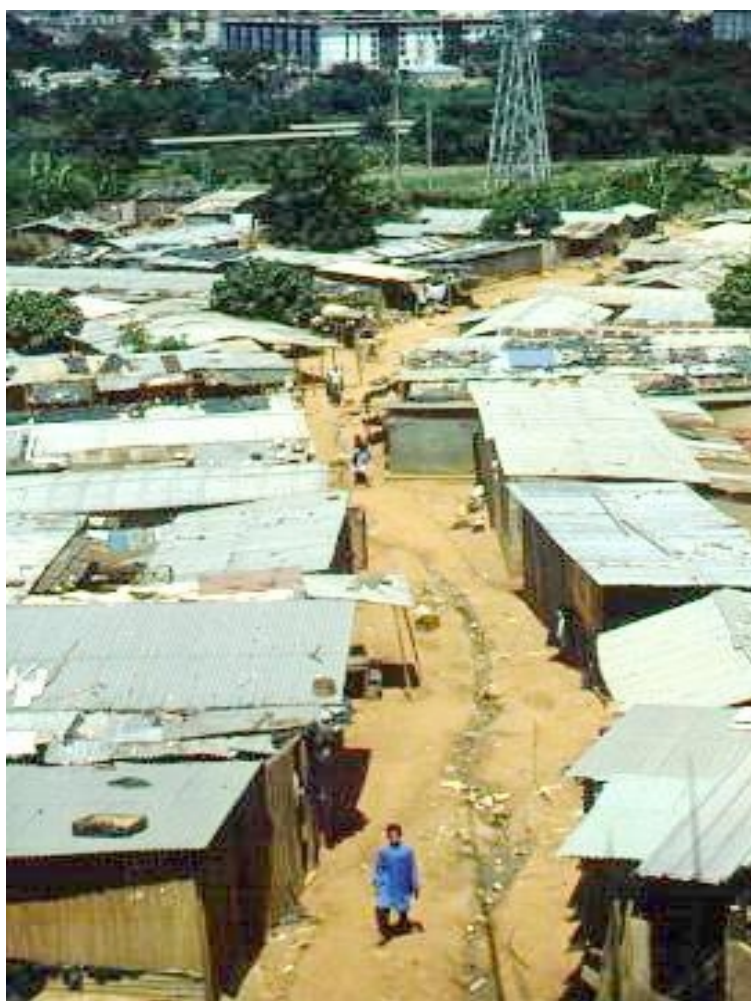


EQUITY AND ACCESS TO QUALITY CARE IN URBAN AREAS

Urban Health Project

Abidjan, Bamako, Conakry, Dakar and Niamey



SYNTHESIS

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Acronyms & Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Consultation
BI	Bamako Initiative
SOC	Basic Obstetrical Care
CHU	Centre Hospitalier Universitaire (Teaching Hospital)
COPE	Client-Oriented Provider Efficient Services
CSCOM	Community Health Centre
CRC	Convention on the Rights of the Child
CPC	Curative Primary Consultation
PDS	Development Health Plan
ECD	District Core Team
MCD	District Doctor
HD	District Hospital
SOU	Emergency Obstetrical Care
EOC	Essential Obstetrical Care
EU	European Union
EPI	Expanded Programme on Immunization
FP	Family Planning
GNP	Gross National Product
HC	Health Centre
PAS	Health Plan of Action
PMI	Infant and Maternal Protection
IEC	Information Education and Communication
IPE	Initiative for Equity
IRD	Institut de Recherche pour le Développement
COGES	Management Committee
MPA	Minimum Package of Activities
MPH	Ministry of Public Health
PNDS	National Health Development Plan
NHIS	National Health Information System
NGO	Non-governmental Organization
PHC	Primary Health Care
RH	Reproductive Health Care
SM	Safe Motherhood
STI	Sexually Transmitted Infection
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Programme
ECA	United Nations Economic Commission for Africa
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Fund for Population Activities
FSUCOM	Urban Community Health Training
PASU	Urban Health Support Project
FSU	Urban Health Training
WHO	World Health Organization

FOREWORD

The Urban Health Project, which began in 1997 in 5 capitals of Francophone West Africa (Abidjan, Bamako, Conakry, Dakar and Niamey), was the fruit of collaboration between UNICEF, the French Cooperation and the five countries concerned. This Project, which primarily aims to improve access to quality health care in urban areas, especially for the poor, was staggered in three phases: i) an action-research phase; ii) an operationalization phase; iii) a final evaluation phase.

This regional report provides a synthesis of:

- the studies of the 3 components of the action-research phase, (socioeconomic, socio-anthropological and quality of care),
- complementary missions on the operation of the urban health system and the structural quality of health services, conducted in three of the five capitals,
- a review of the literature on quality, equity and efficiency of care in urban areas on the continent.

The document was designed in a simple and practical way for easy reading, highlighting major observations that could be corrected in the future, with the adoption of appropriate operational strategies.

The strategies proposed for improving the quality and equity of care in urban areas are not only based on the findings of the Project studies, but also on promising experiences initiated in some countries in the sub-region, in the context of the health system reform. In fact, they constitute a Minimum Package of indispensable operational strategies for improving access to quality care in urban health centres, notably for disadvantaged people. Sooner or later, all the countries will have to adopt these strategies. Differences between countries will relate to the process of implementation which will vary according to the specific context. Often, the implementation will require an in-depth reform of the health sector.

Under the operationalization phase of the project, the various parties involved will have to select strategies, from those to be adopted in a conceptual manner, that are likely to be financed, on the basis of criteria to be defined.

The present report should be perceived as synthesis on which will be based the drafting of preparatory documents of the closing Forum of the action-research phase.

The definition of some of the terms used in this document need to be explained.

Equity^(a) may be defined from two perspectives:

- equity in health care delivery at the health facilities meaning no discrimination according to gender, age and socioeconomic status by the caregivers (horizontal equity),
- equity in access to care meaning an equitable distribution of the financial burden of communities of the health system, notably with the implementing of compensatory mechanisms for the most disadvantaged (vertical equity).

The notion of poverty^(b):

- total household expenditure is the indicator used for assessing the standard of living of communities. Unlike country surveys which used the quantile method for the classification of households, the regional study used the poverty line criterion of \$1 per day per person as defined by the World Bank in 1990 (in Purchasing Power Parity of 1985 and after adjustment on 1998). This choice was guided by the need to harmonize and compare the data collected.

^a WHO World Health Report – 2000.

^b MARIKO M. and CISSE B., L'Équité dans l'accès aux soins et l'utilisation des services de santé, final report, November 2000, UNICEF- French Cooperation -IRD.

Dimensions of quality of care analyzed are as follows:

- non-clinical quality (structure, reception, privacy and confidentiality),
- clinical quality (interview, clinical and supplementary examination and treatment),
- autonomy and satisfaction of users.

The analysis of results and operational strategies proposed in this document are the **views of the author**. Under no circumstances, will they be deemed to be the views of the French Cooperation and the UNICEF West and Central Africa Regional Office.

However, the document was carefully reviewed by the following persons prior to finalization:

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INTRODUCTION

URBAN GROWTH

Rapid urban population growth is one of the major characteristics of contemporary population patterns of countries of the Third World and of Africa in particular. Although Sub-Saharan Africa is one of the least urbanized regions in the world, the spectacular growth of its urban population, particularly those of cities is worrying in view of the weak economic capacities of these societies to manage such a situation.

According to studies of the World Bank on urbanization, in the next 10 years, 50 million people in West Africa alone will migrate to cities.

In 2020, 63% of Sub-Saharan African population will live in the cities.

"Macrocephaly" (concentration of urban population in the largest cities of a country) is a common feature of urbanization in Sub-Saharan Africa. It is characterized by the excessive size of a single city, generally the country's capital, to the detriment of other urban centres.

The urban areas often have a high ethnic cultural and economic diversity. Still, according to studies by the World Bank, since the 1980s, there has been a sharp increase in urban poverty in most West African countries. In these countries, the dramatic increase in monetary poverty, (estimated on the basis of total household expenditures), is associated with a significant degradation of the nutritional status of children.

The massive rural exodus of people in search of employment translates into an inflow of young disadvantaged population, often concentrated in precarious peri-urban neighbourhoods. Often, the corollary of this economic poverty is often "social marginalization". An increasing number of the poor in capitals are affected by the lack of access to education and health.

URBAN HEALTH CRISIS

Following the Bamako Initiative of 1989, most African countries formulated and implemented a cost-recovery policy for health and drugs. This policy aimed at increasing access by communities to a primary health care, particularly in rural areas. Under pressure from the Bretton Woods Institutions, and through Structural Adjustment Plans (SAPs), budget allocations made to the health sectors of these countries particularly targeted the rural primary sector at the expense of the urban tertiary sector seen as a high-spending sector with a poor cost-effectiveness ratio. The fact that the major health indicators (maternal and child mortality) are better in urban areas than in rural areas was a key reason for granting absolute priority to the rural world of African countries.

Box N° 1: Urbanization in Sub-Saharan Africa – 1975-1995

- *The average growth of urban population reached 5.2% per year while the GDP fell by 0.66% annually.*
- *No other region in the world has experienced such high urban growth with such low economic growth.*
- *Two-thirds of city dwellers live in precarious accommodation with inadequate water supply, hygienic conditions and health services.*

Source: World Bank - 2000

Box N° 2: Urban Poverty in RCI, Mali and Senegal 1980-1995

- *In 1995, over a third of the dwellers of capitals of the three countries disposed of less than US \$2 per day to live.*
- *In the three countries, large size urban families including those with the largest number of children or elderly persons were exposed to the risk of poverty the most.*

Source: World Bank - 2000

However, already in 1991, at its 44th World Health Assembly, WHO explicitly recognized the eminent outbreak of health crisis in urban areas, notably in the major cities of the Third World countries. Indeed, in addition to infectious diseases and malnutrition, these cities develop other diseases which are the price to be paid for development (heart diseases, accidents, suicides, alcohol abuse, drug abuse, mental disorders), not forgetting AIDS. This scourge, which poses a particularly serious problem in cities, poses a considerable threat to the health of the people.

For WHO, in urban areas, the group at risk the most is the poor. Poverty intensifies risks associated with children, women's condition, disability and occupation. In the cities, the health of the most disadvantaged groups is worsening in relation to that of the most well-off and accelerated urbanization gives an increasingly worrying aspect to this trend. Urbanization seems to be inevitable and urban poverty is an urgent problem that requires particular attention by governments. According to WHO, the best health indicators of the urban area in relation to the rural areas mask the existence of difficult urban neighbourhoods and morbidity that is clearly higher than that of the wealthiest communities of the same city. Case studies conducted in Accra, show that the risk of mortality due to infectious diseases or circulatory diseases is at least twice as high in poor neighbourhoods as in wealthier neighbourhoods¹.

During the last decade, several conferences and symposia (UN-Habitat II, Istanbul 1996, etc.) were held with a view to encouraging countries to initiate sustainable and less costly interventions that could address the problems posed by urbanization.

The actual impact of cost-recovery on the equity and access to quality care features among the various controversial issues.

Box N° 3: Cost-Recovery in Social Sectors – Addis Ababa – June 1997

- *The Addis Ababa consensus declares that although cost-recovery is necessary, it could have an impact on equity, access and quality particularly for the poor. The consensus recommends the putting in place of solidarity mechanisms to protect the poor.*

Source: Economic Commission for Africa (ECA)

POSITIONING OF UNICEF AND FRENCH COOPERATION

The Bamako Initiative launched by UNICEF at the end of the 1980s was already concerned with the inaccessibility by communities to health services. Since then, UNICEF has expressed its concern about the right to health care by the poor, in a context of structural adjustment. This constant concern for equity in health was concretized through cooperation programmes developed with governments of most West and Central African countries. Furthermore, UNICEF engaged in collaboration with other partners to launch initiatives in favour of equity in the health sector and the protection of vulnerable groups.

Having concentrated its efforts over many years on the rural areas, UNICEF plans to focus on addressing the African urban health crisis.

To this end, UNICEF intends to review its interventions in order to adapt them to new urban realities, with special emphasis on the problem of access to quality care by the most disadvantaged in African capitals.

Box N° 4: Initiative for Equity (IFE) UNICEF-USAID Collaboration 1998

- *The USAID-UNICEF Initiative for Equity (IFE) in West Africa aims at assisting in formulating appropriate policies and strategies for improving affordability in a context of paid care, by vulnerable communities.*
- *The IFE concerns four countries: Benin, Burkina-Faso, Guinea and Mali.*

The creation in recent years of many community health centres in several African capitals thanks to the technical and financial support of French Cooperation reflects the awareness of donors about the specificity of the African urban health environment and the need to undertake appropriate interventions.

Indeed, despite a better geographic accessibility of health services and a multiple health care delivery: public, profit-making and non-profit-making private, new and complex problems characterize this health sector. These problems are mostly related to: i) lack of adequate organization and poor quality of health care delivery; ii) the cost of modern health care, which is exorbitant for the poor; iii) access to

¹<http://worldbank.org/poverty/>

and use of health services by the disadvantaged; iv) weak solidarity in the care and treatment of diseases.

For countries practising cost-recovery, one of the most difficult questions is how to protect the most vulnerable and disadvantaged groups, while at the same time ensuring the financial sustainability of the health system on the whole. This issue of equity and pricing of health care was the source of lively debates at the Health in Capitals Symposium held in Abidjan in 1996, under the auspices of the French Cooperation.

URBAN HEALTH PROJECT

The confrontation between the UNICEF's new concerns and the experience of the French Cooperation and the IRD (former Orstom) gave rise in 1997, to the "Urban Health Project" in five West African capitals: Abidjan, Bamako, Conakry, Dakar and Niamey. As a first step, the objectives of the project were to:

- widen the scope of the study of the health of the poor in urban areas,
- formulate innovative strategies to improve: access to care by the disadvantaged, quality of health care services and the financial support for the poor.

As a second step, the Urban Health Project aims to:

- implement the strategies defined at the operational, regional and central levels,
- build national capacities,
- improve effectiveness and coordination of external support to health development in the urban areas.

The Urban Health Project comprises three phases:

- i) an action-research phase (aim of the present study);
- ii) an operationalization phase;
- iii) a final evaluation phase.

ACTION-RESEARCH PHASE

Under this initial phase of the project, teams of economists, anthropologists and health professionals undertook surveys in five capitals to provide responses to the following questions:

- what are the determinants of access to modern health services, notably for the disadvantaged? (*socioeconomic component*),
- Does the perception of modern health services by communities influence therapeutic role? (*socio-anthropological component*),
- What is the standard of quality and equity of the public health system? (*quality of care component*).

These questions not only aim at determining the major internal and external constraints to access to quality health care for the entire communities of urban areas, but also at identifying a strategic framework for improving the equity and quality of health care services in the five capitals.

The initial chapters of this document provide an analysis of the various findings established by the different surveys conducted in the five capitals. Chapter 4 compares these findings with the literature. Lastly, Chapter 5 proposes a set of operational strategies that could serve as a reference for the second phase of the Urban Health Project.

CHAPTER 1: URBAN HEALTH SYSTEM*

HEALTH SECTOR REFORMS

Over the last ten years, the five countries have undertaken wide-ranging reforms of their health system with a view to making them more efficient.

The chief aim of the National Health Policy of these countries is to enhance access by their population to quality health care.

The major strategic options adopted by these countries are presented in Box N° 5.

These strategic policies aim at correcting the significant differences that exist in the health sector between the urban areas and the rural areas both in terms of geographic accessibility and availability of human

Box N° 5: Common Strategic Orientations of the Health Sector Reform in Five Countries

- *Adoption of Primary Health Care following the Bamako Initiative.*
- *Decentralization and strengthening of the health system based on the notion of health district.*
- *Revitalization of basic health facilities in rural areas and strengthening of technical facilities of the referral structures.*
- *Introduction of pricing for health services and drugs together with the abolition of free care.*

resources and adequate budgetary allocations. For decades, reforms of the health sector focused on the rural world. According to policy-makers and donors, since the problem of geographic accessibility and health coverage was not relevant to capitals, available resources should target, as a priority, the rural primary health sector.

However, the consequences of urbanization on the health of the people are increasingly attracting the attention of decision-makers. Increased urban poverty and the emergence of a health crisis are the basis of this new interest in health in the five cities. However, this awareness has not yet translated into an effective national commitment. None of the five countries has a National Urban Health Policy including an Urban Health Development Plan. In view of this, the major strategic thrusts of this policy have not been defined and the role of the various actors – public/private sector, local authorities, communities – have not been clarified.

URBAN HEALTH SYSTEM

In the five countries, the health system in force is based on the Bamako Initiative model – "three-tiered pyramidal system" – as well as an approach based on the notion of health district. All these primary health structures are supposed to deliver a Minimum Package of Activities, comprising curative, preventive and promotional care.

Unlike the rural area, the urban health system is not adequately structured. In view of the multiplicity of health care delivery (public, private and religious), it is difficult to divide the capital into health districts using the WHO criteria.

Table N° 1: General Characteristics of the Five Capitals studied in 1998

	ABIDJAN	BAMAKO	CONAKRY	DAKAR	NIAMEY
Total Population (1998)	3 150 443	1 069 642	1 094 075	2 012 303	573 908
Number of communes	10	6	5	5	3
Urban Health Districts	1*	6	5	8	3
Average Population / District	3 150 443	178 736	218 815	251 538	191 303

Source: UNICEF 1998 - * In 2001, the City of Abidjan was divided into five health districts

* Chapter 1 was based on the outcomes of the field Missions.

The data in Table N° 1 indicate that in most of the capitals, the average population of a health district is significant. In this regard, the organization and management of such an entity are more difficult than in rural areas.

CARE DELIVERY

In the five capitals, the urban health system is characterized by a multiple and complex health care delivery. This delivery is increasingly marked by a booming profit-making private health sector that the Ministries of Health find difficult to control.

Table N° 2: Health Delivery in the Five Capitals studied in 1998

	ABIDJAN	BAMAKO	CONAKRY	DAKAR	NIAMEY
1 st Level Public and Religious Health Centres	48	NA	34	83	18
Private Community Centres (comUHC Type)	15	26	0	0	0
Private Profit-making Facilities	NA	44	160	431	12
Public 1 st Level Facilities	2	6	5	11	0
Hospitals	4	3	2	7	2
Private Pharmacies	NA	110	NA	220	17

Source: UNICEF 1998 - Ministries of Health - NA = Not Available

We are increasingly witnessing the development of two types of urban health system: a public sector system that is in theory more accessible to the poor and a profit-making private sector for the rich.

REFERRAL / COUNTER-REFERRAL

One of the characteristics of the urban health system is the unavailability of an operational referral and counter-referral system. In the five cities, only two of the three levels of the health pyramid exist: the primary level (dispensaries, health posts, community health centres, maternities, MCH centres and referral health centres) and the tertiary level (national hospitals and teaching hospitals). There is no clear link between these two levels. Except for Bamako, Dakar and, to a lesser extent Conakry, the primary level urban health facilities are not officially linked to a referral health structure. Patients are referred either to the hospital of their choice or to the nearest health service, using rudimentary means of transport (taxi, or sometimes, private cars). Few health centres have an ambulance for evacuations.

The referral system and management of medical and/or surgical emergencies are poorly organized. Referral procedures and tools have not been properly defined. Moreover, there is practically no feedback on patients evacuated.

In many cases, the patients do not have the necessary financial means for transfer from the first level to the first referral level. The most commonly used tariffing method is direct payment, in view of the virtual non-existence of prepayment and/or post-payment mechanisms. Consequently, financial access by the most disadvantaged people to referral services is weakened.

INSTITUTIONAL LEVEL

At the institutional level and in the context of health decentralization, each of the five capitals depends on a Regional Directorate that forms part of the immediate level of the health pyramid. Although the functions and competences of these Directorates are defined by regulatory instruments, their actual weight in the organization of the urban health system remains weak. For example, in the five countries, hospitals do not depend on Regional Health Directorates. This tertiary level does not fall under the supervision of Regional Health Directorates. In addition to problems of legitimacy, these Directorates are affected by a lack of resources (human, equipment and logistical) to carry out their work.

Relations with local authorities in terms of health are inadequately developed. The municipal counselors are relatively uninvolved in the definition of local health policy. Overall (except Dakar in view of its policy of regionalization), health decentralization remains modest from a functional point of view.

CHAPTER 2: HEALTH AND POVERTY

NOTION OF POVERTY

In the context of regional analysis of surveys among communities, undertaken in the five capitals, **total household expenditure** was used as an indicator of the standard of living of the household. Thus: "is considered as poor or very poor any household whose annual per capital expenditure does not exceed US \$370 and \$270 respectively" (reference poverty line of the World Bank fixed in 1985 and expressed in Purchasing Power Parity for 1998).

On this basis, the classification of households interviewed according to standard of living yields the following results:

Table N° 3: Distribution of Persons interviewed by Standard of Living

STANDARD OF LIVING	ABIDJAN		BAMAKO		CONAKRY		DAKAR		NIAMEY	
	Number	%	Number	%	Number	%	Number	%	Number	%
Very Poor	1143	9.8	2079	15.4	1264	21.1	2186	13.2	424	5.4
Poor	2423	20.8	1073	8.0	1420	23.6	2423	14.6	636	8.0
<i>S/Total</i>		30.6		23.4		44.7		27.8		13.4*
Non Poor	8992	77.4	10320	76.6	3321	55.3	11939	72.2	6850	86.6
Total	11625	100	13472	100	6005	100	16548	100	7910	100

NB: The very low percentage of poor in Niamey indicates an under-reporting of cases, probably due to sampling bias.

The data collected helps to define a common poverty profile in the five capitals. Indeed, poor communities are characterized by:

- a high average size of household. (*Higher than 8.0 in all the capitals*)
- a high proportion of young people (<15 years). (*Higher than 40% in all the capitals*)
- high rate of illiteracy, especially among women. (*30 to 50% according to capitals*)
- low access to latrines or proper toilets.
- a significant rate of unemployment, precarious employment or irregular incomes often in the informal sector.

INCIDENCE OF DISEASE IN HOUSEHOLDS

For all the households considered, the rate of morbidity declared according to the review period varies from **40-41 per 1000** (Bamako and Niamey) to **62-67 per 1000** (Abidjan, Conakry and Dakar).

Table N° 4 shows that the frequency of illness is inversely proportional to the standard of living of the people. For the period under review defined in each country, the majority of the persons interviewed reported 1 to 2 cases of illness irrespective of their standard of living. However, beyond 3 cases of illness and more, differences appear according to the standard of living of the households.

Table N° 4: Frequency of Illness during the Period under Review and by Standard of Living

	ABIDJAN	BAMAKO	DAKAR	NIAMEY
CATEGORY	<i>1-2 morbid cases declared per person</i>			
Very Poor	93.9	94.2	100	85.8
Non Poor	97.1	98.5	99.9	89.9
	<i>3 and more cases of morbidity declared by person</i>			
Very Poor	6.1	5.8	0.0	14.2
Non Poor	2.9	1.5	0.0	10.1

NB: Information is not available for Conakry

The % for Dakar are explained by the very short period of review (15 days)

Thus, there is an **"over-morbidity"** related to poverty in the sample of household surveyed. On the whole, infectious and parasitic diseases dominate the morbid table declared and under-five year-olds are the most affected. Irrespective of the standard of living of the persons, malaria represents the major cause of morbidity reported by the households interviewed in the five capitals.

THERAPEUTIC ITINERARIES

Over 90% of the persons interviewed provide self-care in case of illness, irrespective of their standard of living.

The various therapeutic itineraries used by the persons interviewed are distributed in the following categories:

- modern services (public and private)
- self-medication
- home-based care
- traditional care.

In the five capitals, **modern health services** and **self-medication** constitute the most frequently used types of care both at the primary level (between 80% and 98%) and at the secondary level (between 47% and 89%).

Table N° 5: Major Types of Primary Level Care by Standard of Living

	ABIDJAN	BAMAKO	CONAKRY	DAKAR	NIAMEY
STANDARD OF LIVING	<i>Self-medication as Primary Care (%)</i>				
Very Poor	52.5	49.3	42.3	25.4	78.0
Poor	51.0	41.9	40.0	45.0	85.2
Non Poor	45.6	36.0	45.8	31.8	67.1
	<i>Modern Health Structures for Primary Care (%)</i>				
Very Poor	42.8	42.9	35.3	67.3	22.0
Poor	46.3	51.6	39.0	52.0	13.0
Non Poor	50.5	54.5	42.9	64.8	30.6

As indicated in Table N° 5, self-medication is widespread irrespective of the standard of living, although it is more common among the poor. Everywhere except in Dakar, the use of modern health structures is clearly more common among the “non poor”.

Table N° 6: Types of Health Structures used by Standard of Living

	ABIDJAN	BAMAKO	CONAKRY	DAKAR	NIAMEY
STANDARD OF LIVING	<i>Primary Health Facilities (public, parapublic, non-profit-making private)</i>				
Very Poor	64.6	59.2	51.4	76.3	67.9
Non Poor	44.1	58.8	38.1	62.2	58.3
	<i>Private Profit-making Health Facilities (%)</i>				
Very Poor	10.9	15.3	5.8	5.0	7.1
Non Poor	31.6	21.5	13.8	14.7	19.8

The data presented in Table N° 6 indicate that the standard of living has an influence on the type of modern health structure used in case of illness.

The use of profit-making private health facilities is directly proportional to the standard of living of households. However, it

Is surprising to note that 5% to 15.3%, according to capitals, of extremely poor individuals still go to the private sector for care, despite the high cost involved.

Box N° 6: Reasons for avoiding Care

Nearly 10% of the persons who had been ill prior to the survey did not resort to any type of care:

- *financial reasons were given in at least 7 out of 10 cases among the extremely poor*
- *the lack of financial means and the lack of perception of the seriousness of the disease are the major reasons for not resorting to care in the five capitals (cf. regional analysis of socioeconomic component).*

Box N° 7: Use of Modern Health Structures by Standard of Living

- *Public and parapublic health facilities and non-profit-making community health centres attract the poor and the very poor more*
- *Private profit-making health facilities are mainly attended by the non poor.*

SELF-MEDICATION: EXPLANATORY FACTORS

Self-medication which represents the type of care most commonly used among the poor at the primary and secondary levels is in several forms:

- i) purchase of modern drugs in pharmacies or in the informal sector;
- ii) purchase of traditional medicinal plants;
- iii) use of family pharmacy kit.

The choice of the type of self-medication and especially the place of purchase of the drugs are related to the standard of living of the households.

In all the capitals, the very poor tend to purchase their drugs from the "market drug sellers". The non poor on the other hand prefer pharmacies and dispensaries.

Box N° 8 indicates the benefits the poor believe to have from self-medication.

The qualitative surveys among poor households provide explanations for the practice of self-medication.

Self-medication is not a linear phenomenon.

Poor communities seem to be mainly guided by a concern for efficacy, desire to limit the period of waiting and control financial costs.

Table N° 7: Major Places of Purchase of Drugs by Standard of Living

	BAMAKO	DAKAR	NIAMEY
CATEGORY	<i>Pharmacies and Drugstores (%)</i>		
Very Poor	41.7	31.0	5.7
Non Poor	58.5	39.5	20.1
	<i>Market Drugs (%)</i>		
Very Poor	58.3	44.9	68.6
Non Poor	36.6	45.2	55.6
	<i>Home, and Family Dispensaries (%)</i>		
Very Poor	0.0	24.1	14.3
Non Poor	0.0	15.3	18.4

NB: Information is not available for Abidjan and Conakry

Box N° 8: Justification of the Use of "Market Pharmacies"

- *Cultural accessibility and low cost of treatment*
- *Possibility of purchase per unit and on credit*
- *No period of waiting*
- *No discrimination related to social category.*

WAITING TIME IN PUBLIC HEALTH SERVICES

Waiting time is a factor that limits the use of modern health services. For individuals and especially the poor, the waiting period for medical consultation is too long.

According to capitals, **54% to 84.5%** of the poor reported having an occupation. A high proportion of poor men work in the informal sector, namely are self-employed or are employed as labourers or apprentices.

In the case of poor women, most of them engage in small income-generating activities such as: sale of condiments, house-to-house laundry, etc. Often, the survival of poor households depends on the daily activities of the women, particularly where the men are unemployed.

It is understandable that long waiting periods in public health services are incompatible with the precarious professional situation of the poor.

In all respects, self-medication is seen by them as the most suitable therapeutic care.

Box N° 9: Waiting Periods and Public Health Facilities

- *The average waiting periods for users of first referral level public health facilities is long. It ranges between 48 minutes and 144 minutes according to capitals.*
- *In terms of waiting period, there is not significant difference according to standard of living of the users.*

PERCEPTION OF THE SERIOUSNESS OF THE DISEASE

Table N° 8: Self-medication according to the Perceived Seriousness of Disease

	ABIDJAN	BAMAKO	Dakar	Niamey
STANDARD OF LIVING	<i>Not Serious and/or Relatively Serious Illness (%)</i>			
Very Poor	91.1	89.9	96.9	94.3
Poor	92.7	100	100.0	91.3
Non Poor	94.9	88.3	97.3	91.4
	<i>Very Serious Illness (%)</i>			
Very Poor	8.9	10.1	3.1	5.7
Poor	7.3	0.0	0.0	8.7
Non Poor	5.1	11.7	2.7	8.6

The data in Table N° 8 indicates an inversely proportional relationship between the perception of the seriousness of the disease and the use of self-medication. In all the capitals, and irrespective of the standard of living, taking of drugs without prescription is the most commonly used method of treatment of an illness that is not considered to be serious.

According to the findings of the qualitative surveys, the poor tend to under-rate the seriousness of the disease. It will be recalled that Table N° 4 shows that ironically it is the rich who report more cases of illness than the very poor. It is only when the illness is perceived to be very serious that the poor decide to attend a modern health facility. Seriousness criteria mentioned are the duration of the disease and/or inability to work.

The only exception to this type of behaviour concerns sick children who are often immediately taken to modern first-level health structures. According to poor parents, with children, it is not worth taking risks because it is difficult to assess the seriousness of their disease.

FINANCIAL CONSTRAINTS

All the poor people interviewed reported that they hardly had the financial means to purchase drugs prescribed by the health personnel. In-depth interviews among poor communities indicate that the fact of not being able to honour a prescription for financial reasons is felt as a dishonour by heads of households. In order to avert this shame, the poor tend to resort to self-medication. Subsequently, depending on their financial resources, they opt for modern drugs, or traditional medicinal plants.

Among all the public health structures, public and parapublic dispensaries are those in which the pricing of consultation is the lowest. The analysis of the cost of health care in these structures (Table N° 9) shows that on average and according to capitals, the very poor pay about CFAF 2600 to CFAF 7000 for their prescriptions.

<p>Box N° 10: Breakdown of Total Cost of Care</p> <p><i>The total cost of health care, excluding the opportunity costs, comprises:</i></p> <ul style="list-style-type: none"> • transport, • consultation, • additional examinations, • purchase of prescribed drugs.
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If one considers expenditures for transport, consultation and complementary examinations, the average cost for illness among the very poor (without opportunity costs) varies between CFAF 5510 and CFAF 16835, that is from 55% to 168% of an average monthly income of CFAF 10 000 (the poverty line in five cities ranges between CFAF 8 739 and CFAF 11 067 per month).

Table N° 9: Drug Expenditure by Standard of Living in Public and Parapublic Dispensaries			
City	Drug Expenditure (CFAF)		
	V. Poor	Poor	N. Poor
ABIDJAN	2600	5550	3570
BAMAKO	5860	12350	8145
CONAKRY	6845	5965	8180
DAKAR	5430	3360	6125
NIAMEY	NA	NA	13530

NB: V. Poor = Very Poor - N. Poor = Non Poor

Table N° 10: Comparison of Total Average Expenditure by Type of Treatment and by Standard of Living

	ABIDJAN	BAMA KO	CONAKRY	DAKAR
STANDARD OF LIVING	<i>Average Cost of Illness in Public Dispensaries (CFAF)</i>			
Very Poor	4270	7215	8215	6545
Poor	7115	13460	7598	4125
Non Poor	5065	10410	9700	7240
	<i>Average Cost of Expenditure related to Self-medication (CFAF)</i>			
Very Poor	1490	600	2050	1530
Poor	1950	500	2590	2680
Non Poor	2140	4025	2630	2550

NB: The data on the costs of complementary examinations are not available for Niamey

For a given illness and depending on cities, drugs alone account for 47.2% to 69.7% of the average total health expenditure of the disadvantaged.

Table N° 10 indicates that, according to capitals, the average cost of care (excluding additional examinations) is **4 to 12** times higher than in the public dispensaries with regard to self-medication. In the face of these significant cost differences, it is easy to understand the attraction of self-medication for poor people.

When the use of modern health services becomes inevitable, the poor develop particular strategies, namely:

- the splitting up of prescriptions, consisting in buying part of the medicines prescribed at the dispensary of the health facility,
- borrowing money from a network of friends to pay for the entire cost of the prescription.

Box N° 11: Cost Recovery and Disease Coverage in Five Capitals

- *In the five capitals, less than 10% of the individuals interviewed have a health coverage.*
- *Since the introduction of cost recovery in the health sector, the direct payment for care represents the most common form of billing of health services.*

This type of borrowing from friends is related to the peculiarities of urban communities. Usually in the rural areas, solidarity is organized within the extended family, village community or ethnic group. In view of the ethnic, cultural and economic diversity of urban areas, the social network of friends is often the only one that is resorted to.

Qualitative surveys among poor individuals confirm that the social mutual assistance networks operate more on the basis of friendship than on the notion of belonging to a same community. When the social network of friends becomes defective or ceases to exist, the poor find it financially impossible to gain access to modern health services.

Thus, the cost of care of modern public health services is often exorbitant for the poor who find themselves in a situation of social exclusion.

There again, self-medication using drugs purchased from the market provides a solution that is adapted to their socioeconomic situation, not only because of the low cost of the drug, but also in view of the easy access and possibility of purchasing on credit.

Box N° 12: Equity in Access to Care

- *Monetary poverty, when it is associated with social marginalization, is a critical element in the financial access by poor people to basic social services (health and education).*
- *The generalization of direct payment for services in public health structures induces inequity in access to care especially by the poor.*

It is highly likely that easy access of self-medication partly explains why this practice is also common among a significant proportion of the non-poor in the five capitals (35.1% to 67.8% according to cities).

PERCEPTION OF THE HEALTH ENVIRONMENT

In the various capitals, except for Niamey, on average 1 individual out of 2 uses modern health structures in case of illness, even if this is delayed. This reflects the positive perception that households have about the effectiveness of modern medicine. The evidence for this is that the proportion of patients resorting to traditional care is lower than 10% in the five capitals. Part of the total number of patients using modern health structures, 12 to 29.1% chose profitable health services.

The majority of such persons belong to the socially well-to-do categories. However, it needs to be recalled that 5.0% to 15.3% of the very poor patients, according to capitals, choose a profit-making private health facility for their care. The latter paid on average between CFA F 19 445 to CFA F 23 860 for their care, respectively in Bamako and Conakry. This illustrates the negative perception that the poor have of public health services.

Table N° 11: Attendance to Private Profit-making Services by Standard of Living

	Use of Private Profit-making Health Services and Standard of Living		
	Very Poor	Poor	Non Poor
ABIDJAN	10.9%	18.8%	31.6%
BAMAKO	15.3%	19.4%	21.5%
CONAKRY	5.8%	13.6%	13.8%
DAKAR	5.0%	3.2%	14.7%
NIAMEY	7.1%	11.4%	19.8%

PERCEPTION OF USERS

Overall, among the poor individuals interviewed, the perception of the State health system is "negative". The public health service is considered to be closed-in, bureaucratic and difficult to understand. Most of the people interviewed mentioned the lack of consideration by health personnel for them and the practice of pecking order in care services. Access to quality care in the public sector becomes a daunting task. It needs to be noted that the users assess the quality of services provided them by their own standards. Thus, this assessment is mainly based on the non-clinical quality of care (reception, waiting period, respect for one's dignity, sense of decency and confidentiality).

Apart from the geographic proximity, acquaintance with a health professional, recommendations by friends and the sound reputation of the health structure constitute the major criteria for choosing a public health facility. Of all these criteria, acquaintance with a health staff in the structure is the most determining. This person provides protection from the perceived lapses in the health service, to favoured patients.

USER CONDUCT

The negative perception results in the development a particular conduct aimed at avoiding as much as possible "**anonymity**" in order to have a personalized service that guarantees the quality of the care. In fact, this almost always means establishing a greater social relationship with the personnel of the health structure.

In this respect, it is to be expected that the poor encounter more difficulties than the non poor in developing such strategies.

Box N° 13: Type of Strategies put in place by Households

- *Use of self-medication as an initial step*
- *Development of special relationships with the health personnel both within and outside the health structure*
- *Search for an intermediary in the structure*
- *Gifts in kind or in cash to facilitate access to consultation*

CHAPTER 3: HEALTH CARE SERVICES

HEALTH STRUCTURES

In the five capitals, the health structures observed differ in terms of their status (public or non-profit-making private) and their number of staff as well as their rank in the health pyramid (first level or first referral level).

However, some features that are common to all the studies can also characterize the public health system in these cities. These features relate to the reception, organization of work, functions and tasks. All these features help assess the non-clinical quality of public health services.

ALIENATING NATURE OF HEALTH STRUCTURES

Malpractices found in the public administration of African countries are reflected in the public health services. The observation of the latter confirms the opinions expressed by the users in this regard. Inaccessibility, red tape and particularly difficult system of operation that can only be understood by the staff are indeed the dominant characteristics of health services. Faced with this closed or even hostile environment, the user is completely lost.

PRIVATIZATION OF HEALTH SERVICES

At varying degrees according to health structures and capitals, there is a privatization of the health environment by the health personnel. The appropriation of the latter for personal interests may take different forms as shown in Box N° 14.

The consequences for the users range from prolonged period of wait for a medical consultation to the administration of defective medical products (vaccines, blood products, etc.).

Box N° 14: Forms of Privatization of Health Services

- *Receive private visits during working hours, often during consultation*
- *Use of premises and medical equipment for private consultations*
- *Use of the cold chain to preserve food or freeze water for sale*
- *Use of the telephone against payment by persons outside the health structure.*

CONFUSION IN STATUS

In theory, and according to the guidelines of the Ministries of Health, each profession has a set of well-defined functions and duties. The reality is different. In practice, in most public health structures there is confusion in the status of the health personnel that aggravates the disorientation of the users. This confusion is due to upheavals in the top echelons of management.

Box N° 15: Unwarranted Duties in Health Facilities

- *Labourers guide patients and sometimes serve as stretcher-bearers*
- *Ward orderlies administer injections and drips*
- *Nurses undertake diagnoses and issue prescriptions*

Thus, the tasks undertaken do not always correspond to the functions assigned, such as in the job descriptions. In such an environment, acquiring skills for subordinate functions is not necessarily related to one's qualifications but rather the reproduction of technical tasks observed on a daily basis in the health structure.

Such practices are potentially dangerous for the patients. To reproduce technical tasks without mastering the clinical and therapeutic principles underlying them can only adversely affect the quality of care for users.

ORGANIZATIONAL DEFICIT OF RECEPTION-REFERRAL SYSTEM

The lack of organized reception and referral system for patients is a common feature in most public health facilities. Often, it is the security personnel, labourers or ward orderlies, not trained for such tasks, who receive patients. For the illiterate poor, the situation is even more complicated since the posters and signs displayed in the health services are not useful.

Everywhere, the need for efficient management of the recovery of the cost of health services results in procedural bottlenecks. Thus, the time spent by patients from the registration offices through consultation to the pharmacy of the establishment is unduly long.

Since the responsibility for reception-referral of patients is not clearly defined, users often seek "mediators" capable of explaining the administrative procedures, and serving as guides through the various services and consultations. This "mediator" function which serves as an interface between the users and the caregivers is not included in the organization charts of health services. Consequently, it is not surprising to note that people not belonging to the staff of the health facility may play this role, purely for financial reasons and with the connivance of the interns.

Often, the users are compelled to pay these mediators in order to enjoy their services. This results in an "informal invoicing", which is indispensable for gaining access to quality services.

This practice which increases the total cost of health care is particularly harmful to the poor.

Box N° 16: Use of Mediators

- *In exchange for remuneration, the mediators enable the users to bypass the consultation procedures and thus reduce the waiting period and by personalizing the relationships with the caregivers.*
- *Hence, there is discrimination according to the standard of living in the non-clinical quality of care.*

ILLICIT PRACTICES

Granting of favours is a common practice in public health services. This system favours relatives, and friends. For example, such beneficiaries of the favours do not join the queue in the waiting room. The favours may also result in completely free care. The poor, whose social network is weak if not non-existent, do not benefit from such favours.

Many malpractices mainly involving drugs, are engaged in by the caregivers. See Box N° 17.

It is difficult to assess the scale of the phenomenon in view of the silence surrounding them. Be that as it may, such malpractices always result in the over-invoicing of the pharmaceutical products. There again, it is the poor who bear the brunt of this.

Box N° 17: Drugs and Deals

Illicit deals involving drugs take several forms:

- *Reselling of samples provided by pharmaceutical representatives.*
- *Recovery of leftovers of drugs administered to patients.*
- *Private sale of drugs stolen from the pharmacy of the health structure.*

INADEQUATE COMMUNICATION

Public health services are dominated by heavy bureaucracy where pen and paper are the main working tools. The situation is caused by shortages of basic medical instruments (sphygmomanometers, thermometers, stethoscopes, etc.). The various services communicate through written media (Consultation Tickets, purchase order, prescriptions, etc.). The organizational lapses in reception-referral and red tape translate into a deficit of communication that is clearly perceptible at the level of caregiver-patient interaction. This deficit, which results in poor clinical care is also the cause of the negative perception by users, irrespective of their standard of living of public health services.

LACK OF OFFICIAL MECHANISMS FOR FUNDING THE POOR

The health service environment is not favourable for the poor. In most public health services, there are no official mechanisms for funding the poor. Existing mechanisms are informal, without any precise definition of the notion of poverty. Since there are no criteria for granting exemptions, “a poor person” is only identified on a subjective basis by the staff of the health facility (caregivers, social workers and administrative staff).

The decision and type of exemption are considered only when the patient attends the health facility. The health personnel assesses poverty based on criteria such as: clothing, capacity to feed regularly and pay the cost of drugs.

There are hardly any solidarity funds or prepayment mechanisms for the poor.

Box N° 18: Types of Exemption

The various types of exemptions encountered are:

- *complete free care*
- *free consultation but payable drugs*
- *financial coverage of the referral (transport and emergency consultation in hospital).*

In general, the lack of mechanisms for covering health risks is one of the weaknesses of the public health system. There is no safety net for the poor. The most disadvantaged are compelled to pay directly for the cost of the drugs. This situation is particularly worrying in cases where the patient requires an evacuation to a hospital.

CHARACTERISTICS OF MEDICAL PRACTICE

The analysis of the quality of care is based on first level and first referral level of primary health structures except in Abidjan where the first referral level was not explored.

The first level of health facilities selected form a heterogeneous group made up of public and non-profit-making private health services (religious or community).

Table N° 12: Number and Type of Health Facilities

	NUMBER AND TYPE OF HEALTH FACILITIES ACCORDING TO CITIES	
	1 st Level	1 st Referral
ABIDJAN	6	0
BAMAKO	16	2
CONAKRY	8	2
DAKAR	12	6

NB: Data unavailable for Niamey

Table N° 13 shows the major clinical activity areas as well as the size of the samples used in assessing the quality of the clinical and therapeutic procedures.

Table N° 13: Size of Samples for Study on the Clinical Quality of Care, by Capital

	ABIDJAN	BAMAKO	CONAKRY	DAKAR
Curative Primary Consultation	1103	1537	599	2380
Antenatal Consultation	610	1351	281	422
Delivery	301	426	181	417

STRUCTURAL QUALITY

The structural quality of care relates to the architecture, availability of basic equipment (sphygmomanometers, stethoscopes, chairs and benches for waiting rooms) and the general state of cleanness of the health establishment.

The results observed vary significantly from health facility to another. In most capitals, given the lack of an effective reference evaluation (except Bamako), it is not possible to give a precise assessment of the structural quality of the health facilities.

On the other hand, the variability over time of the standard of the basic medical equipment is a common feature to all these health structures. Sphygmomanometers, stethoscopes and otoscopes are hardly available throughout the year.

Box N° 19: Major Observations on Structural Quality

The major lapses observed in the structural quality are:

- *unventilated, poorly lit and unroofed waiting rooms*
- *antenatal consultation rooms do not enable privacy and confidentiality*
- *lack of boxes in delivery rooms*
- *lack of separate male/female toilets.*

Most of the users interviewed found the standard of cleanness of the health facilities satisfactory. However, some observers noted that the management of biomedical wastes (used syringes, placenta) is inadequate. It needs to be noted that users base their assessment of the level of cleanness on their own standards.

CLINICAL AND THERAPEUTIC PROCESS

On the whole, and at varying degrees, the quality of the clinical and therapeutic process was not satisfactory. Interviews are often expeditious. A number of essential technical procedures (taking of temperature and blood pressure) needed for the diagnosis are not followed. These lapses are found in all the services (primary curative, antenatal and deliveries).

The mean duration of primary curative or referral consultation does not exceed eight (8) minutes. This consultation period which comprises: interview, clinical examination, additional examinations and writing of a prescription is often too short to ensure good quality of care.

Table N° 14: Median Duration of Medical and Antenatal Consultations

	Mean Duration of Consultations	
	ANC	PCC
ABIDJAN	11 min	8 min
BAMAKO	NA	NA
CONAKRY	13.7 min	6.5 min
DAKAR	9.8 min	5 min

The problem is more a lack of motivation of the health professionals than competence. Indeed, depending on capitals, 20% to 47% of patients in curative primary consultation are not examined. The expeditious interview and lack of clinical examination account for the short periods of consultations.

Table N° 15: Proportion of Patients Unexamined during Primary Curative Consultation

	Proportion of Patients Unexamined
	Primary Curative Consultation
ABIDJAN	47%
BAMAKO	20%
CONAKRY	38%
DAKAR	35%

PATIENT/CAREGIVER INTERACTION

Overall, respect for the confidentiality and privacy of patients are inadequate. The situation is particularly unpleasant for women during antenatal consultation and delivery. On average, 1 out of 3 persons entering and leaving antenatal and curative consulting rooms have no reason to be there.

Patient/caregiver interaction is characterized by poor communication. This is observable throughout the medical consultation. Right from the interview, inadequacies appear. On average, in one out of two cases, the practitioners do not take into account the socioeconomic conditions of the users.

Curative consultation is generally followed by the issuance of prescriptions at least in 75% of cases. But often there is no explanation given to patients about the application of the drugs. This is also true of complementary examinations. It would therefore appear that the autonomy of the patients is not taken into account by the health professionals. The situation is similar for care follow-up. Indeed, in many cases, schedules are not provided and appointments go unexplained.

All these factors point to the lack of motivation by the health personnel.

MOTIVATION OF HEALTH PERSONNEL

It is surprising to observe that nearly 2/3 of the health personnel interviewed in Abidjan consider that the health care provided in their health structures is of good quality. In the majority of cases, the few problems of quality that they identified related to the degradation of premises and inadequate technical equipment. They seem to be completely unaware of the chronic lapses in clinical and therapeutic procedures. The impression given is that the health personnel has perfectly adjusted to the current practices in their establishment.

The conduct of the health personnel can only be understood in a wider social context that transcends the environment of a health service.

In the five capitals, the salaries of the health personnel were not adequate enough to cater for an adequate family life. In many cases, adhering to a scrupulously honest practice would imply taking a serious social risk. The practice of over-invoicing therefore offers a means of supplementing the basic salary.

Also often, the expectations of the health personnel are not met: no career profile; precariousness of employment; lack of coverage against occupational hazards; feeling of under-utilization of doctors related to the discrepancy between the training received and the Minimum Package of Activities of primary level health facilities.

In the five countries, the governments have adopted health personnel redeployment policies. The objective is to fill the gap between rural and urban areas. Practitioners and midwives who manage to stay in the urban public sector often have strong connections that provide a degree of impunity.

CHAPTER 4: DISCUSSION

IDENTIFICATION OF THE POOR

In its recent publications (Dial 2000, World Development Indicators Database), the World Bank has raised the monetary poverty line defined in 1990. Thus, the extreme poverty line rose from US \$0.74 /day to US \$1/day and that of poverty from US \$1/day to US \$1 to \$2 per day. The poverty lines used in the regional study to classify people as extremely poor and poor were those of 1990.

The World Bank went as far as applying these new poverty lines to all the poverty profile studies it had conducted in Africa since 1992.

At the time of the regional analysis of the socioeconomic component, the recent World Bank publications were not available to the researchers. Consequently, an adjustment has to be made in order to compare the findings of this study with those of the literature reviewed.

Table N° 16: Corrected Estimates of Extreme Poverty based on Updated Poverty Lines of the World Bank

STANDARD OF LIVING	ABIDJAN		BAMA KO		CONAKRY		DAKAR		NIAMEY	
	Number	%	Number	%	Number	%	Number	%	Number	%
Extremely Poor (data of study)	1143	9.8	2079	15.4	1264	21.1	2186	3.2	424	5.4
Extremely Poor (corrected data)	3566	30.6	3152	23.4	2684	44.7	4609	27.8	1060	13.4

Using the current poverty lines defined by the World Bank, a large proportion of the poor studied will be reclassified among the extremely poor. With such an adjustment, the findings observed are close to those of other studies (World Bank 2001). For example, the percentage of extremely poor persons following the adjustment will be 23.4% for Bamako, which is close to the 22% found in other studies (Dial 2000).

Moreover, an unestimated proportion of the category of non poor selected for the regional analysis of the socioeconomic component is in fact poor. This observation can partly explain the use of market drugs by the various social categories studied.

DIMENSIONS OF POVERTY

In targeting the most disadvantaged in the action-research phase of the Urban Health Project, particularly attention was paid to the monetary dimension of poverty by calculating household expenditures. This approach is limited since it does not take into account other dimensions of poverty such as: the living conditions of households (accommodation, equipment, access to potable water), the lack of education and nutritional inadequacies, which are the key determinants of the health status of communities.

EQUITY AND HEALTH SYSTEM

EQUITY IN ACCESS TO CARE

The findings of the Urban Health Project surveys show that in general people resort to modern health services only when their disease appears to be serious. This observation would suggest the inelasticity of the demand for health care in relation to price.

However, a closer analysis of the findings shows that the use of health structures by the poor is delayed as much as possible, in view of the financial constraints. There is a problem of financial access to health services which translates into the preference for less costly health facilities and the splitting up of prescriptions and/or deferred purchase. Another solution for them would be to downplay the seriousness of the illness and resort to market drugs.

The need for the most disadvantaged to resort to borrowing to overcome the cost of health care confirms their lack of financial access to modern health services. This is not surprising since the average cost of the treatment of an illness represents at least 2/3 of the monthly expenditures.

In this regard, the surveys show that direct payment for health services has a dissuasive effect on the poor in case of illness.

With less than 10% of the population enjoying health coverage and the lack of official criteria for defining the poor, the inequities of the public urban health system in the five capitals is obvious. The distribution of the financial burden to the health system among the populations is not equitable. The most disadvantaged must pay as much as the rich for the same health services.

There is considerable controversy among researchers about the relationship between cost recovery and equity. For the World Bank, direct payment by health users' results in a more effective use of the services, while at the same time increasing public resources for such services. However, several studies show that compared to the well-to-do, the poor are more sensitive to variations in health care cost (Leighton 1995, Shaw et al. 1995, Willis 1993).

According to some authors, the introduction of cost recovery without an improvement in the quality of care and effective protection mechanisms, appears to have a negative impact on the poor (Leighton 1995). Results of the Urban Health Project in the five capitals confirm this observation.

EQUITY IN CARE DELIVERY

The findings of the surveys conducted indicates that financial aspects are not the only factors of inequity facing the poor. Other factors such as inadequate non-clinical quality of care (reception, referral, waiting period for consultation) are to be taken into account.

Monetary poverty is often accompanied by a kind of "social marginalization" which is reflected in the poor patient/caregiver interaction. Strategies that users must develop to overcome the inaccessibility and administrative bottlenecks of the health system are a testimony to this. Avoiding anonymity and benefiting from quality care involves costs that are beyond the financial means of the poor. At this level, there is flagrant discrimination related to social class.

MARKET DRUGS

Nearly one out of two extremely poor persons practising self-medication purchase drugs from the market. This ratio is slightly lower among the non poor (about 2/5), reflecting preference for market drugs, irrespective of the users.

This preference is the best indicator of the inadequacies of the urban health system in the five capitals. Indeed, the major reasons given for the practice (cultural accessibility, low cost, purchase on unit basis and on credit, no waiting period, no discrimination according to standard of living), are assets that should exist in the public urban health system. Unfortunately, such is not the case. The fact that a significant proportion of the non poor indulge in this practice translates the negative perception that the population on the whole has of public health structures.

In the studies conducted in Mali (Jaffré Y. -1999) and in Côte d'Ivoire (Assi G. -1992) stress the importance of the informal sale of manufactured drugs in these capitals. This is a fast-growing and structured market that has put in place an effective distribution network, as a result of the laxity of the authorities. In Bamako, financial flows generated by this market are estimated at over CFA F 2 billion.

Box N° 20: Sources of Supply by Market Drugs in Abidjan (1992)

There are three sources of supply:

- *48% come from wholesale dealers in Abidjan*
- *31% from pharmacies*
- *22% from unknown or occasional suppliers.*

Although 7 out of 10 patients are satisfied with the market drugs, this form of self-medication is potentially dangerous in view of the total lack of control of the quality of the pharmaceutical products sold. The best means of effectively combating this flourishing market is not only to improve the quality of the prescriptions but also to reduce the cost of drugs.

CHAPTER 5: STRATEGIES RECOMMENDED

The synthesis of the three research components and the review of the literature on experiences initiated in the region on urban health helped to target the priority intervention areas.

If the objective of governments in the area of urban health is to enhance equity and access to quality care by the entire population, notably the poorest, then all the strategies outlined in the framework below need to be implemented. It will be for each country to decide where to begin and what approach to use (project followed by a programme, or mixed).

Regional Strategic Framework

1 – Advocacy with governments for:

- increased involvement of local authorities in the financing of the health of the most disadvantaged
- putting in place of mechanisms for reducing the cost of drugs
- putting in place of subvention and prepayment mechanisms

2 - Institutional and regulatory strengthening through:

- a revision of the functions of the Regional and District Directorates of Health
- adoption of regulatory instruments on the substitution and unpackaging of drugs
- regulation of the private sector
- formalization of referral system in urban areas
- revitalization of primary level health facilities (more motivating work environment for health personnel)

3 – Building capacities through:

- revision of clinical standards and practical guides
- self-evaluation and problem-solving approach
- on-the-job training of health personnel
- monitoring of clinical and therapeutic process in health facilities
- facilitating supervision

4 – Strengthening of partnership (State, municipalities and health centres) for:

- financing of post-payment mechanisms

5 - Communication and mobilization through:

- vast awareness campaigns for promoting generic drugs
- involvement of communities in the self-evaluation and problem-solving approach processes

6 - Strengthening of decision-making powers of communities through:

- creation of a fund for promoting local initiatives

Each country will also have to define its own objectives in relation to the strategies adopted. For example, the following objectives are presented:

SPECIFIC OBJECTIVE A : Improve the quality of health care in health facilities

- Strengthen the urban health system
- Improve the quality of care provided -

SPECIFIC OBJECTIVE B : Improve financial access to health care by the poor

- Improve equity in health care in urban areas

The framework proposed hinges on 6 major strategic thrusts, using a project-and-programme mixed approach, comprising interventions at the central, intermediate and peripheral levels. Indeed, in order to ensure effectiveness and sustainability, the improvement of equity and access to quality health care can only form part of the reform of the urban health systems of the five countries.

STRATEGY 1: ADVOCACY WITH DECISION-MAKERS

The advocacy aims at increasing the national commitment to the issue of urban health. Governments must draw up a policy and strategic plan for urban health backed by operational plans.

The awareness of an urban health crisis must translate into a clarification of the role of the various stakeholders (local authorities, State deconcentrated services, etc.). the advocacy activities must highlight the role and increased involvement of city councils in the definition and financing of the municipal health policy. It is also important that efforts are made to find ways for reducing the cost of health care for the most disadvantaged.

Eligibility criteria for partial or total exemption will be defined in consultation with the local authorities and neighbourhood associations.

In order to reduce inequity in access to health care induced by direct payment, the governments will have to address the issue of providing alternative mechanisms for the payment of health care. Pilot projects conducted in the region – Guinea, Niger, Rwanda – show that such mechanisms are feasible, given the adequate political will.

In addition to advocacy for the adoption of alternative payments and exempt mechanisms for the poor, decision-makers will be sensitized about the importance of subsidizing some activities of the MPA of the primary level health facilities. It would be left to each country to select activities that provide the best cost-effectiveness ratio in a public health system. Immunization of children, antenatal consultation and delivery are good examples of activities to be subsidized.

Subvention may take different forms ranging from reduced rate for medical consultation and production of low-cost medical kits for the management of some diseases (STIs) or some events such simple childbirth.

Box N° 21: Regionalization Policy in Senegal

With the law on decentralization of 1996, the role of local authorities in the health sector has been strengthened. Thus urban communes are responsible for:

- *the management, maintenance and equipment of primary urban health facilities (1st level and 1st referral level)*
- *the supervision of health structures constructed by the city.*

Box N° 22: Prepayment Experiences in Niger and in Guinea

In 1992, various payment modalities for care were tested in three rural health districts (free and prepayment). The results show a significant increase (> 40%) in the use of health services in the district that opted for a prepayment mechanism, with a slight co-payment at the time of consultation

In 1997, in the city of Dabola in Guinea, a prepayment testing for pregnancy-related risk was conducted. In a period of 1 year, nearly 100 pregnant women joined the scheme.

Box N° 23: Delivery Kits in Abidjan

For some years now, the Public Health Pharmacy has been producing Kits for simple deliveries, that are distributed in the entire public health facilities.

This kit, which cost CFA F 1 500 comprises:

- *pairs of sterile gloves,*
- *injectable uterotonic*
- *sterile compresses.*

This is a form of government subvention.

STRATEGY 2: INSTITUTIONAL AND REGULATORY STRENGTHENING

The governments could create an Urban Health Directorate whose primary mission would be to monitor and supervise the re-organization of the urban health system on the whole. If this cannot be done, then it would be necessary to strengthen the Regional Health Directorate and its communal or district outstations already existing in most of the capitals.

Regulatory instruments governing this Directorate will be revised and/or strengthened, in order to clarify its roles, functions and powers under the urban health policy. Hierarchical relationships with the supervising services, teaching hospitals and the private sector will be redefined. Moreover, requirements in human and financial resources, logistical equipment and training will be evaluated, introduced into the budget and then submitted for approval for financing (government and donors).

The implementation of the urban health policy will require wide-ranging reforms of the mode of operation of the system on the whole. In order to improve equity and access to quality health care, it will be necessary to revise the existing regulation. This revision will concern several sectors (private/public and pharmacies).

Concerning the private sector, the central services of the Ministry of Health, in collaboration with the medical association will revise the criteria for the establishment and authorization for practising private medicine with a view to curbing clandestine and unwarranted practices.

At the level of private pharmaceutical sector, principles of substitution and unpackaging of pharmaceutical products will be adopted and/or strengthened through regulations with a view to promoting the sale of generic drugs in private pharmacies and providing the exact quantity of products required for the treatment of an illness.

These measures, which will help reduce the cost of drugs for patients, are also designed to limit the attraction of market drugs.

The sensitization of the population and the full collaboration of private pharmacists are necessary for the effectiveness of such measures.

The institution of the referral and counter-referral system is at the centre of the reorganization of the urban health system. This is a major challenge that governments will have to meet.

Box N° 24: Urban Health Support Project (UHSP) in Conakry

Since 1998 and under the UHSP, financed by the European Union, the Directorate of the City of Conakry and its 5 Communal Directorates were created by an official decision and provided the necessary resources for their operation.

The Directorate of the City of Conakry aims at formulating and monitoring the execution and evaluating the health development plan of the City of Conakry.

Box N° 25: Critical Stages in the Re-organization of the Urban Health System

- *Identify all the health facilities of the capital (private, public and religious)*
- *Draw up a health map of the capital*
- *Review the procedures for approval of private medical practice*
- *Adopt through regulations the principle of substitution and unpackaging of pharmaceutical products*
- *Review of the public health functions of local authorities*
- *Formalization of referral system in urban areas.*

Box N° 26: Substitution and Unpackaging of Drugs in Côte d'Ivoire

Following the devaluation of the CFA Franc in 1994, the Ivorian Government adopted the principle of substitution and unpackaging of drugs. Private pharmacies have the right to substitute generic drugs for prescribed patented drugs.

Moreover, pharmacists are authorized to practise unpackaging of pharmaceutical products in order to sell the unit products (injectable) or by bubble package (tablets).

The inadequate information by the population and the unwillingness of pharmacists to apply these measures did not enable these measures to be fully effective.

Box N° 27: Major Steps to be followed for the Establishment of Referral System

- *Division of capitals into health communes or health districts*

The involvement of local authorities, health personnel and development partners will be indispensable for the mobilization of the resources needed and to arrive at a consensual and operational referral system. This will mean a step-by-step approach focusing on disadvantaged neighbourhoods first.

Mechanisms for the financial management of emergencies (prepayment, joint-payment, flat hospital fees) will be determined to improve the financial access by the population to such services.

- *Definition of areas of responsibilities based on the urban health map*
- *Revitalization of public and non-profit-making private primary health facilities*
- *Provision of a referral health centre to each health district or health commune*
- *Strengthening of the technical facilities of the 1st level referral facility*
- *Development of specific referral and counter-referral form for each health district.*

STRATEGY 3: CAPACITY BUILDING

The building of the capacities of health personnel is a prerequisite for any continuous improvement of the quality of health care services. The success of such a process mainly depends on the motivation of the personnel and their effective involvement.

Central and deconcentrated services of the Ministry of Health, in collaboration with the Faculty of Medicine and UN agencies (WHO, UNICEF and UNFPA) will undertake a review of the standards and clinical practical guides. The management of malaria, STIs, obstetrical emergencies and childhood illnesses will be targeted as a priority. WHO documents (Mother-child, IMCI) could serve as reference documents. Furthermore, protocols on the hygiene of health facilities and the safety of technical procedures will be drawn up. These guides and protocols will be distributed to all the primary level health facilities.

Box N° 28: Building Capacities for Improving Quality of Care

The building of capacities will be based on:

- *review of clinical norms and practical guides*
- *formulation of guidelines on the hygiene of health facilities and safe technical procedures*
- *self-evaluation and problem-solving approach*
- *on-site training of health personnel*
- *monitoring of clinical practices in health facilities*
- *facilitating supervision.*

In order to initiate change in clinical and therapeutic practices, the regional and district levels will need to test participatory approaches. The latter will foster the awareness and effective involvement of health personnel in correcting lapses in the quality of care.

The participatory approaches tested by ASCV (COPE, on-the-job training and supervision) in Senegal and Tanzania, can serve as a point of departure for the improvement of the quality of care.

Box N° 29: The COPE Approach

The COPE approach developed by AVSC for family planning services is a process for the continuous improvement of quality using 3 methods:

- *Self-evaluation by the health personnel themselves*
- *Training of health personnel at their workplace*
- *Facilitating type of supervision highlighting the clinical and therapeutic procedures.*

Tested in several African countries including Senegal, the results are encouraging. E.g.: the period of waiting for consultation was reduced by half.

It is important for each urban health district to embark on a self-evaluation and problem-solving process in order to initiate the change in clinical practices.

The identification of problems and corrective strategies can be carried out through “establishment projects” or action plans for the quality of care services. The establishment project should be part of the Health Development Plan of the district in order to avoid the verticalization of activities to be carried out.

The aims of the Directorate responsible for urban health and of the district teams will be to provide training in the use of the revised guides and protocols, indispensable for the upgrading of the health personnel. For reasons of cost-effectiveness, on-the-job training will be preferred.

It is also important that the Ministry of Health, Directorate of Urban Health, in collaboration with health personnel, put in place a system for monitoring clinical practices.

To this end, evaluation methods and tools of the clinical and therapeutic process will be defined and tested in health facilities before being adopted on a large scale.

New supervision strategies focused on the care process will be indispensable for a continuous improvement of the quality of care.

STRATEGY 4: STRENGTHENING OF PARTNERSHIP

Local authorities will have an increasingly important role to play in the implementation of urban health policy, particularly in reducing financial barriers to access to quality care. New partnerships between government, local authorities, NGOs and neighbourhood associations are indispensable to clarify the notion of poverty and put in place mechanisms for providing health care cost exemptions for the poor. The creation of solidarity funds backed by a post-payment system is worth exploring.

Box N° 30: Self-evaluation in Guédiawaye Health District of Dakar

Since 1997, the 1st referral health centre, Roi Baudouin, has been engaged in a continuous process of improving the quality of Emergency Obstetrical Care.

The process which combines self-evaluation and problem-solving is based on

- *Tracking of process indicators through computerized records*
- *review of maternal and neonatal deaths in order to define corrective strategies.*

From 1997 to 2000, the rate of fatality by infection was reduced by half (from 50.0% to 25.0%).

The results are encouraging. However, another hurdle must be crossed thanks to the formalization and application of the clinical and therapeutic procedure.

Box N° 31: Monitoring of Clinical and Therapeutic Procedure

The indicators used under the conventional monitoring of health facilities essentially focus on resources and results (effects).

In a quality of care improvement process, monitoring should rather highlight the observation of the clinical and therapeutic procedure.

Possible methods for collecting this type of information are:

- *Direct observation of clinical practices*
- *interview of patients on leaving the services*
- *examination of medical records*

Box N° 32: Solidarity Fund for the Poor

Governments could pass on to the communes part of the municipal's taxes to create solidarity funds for the poor. These funds to be jointly managed by the communes, health districts and neighbourhood associations could be used to cover the cost of health care of the poor through a post-payment mechanism.

Health facilities will be reimbursed only after the verification of the poverty status by investigations at home. Such a system presupposes that specific definition of poverty criteria.

STRATEGY 5 : COMMUNICATION AND SOCIAL MOBILIZATION

Efforts made by governments to promote generic drugs must be strengthened through vast awareness campaigns. Such campaigns must target both the communities and the health personnel. If the principles of substitution and unpackaging of patented drugs are adopted, it will be the responsibility of the Ministries of Health to inform the public through the media.

The public must be informed that health personnel are duty-bound to ensure equity in the delivery of health care in the public sector. To this end, the communities will be involved in the self-evaluation and problem-solving process of the health facilities.

The creation of a fund to promote local initiatives in the urban health area is indispensable. The donors could provide technical and financial support for the creation of such funds.

STRATEGY 6: STRENGTHENING OF THE DECISION-MAKING POWERS OF COMMUNITIES

The strengthening of the empowerment of patients represents a means for combating illicit practices in public health facilities. The fund for the promotion of local initiatives will foster the emergence of a network of diverse associations whose aim will be to:

- identify poor people in neighbourhoods,
- provide information to the poor on the operation of the urban health system,
- support poor patients in health facilities in order that their medical treatment would be as equitable as possible.

Box N° 33: Support Fund for the Promotion of Health in Conakry

Under the urban health support project, support fund for local initiatives on health was set up. The purpose of this fund was to provide resources for the implementation of activities to improve the health of the dwellers of Conakry.

In its two years of existence, the fund has been used to finance ten projects, implemented with the technical partnership of local NGOs (sensitization for the prevention of early pregnancies, prevention of cholera, etc.).

The fund promotes fruitful complementarity between public service and private initiatives of local associations.

ANNEXES

Strategic Matrix or Strategic Plan of Action

Strategy Sub/Strategy	RESPONSIBLE BODIES								INDICATORS	IMPLEMENTATION SCHEDULE		
	PRINCIPAL				ASSOCIATED					2002	2003	2004
GOAL: ENSURE BETTER QUALITY and EQUITY OF SERVICES IN URBAN HEALTH FACILITIES												
SPECIFIC OBJECTIVE A: Improve the quality of care in urban health facilities												
STRATEGIC THRUST 1: Strengthen urban health system												
Strategy N° 1.1: Revision of functions of Regional Directorates												
Strategy N° 1.2: Institution of referral service in urban areas												
Strategy N° 1.3: Regulation of private sector												
Strategy N° 1.4: Promotion of self-regulation												
STRATEGIC THRUST 2: Improve the quality of care provided												
Strategy N° 2.1: Revision of clinical standards and practice guides												
Strategy N° 2.2: Ensure a motivating work environment												
Strategy N° 2.3: Self-evaluation and problem-solving approach												
Strategy N° 2.4: On-the-job training of health personnel												
Strategy N° 2.5: Monitoring of clinical practices												
Strategy N° 2.6: Integration of monitoring of clinical practices in SNIS												
Strategy N° 2.7: Putting in place of a facilitating type of supervision												

Strategy Sub/Strategy	RESPONSIBLE BODIES								INDICATORS	IMPLEMENTATION SCHEDULE		
	PRINCIPAL				ASSOCIATED					2002	2003	2004
GOAL: ENSURE BETTER QUALITY and EQUITY OF SERVICES IN URBAN HEALTH FACILITIES												
SPECIFIC OBJECTIVE B: Improve financial access to care by the poor in urban areas												
STRATEGIC THRUST 3: Improve equity of care in urban areas												
Strategy N° 3.1: Putting in place of mechanisms for reducing cost of drugs												
Strategy N° 3.2: Increased involvement of local authorities in the medical management of the poor												
Strategy N° 3.3: Regulation of private sector												
Strategy N° 3.4: Putting in place of subvention and prepayment mechanisms												