



Thematic Review

Understanding the Health Financing Landscape and Documenting of the Types of User Fees (Formal and Informal) Affecting Access to HIV, TB, and Malaria Services in West and Central Africa

April 30, 2020

Submitted to:
The Global Fund

Submitted by:
ICF

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Acknowledgements

This study was conducted by a team from ICF and University College London. The study team wishes to thank the Health Financing Team at the Global Fund for their leadership and guidance in implementing the study, as well as country teams for their support and inputs. This work would not have been possible without support from Country Coordinating Mechanisms in each of the 23 WCA countries, and we acknowledge and thank them sincerely for their contributions.

Acronyms

ANC	antenatal care
ARI	acute respiratory infection
CAR	Central African Republic
CCM	country coordinating mechanism
DHS	Demographic and Health Survey
DRC	Democratic Republic of Congo
IPTp	intermittent preventive treatment in pregnancy
MOH	Ministry of Health
NGO	nongovernmental organization
NHI	national health insurance
OI	opportunistic infection
NSP	National Strategic Plan
OOP	out-of-pocket
PBF	performance-based financing
PEPFAR	President's Emergency Plan for AIDS Relief
PMI	President's Malaria Initiative
SP	sulfadoxine/pyrimethamine
TB	tuberculosis
UHC	universal health coverage
WCA	West and Central Africa
WHO	World Health Organization

Executive Summary

Context

To achieve the Global Fund's ambitious objective of ending the HIV, tuberculosis (TB), and malaria epidemics, people, especially key and vulnerable populations, need increased access to quality health services. Over the past two decades, the global community has increasingly acknowledged that user fees for health care services are a barrier to accessing health services, especially in West and Central Africa (WCA), where user fees are a predominant feature of health systems as a result of the Bamako Initiative. In an effort to better understand how user fees impact access and utilization of health services in WCA, the Global Fund commissioned a regional study to investigate how health financing structures and user fees in particular are affecting access to and utilization of HIV, TB and malaria services, and the implications for health systems of removing or revising these types of fees in 23 countries in WCA.ⁱ

The Global Fund contracted with ICF in 2019 to carry out the study, which uses a mixed-methods approach to answer 12 research questions. The study methods consisted of desk review and a web-based questionnaire in all 23 countries as well as secondary data analysis of household surveys and primary qualitative data collection in 9 priority countries (Benin, Cameroon, Chad, Cote d'Ivoire, Gambia, Guinea, Mali, Sierra Leone, and Togo). Primary data collection consisted of key informant interviews at national and sub-national levels, and focus groups with community members and exit interviews with patients in approximately three health facilities in each country. Data were collected between October 2019 and February 2020.

Findings

Sources of Health Financing

In most WCA countries, health financing landscapes are characterized by low government expenditures high out-of-pocket (OOP) expenditures by households, and high external donor support. In 2017, the percentage of total health expenditures that came from OOP payments ranged from 14% in Sao Tome and Principe to 77% in Nigeria, with an average of 45% across the 23 WCA countries included in this study. These OOP expenditures consist of direct payments for medical services and typically include payments for formal user fees paid to health facilities in line with the user fee policy of the country, informal user fees that are conditioned payments or gifts that are not in line with the formal user fee policy, and direct purchases of drugs or medical supplies. In addition to these direct OOP expenditures, households often incur indirect costs, including transportation and opportunity costs associated with seeking health care services.

The Global Fund, other donors (notably PEPFAR and PMI), and domestic spending are all significant contributors to the HIV, TB, and malaria responses. Government contributions as a source of financing for these three diseases are beginning to increase, possibly as a result of Global Fund co-financing requirements. While households also incur significant costs related to these three diseases, data does

ⁱ Benin, Burkina Faso, Cameroon, Cape Verde, Central African Republic, Chad, Congo, Democratic Republic of Congo, Core d'Ivoire, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Sao Tome and Principe, Senegal, Sierra Leone, and Togo.

not allow for a more complete assessment of OOP expenditures by households within the three disease areas because most national strategic plans do not account for these costs.

Funding Gaps

Funding gaps exist for the HIV, TB, and malaria responses in almost every WCA country. On average, the gap as a percent of total need over the 2018-2020 period across the 23 countries was 45% for HIV, 28% for malaria, and 24% for TB. Across countries and disease areas, however, there are varying degrees of allocative inefficiency, with some countries and some disease areas facing much larger total gaps than others. Sierra Leone, Congo, Central African Republic and Niger had the largest overall funding gap. It should be noted that the cost of countries national strategic plans also varies widely even when accounting for the relative size of affected populations, and this affects the widening or closing of funding gaps.

Health Financing Structure

In general in WCA, health financing structures are characterized by a lack of pooling mechanisms and input-based purchasing systems, with HIV, TB, and (to a lesser extent) malaria programs operating as vertical national programs that are weakly integrated with the rest of the health system. As a legacy of the Bamako Initiative, primary care facilities in WCA usually operate purely or primarily on a cost-recovery basis. Governments purchase a proportion of each service by providing inputs (often with donor funding), including some health worker salaries, commodities, equipment, and capital investments, and patients purchase the remainder of the service through user fees. Facilities use revenue from user fees to supplement commodities, hire additional health or administrative personnel, pay for facility maintenance expenses, and cover other operating costs. Even in countries where primary care facilities do receive a cash subsidy from government, these are typically small. The vast majority of resources stay at central level and tertiary hospitals, and only a small amount trickling down to primary care facilities.

Because health facility managers do not know the value of the inputs that are provided, facilities included in the study were not able to easily report the portion of their budget that comes from formal user fees. National-level respondents were not aware of the amount that facilities collect in user fee revenue because tracking and accounting practices are weak at best in most countries, so they also were not able to report this proportion. But almost all stakeholders indicated that user fees currently make up a significantly large proportion. This implies that eliminating or reducing user fees would have a detrimental effect on day-to-day operations at facility level.

Performance-based financing (PBF) has been implemented in many countries in WCA as an alternative funding mechanism for facilities that is thought to motivate health workers to provide higher quality care, reduce OOP spending by households, increase service utilization, and better fund facilities at the bottom of the health pyramid, thereby increasing efficiencies in the health system overall.

Social Protection Mechanisms

User fee exemptions are a common type of social protection mechanism for health that are implemented to different degrees in all 23 countries in this study. They provide some amount of financial risk protection for populations that are more vulnerable to negative health outcomes and catastrophic health expenditures, such as pregnant women, children under five, TB patients and PLHIV. Few countries provide funding to health facilities to cover the provision of free care to indigent populations and there are significant challenges with these programs, both in identifying who should be eligible (largely this is left to the discretion of health facility staff despite Bamako Initiative provisions to have

communities perform this role), and in allocating and transferring the funds, which are inadequate and often received late.

Countries are at varying stages of developing and rolling out social insurance mechanisms, usually in the form of national health insurances. and many are still only in the planning stages. Contributions to these schemes are based on each individual's ability to pay and are seen as a way to obtain universal health coverage while increasing efficiencies and risk-sharing. Major challenges are faced in the operationalization of these programs in WCA, however. Most of the population is employed in the informal sector so it can be difficult to determine who should have to pay insurance premiums and how much they should pay. Vast majorities of the population are unable to contribute anything more than a symbolic amount, which necessitates significant contributions from other sources or a reduction in the package of essential services that the plan covers.

Private health insurance and community-based insurance mechanisms (*mutuelles*) are another form of social protection mechanism that exist in WCA but cover a very small percentage of the population.

User Fees Policies and User Fees Assessed

Formal user fees are assessed in all 23 countries included in this study – the default is that fees are charged unless the person or the disease-specific service is covered by an exemption policy. Typically, exemption policies in WCA eliminate payments required for priority populations (commonly pregnant women, children, and the elderly), or priority diseases (commonly HIV, TB, malaria, and other infectious or neglected tropical diseases). Typically, a flat registration or consultation fee is charged to see a provider, and other fees are added for each itemized service that a patient receives, such as medicines, lab tests, and hospital admission.

For HIV, TB, and malaria, the most common formal user fees that are assessed are:

For HIV: consultations for diagnosis in outpatient departments (more common) and ANC departments (less common), treatment of some opportunistic infections (OIs) and co-morbidities, auxiliary lab services, and hospitalization. HIV test kits, ARVs, CD4, and viral load testing are exempt in all nine countries visited.

For TB: consultations for diagnosis in outpatient departments, X-rays, and hospitalization are commonly assessed. Sputum microscopy, medicines, and preventive therapy for eligible patients were exempt in all nine countries. Only Benin and Cameroon have not removed consultation fees for TB patients to monitor treatment.

For malaria: consultations for diagnosis, RDTs, confirmatory testing, subsidized ACT formulations, auxiliary medicines, and hospitalization are much more fragmented than they are for HIV and TB, with certain services not covered at all and the ones that are covered often only for some sub-populations, so it is necessary to look at these by specific country. Fees for IPTp commodities have been removed in all nine countries, but this service is subject to ANC consultation fees in five of the nine countries.

The exemption policies through which user fees are defined are often unclear and are not operationalized to specifically address each possible service. Stakeholders in the nine priority countries were often not aware of which policies outlined exemption policies or did not know how to access them, leading to generalizations such as “HIV treatment is free,” when in fact not all treatment services

for HIV are exempt from formal user fees. Policies are also not updated frequently enough to keep up with changes in treatment guidelines or advances in technology.

Partially as a result of unclear policies, informal fees are also prevalent in WCA. These are typically the result of improper implementation of formal policy by health workers (e.g. adopting coping mechanisms of not adhering to policies to deal with a lack of funding), inadequate provision of commodities by government, supply-chain deficiencies, or incomplete exemptions (e.g. over-prescribing of non-exempt medicines or lab tests) rather than conditioned payments (bribes demanded by health workers) or gifts. The specific legal and policy framework for addressing informal user fees was also not well-understood by stakeholders, except in a few countries like Sierra Leone.

Implementation of User Fee Exemptions

In most instances, facilities have been compensated to provide services that are exempt from user fees by being given commodities free of charge. The problem with this approach is that the commodities provided only account for part of the cost of providing the service to patient. Facilities also have other costs that were covered by the user fee that was charged for that commodity, such as paying staff who are not supported by MOH, purchasing medical and non-medical supplies, transporting specimens, and maintaining the facility. The provision of free commodities helps but is not sufficient to defray costs to the facility of providing care.

PBF and user fee exemption policies can be employed simultaneously to counteract the financial losses that facilities experience when user fees for certain services are eliminated. PBF can also help address the issue of health worker motivation associated with an increased workload that user fee exemptions commonly bring with them. However, significant challenges have been experienced in the implementation and scale-up of PBF programs that limit the effectiveness of this approach. Some countries have chosen to implement fee-for-service reimbursement mechanisms in which facilities invoice a national government agency that reimburses the fee that was previously charged. The administrative burden of such systems is a challenge and delays in reimbursements can result in health workers reverting back to charging fees. Additionally, this approach is limited in that reimbursing the exact amount that was previously charged may not address the underlying issue of inadequate funding of primary care facilities. Other mechanisms for funding the provision of free services were noted in Sierra Leone with a blanket increase of health worker salaries, and in Cameroon with the implementation of a voucher system for ANC services that also used a reimbursement mechanism for each patient. Other possibilities also exist – in Benin as part of a quasi-experimental evaluation of PBF, a subset of facilities was given an increased cash subsidy with no performance criteria attached, and performed similar in many ways to PBF facilities. Literature has also suggested that a need-based allocation model, based on specific health statuses of populations in each region or catchment area, might be more effective at achieving equity, and have less administrative costs, than the other models described here.

In most countries, there has been inadequate attention paid to generating demand for exempt services through advertising or communication efforts to affected populations, possibly because policies are complicated. This also results in weak community enforcement of user fee policies and makes it easy for facilities to charge informal fees.

Service Utilization

Results of this study support the finding that has been described elsewhere that user fees are a barrier to health care access and utilization. Richer people in our analyses were more likely to use health care

services in general when they were sick, and used a larger proportion of HIV and malaria services specifically (data on TB services were not available). Services that are exempt from user fees exhibit less inequality in utilization by the rich as compared to the poor, but this is inconsistent across countries and services, suggesting that user fee exemption is a necessary but not sufficient method for increasing utilization by the most vulnerable groups. Richer people are also less likely to incur catastrophic costs when they do use health services. Aside from wealth status, distance to health facilities, level of education, and quality of care also impact service utilization. The degrees to which each of these factors predicts service utilization varies significantly by country.

Removal of User Fees

There is ample evidence indicating that user fee removal, *when planned and implemented correctly*, increases utilization of health services, at least in the short term. However, eliminating user fees through piecemeal disease- and population-specific exemption policies is inferior to more holistic social protection mechanisms that target scarce resources at the poor, who need them most, and mobilize resources from richer people who are more able to contribute.

Recommendations

In the short and medium-term, we recommend that the Global Fund continue to support the reduction of user fees for HIV, TB and malaria services to help increase access to these services. However, we recommend that they only do so when resources can be mobilized to adequately fund facilities and health workers to provide free services. Without adequate funding, formal fees are likely to be replaced by informal fees or the quality of care will be so diminished that utilization does not improve. Implementing this recommendation requires understanding the true cost of service delivery, prioritizing services to be provided for free based on available resources, and the establishment of a system to reimburse facilities for services provided. In country reports, we have recommended a process for countries to follow to determine which services they can afford to exempt and for which populations, described briefly in the text box below. To support countries in this effort, we recommend that the Global Fund Secretariat develop a regional strategy on user fees that outlines their commitment to eliminating user fees for HIV, TB, and malaria over time, and their approach for ensuring that facilities and health workers are adequately funded to provide free services, so that formal user fees are not replaced by informal user fees and services provided are of a high quality.

Over the current 2020-2022 funding period, we recommend that the Global Fund establish a taskforce on user fees to guide a process of developing a cohesive strategy. Then, Global Fund should issue guidance to countries on the operationalization of the strategy, and help them prepare to implement revised user fee policies by gathering needed information, developing frameworks, and planning to launch purchasing mechanisms. In the 2023-2025 period, we recommend that the Global Fund begin providing funding to countries to implement the revised policies that would also go into effect at that time. Countries would include requests in their grant applications to use grants to purchase services from commodities – both by providing commodities but also by providing funds to cover the cost of other inputs that are vital to delivering high quality services.

However, in the longer term, a more comprehensive and sustainable solution is required to ensure that HIV, TB and malaria patients are able to get the full spectrum of health services they require to manage their diseases at an affordable price. User fee exemptions alone will not be able to achieve this. For this reason, we recommend Global Fund support countries to roll out systems to achieve UHC in the

longer-term. For countries that are more advanced in their implementation of UHC (e.g. Gambia, Ghana and Senegal), we recommend that Global Fund consider directing all support for user fee removal to that effort. Additional recommendations in both the short- and medium-terms, as well as the long-term are described in the Recommendations section at the end of this report.

Introduction

Background

To achieve the Global Fund’s ambitious objective of ending the HIV, tuberculosis (TB), and malaria epidemics, people, especially key and vulnerable populations, need increased access to quality health services. In its 2010 World Health Report, the World Health Organization (WHO) posited that user fees deter people from using health services and cause financial stress. Various studies have examined the effect that user fees have on health care access, utilization, quality of services, and health expenditures with mixed results; still, many stakeholders believe that user fees are an “unnecessary evil” and should be abolished, especially for vulnerable populations.^{215, 278}

Undeniably, inadequate attention has been given to how and when to eliminate user fees and for whom they should be eliminated, especially in West and Central Africa (WCA)—all of which are incredibly complex issues. Evidence suggests that removing formal user fees only results in increased service utilization when these fees are the primary barrier and if care is taken to avoid a reduction to the quality of care that can accompany increases in utilization.²⁰ When other barriers—such as stigma and discrimination or indirect costs (like transport or lost wages), or poor quality of care—are the primary barrier, removing formal user fees for certain services might not increase utilization and might deleteriously impact the health system by removing an important source of funding. Further, as global attention increasingly shifts to universal health coverage (UHC), countries are implementing different social protection and insurance mechanisms to provide coverage to their populations; these policies influence the structure of health financing and add an additional layer of complexity to examining the effect of user fees.

Justification for the Study

The Global Fund is looking for evidence to inform how Global Fund-supported programs can best increase access to and utilization of health services. This study will provide a better understanding of how health financing structures and user fees, in particular, are affecting access to and utilization of HIV, TB, and malaria services, and the implications to the health system of removing or revising these types of fees in WCA.

Intended Use of the Study

The findings from the study will help the Global Fund guide countries in developing strategies on user fees that will increase access to and utilization of health services and accelerate the end of the HIV, TB, and malaria epidemics.

Definitions

Out-of-pocket (OOP) expenses: These expenses for health services are any costs incurred by an individual or household in the process of seeking medical care. These include formal and informal user fees, direct purchasing of drugs or medical supplies, and indirect costs such as transportation. Note that the WHO’s definition is narrower and defined as “direct payments for medical services including medicines and consultation fees, but excluding transportation spending, insurance payments and

reimbursements.” Data presented in this report from the WHO Health Expenditure Database uses this narrower definition.

Formal user fees: These fees are paid by patients to access a facility or obtain a service. They can entail any combination of entrance fees or consultation fees, drug costs, supply and medical material costs, or other components of health care. They are typically paid for each visit to a health service provider, although in some cases follow-up visits for the same episode of illness can be covered by the initial payment.

Informal user fees: These fees are unofficial cash or in-kind payments given directly to health care personnel before or after using health care services, which may or may not be considered “bribes” in other policies and contexts. For our purposes, we include only cash or in-kind payments that health care workers specifically demand or implicitly or explicitly expect to receive in exchange for services. We do not include “gratuity payments” that are sometimes given from community members as a sign of appreciation, although we note that these are rare and are often given as a form of insurance for future illness episodes. Informal fees include directly paying a nurse or doctor to provide care, to jump the queue, or to receive care from a specific provider. Informal user fees also include the improper implementation of formal user fees, such as patients having to purchase or provide their own medical supplies or medications due to stock-outs of commodities that should be free.

Indirect costs: Informal user fees are distinct from indirect costs, which are costs that are not indirectly related to health care services. These might include transportation to a health facility, opportunity costs associated with missing work due to illness, or lodging if distance to a facility requires overnight stay. The scope of this study did not include a specific assessment of indirect costs, although these are a significant barrier in many countries, and they are discussed in several research questions.

Domestic funding sources: WHO defines domestic public sources as including “domestic revenue such as internal transfers and grants, transfers, subsidies to voluntary health insurance beneficiaries, non-profit institutions serving households (NPISH) or enterprise financing schemes as well as compulsory prepayment and social health insurance contributions. They do not include external resources spent by governments on health.”

External funding sources: WHO defines external sources as “resources channeled towards health by all non-resident institutional units that enter into transactions with resident units, or have other economic links with resident units, explicitly labelled or not to health, to be used as the mean of payments of health goods and services by financing agents in the government or private sectors. It includes donations and loans, cash and in-kind resources. External resources can be included in general government health spending or private health expenditures when funding is channeled to nongovernmental organizations and civil society groups.” For the purposes of this report, external funding sources can largely be thought of as donor funding.

Other private expenditures: WHO states that “other private expenditures are spending on private health insurance institutions and non-profit institutions serving households (NPISHs). Private insurance enrolment may be contractual or voluntary, and conditions and benefits or baskets of benefits are agreed upon on a voluntary basis between the insurance agent and the beneficiaries. They are not controlled by government units for the purpose of providing social benefits to members. Expenditures by NPISHs on health are not predominately financed and controlled by government. NPISHs provide goods or services to households free or at prices that are not economically significant.”

Social protection programs: For the purposes of this report, we are defining social protection programs using Oxford Policy Management’s Shock-Responsive Social Protection Systems study,³³⁹ which suggests that social protection includes both contributory instruments (known as social insurance) and non-contributory instruments (known as social assistance or sometimes social safety nets) that target the poor and vulnerable. User fee exemption policies are one type of social protection, as are national health insurance (NHI) systems.

Objectives

The purpose of the study is to provide a deeper understanding of how health financing landscapes in WCA affect access to HIV, TB, and malaria services.

The specific study objectives are:

- To explore the effects of various health financing landscapes and schemes, and user fees on health care access and utilization
- To estimate the possible effects of changing or removing user fees in the context of each country on the provision and uptake of health services as well as on health outcomes
- To present recommendations to the Global Fund on its role in addressing this question, including concrete recommendations on how to minimize the disruption of services if user fees were to be changed or removed
- To understand the role that user fees play in the overall domestic financing landscape and explore options for alternative domestic resources, should user fees be discontinued

Methodology

Study Design

The study used a mixed-methods approach to answer the research questions in Table 1. It included a desk review and a web-based questionnaire that covered the 23 WCA countries included in the study (Table 2). In nine of the countries (pre-selected by the Global Fund and shown in bold in Table 2), the study also included secondary data analysis of household surveys and primary qualitative data collection, which consisted of key informant interviews, focus groups with community members, and exit interviews with patients.

Table 1: Research questions

	Question	Data source
1.	What are the sources of health financing in each country, and what proportion of total funding does each one represent? What proportion of total funding comes from user fees?	Literature—23 countries
2.	To what degree is there a health financing gap, specifically for the HIV, TB, and malaria responses, in each country?	Literature—23 countries Questionnaire—23 countries
3.	How is health financing structured in each country? How is funding pooled and how are services purchased?	Literature—23 countries Questionnaire—23 countries
4.	What user fees (formal and informal) are assessed and which are exempt in each country? Are the same user fees exempt in all provinces/states, including in decentralized settings?	Literature—23 countries Questionnaire—23 countries Focus groups—9 countries

	Question	Data source
		Interviews—9 countries
5.	What user fee exemption policies exist in each country? To what extent do these policies also address informal user fees?	Literature—23 countries Questionnaire—23 countries
6.	How is revenue from user fees used (locally or nationally) in each country?	Questionnaire—23 countries Interviews—9 countries
7.	How have user fee exemption policies been implemented, rolled out, and advertised in each country? What has been the effect of the way in which they were implemented, rolled out, and advertised on service utilization?	Interviews—9 countries
8.	What social protection mechanisms exist and what do they cover? What formal and informal insurance mechanisms exist and what do they cover?	Literature—23 countries Questionnaire—23 countries
9.	To what extent are social protection mechanisms/insurance mechanisms effective at increasing access and utilization of health services?	Interviews—9 countries
10.	What are the largest barriers to accessing health services (especially HIV, TB, and malaria services) among different populations in each country? What are the equity implications, and how do barriers affect different quintiles of population?	Household survey data—9 countries Focus groups—9 countries
11.	To what degree are there gaps in health services in each country, and which populations most experience gaps? What are the drivers of these gaps?	Household survey data—9 countries Program review reports, annual review reports—9 countries Interviews—9 countries
12.	What effect might removing fees only in some disease areas and for some populations have on health care service utilization and supply of quality health care services?	Interviews—9 countries Focus groups—9 countries

Table 3: Countries included in the study

Countries in bold are the nine that were targeted for primary data collection and additional quantitative analyses.

Benin	Congo	Guinea	Nigeria
Burkina Faso	Congo (Democratic Republic)	Guinea-Bissau	Sao Tome and Principe
Cameroon	Côte d'Ivoire	Liberia	Senegal
Cape Verde	Gabon	Mali	Sierra Leone
Central African Republic	Gambia	Mauritania	Togo
Chad	Ghana	Niger	

Desk Review

The study team conducted a literature review to examine the types of user fees and social protection mechanisms that exist across the 23 countries and the role of user fees in health financing in these countries. Particular attention was paid to user fees for HIV, TB, and malaria services. We conducted a web search to identify relevant documents and also requested input from the Global Fund Country Teams in all 23 countries in identifying additional resources that may not be publicly available. In total, more than 400 documents were reviewed, including peer-reviewed papers, grey literature, national policies, national strategic plans, National Health Accounts, health expenditure databases, and donor funding reports. A list of documents included in the desk review is included in the bibliography at the

end of this report. Researchers populated information from the desk review into a data abstraction tool to capture evidence and organize the information by country and by research question.

Web-Based Survey

The ICF team developed a web questionnaire to obtain information from the 23 countries, which was intended to supplement and confirm the information found through the literature review. The web questionnaire asked about current health financing structure, policies regarding user fees and their implementation, the use of user fee revenue, and implementation challenges. It also asked about other types of insurance and social protection mechanisms that exist and their level of coverage. Country coordinating mechanisms (CCMs) were asked to designate one person to complete the web questionnaire, with the understanding that to provide their responses, the main respondent could gather feedback across multiple stakeholders. The web questionnaire was launched on a rolling basis as contact information was obtained from the Global Fund. Countries were given at least two weeks to submit their responses via Google Forms. Email reminders were sent by ICF and the Global Fund's Fund Portfolio Managers to encourage response. Responses were received from 18 out of 23 countries.ⁱⁱ

Secondary Data Analysis

The ICF team undertook quantitative data analysis using existing household survey data for the nine countries targeted for more in-depth research. These analyses assessed the following: (1) the existing inequalities in health service utilization by wealth status, (2) determinants of health service utilization, (3) the distribution of out of pocket spending on health by household income, (4) existing levels of catastrophic health expenditures, and (5) the determinants of catastrophic health expenditures. We used bivariate analyses and multivariate regression to explore determinants of service utilization and of experiencing catastrophic health expenditures. To explore levels of inequality in service utilization and out of pocket spending for health, we constructed concentration curves and estimated concentration indices. Data sets used for this analysis, listed in Table 4, included national living standards surveys (or equivalent) and Demographic and Health Surveys (DHS). We were unable to access living standard surveys for Benin and Cote d'Ivoire.

Table 4: Data sets used for the quantitative analysis

Country	Data sets
Benin	DHS 2017-18
Cameroon	DHS 2011 <i>Enquête Camerounaise Auprès des Ménages (ECAM 4) 2014</i>
Chad	DHS 2014-15 <i>Enquête sur les Conditions de vie des ménages et la Pauvreté au Tchad (ECOSIT 3) 2011</i>
Cote d'Ivoire	DHS 2011-12
Gambia	DHS 2013 Gambia Integrated Household Survey 2015

ⁱⁱ Responses were not received from Benin, Cameroon, Guinea-Bissau, Nigeria, or Senegal.

Guinea	DHS 2018 <i>Enquête Harmonisée sur les Conditions de Vie des Ménages 2018-2019</i>
Mali	DHS 2018 <i>l'Enquête Modulaire et Permanente (EMOP) 2018-2019</i>
Sierra Leone	DHS 2013 Malaria Indicator Survey (MIS) 2016 Sierra Leone Integrated Household Survey 2018
Togo	DHS 2013-14 Malaria Indicator Survey, 2017 <i>Questionnaire Unifié des Indicateurs de Base du Bien-Etre (QUIBB) 2015</i>

Qualitative Data Collection

Between December 2019 and March 2020, an ICF team of international and local consultants conducted country visits to eight countries pre-selected by the Global Fund to conduct primary data collection. This consisted of in-depth interviews with government stakeholders (from the national and regional/district levels), health insurance managers, and health care providers, along with exit interviews with patients. We also conducted focus group discussions with community members who are users and non-users of health services. The team had anticipated doing the same in Benin, but had to cancel because the CCM was not available to support this study. In addition, the team was not able to conduct all anticipated interviews in Cote d'Ivoire and Cameroon due to scheduling conflicts of the CCM and of Ministry of Health (MOH) staff.

The number and type of respondents varied by country, based on availability to meet with the teams during the country visits (Table 5). In each country, the study team aimed to conduct national-level interviews with MOH officials; representatives of the HIV, TB, and malaria programs; persons responsible for allocating MOH funds; and health insurance representatives. National-level interview respondents were identified by CCM members. For facility-level interviews, three regions were purposively selected for inclusion in the study based on the level of service utilization in the region.ⁱⁱⁱ

Table 5: Number and type of interviews and focus groups conducted during country visits, per country

Type of respondent	Cameroon	Chad	Cote d'Ivoire	Gambia	Guinea	Mali	Sierra Leone	Togo
National-level respondent	1	5	2	6	9	9	5	8
Region or district-level MOH representative	0	0	3	0	3	0	3	2
Health facility administrators	2	5	9	3	4	3	4	1

ⁱⁱⁱ Data from the most recent Demographic and Health Survey (DHS) was used to categorize regions by service utilization levels. Each region was classified as high, medium, or low service utilization, as measured by three main indicators (1) percent of children under five with fever whose blood was drawn, (2) percent of women and men who have had an HIV test in the last 12 months and received the results, and (3) percent of children 12-23 months who have had all vaccines appropriate for their age group. Generally, regions were low, medium, or high consistently across all three indicators, but where a region exhibited mixed classifications, e.g. low HIV testing but high malaria testing and vaccine utilization, the vaccine indicator was used since it is the least driven by disease prevalence.

Health care workers	5	5	7	9	9	4	8	7
Community health worker	0	0	0	0	3	0	1	1
Representatives of key populations	0	0	0	1	0	0	1	0
Patients								
HIV	9	6	6	9	6	1	9	9
TB	0	7	9	9	5	1	8	5
Malaria	9	8	12	10	9		6	5
Focus group discussions	4	7	10	6	6	6	5	5

In each of the three regions, we included one high-utilization region, one medium-utilization region, and one low-utilization region. One facility in each region that provided HIV, TB, and/or malaria services was then also purposively selected, one at each level of the health system. In each region, the study team conducted the following: (1) in-depth interviews with facility administrators and health workers at the selected facility; (2) exit interviews with HIV, TB, and malaria patients (up to three patients for each service), based on which patients finished with their services next and were willing to participate; (3) focus groups with community members, selected randomly but ensuring that at least half of participants were not found at a health care facility, to increase the probability of including non-users of services; and (4) interviews with district or provincial health management teams. Not all facilities provide services across all three disease areas (HIV, TB, and malaria), so we were not always able to interview three patients for each service type. The numbers and types of respondents interviewed in each region is presented in Table 5.

Limitations

By design, the study team planned to conduct primary data collection and do a deeper dive for only nine of the 23 countries in WCA. The information for the other 14 countries is limited to what was available in literature and provided through the online questionnaire. However, this did not provide a complete picture of the landscape in some countries. We found that documentation regarding health financing and especially HIV, TB, and malaria user fees did not always provide the level of detail needed. In addition, available documentation was sometimes out of date and therefore may not adequately reflect the most current status of the landscape in all countries. Five countries did not respond to the online questionnaire, and many of those that did provided incomplete information or information that conflicted with data from other sources. We have triangulated these responses with data from other sources and noted conflicts as much as possible.

In the countries that were selected for a deeper dive, data collection was limited to two weeks. This limited the number of interviews and focus group discussions we could conduct and the number of health facilities we could visit. Thus, the findings are not intended to be nationally or regionally representative. Revisions were made to our data collection instruments after the first two country visits in Mali and Guinea, and information, specifically on the amounts of user fees charged, is more limited for these two countries. Further, we realized later on in the study that additional probes and questions would have been helpful in answering some of the research questions – notably, we focused on outpatient, HIV, and TB departments and inadequate information is reflected in some cases about

services provided in antenatal care. Follow-up with data collection teams and additional literature review was conducted where feasible.

Data collection was not conducted as planned in Benin due to challenges engaging stakeholders in-country. Additional literature review was conducted to supplement our understanding. A more limited number of national-level interviews were conducted in Cameroon and Cote d'Ivoire also due to challenges with engaging CCMs to identify and introduce the study team to respondents. Due to the outbreak of COVID-19, data collection in a one of the planned regions had to be canceled.

For the quantitative analysis using national livelihood surveys, some countries only had data sets that were several years old, dating back to 2011-2015 (as shown in Table 5). Therefore, analysis of service utilization and health expenditures may not reflect the current trends in health care utilization in light of the most recent policies. Additionally, in the exploration of the determinants of service utilization and health expenditures, we are limited by what variables were included in the national surveys. This limits our ability to explore the role that non-measured factors, such as stigma or quality of care, have on these outcomes. We have triangulated this information using qualitative data collected from interviews and focus group discussions. No livelihood surveys were obtained for Cote d'Ivoire or Benin so the results presented on services utilization in these countries rely solely on the DHS analyses. Some DHS surveys were also several years old, dating back to 2011 for Cameroon (also shown in Table 5). The DHS does not include TB-specific indicators so our analysis is unable to specifically address TB service utilization.

For focus groups, we recruited persons directly from the community to try to get the perspectives of people who use services as well as those who do not. We conducted exit interviews with HIV, TB, and malaria patients, but these questions focused on capturing their experience in the facility that day rather than their perspectives on access to and utilization of services overall. In two countries, interviews with representatives of key populations helped provide these perspectives.

Lastly, delays in receiving ethical approval from national ethical committees and scheduling conflicts with national stakeholders necessitated almost all country visits to be pushed back from their originally scheduled dates. This left less time for data analysis, report development and review.

Findings

Research Question #1: Sources of Health Financing

What are the sources of health financing in each country, and what proportion of total funding does each one represent?

What proportion of total funding comes from user fees?

The health financing landscapes of WCA countries are complex and varied. Countries' reliance on government funds, external funds, OOP payments, and the private sector vary considerably (Figure 1). The percentage of total health expenditures financed by the government^{iv} ranges from 8% in Guinea Bissau to 63% in Gabon. In most countries studied (61%) government expenditures represent less than a third of total health expenditures. External health expenditures range from 1% (Gabon) to 55% (Central

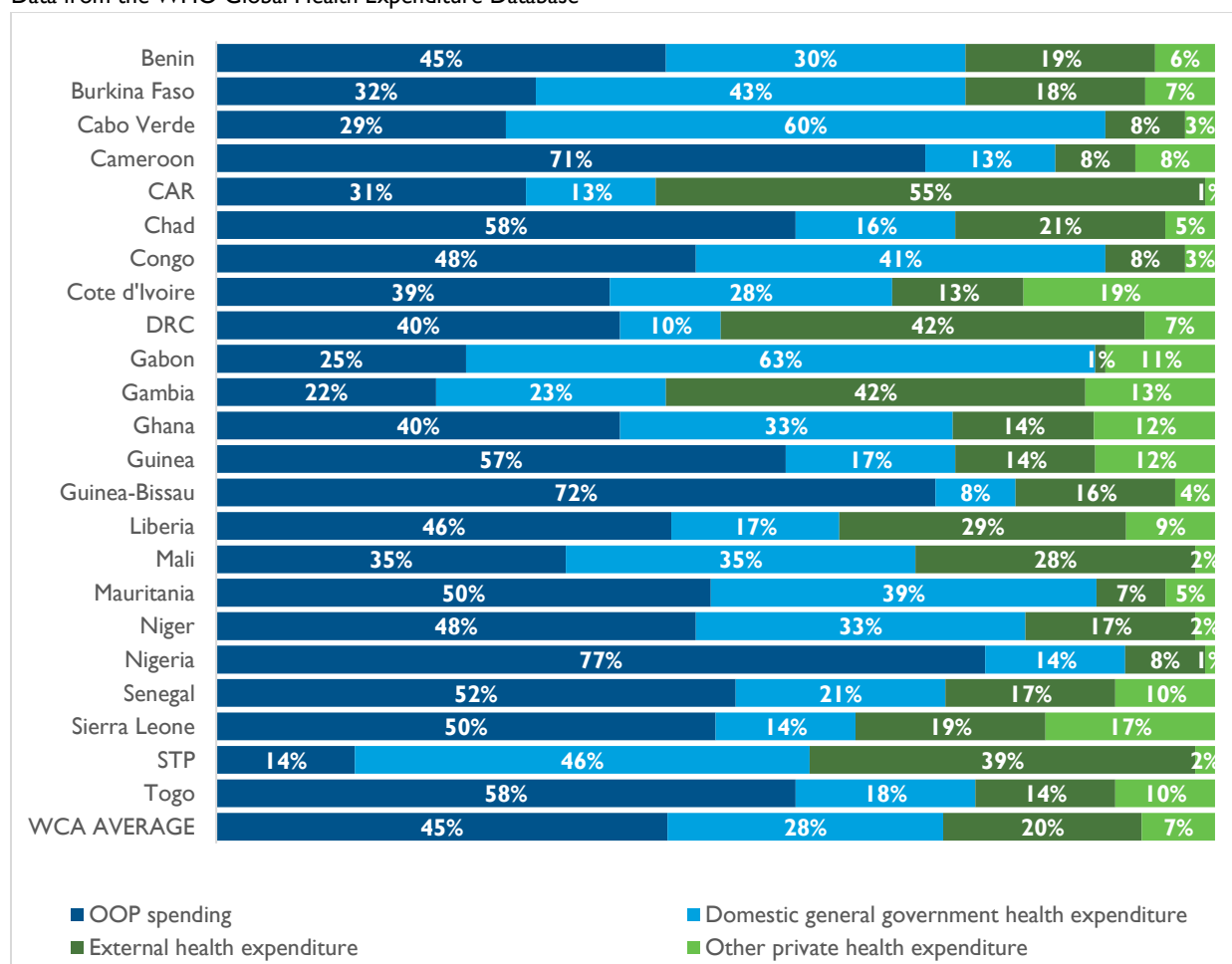
^{iv} WHO definitions for domestic, external, OOP, and other private health expenditures are presented in the definitions section.

African Republic [CAR]) of total expenditures. CAR, Democratic Republic of Congo (DRC), Gambia, and Sao Tome and Principe have the heaviest reliance on external sources of funding (more than 35% of total health expenditures). OOP spending represents a significant part of health spending in all 23 countries in WCA, ranging from 14% in Sao Tome and Principe to 77% in Nigeria. Overall, OOP spending makes up more than 25% of health expenditures in all but three WCA countries (Gabon, Gambia, and Sao Tome and Principe), and more than 50% of total spending in nine of the countries (Cameroon, Chad, Guinea, Guinea-Bissau, Mauritania, Nigeria, Senegal, Sierra Leone, and Togo). Other private health expenditures, such as those made by nongovernmental organizations (NGOs) or private companies, are the smallest contributor in most countries, ranging from 1% in CAR to 19% in Cote d'Ivoire.

OOP expenses for health services are any costs incurred by an individual or household in the process of seeking medical care. In the data presented below, WHO =limits OOP expenses to those used to directly purchase services including formal and informal fees and cost for buying drugs or medical supplies. However, other OOP payments often include other costs such as transportation, costs for food or lodging. There are no data reporting the proportion of total health funding attributable specifically to user fees (see Question 6 for more details).

Figure 1: Sources of health expenditure as a percentage of current health expenditures in 23 WCA countries, 2017

Data from the WHO Global Health Expenditure Database



To look more closely at sources of financing for HIV, TB, and malaria, we present below a brief summary for each disease using data provided by the Global Fund. These data come from a standardized estimation by countries of contributions from government, the Global Fund, and other external partners to national strategic plans (NSPs). NSPs are intended to provide the overall strategic direction for a country's programs over a defined period of time (usually 5 years). They serve as the basis for Global Fund financing. NSPs are methodologically consistent and allow us to see in broad strokes what the sources of financing are for each of these diseases. However, NSPs do not include out-of-pocket spending by households as a source of health financing. For this reason and reasons discussed later related to countries' ability to track user fee revenue at the facility level, it is not possible to state definitively what proportion of total funding comes from user fees. Doing so would require a more comprehensive review of data related to budgets and revenue at multiple levels of the health system, and possibly a population-based survey to understand informal fees and indirect costs.

Financing for HIV

In total across the region for 2018-2020, other external partners, presumably mostly PEPFAR, contributed 42% of total resources, governments contributed 34%, and the Global Fund contributed 24% (Figure 2). However, in 15 countries (Benin, Burkina Faso, CAR, Chad, Gambia, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Sao Tome and Principe, Senegal, Sierra Leone, and Togo)^v, the Global Fund was the largest contributor to HIV national strategic plans. Government is the largest contributor in Cape Verde, Congo, and Ghana, and other external partners are the largest contributor in Cameroon, Cote d'Ivoire, and DRC, and Nigeria, reflecting PEPFAR priorities within the region.

A slight reduction in total government contributions to the HIV response was noted between the 2012-2014 and 2015-2017 periods, but a sizeable increase of 38% was noted between the two most recent periods (Figure 3). The percent of the total response that came from governments also increased. These observations may be the result of Global Fund co-financing requirements that have been in effect since 2016, which require countries to demonstrate increasing co-financing of Global Fund supported programs over each allocation period, and offers incentives for doing so. Global Fund contributions increased by 13% between the 2014-2014 and 2015-2017 allocations but were virtually the same between 2015-2017 and 2018-2020.

^v In Senegal and Niger, the government and the Global Fund contribute virtually equal amounts, but Global Fund contributions are slightly higher.

Figure 2: Sources of Funding for HIV National Strategic Plans in WCA, Millions of USD, 2012-2020.

Data from Internal Global Fund Database.

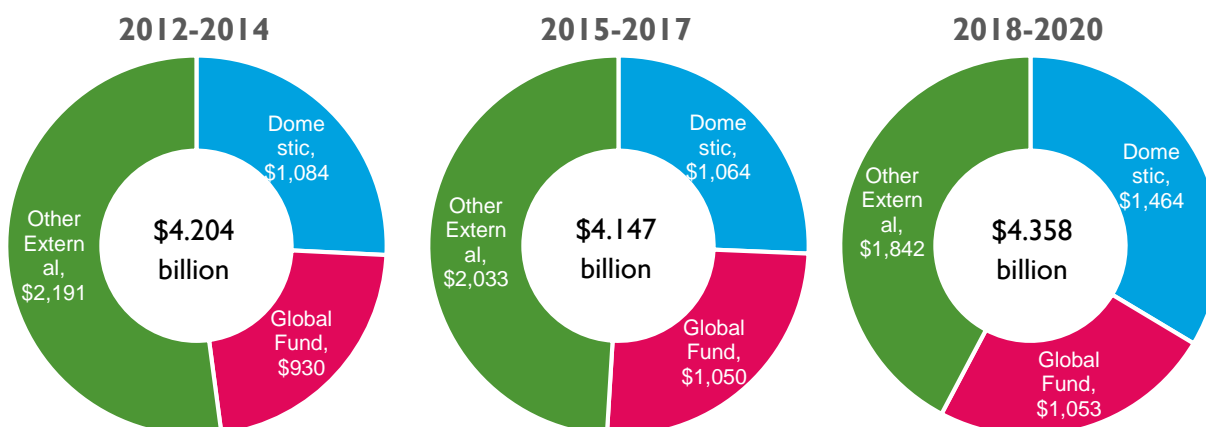
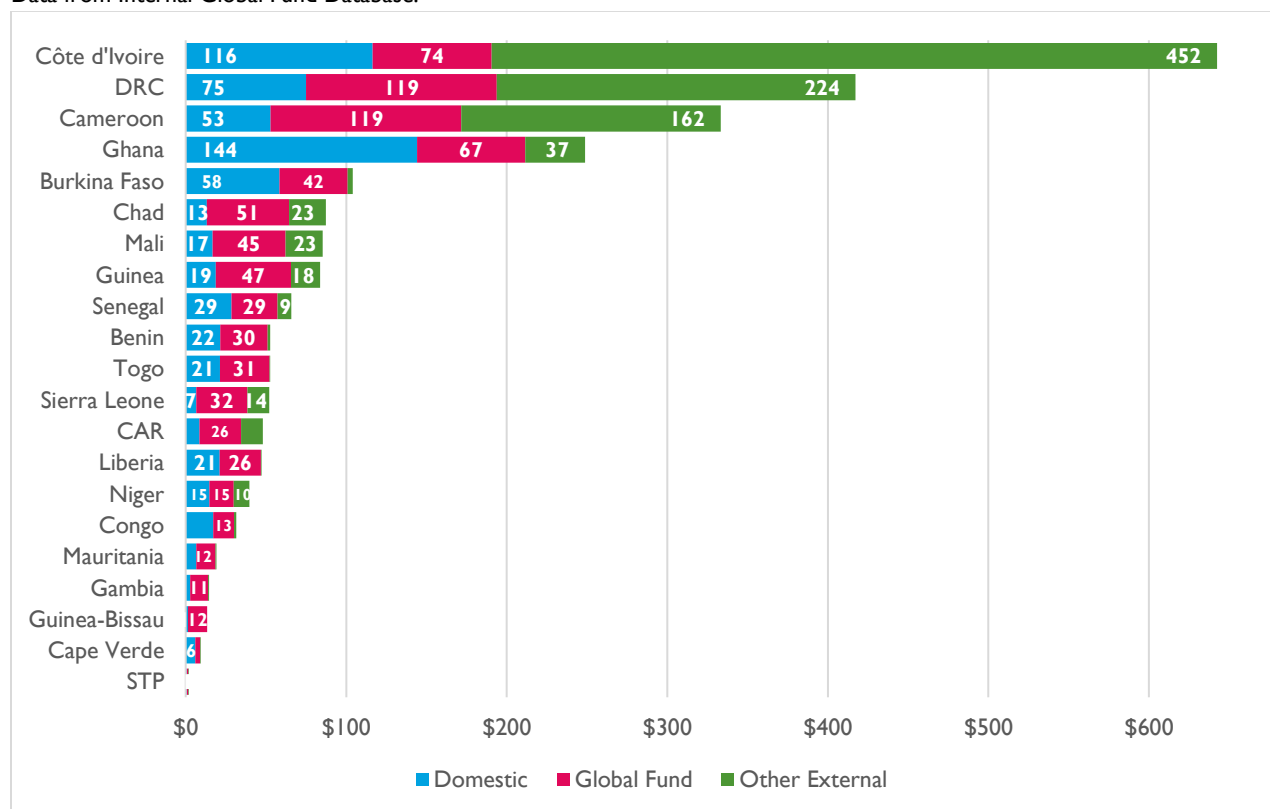


Figure 3: Sources of Funding for HIV National Strategic Plans by Country, Millions of USD, 2018-2020.

Data from Internal Global Fund Database.



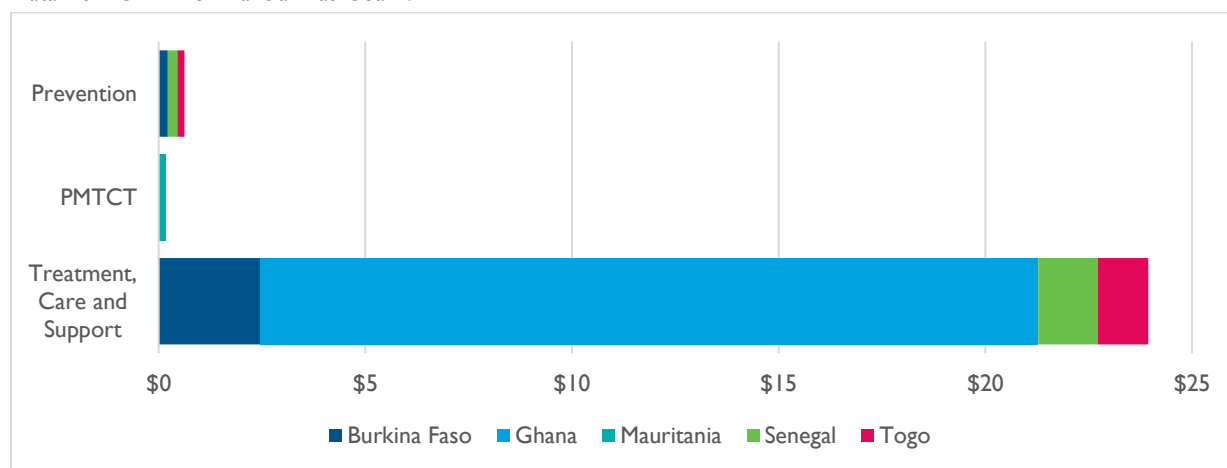
Notes: Data for Gabon were not available. Nigeria has been removed from this figure for scale. Funding for the Nigeria HIV National Strategic Plan for 2018-2020 was \$811 million from government, \$248 from Global Fund, and \$849 million from other external partners.

UNAIDS also collects data from countries on HIV expenditures as part of development of the Global AIDS Monitoring and Global Gap Reports, which most countries seem to use National AIDS Spending

Assessments to complete. However, most countries appear to be unable to attribute spending to households, as only five countries in WCA reported any household expenditures even though we know that OOP payments for HIV do exist in other countries. For the five countries that did report household expenditures, the vast majority went to the treatment, care, and support category (Figure 4). Most of these expenditures came from Ghana, which used information from a revised module within the national Ghana Living Standard Survey to estimate household expenditures.

Figure : Household Expenditures for HIV by NASA Category, Millions of USD, 2012-2020.

Data from UNAIDS Financial Dashboard.⁴⁴



Notes: Most recent year available: Burkina Faso–2017, Ghana–2016, Mauritania–2018, Senegal–2014, Togo–2017. Other countries did not report household expenditures. Togo reported other small expenditures by households that are not pictured related to programs for children and adolescents, social protection, community mobilization, governance and sustainability, planning and coordination, procurement and logistics, health systems strengthening, education, and critical enablers.

Financing for TB

Since 2012, on average \$170 million was contributed to the achievement of NSPs for TB across the region, with increases seen in each allocation period (Figure 5). The Global Fund is the primary source of financing for TB in WCA, with significant contributions from government and other external partners as well. In total across the region for 2018-2020, the Global Fund contributed 57% of total resources, government contributed 26%, and other external partners, primarily USAID which contributed mostly to Nigeria and DRC, contributed 16%. Global Fund contributions increased by 13% between the 2014-2014 and 2015-2017 allocations but were virtually the same between 2015-2017 and 2018-2020. In total across the region, an 18% reduction in total government contributions to the TB response was noted between the 2012-2014 and 2015-2017 periods, but a sizeable increase of 50% was noted between the two most recent periods. The proportion of the total response that came from governments also increased. Global Fund was the largest contributor in every country except Liberia, where government provided 86% of funding for the NSP (Figure 6).

Figure 5: Sources of Funding for TB National Strategic Plans in WCA, Millions of USD, 2012-2020.

Data from Internal Global Fund Database.

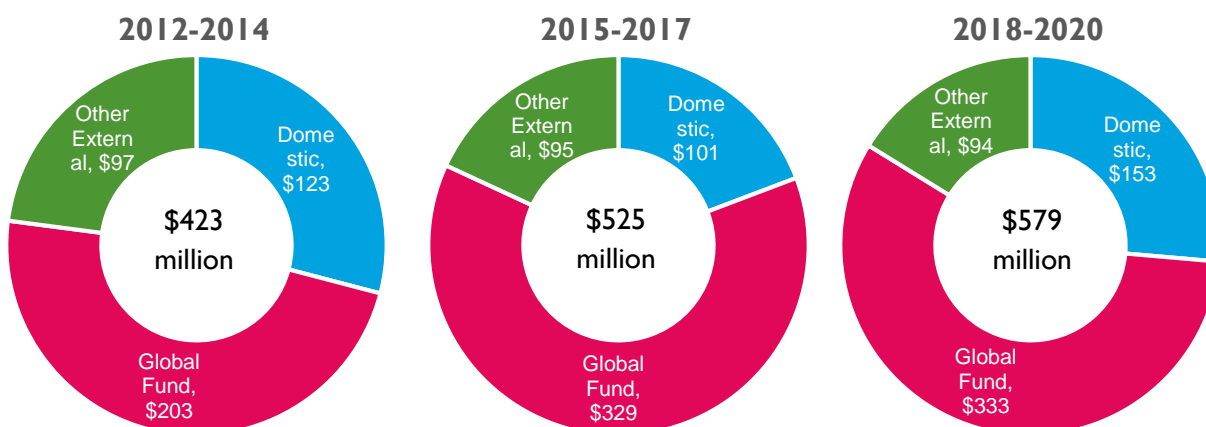
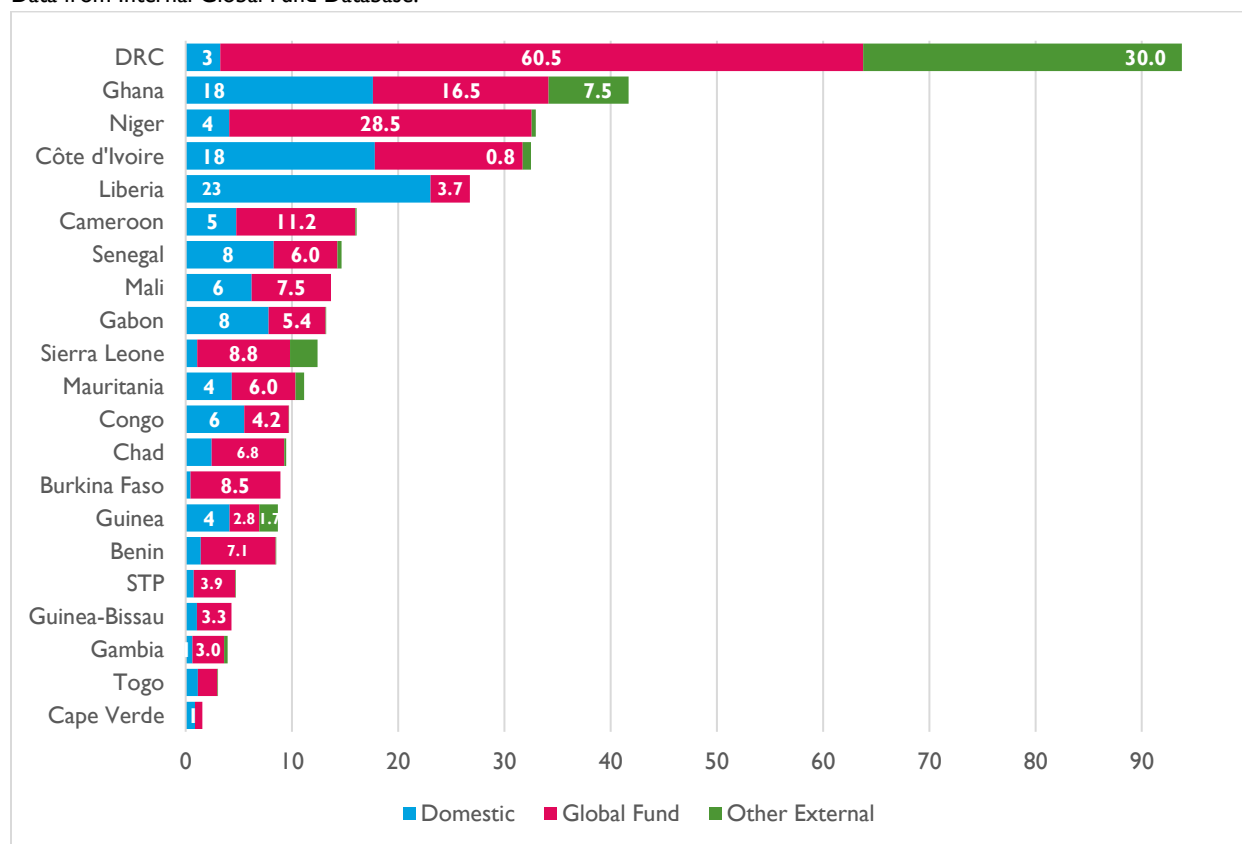


Figure 6: Sources of Funding for TB National Strategic Plans by Country, Millions of USD, 2018-2020.

Data from Internal Global Fund Database.



Notes: Data for Gabon were not available. Nigeria has been removed from this figure for scale. Funding for the Nigeria TB National Strategic Plan for 2018-2020 was \$34 million from government, \$117 from Global Fund, and \$48 million from other external partners.

Financing for Malaria

The Global Fund and government are the two largest funders of the malaria response in WCA, with significant contributions from other external partners as well, primarily USAID/PMI (Figure 7). Global Fund has increased their contribution in each funding period. Government's contribution increased by 35% between the first two period but decreased slightly between the last two periods. About 75% of Global Fund and other external partner support goes to Nigeria and DRC. Government contributions to the malaria response in each country in the 2018-2020 period varied widely, ranging from 1% in DRC and CAR, to more than 70% in Ghana, Cape Verde, and Sao Tome & Principe (Figure 8).

Figure 7: Sources of Funding for Malaria National Strategic Plans in WCA, Millions of USD, 2012-2020.

Data from Internal Global Fund Database.

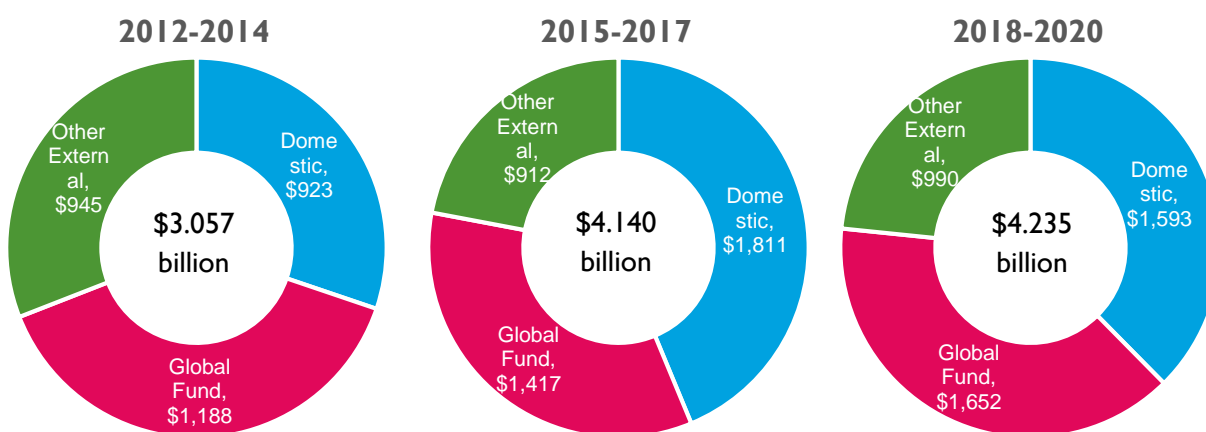
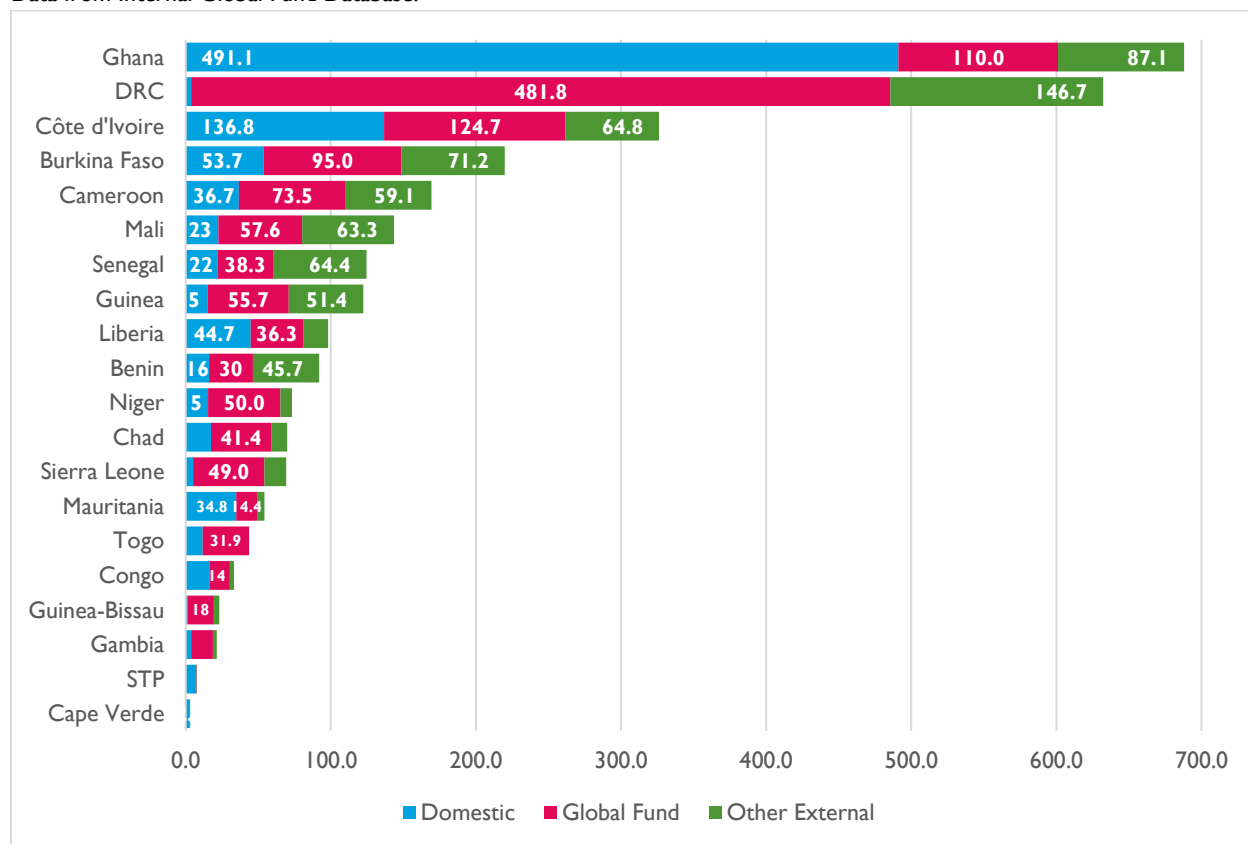


Figure 8: Sources of Funding for Malaria National Strategic Plans by Country, Millions of USD, 2018-2020.

Data from Internal Global Fund Database.



Notes: Data for Gabon were not available. Nigeria has been removed from this figure for scale. Funding for the Nigeria malaria NSP for 2018-2020 was \$635 million from government, \$283 from Global Fund, and \$270 million from other external partners.

Research Question #2: Health Financing Gaps

To what degree is there a health financing gap, specifically for the HIV, TB, and malaria responses, in each country?

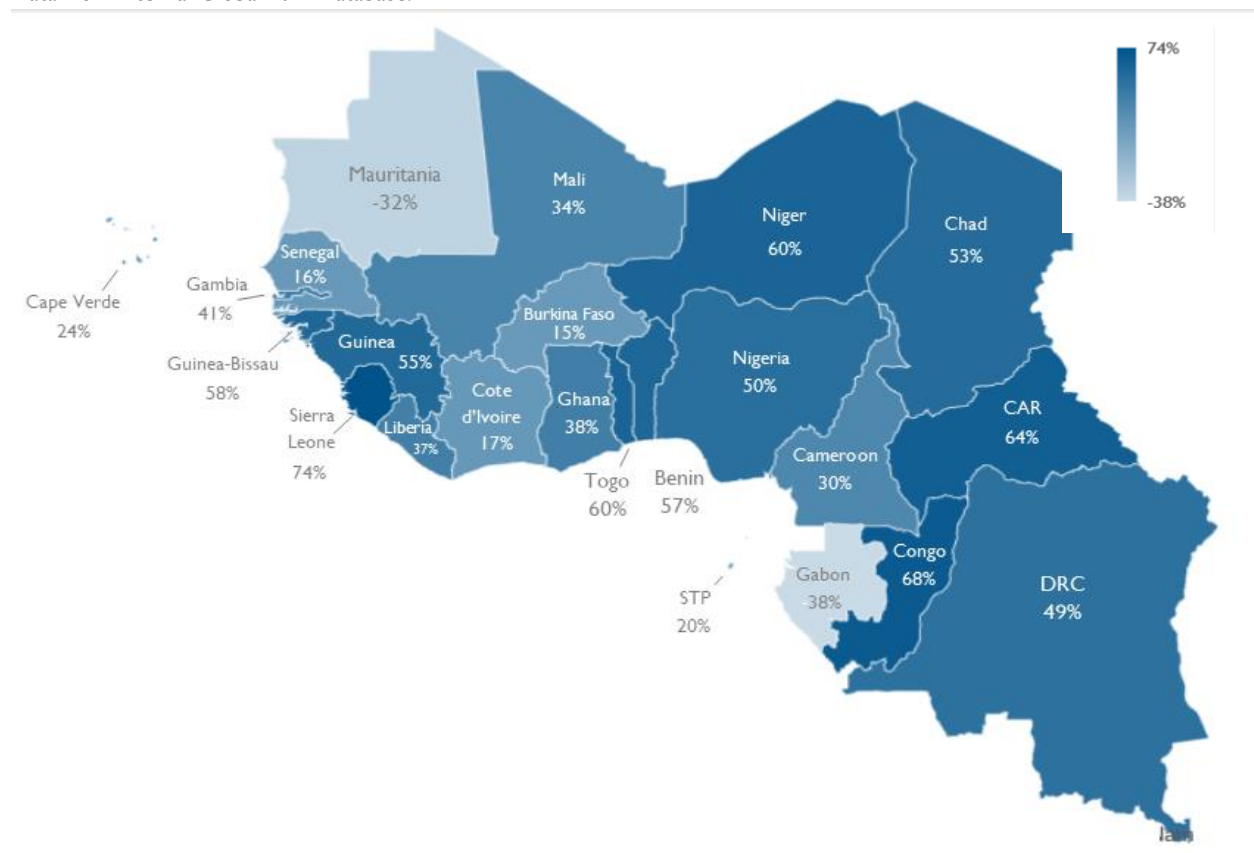
Internal data from the Global Fund was used to assess health financing gaps for the HIV, TB, and malaria responses in each country. However, there are challenges with using these data for this purpose as well. First, in calculating the total need for each of the disease’s response, NSPs do not usually include some hidden costs that are borne by the health system, usually government, to provide HIV, TB, and malaria services. Examples include the cost of paying health workers and other staff that are not specifically dedicated to a specific disease area, the cost of building and maintaining health facilities where HIV, TB, and malaria services are integrated with other services, and operational or administrative costs of running health facilities. They also do not include contributions from households. This makes it difficult to report exactly what the total cost of the HIV, TB, and malaria responses is, so the numbers presented here are likely underestimated. This also results in a challenge when trying to understand how much to reimburse facilities for providing free services, discussed later.

All 15 countries that responded to the component of the web questionnaire on funding gaps indicated that they estimated that a financing gap exists for the HIV, TB, and malaria responses (Burkina Faso,

Cape Verde, CAR, Chad, DRC, Gabon, Gambia, Ghana, Guinea, Liberia, Mali (gap for HIV only), Niger, Sierra Leone, and Togo). Global Fund data confirm that needed resources exceed available funding in almost every country, but the size of the gaps vary widely within and across countries and disease areas. The size of the total combined funding gap for HIV, TB, and malaria ranges from 74% in Sierra Leone and 68% in Congo, to funding surpluses of 32% in Mauritania and Gabon, respectively (Figure 9).

Figure 9: Funding gap as percent of combined total of HIV, TB, and malaria NSPs in each WCA country

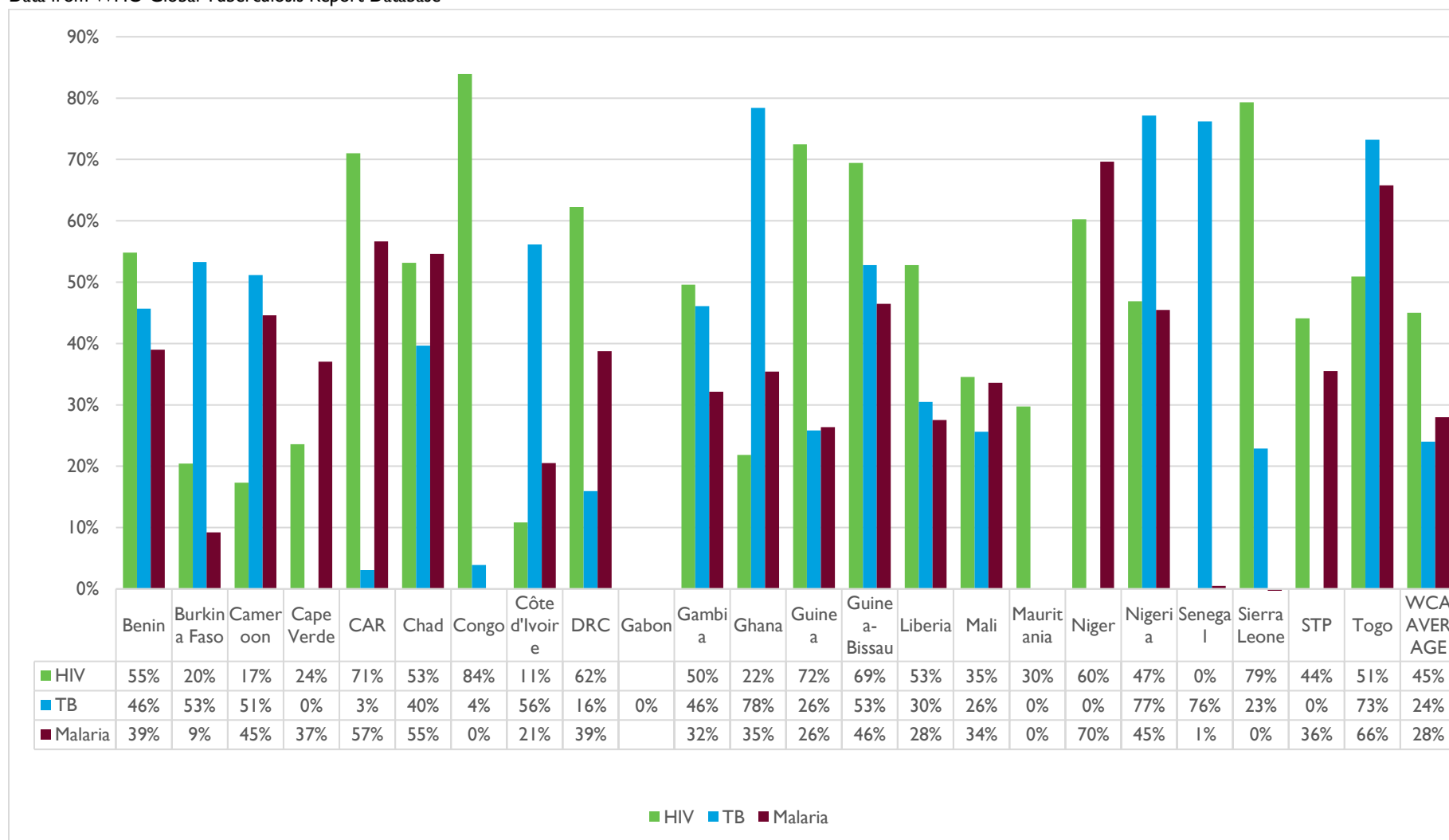
Data from internal Global Fund database.



The size of the funding gap varies significantly across countries for each disease area (Figure 10), which points to the need for increased allocative efficiency in some cases, especially of government resources. On average, there is a larger funding gap for HIV NSPs compared to TB and malaria NSPs – the gap in WCA countries for HIV NSPs is on average 45% of the total cost of each NSP, where for TB it is 24%, and for malaria it is 28%. Sierra Leone and Congo provide examples of challenges in allocative efficiency within countries – in Sierra Leone, the HIV NSP had a funding gap of 79% of the total, TB 23%, and malaria only 7%. Government contributions were \$6.6 million, \$1.1 million, and \$5.2 million, respectively. In Congo, the HIV NSP gap was \$165 million and had a funding gap of 84% where malaria had a \$6.1 million surplus of funding during the same period.

Figure 10: Funding gap as a percent of total need for HIV, TB, and malaria NSPs in WCA, 2018-2020 period

Data from WHO Global Tuberculosis Report Database

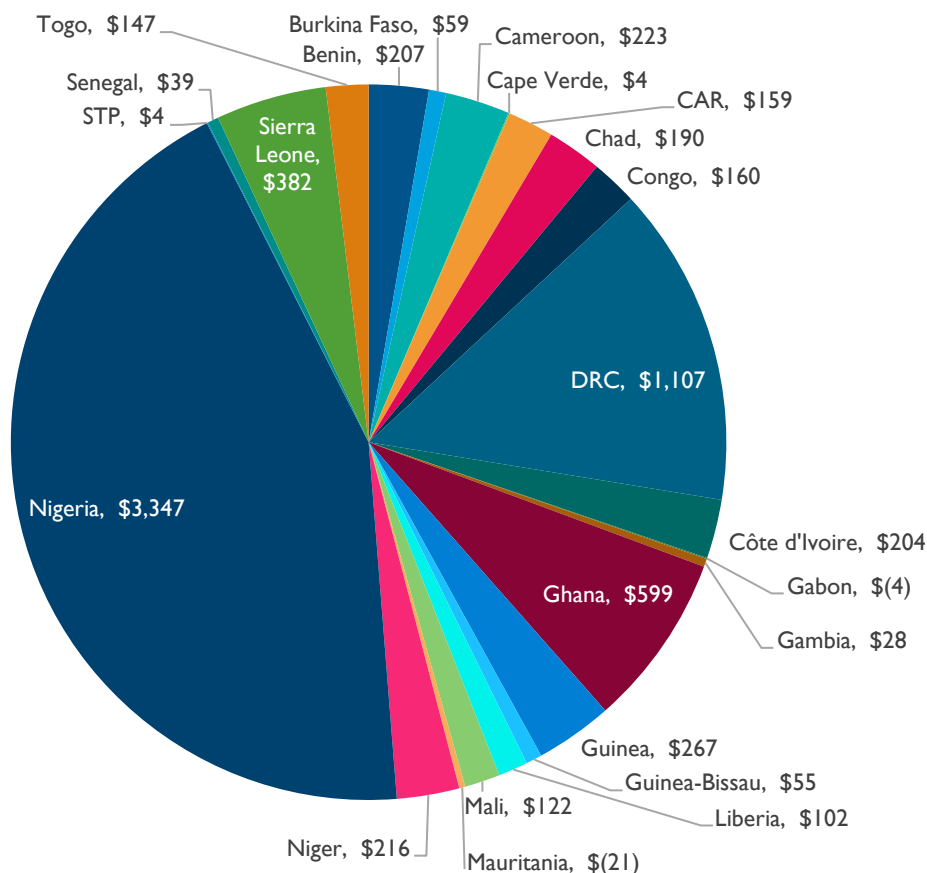


Note: Several countries had surpluses in funding in one or more disease areas that are pictured as zeroes in this figure. Cape Verde: 20% surplus for TB; Congo: 22% surplus for malaria; Gabon: 38% surplus for TB; Mauritania: 99% surplus for malaria, 20% for TB; Niger: 61% surplus for HIV; Senegal: 15% surplus for HIV; STP: 94% surplus for TB.

In terms of total dollar amount, there is also significant variation in the region. The total need to fund all HIV, TB, and malaria NSPs in WCA in the 2018-2020 period was \$16.8 billion (Figure 11). Of this, \$9.1 billion was committed, leaving a funding gap of 54% in total. The dollar amount of the funding gaps was largest in Nigeria, DRC, Sierra Leone, and Ghana. While it is not surprising to see large gaps in Nigeria and DRC given the size of their populations, the existence of large gaps in Sierra Leone and Ghana points to the fact that the cost of NSPs in each country varies widely. For example, if we look at the cost of HIV NSPs per estimated PLHIV in each country, we see a range of \$746 per person in Cameroon compared to \$5,093 in Cape Verde, with an average of \$2,083. Ghana developed the second-highest costliest malaria NSP in the region at \$1.1 billion in an effort to make significant strides toward control and elimination, and government allocated a significant amount of resources to its implementation, but a significant gap still remained. Similarly, Sierra Leone's HIV NSP was also extremely costly relative to the size of its population, and had a funding gap of 79%, leaving a gap of \$200 million. There is a need to balance having an ambitious NSP that pushes the country to meet targets with the feasibility of mobilizing enough resources to fund it.

Figure 11: Total gap in combined HIV, TB, and malaria funding in WCA, millions of USD, 2018-2020 period

Data from Internal Global Fund Database



The size of the gaps in terms of total dollar amount also varies within each disease area (Figures 12-14). The total need to fund all 22 HIV national strategic plans in the 2018-2020 period in WCA was \$8.1 billion dollars. Of this, \$4.3 billion was committed, leaving a funding gap of 46%. For the 23 TB national strategic plans, total need was \$1.57 billion dollars. Of this, \$579 million was committed, leaving a funding gap of 63%. The total need to fund all 22 malaria NSPs in WCA in the 2018-2020 period was \$6.92 billion dollars. Of this, \$4.24 billion was committed, leaving a funding gap of 61%. The total dollar amount of the gaps is largest for Nigeria, which is driven by need. DRC is the second largest for HIV and malaria but closed the gap significantly for TB in this period, partially by reducing need from \$180 million in 2015-2017 to \$112 million in 2018-2020.

Figure 12: Total gap in HIV funding, millions of USD, 2018-2020

Data from Internal Global Fund Database

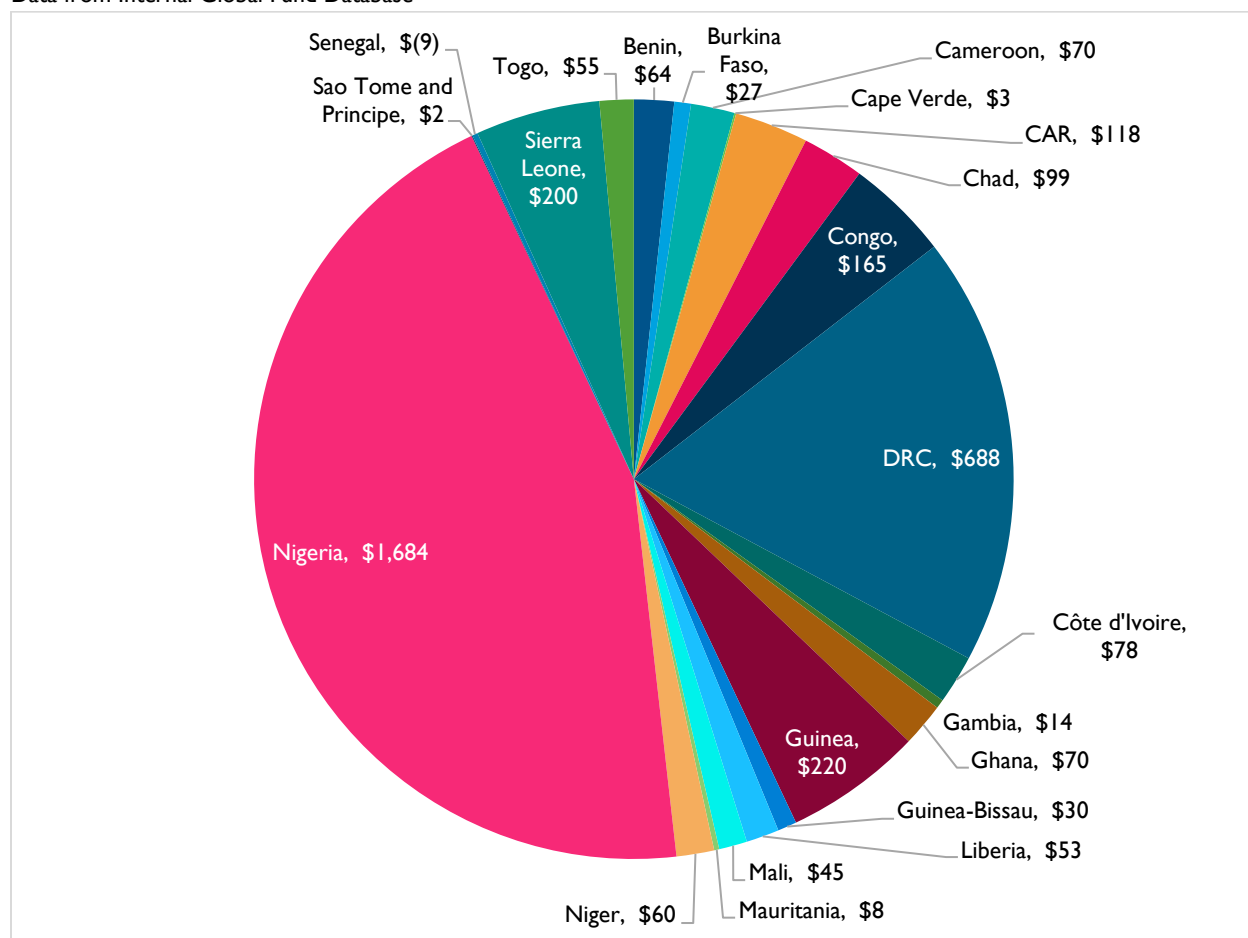


Figure 13: Total gap in TB funding, millions of USD, 2018-2020

Data from Internal Global Fund Database

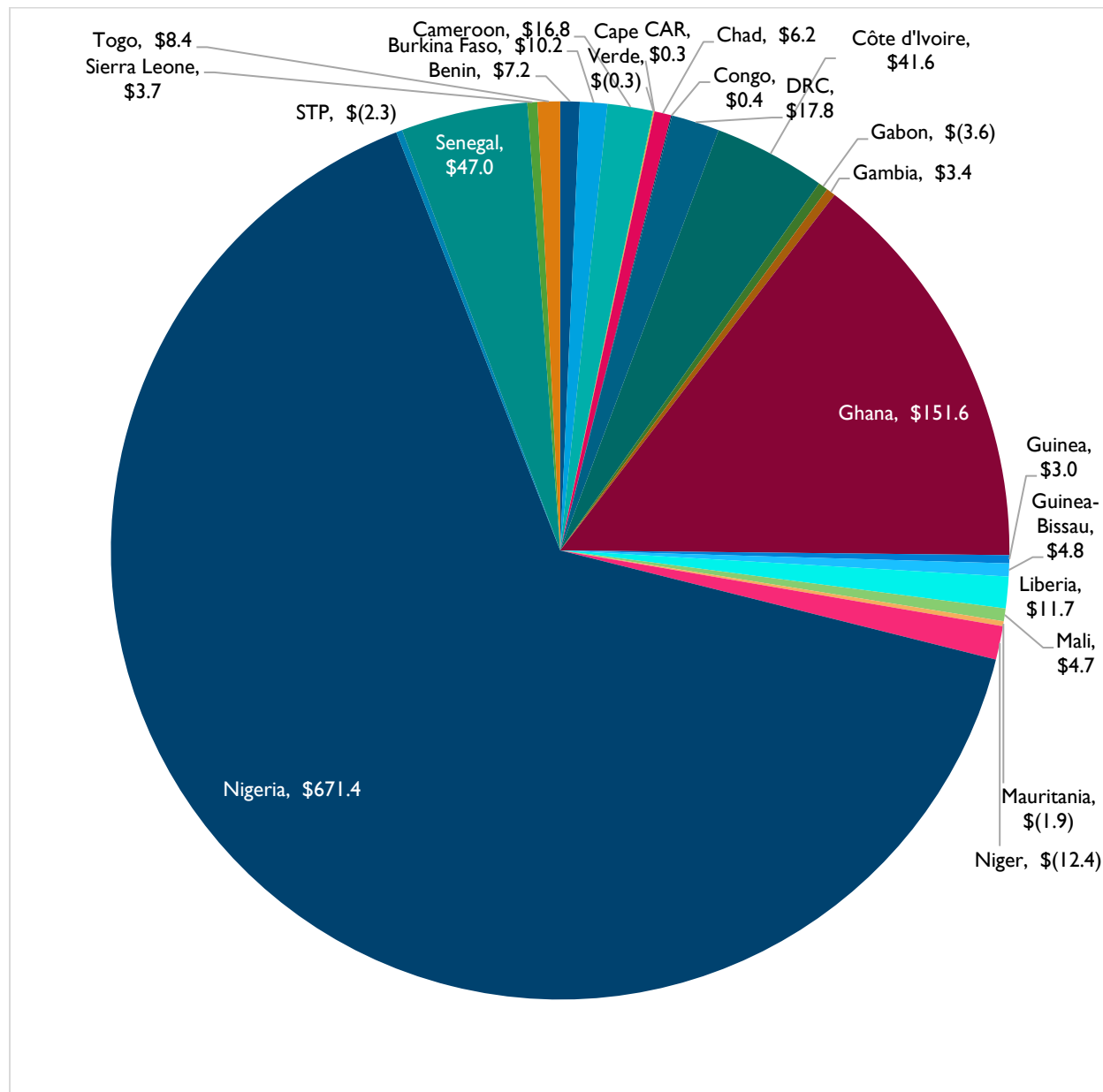
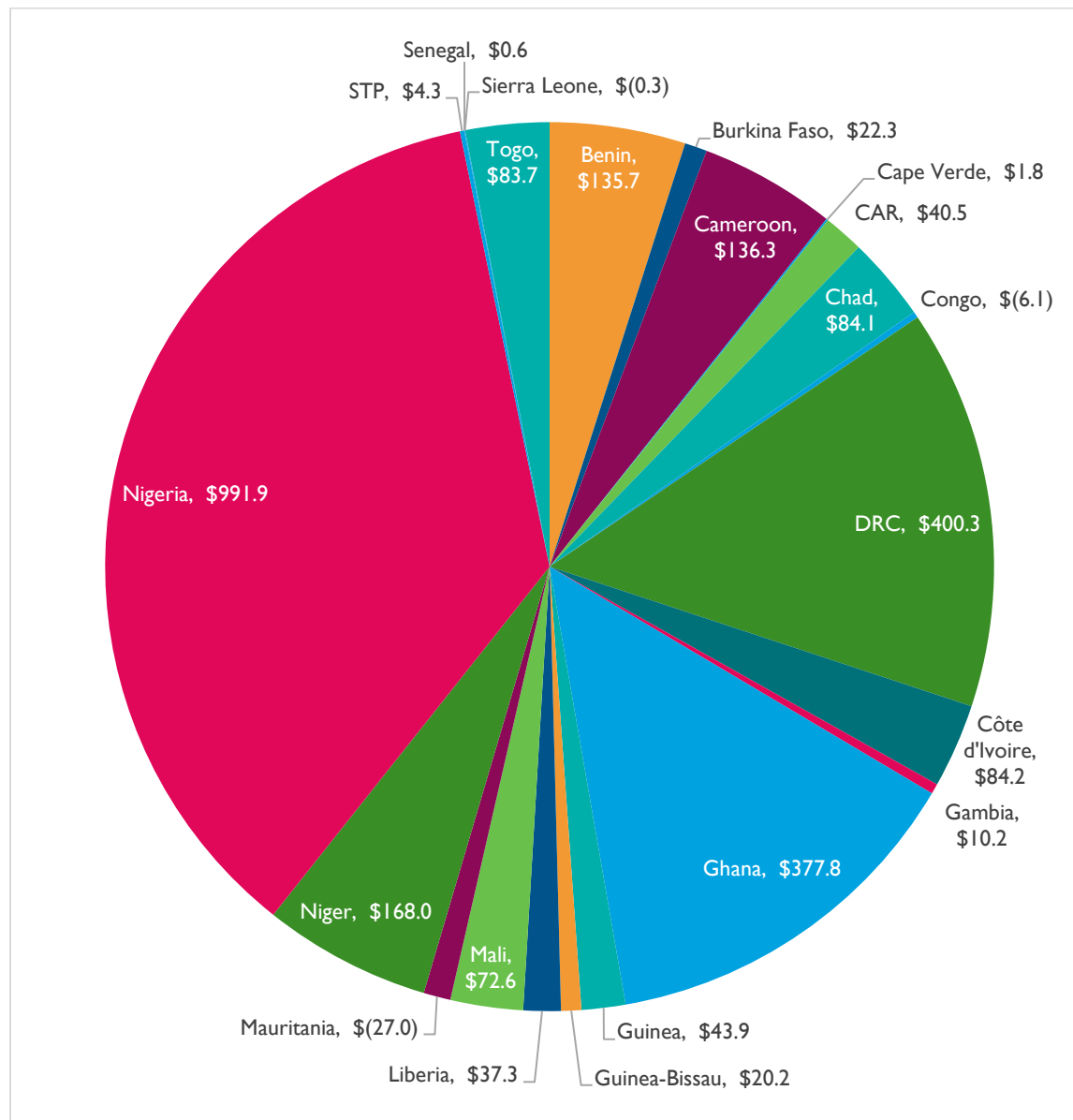


Figure 14: Total gap in malaria funding in WCA, millions of USD, 2018-2020 period

Data from Internal Global Fund Database



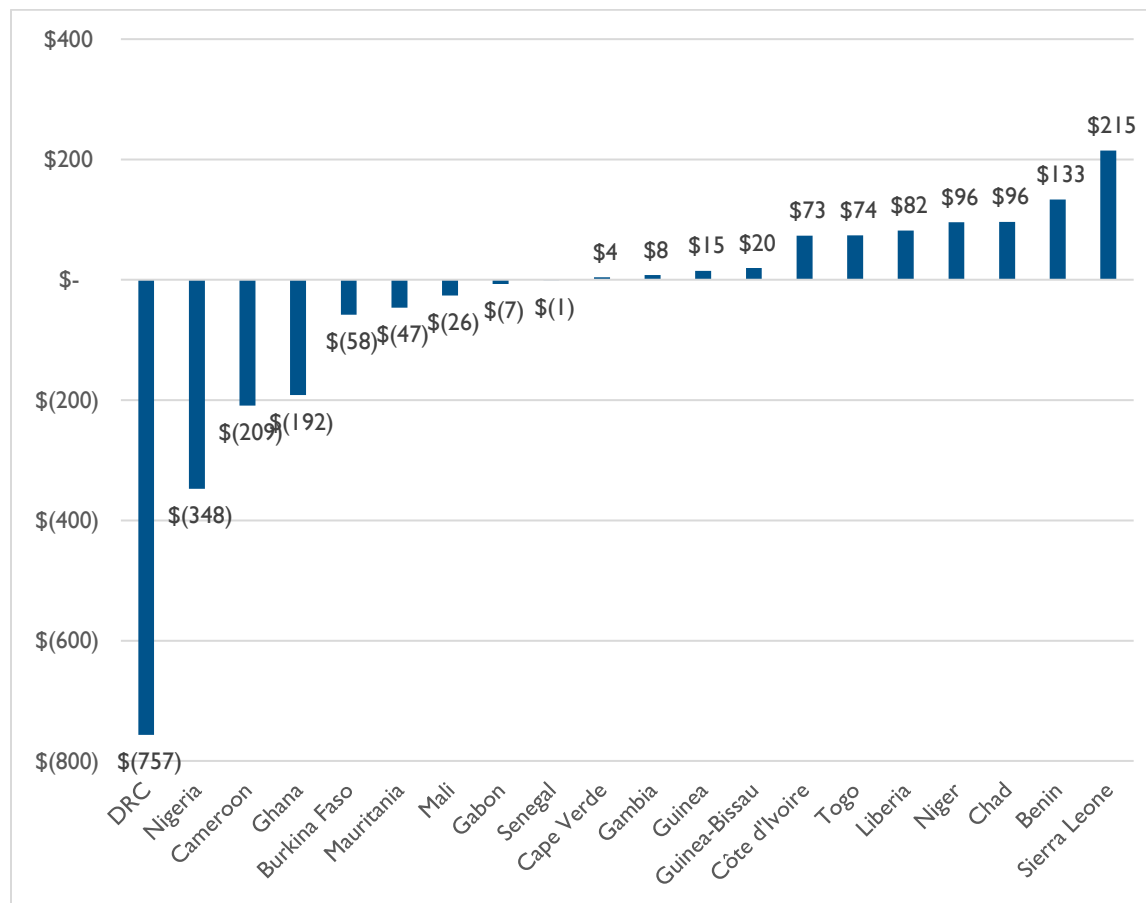
Closing the Gap

Closing the funding gaps noted above will require a significant increase in funding. It is unlikely, however, that increased resource mobilization will be adequate on its own given the economic outlook in most countries and the size of the gap. Thus, increased resources must also be coupled with efforts to increase efficiency, doing more with less, to reduce the cost of NSPs while still meeting ambitious targets. Between the two most recent periods, DRC, Nigeria, Cameroon, and Ghana made significant strides toward closing the total funding gaps (Figure 15). DRC and Nigeria did so largely by reducing the cost of their NSPs, while Cameroon instead increased domestic, other external and Global Fund resources. Ghana's reduction was largely driven by an increase in domestic resources alone. Gaps increased significantly in Cote d'Ivoire, Togo, Liberia, Niger, Chad, Benin, and Sierra Leone. In all seven

of these countries, the total combined cost of the NSPs increased significantly, but additional resources were not mobilized to keep up with the increased need.

Figure 15: Change in funding gap between 2015-2017 and 2018-2020, millions of USD.

Data from Internal Global Fund Database



Notes: Total need for at least one component in Congo, CAR, and STP was not estimated for the 2015-2017 period so are not included in this graph.

Looking at each disease area, progress toward closing funding gaps varies. The HIV funding gap has closed slightly, as \$4.1 billion was committed in 2015-2017 (compared to \$4.4 billion in 2018-2020), leaving a funding gap of 57% (compared to 46%) (Figure 16). However, the progress is limited. The improvement was primarily driven by reductions in the total need for Nigeria (reduction of \$1.1 billion) and DRC (reduction of \$768 million), and not by a significant increase in total resources. Excluding these two countries, the average need per country in 2018-2020 was \$170 million, compared to \$165 million in the preceding period. Only 5% more was committed to the response in 2018-2020 than in the previous period – an increase of 89% would have been needed to actually close the gap.

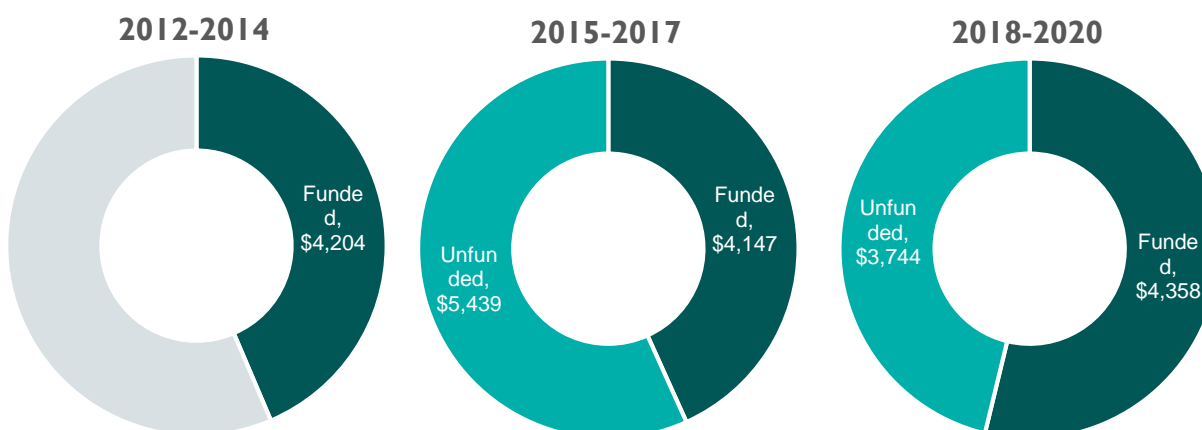
There is also evidence that progress has been made toward closing the TB funding gap, as increases in the total amount committed were noted between each period (Figure 17). However, the progress is limited, as the funding gap decreased by only one percentage point between the two most recent periods. This is primarily driven by increases in need in the strategic plans – the cost of the strategic plans in twelve countries reduced by a total of \$126 million between the two most recent periods, but this was not enough to offset an increase of \$219 million, driven primarily by Nigeria, which needed

\$148 million more. Only 10% more was committed to the response in 2018-2020 than in the previous period – an increase of 198% would have been needed to actually close the gap.

While more resources have been committed to the malaria response each year, the funding gap in 2018-2022 was wider than in the previous period (Figure 18). This is primarily because the need in every country except Mauritania, Nigeria, Sierra Leone, and Sao Tome & Principe grew, but additional resources were not able to keep up with the growing need. Only 2% more was committed to the response in 2018-2020 than in the previous period – an increase of 67% would have been needed to actually close the gap.

Figure 16: Funded and unfunded portions of HIV NSPs in WCA, Millions of USD, 2012-2020

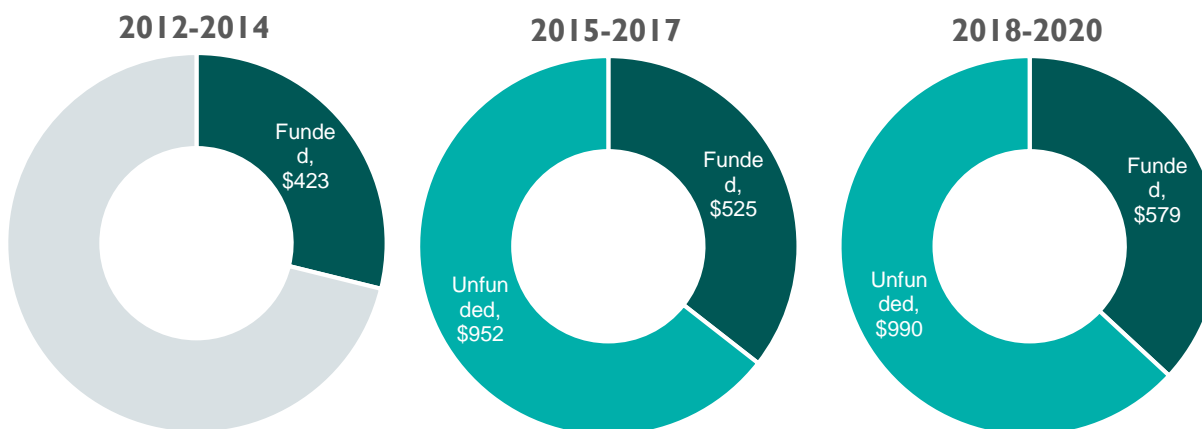
Data from WHO Global Tuberculosis Report Database



Notes: Total need was not estimated for 2012-2014, so the unfunded amount is unknown for this period.

Figure 17: Funded and unfunded portions of TB NSPs in WCA, Millions of USD, 2012-2020

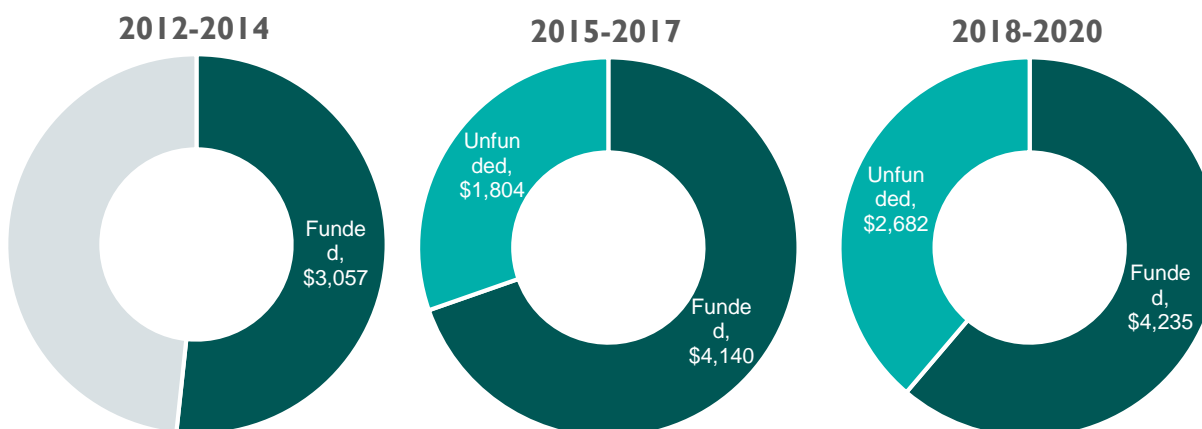
Data from WHO Global Tuberculosis Report Database



Notes: Total need was not estimated for 2012-2014, so the unfunded amount is unknown for this period.

Figure 18: Funded and unfunded portions of malaria NSPs in WCA, millions of USD, 2012-2020

Data from WHO Global Tuberculosis Report Database



Notes: Total need was not estimated for 2012-2014, so the unfunded amount is unknown for this period.

It should be noted here that funding gaps can result in increased OOP expenditures by households, as costs are passed on to them. However, there is no mechanism for looking at the funding gap and then deciding how much of these costs to pass on to households, so funding gaps do not directly result in changes in formal fees. Rather, the funding gaps can result in declines in the quality or availability of services, and this can lead to higher informal fees and indirect costs, depending on which parts of NSPs are not funded. For example, when there is inadequate funding at the national level to procure rapid diagnostic tests, patients may end up being referred to private vendors to purchase them. Commodities, human resources, and equipment maintenance were most frequently mentioned as gaps by questionnaire respondents. These are consistent with findings from focus groups and patient interviews around barriers to care and the existence of informal user fees, suggesting that there is a direct link between national-level funding gaps and access to services. However, it should also be noted that funding gaps are not necessarily the primary drivers of these barriers, as they can also be caused by inefficiencies in service delivery or programmatic gaps. These dynamics are explored in further detail in the country briefs that accompany this report.

With a few exceptions, all countries who submitted responses to the questionnaire indicated that they expected funding gaps to increase over the next two to five years, because more resources would be needed to achieve ambitious targets. The exceptions were countries that indicated that they expected gaps to decrease as a result of increased resource mobilization associated with the implementation of performance-based financing (PBF) (CAR and Mauritania) and exemption policies (CAR), and increased economic growth/health financing (Gambia, Mauritania). Gabon estimated that in spite of the economic growth outlook, the gaps would remain about the same due to external debt obligations, and DRC felt that the gap for HIV would decrease because government had increased allocations to health from 5% to 14%, but that TB and malaria gaps would increase. Two countries (DRC, Sierra Leone) indicated that their governments are often unable to meet co-financing requirements, which exacerbates funding gaps, as do financial and security crises (Burkina Faso, Niger). It is currently unknown how the COVID-19 outbreak may affect funding gaps both in terms of funding being repurposed or redirected to address the outbreak, or the global economic outlook.

Research Question #3: Health Financing Structure

How is health financing structured in each country? How is funding pooled and how are services purchased?

Government Allocations

In all 23 countries, the government provides a share of health financing, although the levels vary substantially (see Question 1). According to study respondents, the Ministry of Finance generally obligates a portion of the national budget to the MOH based on a detailed budget request and on available funds. Budgets notified by the Ministry of Finance for health are often substantially lower than the amounts requested by the MOH, owing to the scarcity of domestic resources and competing priorities. The MOH, in turn, allocates funding for specific items, which typically include the following:

- Salaries and benefits of MOH staff
- Administrative costs of the different departments and national programs (at national and sub-national levels)
- Capital investments (e.g., for equipment or infrastructure)
- Funds for NHI or social protection schemes (in some countries)
- Procurement of drugs and other commodities
- Subsidies for health facilities

In some countries, the MOH may allocate funding directly to facilities, whereas in others with more decentralized governments, the MOH will allocate funds to regions, districts, or communes, which are then charged with allocating funds to facilities.

Most often, facilities will receive support from the MOH in three ways:

- The MOH will cover the salaries and benefits for a predetermined number of health workers at the facility. These are usually paid directly by the central level to workers, bypassing the facility.
- The government will provide a set package of essential drugs and medical supplies to the facility free of charge. This package is procured at the central level and distributed to facilities through the central medical stores (or national pharmacy). It includes drugs and commodities that the facility can sell to patients as well as those that must be provided for free. However, the amount of commodities provided is generally not sufficient to cover all services rendered, and facilities must replenish periodically using their own funds.
- Facilities may receive a pot of money (subsidy) to cover operational costs, although in some countries this may only apply to certain types of facilities (e.g., in Gambia, Mali, and Togo, primary care facilities do not receive any cash subsidy). The funds may be earmarked for specific types of expenditures or may be transferred as a global budget to be used at the facility's discretion to cover supplies and running costs. Facilities visited for this study report that the amount provided is insufficient to meet their needs. Subsidies are typically larger for hospitals that must deliver more specialized and expensive care, which cannot be recovered fully from user fees.

More rarely, the central government may also support the facilities through:

- Purchasing or maintaining equipment
- Paying for utilities (e.g., in Gambia)
- Providing funds to subsidize services that are exempt of user fees (i.e., that facilities are obligated to provide free of charge) or care provided to those who are unable to pay (e.g., in Cameroon, Gambia, Ghana, and Mali – though significant challenges are often experienced with receiving these funds)

There are different approaches used by the MOH to determine the level of funding to allocate to each facility. Depending on the country, criteria for selecting funding levels include the following:

- The type of facility (and the level of care provided)
- The volume of services provided
- The size of the population in the facility catchment area
- Budgets prepared by health facilities based on anticipated needs for the coming year

However, in the countries where we were able to conduct interviews, respondents noted that in the end budgets tend to be allocated based on historical funding levels rather than on other specified criteria. This, combined with limitations of the total funding envelope available to the MOH, also means that the amount allocated does not meet actual needs. In countries where service volume and population size are not taken into account (e.g., Cameroon and Guinea), this has led to issues of inequity because some facilities end up more underfunded than others.

Local Government Allocations

In some countries, such as Guinea, local authorities at the regional or district level are required to provide additional funding to health facilities from local taxes, although the amounts are not very large. In other countries, such as Burkina Faso, communities are expected to provide some support to health facilities either financially or by providing in-kind support for things such as renovations, transportation, or organizing community health campaigns.

Vertical Programs

In WCA, health programs such as HIV, TB and malaria typically operate as vertical programs that receive earmarked funds from the government and external donors to provide select services and implement preventive activities. HIV responses are typically led by national AIDS councils, which often sit directly under the office of the president and sit apart from the Ministry of Health. These vertical programs are the result of donor interest in channeling funds exclusively to specific diseases, and generally do not pool resources with other health areas. Funding for vertical programs can be channeled through the national government, but a considerable portion is provided by external donors directly to non-government organizations who provide direct service delivery or technical assistance to improve delivery in public facilities.⁴²⁰ Only a portion of funding goes to direct care and treatment at health facilities. Vertical programs usually allocate resources to health facilities for specific services only, and these are almost always in the form of inputs rather than cash subsidies, which are left to MOH. In many WCA countries, HIV and TB programs operate their own clinics or wards within hospitals, and may hire their own staff.⁴¹⁹ For malaria, diagnosis and treatment are more integrated into primary health care, but facilities still receive earmarked funds or commodities from the program to deliver a specific package of services.

It is widely recognized that vertical programming enables funding to be targeted at diseases that cause the most mortality, but does so at the expense of building stronger, more sustainable health systems. In some systems, coordination and cooperation between national programs and MOH is poor. This is at least in part why Global Fund began providing RSSH funding to supplement disease-specific funding. Other donors have also taken up the cause of health systems strengthening to complement vertical programming.

There have been efforts in many WCA countries to integrate HIV services into primary care, which from a public health perspective can reduce stigma toward PLHIV and make it easier for people to obtain HIV services. However, from a financial barrier perspective, many of these countries charge fees for general primary care services, which means that integrating services can result in consultation or registration fees being charged unintentionally for HIV services. It can be difficult to implement mechanisms to identify PLHIV or people seeking a test and exempt them from fees charged at primary care clinics, such as through referral forms or an identifying card, without stigmatizing the recipients of these services – people rely on the anonymity that VCT and ART clinics offer and the ability to tell the person at the registration desk that they are going to the “infectious disease clinic,” as many HIV units have been renamed.

Most WCA countries use the Global Fund’s procurement platform to procure HIV, TB, and malaria commodities. Commodities contributed by external partners such as the Global Fund are typically distributed through the national supply chain, but national programs may be involved in determining allocations of commodities.

Performance-Based Funding

Recently, various WCA countries, with World Bank support, have been piloting and beginning to roll out PBF programs as an alternate or supplemental mechanism to fund facilities. PBF has been implemented to try to motivate staff to provide higher quality care and in some cases to counteract the financial losses that facilities experience when user fees for certain services are eliminated.⁵⁹ These programs have been implemented with differing levels of success. In Cameroon, the regions where PBF was implemented saw increases in utilization of maternal and child health services, in quality of care, and in the availability of commodities and qualified health workers. Utilization increased for certain services, but not for others.^{125, 380} The authors of an impact evaluation for this project suggested that it could be that supply-side incentives for providers were not sufficient given existing user fees that acted as a barrier on the demand-side, i.e. that user fees still prevented people from seeking treatment despite an improvement in quality of care.³⁸⁰ Importantly, OOP health expenditures

Common funding mechanisms for health facilities in WCA

- **Staff:** Salaries and benefits for permanent civil servants are typically paid directly at the central level.
- **Commodities and supplies:** The central level (or donors) procures a set amount, and central medical stores distribute it to facilities. Facilities have to supplement any shortages from their own funds
- **Cash funds:** Central or sub-national government authorities provide cash subsidies to some facilities to cover operating and recurring costs, maintenance, equipment, etc.
- **Local governments** may provide a small amount of funds, which may be reserved for specific aspects such as serving indigent populations
- **User fees:** These fees cover all other operating costs, including replenishing drugs and supplies, facility maintenance, contractual staff, etc.
- **NGOs** may provide some additional resources and equipment, but this is not guaranteed.

decreased for households in the PBF arm, including unofficial payments. Cote d'Ivoire also experienced improvement in quality of care in facilities receiving PBF and is planning to scale up this funding model.¹⁸² The process of validating results and assessing quality at health facilities can be onerous and has proved challenging in certain settings. In Benin, for every 1 USD given to facilities, about 0.50 USD was spent on verification, and there was little impact on health worker productivity or quality of care.⁴⁰⁹ In Sierra Leone, PBF programs encountered considerable challenges in verifying results and in disbursing funds to facilities in a timely fashion. In addition, one PBF pilot, funded by external donors, was not scaled up because it was deemed too expensive for the government to take over.⁵⁹ Additional information on PBF is available in the country briefs that accompany this report.

Health Insurance

Health insurance is an additional mechanism used to purchase health services from facilities. This encompasses private insurance typically paid for by employers or employees of the formal sector; social insurance, in which premiums for poorer segments of the population are subsidized by the government; and community health insurance, in which individuals who are usually from the informal sector pay relatively low premiums to join risk-pooling schemes. These insurance schemes use a system of reimbursement to pay facilities for services rendered. In the majority of WCA, the coverage of health insurance is so low that this is not currently an important contributor to financing health services. Across the eight focus countries visited in our study, the majority of facility staff interviewed noted that their patients did not have any type of insurance. However, many countries are moving toward implementing NHI schemes as part of a push toward UHC, and, if successful, this will likely become a key mechanism for purchasing health services. This topic is explored in more detail in Question 8.

User Fees

Direct payment by patients in the form of user fees is one of the most important ways that health services are purchased across the WCA countries studied. We discuss user fees at length, including their role in health system financing, in Questions 4–6.

Research Questions # 4 and #5: User Fee Policies and User Fees Assessed

What user fee exemption policies exist in each country? To what extent do these policies also address informal user fees?

What user fees (formal and informal) are assessed and which are exempt in each country? Are the same user fees exempt in all provinces/states, including in decentralized settings?

All the countries studied were implementing user fees as a result of the Bamako Initiative, which established this means for the health system to recover costs. In the 23 countries, the default is for all services to have fees associated with them. However, the majority of the 23 countries have implemented some form of user fee exemptions for certain sub-groups of the population or for specific types of services.

In 1987, African ministers of health adopted the Bamako Initiative, sponsored by UNICEF and WHO as a way to increase the effectiveness, efficiency, and financial viability of health services.³⁹⁹ The initiative was based on two core tenants: community financing of the health system and community involvement in health facility management, particularly funding. Because facilities were under-resourced, most people were paying for health services and commodities in the private sector. The Bamako Initiative intended

to set user fees low enough to attract people back to the public health system to increase their resource base, and for village management committees to establish criteria for exempting the poor from these user fees. An increase in government and donor spending was an integral part of this Bamako vision³⁹⁹ that did not materialize in every country.

Implementation of the Bamako Initiative varied from country to country, and the collection of user fees began to draw criticism in the early 2000s for creating a barrier to essential primary health care services for much of the population in African countries, as did the reliance on community participation in the management of health facilities over the professionalization of health system management.⁴⁰⁶ Countries have been re-examining and adjusting these policies since then as the focus increasingly moves toward UHC.

Most countries charge a registration/consultation fee to the general population for outpatient services, which is the entry point for many HIV, TB, and malaria services, especially diagnostic testing. The exact amount of the fee depends on a variety of factors, including the level of the health facility at which patients present, the department or ward at which they present, whether they have insurance coverage, and whether they are a foreign national, but ranges from about USD \$0.50 to about \$8.00 (Table 6).

Table 6: Consultation/registration fees charged for basic outpatient services, select countries for which data were available

Country	Basic consultation fee	USD equivalent
Benin	4,000 XOF**	\$6.84
Cameroon	1,000 XAF*	\$1.71
Chad	1,000-5,000 XAF***	\$1.71 - \$8.54
Cote d'Ivoire	1,000 XOF*	\$1.71
Gambia	25 Dalasi***	\$0.48
Guinea	5,000-8,000 GNF***	\$0.52
Mali	500-2,000 XOF*	\$0.85 - \$3.41
Sierra Leone	5,000 Leones*	\$0.50
Togo	500-1,000 XOF*	\$0.85 - \$1.71

* As reported in interviews

**As reported in documentation

*** As reported in interviews and confirmed through documentation

Notes: The consultation fee for Benin is for tertiary facilities. It is likely lower in primary care facilities, but the study team was not able to confirm the price of fees in other facilities. USD equivalents are based on exchange rates from January 1, 2020 from www.oanda.com.

On top of this fee, additional formal user fees are added for each itemized service that the patient receives, which typically include fees for medicines, lab tests, and hospital admission (bed fees), but some countries also charge formal user fees for prescription refills, health booklets, opening a patient file, bed fees for observation, discharge from the hospital. Hospitalization fees may include food and use of toilet or showers. The price of each service varies across countries, by level of the health facility, and sometimes geographically within countries. Of the 23 countries, only Liberia has abolished user fees across the board for a package of essential services.

Most countries have implemented a differentiated fee structure to encourage the use of primary care by charging lower prices for the same services at primary care facilities compared to secondary and tertiary facilities—only Gambia does not, and this is because a flat consultation fee of 25 Dalasi is charged in all facilities that is intended to cover the services received and any needed medicines. In some countries, fees are set at the national level (e.g., in Cote d’Ivoire and Togo), and in others they are set by facilities or sub-national authorities (e.g., CAR, Chad, Mali, Mauritania), usually in partnership with the community management committee.

As mentioned, user fees are charged unless specifically exempted, which is typically done through one of two main mechanisms: (1) formal social protection or health insurance schemes are put in place to partially or wholly subsidize the cost of the service and refund facilities for the provision of said services; (2) simple decrees announcing that specific services are free or that specific populations are exempted from paying user fees. These policies can be in the form of legislation that is legally adopted by governments, ministerial decrees, or guidelines and directives from ministries of health to public health facilities (which might be as little as a one-sentence description on a fee schedule). Generally, there are two types of user fee exemption policies—those for specific populations considered to be vulnerable, which exempts people from paying for a package of health care services deemed essential, and those for specific diseases, which exempt people from paying for certain services, although there is overlap between these two categories.

The most common types of population-based exemption policies in WCA are for pregnant women and children under five. Some countries, including Mali, have implemented exemption policies that remove fees for pregnant women and children for all essential health services (although this policy has not been rolled out nationally).⁴⁰⁰ The Malian policy also includes people over age 70. Other countries have removed user fees for pregnant women for a more limited set of priority services, as is the case in Benin for malaria services, Burkina Faso for all ANC-related services, and Sao Tome and Principe for medications.

User fee exemptions for HIV, TB and malaria services

Although all WCA countries have implemented exemptions around user fees for some HIV, TB, and malaria services, we were not able to identify specific policies in many cases. At times, these exemptions were documented in the national strategic plans. In other countries, such as Mali, they were noted in official decrees. Generally, for the countries we visited, decisions to exempt user fees appear to have been made on a service by service basis, rather than tackling the issue of user fees comprehensively and through formal policy processes.

Furthermore, documentation of exemption policies often lacks specificity and clarity. Although HIV, TB and malaria testing and treatment are said to be “free,” most of them do not define in adequate detail which specific services are supposed to be free. The exact charges that can or cannot be charged in relation to a service are rarely specified. Thus, a policy may require the diagnostic test to be free, but does not address whether the facility can charge for the consultation or supplies required to collect samples. In some countries like Gabon, ‘free treatment’ means only the drugs are provided for free, whereas in others such as Cote d’Ivoire, Mali, and Sierra Leone, ‘free treatment’ includes a broader range of services related to case-management that are offered free of charge. Again, these are often ill defined. For example, the policy may indicate that opportunistic infections are treated for free, without noting which OI or what specific treatment services are included. For malaria, some policies indicate

that malaria treatment is free, when in reality only ACTs are exempt from user fees while other drugs required to treat fever or nausea are not.

For HIV, fees for prevention of mother-to-child transmission of HIV services, rapid diagnostic tests, antiretrovirals, consultation fees for treatment monitoring, and CD4 and viral load testing have been removed in most study countries. The main formal user fees that still exists for HIV are for voluntary male circumcision, consultation fees for diagnostic services, diagnosis and treatment of OIs and co-morbidities, and hospitalization fees (Table 7).

For TB, formal fees have been removed in all nine countries for directly observed therapy, short course and anti-TB medicines, and most countries have successfully eliminated payments for TB services after a patient is diagnosed. The primary challenge related to formal TB user fees is related to diagnosis (consultation fees and X-rays) (Table 7).

Fees for malaria have not been completely eliminated for all population groups in any country, and although countries have made significant progress in recent years to cover vulnerable populations, primarily pregnant women and children under five, various formal user fees remain in place in all countries. Generally, fees for specific commodities that are subsidized by partners are free, and other services are often not exempt. An example from Mali shows that these types of exemptions are not entirely effective. A paper by Touré et al. (2015)¹⁷⁴ demonstrated that in Mali, on average, despite exemptions, patients end up paying in total between 8,000 and 10,000 FCFA for uncomplicated malaria, and around 15,000 FCFA for complicated malaria, for consultations, drugs to manage symptoms, co-morbidities, and hospitalization costs. Malaria cases that qualify for free treatment only pay 1,000–1,500 FCFA less than cases that are not exempt, illustrating how simply removing the formal fee charged for commodities is not always sufficient to eliminate user fees.

The most common user fees that are in still in place for HIV, TB, and malaria are described in Table 7, and more detail for the nine case study countries is included in the country briefs that accompany this report.

Table 7: HIV, TB and malaria services for which formal user fees are charged or exempted in WCA countries. (If countries are not listed in either column, information was not available for that service).

Service	Countries where formal fee exists	Countries where formal fee has been removed through policy	Discussion
HIV			
Voluntary male circumcision	Chad Gambia Mali Togo		Most males are circumcised as infants or young children in most West African societies, so this service is not frequently needed. National strategic plans did not reference this as one of the services exempt from user fees, so we assume formal fees exist in most countries, but could only confirm in a few of the ones our study team visited.
HIV diagnostic test		Benin Burkina Faso Cameroon Cape Verde Chad Cote d'Ivoire Gabon Gambia Ghana Guinea Liberia Mali Mauritania Niger Nigeria Sao Tome and Principe Senegal Sierra Leone Togo	
Consultation fees for diagnosis in outpatient departments	Benin Chad Gambia Guinea Mali Togo	Cameroon Cote d'Ivoire ^{C5/P} Sierra Leone ^{C5/PB} Liberia	Although HIV testing is by policy free in most of these countries, policies often do not specifically address consultation fees, so patients are subject to the same fees charged for general outpatient services, and only the HIV test kit is free. Patient flow dictates whether a consultation fee is charged. In most countries, this fee is charged upon entry to the facility. If patients were to state at registration that they were seeking an HIV or TB test, they may not be charged a fee. However, patients would firstly have to know to do this, which is unlikely, given that these policies are generally not widely publicized, and would secondly have to disclose this information to the person collecting fees, which is also unlikely, given the stigma that exists around these two diseases. In practice, patients are often seen multiple times in outpatient care and are misdiagnosed several times before they are confirmed to have HIV or

Service	Countries where formal fee exists	Countries where formal fee has been removed through policy	Discussion
			TB. Each time, patients have to pay the registration/consultation fee, as well as any other fees associated with treating the condition with which they are diagnosed. For this fee to be eliminated, a specific mechanism would need to be put in place at outpatient services to revise the registration process. ⁶
Consultation fees for antenatal care (ANC)	Benin Cameroon CAR Chad Congo DRC Guinea Mali Mauritania Nigeria Senegal Togo	Burkina Faso Cote d'Ivoire Gambia Guinea-Bissau Liberia	The information here is not specific to HIV testing in ANC, but rather whether women are charged a consultation fee to access ANC in general, as this would affect access to HIV testing in pregnancy. According to WHO and UNAIDS, several countries do not have user fee exemptions for ANC services. ^{401, 415} In these countries, these policies imply that women should be charged a consultation or registration fee to receive an HIV test as part of antenatal services, even if the test itself is provided for free.
ARVs		Benin Burkina Faso Cameroon Cape Verde Chad Congo Cote d'Ivoire Gabon Gambia Ghana Guinea Liberia Mali Mauritania Niger Nigeria Senegal Sierra Leone Togo	ARVs are provided for free in most countries. This includes prophylaxis for pregnant women.
Treatment of common OIs	Benin Burkina Faso Congo Gabon Gambia	Cameroon Chad (not enforced) Cote d'Ivoire Guinea ^{C5}	None of the countries that have policies requiring treatment of OIs to be provided for free for PLHIV have a well-defined list of OIs that are included in the policy. Although TB is generally exempt through other exemption policies, the fees associated with the

⁶ There were no refund mechanisms described in any of the nine case studies to reimburse fees for patients who tested positive for HIV or TB, nor has patient flow been adjusted in any country that we are aware of to have patients pay for services rendered at the end of the consultation rather than at registration. However, in at least one country, a voucher system has been established in which community health workers give patients who have symptoms of TB a voucher along with a referral to the nearest testing facility. A similar system was used in Cameroon by an NGO for HIV testing among key populations. With the voucher, the patient is referred at registration to the HIV or TB department and should not have to pay a consultation fee.

Service	Countries where formal fee exists	Countries where formal fee has been removed through policy	Discussion
	Niger Nigeria	Mali Mauritania Sao Tome and Principe Sierra Leone Togo	treatment of other OI such as sexually transmitted infections, is unclear. Functionally, HIV treatment clinics have some supplies of medicines for OI that are subsidized by the government or donors and that are provided to patients free of charge. Often, however, patients are referred to other departments or clinics for treatment of OIs where they are charged a fee. None of the nine case study countries described a systematic process for ensuring that OIs were treated for free in other departments.
Treatment of common co-morbidities	Benin Chad Congo Cote d'Ivoire Gabon Mali Mauritania Niger Nigeria Togo	Cameroon Gambia Guinea ^{C5} Sierra Leone	Similar to OIs, exemptions for co-morbidities or management of side effects are not well-defined in policy. In Sierra Leone, co-morbidities that can be treated with subsidized medications are treated for free.
CD4, viral load testing	Burkina Faso (VL) Gabon	Benin Burkina Faso (CD4) Cameroon Chad Congo Cote d'Ivoire Gambia Ghana Guinea Liberia Mali Nigeria Sao Tome and Principe Senegal Togo	Most countries have created specific provisions to cover CD4 and viral load testing as Test and Treat has been rolled out. From the review of national strategic plans we identified a few exceptions, recognizing that this information may not be most up to date.
Laboratory monitoring other than CD4 and viral load	Gabon Guinea	Benin Cameroon Chad Cote d'Ivoire Gambia Sierra Leone Togo	Most countries have created specific provisions to cover CD4 and viral load testing as Test and Treat has been rolled out. However, many countries have unclear policies regarding other tests that are important for treatment monitoring, such as creatinine, liver function, full blood count, and blood chemistry. Whether a patient is charged for these is often left at the discretion of the lab facility and is often determined by whether there is an HIV-specific lab that can perform the tests. While Cameroon has exempted creatinine and full blood count testing, only Sierra Leone and Togo have specific

Service	Countries where formal fee exists	Countries where formal fee has been removed through policy	Discussion
			policies that we could find indicating that all other required testing was also meant to be free.
Hospitalization	Benin Cameroon Chad Gabon Gambia Nigeria Togo	Cote d'Ivoire Guinea ^{C5} Guinea-Bissau Mali Sierra Leone	There are myriad costs related to hospitalization for HIV, and policies do not generally describe which of these costs should be provided for free. Generally, HIV patients are subject to the same hospitalization fees as the general population. Gambia has not removed user fees for hospitalization, but the costs are extremely minimal (about \$2 per week); in other countries, these can quickly add up to catastrophic levels of spending.
Tuberculosis			
Consultation fee for diagnosis			Please see more detailed explanation below of the mechanism through which consultation fees are charged in outpatient departments in the Informal User Fees section.
Laboratory diagnostic	Cameroon (sputum collection) Guinea Senegal	Benin Cape Verde Chad Cote d'Ivoire Gambia, Guinea ^{C5/PLHIV} Mali Mauritania Niger Sierra Leone Togo	
X-Rays	Benin Chad Cameroon Gambia Guinea	Cote d'Ivoire Gambia Mali Sierra Leone Togo	Gambia is listed twice because X-rays should be free when used as part of treatment monitoring but not when used for diagnosis. X-rays can be extremely costly to patients, and although providers report that they are not used often, user fees for them can be an important barrier to care for patients who need them.
Anti-tuberculosis drugs		Benin Burkina Faso Cameroon Cape Verde Chad Cote d'Ivoire Gabon Gambia Guinea Mali Mauritania Niger Nigeria Senegal Sierra Leone Togo	Practically all countries have user fee exemption policies for TB drugs.

Service	Countries where formal fee exists	Countries where formal fee has been removed through policy	Discussion
Consultation fee for treatment	Benin Cameroon	Burkina Faso Chad Cote d'Ivoire Gambia Guinea Mali Niger Sierra Leone Togo	Consultation fees for treatment have not been formally removed in Benin and Cameroon, although it is not clear to which services they apply. Presumably, this would only be for regular monitoring visits rather than directly observed therapy, short course visits for medication administration. Most TB policies were adopted several decades ago and have not been updated to reflect new guidelines and treatment methods, leaving a large degree of ambiguity.
Hospitalization	Benin Cameroon Chad Gabon Gambia Togo	Burkina Faso Cote d'Ivoire Gambia Guinea Mali Mauritania Sierra Leone	There are myriad costs related to hospitalization for TB, and policies do not generally describe which of these costs should be provided for free. In many countries, hospitalization fees are not charged in a TB ward. However if a TB patient requires hospitalization elsewhere they may be charged hospitalization fees. Inclusion of food is the main item that varies among countries, which can be an important determinant of treatment success and a barrier when family members or caretakers have to provide food for the patient. Gambia has not removed user fees for hospitalization, but the costs are extremely minimal (about \$2 per week); in other countries, these can quickly add up to catastrophic levels of spending, particularly considering that TB is a disease that disproportionately affects the poor.
Malaria			
Intermittent preventive treatment in pregnancy (IPTp)		Benin Burkina Faso Cameroon Chad Cote d'Ivoire Gambia Mali Nigeria Sierra Leone Togo	All nine countries have eliminated fees for IPTp, although there are restrictions in some cases on how many doses are covered and during which trimesters. However, IPTp services are subject to same consultation fees mentioned above for HIV testing in ANC.
Consultation fees for malaria diagnosis	Burkina Faso Cameroon Chad Guinea Liberia Mali Togo	Benin ^{C5/P} Cote d'Ivoire ^{C5/P} Gambia ^{C5/P} Guinea-Bissau ^{C5/P} Sierra Leone ^{C5/P}	Four out of the eight countries have eliminated consultation fees, but only for children and pregnant women. In Cote d'Ivoire and Sierra Leone, this is through social protection mechanisms that exempt these populations from consultation fees for primary care services in general, and in Benin and Cameroon, it is through malaria exemption policies specifically. In Benin, the consultation fee is only free if the patient tests positive for malaria. In Cameroon, it is unclear how this exemption is supposed to be implemented.

Service	Countries where formal fee exists	Countries where formal fee has been removed through policy	Discussion
Rapid diagnostic tests		Benin ^{C5/P} Burkina Faso ^{C5/P} Cameroon ^{C5} Chad Cote d'Ivoire Gambia Guinea Guinea-Bissau Liberia Mali ^{C5/P} Mauritania Niger ^{C5/P} Sao Tome and Principe Senegal Sierra Leone Togo	User fees for rapid diagnostic tests have been removed for everyone in five countries, and for pregnant women and children in three countries.
Confirmatory test (microscopy)	Chad Gambia Guinea Mali Togo	Benin ^{C5/P} Cameroon ^{C5} Cote d'Ivoire Guinea-Bissau Sierra Leone	User fees for confirmatory tests have been removed for everyone in three countries, for children and pregnant women in two countries, and they remain in place for everyone in three countries. User fees for confirmatory tests are often relatively high, and in countries where they are non-exempt, they are often prescribed more often than medically necessary.
Artemisinin-based combination therapies	Burkina Faso (uncomplicated malaria)	Benin ^{C5/P} Cameroon ^{C5} Chad (not functional) Congo ^{C15/P} Cote d'Ivoire Gambia Guinea Guinea-Bissau Liberia Mali Mauritania Niger ^{C5/P} Sao Tome and Principe Senegal Sierra Leone Togo	Many countries have at minimum a policy that exempts people from user fees for artemisinin-based combination therapies. They can apply to the entire population or in some cases only to pregnant women and children under five. However, these policies only cover drug formulations that are subsidized (often by the Global Fund). Other forms of anti-malarials are not exempt, which facilitates the charging of informal fees, discussed below.
Auxiliary medicines	Burkina Faso Cameroon Chad Cote d'Ivoire Gambia Mali Togo	Benin ^{C5/P} Guinea ^{C5} Sierra Leone ^{C5/P}	Although not typically expensive, lack of exemption for auxiliary medicines such as fever reducer and antibiotics can lead to overprescribing as a cost recovery mechanism. In Gambia, auxiliary medicines are not technically free but are included in the consultation fee, so this does not apply.

Service	Countries where formal fee exists	Countries where formal fee has been removed through policy	Discussion
Medicines for severe malaria		Benin ^{C5/P} Burkina Faso ^{C5/P} Cameroon ^{C5} Chad Congo ^{C15/P} Cote d'Ivoire ^{C*/P} Gambia Guinea Guinea-Bissau Mali Mauritania ^{C5} Sierra Leone Togo	All countries have at minimum a policy that exempts some people from user fees for treatment of several malaria (generally injectable artesunate). In several countries they apply to the entire population, but in others only children under five and pregnant women are exempt from paying fees.
Hospitalization	Cameroon Chad Gambia Mali Togo	Benin ^{C5/P} Cote d'Ivoire ^{C*/P} Guinea ^{C5} Sierra Leone ^{C5/P}	Hospitalization fees for severe malaria vary widely across countries, and total costs often depend on several factors. In countries where fee exemptions exist, they only apply to children under five and pregnant women. Gambia has not removed user fees for hospitalization, but the costs are extremely minimal (about \$2 per week); in other countries, these can quickly add up to catastrophic levels of spending.

^{C5/P} Superscripts indicate whether the policy applies to a certain sub-population only (e.g., C5 indicates it is applicable only to children under five years of age. C15 indicates it is available only to children under fifteen years of age, P indicates it is available only to pregnant women. C5/P indicates that the policy is only applicable to children under five and pregnant women. C* is specific to Cote d'Ivoire, where male children under 16 years of age and female children under 25 years of age receive free services.)

Note: For countries not presented in this table, the study team was either not able to find data or policies were inconclusive.

In summary, in each country, there is a complicated web of disharmonized policies and user fee structures that leads to confusion among health workers and individuals, and makes policies difficult to control or enforce, which contributes to the charging of informal user fees, discussed next.

Informal User Fees

Among the 15 countries that responded to this component of the online questionnaire, almost all indicated that informal user fees were rarely charged for HIV, TB, and malaria services in public facilities (i.e., less than 20% of the time [Burkina Faso, Cape Verde, Chad, Cote d'Ivoire, DRC, Ghana, Liberia, Mauritania, Niger, Sao Tome and Principe, Sierra Leone, and Togo]). Respondents for Gabon and CAR indicated that informal payments are charged 20–39% of the time. Respondents for Guinea indicated the fees were charged more than 80% of the time.

Scientific literature and country case studies do not support the assertion that informal user fees for HIV, TB, and malaria are rare in most countries^{9, 33, 106, 104, 125, 174, 213, 255, 308} – the discrepancy could be related to a lack of understanding of what constitutes an informal fee, though a definition was provided in the questionnaire. Or it is possible that national level respondents are not aware of the practices occurring in health facilities since few countries monitor adherence to exemption policies. There are three main types of user fees relevant to HIV, TB, and malaria that were noted in the case studies:

- **Fees that result from stockouts.** It is apparent in many countries that the supply chain is not working effectively and greatly contributing to informal fees. When health commodities that are supposed to be free are stocked out, the health facilities may purchase their own drugs or testing supplies and resell to patients, or providers will refer patients to private pharmacies or laboratories to purchase the drug or testing service. This was noted across all three diseases but was especially prevalent for HIV and malaria because HIV and malaria commodities were more frequently reported to be stocked out.^{211, 325} In some cases, these stockouts may be artificially created to justify the charging of informal user fees (see the Togo Country Brief in Appendix J for more information). Similarly, in some countries health workers were prescribing certain brands of drugs that they explained were more effective but are actually just not covered by an exemption policy. Patients would then be asked to purchase them at the facility's pharmacy or be referred to purchase them from private vendors, which in some cases are owned by the same health workers who issued the referral, or people in their health worker's social circle. This was specifically noted for artemisinin-based combination therapies in Gambia, Sierra Leone, and Togo, but it may be present in other countries as well.
- **Add-on fees used by facilities to recoup costs of free services.** Overprescribing of medicines and lab tests that are not free (e.g., ordering microscopy confirmation of malaria or artesunate injections for simple malaria) were frequently noted to be occurring in case study countries where these services were not free. Additionally, some health workers mislead patients about which services are exempt as a way to increase earnings for either the health worker or the facility, depending on whether the health worker keeps the payment or deposits it into the facility's account. For example, some respondents shared that they were charged fees for consumables associated with services intended to be free of charge. These include charging an injection fee for services that are formally exempt in Mali, charging 100–200 FCFA for gloves for rapid testing services in Togo, and, alarmingly charging a fee of 100–200 FCFA to hospitalized patients every time they use the toilet in Chad. Further country-specific information is reported in the countries briefs included in the appendices of this report.
- **Paying of bribes.** The study did not identify any strong evidence of bribes being charged for special treatment (e.g., being seen ahead of other patients) related to HIV, TB, or malaria services in any of the case study countries. In fact, many health workers indicated that asking for bribes for HIV and TB patients was unethical because they are mostly poor, and health workers themselves often give patients money for transport. Focus group data and patient interviews seem to suggest that paying bribes for health services is quite frequent because patients report paying for services that they believe are supposed to be entirely “free,” and assume they are being asked to pay a bribe. However, it is likely that patients do not fully understand the formal user fee exemption policies. As stated earlier the term “free testing” or “free treatment” lead to confusion when the intent is that only specific drugs or testing kits are provided free of charge. In some countries, receipts are not provided, making it difficult for patients to understand what they are being charged for, and even in settings in which receipts are provided, they are often not itemized or use medical terminology that patients do not understand.

Policies on informal fees were also difficult to identify. In many countries, it is understood that informal fees should not be collected, but stakeholders were often unable to point to specific policy or legal framework that addresses informal user fees or that describe penalties for charging them. Exceptions include Sierra Leone, which has an anti-corruption policy that addressed the matter of user fees, and

Cameroon, which has issued ministerial decrees, and Cote d'Ivoire, which has issued directives to facilities, stating that it is illegal to collect any type of fee for exempt HIV services.

Research Question # 6: User Fee Revenue

How is revenue from user fees used (locally or nationally) in each country?

How user fees are managed and used varies among countries. In more than half of the countries for which data were available (9 of 15 countries),⁷ between 90% and 100% of user fee revenue is retained at the facility where it is collected (Table 8). Two countries (Cabo Verde and Gambia for lower-level facilities only) reported that all revenue is sent to the central level, where it is pooled and re-invested. In the other countries, a portion of revenues, ranging from 40% in Mauritania to 70% in CAR, is transferred to the central level, where the revenue is pooled to finance the health system. Pooled user fee revenue is most commonly used to cover staff salaries and procure drugs and medical supplies, which are then redistributed to facilities.

Table 8: Proportion of funds retained at the facility, by country

Country	Proportion of user fee revenue retained at the facility	Proportion sent elsewhere
Benin	n/a	n/a
Burkina Faso	n/a	n/a
Cabo Verde	0%	100% to central level where it is pooled to finance health system
Cameroon	85%–100% for hospitals 90% for primary care facilities	One hospital reported having to transfer 15% of user fee revenue to the public treasury. 10% of revenue from primary care facilities is deposited in a centrally managed “solidarity fund” (unclear how this is used).
CAR	30%	70% to central level (no additional information available)
Chad	100%	0%
Congo (Brazzaville)	n/a	n/a
Cote d'Ivoire	0–50%	100% sent to central level. Central level usually returns up to 50% to facilities if justified through budgeting process.
DRC	100%	0%
Gabon	25–50%	50–75% sent to central level to cover salaries, investments, and health system operations
Gambia	100% for hospitals 0% for lower-level facilities	Lower-level facilities transfer 100% of revenue to the region, which is then pooled at the national level

⁷ Information is based on responses to the web questionnaire, interviews, and document review. For eight countries (Benin, Burkina Faso, Cabo Verde, Guinea-Bissau, Liberia, Nigeria, Sao Tome and Principe, and Senegal), we were unable to obtain any information regarding the types of expenses covered with user fees. For Gabon and Mauritania, only limited information was available, so we do not have a comprehensive understanding of this question.

Country	Proportion of user fee revenue retained at the facility	Proportion sent elsewhere
		in the Consolidated Revenue Fund for procurement of drugs and commodities.
Ghana	100%	0%
Guinea	100%	0%
Guinea-Bissau	n/a	n/a
Liberia	n/a	n/a
Mali	100%	0%
Mauritania	60%	40% is supposed to be deposited in savings account for emergency funds which must be approved by MOH. There is little oversight or accounting of this.
Niger	100%	0%
Nigeria	n/a	n/a
Sao Tome and Principe	n/a	n/a
Senegal	n/a	n/a
Sierra Leone	90%	10% transferred to a centrally managed Consolidated Revenue Fund (for drug purchases)
Togo	100%	0%

n/a=information not available

User fees retained at the facility level are used to supplement funds provided by the government. A recurrent theme across all countries is that the government funding allocation (whether in cash or in-kind) received by health facilities is not sufficient to cover their operating costs and that user fees are necessary to bridge the gap. The proportion of facilities' budgets that come from user fees varies by country and by type of facility and depends directly on the level of funding that they receive from the national government. In DRC, various studies suggest that user fees represent up to 90% of facility operating costs.¹¹⁹ In Mali, administrators in two facilities reported that excluding staff salaries, equipment, and exempt drugs, user fees covered 98% of the facility operating costs. Exact estimates were unavailable for most countries, and facility administrators interviewed were rarely able to provide a specific number because of various funding streams and inadequate accounting practices. However, in countries where user fees are retained at the facility, respondents noted that that user fees represent the majority of the facility operating costs. In several countries (Cameroon, Guinea, Mali, and Togo), it was also reported that primary care facilities are much more dependent on user fees than hospitals, because the latter receive large cash subsidies to finance operating costs, whereas primary care facilities receive very small cash subsidies or none at all.

All countries (regardless of where user fee revenues are managed) reported that a substantial portion of user fee revenue is dedicated to the procurement of additional drugs and medical supplies to replenish facility stocks. When revenue is retained at the facility, the facilities either purchase commodities directly from the national pharmacy, or from private entities in the case of stockouts. Almost all countries reported that user fee revenue is also used to procure non-medical supplies (92.3%) or equipment (61.5%) and to supplement or cover salaries for health workers (71.4%) (Table 9). If revenue is retained at the facility, facilities will often hire contractual health workers and administrative staff (such as janitorial staff and security) with the user fee revenue. In two-thirds of countries, facilities utilize user fees to cover costs such as facility maintenance, utilities and transportation, and in 29% of countries, user fee revenue is used to pay for allowances, which might include bonuses or other benefits such as

housing. These expenses are reported only by countries where user fee revenue is retained at the facility. Not all countries reported on the use of user fees for allowances, so we may be underreporting this estimate.

If user fee revenue is retained at the facility, the facility deposits it in a bank account and relies on a management committee to oversee accounting and make decisions on how user fees are spent. Often, these committees will include facility staff and members of the community. The amount of discretion facilities have in deciding how to spend funds varies by country. In some, there are official rules guiding what types of expenses can be made and the proportion of user fee revenue that can be spent on each (such as in Cote d'Ivoire and Mali), and in others, the facility management committees can decide independently how best to allocate their resources (as is the case in Guinea).

Table 9: Percentage of countries indicating that revenue from user fees is used for various costs

Type of expenditure	Percentage of countries reporting using revenue from user fees for specific expenditures	Countries reporting use of user fee revenue for specific expenditures
Medications/drugs	100.0%	Benin, Burkina Faso, Cameroon, CAR, Chad, Congo, Cote d'Ivoire, DRC, Gambia, Ghana, Guinea, Mali, Niger, Sierra Leone, Togo.
Medical supplies	84.6%	Burkina Faso, CAR, Chad, Congo, Cote d'Ivoire, DRC, Ghana, Guinea, Mali, Niger, Sierra Leone, Togo.
Non-medical supplies	92.3%	Burkina Faso, Cameroon, CAR, Chad, Congo, Cote d'Ivoire, DRC, Ghana, Guinea, Mali, Niger, Sierra Leone, Togo.
Salaries for health workers	71.4%	Burkina Faso, Cameroon, CAR, Chad, Congo, Cote d'Ivoire, Gabon, Guinea, Mali, Niger, Togo.
Wages for administrative staff	57.0%	CAR, Chad, Congo, Cote d'Ivoire, DRC, Gabon, Niger, Togo.
Allowances (non-wage payments to staff)	28.6%	CAR, Mauritania, Sierra Leone, Togo
Purchase of equipment or other capital	61.5%	Cameroon, CAR, Chad, Ghana, Guinea, Mali, Niger, Togo
Facility maintenance/transport or other	64.3%	Burkina Faso, Cameroon, CAR, Chad, DRC, Ghana, Guinea, Mali, Mauritania, Sierra Leone.

Note: Information was gathered from web questionnaires, interviews for countries that were visited, and occasionally from literature. Not all countries provided information for all expenditure type, so denominators for percentages vary. Benin, Cape Verde, Gabon, Guinea Bissau, Liberia, Mauritania, Nigeria, Sao Tome and Principe, and Senegal did not provide response to the questionnaire or to this question. In some cases information was obtained from the document review.

Research Question # 7: User Fee Implementation

How have user fee exemption policies been implemented, rolled out, and advertised in each country? What has been the effect of the way in which they were implemented, rolled out, and advertised on service utilization?

Empirical studies looking at the effect of implementation, rollout, and advertisement of user fees for HIV, TB, and malaria in WCA were not identified. This is an issue that can significantly impact the

effectiveness of user fee policies but receives an inadequate amount of attention. Some valuable lessons learned about specific aspects have surfaced through this research. They are outlined below.

Implementation

Planning

Literature (for non-HIV/TB/malaria) describes the importance of planning and properly costing services, understanding the volume of care, and ensuring that facilities are adequately resourced and reimbursed so that they do not end up with stockouts or reduced quality of care before implementing policies like those for fee exemptions.

Compensation to Health Care Workers and Facilities

In many countries, HIV, TB, and malaria services are declared exempt from user fees because the commodities (tests, drugs, etc.) are provided free of charge to facilities. However, facilities do incur costs associated with providing these free services (e.g., for medical supplies, cleaning products, disposal of biohazards, wages for contracted staff who interface with patients). When fees are eliminated, facilities are not only missing out on revenue, they are also losing money, because the price they were charging patients for these commodities was inclusive of these other costs. Generally, there are not systems in place to reimburse facilities for costs incurred during delivery of free services, and there have been limited cases in which governments have increased subsidies to compensate for lost revenue. Evidence indicates that this leads health care workers to charge informal fees to recover some of these costs.¹⁰³ Examples of fee-for-service reimbursement mechanisms that have been put into place include the following:

- In Benin, a fee-for-service system of reimbursement for exempted malaria services has been established, in which facilities compile monthly invoices for services that are sent to the district level and then to the Directorate for Financial and Material Resources and the National Malaria Program.¹¹³ There is evidence that this system is under-resourced, however, and facilities are often not reimbursed for services they provide, which leads them to cease implementation of the exemption policy and charge patients instead.
- In Sierra Leone, free maternal and child health care was rolled out in 2010 through a program called the Free Health Care Initiative. The success of the program, in terms of increased utilization and improved outcomes, is attributed in part to funding being available to augment health care worker salaries to compensate for increased workloads, and to increase the number of health care workers offering services.^{59, 63} However, the initiative is heavily dependent on donor funds, thus limiting its sustainability.²⁵⁰
- In Cameroon, a voucher system for pregnant women was implemented in which women pay a small amount up front and receive a package of ANC services free of charge. The program was also considered successful because it included incentives for the facilities.¹²⁵
- Several countries (notably Benin, Cote d'Ivoire, and Gambia) have implemented PBF schemes, either nationally or as pilot initiatives, as a way to augment health workers' salaries and improve quality of care. Evidence of the effectiveness of these initiatives is limited (see the Benin Country Report for more information).

Implementation Mechanisms

As noted in Research Question #4, policies that include changes to implementation mechanisms are likely to be most effective. As an example, some countries provide tests and medicines for free, but

patients still pay a consultation charge prior to diagnosis because the structure of patient registration was not changed to facilitate the exemption. This may discourage some patients from seeking care.

Enforcement

Under the Bamako Initiative, enforcement of user fee policies was seen as one of the responsibilities of community members, but in practice this has not proven to be effective. Evidence suggests that enforcement capacities in most countries are weak. Some countries do spot checks (Benin¹⁰³ and Cote d'Ivoire), but most rely on a passive system in which the onus is on patients to file complaints. Even when patients do file complaints, there are generally limited mechanisms of penalization. Exceptions include Sierra Leone, in which violations are enforced through the regular law enforcement system, and Cameroon, which has recently established a taskforce to oversee the implementation of the new HIV fee exemption policy.

Typically, there is little active monitoring and enforcement of user fee exemptions, which makes it easier for facilities to charge informal fees. In many countries, receipts are not provided to clients for fees paid for services, so they have no documentation or proof, and no way to verify to which services the charges corresponded. In countries that do provide receipts, costs are not itemized, so patients cannot verify whether charges are valid. Patients often do not understand the medical terminology that health workers use on receipts when they are itemized. Furthermore, accounting systems that properly document fees collected by facilities are not systematically implemented. Respondents in Sierra Leone indicated that processes to digitize user fee payments could help with tracking revenue as well as enforcement of user fees.

Respondents in Gambia and Guinea indicated that it is up to the patient to report illegal fees, and also acknowledged that the country lacks systems for lodging complaints. Relying on patient complaints implies that the patient understands the fee structure and what they were charged for, and the patient knows where to file a complaint. One of the instances in which countries are actively enforcing user fees policies is in Cote d'Ivoire, which sends "mystery clients" to verify that HIV services are provided free of charge.

Advertisement

Generally, inadequate attention has been paid to advertising exemption policies. Communication activities are largely left to donors to finance and are mostly an afterthought. Some radio campaigns have been conducted, and printed materials have been created to post in health facilities. Fee structures were posted on walls in health facilities in some countries (Gambia, Mali, and Sierra Leone), but the number of services that are available in some health facilities make it impossible to include all the information in a legible format. Furthermore, prices change at various frequencies in each country due to advances in technologies and protocols, and policies also change, so these lists have to be constantly updated or they become out of date as soon as they are posted on the wall. Cote d'Ivoire and Guinea have attempted to use chalkboards for this purpose, but if facility staff can change to lists too easily, this defeats the purpose and makes it easy to charge informal fees. Largely, it is left to providers to communicate information about fee structures to patients, and they are unlikely to do so for myriad reasons described in this study. The lack of awareness of exemption policies leads to inadequate demand creation by the populace, which would help serve as an enforcement mechanism and enable patients to know their rights.

Rollout

We initially expected there to be some phased approaches to rollout of exemption policies, but we did not find evidence of this in our review, except for broader social protection mechanisms, discussed in Research Question #8.

Unstable funding

In countries such as CAR, Chad and Congo Brazzaville, that have experienced economic crises in recent years, user fee exemptions have been very difficult to sustain.^{213, 295, 296, 421} During such times, health facilities typically see great reductions in their funding levels, government-funded commodities become scarcer, and supply chains less efficient. Health facilities, facing financial deficits and stock-outs are unable or unwilling to provide services for free even if free commodities are made available to them for distribution.

Research Question #8: Social Protection Mechanisms

What social protection mechanisms exist and what do they cover?
What formal and informal insurance mechanisms exist and what do they cover?

For the purposes of this report, we are defining social protection programs using the Oxford Policy Management's Shock-Responsive Social Protection Systems study,³³⁹ which suggests that social protection includes both contributory instruments (known as social insurance) and non-contributory instruments (known as social assistance, or sometimes social safety nets) that target the poor and vulnerable. Most countries included in this study have both social insurance and social assistance programs, although they vary in terms of coverage, implementation status, and effectiveness.

Social assistance instruments are non-contributory instruments that help vulnerable individuals cope with poverty and meet basic needs. They are generally provided by the state and financed through national taxes or, in the case of many WCA countries, by donors. At the national level, social assistance instruments typically encompass user fee exemptions and funds for indigents. Many projects and NGOs also have programs targeting the poor, but we will not discuss them here.

User Fee Exemptions

User fee exemptions are a common type of social protection for health that are implemented in all 23 countries in this study. Through user fee exemptions, countries allow for certain priority populations (most often children under five and pregnant women) to access health care, or at least specific services, free of charge. Generally, exemptions apply to groups that the government wants to encourage to use services because they are particularly vulnerable to negative health outcomes. In the case of HIV and TB patients who face long-term care and expensive treatment, user fee exemptions are also intended to provide financial protection.

It is worth noting that only rarely are user fee exemptions used as a mechanism to target and protect the poorest and most vulnerable segments of the population (i.e., those with least ability to pay for health services). Instead, user fees are typically applied to entire categories of individuals without sufficient attention paid to implications around equity. Identifying the poor and classifying the population according to their ability to pay is a complex and challenging process, which many countries have shied

away from. Unless there are official approaches to register those who qualify, the system can lead to abuses and health workers arbitrarily deciding who can receive free care. To simplify matters, governments have opted for blanket eligibility criteria based on age or health condition. In doing so, they end up using scarce resources to subsidize individuals who are not needy. Yet, studies have shown that members of the population are often willing to help pay for a portion of their health care and do not require services to be provided completely free of charge.⁴¹⁴

Funds for Indigents

Some countries have set aside funds to cover the cost of health care for indigent populations. The management and scale of these funds vary. However, none of the programs are able to completely cover the population in need.

In Benin and Cameroon, there are official funds established at the national level to cover costs provided to indigent populations.^{112, 261} In Cameroon, the Ministry of Social Affairs transfers funds directly to facilities.¹¹² However, respondents seemed to indicate that this was not widespread, and facilities end up covering costs out of their own accounts or even collecting contributions from health workers when needed.

In Togo, hospitals also receive separate line items to cover the poor but report that the funds are insufficient to meet the need. In Guinea, only limited funds are transferred to hospitals to cover very poor patients who come in for emergency services. It up to the hospital to determine who to use the funds for. MOH and facility staff noted that at lower levels of the health system, facilities are unable to support the very poor and may turn patients away if unable to pay. Likewise, in Sierra Leone, facility administrators reported that those unable to pay are only treated if it is a life-saving emergency. Many of these countries do not have a way to adequately identify who is considered poor, and developing standardized systems for doing so and registering individuals or households is costly and complex.

Some countries have experimented with vouchers for the more vulnerable and poor, as was the case in Cameroon for HIV prior to widespread fee exemptions.¹²⁵ Such a system removes responsibility for identifying the poor from the facility and places it on other stakeholders, which could be projects, civil society organizations, or local leaders.

The World Bank has been supporting some countries, including Benin and Guinea, to establish mechanisms for identifying and registering the extremely poor as part of the move toward achieving social insurance and UHC.

Social Insurance

In a social insurance system, participants (or their employers, or the state, on the participants' behalf), make regular payments (premiums) to a scheme that then pays benefits for life-course events, such as old age, unemployment, sickness, injury, and maternity/paternity benefits. Most countries in WCA have established social insurance systems that provide health insurance coverage to some populations, namely government employees. However, as the global outlook is increasingly focused on achieving UHC, many countries in WCA are developing plans for an NHI system that enrolls the entire population into a resource- and risk-pooling mechanism.²⁷⁵ The principle behind an NHI is that premiums are based on each individual's ability to pay. Generally, everyone pays a monthly or annual premium for a package of health services that varies from country to country, plus in some cases a co-payment for services. Some populations are subsidized partially or completely and pay lower premiums and co-payments or none at

all. NHIs are described in more detail in the country reports for Chad, Cote d'Ivoire, The Gambia, Mali, Sierra Leone, and Togo.

Private Health Insurance

In the majority of WCA countries, private health insurance schemes are extremely limited and are affordable for a very limited portion of the population usually employed in the formal sector by large, often multi-national businesses.

Community Health Insurance—*Mutuelles*

In the 1990's, community-based health insurance schemes were promoted, especially by donors, as a way to help people in the informal sector cover the user fees charged at health facilities.⁴²¹ This model was envisioned to continue to promote the essential tenant of the Bamako Initiative of community participation in the management of health care. In some WCA countries, particularly the francophone ones, a significant number of *mutuelles* still exist, but they cover a very small percentage of the population and are plagued by challenges that contribute to the low coverage and sustainability of these schemes..

Research Question #9: Effect of Social Protection on Utilization

To what extent are social protection mechanisms/insurance mechanisms effective at increasing access and utilization of health services?

Health insurance has the potential to improve utilization of health services, but coverage is still too low in most WCA to make much difference. Studies have shown that persons with insurance use health services more than the uninsured and are less likely to use self-treatment, and less likely to forego treatment.^{29,421} Most WCA countries in this study have initiated plans to expand insurance in an effort to achieve UHC. However, other than Ghana, most are in the early stages of planning and coverage has not been scaled. The social insurance schemes that do exist have very low enrollment and many are underfunded and face many implementation challenges (e.g., mismanagement and reimbursement delays).

Many insurance schemes do not currently include services that are offered for free in the country, such as HIV and TB services (less so for malaria). If these services are not included in the insurance schemes, then increased coverage in insurance will not translate to increased utilization of HIV and TB services.

To be impactful, insurance schemes need to address many challenges:

- Enrollment in these insurance schemes is very low because people do not understand the value or do not want to pay. This will require concerted communication efforts.
- Affordability has to be addressed to increase the pool of participants, and that means heavy subsidies for a large number of the poor in most WCA countries. It is unclear how governments will fund this in the long term.
- Logistically, it is difficult and costly to reach and enroll the poor in remote areas who may need this most. Though the World Bank is working with a few countries to establish such mechanisms.

Evidence that community health insurance, or *mutuelles*, improves utilization is mixed. Some studies indicate that they can improve access to health services.^{32, 421} These schemes tend to be more affordable to the poor and those in the informal sector than private insurance, and their presence in the community allow them to enroll hard to reach populations. Studies in Ghana have shown that persons

with community health insurance have lower OOP expenditures.⁴²¹ However, the challenges faced by these schemes have reduced their impact. Information and awareness among the targeted populations is not widespread. This results in low membership which leads to low revenues. The low premiums also limit the funding pool sometimes below the level needed to meet demand making access to funds unreliable. Furthermore because enrollment is voluntary, these schemes have tended to attract individuals with worse health.⁴²¹ Many *mutuelles* have limited capacity to manage insurance, and financial and technical support as well as leadership from the associated ministries has been limited.^{386,128} Relations with contracted health care providers are poor. On the other hand, there have been cases such as in Senegal where capacity-building efforts to improve management and accounting have increased the effectiveness of these programs. The vision for several UHC initiatives is that *mutuelles* will be incorporated into broader insurance networks and will still have a role to play. Both Senegal and Ghana have moved to consolidate community health insurance schemes into larger district and national managed schemes as part of their efforts to achieve UHC.⁴²¹

Research Question #10: Barriers to Utilization

What are the largest barriers to accessing health services (especially HIV, TB, and malaria services) among different populations in each country? What are the equity implications, and how do barriers affect different quintiles of population?

Secondary analyses using standard of living surveys from seven countries (Cameroon, Chad, Gambia, Guinea, Mali, Sierra Leone, and Togo) were conducted.⁸ These surveys collect information on health service utilization of household members, health expenditures, and household income (or household expenditures as a proxy for income), among other things. We examined the association between the utilization of health care services at formal facilities and various determinants. To explore these associations, we used multivariate regression, and we also used concentration curves to assess the degree of inequality across income or wealth. This section provides a general summary of results across the various countries (Table 10). Because the surveys are not standardized across countries, the indicators used in the analysis may vary somewhat, and we therefore caution about making direct comparisons across countries. For example, in Sierra Leone, health care utilization is defined as seeking care at a formal health care facility for those experiencing illness in the previous month. Whereas in Cameroon, we are measuring seeking health care consultation (anywhere) in the previous two weeks. More detailed analyses are included in the country reports that accompany this report.

⁸ The surveys used for these analyses are listed in the methodology section of this report.

Table 10: Utilization of healthcare services by select characteristics across countries,

Data from national livelihood surveys⁹

	Cameroon (2014)	Chad (2018-19)	Gambia (2015)	Guinea (2018-19)	Mali (2018-19)	Sierra Leone (2018)	Togo (2015)
	% who used health care services, among those with illness episode in the last two weeks	% who used health care services, among those with illness episode in the last month	% who used health care services, among those with illness episode in the last two weeks	% who used formal health care services, among those with illness episode in the last month	% who used health care services, among those with illness episode in the last three months	% who used formal health care services, among those with illness episode in the last month	% who used formal health care services, among those with illness episode in the four weeks
Total sample	51.6%	69.7%	81.3%	52.9%	51.3%	48.7%	60.3%
Women	52.3%	69.9%	81.6%	52.0%	52.6%	48.5%	n/a
Men	50.3%	69.3%	80.9 %	53.7%	49.9%	49.0%	n/a
Child under five	57.8%	73.8%	86.4%	59.8%	53.0%	67.5%	n/a
Rural	52.0%	62.9%	81.2%	49.5%	44.8%	54.0%	n/a
Urban	51.2%	73.9%	81.6%	55.4%	59.8%	43.2%	n/a
Poorest quintile	47.1%	59.1%	81.4%	38.0%	45.8%	45.2%	43.3%
Richest quintile	58.6%	78.4%	82.2%	62.7%	66.7%	53.1%	74.9%

Income

Across countries, there was consistent evidence that richer segments of the population are more likely to use health care services at health facilities. We examined inequalities using concentration curves and corresponding indices, which provides means of assessing degree of income or wealth related inequalities in the distribution of various health-related indicators¹⁰. A concentration curve plots the cumulative percentage of a variable on the y-axis, here outpatient health care service utilization, against the cumulative percentage of the population, ranked by another variable, on the x-axis, here wealth quintile beginning with the poorest and ending with the richest. If each quintile used exactly the same proportion of outpatient services, the concentration curve would be a 45-degree line, depicted as the line of equality marked in red. If poorer quintiles instead used a smaller proportion of services than richer quintiles, the concentration curve would lie below the line of equality, as it does here. The farther the curve is below (or above) the line of equality, the more concentrated the y-axis variable is among the rich (or the poor). The concentration index is the area between the calculated concentration curve and the line of perfect equality. A negative value indicates disproportionate concentration amongst the poor, while a positive value indicates disproportionate concentration amongst the rich. Health care

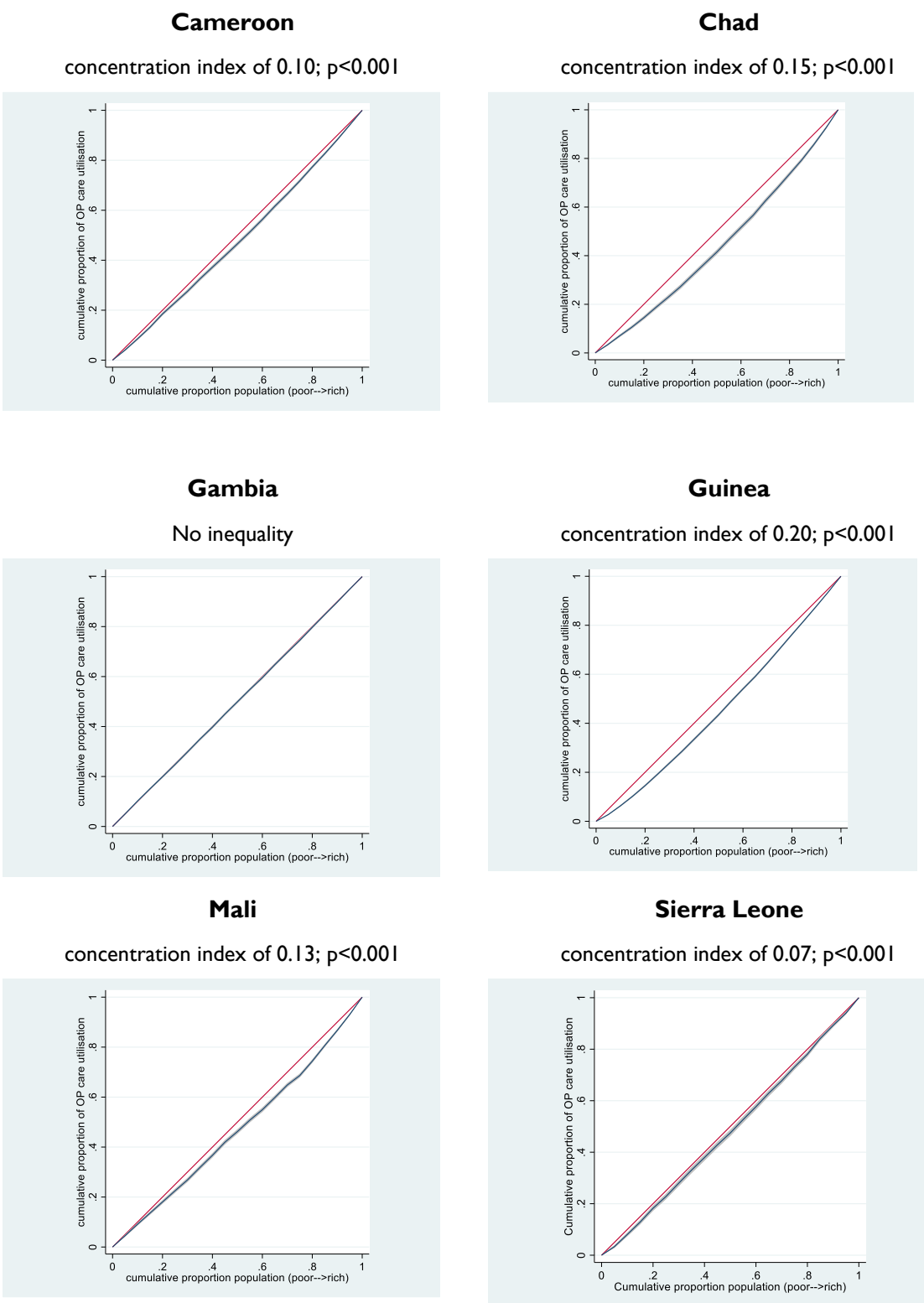
⁹ See Methodology for full list of livelihood surveys used.

¹⁰ Additional methodological details on the concentration curves are available in the [World Bank Technical Note](#)

utilization was significantly higher in the richest segments of population for Cameroon, Chad, Mali, and Sierra Leone. The concentration curves were all significantly skewed toward the rich, although to differing degrees (Figure 19). Chad had the highest concentration index (0.15), indicating higher levels of inequality in service utilization. In multivariate models of service utilization, income was a statistically significant predictor across countries after controlling for other variables such as education, distance to facilities, age, gender and household size (Table 11).

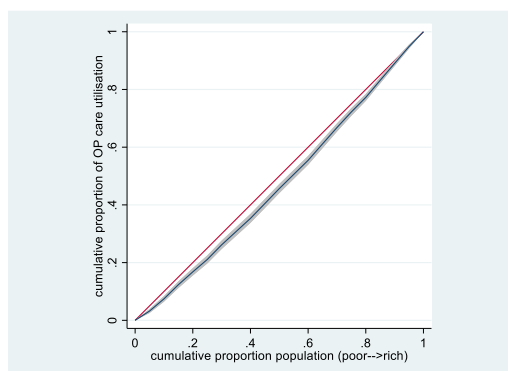
A notable exception was Gambia, where a relatively high proportion of the population reported accessing health services and no significant inequities in health care utilization based on wealth were found in our analysis when comparing the poorest to richest quintile or through our estimation of concentration indices. After controlling for other factors, such as education, distance to facilities, age, gender and household size, with multivariate regression, income does show a significant positive association with service utilization in Gambia. It is likely that one or more of these factors was confounding the association between income and health care utilization. Nevertheless, the magnitude of the effect of wealth (measured by the regression coefficient of income) is smaller in Gambia than other countries. It should be noted that Gambia is the only country in our study that had a flat rate for health services that included consultation and all prescription drugs, regardless of illness. Every other country used a fee-for-service model that charges for every consultation, test, and drug required for case management. The fee-for service model results in higher OOP expenditures for patients than the mechanism established in Gambia which may explain why we see greater association between wealth and health care utilization in those countries.

Figure 19: Concentration curves for service utilization among those who were sick:
Data from national livelihood surveys



Togo

concentration index of 0.14; $p < 0.001$



In addition, in most countries, there were clear patterns of differences between the types of facilities more commonly used by people from different wealth quintiles. Poorer quintiles were more likely to use lower-level facilities (like health centers or health posts) where user fees are lower, and respondents from the richest quintile were significantly more likely to use hospitals and private facilities or providers where user fees are higher (data not shown but available in country reports).

Table 11: Multivariate regression models for health care utilization

Data from national livelihood surveys

Cameroon			Chad		
Variable	Coefficient	se	Variable	Coefficient	se
Individual level			Individual level		
Household head	-0.021	(0.055)	Household head	-0.178**	(0.070)
Age	0.009**	(0.004)	Age	0.021***	(0.005)
Age-squared	-0.000	(0.000)	Age-squared	-0.000***	(0.000)
Gender	0.124***	(0.037)	Gender	-0.005	(0.046)
Child under five	0.551***	(0.064)	Child under five	0.448***	(0.080)
Malaria symptoms	0.336***	(0.042)	Malaria symptoms	-0.041	(0.047)
Household level			Household level		
Education household	0.126*	(0.066)	Education household	0.136**	(0.061)
Income level	0.481***	(0.040)	Income level	0.359***	(0.044)
Household size	0.035***	(0.008)	Household size	0.044***	(0.011)
Community level			Community level		
Distance to health facility	0.003	(0.030)	Distance to health facility	-0.160***	(0.043)
Urban	-0.333***	(0.060)	Urban	0.137*	(0.081)
Observations	14,576		Observations	12,094	
Pseudo R-squared	0.0350		Pseudo R-squared	0.0450	
Robust standard errors in parentheses *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$			Robust standard errors in parentheses *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$		

Gambia

Variable	Coeff	se
Individual level		
Household head	-0.164	(0.119)
Age	0.006	(0.007)
Age-squared	-0.000	(0.000)
Gender	0.087	(0.075)
Citizenship	0.042	(0.218)
Child under five	0.641***	(0.120)
Malaria symptoms	0.407***	(0.088)
Severity	0.130***	(0.014)
Household level		
Education household	0.081	(0.297)
Income level	0.240***	(0.067)
Household size	0.025***	(0.008)
Community level		
Distance to health facility	0.337	(0.423)
Urban	0.263*	(0.148)
Observations		
	6,721	
Pseudo R-squared		
	0.0664	
Robust standard errors in parentheses *** p<0.01, ** p<0.05, * p<0.1		

Guinea

Variable	n	Mean
Individual level		
Age	0.001	(0.003)
Age-squared	0.000*	(0.000)
Gender	-0.102***	(0.027)
Religion	0.017	(0.068)
Child under five	0.557***	(0.048)
Malaria Symptoms	0.590***	(0.029)
Severity	1.900***	(0.034)
Household level		
Education Household	0.152***	(0.056)
Income level	0.875***	(0.047)
Household size	0.047***	(0.007)
Community level		
Distance to health facility	-0.730***	(0.116)
Urban	-0.005	(0.049)
Observations		
	31,039	
Pseudo R-squared		
	0.196	
Robust standard errors in parentheses *** p<0.01, ** p<0.05, * p<0.1		

Mali

Variable	Coeff	se
Individual level		
Household head	0.339***	(0.075)
Age	0.004	(0.004)
Age-squared	-0.000	(0.000)
Gender	0.160***	(0.043)
Child under five	0.235***	(0.066)
Malaria symptoms	0.799***	(0.052)
Household level		
Education household	0.327***	(0.060)
Wealth quintile 2	0.011	(0.086)
Wealth quintile 3	-0.071	(0.088)
Wealth quintile 4	0.067	(0.097)
Wealth quintile 5	0.629***	(0.116)
Household size	-0.011**	(0.005)
Community level		
Urban	0.283***	(0.074)
Observations		
	12,145	
Pseudo R-squared		
	0.0696	
Robust standard errors in parentheses *** p<0.01, ** p<0.05, * p<0.1		

Sierra Leone

Variable	Coeff	se
Individual level		
Household head	0.168**	(0.078)
Age	-0.003	(0.006)
Age-squared	-0.000	(0.000)
Gender	0.059	(0.054)
Muslim	-0.189**	(0.081)
Other religion/no religion	-0.052	(0.341)
Free malaria consultation	0.988***	(0.095)
Malaria symptoms	0.333***	(0.064)
Severity of illness	0.090***	(0.007)
Household level		
Education household	-0.105	(0.077)
Income level	0.787***	(0.079)
Household size	0.056***	(0.011)
Community level		
Distance to health facility	-0.116***	(0.042)
Urban	-0.787***	(0.091)
Observations		
	9,520	
Pseudo R-squared		
	0.101	
Robust standard errors in parentheses *** p<0.01, ** p<0.05, * p<0.1		

Togo

Variable	n	Mean
Individual level		
Malaria Symptoms	0.263***	(0.095)
Household level		
Income level	0.590***	(0.088)
Household size	0.094***	(0.022)
Community level		
Distance to health facility	-0.284**	(0.143)
Urban	-0.244*	(0.134)
Observations		
	2,592	
Pseudo R-squared		
	0.0522	
Robust standard errors in parentheses		
*** p<0.01, ** p<0.05, * p<0.1		

In both Gambia and Sierra Leone, about 20% of those who did not seek treatment indicated that it was because of cost (Figure 20). In Chad, almost half (43%) who did not seek care for an illness cited cost as the main reason.

Distance to Facility and Transportation

Information on distance to facility was not available consistently across countries.¹¹ However, in those countries for which robust indicators on either distance or time to travel to facility were available, results indicated a significant negative association between how far the health facility is and probability of using health services. Findings on differences in health service use by location were mixed. For example, in Gambia and Mali, respondents in urban locations were significantly more likely to use health services, and the opposite was true in Cameroon and Sierra Leone. In Gambia, 11% of those who did not seek care noted that distance to facility was the reason, and an additional 3% cited the cost of transportation as a barrier.

Participants in focus group discussions across countries also highlighted the cost of transportation as a key barrier to accessing care. Transportation costs are especially problematic in countries in which HIV and TB services are offered in a subset of all health facilities. Transportation costs can be considerably higher than direct payments for medical care and have been found to be an important contributor to catastrophic health expenditures in some studies.

Education

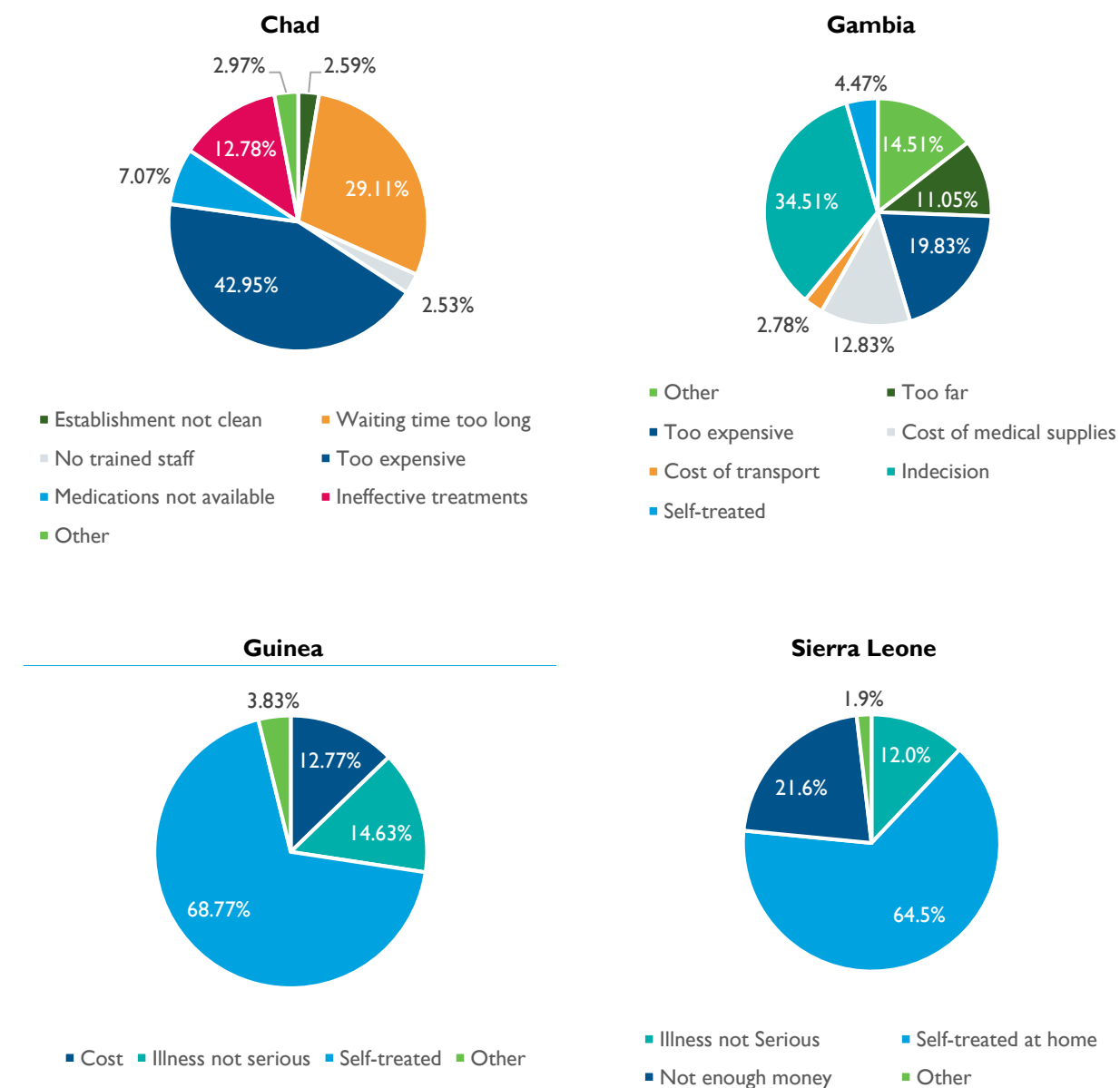
Although education was not a significant predictor of health service use in all countries, higher education was generally positively associated with health care utilization after controlling for other factors, such as place of residence and income. Education indicators were not always consistently defined or collected across countries, and, as a result, some of the observed variation in the effects can be due to the differences in available indicators.

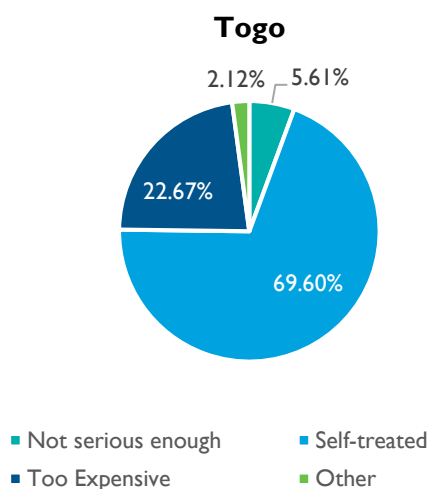
¹¹ In some countries, this indicator was not present at all, and in other countries data had to be imputed for patients who reported being sick but did not use health services.

Quality of Care

Participants in focus group discussions noted that poor quality of care is a deterrent to seeking care at health facilities. Stockouts of drugs and inadequate equipment were cited, as was low capacity of health care workers to quickly diagnose illness. All these issues also contribute to added OOP costs for patients. Survey results from Chad (Figure 20) also show that poor quality of care is a major reason why people choose not to seek care even if they are ill.

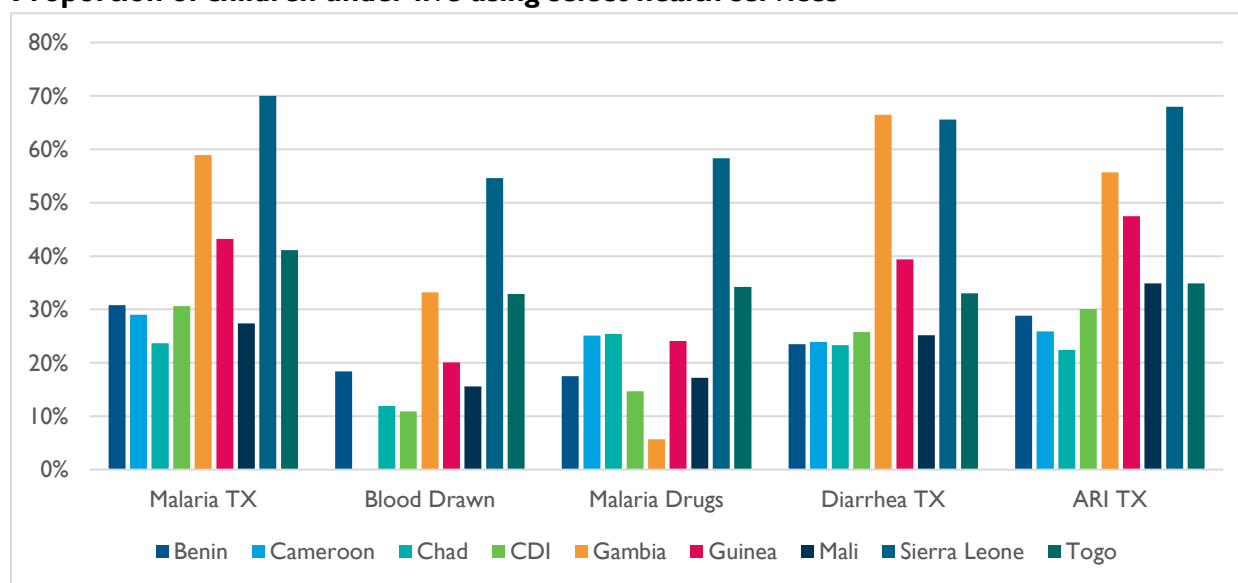
Figure 20: Reasons for not using health services, data from national livelihood surveys



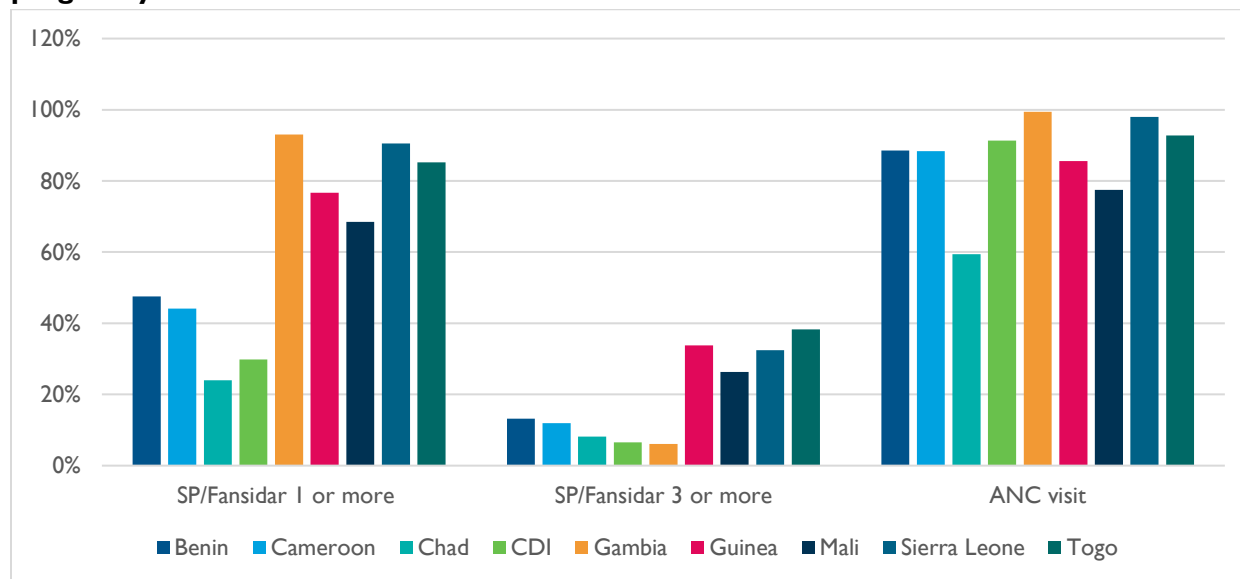


To further examine the equity implications observed, we conducted an additional analysis of 16 service-specific indicators using DHS data. Figure 21 presents utilization of specific services across overall population in each country. Results indicate that overall, utilization of services for children under five, such as medical treatment for malaria, blood draws for malaria testing, use of malaria drugs, medical treatment for diarrhea, and medical treatment for ARI was higher in Gambia and Sierra Leone, of sulfadoxine/pyrimethamine (SP) (Fansidar) use among pregnant women was higher in Gambia, Guinea, Mali, Sierra Leone, and Togo. No large differences in ANC use across the countries were observed, with the exception of lower use in Chad. HIV related indicators among women were highest in Gambia, Sierra Leone, and Togo. Among men, highest utilization rates were observed for Cameroon.

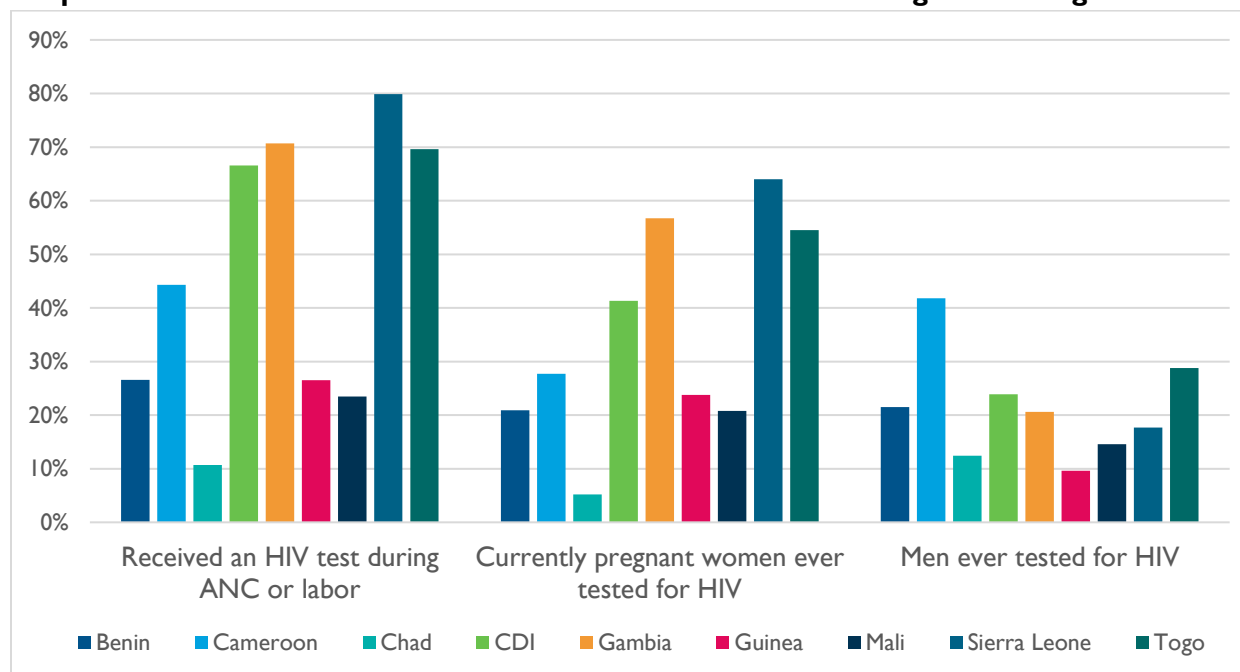
Figure 21: Utilization of specific services, source most recent DHS or MIS survey for each country
Proportion of children under five using select health services



Proportion of women who received ANC and malaria preventative services during last pregnancy



Proportion of women and men who received select HIV counseling and testing services



Findings from this analysis were generally consistent with the results observed for overall use of health services, with richer segments of populations being more likely to use specific services. Similar to the results described above, less income inequalities were observed for Gambia across the various indicators considered (with the exception of some of the HIV service utilization-related indicators). However, depending on the indicator, there were differences across countries in the presence and the extent of inequalities, as measured by the concentration index. Income inequalities in the use of malaria-related services use for children under five were present in majority of countries. Gambia, Mali,

Sierra Leone, and Togo were less likely have significant differences across wealth quintiles for this set of indicators. The highest degree of income-related inequality for malaria services utilization among children under five was found in Guinea and Cameroon. Analyses of use of sulfadoxine/pyrimethamine (Fansidar) by pregnant women showed significant income inequalities in all countries, except Cote d'Ivoire, Gambia, and Sierra Leone. The highest degree of inequality for this indicator was found in Cameroon. For treatment of diarrhea among young children, income inequalities were observed only for Cameroon, Chad, and Guinea, with Guinea having the highest level of inequality. Income inequality in utilization of health services among children under five with symptoms of acute respiratory infection (ARI) were found in all countries except Gambia, Mali, and Togo. Inequality in ANC use was observed in all countries except Gambia, with the highest degree of income inequality found in Cameroon. Across all HIV testing-related indicators, all countries (with the exception of Gambia) tended to have significant income-related inequality. Results were consistent across various population groups, such as pregnant women, and men.

Research Question #1 I: Gaps in Access to Care

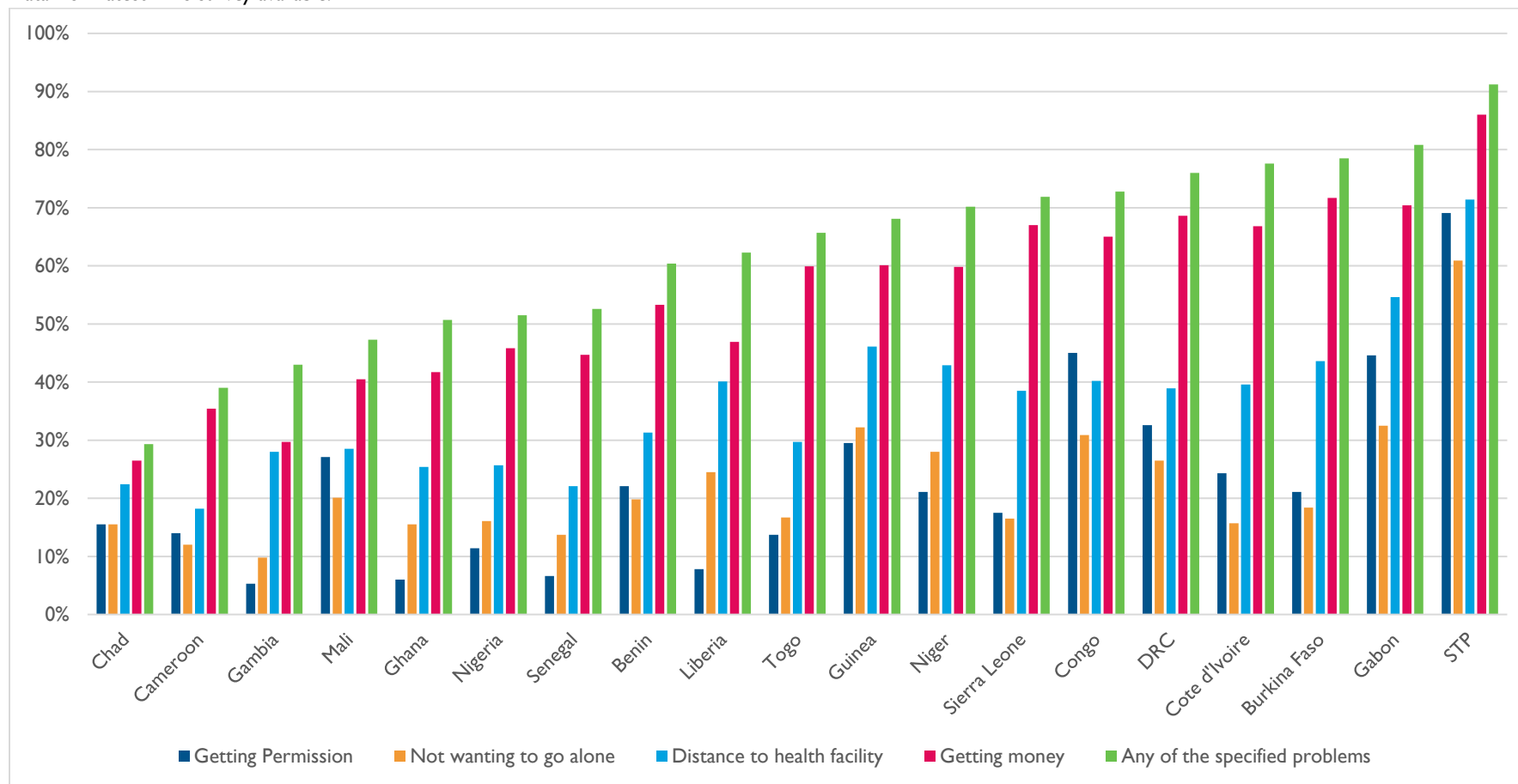
To what degree are there gaps in [access to] health services in each country, and which populations most experience gaps? What are the drivers of these gaps?

Several gaps in access to HIV, TB, and malaria services have been identified in the literature. The existence and degree of gaps vary from country to country, as is clear from the health outcome data presented in the Disease Profiles section of each country report (Annexes B-J). Overall, access to health care services and health outcomes related to HIV are low among adolescent girls and young women, particularly in WCA, in addition to other key and vulnerable populations like MSM, prisoners, and sex workers.²⁵⁶ PMTCT and EID services are a key area of concern¹⁵² and are often inaccessible in WCA due to geographic service coverage and stockouts of key commodities. Findings from this study and others show unequal utilization of health services between urban and rural populations, where patients in rural areas have less access to health care than those in urban areas. It has been noted elsewhere that pregnant women and children under five living in rural areas find it difficult to access preventive care and treatment for malaria, TB, and HIV.⁸⁷ Longer distances to facilities are a factor, especially in WCA countries where HIV and TB services are offered in a limited number of facilities across the country.

As mentioned in question #10 above, our analysis points to the fact that the poor continue to have significantly lower levels of service utilization in general and for malaria and HIV services specifically, even when these services are offered free of charge. Data from DHS surveys suggest that cost is a significant driver of inaccessibility of curative health services in general (Figure 22). Among women of reproductive age in 19 of the 23 countries in WCA, getting money was the most reported problem with accessing health services for general illness. Distance to health facility, which is also associated with costs as people have to pay for transport if the facility is too far to walk, was the second-most reported problem in all countries except Congo, where getting permission to go was a more significant problem. It is notable that women in Chad and Cameroon were among the least likely to report money as a problem in accessing treatment, given that we know that out-of-pocket expenditures for health care in these two countries are among the highest as a percent of total expenditures. However, the data for

Figure 22: Problems in accessing health care among women of reproductive age, 2008-2018

Data from latest DHS survey available.



Notes: Data are reported for the most recent year available: Benin 2017-2018; Burkina Faso 2010; Cameroon 2011; Chad 2014-2015; Congo 2011-2012; DRC 2013-2014; Cote d'Ivoire 2011-2012; Gabon 2012; Gambia 2013; Ghana 2014; Guinea 2018; Liberia 2013; Mali 2018; Niger 2012; Nigeria 2018; Sao Tome and Principe 2008-2009; Senegal 2017; Sierra Leone 2013; Togo 2013-2014. Data not available for Cape Verde, CAR, Guinea-Bissau, or Mauritania.

these two countries are from 2014-2015 and 2011, respectively, before significant economic crises caused by a fall in oil prices affected both countries. Women in Gambia were the second least likely to report money as a problem, which we would expect given the low and predictable cost of basic health services in that country.

The same analysis using DHS and MIS data described in question #10 above also speaks to inequalities between richer and poorer populations in the nine priority countries, and shows similar results as those discussed in the use of outpatient services. Appendix A contains concentration curves for the use of these services. Concentration indices for each country and indicator and associated significance of measured inequities are presented in Figure 23 and Table 12 contain a graphical representation of the relative size of concentration indices to facilitate comparison across countries and indicators:

- Cells shaded in green indicate either that the index was not statistically significant, indicating that there was no significant inequality, or the index was negative and significant, indicating that poorer segments of population were more likely than richer segments to use a specific service.
- Cells shaded in pink represent the relative size of inequalities as measured by the value of the concentration index.

Figure 23: Concentration indices for various service-specific indicators among nine case study countries, 2011–2018: graphical representation of relative scale

Data from most recent DHS/MIS available

Indicator	Benin	Cameroon	Chad	CDI	Gambia	Guinea	Mali	Sierra Leone	Togo
Malaria TX									
Blood Drawn									
Malaria Drugs									
Diarrhea TX									
ARI TX									
SP/Fansidar 1 or more									
SP/Fansidar 3 or more									
ANC visit									
HIV Counselling ANC									
HIV Test ANC									
HIV Test Ever Pregnant									
HIV Test Ever Men									
HIV Test Results Pregnant									
HIV Test Results Men									

What is clear from this analysis is that countries who have eliminated barriers to access (user fees) for children under five and pregnant women, namely Gambia and Sierra Leone, see less inequality in service utilization. However, this is not enough to eliminate all inequality – several indicators still exhibit significant inequality, and more specific interventions are needed to increase access and utilization of services. The main driver of the gap in access between rich and poor is a lack of adequate financial risk protection measures. User fee exemptions are the primary form of health-related social protection in WCA. They are a necessary but not sufficient step to eliminate gaps in and barriers to access as they do not adequately target the poor. In most countries in WCA, classifying who is poor and who is not is difficult and time-consuming in contexts where most people are employed in the informal sector. In these contexts, the only way that countries have found to remove barriers for the poor is to eliminate user fees for entire groups of the population, like children under five, or entire services, like RDTs,

Table 12: Concentration indices for various service-specific indicators among nine case study countries, 2011–2018: values

Data from most recent DHS or MIS survey available

	Benin		Cameroon		Chad		Cote d'Ivoire		Gambia		Guinea		Mali		Sierra Leone		Togo	
	n	Index	n	Index	n	Index	n	Index	n	Index	n	Index	n	Index	n	Index	n	Index
Services for children under five																		
Proportion of children under five with fever in the 2 weeks preceding the study who received treatment at a health facility (public or private – excluding pharmacies)	2429	0.09***	2680	0.24***	3546	0.19***	1662	0.19***	977	0.01	1221	0.29***	1503	0.09**	1435	-0.01	777	-0.05
Proportion of children under five with fever in the past 2 weeks preceding the survey that had their blood drawn	2429	0.04*	Not reported		3546	0.11***	1662	0.07**	977	0.13**	1221	0.14***	1503	0	1435	-0.04	777	-0.09*
Proportion of children under five with fever in the 2 weeks preceding the survey who took antimalarial drugs	2429	0.06**	2680	0.23***	3546	0.06**	1662	0.11***	977	0.02	1221	0.1***	1503	0.03	1435	0	777	-0.1*
Proportion of children under five with diarrhea in the 2 weeks preceding the survey who received treatment	1342	-0.01	2078	0.17***	2151	0.13***	1276	0.1***	1340	-0.02	1011	0.31***	1590	0.01	1214	0.07	537	-0.01
Proportion of children under five with signs of ARI in the 2 weeks preceding the survey who received treatment	702	0.1*	1664	0.22***	1794	0.2***	615	0.2***	673	-0.08	318	0.22**	312	0.06	1200	0.03	922	0.14**
ANC and malaria prevention services for pregnant women																		
Proportion of women who had at least one ANC visit during her last pregnancy	8994	0.2***	3675	0.28***	6944	0.13***	2597	0.14***	5385	0	5530	0.18***	6368	0.22***	8524	0.02***	5016	0.11***
Proportion of women who had a live birth in the 2 years preceding the interview who received one or more doses of SP/Fansidar in the two years preceding the interview	5733	0.2***	2441	0.19***	4217	0.12***	1575	0.03	1677	-0.06*	3183	0.18***	4089	0.18***	2554	0	1456	0.09***
Proportion of women who had a live birth in the 2 years preceding the interview who received three or more doses of SP/Fansidar	5733	0.13***	2441	0.12***	4217	0.05***	1575	0.05*	1677	-0.01	3183	0.22***	4089	0.09***	2554	-0.13***	1456	0.26***
HIV testing services																		
Proportion of women who received an HIV test during ANC or labor	8994	88.5%	0.2***	3675	88.4%	0.28***	6944	59.4%	0.13***	2597	91.3%	0.14***	5385	99.4%	0	5530	85.6%	0.18***
Proportion of pregnant women who have ever received an HIV test	0.28***	2460	0.08***	1016	0.42***	852	0.1	946	0.3***	1145	0.33***	1426	0.11**	811	0.51***	0.28***	2460	0.08***
Proportion of men who have ever received an HIV test	0.38***	5248	0.17***	5135	0.25***	3821	0.12***	4117	0.15***	4618	0.21***	7262	0.16***	4476	0.31***	0.38***	5248	0.17***

which is inefficient because it exempts even those who can afford to contribute. Given that there are a limited number of resources available to support improved access and utilization of health services, it is vital that those who can contribute to paying for health care do, and those that cannot still have access to high quality services.

Research Question #12: Removing User Fees

What effect might removing fees only in some disease areas and for some populations have on health care service utilization and supply of quality health care services?

There is ample evidence indicating that user fee removal, *when planned correctly*, increases utilization of health services, at least in the short term.² Respondents in our study indicate that user fees lead to important delays in seeking care, self-medication, refusal of prescribed treatments, and use of traditional healers instead of formal health care professionals. Studies suggest that formal and informal user fees are one of the reasons that HIV patients drop out of care.⁴¹⁵ Eliminating user fees for some populations has been effective in increasing the use and retention of TB treatment (when TB patients become exempt from paying), or malaria services, and use of maternal and child health services (when children under five are exempt). However, the disadvantage is that this approach does not target those most in need of subsidized care, which are the poor.

Removing fees for only select services may not be sufficient to eliminate the barrier that user fees represent. In the countries we have studied that charge a fee for every service received (as opposed to a flat rate), patients are unsure of what they will be charged when they arrive at facility. Even if knowing that malaria medicines will be given free of charge, it is unclear whether other fees, for other drugs, for consultation, or for additional testing, will be requested. This uncertainty can be a barrier to accessing free services. This same fee structure can lead to abuse and the introduction of informal fees as described in Question 4, because health workers can easily find ways to make patients pay for something to recover some costs. Evidence indicates that removing consultation fees is associated with increased utilization of health services. Countries with user fees for ANC had the lowest percentage of pregnant women using PMTCT services.⁴¹⁵

To maintain quality when user fees are eliminated, it is critical to identify a mechanism by which facilities can recover the cost of providing free services. These costs include medical supplies, cleaning supplies, disposal of biohazards, utilities, etc. When only commodities are given, the facilities have to absorb those other costs and find a way to pay for them. This can mean less money to purchase essential drugs, retain contracted staff, or maintain the facility. If utilization increases as a result of reduced fees, then even more of the facility's resources must be deviated away from their usual line items to cover the costs of providing the free services. Both Mali and Togo experienced declines in quality of care after malaria fees were eliminated (see country reports for more information). Question 7 elaborates more on this issue.

Conclusions

Across West and Central Africa, user fees are a significant barrier to access and utilization of HIV, TB, and malaria services. To differing degrees, countries have put in place fee exemptions for many of these services. While this is a positive step toward increasing access to care, there are several challenges that

remain to be addressed in order to adequately reduce financial barriers to service utilization. The main challenges in the region are:

Exemption policies are not well defined.

The removal of user fees for certain services and populations is done through the enactment of exemption policies, usually in the form of ministerial decrees or guidance notes distributed within health systems. In most countries, these policies do not specify in adequate detail which specific services, commodities, and procedures are free and are not free. For example, a policy may note that a test is to be provided free of charge but does not state what the policy is for charging for the consultation visit associated with that test, or for consumables used to obtain a sample for testing. As a result, facilities are free to interpret it as they want so long as the actual test (i.e. commodity) is not charged for. This also leads to confusion for patients who have been told that testing or treatment is free but are then faced with fees when seeking these services. Additionally, exemption policies are not regularly reviewed or modified to account for advances in technology and clinical guidelines require the provision of new and different services, so some services are not addressed at all. Furthermore, in most WCA countries, fee structures vary by type of facility and even between facilities of the same type so countries do not have a standardized fee structure that people can consult to understand what is supposed to be charged. The lack of clearly defined policies and fee structures makes it easier for facilities to charge patients for services that are supposed to be free.

Exemption policies do not cover all services and all populations.

In most WCA countries only a subset of HIV, TB and malaria services are exempt from user fees, though the range of free services varies among countries. Most countries have removed user fees for most preventive services, drugs, and some types of diagnostic testing for HIV, TB, and malaria. Other services, like consultation fees at entry points like outpatient care and ANC, fees for hospitalization, laboratory exams, management or treatment of co-infections, co-morbidities, and side effects, and medical booklets, are not exempt from payment in many countries. Additionally, often only certain drug formulations are exempt – generally the ones that are provided by donors. Thus, patients still incur costs for services needed to manage illness, and those costs create barriers to health care utilization and lead to catastrophic health expenditures for many. Not surprisingly, many patients decide to skip certain tests or treatments prescribed by a health worker. Selective exemption policies help reduce the cost to the patient, but typically not enough to avoid adverse economic impact.

In some countries, the exemptions may only apply to certain populations, such as pregnant women and children under five (typically for malaria) or to populations living in a given geographical region. This is a reasonable decision when funding is not sufficient to cover everyone, but leaves financial barriers in place for the rest of the population, and exempts from payment even people who can afford to contribute to the cost of their care.

Facilities are not adequately funded to provide free services.

In many countries, services were exempted from user fees without establishing a way to fully replace the revenue that facilities were earning from those fees. Generally, there are two mechanisms to reimburse facilities for services they are expected to offer for free: (1) reimbursing a fee-for-service for each patient provided the service, and (2) providing the inputs or commodities required to offer the service. In WCA, the second mechanism is the one most commonly used. The problem with this is that the commodities provided only account for part of the cost of providing the service to patient. For

example, when facilities charge for testing, the price does not only include the actual testing commodities, it also includes the other direct costs associated with providing services – such as the salary of the health worker and lab technicians (when needed), the medical and non-medical supplies used to collect samples and tend to patient, and indirect costs the facility incurs such as cost of facility maintenance, security, and administration. The provision of free commodities helps but is not sufficient to defray costs to the facility of providing care.

Some countries (such as Benin) have implemented reimbursement mechanisms to account for lost revenue. Others (such as Togo) have provided facilities other drugs for free for facilities to sell to replace this revenue. But even these mechanisms have experienced challenges because insufficient funds are available to meet demand, and because of poor management which leads to delays in reimbursement. Many of the WCA countries have opted to only provide commodities and expect facilities to absorb the other costs of service provision.

Informal fees are charged on top of formal user fees.

Many factors lead to the charging of informal fees for HIV, TB and malaria services. These include:

- The under-resourcing of the health system, and of free services in particular, drives the charging of informal user fees by creating shortages in health facility budgets. Faced with an inability to pay for essential commodities, compensate health workers and cover other facility functioning costs, health workers and administrators resort to informal fees to supplement their incomes and revenue base.
- Inefficient supply chain systems commonly lead to stock-outs of key commodities required to provide free services. In the absence of free commodities, facilities purchase their own goods through the national pharmacy or private market and then recover costs from patients or send patients directly to private pharmacies to buy medicines themselves.
- Poorly defined exemption policies leave loopholes for facilities to charge for certain services, such as consultations or health booklets, even if the intent of the policy was that the entire service was free to patients.
- Inexistent systems for monitoring and enforcing exemption policies mean facilities have no incentives to follow the rules, patients have no means for lodging complaints, and the government has little recourse to impose sanctions when policies are not implemented.
- Poor communication and dissemination of the exemption policies leads to patients' having poor understanding of what services they are entitled to free of charge.

The study identified several types of informal fees that are charged: (1) referral to the private sector because of stock outs, which may be real or artificially created (2) prescribing drug formulations that are not covered by an exemption policy, (3) charging fees for registration, consultations, or supplies (4) overprescribing tests and medicines that are not medically necessary, and (5) demanding bribes (this was noted very infrequently).

Other barriers to service utilization also exist.

While findings point to user fees being an important barrier to utilization, other non-fee related barriers exist as well that deter people from seeking services. These include a lack of adequately skilled health providers, poor quality of care in health facilities, incomplete geographic service coverage, lack of awareness or knowledge about the three diseases, preferences for non-western medicine, and stigma towards people affected by HIV and TB. One of the main barriers reported to our study teams was the

large distances patients had to travel to get to facilities and the high cost they incurred for transportation. This was particularly true for HIV and TB patients since these services are typically offered in only a sub-set of health facilities in a given country and require multiple visits to a health facility. As a result, service utilization remains low for these three diseases in many of the countries, despite some services being offered free of charge.

Utilization of services is lower among poorer people.

The results of this study suggest that eliminating formal user fees is a necessary but not sufficient step towards achieving equity in service utilization. For example, only one of the nine focus countries included in the study, Gambia, did not exhibit significant inequality in utilization of ANC services, even though several others (Guinea, Sierra Leone, Cote d'Ivoire), have removed fees for ANC care and utilization is overall fairly high. The fact that the poor continue to underutilize health services, points to the need to address other financial barriers such the fees incurred for other (non-exempt) services needed to treat their condition, informal fees, and transportation costs.

As a result, user fee exemptions do not benefit those they were intended to protect. In fact, these policies end up supporting many who are not in need of subsidies because they rarely take into account ability to pay.

User fee exemptions can be negatively affected when countries face economic crises.

Evidence indicates that countries, such as Chad, that have experienced economic downturns, and cuts to health spending result in a difficult time maintaining implementation of fee exemption policies. Under these circumstances, countries may reduce their investment in supplies or commodities needed to provide free services, creating shortages and stockouts, and the inevitable need to make patients pay for these. Even when commodities are provided, the sharp declines in funding experienced by facilities, often leads to patients being charged informal fees to help cover the facility's costs. Furthermore, user fee exemptions rely heavily on donor support and commodity provision, and are not sustainable in the long run.

User fee exemptions are not an ideal solution to improve access to care for HIV, TB and malaria patients.

User fee exemptions can be a powerful mechanism for ensuring those in need can access some types of testing and treatment services. However, because user fee exemptions apply only to a few specific services, they do not lead to adequate case-management, and patients often refuse additional tests and treatments prescribed by their health care workers that are not offered for free. Narrow fee exemptions that only cover certain commodities or services lead providers to prescribe services that are not medically necessary to recover costs. Additionally, user fee exemptions end up supporting many who are not in need of subsidies because they rarely take into account ability to pay. This is inefficient given the scarcity of resources available to health systems in WCA countries.

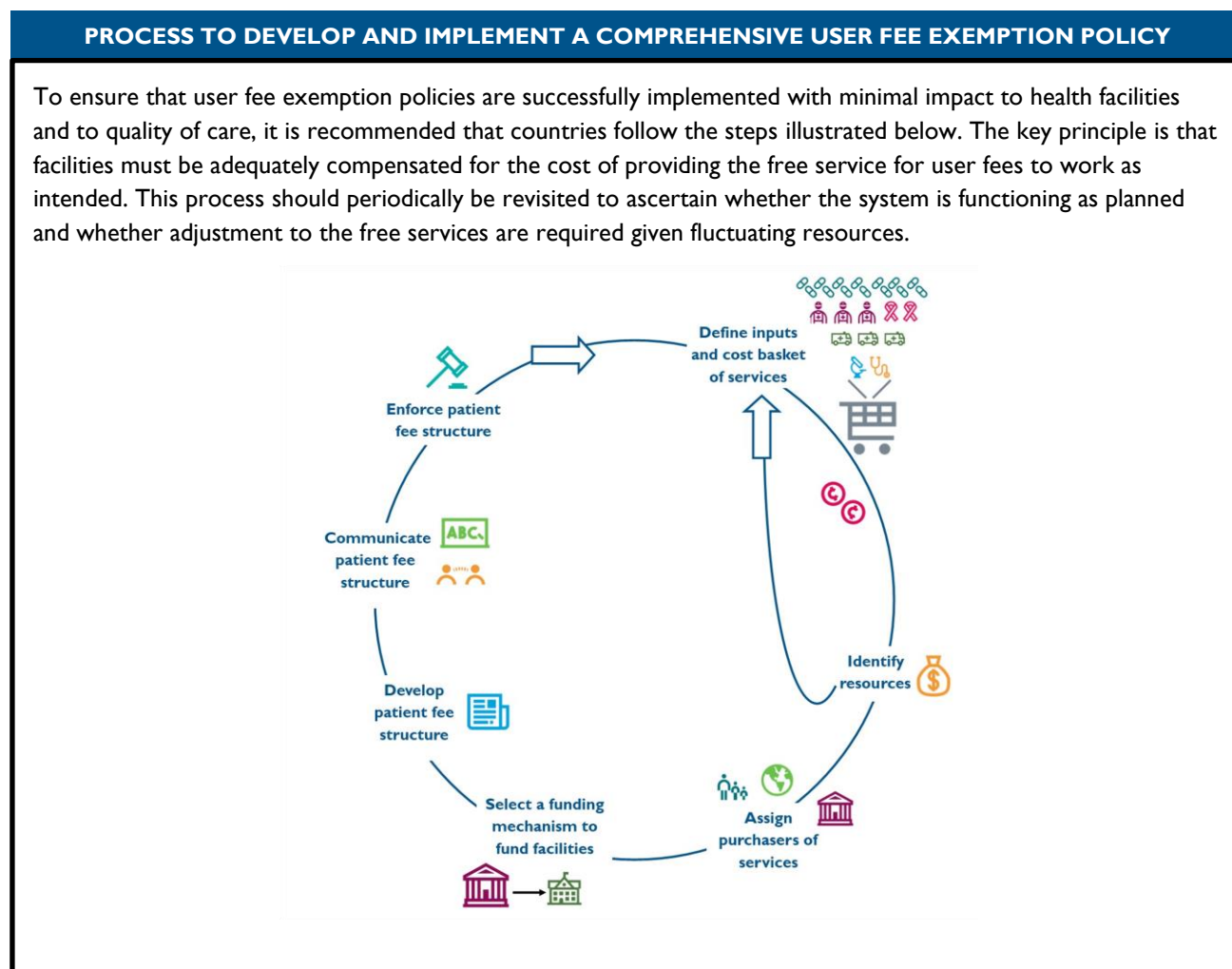
Recommendations

In the short and medium-term, we recommend that the Global Fund continue to support the reduction of user fees for HIV, TB and malaria services over time to help increase access to these services. However, in the longer term, a more comprehensive and sustainable solution is required to ensure that

HIV, TB and malaria patients are able to get the full spectrum of health services they require to manage their diseases at an affordable price. User fee exemptions alone will not be able to achieve this. We provide recommendations for how Global Fund can improve implementation of user fee exemptions in the shorter term, and support countries to roll out systems to achieve UHC in the longer-term. For countries that are more advanced in their implementation of UHC (e.g. Gambia, Ghana and Senegal), consider directing support to that effort.

Short- and Medium-Term

Our overarching recommendation is that the Global Fund **support countries to enact exemption policies only when resources can be mobilized to adequately fund facilities and health workers to provide free services**. This requires understanding the true cost of service delivery, prioritizing services to be provided for free based on available resources, and the establishment of a system to reimburse facilities for services provided. In country reports, we have recommended a process for countries to follow to determine which services they can afford to exempt and for which populations, summarized briefly in the text box below.



The outcomes of this process will look different in different countries. In Chad and other countries that have exempted a lot more services than they can afford to fully fund, and also face large funding gaps, there should be a rolling back of exemptions and more clearly defined policies. In countries like Gambia that are farther along in the rollout of UHC schemes, the outcome of the process will be exemptions for the poor from paying insurance premiums, rather than disease-specific exemptions – this means that richer people may have to pay for HIV and TB services (through insurance premiums or co-payments) that they did not pay for before. Cameroon might see higher co-payments for some people and services, as households seem more able and conditioned to contribute to the cost of health care, but targeted exemptions are needed for disadvantaged regions and the poor to reduce inequalities in utilization. In countries like Sierra Leone where most HIV, TB, and malaria services are already exempt from user fees, the utilization of these services is fairly equal among the rich and the poor, and there are enforcement mechanisms in place, the outcome will be a slight increase in the amount of funding that facilities receive, which must be complemented by improvements in supply chain efficiencies to reduce informal fees, and an expansion of exemptions at points of entry to the health system. In Togo, user fee exemptions for these services are also relatively complete, but better purchasing and monitoring mechanisms are needed, as is better cooperation with the private sector. However, countries where there is low utilization and more inequality between the rich and the poor, like Guinea, should also prioritize the removal of barriers to entry to the health system, along with the clarification of user fee policies and the adequate funding of facilities. Countries like Benin that already have relatively clearly defined exemptions that they can afford to fund will need to focus more on identifying a more effective purchasing / funding mechanism for fee exemptions, and countries like Mali will need to develop clearer, more enforceable user fee policies.

It should be noted that the steps of the process are unlikely to work in isolation from one another, as countries experience all of these challenges to varying degrees, and they are causes and consequences of one another. For example, *only* focusing on identifying a better purchasing mechanism in Togo would still result in the charging of informal fees because the underlying problem of facilities being inadequately funded and health workers inadequately compensated to provide free services would not be addressed, and there would be no way to enforce violations.

Recommendations for the Global Fund Secretariat to support countries in this effort are presented below.

- I. **Provide technical assistance to countries** to develop revised user fee policies, as described in the text box above and further in country reports: Technical assistance could either be through a third party or through country teams. Guidance should cover:
 - **Determining what each country can afford to exempt** by fully accounting for the cost of all inputs needed to provide high quality services – not just commodities, but health workers and administrative staff, medical and non-medical supplies, operational costs, transportation, etc. Encourage countries to include these costs in NSPs moving forward.
 - **Determining what households can afford to contribute**, and if some type of copayment is advisable for some services and for all or a sub-set of patients. In some countries like Gambia a low flat rate for consultations and drugs across all patients has been successful in attracting clients. Participants in focus groups in this study indicated that they are more willing to pay for medicines and lab tests than for other types of

services. Other studies in the region have also shown that people are willing to pay for medicines.

- **Determining which services to exempt.** Prioritize the removal of fees associated with barriers to entry to the health system. Having to pay for registration or consultation fees at first contact for outpatient care or ANC can discourage patients from getting the diagnostic tests they need to determine whether they are infected and eligible for free treatment services. To balance costs, consider an approach like that used in Cameroon where the first ANC visit was exempted but not subsequent ones. It is also important that countries maintain an adequate focus on the needs of key and vulnerable populations, e.g. by continuing to provide free or low-cost ARVs and anti-TB medicines.
 - **Determining how to fund facilities to provide services.** Share learning from other countries who have been implementing fee-for-service or performance-based mechanisms, and should help countries assess existing mechanisms used to transfer funds to facilities and reasons for current bottlenecks in allocating funds to facilities. Discuss new or improved tracking mechanisms that may be required to ensure transparency/reduce probabilities of abuse/misreporting, and recommend resources for facility staff to receive training in financial management, where needed.
 - **Determining how to communicate and enforce fee structures.** Share best practices in these areas, such as by evaluating the monitoring mechanisms currently being implemented in Cameroon and Sierra Leone.
2. **Allocate regional-level funding and work with other partners to support the following:**
- **Input definition and costing,** perhaps through adaptation of the OneHealth tool to develop a standardized costing process that can be regularly used at low cost to revisit changing baskets of essential services and fee exemptions.
 - **Affordability studies** for households, which might be done using household livelihood surveys that discuss typical expenditures on other household goods, rather than costly primary data collection.
 - **Development of standardized communication materials** (posters, radio ads, etc.) that can be tailored by countries.
3. **Institute new grant application requirements that require countries to submit the following:**
- A user fee structure for each disease component, and a description of the process used to develop it.
 - A description of how the country intends to reduce or remove financial barriers to health care services, including user fees, over time.
 - A description of how the country will monitor adherence to user fee exemptions. Regular audits of facility-level financial records and supply chains may be required to do this, and countries should agree that they will allow LFAs access to records to do so.
 - Inclusion of user-fee related indicators in performance frameworks and monitoring and evaluation plans.

- For countries that plan to use Global Fund grants to fund facilities to provide free services (see #4 below), a description of the plan for mobilizing domestic resources over time to absorb these costs.
4. **To incentivize countries to remove user fees, where allocations allow, permit countries to use Global Fund grants to fund facilities provide free services**, (i.e. to purchase services from facilities), with explicit requirements that government absorb these costs over time as part of co-financing commitments. This includes providing commodities but also cash subsidies to cover the full cost of delivering high quality care. Essentially, Global Fund will be covering the expenses that user fee revenue currently covers, and over time, governments will take over. This model has been used in Vietnam to pay health insurance premiums for PLHIV.

To implement these recommendations, we recommend that the Global Fund Secretariat establish a taskforce on user fees to guide the development of a regional strategy on user fees. For the remainder of 2020, the taskforce could lead the development of an organizational approach and consensus-building around whether and to what extent Global Fund grants can and should be used to purchase services, i.e. to directly fund or reimburse facilities to provide free services, beyond the provision of commodities. In addition, Global Fund will need to consider in which contexts it will allow resources to be pooled with other resources to purchase services, which would reduce administrative costs and strengthen the system as a whole. In countries where there is too much risk associated with pooling of funds, it may still be possible to implement a purchasing mechanism for HIV, TB, and malaria services that does not involve pooling by funding a PR or SR to serve as a purchasing entity. Given that there are already large funding gaps for the HIV, TB, and malaria responses in most WCA countries, Global Fund will also need to decide on an organizational approach to prioritizing user fee removal over other important interventions that are already included in NSPs. This prioritization should be context-specific and reflect input from stakeholders, keeping in mind that user fee removal, especially for the poor, is a key step toward ending these epidemics and achieving UHC.

In 2021, the Global Fund could then develop an externally facing regional strategy on user fees that (1) outlines their commitment to eliminating user fees for HIV, TB, and malaria over time, and (2) describes their approach for ensuring that facilities and health workers are adequately funded to provide free services, so that formal user fees are not replaced by informal user fees and services provided are of a high quality. The regional strategy could be accompanied by the technical assistance and guidance described in recommendation #1 above. This would allow countries time to prepare to implement revised user fee policies by gathering needed information, developing frameworks, and planning to launch purchasing mechanisms, as well as to develop grant applications to apply for funding. We recommend that the requirements for grant applications, and thus the revised user fee exemption policies, go into effect in the 2023-2025 period. More specific details and steps are described below.

We note here that PEPFAR has recently adopted a policy on user fees for HIV services and has prioritized the elimination of financial barriers to service utilization as a key issue in WCA, especially in priority countries (Cameroon and Cote d'Ivoire). The PEPFAR requirement is for countries to eliminate "all formal and informal user fees in the public sector for access to all direct HIV services and related services, such as ANC, TB, and routine clinical services, affecting access to HIV testing and treatment and prevention." In the operationalization of this policy, however, there is more flexibility – further

details are provided in the Cameroon country report on how this works in practice. The strategy recommended above aligns with the spirit and basic tenants of PEPFAR's, but encourages countries to remove user fees over time rather than immediately, which we believe is important to allow for proper planning and resource mobilization. It uses more of an incentive approach by providing funding for countries in the short term, rather than a punitive approach that requires countries to find funding or lose access to PEPFAR funds. Cameroon was able to mobilize domestic resources to remove most HIV-related user fees, but this may not be feasible for others in the region and would likely result in the imposition of informal user fees and poor-quality services, especially given that Global Fund grants cover not just one but three diseases, and user fees from malaria make up a large portion of facility revenue. We recommend that the Global Fund coordinate with PEPFAR, countries, key populations, civil society, and other donors to ensure there is agreement on what it means to remove user fees, so that funding is not compromised and there is cohesive direction provided to countries.

Long Term

In the longer term, the process of revising user fee policies described above can complement efforts to attain UHC by 2030. Implementation of NHI and UHC schemes requires the definition of baskets of essential services, determining premiums and premium exemptions, and determining how to purchase services. The efforts described above to develop revised HIV, TB, and malaria user fee policies can feed into this larger process. Reaching internal consensus about the extent to which Global Fund funding can be used to purchase services can be built on to inform Global Fund's role once HIV, TB, and malaria services are integrated into NHI schemes. Additional actions that we recommend that Global Fund take in supporting this effort are described below.

1. **Coordinate with the government and other stakeholders who are developing plans for UHC to align approaches to funding facilities, and to ensure that key HIV, TB and malaria services are included in packages of essential services that will be covered.** Engage with the appropriate stakeholders, participate in planning meetings, and advocate for the inclusion of a basic package of services for HIV, TB, and malaria to be covered through UHC and NHI schemes. Note that while this recommendation is included as a long-term solution, many countries are already in the process of or have already developed packages of services that will be covered – Global Fund and CCMs should act quickly to negotiate the inclusion of key services now. Explore ways in which Global Fund can contribute to funding such a plan, both its development and its implementation. This may require the Global Fund to fundamentally change its approach, moving from vertical programming to a model where funds are pooled and used to purchase HIV, TB, and malaria services from facilities.
2. **Support countries in developing systems to identify the neediest populations** who most deserve subsidies from the government to increase access to care. Countries are struggling with how to identify poor and vulnerable groups that should be eligible for subsidies and exemptions from paying insurance premiums for UHC and NHI schemes. There is a need for cross-country learning, technical assistance, and funding in this area. Ghana appears to be the only country in WCA that has established and rolled out a fully functioning NHI (although not without its challenges), and other countries can learn from Ghana's experience. WCA nations could also draw inspiration from examples in Thailand and some Indonesian provinces, where the government gave everyone in the informal sector free membership to national insurance systems, financed through taxes.⁴⁰⁶

3. **Establish means for exchanging experiences across countries**, via regional networks, conferences, or communities of practice.
4. **Continue to invest in RSSH in WCA** countries including substantial funding for human resources for health to increase the supply, retention and quality of health workers, and for strengthening in-country procurement and supply chain systems. These are critical to maintaining high quality care when reducing fees or reforming health financing in general.
5. **Continue to invest in service delivery mechanisms that can expand access**, such as service delivery at the community level by CHWs and reducing the number of visits required by offering multi-month prescriptions that reduce other financial barriers to accessing health services.

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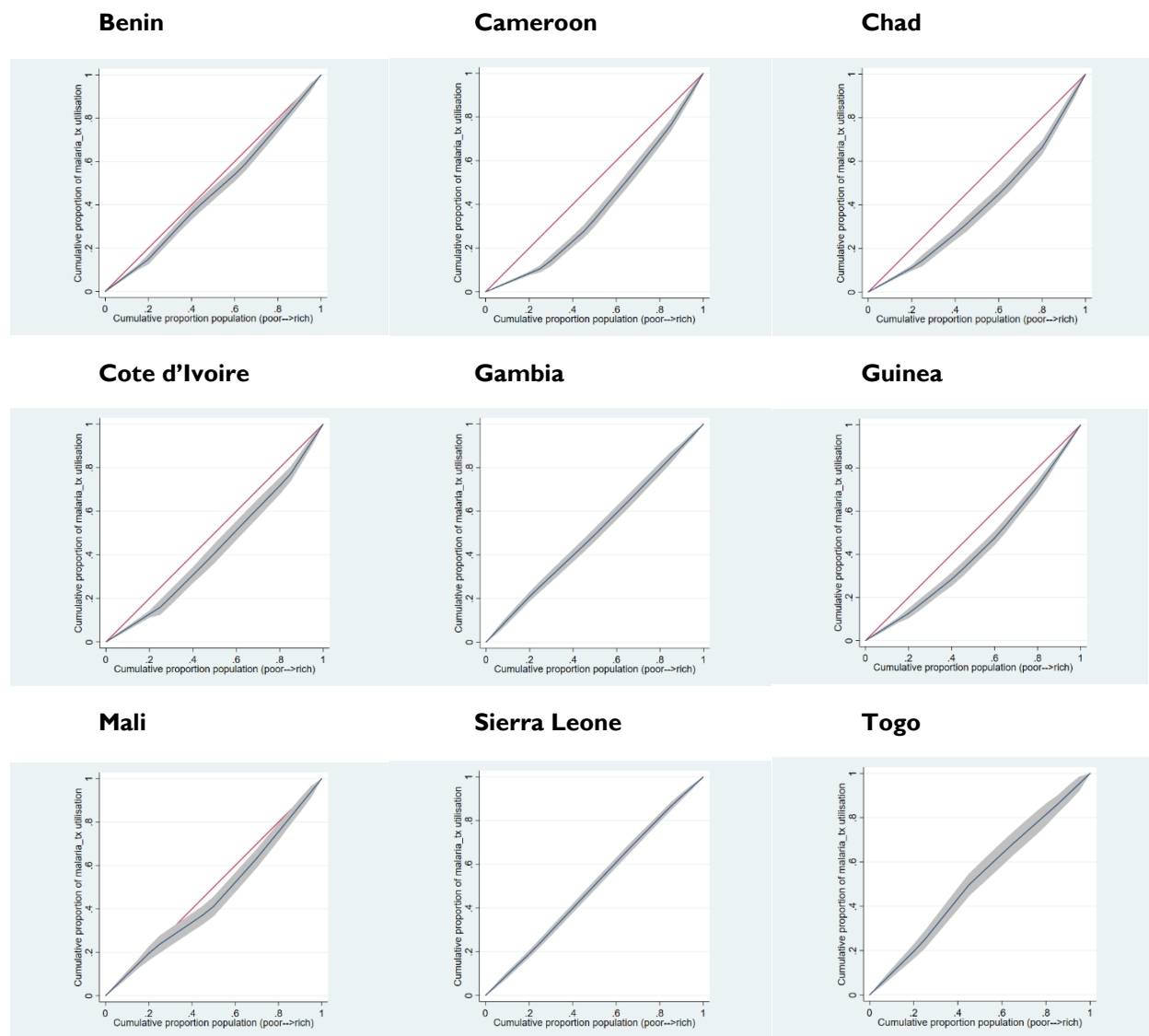
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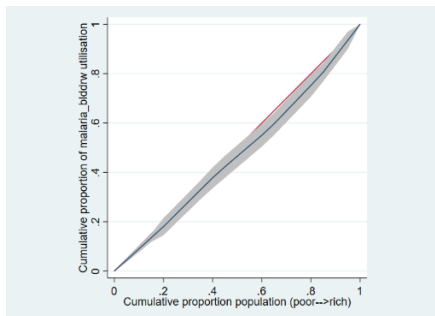
Appendix A: Concentration Curves for Specific Service Utilization Indicators

Number of children under five with fever in the two weeks preceding the study who received treatment

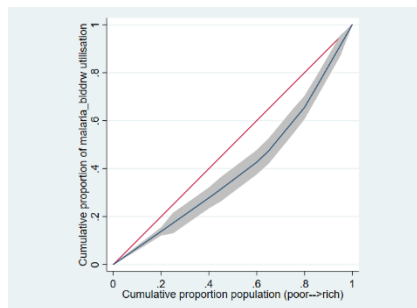


Number of children under age five with fever in the past two weeks preceding the survey that had their blood drawn

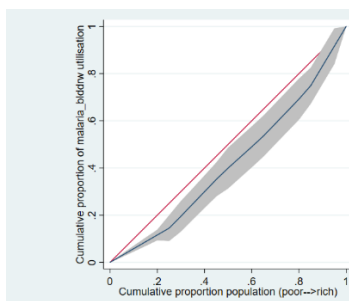
Benin



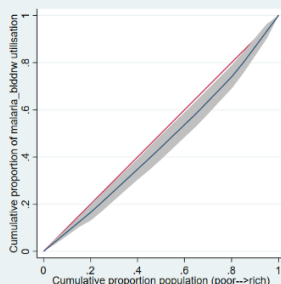
Chad



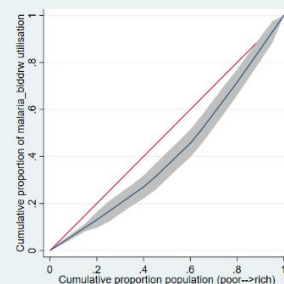
Cote d'Ivoire



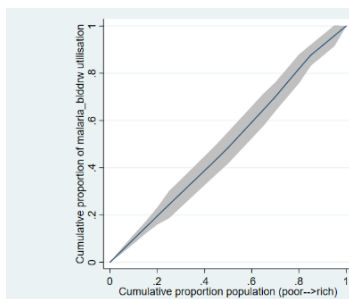
Gambia



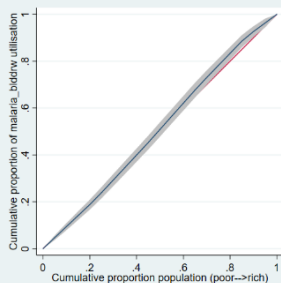
Guinea



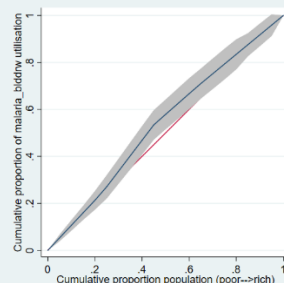
Mali



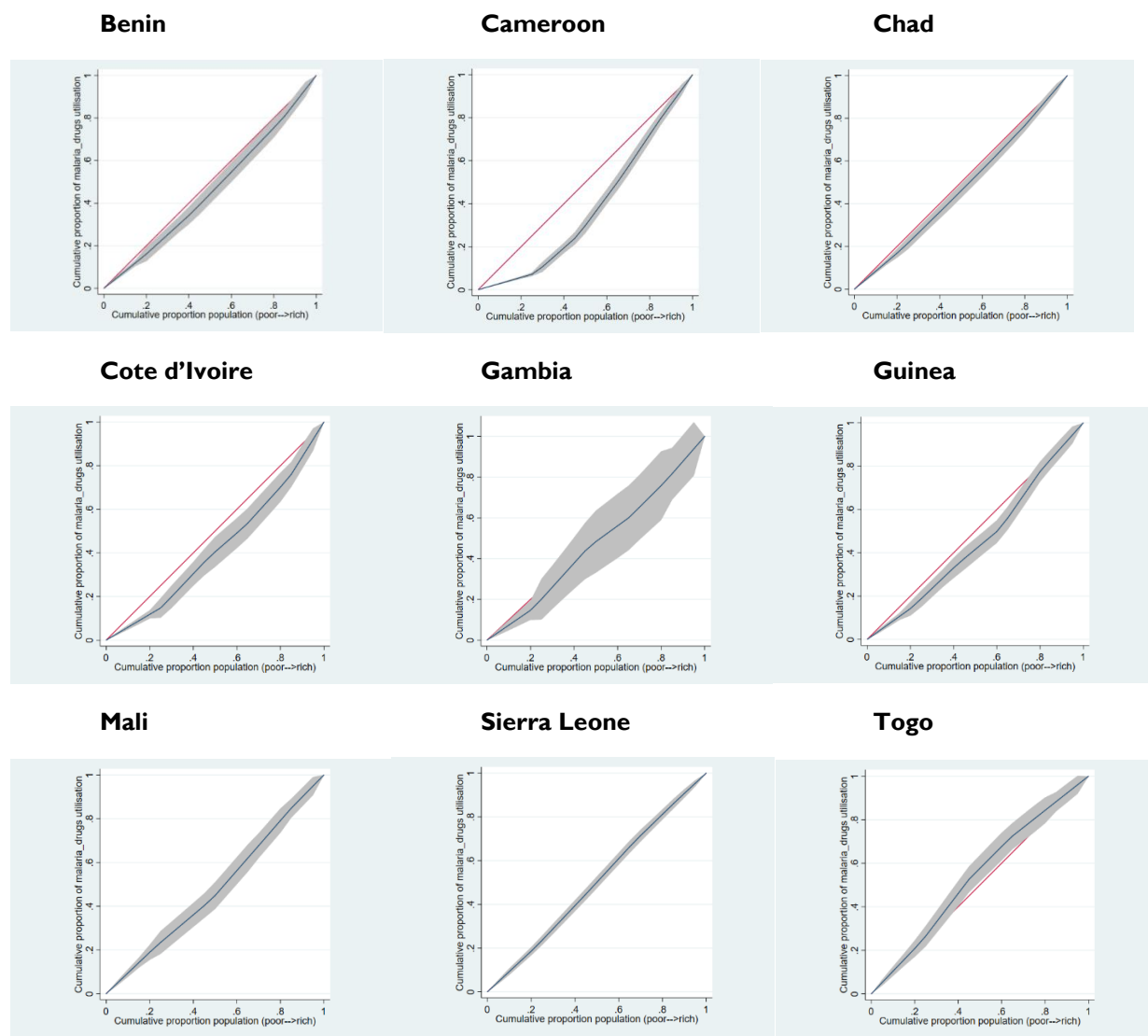
Sierra Leone



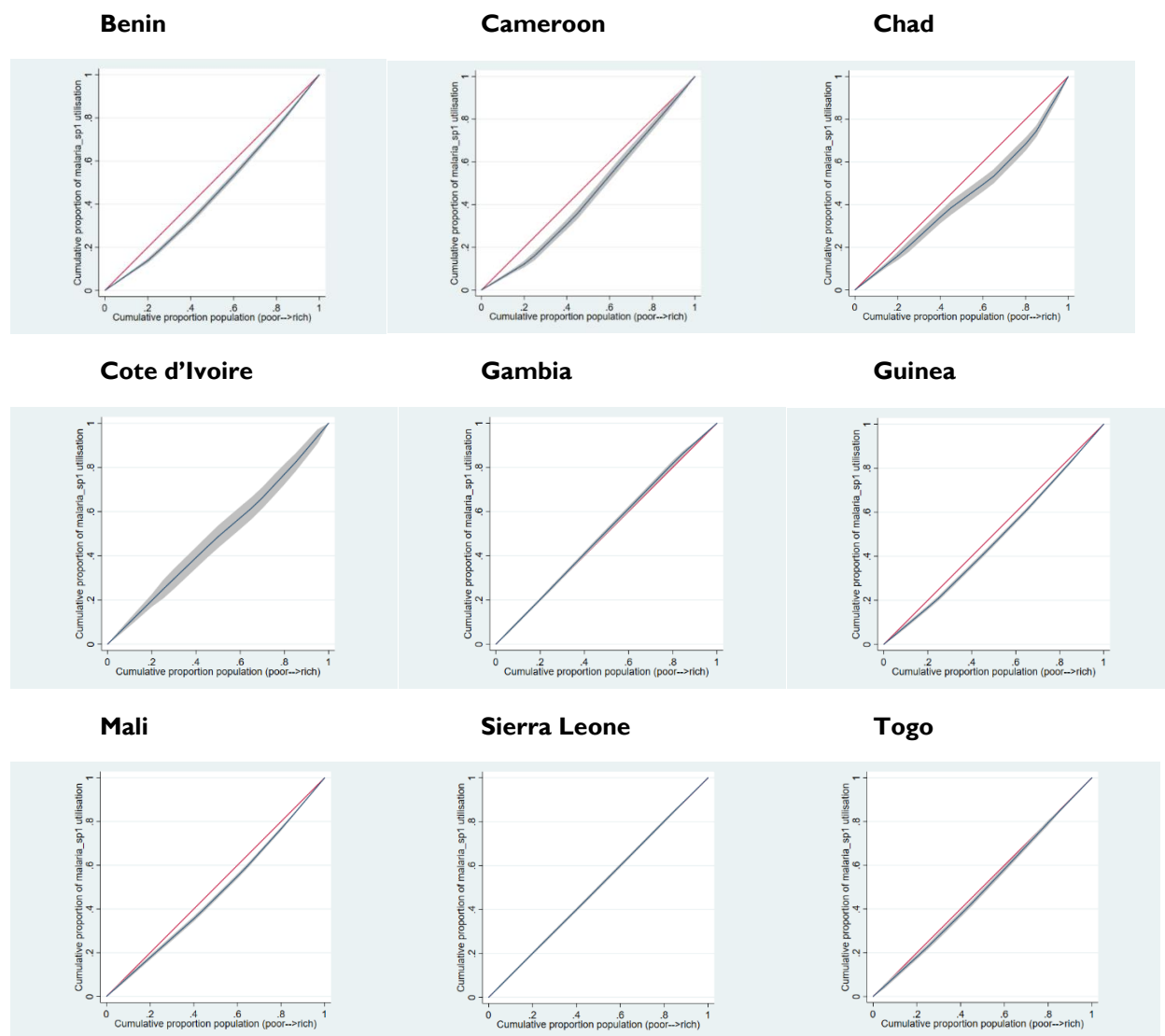
Togo



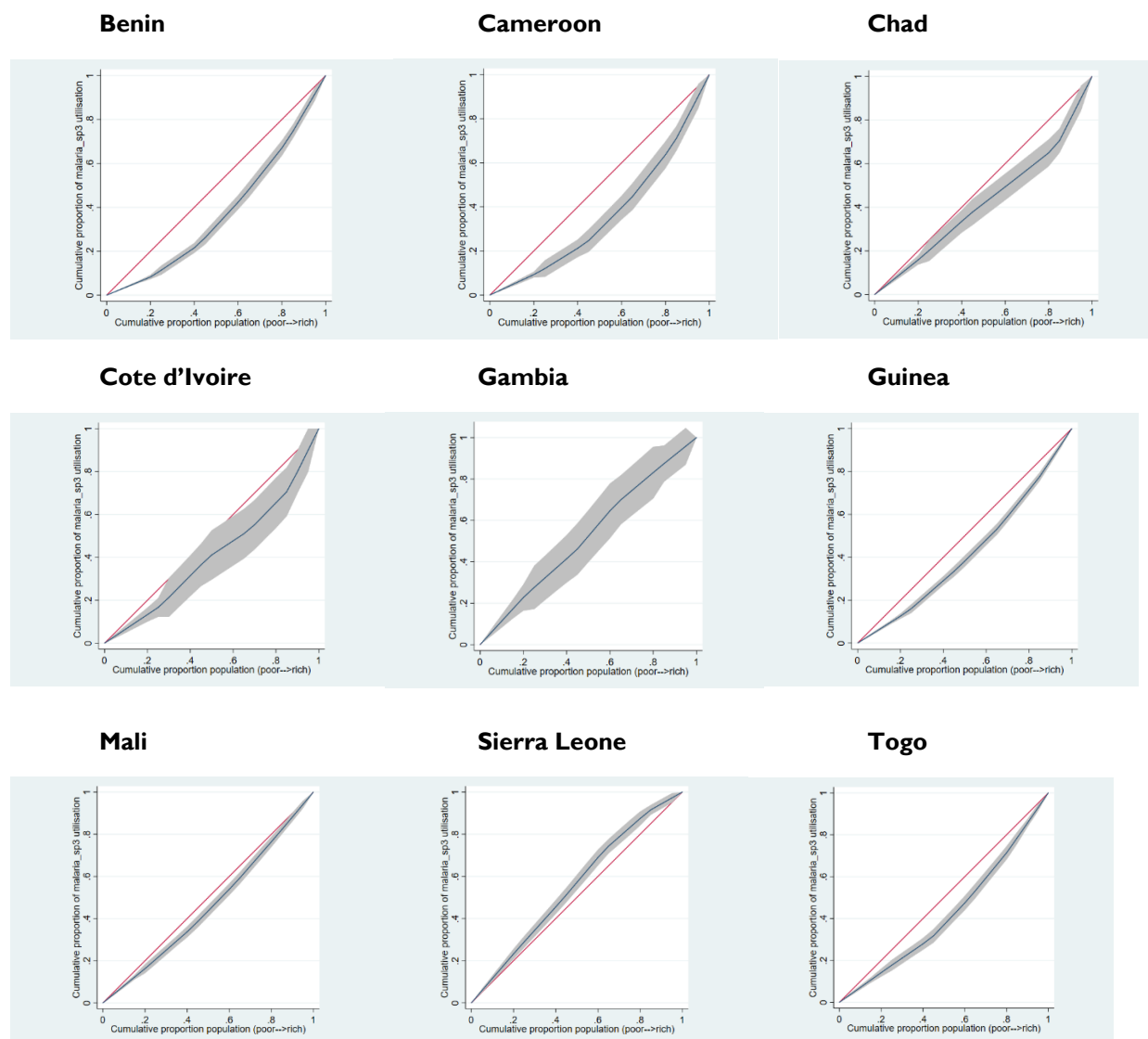
Number of children under age five with fever in the two weeks preceding the survey who took antimalarial drugs



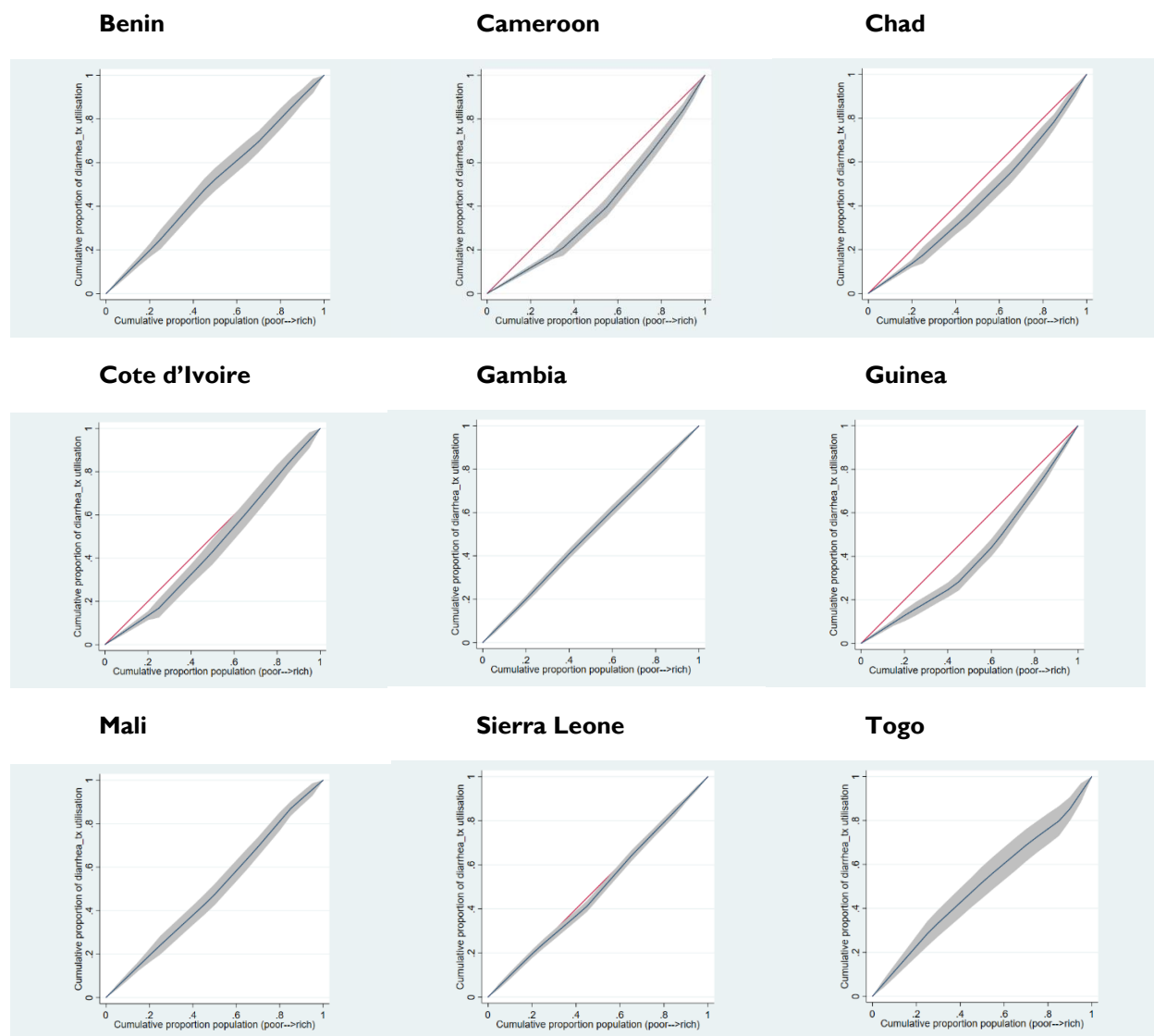
Number of women who had a live birth in the two years preceding the interview who received one or more doses of SP/Fansidar in the two years preceding the interview



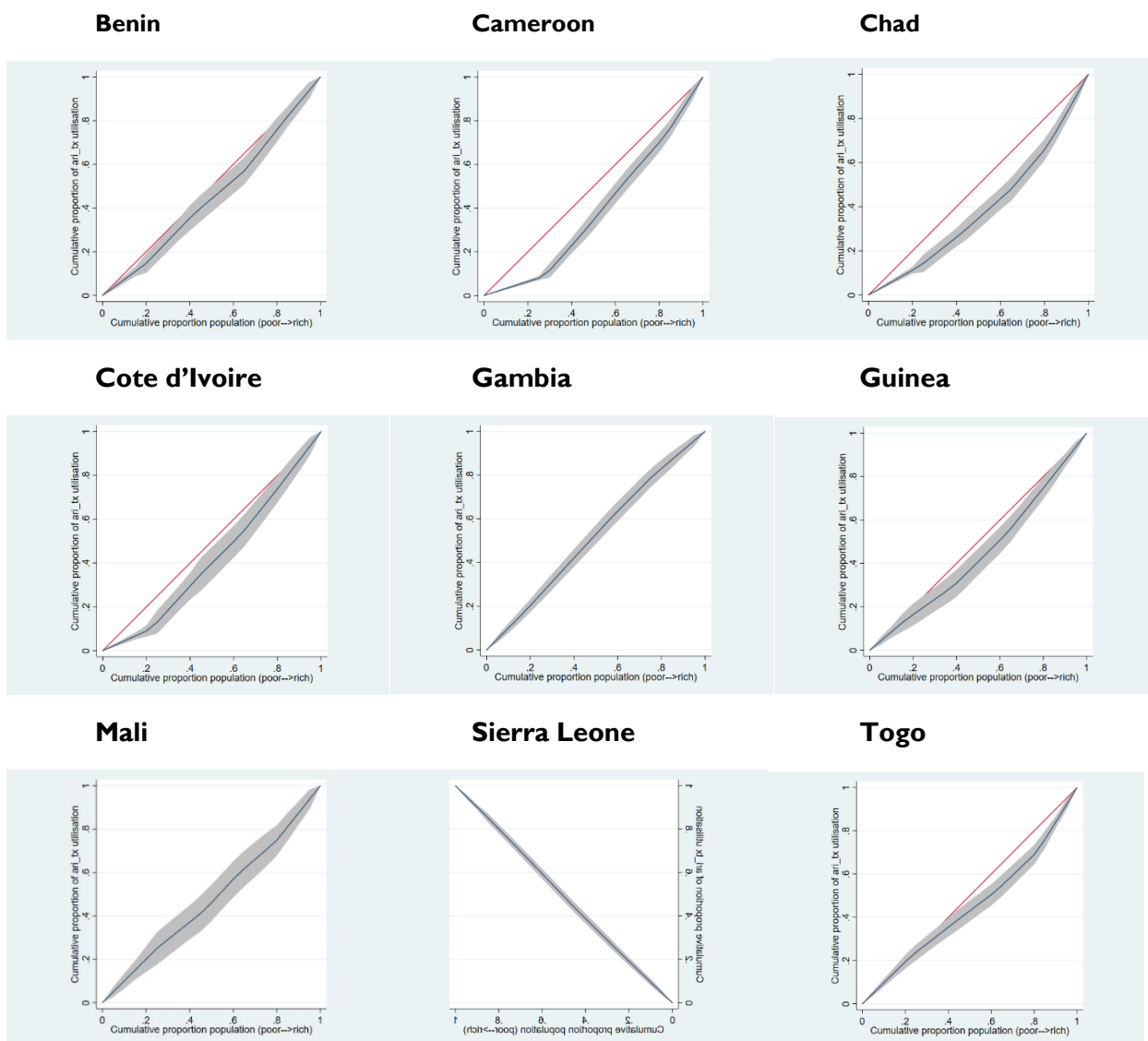
Number of women who had a live birth in the two years preceding the interview who received three or more doses of SP/Fansidar



Number of children under age five with diarrhea in the two weeks preceding the survey for who received treatment

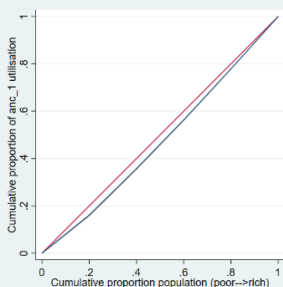


Number of children under age five with signs of ARI in the two weeks preceding the survey who received treatment

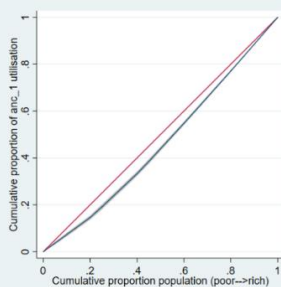


Number of women who had at least one ANC visit during her last pregnancy

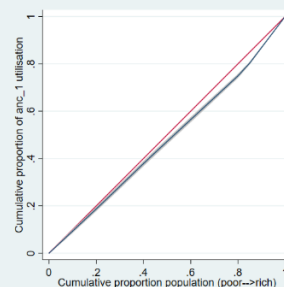
Benin



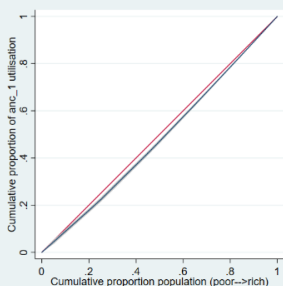
Cameroon



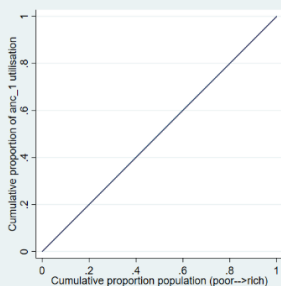
Chad



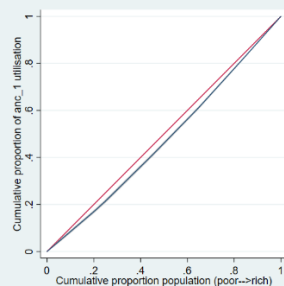
Cote d'Ivoire



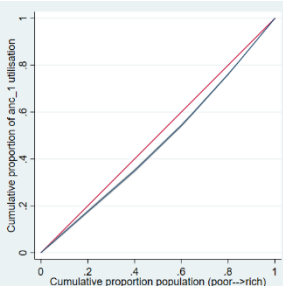
Gambia



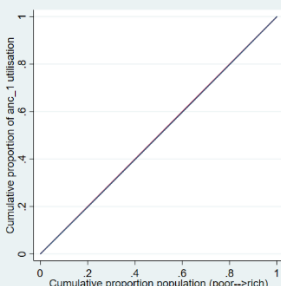
Guinea



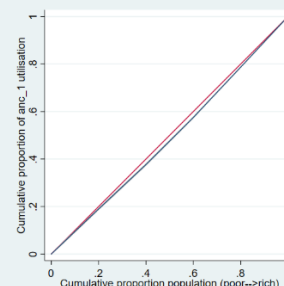
Mali



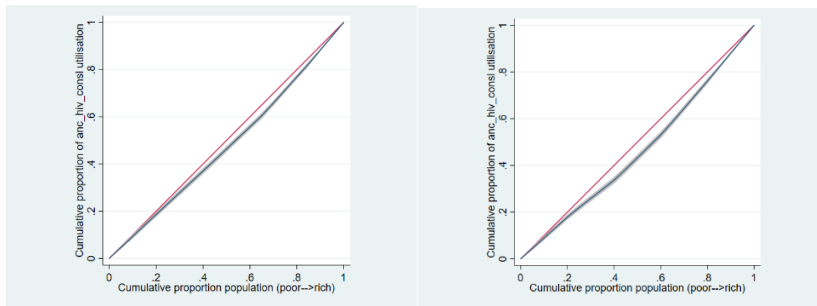
Sierra Leone



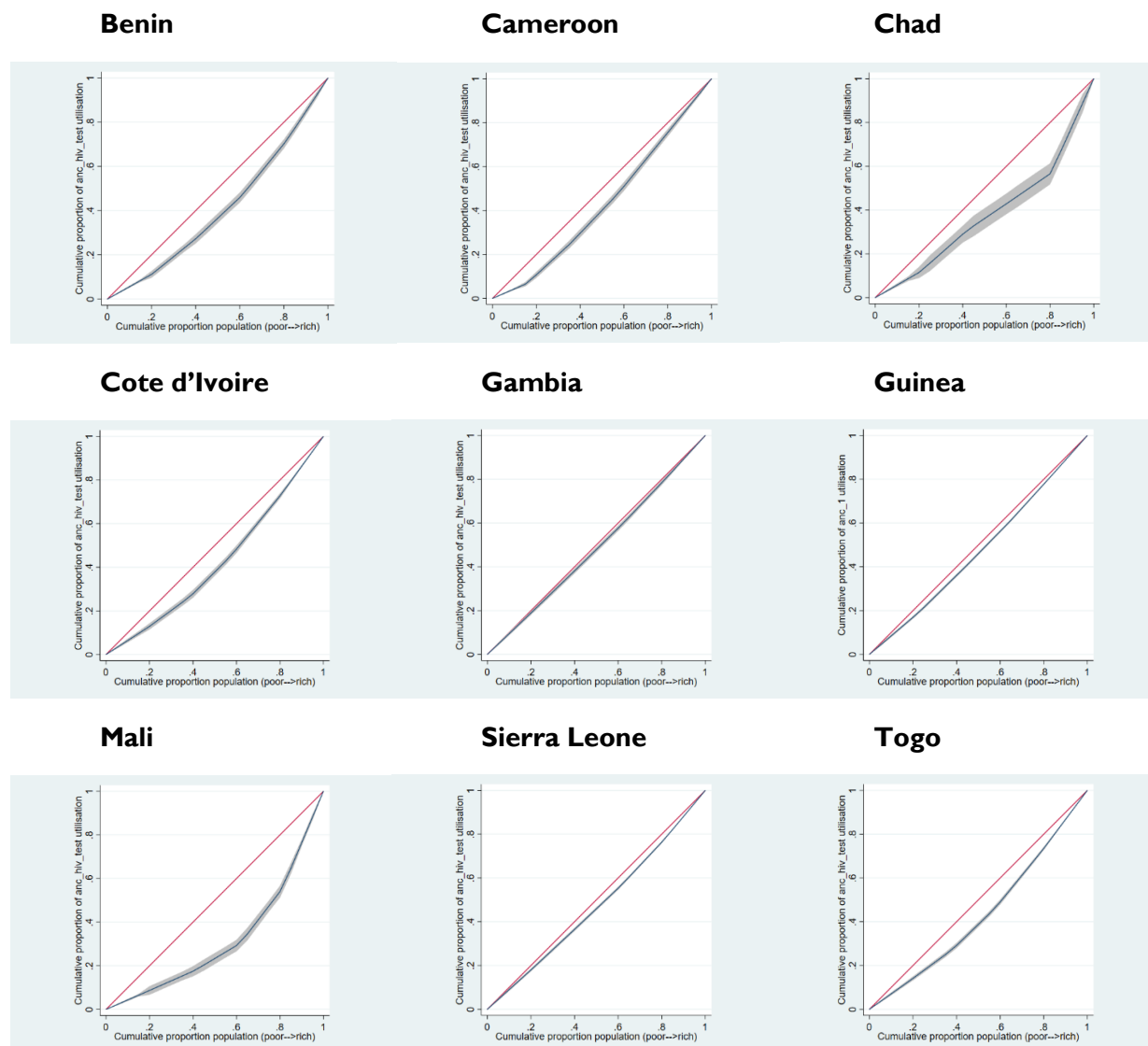
Togo



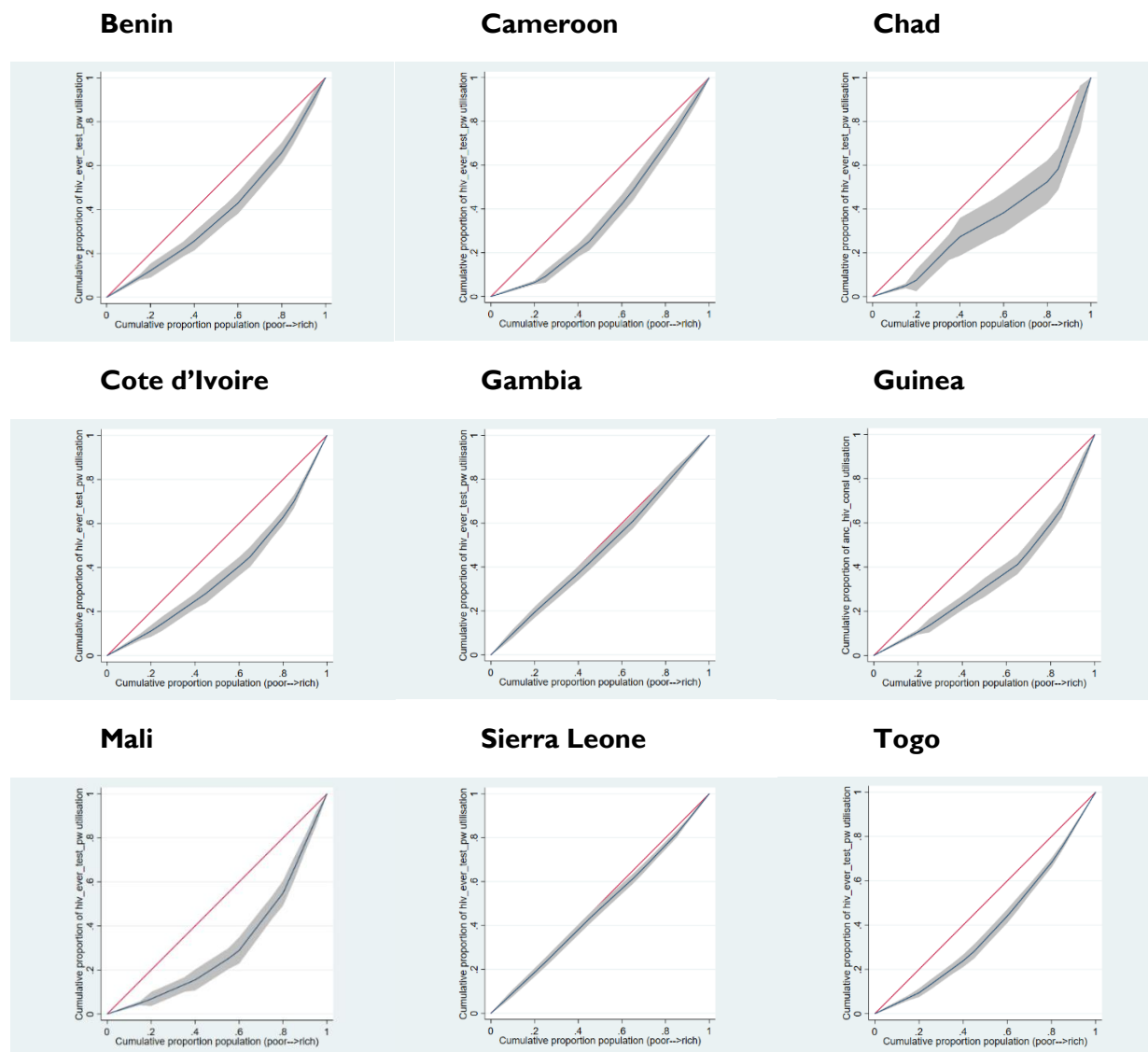
Understanding the Health Financing Landscape and Documenting of the Types of User Fees
(Formal and Informal) Affecting Access to HIV, TB, and Malaria Services in West and Central Africa



Number of women who received an HIV test during ANC or labor



Number of pregnant women who have ever received an HIV test



Number of men who have ever received an HIV test

