sessions case studies were presented for Senegal, Cameroon, Niger, Burkina Faso, Benin, Mali, and Guinea Conakry. In light of these discussions, the following observations and recommendations were made:

1. **Community Cost-sharing:**
Communities agree to contribute, based on their ability, to expenses related to health care and, in certain instances, to operational costs.
2. **Application of an essential drugs policy:**
Stocking and providing drugs, based on the list formulated by the World Health Organization (WHO).
3. **Local management of financial resources:**
This is intended to contribute to increasing the efficiency of health services and constitutes an incentive for health personnel and the community.
4. **Progressive stocking of medicines:**
Medicines constitute a basic element in the sustainability of health financing that is threatened by the weak national drug supply structures and the devaluation of the FCFA.
5. **Management of cost recovery:**
The sustainability of cost recovery is linked to the development of training for of all players, uniform management tools, and procedural codes.
6. **Partnership:**
There is a general awareness of notions related to the sharing of costs by the State, the community, and international donors.
7. **Indigence, equity, and cost recovery:**
There is a general awareness of the need to ensure that indigents on both rural and urban areas are protected in cost recovery efforts.

8. **Implications for the private health sector:**
The private sector's role should assume an increasingly important role in improving the coverage and financing of health services, since the State has demonstrated its limitations in this area. The involvement of the private sector would permit stock to be taken of all actors in the overall provision of health care.
9. **Efficiency:**
In minimizing the cost of care, it is important to take into account the quality and accessibility of care by those who demand it.
10. **Streamlined reallocation of resources:**
It is imperative to reallocate resources for and within the health sector and to grant hospitals managerial and fiscal autonomy.

Since it is the goal of governments to use these strategies in the design of health projects and programs, the workshop has examined three projects now at the design or execution stage. Workshop participants reviewed bilateral projects between USAID and the Governments of Niger, Senegal, and Guinea Conakry.

In the case of Niger, the following suggestions and recommendations were proposed with respect to the private sector, community participation, and technical assistance:

1. The private sector should adhere to the strict framework of the objectives of the MOH. certain precautions should be taken to ensure that private sector groups that assume an active role in the health sector are of a certain calibre. Further, an efficient system to supervise such private sector organizations should be put in place.
2. Ensure community participation in setting fees and other modes of payment.
3. Streamline the utilization of technical assistance and promote national experience.

In the case of Senegal, the workshop put forth the following suggestions and recommendations:

1. Monitor the effective transfer of skills from technical assistance to national managers.
2. Include family planning and MCH services in cost recovery efforts.
3. Standardize family planning and MCH services throughout all health centers.
4. Include distribution channels for contraceptives in the national pharmaceutical supply system.
5. In efforts to manage the sustainability of projects, assure support for training, supervision, and information systems.
6. Ensure effective decentralization and deconcentration of power by transferring resources and responsibilities.

7. Include family planning in the minimum package of activities available at health posts.
8. Organize and strengthen community participation.
9. Plan for the possibility of recovering the costs of contraceptive products.
10. Develop a plan for the sustainability of the USAID/GOS project.

In the case of **Guinea**, the recommendations and suggestions proposed by participants appear below:

1. Involve nationals in the management of social marketing to assure sustainability following the departure of foreign NGOs.
2. Strengthen the supervision and training of staff at health centers. It is necessary to plan for ways to protect indigents in the provision of family planning services; this was not done previously.
3. Allow for flexible adjustment of fees.
4. Improve follow-up and referral procedures. It has been noted that if there is an increase in the number of first-time visits, then return rates are not good.
5. Adjust the supply of drugs to avoid stock-outs.
6. Strengthen information, education, and communications program.
7. The extension of the remaining health centers, since they must cover approximately sixty communities, compared to fifty previously.

The following priority themes were identified for research needed in the area of health financing and sustainability:

1. Identification of and responsibility for indigents.
2. A study of hospital autonomy in various countries, particularly of the effects MOH budget allocation, and the quality and efficiency of services.
3. Factors determining the demand for services by traditional practitioners: costs compared to the modern sector.
4. Test of operational approaches for health insurance, the evaluation of different insurance plans.
5. Research on public and private health expenses (national health accounts/budgets).

6. Case studies on the implementation of a package of basic services/comparing efficiency to cost and experiences with decentralization.
7. Factors and political processes influencing the distribution of resources.
8. Study of implications of plans for the efficiency, equity, and quality of different types of decentralization.
9. Evaluation of the efficiency of different traditional welfare systems.
10. Study of factors influencing preferences of consumers for different sources of care (for example, modern or traditional, private, self).

In conclusion, the participants return to their respective countries full of new ideas to improve the financing and sustainability of the health sector, which will permit a clearer sense of direction as they approach the goal of Health for All in 2000.

6.3.1 FOLLOW-UP

Participants indicated their intent to make the following concrete applications of workshop recommendations that they plan to make after returning home, such as:

- ▲ Reexamination of ways to provide health services to the poor in the framework of cost recovery;
- ▲ Collection of information for decision-makers as a basis for developing a cost recovery program;
- ▲ Design and conduct of pilot tests;
- ▲ Organization of a national seminar for an exchange of views on health financing and sustainability;
- ▲ Reassessment of on-going activities to ensure that concerns raised during the workshop are addressed;
- ▲ Discussions with colleagues of workshop recommendations and proposals for future research;
- ▲ Reexamination of the choice and modes of health financing strategies and mechanisms; more thorough dissemination of results of on-going activities; and
- ▲ Conduct research on health insurance systems.

6.3.2 CLOSING REMARKS BY A REPRESENTATIVE OF THE SENEGALESE MINISTRY OF HEALTH

Ladies and Gentlemen,

I would like to reiterate the sincere regrets of the Minister of Health and Social Action that he could not be here.

Representative(s) of USAID,
Representative(s) of REDSO/Abidjan,
Representatives of HFS/Abt Associates,
Donors representing international organizations and agencies for bilateral and multilateral cooperation,
Honored Guests,
Ladies, Gentlemen, Participants:

We are here at the end of our work related to the financing and sustainability of health services, and I am aware that these past few days have demanded hard work and sacrifice. You have examined the policies and strategies of health financing in sub-Saharan Africa, prepared balance sheets for the current situation, and defined the scope and objectives of health care sustainability, as well as strategies for such sustainability. You have also established the role of collaboration among private and public sectors in the delivery of care and presented the health financing experiences of your different countries. You have produced strategy designs for health sustainability. After reviewing these different issues, you have formulated recommendations which I find to be extremely pertinent, and all countries represented here will not fail to make careful use of these recommendations, I am sure. The results from this workshop provide us a mass of information that will assist us, not only to grasp issues related to health financing, but also to articulate health financing and sustainability goals.

Your conclusions will enrich the execution of Senegal's financing programs and strategies already developed or soon to be developed. A steering committee has been developed and tasked with, among other things, implementing health financing experiments in two pilot regions: Kaolack and Thiès. These experiments should eventually offer input for the elaboration of health financing alternatives, for illustrative purposes, using the State health budget. In spite of the commendable efforts by the State and various levels of the State, support is always needed from donors and bilateral and multilateral cooperation agencies. In regard to experiments that my department plans to implement, your technical, material, and financial support would be very much appreciated.

I would like to take this opportunity to warmly thank all donors and representatives of international organizations and bilateral and multilateral cooperation agencies. My appreciation is also extended to HFS and Abt Associates for the technical assistance provided with our various health programs. Of course, I congratulate all participants for their work and the fertile thought that this workshop has guided.

I would like to commend USAID for the constant and valuable support they have continued to provide to our different countries. Finally, I wish that this regional workshop succeeds in creating an African network for the exchange of information and experience among our different countries in the area of health financing and sustainability during this era of African integration. This network inevitably would

be an effective instrument for health sustainability in the region. Wishing you a safe return trip to your respective countries, and reiterating my trust in you and appreciation for your efforts, I close this workshop on health financing and sustainability.

Thank you for your attention. The session is adjourned.

Alioune Mbaye
Ministry of Health

**APPENDIX A: SUMMARY OF PARTICIPANT EVALUATIONS
AND SUGGESTIONS FOR FUTURE WORKSHOPS**

TECHNICAL CONTENT

Every participant who completed an evaluation form ranked the overall quality of the workshop and its speakers as either good or excellent. There was, however, broad agreement that:

- ▲ The agenda was too ambitious; The topics were relevant to present concerns but more time should be allotted for discussion.
- ▲ There should be representatives of the private sector present for future discussions.
- ▲ More presentations and discussions should be included on the role of the traditional health sector; and have less introductions and presentations of Washington-based projects and programs.
- ▲ Planners should allow more preparation time for technical consultants to assist presenters from diverse countries with the development and production, if necessary, of their presentation materials.
- ▲ The small work group sessions were very practical and this format was most useful for exchange of experiences and the most popular of all the session formats; more should be included in future programs and earlier in the agenda. The case study presentations were also well-received.
- ▲ The listing of research priorities was a very useful exercise for planning.
- ▲ Issues considered to be among the most useful and pertinent included discussions of how to protect the poor, cost recovery, collaboration between the private and public sector, and presentations on the effects of the FCFA devaluation.
- ▲ Whenever possible, participants prefer to receive the complete text of presentations rather than just summaries or copies of overheads.

LOGISTICS

To assist planners of future workshops, the arrangements made by SENECEI in preparation for the REDSO workshop are described below. Suggestions for future conferences are based largely on information collected from evaluation forms prepared by SENECEI and distributed to workshop participants.

Communications with Participants prior to Workshop

Given the inevitable communication difficulties that exist among certain countries, it would be advisable for planners of future workshops to identify a contact person in any and all countries sending representatives to the workshop, who can coordinate travel arrangements, the transfer of per diem allowances, submission of written presentations/hand-outs, etc.

Contractual Arrangements with Subcontractors

Delays in signing contracts and releasing funds complicate all efforts to ensure the smooth coordination of workshop plans.

Workshop Agenda

The agenda for the REDSO particular workshop was considered by the majority of participants to be excessively long. Future workshops should strive to develop more focused agendas that extend over fewer than five days.

Per Diem Allowances for Participants

The majority of participants in the REDSO workshop expressed a preference to have their own per diem allowances, as opposed to prepayment of all hotel-related expenses in advance by the workshop's organizers.

Reproduction of Hand-outs, etc.

Whenever possible, copies of presentations to be delivered by workshop participants should be made available for reproduction at least one week before the workshop. In this way, it would be possible for each participant to receive, upon arrival in the country where the workshop is held, a complete package of presentations permitting them to familiarize themselves with the content before the workshop begins.

List of Participants

One week before the beginning of the workshop, a complete list of participants should be finalized including their exact address and telephone contact, in preparation for issuing air line tickets.

Air Line Reservations

In order to take advantage of special group rates on air tickets, it is necessary to know who will be attending the workshop as soon as possible. It should be recognized that, with special group rates, tickets can only be issued at the last minute.

Airport Arrivals/Departures of Participants

For all participants arriving over the span of several days in the country where a workshop is to take place, it is advisable to arrange for a hostess to meet them individually at the airport. In addition, arrangements should be made for a driver, a mini-van, an airport official to assist with registration procedures with customs, and a coordinator to supervise that all this work is done.

In addition to knowing the schedules for return air travel of workshop participants in advance, it is advisable to arrange for someone to remain at the airport, coordinating with customs officials, in order to avoid any last-minute difficulties participants could experience leaving the host country.

Equipment at Conference Site

Office supplies such as not pads, pens, erasers, pencils, etc. were distributed to all workshop participants in folders containing the agenda and list of participants. In addition, certain equipment was installed in a room of the hotel serving as the secretariat, for example, a word processor and laser printer,

flip charts, video and slide projectors, microphones, speakers, a tape recorder, a xerox machine and 52 reams of paper, in addition to vehicles and a driver to transport participants to and from the conference site.

Staffing Arrangements

In addition to staff assigned to escort workshop participants through customs at the airport, seven SENECEI staff members remained at the site of the conference throughout its duration: the president of the firm, her assistant, someone overseeing registration of participants, an administrative/secretarial assistant, a hostess/secretary, a xeroxing assistant, and a driver. Three other staff members at SENECEI's headquarters provided administrative and secretarial support during the weeks prior to the workshop and follow-up activities.

ANNEX B: WORKSHOP AGENDA

SOUS LE HAUT PATRONAGE DU MINISTERE DE LA SANTE

PROGRAMME² DE L'ATELIER SUR LE FINANCEMENT ET LA PERENNITE DES SOINS DE SANTE

Savana Saly, 14 - 18 février 1994

LUNDI 14 FEVRIER 1994

- (Modérateurs Bineta BA, REDSO/WCA ; Marty MAKINEN, HFS)
- 10h00 - 10h15 Discours d'ouverture de Monsieur Julius COLES,
Directeur de l'USAID
- 10h15 - 10h30 Discours de Monsieur Assane DIOP, Ministre de la Santé

PAUSE CAFE

CONTEXTE DE PERENNITE

- (Modérateur James SETZER, HFS Consultant)
- 10h45 - 11h00 Présentations, vue générale de l'Atelier, attentes des participants
- 11h00 - 11h30 Politiques et stratégies de financement sanitaire en Afrique sub-saharienne 1960-1993
(Rapporteur Marty MAKINEN, HFS)
- 11h30 - 12h00 L'Afrique de l'Ouest et du Centre : situation actuelle et bilan sur le plan de financement de la santé
(Rapporteur Mme Bineta BA, REDSO/WCA)
- 12h00 - 12h30 Discussion générale et synthèse
- 12h30 - 13h30 Mise en place de Projets de Santé solides et viables en Afrique de l'Ouest/Recommandations (Eckhard KLEINAU, HFS Consultant)
- 13h30 - 14h00 Discussion générale et synthèse

DEJEUNER

STRATEGIES DE PERENNITE

- (Modérateur Ricardo BITRAN)
- 15h00 - 16h00 Définition, portée et objectifs de la pérennité (J. SETZER)
- 16h00 - 17h15 Perspectives actuelles sur les stratégies de la pérennité : Table ronde des représentants de la Banque Mondiale (Alassane DIAWARA, Directeur des Opérations), AID/WASHINGTON, AID/TCHAD, AID/REDSO)

PAUSE CAFE

- 17h30 - 18h30 Discussion générale

MARDI 15 FEVRIER 1994

**QUESTIONS CLES DU FINANCEMENT DE LA SANTE POUR LA PERENNITE -
PARTIE I**

(Modérateur M. MAKINEN)

08h30 - 09h30 Recherche prioritaire et des problèmes de financement de la santé et de la pérennité en Afrique
(Rapporteur Abraham BEKELE, HHRAA, Alex ROSS, Hugh WATERS)

09h30 - 10h30 Discussion

PAUSE CAFE

10h45 - 11h45 Le Rôle de la collaboration des secteurs privé et public dans les prestations de soins de Santé en Afrique préparé par le Projet des Données pour les Décideurs
(Rapporteur A. BEKELE, Alex ROSS, Hugh WATERS)

11h45 - 12h30 Discussion

DEJEUNER

(Modérateur J. SETZER)

14h30 - 15h45 Efficacité dans les secteurs public et privé : recherche au Sénégal
(Rapporteurs R. BITRAN, B. BA)

15h45 - 16h15 Réforme de financement hospitalier
(Rapporteur M. MAKINEN)

PAUSE CAFE

16h30 - 17h00 Expérience Camerounaise en matière de soins de santé primaire et de réforme hospitalière
(Rapporteur Laurentine BIHINA)

17h00 - 18h00 Discussion générale et synthèse

MERCREDI 16 FEVRIER 1994

**QUESTIONS CLES DU FINANCEMENT DE LA SANTE POUR LA PERENNITE -
PARTIE II**

08h30 - 10h00 (Modérateur Bineta BA)
Rôle des prestataires de services dans le secteur privé
(Rapporteur M. MAKINEN)

10h00 - 10h30 Discussion et questions

PAUSE CAFE

10h45 - 11h30 Impact des honoraires : résultats et expériences au Niger
(Rapporteur R. BITRAN)

11h30 - 12h15 Discussion générale et synthèse

DEJEUNER

(Modérateur Abdou DIENG)

14h00 - 14h30 Le CREDESA/SSP au Bénin et le financement communautaire des
soins de santé
(Rapporteur Félicien HOUNYE)

14h30 - 15h30 Impact et résultats de l'Initiative de Bamako
(Rapporteur Rudolph KNIPPENBERG)

15h30 - 16h00 Expérience de l'Initiative de Bamako en Guinée
(Rapporteur Lamarana DIALLO, Coordinateur National/AGBEF,
Mohamed L. TOURE)

PAUSE CAFE

(Modérateur Abdou DIENG)

16h15 - 16h45 L'impact de Redevances des utilisateurs au Mali
(Rapporteur Salif COULIBALY)

16h45 - 17h15 Projet pilote Boulgou au Burkina Faso
(Rapporteurs A. BEKELE, B. BA, I. IBRANGO, B. BASSAME,
P. COMBARY)

17h15 - 18h30 Discussion générale et synthèse

JEUDI 17 FEVRIER 1994

CONCEVOIR DES STRATEGIES POUR LA PERENNITE

(Modérateur Perle COMBARY)

- 08h30 - 09h15 Test des moyens pour le Recouvrement des Coûts des services de Santé des pays en développement
(Rapporteur M. MAKINEN)
- 09h15 - 10h45 Table ronde sur l'assistance hors projet et les préalables de la Banque Mondiale (Représentant de REDSO/Afrique de l'Ouest, Banque Mondiale, un Représentant de pays et un Représentant de HFS)
- 10h45 - 11h00 Pause-Café
- 11h00 - 13h00 Travaux de groupe pour échanger des idées pour concevoir des des réformes durables dans le secteur sanitaire

DEJEUNER

ETUDES DE CAS SUR LA PERENNITE

(Modérateur O. KANE)

- 14h30 - 16h30 Introduction aux études de cas et directives pour le travail de petits groupes
(Rapporteurs L. DIALLO, O. KANE, F. SY)
- 16h30 - 17h30 Travail en petits groupes sur les projets de survie de l'enfance, de planification familiale et de SIDA/VIH au Sénégal, au Niger et en Guinée
- 17h30 - 18h30 Présentations des petits groupes
Discussion générale et synthèse

VENDREDI 18 FEVRIER 1994

CONCLUSIONS ET SUIVI

(Modérateur F. SY)

- 08h30 - 09h15 Impact de la dévaluation du franc CFA sur le secteur Santé
(Rapporteur M. MAKINEN)
- 09h15 - 09h30 Résultats sur les priorités de la recherche
- 09h30 - 10h30 Synthèse des idées courantes et des questions de recherche sur la
pérennité
- 10h30 - 10h45 Pause Café
- (Modérateur B. BA)**
- 10h45 - 11h15 Planifier un suivi de l'atelier
- 11h15 - 12h00 Evaluation des participants / Recommandations pour d'autres ateliers
- 12h00 Cérémonie de clôture sous la présidence de
son Excellence Monsieur Assane DIOP, Ministre de la Santé
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ANNEX C: LIST OF PARTICIPANTS

LISTE DES PARTICIPANTS

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