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14. Abstract (Limit: 200 words) I. Introduction, II. The Economy and Health System of Upper Volta, III. Major Findings and Conclusions, IV. Discussion. Major Findings and Conclusions: 1) The business climate in UV is unlikely to attract new foreign private investment soon, with political climate unstable, credit markets inefficient, basic infrastructure lacking, and market research entirely unknown. An inexpensive, low risk activity in this area is the promotion of market research, specifically with respect to the family planning project described in the "Population Needs Assessment: Upper Volta" Report. That report covered the supply of family planning products and services, but ignored its own warnings that there may be little expressed demand. Even if the supplies are donated, the users must support the costs of distribution and administration. 2) In light of the very low coverage rates of the population with modern services, simple field research should be instituted which describes the extent to which rural populations purchase traditional care. Such information may prove invaluable in estimating rural populations' demand for health services, especially MCH services. 3) Efforts should be undertaken to join in the design of the 1985 UNFPA national census. Until then, sample surveys should be conducted in order to fill in the large gaps in our knowledge about resources, costs, and expenditures.				
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Project No. 698-0135-3-6134605

UPPER VOLTA

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PLEASE NOTE

This paper is one of a series by the author on the topic of private sector financing of primary health services in Africa.

The titles in the series are the following:

"Private Sector Research Retrieval and Analysis Project: Somalia," October 18, 1983, NTIS Accession Number JDMCG/TR-83/1

"Private Sector Research Retrieval and Analysis Project: Liberia," November 29, 1983, NTIS Accession Number JDMCG/TR-83/2

"Private Sector Research Retrieval and Analysis Project: Upper Volta," December 20, 1983, NTIS Accession Number JDMCG/TR-83/3

"Private Sector Research Retrieval and Analysis Project: Niger," January 22, 1984, NTIS Accession Number JDMCG/TR-84/1

"Private Sector Research Retrieval and Analysis Project: Zimbabwe and Lesotho: Bibliographies," February 16, 1984, NTIS Accession Number JDMCG/TR-84/2

"Private Sector Research Retrieval and Analysis Project: Rwanda," February 22, 1984, NTIS Accession Number JDMCG/TR-84/3

"Private Sector Research Retrieval and Analysis Project: Swaziland," March 8, 1984, NTIS Accession Number JDMCG/TR-84/4

"Private Sector Research Retrieval and Analysis Project: Senegal," June 1, 1984, NTIS Accession Number JDMCG/TR-84/5

"Private Sector Research Retrieval and Analysis Project: Sierra Leone," June 2, 1984, NTIS Accession Number JDMCG/TR-84/6

"Private Sector Research Retrieval and Analysis Project: Overview and Recommendation - Household Expenditure Survey," June 2, 1984, NTIS Accession Number JDMCG/TR-84/7

I. INTRODUCTION

"A young American Peace Corps volunteer in Diapaga, a village near the Niger border, recently asked her students what would happen if the long-awaited rains did not come and the crops failed.

'The Americans will send us food,' answered an 11 year old.

'And if the Americans don't send food?' she pressed.

'Then,' said the little boy in an even tone, 'then we will die.'" (May, p.D1)

The focus of this paper is on the opportunities for Upper Volta to strengthen its self-reliance. Attention is directed toward the non-governmental, non-foreign aid system in health and population activities. Upper Volta is among the poorest countries in the world, and has had to rely on grants and loans from foreign countries (primarily the United States), multilateral organizations (EEC, World Bank, and United Nations agencies) and private and voluntary organizations (notably OXFAM-UK, Save the Children-US and UK, and Africare) to pay for much of its essential services.

These vast and generous efforts notwithstanding, about half the entire population, more than half of the rural population, has been reached with health services by neither

the government of Upper Volta nor foreign donors. The long-term (20 years plus) solution to this problem may be to extend coverage to all the population. Before that can happen, however, enormous amounts of resources will need to be shifted into the health sector, thousands of providers will require training, and management practices will have to be drastically changed. In the short-term (0 to 5 years), realistic solutions will depend on the intelligent use of the extant resources and systems. Undoubtedly there can be improvements made in the operations of the government of Upper Volta system and in foreign assistance programs. They are not the concern here. The improvement of the private sector operations in health is the concern. Special attention is paid to the "Population Needs Assessment: Upper Volta" by Dr. Willard Boynton, et al. The assessment is evaluated in light of its assumptions, recommendations, and conformity to the objectives of primary health care and minimization of recurrent cost expenditure (exclusive of expenditures on the contraceptive pharmaceuticals themselves).

The organization of this paper is as follows: Section II contains background material - the economy and health system of Upper Volta. Section III contains the major findings and conclusions. Section IV contains the discussion on which the findings and conclusions are based.

II. BACKGROUND: ECONOMY AND HEALTH IN UPPER VOLTA

Upper Volta is one of the 25 poorest countries in the world. 80% of its gross domestic product derives from the agricultural sector, which relies on a harsh and unpredictable climate. When the weather is favorable, Upper Volta can be self-sufficient in food, but in the 1968-1974 drought, it required large food imports. Crop production and livestock numbers have recovered from the drought, but poor irrigation practices and overgrazing limit further expansion. As of 1978, Upper Volta experienced serious balance of payments deficits. In that year, total imports were US \$209 million, while total exports were US \$110.6 million.

Health conditions place severe constraints on national growth and development. Life expectancy at birth is currently about 38 years. The infant mortality rate is extraordinarily high at 161 per 1,000 live births. Fully 27% of all children die before their fifth birthdays.

The external factors which influence health status are:

- 1) Low income -- ability/willingness to pay for essential services, including health;
- 2) Unstable environmental conditions -- intermittent droughts;
- 3) Food shortages -- both regular seasonal ones and intermittent more severe, drought induced, ones; and,

4) Weak physical and administrative infrastructures -- that is, access to rural areas is difficult and Ministry of Health effectiveness is low.

The scarcity of health resources provides a further clue to the causes of such poor health conditions. Rough estimates of the health resources in this country which has the combined area of New York and New England, follow.

Human Resources

Physicians (including military)	132
Pharmacists	55
Dental Surgeons	16
Nurses (reports vary)	420 - 1700
Midwives	225
Assistant Midwives	575

Facilities

Hospitals (approx. 200 beds)	5
Medical centers	
functional	13
non-functional	26
Dispensaries	
fully functional	48
partially functional	410
Health posts	964
(Approximately 1,800 beds exist in the medical	

centers and dispensaries.)

Health expenditures are very rough estimates, but the figure seen most prevalently is US \$6.50 per capita, as of about 1980/1981. This translates to approximately US \$40 million per year, composed of about US \$16.4 million in foreign aid, about US \$14 million in GOV expenditures, and about US \$9.6 million in private expenditures. Thus, on a per capita basis, the private sector spends about US \$1.50 more than that which is provided through MOH services and foreign aid. Most of that \$1.50, over \$1.00, goes to medicines, the remainder presumably for professional fees. Transportation costs, not an insignificant part of the cost of care, has not been included in these estimates.

Almost 90% of the MOH budget pays salaries. While hospitals have established fee schedules, whatever revenues are generated remain in the units. It is not known to what extent the fees are collected, nor how much in revenues the facilities collect.

III. MAJOR FINDINGS AND CONCLUSIONS

1. The business climate in Upper Volta is unlikely to attract new foreign private investment soon. The political climate is unstable, credit markets are inefficient, basic

infrastructure is lacking, and market research is entirely unknown.

An inexpensive, low risk activity in this area is the promotion of market research, specifically with respect to the family planning project described in the "Population Needs Assessment: Upper Volta" report. That report covered the supply of family planning products and services, but ignored its own warnings that there may be little expressed demand. Even if the pharmaceuticals are donated, the users must support the costs of distribution and administration.

2. In light of the very low coverage rates of the population with modern services, simple field research should be instituted which describes the extent to which rural populations purchase traditional care. Such information may prove invaluable in estimating rural populations' demand for health services, especially MCH services.

3. Effort should be undertaken to participate in the design of the 1985 UNFPA national census. Until then, small sample surveys should be conducted in order to fill in the large gaps in our knowledge about resources, costs, and expenditures.

IV. DISCUSSION

Private Practice of Medicine

In theory, only those medical officers with 10 years of

service are permitted private practice. Officially, only two private clinics are recognized. In fact, government paid physicians and nurses carry on private practices, often in the government facilities and sometimes at home. The MOH reported figures tend to understate the actual level of private services delivered since they do not recognize any private practice beyond the two clinics mentioned above.

Private Financing of Health Services

Most health services in Upper Volta are financed privately, at least in part. Services delivered in government facilities often require private payment for medicines (e.g., 1 CFAF per malaria prophylaxis tablet) and registration fees (e.g. 25 CFAF per registration), and sometimes (officially, always) payment for professional services. Similarly, though not well reported, services delivered through the many PVOs also require private payment. Private health insurance is very rare in Upper Volta. A World Bank estimate for private insurance coverage is 60,000 workers and limited to only disabilities due to occupational injuries. A large segment of private expenditures, though unreported and assumed inferentially is on traditional medicine. Since 90% of the population is rural, and most of the modern health resources are in Ouagadougou and Bobo-Dioulasso, a generous estimate of coverage by modern

practitioners is 50%. Thus, over 3 million inhabitants are left to the traditional practitioners (guerisseurs), about whose use very little in Upper Volta is known. If they offer their services in a similar fashion as in other West African countries, partial payment is made for services delivered and the remainder upon cure. Payment is sometimes made in cash, sometimes in kind. Sometimes payment is made through the services of family members to the healer. In any case, traditional healers and sellers of herbs, traditional medicines, and modern medicines are far beyond the purview of MOH reporting, yet represent the major component of the private sector in rural areas. More study of the extent of resource use on traditional practitioners is warranted.

In terms of total modern sector expenditures on health, the following was estimated by MOH, the National Statistical Institute, the National Social Security Fund (Caisse Nationale de Securite Sociale, CNSS), and donors. It includes 1980 and 1981 data.

SOURCE	CFAF (Millions)	% OF TOTAL
A. Central Government		
MOH	3,086	27
Others, excluding		
Armed Forces	1,068	10
B. Local Government		
	190	2
SUBTOTAL, Public Domestic	4,344	39

C. Foreign Aid	4,132	37	37
D. Private Expenditures			
Medicines	2,300	20	
Social Security (CNSS)	200	2	
Hospital Fees Collected	265*	2	
SUBTOTAL, Private	2,765	23	
TOTAL	11,241	100	99§

* Including estimate of unofficial charges and bribes, 75% of total.

§ Rounding error.

Pharmaceuticals

Private sector medicines all come into the country through the Office National d'Approvisionnement Pharmaceutique (ONAP). ONAP is fully supported by its resale operations to public and private pharmacies, and directly to the general public. (Possibly 2.3 billion CFAF are used to import medicines each year.) A problem with ONAP operations is that the government of Upper Volta does not transfer credit to ONAP for its purchases. Reordering is not related to inventories.

The private pharmacies are mammoth and located primarily in Ouagadougou and Bobo-Dioulasso. The ten largest of them account for over 60% of all the medicines in Upper Volta. As contrasted with the Ministry operated pharmacies, the large private ones are well-stocked and clean. They

respond to demand in their market supply activities. Their pricing activities, on the other hand, appear to insure very weak operations of rural pharmacies. They sell to rural pharmacies at a discount of only 5% to 15% below retail. This helps to account for the reason that only 100 village pharmacies have been established since the National Pharmacy Laws have permitted village pharmacies. The MOH estimated a need for 500 more village pharmacies.

Boynton's recommendations start from the assumption that the public sector will play a larger role in the importation and distribution of pharmaceuticals and pharmaceutical products. Specifically, they include the following:

1. USAID should provide contraceptives free "in sufficient quantities" or at minimum cost to include international transportation.
 - A. ONAP should be the exclusive recipient of such pharmaceuticals.
 - B. USAID should provide training and technical assistance to ONAP personnel.
 - C. ONAP's prices should cover its actual costs of operating (with cost of contraceptives = zero) and rebuilding (capital costs). Note: It is not expected to deliver the pharmaceuticals.
 - D. Local pharmacies are expected to charge consumers the cost (including transportation) plus a margin

(misnamed profit in the report, and suggested at 25 CFAF per unit) if they are pharmacies, Ministry or private. If they are Ministry facilities, for some reason they are to receive the contraceptives for free and distribute them for free.

E. The National Pharmacy Laws should be amended to provide for the operations as described above.

The result of such a policy as recommended above, is a system which is not self-perpetuating, even if all the contraceptives are given to ONAP for free. The pricing is set up such that the pharmacies (public and private) subsidize the Ministry facilities by paying to ONAP all administrative and transportation costs for ONAP, the pharmacies, and the Ministry facilities. This necessarily raises the price of contraceptives to the consumers at the pharmacies above zero, probably well above zero. Since the same contraceptives are offered for free at the Ministry facilities, demand at the pharmacies would drop precipitously, thereby killing the goose that laid the golden egg. How long it would be before the sale of contraceptives stopped generating revenue altogether depends on a number of factors, including

- 1) Time costs
- 2) Price responsiveness of the consumers
- 3) Distance to the pharmacy v. the Ministry facility.

In any case, until the pharmacies stopped offering

contraceptives for sale, there would exist in the Ministry facilities strong incentives for providers to charge bribes for contraceptives. The amount of the bribe would most likely be less than the price at the pharmacy, and would depend on, among others, the three factors above. The program for selling contraceptives would very likely operate poorly in the near-term and not at all in the long-term without reliance on outside sources of funds. This independent recommendation is not to implement the system described on pages 45 to 46 of the "Population Needs Assessment: Upper Volta."

Market Analysis

A key recommendation which comes from this research and evaluation is the need for a market analysis. The purpose of it is to estimate the prices consumers would be willing to pay for condoms, pills, and exams. Its form would be sample consumer surveys throughout the country, of approximately 100 respondents in each of about a dozen sites. The program which is described and recommended by Boynton, et al is heavily front loaded with training and, to a lesser extent, putting equipment in place. These activities are costly and totally non-recoverable. The partial cost recovery, as envisioned by Boynton, et al, would come after the training and equipment. The importance of the market analysis, before any training or equipment

purchase were to begin, would be to determine the extent to which user fees would cover even the costs of distributing and administering the program.

"The consultants (Boynton, et al) clearly understood that the family planning component cannot possibly be a main priority for years to come unless the needs are felt at the village level Despite some infertility problems, Voltaic women have in common the desire for having many children . . . the present family size norm is 6.5 children." (pp. 53-54). The authors of "Population Needs Assessment: Upper Volta" reported that Voltaic health and social workers believe that urban women, particularly the more highly educated, are changing their attitudes about the value of the large family. This implies that the women who would be using family planning, the educated urban women, those who would use family planning methods in the absence of a program, are the only ones who really want it. The others, non-urban and poorly educated, the vast majority, do not yet value the smaller family. (pp. 32-34). In the absence of a felt need, especially among rural populations, for smaller families, family planning activities could be considered a "bad," not a "good," or something for which they would be willing to pay to avoid.

The rural population will value smaller families, the authors assert, when rural groups have been properly and adequately informed, when school children will have received

sex education, and when medical and paramedical personnel promote family planning. (p. 54). The crux to expanding the desire for family planning is information and education, they assert. That may be the case, but it should be investigated before accepting it on faith. An implication of this, if it proved true, is that women may be willing to pay for family planning products and services. A pricing/subsidy policy needs to be considered, if demand can be stimulated through information and education.

The consumers' response to price is likely to have a dominant effect on acceptance rates and revenue generation. The authors recommended the addition of a sample contraceptive prevalence study to Westinghouse's expected health survey. This study should report on contraceptive knowledge and use and provide data for an evaluation of the effect of family planning on the health of mothers and children, including full pregnancy histories. (p. 35). Such a study may well document the scarcity of contraceptive use, and the avoidable health hazards with which deliveries are made. It would be important in documenting the case for a family planning program, but it would be insufficient. However, if the importance of such a program were already accepted, what is needed is a study directed more toward its implementation.

If recurrent cost financing were an interest, the implementation activity would best be directed to demand

estimation and pricing policy. Though formally unsupported, anecdotal references to alternative pricing policies for health and population services in LDCs indicate that people impute a greater value to services which have a positive price than to free services. Moreover, incomes in LDCs are very low, and in Upper Volta, especially low, thus making prices, at higher levels, serious barriers to participation. If USAID is interested in stimulating demand for services and recovering some fraction of recurrent costs, attention should be paid to the pricing of services.

Even if the prices are established to cover only distribution and administration of the program, it may turn out that the prices implied by such support reduce the demand for services among the groups targeted. It should not be assumed that in Upper Volta, simply because the pharmaceuticals are donated, the remaining costs of the program will be self-supported. The costs of program administration and pharmaceutical distribution should be investigated prior to a decision regarding the program. The research recommended in the "Population Needs Assessment: Upper Volta" was the following: "Applied research projects should be introduced into the existing successful facilities. AID will have an opportunity to test various approaches and determine how the program might realistically develop in the future." (p. 58). The selection of existing

successful facilities would result in an uncharacteristically rosy view of the potential for the entire country. Instead, efforts should be directed toward studying the unsuccessful, perhaps unserved areas. They would be more representative of the country and may prove more instructive.

The following are brief thoughts regarding additional selected recommendations of Boynton, et al.

- 1) Add equipment to the rural centres medicaux and provide equipment to the traditional birth attendants and the primary health care agents. (pp. 59-60).

The motivation for these recommendations is to increase the acceptability of institutional delivery in rural areas. That appears to be an expensive solution with potentially high recurrent cost implications. On the face of it, sending equipment to increase acceptability sounds like unneeded equipment will soon be unused and thereby reduce the image of modern practitioners. Unless the demand for the services which the equipment would produce were known, the equipment would most likely remain unmaintained and unusable.

- 2) Upgrade the facilities in the two largest cities making them training and referral centers. (pp. 59, 62-63).

Only 3.5% of the country's population lives in those

two cities (Ouagadougou-150,000; Bobo-Dioulasso-90,000; Upper Volta-6.6 million). While there may be a real need for those services, they should be considered in light of commitments to primary health care and affordable health care. Allocations of additional resources to Ouagadougou and Bobo-Dioulasso would exacerbate the serious urban bias in health services. For example, 81% of all urban births were attended by modern practitioners, while only 20% of rural births were so attended. (Upper Volta, MOH, Epidemiological Division, 1978).

- 3) It is recommended that new elements be added to the health information system, that the system be simplified, and that summary regional and national statistics be produced at least twice per year, preferably four times per year. (pp. 67-72).

The information system was described as being a) five years behind in producing annual data, and b) structured to eliminate the incentive to report any reductions in ability to provide service. "Changes in the status of resources may not be reported because of the risk of budgetary reductions in the upcoming annual allocations. For example, if a dispensary becomes inactive, the allocation of drugs for the region might be proportionately reduced or if a health worker resigns, his post could be eliminated." (Boynton, p. 67)

67) Expanding the responsibilities of a non-functioning

statistical unit will not work. Calling for any reporting, let alone biannual reporting, when no reports have been issued in five years, is unrealistic. Without an incentive to report, local providers are unlikely to comply. A simple requirement to attend a meeting in some district or regional capital, in order to remain on the payroll, may reveal the extent to which salaries are paid to non-existent Ministry personnel. As an alternative, special surveys conducted by outsiders may be necessary. These would remove the need to report by sending survey teams out to find the personnel on the payroll. Probably the most realistic solution is not to strengthen the information system, but to rely on ad hoc methods until 1985 and incorporate health and health resource questions into the 1985 national census, currently planned by UNFPA.

A Private Sector Assessment was prepared for Upper Volta in September, 1983, (David, Harmon, et al). Although it focused on the agricultural sector, some of its findings are relevant here. They include:

- 1) There are three levels of the private sector. The largest part is composed of the rural, subsistence farmers and herders. The second level consists of the 200,000 small entrepreneurs, who comprise the traditional, commercial sector. The third level is the modern, industrial sector. This modern sector is

the object of the Private Sector Assessment, while the primary objects of this inquiry are all three levels.

- 2) As yet, the GOUV has not introduced public policy measures which serve to integrate the private sector into the development program.
- 3) The business climate in Upper Volta has been less than favorable. (Note: Much of what the Assessment was based on occurred before the coup of August, 1983. Since then, reports indicate a further chilling of the business climate, awaiting stability in the political scene.) Following are the principal effects of the recent business stagnation:
 - i) Returns on investments have turned negative;
 - ii) Increasing cash flow problems;
 - iii) Many businesses report having to extend increasing amounts and easier terms of credit just to keep operating;
 - iv) Decrease in consumers' purchasing power, and
 - v) Increases in the number of business bankruptcies and bank foreclosures.

(Harmon, et al, pp. 19-20).
- 4) There is no organized capital market in Upper

Volta. The Fonds Voltaiques de Capital des Enterprises exists, but only on paper. It has no infrastructure. (Ibid., p. 32).

5) Voltaic businessmen have imaginative ideas, well thought out, for producing new goods and services. Absent is the appreciation of the marketplace in which these new products must compete. In the terms of the economist, they understood the supply side, but failed to understand the demand side of the enterprise. (Ibid., p. 28).

6) Management practices and information upon which to base practice, were very weak. Cost accounting did not exist. Organizations lacked well-defined lines of authority. Employees received poor or no training related to job performance. (Ibid., pp. 41-42).

In sum, there exists in Upper Volta an enormous potential for private sector industrial activity, but the time for exploiting that potential is far off. Foreign investment is unlikely to be attracted very soon, in light of the current political and economic climate. The new regime, headed by Captain Thomas Sankara, has not yet adopted detailed economic policies, but its orientation is clear. "The revolution's main objective," Mr. Sankara said recently, "is to destroy imperialist domination and exploitation."

(May, p. D1).

The most likely successful course would be to concentrate on the indigenous private sector, primarily levels 1 and 2, the non-industrial sectors.