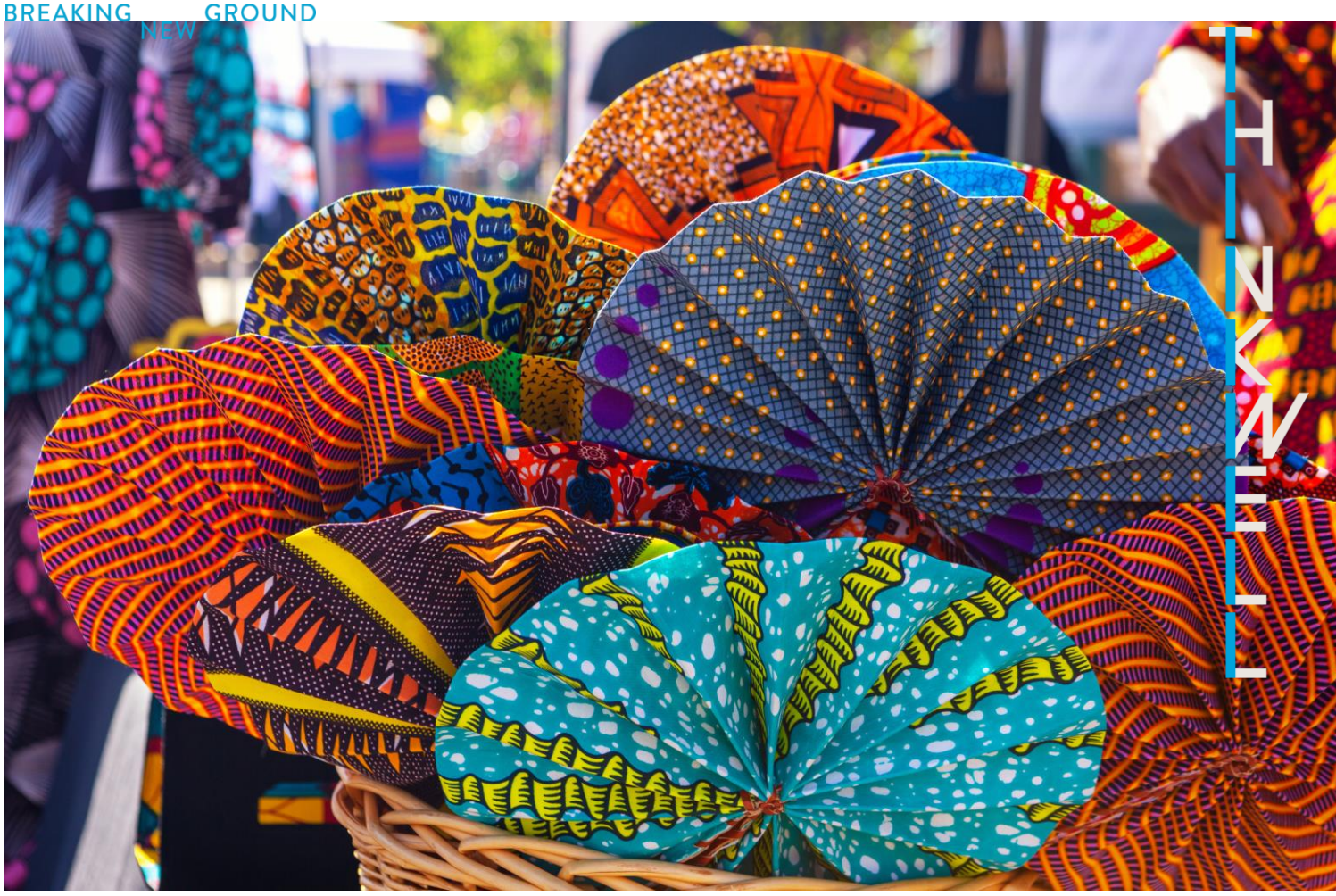
BURKINA FASO REPORT 1

An Overview of the User Fee Exemption Policy (*Gratuité*) in Burkina Faso

September 2020



ThinkWell
@thinkwellglobal
www.thinkwell.global

ACKNOWLEDGMENTS

The authors would like to express their sincere gratitude to all individuals and organizations in Burkina Faso and elsewhere who gave their valuable time to comment on this report. In particular, the authors thank Dr. Pierre Yaméogo (Technical Secretary for Universal Health Coverage, Ministry of Health Burkina Faso).

Recommended citation:
Boxshall, Matt, Joel Arthur Kiendrébéogo, Yamba Kafando, Charlemagne Tapsoba, Sarah Straubinger, Pierre-Marie Metangmo, 2020. "An Overview of the User Fee Exemption Policy (Gratuité) in Burkina Faso." Washington, DC: Recherche pour la Santé et le Développement and ThinkWell.

This report was produced by ThinkWell under the Strategic Purchasing for Primary Health Care (SP4PHC) grant from the Bill & Melinda Gates Foundation. ThinkWell is implementing the SP4PHC project in partnership with Government agencies and local research institutions in five countries. For more information, please visit ThinkWell's website at **https://thinkwell.global/projects/sp4phc/**. For questions, please write to us at **sp4phc@thinkwell.global**.

TABLE OF CONTENTS

ABBREVIATIONS

AMU	assurance maladie universelle [national health insurance]
ANC	antenatal care
ASBC	agents de santé à base communautaire [community health workers]
BMGF	Bill & Melinda Gates Foundation
CAMEG	Centrale d'achat de médicaments essentiels et génériques [central medical store]
CBO	community-based organization
CHE	current health expenditure
CHR	centre hospitalier régional [regional hospitals]
CNAMU	Caisse Nationale d'Assurance Maladie Universelle [National Health Insurance Agency]
CM	Centre médical [medical centers]
CMA	Centre medical avec antenne chirurgicale [district hospitals]
CHU	centre hospitalier universitaire [teaching hospitals]
CSO	civil society organization
CSPS	centre de santé et de promotion sociale [primary health care centers]
DAF	Director Administratrif et Financier [Directorate of Administration and Finance
DHIS2	district health information software 2
DRD	dépôt répartiteur de district [district warehouse]
FP	family planning
GDP	gross domestic product
HMIS	health management information system
IMCI	integrated management of childhood illness
KII	key informant interview
mCPR	modern contraceptive prevalence rate
MNCH	maternal, newborn, and child health
MOH	Ministry of Health
MMR	maternal mortality ratio
NGOs	non-governmental organizations
NMR	newborn mortality rate
PBF	performance based financing
PHC	primary health care
PNDS	Plan National de Développement Sanitaire [National Health Development Plan]
RDT	Rapid diagnostic test
RESADE	Recherche pour la Santé et le Développement
RMA	Rapport mensuel des activités [monthly activity reports]
SDG	Sustainable Development Goals
SP4PHC	Strategic Purchasing for Primary Health Care
ST-ATD	Secrétaire Technique pour l'Accélération de la Transition Démographique [Technical Secretariat for Demographic Dividend]
ST-CSU	Secrétaire Technique Pour La Couverture Sanitaire Universelle [Technical Secretariat for Universal Health Coverage]
TLOH	télégramme lettre officielle hebdomadaire [official weekly telegram]
U5MR	under-5 mortality rate
UHC	universal health coverage

EXECUTIVE SUMMARY

In 2016 the Government of Burkina Faso introduced Gratuité, a user fee replacement policy, to increase access to and use of health care services for women and for children under 5 years of age. One of the poorest countries in the world, Burkina Faso continues to face a high rate of maternal and child mortality. While coverage of key maternal, newborn, and child health (MNCH) interventions has improved, financial barriers to access continue to keep many from seeking the services they need, when they need them, limiting further progress in reducing high mortality rates. Through this policy, the Government of Burkina Faso takes on the full cost of a defined package of MNCH services, pre-positioning funds to replace out-of-pocket payments, and allowing public health facilities to provide MNCH services free of charge.

ThinkWell and its learning partner Recherche pour la Santé et le Développement (RESADE) conducted a detailed review of the Gratuité policy in collaboration with the Ministry of Health (MOH). This review is part of ThinkWell's Strategic Purchasing for Primary Health Care (SP4PHC) project to improve primary health care, implemented in five countries with support from a grant from the Bill & Melinda Gates Foundation. The team reviewed the Gratuité policy to better understand and describe how it works in the field, what its challenges are, and which lessons can be drawn for the way forward. The assessment was conducted using a literature review, data analysis, and key informant interviews (KIIs).

OVERVIEW OF GRATUITÉ

Burkina Faso's Gratuité policy has a long history. Burkina Faso's health care system provided services free of charge until the 1980s. Increased budget deficits resulted in a decline in the quality of publicly subsidized health services, ultimately leading to the introduction of user fees through the Bamako Initiative in 1990 (McPake, Hanson, and Mills 1993). The first pilot projects for user fee exemption started in Burkina Faso in 2008, followed by several others through to 2015 (Ridde 2015), often in partnership with international non-governmental organizations (NGOs).

The Gratuité policy, designed to remove financial barriers to MNCH services, was adopted by the Council of Ministers of Burkina Faso on March 2, 2016. Gratuité is implemented in all public health facilities and a small number of private facilities. Contracted facilities provide a defined package of MNCH services free of charge, funded by the government budget. Instead of charging out-of-pocket payments, equivalent fee-for-service payments are made to facilities by the central government. Funds should be pre-positioned for the facilities on a quarterly basis, and subsequent payments adjusted based on service reports. Sixty to 80% of these funds are earmarked for drugs, and facilities can use the remainder for consumables and operating costs. The scheme is managed by the MOH, Secrétariat Technique en charge de la Couverture Sanitaire Universelle[1] (ST-CSU), and verification and data validation are contracted out to third parties.

Gratuité benefits all children under 5 years of age, as well as pregnant and postpartum women, and does not require registration of the client. The benefits package includes services for children as defined in integrated management of childhood illness (IMCI) protocols. For pregnant women, Gratuité covers antenatal and postnatal care, deliveries, emergency obstetric care, and cesarean sections. Treatment of obstetric fistulas and screening for pre-cancerous cervical lesions and breast cancer are covered for all women.

[1] Technical Secretariat for Universal Health Coverage

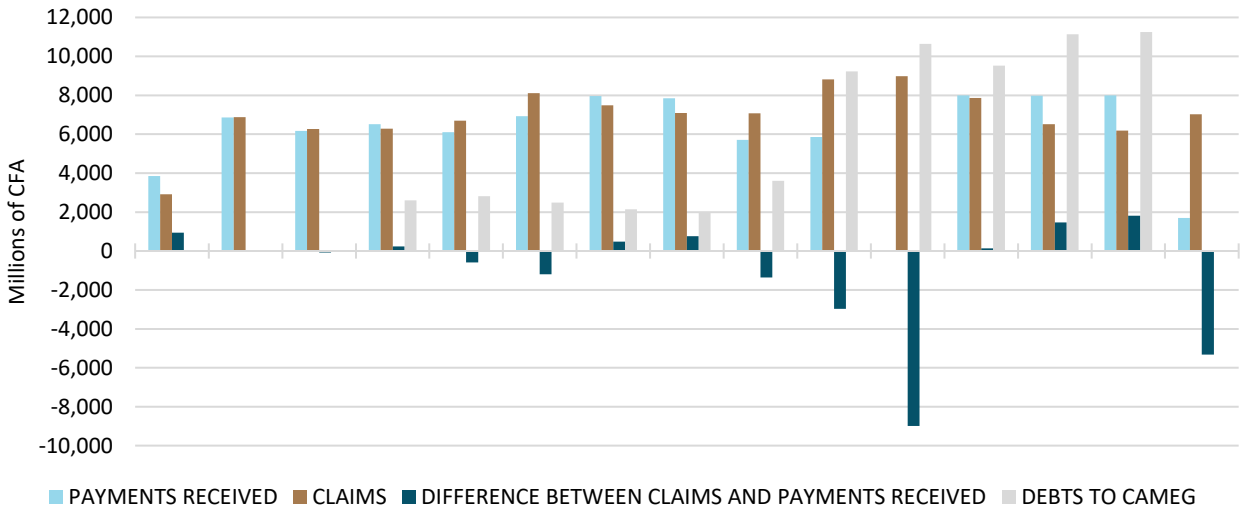
KEY FINDINGS

Gratuité appears to have achieved its primary goals of improved access to services and reduced out-of-pocket expenditure on health. For example, the average number of contacts between children under 5 and formal health services increased from 1.7 per annum in 2015 to more than 3 per annum in 2017, following the introduction of Gratuité (Ministère de la santé du Burkina Faso[2] and Institut national de la statistique et de la démographie[3]*).* Out-of-pocket payments, while still significant, declined from 36.2% of current health expenditure (CHE) to 31.7% in the same period, but rebounded in 2018 when Gratuité payments to facilities were interrupted (Ministère de la santé du Burkina Faso 2019). Routine Gratuité data does not allow equity analysis, but the majority of Gratuité payments go to peripheral health facilities and to rural areas.

Gratuité is not designed to directly incentivize improvements in service quality, and unsurprisingly, there is no evidence that quality has improved as a result of Gratuité. Gratuité has been implemented in the context of increasing security challenges, leading to more than one million internally displaced people by August 2020 (United Nations High Commissioner for Refugees 2020) and significant labor unrest, both factors that undermine improvements in quality and therefore in health outcomes. Nevertheless, service quality is a significant underlying challenge to health in Burkina, and the fact that Gratuité is not explicitly linked to quality may be a missed opportunity.

Gratuité was not adequately funded in 2018 and 2019, which likely led to increased debts to the central medical store, **Centrale d'achat de médicaments essentiels et génériques** (**CAMEG).** This analysis shows significant gaps between Gratuité claims submitted to the central government and payments received, most notably toward the end of financial years 2018 and 2019. Debts to CAMEG follow a similar pattern, growing rapidly when Gratuité payments fall short.

Figure A: Evolution of invoices, payments, and health district debts to CAMEG from 2016 to 2019



Source: ST-CSU data from e-Gratuité 2020

[2] Ministry of Health of Burkina Faso
[3] National Institute of Statistics and Demography

Gratuité's fee-for-service payment mechanism was chosen to be perceived as 'fair' by providers and to avoid undermining service quality. The ST-CSU recognizes a compromise between this and the potential of alternative provider payment mechanisms to control costs and promote administrative efficiency. Fee-for-service payments do not promote quality directly, but at least they do not incentivize cost-cutting, and so should not undermine quality. Fee-for-service payments do, however, risk driving increases in health expenditure (Langenbrunner, O'Duagherty, and Cashin 2009). There is some evidence of increased average cost per claim, but inflation of the cost of Gratuité does not appear to be a major factor driving the funding shortfall.

Perceptions of late or inadequate payment drive dissatisfaction with Gratuité among service providers. Qualitative interviews revealed little understanding of the Gratuité mechanism in the field, but rather a consistent sense that payment had become less reliable over time and that this had reduced facilities' autonomy, flexibility, and ultimately their ability to deliver high-quality services. All facilities reported payment shortfalls, and interviewees had not been told why full payment was not remitted.

Gratuité control and validation systems are fit for purpose so long as contracts with implementers are maintained. Contracts with third parties to validate Gratuité claims provide important controls, and results are generally positive; roughly 90% of claims are valid. However, these contracts lapsed through much of 2018, reducing control and increasing risk.

RECOMMENDATIONS

Ensure adequate budget allocation for Gratuité. Free essential MNCH services are an important step on Burkina Faso's journey toward universal health coverage (UHC). The Gratuité scheme is a pragmatic approach and has demonstrated effectiveness. Many of the challenges found are the result of uncertain and inadequate funding rather than design. Changing the scheme design, particularly if more complexity is introduced, may exacerbate rather than solve this problem. Further strengthening the scheme will not be possible without sufficient funding.

Consider simplifying payment mechanisms. Implementing case-based payments for Gratuité could simplify systems, reduce administrative burden, and control potential claims inflation. While this is unlikely to reduce total costs in the short term, it should be carefully considered. However, case-based payments risk undermining service quality and so should not be implemented unless effective links of payment to quality are in place.

Link Gratuité to quality, rewarding facilities that achieve higher quality standards. Improving the quality of health services is a fundamental challenge for Burkina Faso. Gratuité has improved access, but frontline staff say that they feel that they are expected to manage more clients with uncertain facility income, and so quality is certainly at risk. More effective links between Gratuité and schemes designed specifically to improve quality, such as performance-based financing (PBF), would improve efficiency and reinforce both schemes

I. INTRODUCTION

Burkina Faso began implementing Gratuité, a user fee replacement policy, in April 2016. The Gratuité policy is intended to reduce financial barriers and improve access to reproductive, maternal, newborn, and child health (MNCH) services for women and for children under the age of 5. These exemptions from direct payment for essential health care services align with the country's commitment to universal health care (UHC) and will contribute to the attainment of the Sustainable Development Goals (SDGs). However, their implementation is challenging in an environment where insecurity is growing, and labor unrest undermines health service delivery. In this context, ensuring Gratuité's effectiveness in promoting access and quality of primary health care (PHC) is critical for addressing Burkina Faso's most pressing health challenges, including the high rate of maternal and child mortality and low prevalence of modern contraception.

ThinkWell is supporting Burkina Faso strengthen Gratuité through the Strategic Purchasing for Primary Health Care (SP4PHC) project. SP4PHC is implemented in partnership with government agencies and local research institutions in five countries, with support from a grant from the Bill & Melinda Gates Foundation. In Burkina Faso, SP4PHC is working with the Ministry of Health (MOH) to support reforms through pragmatic steps to make purchasing of family planning and MNCH services more strategic. Purchasing refers to the allocation of pooled funds to providers of health services (World Health Organization 2000). Strategic purchasing recognizes that purchasing can be used as a tool to purposefully support the achievement of health system goals (Resilient & Responsive Health Sytems 2014; World Health Organization 2010). ThinkWell's approach to strategic purchasing in Burkina Faso focuses on improving the effectiveness of Gratuité to purchase high-quality primary health services, improving the coherence of Gratuité and other purchasing schemes, and supporting the Government of Burkina Faso to prepare for the transition of Gratuité management from the MOH to Caisse Nationale d'Assurance Maladie Universelle (the national health insurance agency, or CNAMU).

To inform this strategy and advance project implementation, ThinkWell and its learning partner RESADE conducted a detailed review of the Gratuité user fee removal and replacement policy. The purpose of this report is to succinctly describe how the Gratuité policy works, identify challenges, draw lessons that could orient ongoing discussion around strategic purchasing of PHC, and guide future policy reforms. Findings of this review will be presented to key stakeholders at a dissemination meeting where this first version of the report will be discussed and validated. ThinkWell hopes to trigger discussion and build consensus around opportunities to increase the efficiency and effectiveness of the policy. Such opportunities could include simplifying the administration of payment mechanisms, improving integration and harmonization (including with PBF), and ultimately transitioning Gratuité management from the MOH to CNAMU.

II. BACKGROUND

Burkina Faso is one of the poorest countries of the world, ranking 182 out of 189, with a Human Development Index of 0.434 (United Nations Development Programme 2019)**.** Burkina Faso is a landlocked Sudano-Sahelian country in West Africa with an estimated population of 21.5 million (Ministère de la santé du Burkina Faso and Institut national de la statistique et de la démographie 2020). Approximately 63.9% of the population is under the age of 25, with 33.2% between 15 and 35 years of age (World Bank 2020). The average life expectancy at birth in Burkina Faso is 61.8 years for women and 60.4 years for men (refer to Table 1) (World Bank 2020).

Table 1: Basic demographic indicators

Indicators (2019)	Rate
Total population (million)	21.5 (2020)
Population growth (annual %)	3.1 (2020)
Urban population (% of total population)	29.4
Life expectancy at birth (years)	61.2 (2018)
Gross domestic product (GDP) growth (annual %)	6.1
GDP per capita, Purchasing Power Parity (current international $)	1975.40
Poverty headcount ratio at $1.90 USD/day (% of population)	43.7 (2016)
Human Development Index Rank (out of 189)	182

Source: Ministère de la santé du Burkina Faso and Institut national de la statistique et de la démographie 2020; World Bank 2019; United Nations Development Programme 2019

Since 2012, Burkina Faso has adopted a policy of decentralization that provides more power to local authorities. The country is subdivided into 13 administrative regions, each headed by a regional governor. These regions encompass 45 provinces subdivided into 301 departments that are made up of 351 municipalities. In the last decade, Burkina has passed laws and regulations to promote more autonomous governance of health districts and hospitals. The Politique National Sanitaire 2011[4] operationalized through the Plan National de Développement Sanitaire 2016-2020[5] (PNDS) confirms that primary health care is a priority for Burkina Faso (Ministère de la santé du Burkina Faso 2016b; 2011a). The PNDS is articulated around three programs: access to health services, health services delivery, and management and support of the services of the MOH (Ministère de la santé du Burkina Faso 2016b).

Burkina Faso is facing increased internal and external security threats linked to terrorism and instability in neighboring Mali and Niger (United Nations High Commissioner for Refugees 2019). As the security situation continues to deteriorate in Burkina Faso, more than 1 million people have been internally displaced (United Nations Office for Coordination of Humanitarian Affairs 2020). The sudden change in regime in 2014 has also left deep political divides in the country leading to a greater vulnerability at all levels. The Government of Burkina Faso is working with the international community to build resilience and improve the country's ability to withstand those shocks.

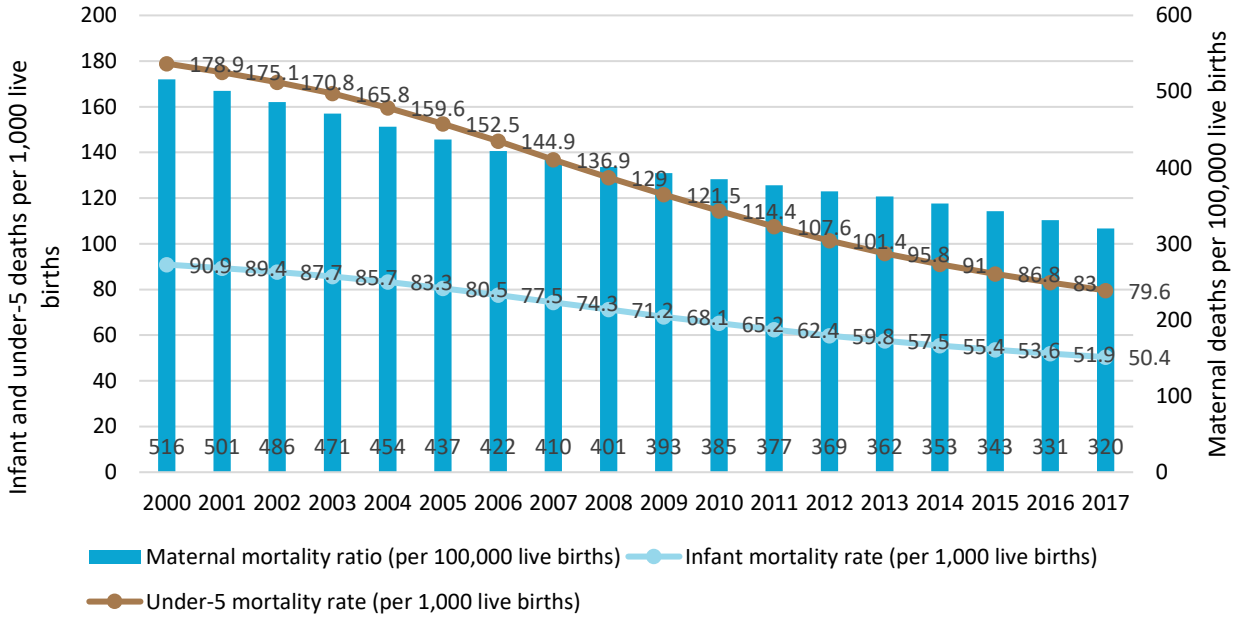
MATERNAL, NEWBORN, AND CHILD HEALTH

Maternal, newborn, infant and child mortality ratios remain high in Burkina Faso, despite significant improvements over the last 20 years. Increased access to MNCH services has driven down mortality from very high levels, but further improvement will require not only continued improvements in equity and access, but also increased attention to service quality in primary health care.

[4] National Health Policy
[5] National Health and Development Plan

Preventable causes continue to drive the high rate of maternal and child mortality. Between 2000 and 2016, the newborn mortality rate (NMR) decreased from 90.9 to 51.9 deaths per 1,000 live births, and the under-5 mortality rate (U5MR) halved from 178.9 to 83 deaths per 1,000 live births (World Bank 2020). Infant and child mortality is mainly due to malaria (23.8%), acute respiratory infections (13.4%) and diarrhea (11.5%), neonatal causes (22.2%), measles (3%), and HIV/AIDS (0.7%) (Institut National de la Statistique et de la Démographie and ICF International 2012). The maternal mortality ratio (MMR) remains high at 320 deaths per 100,000 births, down from 516 between 2000 and 2016 (see Figure 1) (World Bank 2020). Direct causes of these maternal deaths, most of which are preventable, include hemorrhages (30%), infections (23%), retained placenta (11.40%), uterine ruptures (10%), complications of abortions (10%), and eclampsia (4%) (Institut National de la Statistique et de la Démographie and ICF International 2012).

Figure 1: Changing trends in maternal, under-5, and neonatal mortality, 2000–2017

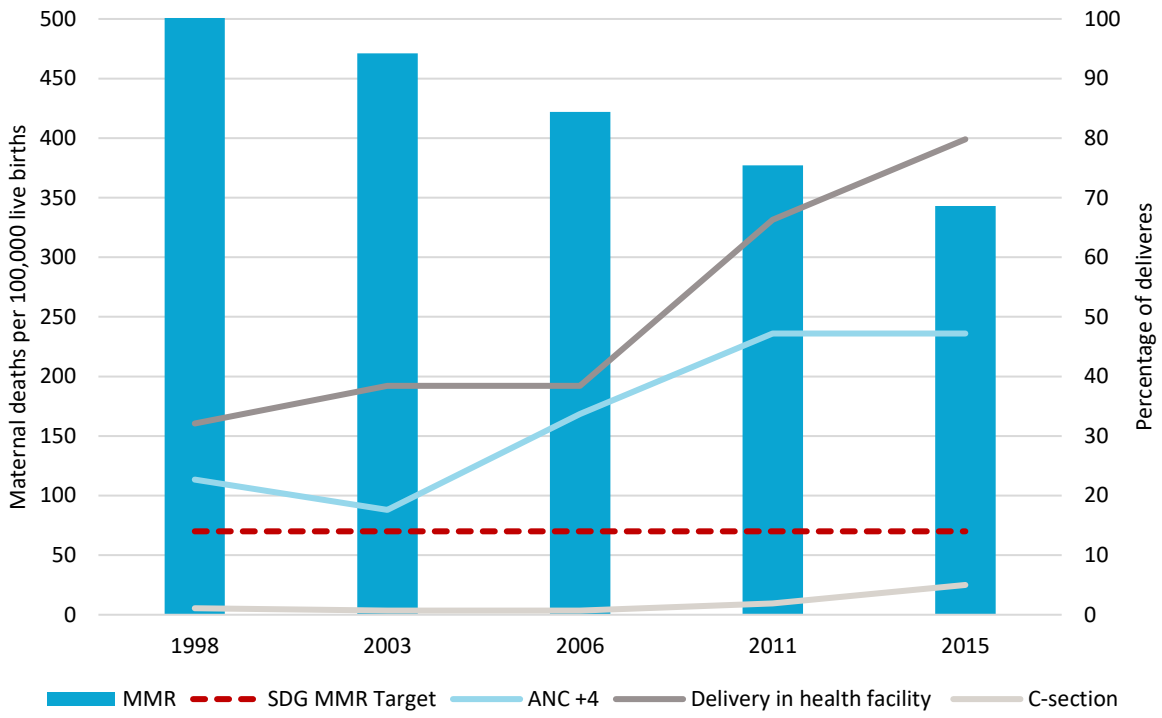


Source: World Bank 2019

According to the Demographic and Health Survey, 94.9% of women received some antenatal care (ANC) during their pregnancy, but fewer than half these women completed four visits (Figure 2) (Institut National de la Statistique et de la Démographie and ICF International 2012)**.** In 2016, estimates of national coverage were 80% for ANC1, 70% for ANC2, and 47% for ANC4+ (four or more visits), just above the PNDS 2011-2020 ANC4+ target of 45% (Ministère de la santé du Burkina Faso and Institut national de la statistique et de la démographie 2018). Barriers to access ANC are associated with a lack of information and awareness, perceptions of low quality of care, and socioeconomic barriers to accessing services (Ministère de la santé du Burkina Faso and Organisation mondiale de la Santé[6] 2017; Ministère de la Santé and Direction Générale des Etudes et des Statistiques Sectorielles[7] 2014).

[6] World Health Organization
[7] Directorate General of Sector Studies and Statistics

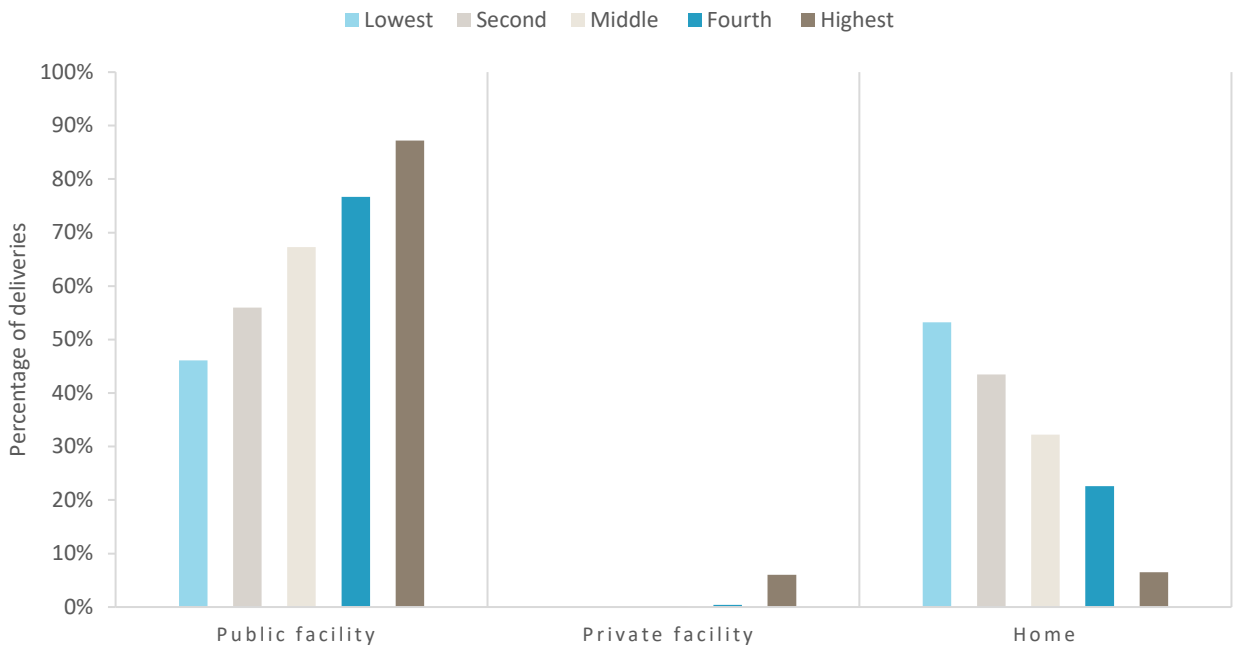
Figure 2: Trends in antenatal care, skilled birth attendance, facility deliveries, c-sections, and maternal mortality ratio, 1998-2015



Source: World Health Organization 2019; World Bank 2019

Access to maternity services has improved over the last decade, but facility delivery remains strongly associated with wealth, and half of the poorest quintile still deliver at home (Figure 3). Between 2005 and 2015, the proportion of births attended by skilled birth attendants increased from 53.5.7% to 79.8% (World Bank 2020)**.** This gain of 26% points in 10 years represents remarkable progress that moves the country very close to the set target of 85% of deliveries attended by qualified personnel (Ministère de la santé du Burkina Faso 2016b). Almost all the women who gave birth in a health facility (99.6%) were assisted by a trained health provider (Ministère de la santé du Burkina Faso 2016b). Approximately two-thirds of pregnant women (65.3%) in the country deliver at a facility, an overwhelming majority of whom favor the public sector (only 1% delivered in a private facility) (Figure 3) (Institut National de la Statistique et de la Démographie and ICF International 2012). Despite progress made in the coverage of key MNCH services, maternal mortality rates are extremely disappointing, and are driven by limited service availability and readiness (Ministère de la Santé and Direction Générale des Etudes et des Statistiques Sectorielles 2014; Institut National de la Statistique et de la Démographie and ICF International 2012).

Figure 3: Proportion of all deliveries by place of delivery and wealth quintiles



Source: Institut National de la Statistique et de la Démographie and ICF International 2012

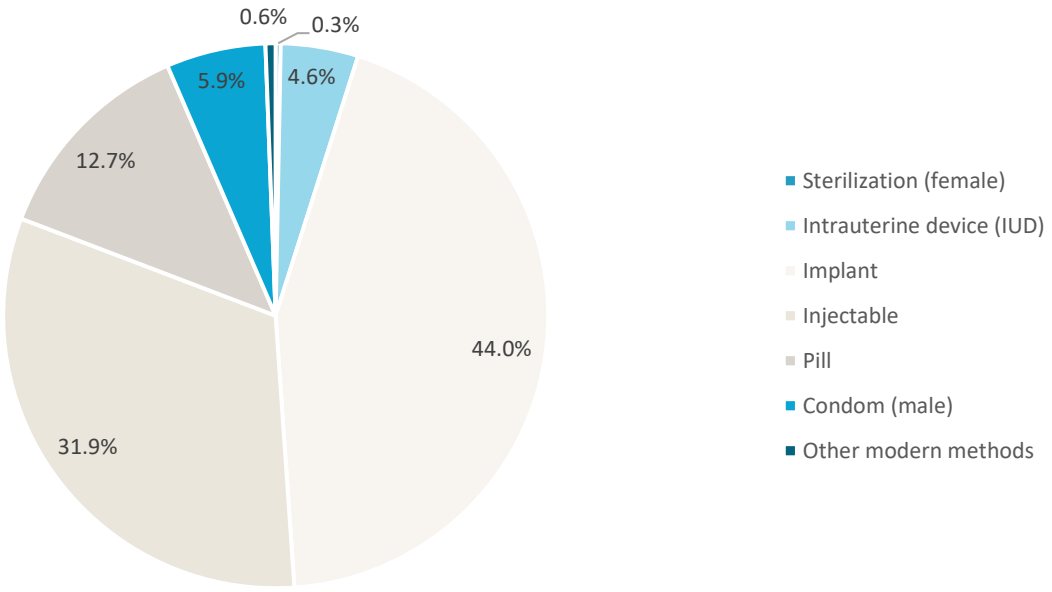
Malnutrition contributes to many infant and child deaths, with 21.2% of children under 5 suffering from chronic malnutrition, 8.6% from wasting, and 16.2% from being underweight (Ministère de la santé du Burkina Faso 2016a)**.** More than half of children under six months (52.2%) do not benefit from exclusive breastfeeding, and only 17.9% and 17.5% of those aged 6 to 23 months have good dietary diversity and a minimum acceptable diet, respectively. The country has been certified free from polio, and the MenAfricvac vaccination mass campaigns organized by the MOH since 2010 have drastically reduced meningitis epidemics. However, despite those good performances in terms of vaccination, the objective of achieving coverage of at least 80% of all antigens in at least 80% of health districts is yet to be reached (Ministère de la santé du Burkina Faso and Institut national de la statistique et de la démographie 2018).

FAMILY PLANNING

Uptake of family planning (FP) in Burkina Faso is relatively high by regional standards, but there is still much room for improvement. Fertility remains high, with a total fertility rate of 5.2 per women in 2018 (World Bank 2020). The Plan National d'acceleration de planification familiale du Burkina Faso 2017-2020[8] set a target for the modern contraceptive prevalence rate (mCPR) at 32% for married women by 2020 (Ministère de la santé du Burkina Faso 2017). Data collected by PMA2020 in December 2018 and January 2019 show mCPR at 27.3% for all women and 30.7% for married women (PMA2020 et al. 2019). Young married women of 15 to 19 years have the lowest mCPR at 12.4%, against 33.3% for women between 30 and 34 years old (Track20 2019). Among modern methods, hormonal methods dominate, and the three preferred contraceptive methods are implants (44.0%), injectables (31.9%), and the pill (12.7%) (see Figure 4) (Track20 2019).

[8] National Plan for Family Planning Acceleration 2017-2020

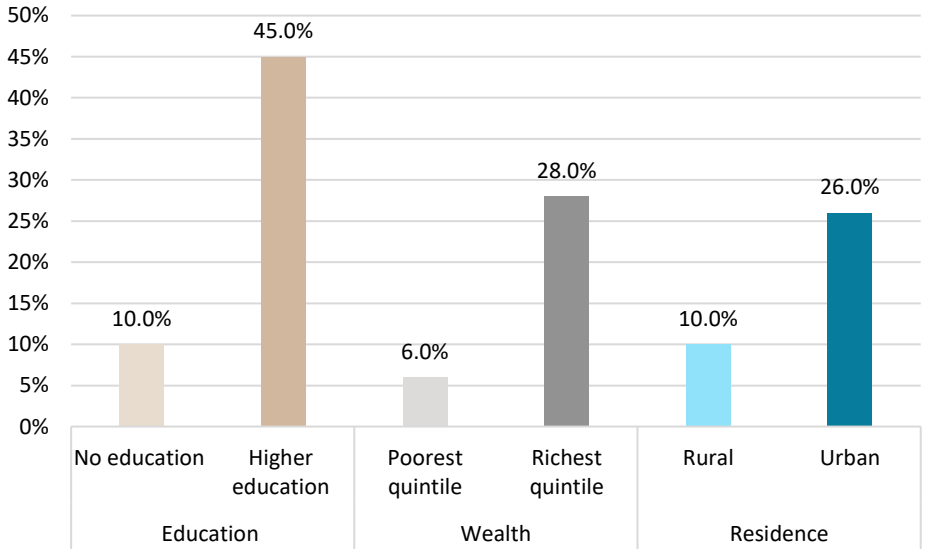
Figure 4: Modern contraceptive method-mix (married women) in 2018



Source: Track20 2019

Unmet need for family planning among married women was 23.3% in 2018 and the demand satisfied by modern methods was 55.0% (PMA2020 et al. 2019)**.** Most unmet need is for birth spacing, while a smaller share of women seek to limit births. Unmet need is strongly associated with socioeconomic status; Figure 5 contrasts unmet across different levels of education, places of residence, and wealth quintiles.

Figure 5: Rate of use of modern contraceptive methods (all women) across key domains



Source: Track20 2020

HEALTH SYSTEM FINANCING

Funding for the health sector in Burkina Faso comes from three main sources: the state budget, international aid, and out-of-pocket user fees from households. While the Government of Burkina Faso has traditionally allocated a large part of national budget to finance health care services, out-of-pocket payments remain significant (see Table 2). State health expenditure as a percentage of the state budget increased from 6.2% in 2014 to 10.3% in 2016 (Ministère de la santé du Burkina Faso 2018a). The contribution of households remains high and reached 36.2% of CHE in 2015. This decreased following the introduction of Gratuité but progress has been undermined by increased insecurity since mid-2018 – refer to Figure 14 in the **Review of costs, payments and debts section** of the report (Ministère de la santé du Burkina Faso and Institut national de la statistique et de la démographie 2020). From 2007 to 2016, expenditure for MNCH amounted to 260,723 million CFA francs representing 8.3% of CHE (Ministère de la santé du Burkina Faso 2018a).

Table 2: Key health financing indicators 2017

Indicator	Values
CHE per capita in US$	$44.40
Domestic general government health expenditure as % of CHE (%)	43.3%
External expenditure as % of CHE (%)	17.9%
Out-of-pocket expenditure as % of CHE (%)	31.7%
Current PHC expenditure as % of CHE (%)	69%

Source: World Health Organization 2020; Primary Health Care Performance Initiative 2018

The central government remains the largest public purchaser of primary health care services in Burkina Faso. In 2017, the Government of Burkina Faso adopted a program-based budgeting approach, moving away from traditional line items. The MOH created a budget that included three major budgetary programs, which were aligned with the priorities laid out in the PNDS (Ministère de la santé du Burkina Faso 2011b). Public sector health workers salaries are managed separately from the MOH budgetary process; in fact, the Ministry of the Economy, Finance, and Development maintains responsibility for health worker salaries.

Although decentralization began formally in 2012, it remains incomplete and much authority is retained at the central level. There is limited financial autonomy at the district level; districts receive funds from the MOH Directeur Administratif et Financier[9] (DAF) to transfer to primary care facilities to support facility operating expenses. User fees also support facility operating costs. The MOH uses pre-positioned funds earmarked for facilities to procure drugs and commodities from Centrale d'achat des médicaments essentiels et génériques[10] (CAMEG). Vertical programs purchase commodities for tuberculosis, HIV, malaria, and vaccines through CAMEG and distribute to districts free of change.

CNAMU, the national health insurance fund, is emerging as a new player in the health financing landscape. In 2015, the Government of Burkina Faso adopted a law designating the assurance maladie

[9] Directorate of Administration and Finance
[10] Central Medical Store

universelle[11] (AMU) as the instrument to reach full population coverage by 2025 (Ministère de la fonction publique du travail et de la protection sociale[12] and Secrétariat Technique pour la Couverture Maladie Universelle 2018). This law aims to pool health purchasing schemes under one umbrella, bringing together *mutuelle*[13] schemes and establishing a scheme for formal sector workers. The plan is to harmonize community-based health insurance under CNAMU, expanding coverage from current low levels (estimates vary, but total coverage of mutuelles is less than 10%) (Barroy, Andre, and Nitiema 2018; Parmar et al. 2014). Contributions to CNAMU will be based on principles of solidarity; formal sector workers will pay premiums based on salary, informal sector workers will likely pay a flat per capita premium, while membership of indigents will be fully subsidized. The Government of Burkina Faso has also planned to transfer management of the Gratuité scheme from the MOH to CNAMU. There is potential for CNAMU to become a significant strategic purchaser of health services in Burkina Faso, but progress to date has been limited.

Since 2011, the Government of Burkina Faso has been implementing successive PBF programs that have attempted to address the quality gap. The current World Bank-funded Health Services Reinforcement Project (2018-2023) supports a range of health financing and purchasing reforms contributing towards UHC, and situates a revised PBF scheme managed by the MOH within this broader agenda (World Bank Group 2018). In previous iterations of PBF in Burkina Faso, facilities were remunerated based on both the quantity and the quality of services provided. In recognition of the impact of Gratuité on rewarding service volume, the revised approach will focus on quality alone. The process of defining, measuring, and reimbursing facilities based on quality is in process, and facility payments have yet to start.[14]

[11] National Health Insurance Policy

[12] Ministry of the Civil Service or Labor and Social Protection

[13] Community-based health insurance

[14] At the time this report was being finalized, the World Bank and MOH were in discussions about restructuring the investment to support strategic purchasing in a way that more formally aligns with the Gratuité

III. STUDY OBJECTIVES AND METHODOLOGY

OBJECTIVES

The objective of this landscaping was to document how the Gratuité policy is implemented in practice. In developing and refining this report, the team has engaged stakeholders to build a shared understanding of how Gratuité is delivered. In the process, we have identified key challenges and opportunities to strengthen Gratuité, to better integrate it within Burkina Faso's health system, and to build on its successes.

METHODOLOGY

The methodology used for this study was descriptive and non-experimental. Methods included a review of policy documents, administration of an online questionnaire, data analysis from the e-Gratuité platform and other government sources, as well as qualitative and quantitative field research.

Key outputs from this methodology, summarized in this report, are:

- A succinct description of how the Gratuité mechanism should work, at both the national and district levels.
- A quantitative analysis of Gratuité data over time, including costs, funds allocation, claims, and debts.
- A qualitive assessment of how Gratuité works in practice, including stakeholders' understanding of the policy and its implementation, and their perceptions of workload and challenges.

Documents reviewed are detailed in Annex B and **Annex C.** The team reviewed 12 policy documents, meetings/workshop minutes, study and activity reports, laws, decrees, and joint orders issued by the Government.

A semi-structured questionnaire was used to remotely interview key informants and stakeholders at central and peripheral levels. Respondents at both levels included directeurs régionaux de santé,[15] directeurs généraux[16] of hospitals, médecins chef de district,[17] and infirmier chefs de poste.[18] Participants were expected to respond directly to the online questionnaire. The form was comprised of questions with closed- and open-ended answers, as well as questions with multiple choice answers. The questionnaire was administered to 300 participants over the course of a one-month period, to which 260 provided responses. The questionnaire was designed to address the following:

- How funds are accessed, used, and accounted for at health facilities.
- What data are required by the MOH to trigger Gratuité reimbursements (including forms used) and the reporting mechanism.
- How the MOH verifies the data reported by districts and facilities.
- How and in what timeframe the MOH releases funds to facilities.
- How facilities procure commodities.
- Linkages between the Gratuité and quality assurance/improvement mechanisms.
- Main challenges and issues related to both access to and equity/quality of services.
- Identification of related governance structures at the national, district, and facility levels.

[15] Regional Health Directors
[16] Director Generals of hospitals
[17] District Medical Officers
[18] Chief Nursing Officers

- Identification of areas where practice diverges from policy as well as key bottlenecks and associated options for improvement.

Quantitative performance data is based on analysis of the e-Gratuité database. This database collects data from all government health care units at all levels of the government health service delivery system. The first dataset collected important indicators, such as service utilization, cost of health services delivery, cost of goods and services, and satisfaction rate since the inception of the Gratuité. The team used other sources to assess out-of-pocket expenses during the same period. The second dataset focused on financial flow and debt to CAMEG and included the amount of bills claimed versus amounts paid, medication orders, variation of the debt to CAMEG, and NGO controls.

For additional stakeholder feedback, in-depth face-to-face interviews were conducted in eight health facilities. An assortment of facilities from different levels of the health system were selected to gather a range of experiences with Gratuité. The facility selection for the in-depth face-to-face interviews included four centre de soins et de promotion sociale (CSPS),[19] two centre medical avec antenne chirugicale (CMA),[20] one centre hospitaller régional (CHR),[21] and one centre hospitalier universitaire (CHU).[22] Interviews were conducted with 21 key informants with connection to the implementation of Gratuité in the eight selected health facilities. The questionnaire was designed to explore the following:

- What are the effects of the Gratuité payment model on the functioning of health facilities, particularly regarding availability of financial resources and drugs in health facilities?
- How much do households pay, on average, outside of health facilities for drugs that are supposed to be given free of charge in the Gratuité policy?
- What are stakeholders' points of view regarding Gratuité payment mechanisms? Are these adapted to the needs of health facilities?
- What are the approaches and options proposed by stakeholders to improve Gratuité mechanisms?

Quantitative data were collected from six of these eight facilities. These included data on allocations received by health facilities from the MOH (Gratuité payments), and on reports of expenditure (Gratuité 'claims') sent back to the MOH. Additional data were gathered on the amount of debt to CAMEG during the period from 2016 to 2019. Consensus was reached to select facilities from two health districts with a high level of debts to CAMEG and from two health districts with lower debts. The CMA facilities were unable to produce accurate financial records and were excluded from this analysis.

DATA ANALYSIS

This mixed methods study combined a quantitative assessment of financial data and analysis of qualitative data. The analysis of quantitative data (financial flows, additional disbursements of households, opinions of stakeholders on the free payment model) was done by Excel 2010 and STATA 15 software. For qualitative data, notes taken during interviews as well as full transcription of the interviews were used to conduct thematic analysis manually for the final report.

[19] Primary health care centers
[20] District hospitals
[21] Regional hospitals
[22] Teaching hospitals

IV. RESULTS AND FINDINGS

OVERVIEW OF THE GRATUITÉ POLICY

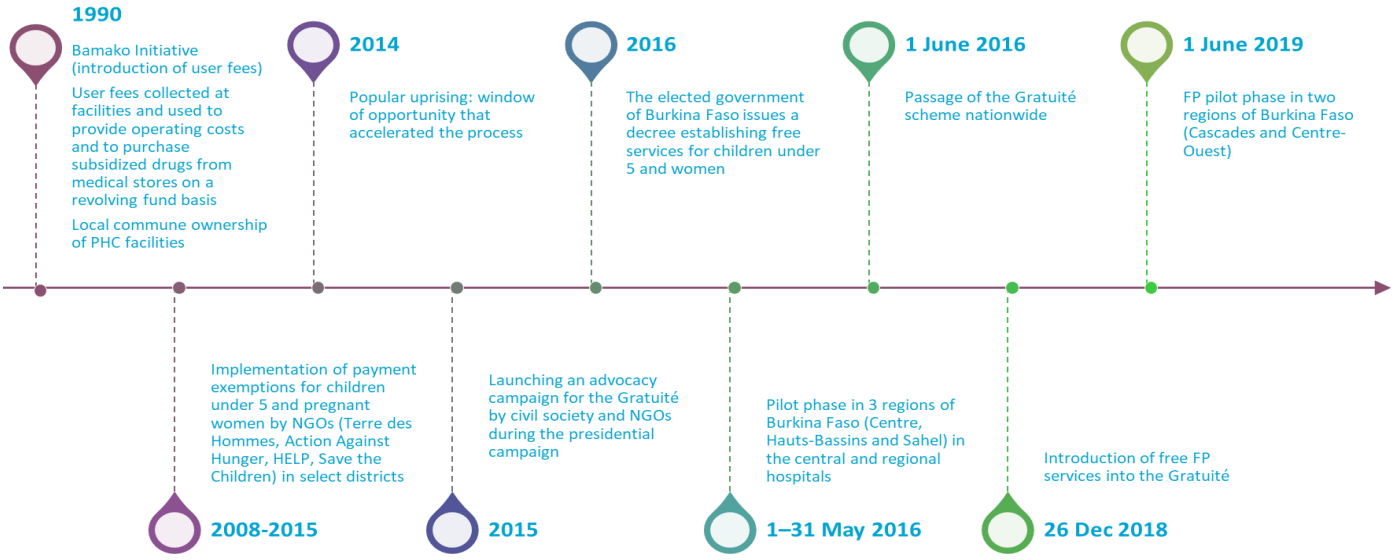
Chronology of key health reforms leading to Gratuité

Until the 1980s, Burkina Faso's health care system followed a colonial-era model that provided health services free of charge. But increased budget deficits resulting in a decline in the quality of public subsidized health services ultimately led to the introduction of user fees through the Bamako Initiative in 1990, intended to mobilize community financing for primary health care (McPake, Hanson, and Mills 1993).

Concerns about user fees for primary care undermining access and equity led to the first pilot projects for user fee exemption in Burkina Faso from 2008. Several other pilot schemes followed the original through to 2015 (Ridde 2015) as part of a long and complex process leading to the eventual adoption of the Gratuité policy (see Figure 6).

On March 2, 2016, the Council of Ministers of Burkina Faso adopted a national health care user fee exemption policy for women and for children under 5: the Gratuité policy. This policy shift reflects a growing consensus that user fees are regressive and undermine equity in access to essential health services. Under Gratuité, public facilities provide a defined package of MNCH services free of charge, fully funded by the government budget. Recently, **Gratuité was expanded to include free family planning services**; a pilot began in two regions (Cascades and Central West) in June 2019 with the hope of drawing lessons for scale-up to the whole country in 2020 (Koulidiati et al. 2020).

Figure 6: Chronology of key user fee reforms towards Gratuité in Burkina Faso



Source: Ridde and Yaméogo 2018, adapted by ThinkWell 2020

Along with the Gratuité policy, the Government of Burkina Faso recently adopted the National Strategy of Health Financing for UHC (Ministère de la santé du Burkina Faso 2018e) and the Strategic Purchasing Orientation Document (Ministère de la santé du Burkina Faso 2018c). These initiatives, which are the result

of numerous discussions among senior policymakers, provide the broad framework for health financing policy in Burkina Faso, but the envisioned reforms have yet to be operationalized.

Gratuité operations are detailed in the *Manuel de procédures descriptives des modalités de gestion, de suivi et de contrôle des mesures de Gratuité des soins au profit des femmes et des enfants de moins de cinq ans vivant au Burkina Faso*, published by the MoH in 2018 (Ministère de la santé du Burkina Faso and Ministère de l'économie des finances et du développement[23] 2018)**.** In the sections below, we explain key aspects of Gratuité operations as they are practiced. It is important to note that not everything set out in the manual has been implemented. Where necessary, based on feedback from implementers, we highlight planned operations that have yet to be implemented, or operations that are managed differently in practice from the manual.

Beneficiary population, benefit package, service providers

Population

The population targeted by the Gratuité policy for MNCH services include:

- Children under 5 years.
- Pregnant women.
- Parturients.
- Postpartum women, up to 42 days after childbirth.
- Women living with obstetric fistula.
- Women aged 25 to 55, for screening and treatment of precancerous lesions of cervical cancer.
- Women aged 25 or older for physical breast examination (screening of breast cancer).

The Gratuité operations manual includes the provision of free family planning services, which have yet to be implemented beyond a two-region pilot. A much wider group of beneficiaries for these services is proposed, and specific target populations are defined.

Benefit package

For children under 5, the Gratuité policy covers conditions and illnesses targeted by the integrated management of childhood illnesses (IMCI) strategy in the country (Ministère de la santé du Burkina Faso 2003). The IMCI strategy is a systematic approach to children's health that includes preventive actions at the family and community levels and curative actions to be taken by health workers both in health facilities and in the community. IMCI principles have been adopted by Burkina Faso as the basis for the Gratuité service package for children under 5, although the management of chronic conditions for children is not included. Community and preventative components of IMCI are included in the Gratuité operations manual, but in practice Gratuité implementation has focused heavily on facility based and curative services.

The Gratuité policy covers all preventive and curative care (including laboratory tests) for conditions linked to pregnancy. This includes antenatal care, maternity services, and postpartum care. Screening and treatment of precancerous lesions of the cervix as well as screening for breast cancer are also covered.

The package of Gratuité benefits includes the following specific goods and services:

[23] Ministry of Economy, Finance and Development

- Medical “acts” of health professionals (consultation, counseling, injections, surgery, bandaging, etc.) related to conditions covered.
- Drugs, medical consumables, and medical imaging consumables. Generic essential drugs are prioritized, but necessary specialty drugs that do not exist in generic form are accepted in accordance with a list previously established by the therapeutic committee.
- Additional tests necessary for case management include:
    - Laboratory tests: hematology, biochemistry, parasitology, bacteriology, immunology (search for blood group and Rh factor; serology VDRL (syphilis); hemoglobin or blood cell count; screening for viral hepatitis C and B; electrophoresis of hemoglobin; HIV test; search for albumin and sugar in the urine.
    - Imaging tests (ultrasound, radiographs, scanner, etc.).
- Observation and hospitalization.
- Fuel for medical evacuations inside the country, including for emergency obstetric care.

Family planning services are detailed in the Gratuité policy but are yet to be implemented. The Gratuité package of family planning services was piloted in two districts in late 2019 and may roll out nationally in 2020. The package includes contraceptive products and fees for the insertion and removal of implants and IUDs.

Costs related to support activities (monitoring-control-evaluation, communication, production of tools, training) are included in policy but not currently funded through Gratuité.

Gratuité policy includes key services at the community level, but implementation of these began only in 2019 and on a limited scale. 2019 claims for community level services were valued at less than one tenth of one percent of total claims. Eligible medicines and medical consumables for free community services should include:

- Oral rehydration salt (ORS) + ZINC kit.
- Antimalarial drugs for children:
    - Artemether + Lumefantrine.
    - Amodiaquine + artesunate.
    - Dihydroartemisinin + piperaquine.
    - Artesunate suppository.
- Amoxicillin tablet (dispersible) for children.
- Paracetamol 500mg scored tablet.
- Rapid diagnostic tests (RDTs) for malaria.
- Male and female condoms, contraceptive pills, Sayana Press.

The plan for free community -level services includes the motivation of volunteer agents de santé à base communautaire[24] (ASBC) with a stipend of approximately $40 per month out of the Gratuité budget

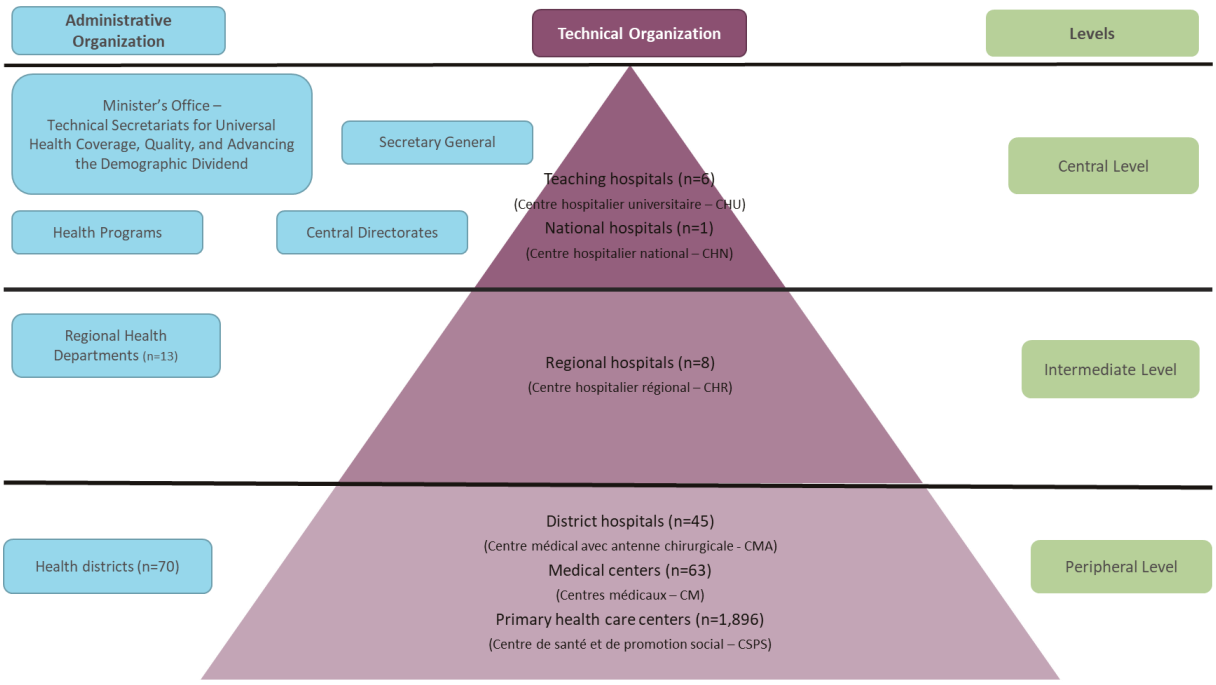
[24] Community Health Workers

(Ministère de la santé du Burkina Faso 2018b)**.** This has yet to be implemented but linking the payment of ASBC community workers to performance continues to be the focus of policy development in Burkina Faso, and a comprehensive plan was released in late 2019 (Ministère de la santé du Burkina Faso 2019).

Health care service providers

The Gratuité policy is implemented in all public health facilities and in the handful of private facilities that have signed an agreement with the MOH (see Figure 7)**.** The implementation of Gratuité is voluntary for private health facilities but mandatory for all public health facilities.

Figure 7: Administrative and technical organization of public health system in Burkina Faso



Source: ThinkWell Strategic Purchasing for Primary Health Care 2020

The Burkina health care system is organized in a pyramid with three levels of governance: the central administration, under the authority of the Minister's Cabinet, which is responsible for setting national policies; the intermediate level made up of 13 regions run by regional health administrations, which are in charge of the supervision of field operations; and the peripheral or operational level made up of 70 health districts, run by district health management teams that implement programs and deliver services.

At the community level, health services are provided by ASBCs, community-based organizations (CBOs), and civil society organizations (CSOs) involved in the health sector. The head of each health facility (CSPS, CM, and CMA) draws an exhaustive list of ASBCs providing services at the community level within its catchment area. This head provides supervision to those ASBC and ensures their supply of the necessary drugs and commodities. Only ASBCs in villages located five kilometers or more from a health facility are, in principle, eligible to provide Gratuité services.

Management structure, funds flow, monitoring and control

The Gratuité management structure is made up of institutions and people from the MOH and the Ministry of Finance, with specific roles and responsibilities in the flow of funds:

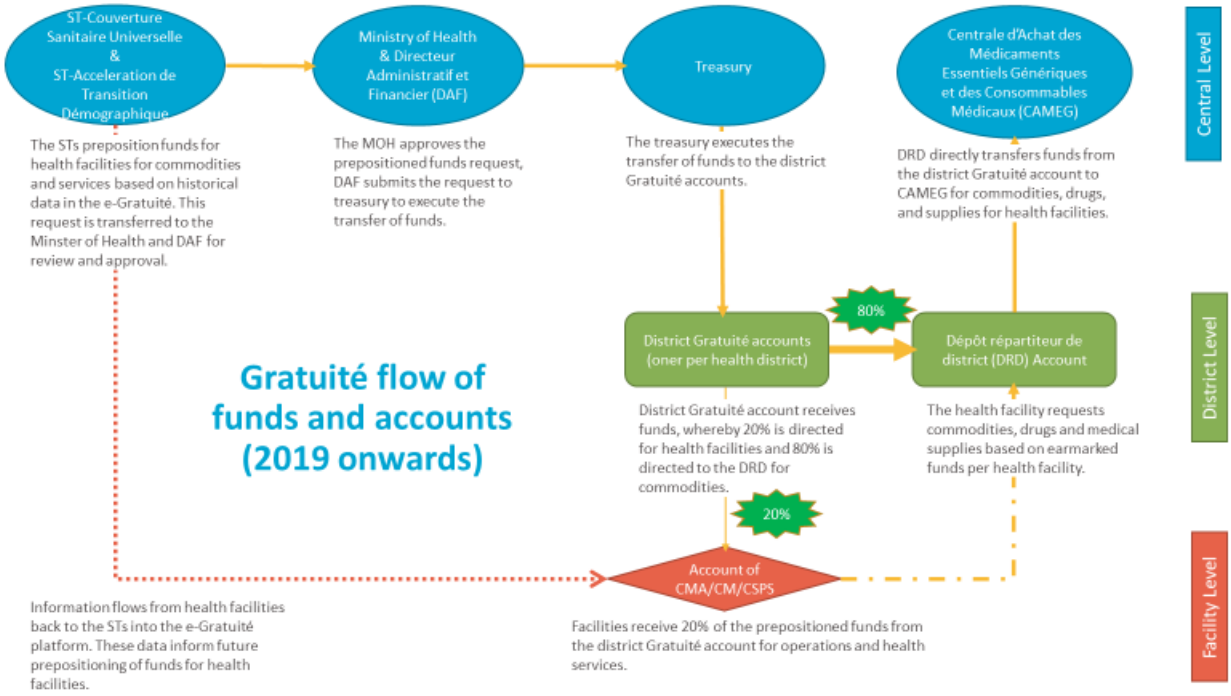
- ST-CSU oversees all Gratuité purchasing activities related to MNCH.
- DAF deals with administration and operations within the MOH.
- The national treasury deals with all government financial and monetary activities.
- CAMEG handles drugs and commodities supply.
- Special Gratuité bank accounts, separate from accounts used for other funding sources, exist at the district and hospital levels.
- Health facilities apply Gratuité.

Funds flow

The flow of funds follows a predetermined circuit in which all the actors listed above play a role (see Figure 8). Funds for health care services covered by the Gratuité policy are pre-positioned quarterly into district or hospital special Gratuité accounts to cover eligible service charges when they occur. The amounts to be pre-positioned for each facility are calculated by ST-CSU using service delivery data from previous quarters' reports. This calculation considers balances of previous transfers, adding money to cover the deficit or subtracting when there is money left from the previous installment. The result of this exercise is stored in the e-Gratuité platform and health facilities are informed of their allocation.

Information on facility level allocation of Gratuité funds is sent by ST-CSU to DAF after MOH's approval. The DAF issues corresponding money transfer orders to the National Treasury, which then sends the requested amounts to designated district or hospital Gratuité accounts. Gratuité funds for all peripheral level health facilities (CMA, CM, and CSPS) of a given district are pre-positioned in one common Gratuité special account for the district. The district DAF officer then transfers funds to each health facility against costed activity reports until the total pre-positioned amount for that facility is exhausted. Whilst funds for peripheral health facilities do flow through district accounts in the same way as line item budget transfers (and in contrast to schemes like PBF which transfer funds directly to facilities), in practice Gratuité funds are earmarked for specific facilities and so districts have little control over their use. The Gratuité funds circuit for public health facilities at the district level is presented in Figure 8 below.

Figure 8: Payment mechanism for health facilities at the health district level



Source: ThinkWell Strategic Purchasing for Primary Health Care 2020

For public health facilities, 70% to 80% of the amount pre-positioned typically corresponds to the cost of drugs and consumables, and these funds are directly transferred to CAMEG by the dépôt répartiteur de district[25] (DRD). Each health facility of the district receives notification from the DRD of the amount pre-positioned for their drugs and consumable use. The remaining 20% to 30% of the amount is paid to facilities for operation and other service charges; use of these funds is guided by public financial management regulations. Private health facilities enrolled in the Gratuité policy receive the total amount calculated for drugs, consumables, and operations. Funds for private facilities pass through the district accounts, but no deduction for CAMEG is made. Private facilities are free to purchase drugs from any source.

Claims reporting flow

The Gratuité activities claim reporting flow follows a defined mechanism divided into four steps:

Step 1: Development of monthly Gratuité activity reports

At the end of each month, health facilities (CMA/CSPS/CM) prepare costed Rapport mensuel d'activités[26] (RMA) using Gratuité report forms. These reports summarize all services, products, and consumables (e.g. "acts," medications, lab exams, fuel) used for Gratuité during the month, including the cost of each, and are compiled with receipts and supporting documents (refer to **Annex D** for the full list of reporting forms). From health workers interviewed in the field, the process of assembling receipts and supporting documents to fill the form could take from a day for well-organized facilities to a couple of days for those less

[25] District Warehouse
[26] Monthly Activity Reports

organized. A separate RMA is completed for routine health management information system (HMIS) reporting to be entered into district health information system 2 (DHIS2) at the district level.

Step 2: Transmission of RMA to the district

The RMAs collected from all health facilities and hospitals of the district are sent in paper format to the district HMIS unit responsible for entering them into the e-Gratuité database. Reports from health facilities must be submitted no later than the fifth of the subsequent month.

Step 3: RMA data verified and computerized

After receiving the RMA, the HMIS unit verifies completeness and enters the data in the e-Gratuité platform online. This data entry process happens at the district level only for health centers. Hospitals and bigger facilities with functional IT equipment can access the database for data entry directly from their sites. The HMIS unit may alert health facilities when there are questions or missing data. This unit generates a quarterly report that is the basis for payment. The quarterly report is signed by the district health officer and sent in printed format to ST-CSU even though data are entered in the e-Gratuité platform; the signed reports are legally binding for the facility and the district in case of falsifications and wrongdoing identified during control. Districts do not send copies to health facilities; this is unfortunate as controls show that mistakes are often made during the data entry at the district level.

Step 4: ST-CSU payment estimates

The ST-CSU checks the accuracy of RMA data entered in the system and does some data cleaning, requesting missing data for completeness. Based on those assessments and the trend from previous reports, ST-CSU makes quarterly calculations to determine the amounts of money to be pre-positioned in Gratuité accounts for each district. Allocations therefore reflect claims submitted, but if the budget available to ST-CSU is insufficient, not all claims are paid. Where there is a budget shortfall, the ST-CSU prioritizes payments to hospitals (considered to provide "essential services"). Decisions on payment to lower-level facilities are influenced by past performance; facilities may be penalized for poor control results, for example. Qualitative findings suggest that this information is not always communicated to health facilities; most of the time staff do not understand why they receive the funds they do, or how this amount is calculated. This risks creating uncertainty, rather than a virtuous feedback loop.

Information and monitoring platform (e-Gratuité)

A separate electronic Information and monitoring platform called e-Gratuité was developed for the management of Gratuité (Ministère de la santé du Burkina Faso 2020). This parallel platform is built from DHIS-2, as is the national HMIS. In addition to monthly activity reports and *télégramme lettre officielle hebdomadaire*[27] (TLOH) shared with the country HMIS, specific tools have been developed for the collection of Gratuité data at the facility level and are listed in **Annex D** through **Annex E**. The reporting circuit, periodicity, and transmission deadlines for those tools are the same as for the country HMIS, but otherwise the systems are separate.

The e-Gratuité platform is accessible for data entry, processing, and analysis by health information officers from all regions, districts, and hospitals. At the central level, data processing and analysis are performed primarily by ST-CSU. FP data is managed by the Secrétaire Technique pour l'Accélération de la

[27] Official Weekly Telegram

Transition Démographique[28] (ST-ATD). But the platform is open to any manager or partner organization with an access account.

Based on monthly reports received from districts and hospitals, ST-CSU and ST-ATD develop quarterly and annual reports on the implementation of Gratuité. These reports are sent to the DAF to account for funds disbursed and used through facility and district Gratuité accounts.

Supervision and control

The supervision of Gratuité activities is integrated in the regular MOH cascade system of routine supervision, from the central to the regional and district levels. In collaboration with the Ministry of Economy, Finance, and Development, the MOH is expected to conduct regular field visits both for supervision and control of health facilities expenditures, with the aim of:

- observing and analyzing implementation of activities and use of allocated funds;
- identifying health facilities in difficulty and proposing corrective actions;
- providing continued support to health facilities, with a focus on those with difficulties.

In addition to routine supervision, the MOH applies specific controls to Gratuité activities. These controls start with an analysis of services, drugs, consumables, and related costs using data from the e-Gratuité platform. This monthly review allows MOH to identify health facilities with potential problems and to select facilities for further investigation. In the first step of this analysis, the MOH determines averages for the cost of services by type and facility level. For each type of service, facility-reported services costs are compared to calculated averages, and outliers are identified. In principal, the MOH also manages a complaints system that allows clients and other community members to identify facilities requiring additional checks, but this system does not appear to be functional.

The MOH has contracted with NGOs that carry out control and evaluation when requested in all 13 regions (see Table 3). Roles and responsibilities are clearly defined, with the MOH identifying facilities to be visited and the NGOs carrying out the control in the field. NGOs are contracted to visit at least one third of all the facilities in their area annually. Field control visits start with a review of health care registers and accounting documents to compare in-situ findings with e-Gratuité data. This review is followed by an interview of health workers to enquire about identified discrepancies. A sample of beneficiaries drawn from the register are then interviewed in the community to verify that they did receive the services listed in the register and that they did not pay out-of-pocket fees for those services or commodities. The opportunity is then taken to discuss interviewees' perception of the demand to pay for Gratuité commodities or drugs when those are out of stock. The control visit is completed with a restitution meeting, where findings are discussed, and follow-up actions agreed upon. The ST-CSU also considers data from NGO control visits when making calculations of subsequent payments, but the formal relationship between control findings and payments – for example through application of sanctions for poor performance - is unclear.

[28] Technical Secretariat for the Acceleration of the Demographic Dividend

Table 3: List of NGOs and associations contracted for the control of Gratuité, and regions covered

Name of the NGO / association	Status	Health regions covered
Terre des Hommes (TdH)	International NGO	Boucle du Mouhoun, Plateau Central
Action Contre la Faim (ACF)	International NGO	East, East Central
Save the Children	International NGO	North Central, Cascades
Help	International NGO	Centre, Hauts-Bassins, Sahel
SOS Sahel International	International NGO	North
Association Vision Nouvelle	National association	West Central
Réseau Accès aux Médicaments Essentiels (RAME)	National association	South Central
Association Songui Manégré/Aide au développement endogène (ASMADE)	National NGO	South West

Source: Ministère de la santé du Burkina Faso and Ministère de l'économie des finances et du développement 2018

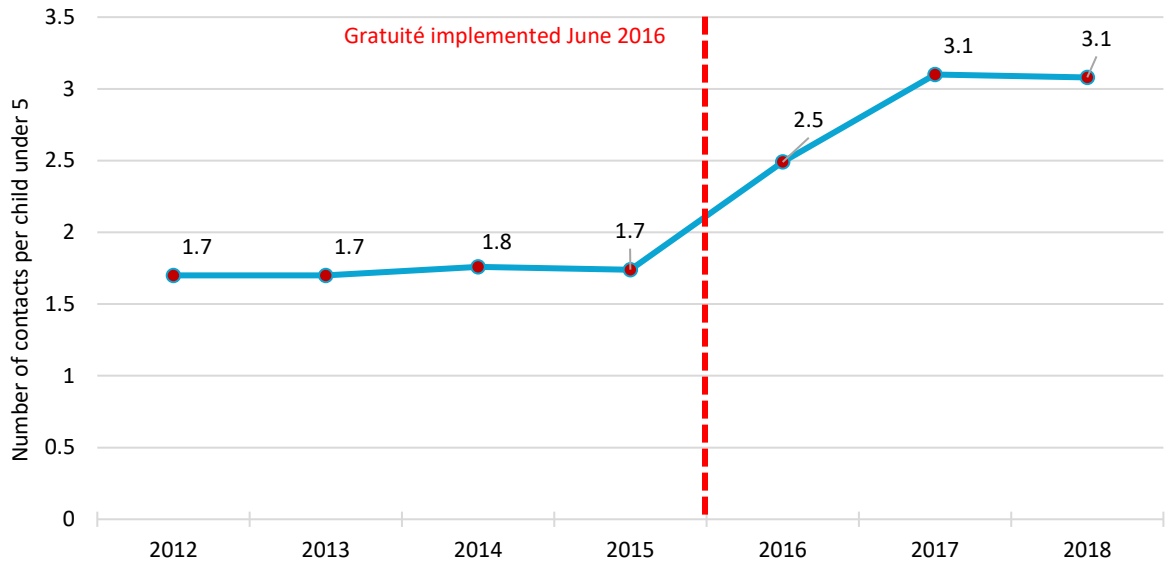
REVIEW OF COSTS, PAYMENT MECHANISMS AND DEBTS

Increased service use and funds shortage

Service utilization data suggests that the Gratuité policy has increased access to MNCH services. This aligns with evidence from studies across several low-income countries, which show that removing point-of-service user fees typically increases the use of maternal and child health care services (Bassani et al. 2013; Lagarde M 2011; Ridde and Morestin 2011). It is also consistent with studies looking at uptake of services in Gratuité pilot areas prior to national roll-out (Zombré et al. 2019; Nguyen et al. 2018). Figures 9 and 10 below show an increase in the number of contacts per child under 5 and in the proportion of women making four ANC visits after the introduction of the Gratuité policy.[29] We recognize that this simple trend analysis does not allow us to rule out possible confounding factors.

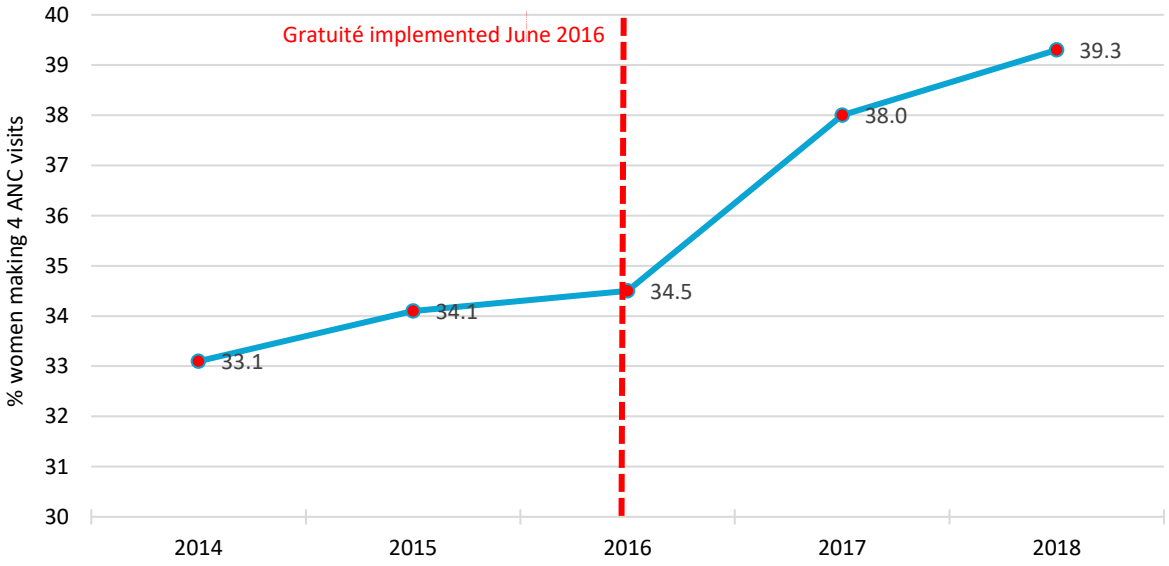
[29] In 2019, reporting of service data was severely affected by health worker industrial action. Service data has not been officially released at time of writing, and whilst some initial presentations of this data suggest a decline in uptake, further analysis will be required to draw firm conclusions.

Figure 9: The use of health care service in public facilities for children under 5 years, 2012-2018



Source: Ministère de la santé du Burkina Faso and Institut national de la statistique et de la démographie 2019

Figure 10: The proportion of women making four antenatal care visits, 2014-2018

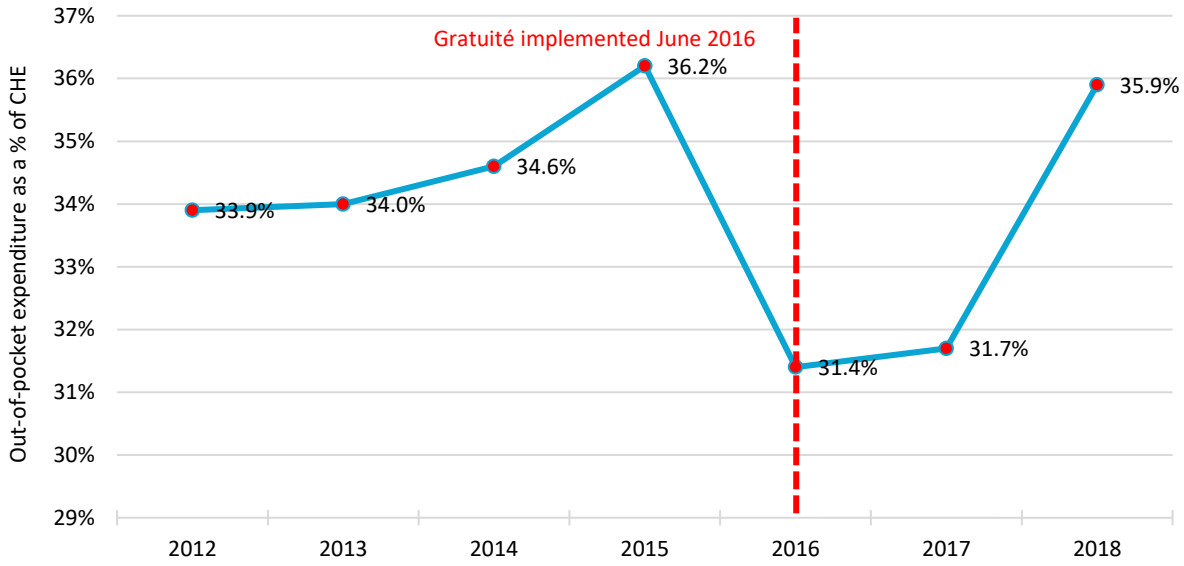


Source: Ministère de la santé du Burkina Faso and Institut national de la statistique et de la démographie 2019

Figure 11 suggests that the introduction of Gratuité in 2016 initially reduced out-of-pocket expenditure as a proportion of CHE. Out-of-pocket household health expenditures for Burkina Faso, while still a major cost, declined from 36.2% of CHE in 2015 to 31.7% in 2017, following the introduction of Gratuité. Out-of-pocket expenditure then increased back to nearly 36% of CHE in 2018. Further analysis will be required to understand this rebound, but the 2018 data may reflect the impact of Gratuité payment shortfalls towards the end of 2018, associated debts to CAMEG, and drug shortages. An increase in out-of-pocket expenditure

could also have been exacerbated by factors outside the health sector, particularly growing insecurity and internal displacement.

Figure 11: Out-of-pocket household health expenditure, 2012-2018



Source: Ministère de la santé du Burkina Faso and Institut national de la statistique et de la démographie 2019

Gratuité supports mainly peripheral level facilities and rural locations. Beneficiary information is not collected in the Gratuité scheme, and so a formal equity analysis is not possible without further research. However, as claims data is facility-specific, it is possible to see that the majority of claims come from peripheral health facilities (96.0% of contacts at CSPS or CM facilities) (Figure 13) and rural locations (76.5% of contacts in rural locations, compared to 70.0% of the population) (Figure 12) (Ministère de la santé du Burkina Faso 2020; World Bank 2020). There has been little change in this distribution between 2017 and 2019.

Figure 12: Percentage of Gratuité beneficiary contacts by location, 2017-2019by

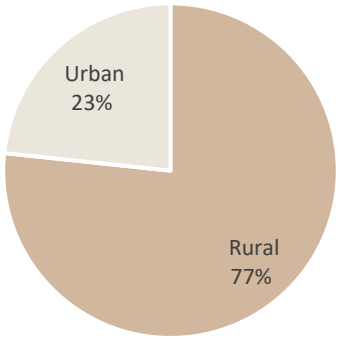
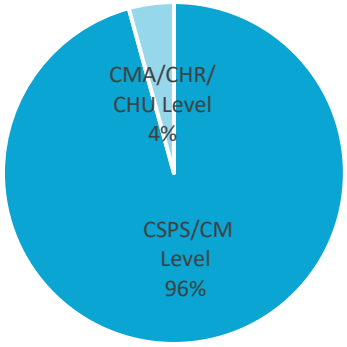


Figure 13: Percentage of Gratuité beneficiary contacts between peripheral and hospital levels, 2017-2019



Source: Ministère de la santé du Burkina Faso 2020

The value of claims is more evenly distributed, as might be expected with a higher cost per contact in hospitals and urban settings. 51.7% of gratuité payments by value go to rural locations, and 68.8% to peripheral-level facilities (refer to Figure 14 and 15) (Ministère de la santé du Burkina Faso 2020).

Figure 14: Proportions of Gratuité costs by location, 2017-2019

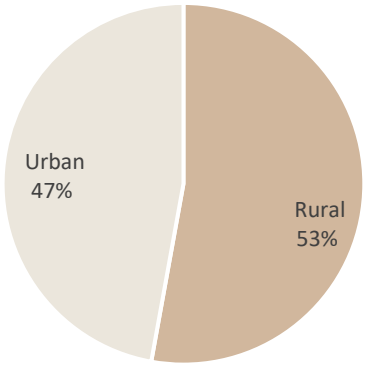
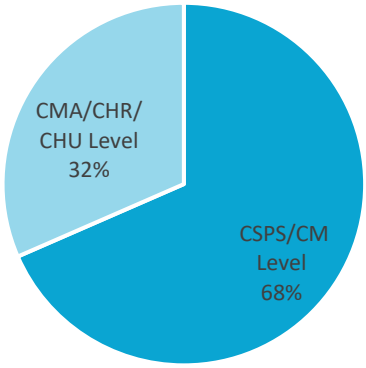


Figure 15: Proportions of Gratuité costs between peripheral and hospital levels, 2017-2019



Source: Ministère de la santé du Burkina Faso 2020

The Gratuité policy is funded by the state budget, which bears all direct health care expenses of the covered services. Table 4 summarizes annual claims submitted from facilities against services covered by Gratuité. Services for children under 5 make up the bulk of claims, and approximately half of the total value of claims. The average cost of these services is stable between 2017 and 2019. Other major costs are driven by services for pregnant women, specifically antenatal care and deliveries. Cesarean section costs have increased rapidly and are close to half the total cost of normal deliveries. But overall, Gratuité claims costs are reasonably well controlled;[30] the average cost per claim across all services increased by 6.8% between 2017 and 2019, and the total cost of all claims increased by 4.5% between 2017 and 2019.

[30] Compared to Consumer Price Index inflation, which was negligible (0.3% net) between 2016 and 2019 https://www.theglobaleconomy.com/Burkina-Faso/inflation/.

Table 4: Sample data on Gratuité-covered health service quantities and costs

	2016 (June - December)			2017			2018			2019			2017 - 2019			
	# services (x1,000)	Claims (million CFA)	Averge Cost per service	# services (x1,000)	Claims (million CFA)	Averge Cost per service	# services (x1,000)	Claims (million CFA)	Averge Cost per service	# services (x1,000)	Claims (million CFA)	Averge Cost per service	% Increase in Average Cost	Increase in Total Cost	% increase in total cost	% of total cost 2019
Dystocic deliveries	75	914	12.2	138	1,720	12.5	142	1,975	13.9	146	1,923	13.2	5%	203	11.8%	6.4%
Eutocic deliveries	351	1,263	3.6	577	2,169	3.8	586	2,259	3.9	568	2,129	3.7	0%	(40)	-1.8%	7.1%
Caesarean sections	14	1,119	79.9	21	1,838	87.5	24	2,226	92.8	18	1,864	103.6	15%	26	1.4%	6.2%
Cure of obstetric fistula	0	3	7.5	0	3	15.0	1	7	8.1	0	4	12.7	-18%	1	26.7%	0.0%
Laparotomy for extra uterine pregnancy	1	25	41.7	1	46	76.7	1	68	68.0	2	87	37.8	-103%	41	89.1%	0.3%
Laparotomy for uterine rupture	0	55	275.0	0	16	80.0	0	23	115.0	0	22	110.0	27%	6	37.5%	0.1%
Postpartum curative care	165	288	1.7	424	451	1.1	350	527	1.5	319	451	1.4	25%	-	0.0%	1.5%
Emergency care for newborns	24	115	4.8	42	280	6.7	51	445	8.7	48	505	10.5	37%	225	80.4%	1.7%
Emergency obstetric care	25	274	11.0	42	507	12.1	42	605	14.4	39	550	14.1	14%	43	8.5%	1.8%
Antenatal care	2,568	3,391	1.3	4,836	6,708	1.4	5,062	7,596	1.5	4,747	7,517	1.6	12%	809	12.1%	24.9%
Care for children under-five	7,068	9,039	1.3	10,815	15,088	1.4	11,692	16,090	1.4	10,557	15,036	1.4	2%	(52)	-0.3%	49.9%
Screening of precancerous lesions	8	12	1.5	23	33	1.4	32	56	1.8	34	70	2.1	30%	37	112.1%	0.2%
All Claims	**10,299**	**16,498**	**1.60**	**16,919**	**28,859**	**1.71**	**17,983**	**31,877**	**1.77**	**16,479**	**30,158**	**1.83**	**6.8%**	**1,299**	**4.5%**	**100.0%**

Source: Ministère de la santé du Burkina Faso 2020

At the beginning of the Gratuité policy implementation in 2016, funds allocated by the Government were sufficient to cover claims, but this changed in 2018. Starting in mid-2018, perhaps because of a deteriorating security situation, the Government found it increasingly difficult to allocate requested amounts. A major shortfall occurred in Q3 2018, and then no payments were made at all in Q4 (as described in Table 5). Districts requested or claimed 32 billion CFA for 2018, but the Government could only pay 16 billion CFA. Some of this underpayment was repaid in Q2 and Q3 of 2019, when payments exceeded claims. At the end of 2019, however, there was again a major shortfall; against a total amount claimed of 32 billion CFA in 2019, only 26 billion was paid.

Table 5: Gratuité Pre-positioned vs. invoiced amounts and gaps per quarter at national level

Year	Quarter	Money pre-positioned (CFA)	Amount billed (CFA)	Money pre-positioned/ Amount billed
2016	Quarter 2	3,854,268,853	2,910,340,204	132%
	Quarter 3	6,853,542,789	6,872,854,824	100%
	Quarter 4	6,176,217,124	6,261,495,309	99%
	Total	**16,884,028,766**	**16,044,690,337**	105%
2017	Quarter 1	6,516,153,050	6,280,809,687	104%
	Quarter 2	6,106,070,012	6,690,750,408	91%
	Quarter 3	6,923,616,405	8,114,342,425	85%
	Quarter 4	7,956,545,982	7,480,753,872	106%
	Total	**27,502,385,450**	**28,566,656,392**	96%
2018	Quarter 1	7,838,585,843	7,083,096,117	111%
	Quarter 2	5,714,838,596	7,079,584,821	81%
	Quarter 3	5,850,000,000	8,817,250,543	66%
	Quarter 4	-	8,987,176,357	-
	Total	**19,403,424,439**	**31,967,107,839**	61%
2019	Quarter 1	8,000,000,000	7,866,469,904	102%
	Quarter 2	7,984,589,363	6,520,057,693	122%
	Quarter 3	8,000,000,000	6,187,318,377	129%
	Quarter 4	1,700,000,000	7,030,507,377	24%
	Total	**25,684,589,364**	**27,604,353,350**	93%

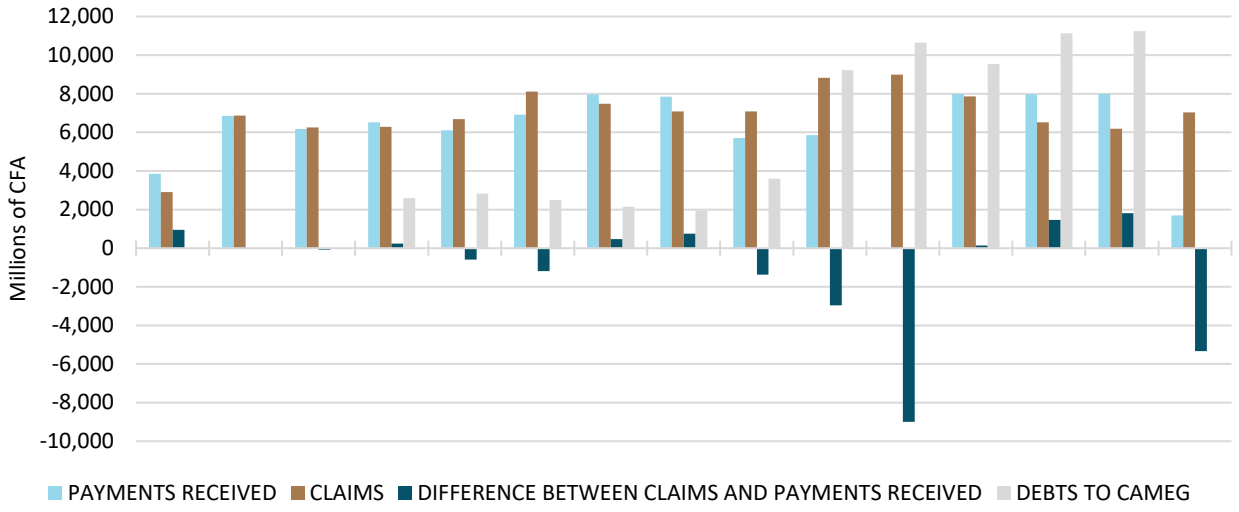
Source: Ministère de la santé du Burkina Faso 2020

Debt to CAMEG

CAMEG is Burkina Faso's central medical store. CAMEG is a nonprofit association with an independent legal personality and financial autonomy and is responsible for procurement and supply management of drugs and medical products. CAMEG provides drugs to public health districts on credit and invoices them for costs. Outstanding debt to CAMEG limits its ability to procure drugs effectively on the international market. Growing debt to CAMEG is a significant concern to national stakeholders and development partners, and key informants interviewed often associated this debt with the growth of Gratuité.

The growth of district debt to CAMEG follows the growth of the gap between Gratuité invoices issued and transfers received. At the beginning of the Gratuité in 2016 and 2017, transfers covered almost all the claims, and CAMEG debts were very small or nonexistent. But by mid-2018, the discrepancies between the transfers made and the invoices claimed were growing. This is associated with an increase in debts to CAMEG, shown in yellow in Figure 16. CAMEG was owed less than 2 billion CFA in the first quarter of 2018, and this grew to more than 10 billion by the year's end.

Figure 16: Evolution of invoices vs. payments and vs. debts to CAMEG from 2016 to 2019



Source: ST-CSU data from e-Gratuité

STAKEHOLDER VIEWS ON GRATUITÉ PAYMENT MECHANISMS

Surveys conducted at the facility level highlighted irregularities in the payment of Gratuité claims. These range from payments delays – sometime of several months – to discrepancies between invoices submitted and refunds received. In all health facilities visited, data analysis showed that the amount of payments received did not cover the expenses claimed.

> *"Health facilities are struggling, and on top of that, you work, and you are not reimbursed for what you spent. So, this is a situation to be reviewed. It even happens that we do five to seven months without receiving a penny. We are told to continue with fee exemption, but we are never reimbursed in full, while CAMEG requires us to pay our bills. How can we pay these bills if Gratuité does not reimburse us?"* (Respondent code: RTP 06)

Almost all people interviewed identified irregularity of payments to facilities as a major issue in the implementation of Gratuité. During the first year of implementation, payments were regular, but this did not last long, as declared by one respondent:

> *"At the beginning, they proceeded by pre-positioning for three months. Money for the next quarter was available on request. But this didn't last long."* (Respondent code: RTP02)

Another one added:

> *"Payment is never regular. For example, since November (2019), we have received no payment. It has happened in the past that we stay about six (06) to seven (07) months with no payment."* (Respondent code: RAK 01 – interviewed in February 2020.)

Table 6 below illustrates those discrepancies from six of the eight health facilities included in the in-depth stakeholder analysis.[31] A detailed table including figures and percentage with a breakdown in quarters is provided in **Annex F**.

Table 6: Cumulative invoices versus payments by six health facilities surveyed from 2016 to 2019 (CFA)

Health facilities	Bills issued	Payments received	Gap
CHR 1	1,385,057,110	1,206,948,215	-178,108,895
CHU 1	3,736,942,562	3,353,939,895	-383,002,667
CSPS 1	35,877,758	30,527,010	-5,350,748
CSPS 2	33,685,468	28,684,002	-5,001,466
CSPS 3	189,498,985	158,425,531	-31,073,454
CSPS 4	5,956,880	4,729,103	-1,227,777

Source: Ministère de la santé du Burkina Faso 2020; Kafando, Kiendrébéogo, and Tapsoba 2020

In addition to having delays of several months, reimbursement is unpredictable and therefore quite challenging for health facility planning and management. Irregularities lead to major disturbances in day-to-day operations, as pointed out by a respondent:

> *"Imagine a CSPS which has a capital of one million (1,000,000) CFA francs, and it takes five hundred thousand francs (500,000) to put in Gratuité* [i.e. to provide Gratuité services]. *But the Gratuité payments take forever to be executed. The CSPS will use the other half to operate, hoping to be paid later. But how long can such an operation last? The facility will inevitably run out of money at a point in time*." (Respondent code: RTP 06)

The Gratuité reporting system was perceived to be complex, with a number of accounting operations and management tools that require record cards, invoices, and slips of paper for various purposes. The need for a computerized system starting at the health facility was expressed strongly. For example, the health care provider could be given a tablet to record as they consult and treat patients, all related information and data for future use. One of the respondents said:

> *"We need a computerized system that will record all the procedures performed on a patient, as well as prescriptions. ... This is the kind of thing that could ease our reporting burden and facilitate controls as controllers will be able to see some discrepancies directly on the platform and call the agent for correction."* (Respondent code: CDC 02)

[31] Cumulative invoice and payment data from the surveyed CMAs were not included in this analysis due to poor data quality and missing data.

CAMEG is required by law to supply public health facilities with drugs and commodities even if there are debts or delays in payment. This has not changed with the introduction of Gratuité. Unfortunately, some district officers and CAMEG clerks either do not know or are reluctant to apply these laws. They commonly argue that because Gratuité is transferring money to districts and health facilities, it is then up to the facility to pay the CAMEG for drugs and consumables ordered. This is not always possible when health facilities for some reason run out of funds.

> *"In order to buy essential drugs on credit at the district level, you have to attach your center's cash book to prove that you are out of treasury and can't pay for your orders. A long procedure must then be followed for the authorization to be issued; four opinions are requested, including the president of COGES, the town hall mayor, the accountant, and the pharmacist. Also, the district medical officer has a say. This long procedure has led us to avoid ordering for drug credit." (*Respondent code: RTP 01)

ThinkWell's online survey of public sector health workers revealed limited understanding of the details of the Gratuité mechanism (see results in Annex G). Only 44% (106 out of 243) of the respondents knew that the payment mechanism was a pre-positioning of funds in the special Gratuité account, and 12% (31 out of 243) had no idea of the reimbursement mechanism. Although facilities are informed of the amount of Gratuité funds made available to them in the district account, there is no explanation of how that amount is calculated, or even which period it is for. Many respondents did associate Gratuité with drug stockouts, but equally, the current mode of payment was not perceived as the main cause of difficulties encountered by health facilities. As a result, people interviewed were not favorable to radical changes. Rather, they demanded payments be made more regularly and in full, as shown in the following statement of one interviewee:

> *"In any case, I hope you will transmit our plea to the Government for the payment in full of our claims when controlled and validated. Most important, those payments should be made in time. … From the moment the reports of the control and verification of our claims are validated, in principle there should be no further problem to release the funds… Otherwise the resulting delays impact our work negatively and our center's health indicators. When there are no drugs, it is complicated for health workers to explain to patients who for some may have traveled long distances."* (Respondent code: RTP 01).

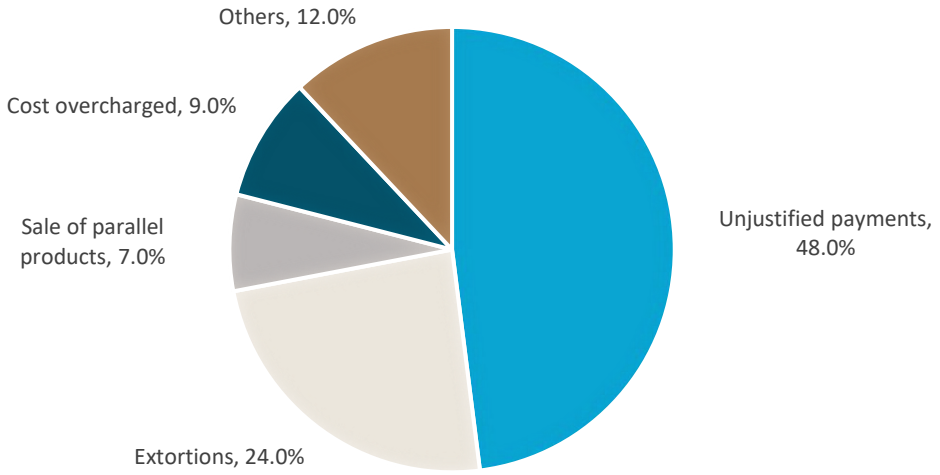
Most of the stakeholders interviewed in this survey at all levels perceived positive synergies between Gratuité and PBF; several explained that the first increases in use of services, while the second compensates health workers for the increase in workload and incentivizes improvement in service quality. The PBF program was introduced in Burkina in 2011 as a major health system reform designed to help improve the quality and use of health services. It focused on MNCH but also included components on nutrition and disease surveillance. In 2016 when the Government of Burkina Faso adopted the Gratuité policy, the two programs were not integrated, perhaps missing an opportunity. Both programs operated in parallel through 2018, with separate management and reporting mechanisms. Although PBF formally stopped before interviews were conducted, respondents nevertheless reported that the parallel systems had resulted in an increased workload for health workers in facilities implementing both programs.

> *"Before Gratuité launched in our center, we were already implementing the PBF program. At the beginning we were happy with the resources the two programs were bringing. But quickly we realized that the workload was doubled. Gratuité has its own reporting, payment, and evaluation*

systems, which are totally different and separated from the PBF, and this is to be handled by the same health workers." (Respondent code: RTP03)

In controls carried out by Terre des Hommes in 2017 in 530 health facilities, 13% of clients interviewed reported irregularity in the implementation of Gratuité. The most common irregularities were unjustified payments (direct payment by beneficiaries for services supposed to be free of charge) and extortions (overcharges, parallel sale of drugs, theft, or misappropriation of Gratuité drugs). Controls also uncovered other irregularities, such as fictitious patients, non-compliance with the prices of drugs and medical "acts", and discrepancies between the data transmitted to the higher level and those noted by the controllers (Nebie. et al. 2017). The breakdown of irregularities and dysfunction reported during those controls is shown in Figure 17.

Figure 17: Irregularities breakdown for NGO control findings



Source: Dabire et al. 2017; Nebie. and Guissou 2017; Nebie. et al. 2017; Secrétariat Technique pour la Couverture Maladie Universelle 2020

When controls report overbilling, the amount is subtracted from the subsequent payment to concerned health facilities. Control results are shared at restitution meetings conducted at health facilities. Also, a list of health facilities with cuts in their payment is communicated to the district health management team. However, undue payments sometimes persist despite controls carried out by contracted NGOs and associations. This could result from a number of factors, but it is reasonable to argue that the impact of sanctions could be undermined by limited understanding of Gratuité and uncertainty about payments.

V. DISCUSSION AND RECOMMENDATIONS

Gratuité is intended to reduce financial barriers to access, leading to increased use, and in turn improved health outcomes. In the following sections, we use this framework to discuss the strengths and weaknesses of Gratuité, to review potential opportunities, and finally to offer recommendations to strengthen policy.

THE IMPACT OF GRATUITÉ

Has Gratuité been successful in reducing financial barriers?

Few people report paying out-of-pocket for services covered by the Gratuité policy. ThinkWell found 13% of clients reporting irregularities, while only approximately 10% (63 out of 652) of the people interviewed by NGOs during controls in the Center-West region paid out-of-pocket money for drugs and commodities that are included in the Gratuité package (Nebie. et al. 2017). In a more formal study of Gratuité shortly after roll-out in 2016, Meda and coauthors found approximately 30% of women paid out-of-pocket for maternity services, specifically (2019). While far from perfect, these data compare favorably with other efforts to remove user fees in the region (Kruk et al. 2008). We should note, however, that the potential impact of gratuité payment shortfalls from late 2018 on these irregularities has yet to be assessed.

User expectations may not fully match Gratuité policy on the breadth of what is supposed to be free. In qualitative work evaluating the free family planning pilot (Koulidiati et al. 2020), ThinkWell found that payments for unavailable or out-of-stock consumables were considered to be common practice by both providers and clients. Often the client is told to go and purchase what is needed at a local drug seller. If these types of payment are normalized, they may not be considered as inappropriate, and it is possible that the scale of this practice is underestimated in NGO validation. This issue is explored further by Meda and coauthors (2019), who suggest that the persistence of out-of-pocket payments in the context of Gratuité could be explained by the unavailability of drugs in health facilities, parallel sale of drugs, and payment for services supposed to be free of charge. Besides, women seeking services still face financial barriers in the form of indirect costs such as transportation costs, as well as opportunity costs. Removing out-of-pocket payments for a narrow range of services is only a partial solution to financial barriers (Kruk et al. 2008).

Gratuité also appears to have reduced total out-of-pocket payments. MOH data show out-of-pocket payments for health care services in Burkina Faso, while still significant, declined from 36.2 % of CHE to 31.7% between 2015 and 2017 (Ministère de la santé du Burkina Faso 2018a). Further research would be necessary to firmly attribute this reduction to Gratuité, but this evidence is encouraging. However, out-of-pocket expenditure rebounded to 35.9% in 2018. This could be related to shortfalls in Gratuité payments to facilities and associated debts to CAMEG, but again, further analysis is required to better understand this.

Has removal of financial barriers increased use of health services?

Use of key MNCH services have shown impressive increases through Gratuité. Reported consultations for children under 5 have almost doubled from 2015 to 2018. The proportion of women completing four ANC visits remains low, but Gratuité is associated with an increase from 34.1% in 2015 to 39.3% in 2019. Facility deliveries are on an upward trend and have reached almost 85% of births in 2017. The impact of Gratuité on these is not clear; annual data from the *Annuaire Statisque*[32] show a continuing improvement, but no obvious change in the trend. Studies carried out elsewhere in West Africa show that interventions to reduce

[32] Statistical Yearbook

financial barriers have often been effective in increasing the use of health care services (Witter et al. 2016; Nguyen et al. 2018), so these results might have been anticipated, yet remain impressive and important nevertheless.

By removing user fees, Gratuité might be expected to support equity in access to health services. The location of claims suggests that it may do so; more than 90% of contacts occur in lower level, peripheral facilities, and mostly in rural areas (Ministère de la santé du Burkina Faso 2020). This is encouraging; it suggests that poor people are likely to benefit from the scheme. However, Gratuité does not gather beneficiary information, and without further research it is not possible to say definitively whether Gratuité is reaching the poorest, or how improvements in equity might be achieved.

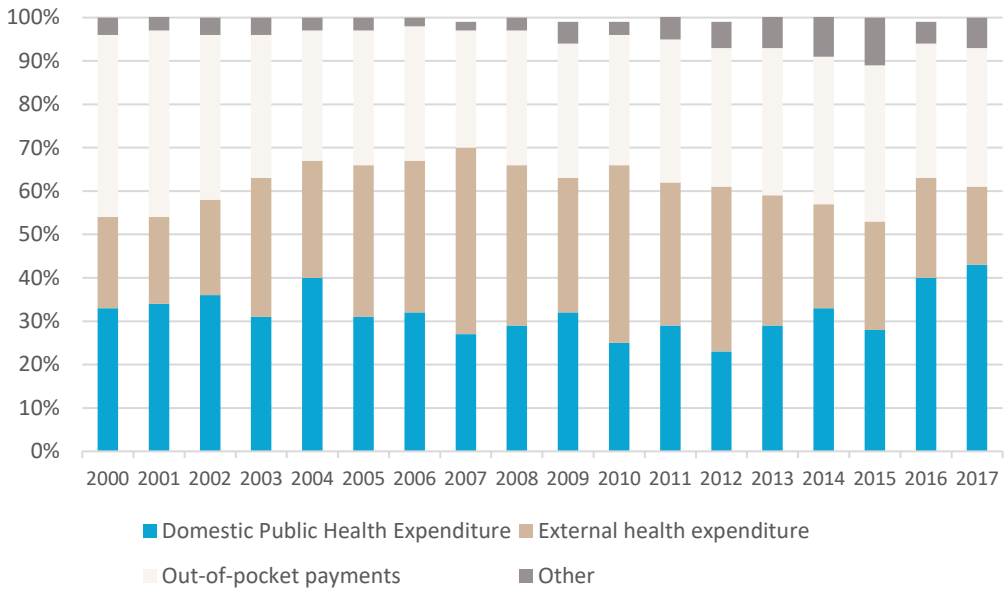
Has increased use of services resulted in improved health outcomes?

No nationally representative survey has yet been published that would allow measurement of changing health outcomes since the introduction of Gratuité. Burkina has faced many challenges over the last four years, and it seems likely that any positive impact of gratuité on outcomes would be swamped by these wider challenges**.** Gratuité has been implemented in the context of increasing security challenges and significant labor unrest. The security situation has deteriorated; the United Nations High Commission for Refugees describes Burkina Faso as “experiencing an unprecedented and complex humanitarian crisis … which has led to significant internal displacement”(United Nations High Commissioner for Refugees 2019) and current data indicate more than one million internally displaced people in Burkina Faso (United Nations High Commissioner for Refugees 2020). Labor unrest in the health sector has limited services: “for nearly eight months, from April to November [2019], strikes often without minimum service gave way to a boycott of guards and offices, and the refusal to provide statistical reports and carry out field visits and missions." (Bonkoungou 2020).

CHALLENGES, OPPORTUNITIES, AND THE FUTURE OF GRATUITÉ

The Government of Burkina Faso prioritizes primary health care, but fiscal space is limited. By regional standards, the Government allocates an impressive proportion of its budget to health services (averaging 12% of total public expenditure between 2012 and 2015) (Barroy, Andre, and Nitiema 2018), and to primary care in particular (83% in Burkina Faso compared to a regional average of 65%) (refer to Figure 18) (World Health Organization 2020a). But government health expenditure only totals around $320M (World Bank 2020), or roughly $16 per person per year. Gratuité claims in 2017 and 2018 cost around $50M per year, roughly 15% of total government expenditure on health.

Figure 18: Sources of health financing in Burkina Faso



Source: World Health Organization 2020b

Growing transnational security threats necessitated a significant realignment of Government priorities starting in early 2018. This culminated in the dissolution of the Government following the resignation of Prime Minister Paul Kaba Thieba and all members of his government, including the Minister of Health, in January 2019 ("Burkina Faso: Prime Minister and Cabinet Resign from Office" n.d.). It seems likely that this realignment toward security spending was associated with a reduction of available government funds for health. The process of prioritization of spending within MOH is unclear; Gratuité is a presidential priority, but difficult compromises would have had to be made by the Ministry.

The Ministry of Health was not able to make sufficient funds available for Gratuité to pay claims in 2018 and 2019, and this likely led to increased debts to CAMEG. This analysis shows significant gaps between Gratuité claims submitted to the Government and payments received, most notably toward the end of financial years 2018 and 2019. Debts to CAMEG follow a similar pattern, growing rapidly when Gratuité payments fall short.

Perceptions of late or inadequate payment drive dissatisfaction with Gratuité among service providers. Qualitative interviews revealed little understanding of the Gratuité mechanism in the field but instead a consistent sense that payment had become less reliable over time, and that this had reduced facilities'

autonomy, flexibility, and ultimately their ability to deliver high-quality services. All facilities reported payment shortfalls, and interviewees had not been told why full payment was not remitted.

Key informants believe that it is unlikely that the politically popular Gratuité program will be closed, but it does seem possible that, starved of funds, Gratuité could become free in name only. Inadequately funded free health care programs rebalance through a combination of implicit rationing of services and informal payments (Chuma et al. 2009). Given concerns expressed by national-level stakeholders about debts to CAMEG, it is also possible that the Government will redirect a significant proportion of funding for free services directly to CAMEG rather than linking it to performance through Gratuité.

Recommendation 1: Ensure adequate budget allocation for gratuité

Free essential MNCH services are an important step on Burkina Faso's journey toward UHC. The Gratuité scheme is a pragmatic approach and has demonstrated effectiveness. Many of the challenges are the result of uncertain and inadequate funding, rather than design. Changing the scheme design, particularly if more complexity is introduced, may exacerbate rather than solve this problem. Further strengthening the scheme will not be possible without sufficient funding.

To maintain and build on the positive impact of Gratuité, it will be necessary to either find additional funds, or to reduce costs, or both. Options are explored in the following sections.

What options exist to generate additional funds for Gratuité?

Gratuité is funded from general government revenues. Gratuité is budgeted as a specific activity within Burkina Faso's program-based budgeting approach; since 2017, it has been defined as the activity "ensuring the implementation of the free health care strategy" in the action "promotion of mechanisms for sharing health risks" in the access program. The simplest solution to the challenge of funding Gratuité will be to increase allocation to this budget line, and to ensure its execution, but of course, the Government must wrestle with competing priorities. Should other, complementary, options be explored?

Increasing tax revenue for Gratuité is out of the scope of this revue, but regional experience might provide useful options. Ring-fenced taxes for health could leverage popular support for Gratuité. Neighboring Ghana has experience with a VAT levy for its National Health Insurance Scheme, and it might be worth reflecting on international examples of successful ring-fenced taxes for specific health programs (Doetinchem 2010). Stakeholders in Burkina have suggested that co-payment will be an important part of a health insurance model (Yameogo, Kagonesalou, and Sorgho 2019)**.** No specific discussions were found of the idea of a small, fixed consultation fee in Burkina Faso, but the example of the '30 Baht' scheme in Thailand might be relevant (Tangcharoensathien et al. 2018).

Health insurance (through CNAMU) has been proposed as an alternative to Gratuité that would allow the Government of Burkina Faso to raise additional funds for health, while continuing output-based payments to facilities. However, there is little evidence to suggest that health insurance is an effective mechanism to raise additional funds for health in economies heavily reliant on informal sector workers (Kutzin, Yip, and Cashin 2016). And indeed, some recent publications warn specifically against this approach (Yazbeck et al. 2020). Health insurance is also an administratively more complex option, and if access to services requires proof of membership, there are significant equity risks. Careful consideration is required.

Nevertheless, CNAMU management of Gratuité could be a useful intermediate step toward a national health insurance model. Separating the administrative functions of Gratuité from the governance role of the MOH could increase efficiency, as well as giving CNAMU the valuable experience of managing high-volume purchasing schemes without the complexity of a contributory mechanism.[33]

What options exist to control or reduce the cost of Gratuité, and what risks are associated with these options?

The cost of Gratuité claims is growing year by year, but not excessively, and this is not the cause of payment shortfalls. Fee-for-service provider payment mechanisms can stimulate claims inflation by reducing incentives to control costs (Langenbrunner, O'Duagherty, and Cashin 2009). Average cost per claim across all services has increased by 6.8% between 2017 and 2019, so this is certainly something to monitor, but does not appear to be cause for alarm. The cost of this increase was around 3 billion CFA between 2017 and 2018, which is less than a third of the shortfall between claims and payments in 2018. The total cost of all claims increased by 10.5% between 2017 and 2018, the result of a combination of increased cost per claim and increased claims numbers. Total cost of claims fell back in 2019 as the result of a reduced number of claims, likely associated with industrial action by health workers. Comparison between average claim costs by health district and health facility is part of routine monitoring and helps to identify facilities to prioritize for verification and validation visits.

Gratuité claims costs are substantially driven by the cost of care for children under 5 (49.5% of total claims in 2019). In comparison, ANC costs account for 24.9% of the total, and all deliveries account for 19.6%. Basing the package of child health services included in Gratuité on the IMCI protocols seems sensible, but further detailed analysis of claims might be useful to identify whether there are particular cost drivers within this bundle that might be reviewed. The growth in cesarean section costs is also worth noting, since these costs already account for one-third of maternity costs and could expand rapidly. Finding the balance between protecting women from the catastrophic costs of emergency cesareans while ensuring that elective cesareans do not drain scarce public resources is a challenge faced by purchasers (Sombie et al. 2017; Leone et al. 2016). Overall, however, Gratuité is designed based on proven cost-effective interventions (Ridde and Yaméogo 2018), and there seems to be limited scope for reducing the Gratuité benefits package to control costs.

Gratuité is an entitlement, making free services available to anyone who needs them in Burkina Faso. Targeting subsidy to those most in need is clearly a way to control costs. However, targeting may be politically and administratively complex, and runs the risk of excluding those it is intended to reach; Regional examples are not encouraging in this regard (Dake 2018). In Burkina Faso, where almost half the population lives below the poverty line and insecurity has grown, targeting may seem theoretically attractive but is unlikely to be a practical option in the short term. Long-term efforts to identify and maintain a register of the poor, funded by the World Bank and others as part of the Social Safety Net Project (Independent Evaluation Group 2011) might be a promising vehicle for an integrated approach to targeting.

Case-based payments, based on a standardized cost per case, could be an option to control claim cost inflation. Implementing case-based payments for Gratuité could simplify systems and reduce administrative burden, as well as controlling claims inflation. Burkina endorsed plans to move to case-based payments in 2018, but has yet to implement them (Ministère de la santé du Burkina Faso, Ministère de la fonction

[33] ThinkWell has conducted a stakeholder analysis exploring opinions on transitioning of Gratuité to CNAMU and plans to publish results in the coming weeks.

publique du travail et de la protection sociale, and Ministère de l'économie des finances et du développement 2017). When implemented, case rates would be calculated from average reported costs per service from e-Gratuité data, which seems pragmatic and sensible (Ministère de la santé du Burkina Faso, Ministère de la fonction publique du travail et de la protection sociale, and Ministère de l'économie des finances et du développement 2017). While implementing case-based payments is unlikely to reduce total costs in the short term, it should be carefully considered for its long-term potential. However, case-based payments incentivize reduced resource use per case, which risks undermining service quality (Langenbrunner, O'Duagherty, and Cashin 2009). Hence, it should not be implemented unless effective links of payment to quality are in place.

Recommendation 2: Consider simplifying payment mechanisms

Implementing case-based payments for Gratuité could simplify systems, reduce admin burden, and control claims inflation. While this is unlikely to reduce total costs in the short term, it should be carefully considered. However, case-based payments risk undermining service quality and so should not be implemented unless effective links of payment to quality are in place.

Gratuité control and validation systems appear to be fit for purpose, so long as contracts with implementers are maintained. Contracts with third parties (NGOs and CSOs) to validate Gratuité claims provide important controls, and results are generally positive; roughly 90% of claims are valid. Gratuité control and validation systems are essential to verify the proper implementation of planned activities and use of allocated funds, while identifying difficulties and providing support for corrective actions. However, control activities and contracts with third parties NGOs were suspended through much of 2019, possibly due to shortages in funding. The perception that control is in place is important, and reduced control levels may drive inflation and so be a false economy. It may also be useful to formalize sanctions for misreporting, and to clarify communications around these; qualitative work suggested little understanding of this process, which will limit its influence on behavior.

The team did not have access to data on the administrative costs of the Gratuité program. Central-level administration in the MOH seems efficient; arguably, more resources might reduce the risks of too much reliance on a very few people. Validation and control are contracted out at an annual cost of approximately $1.5 million or 3% of program cost. This approach also leverages support from development partners and, because of its impact in controlling costs, is likely to be a good investment. The field work suggests that health staff spend a significant time (at least one or two days per month) preparing Gratuité claims. The opportunity cost of this administrative burden was not formally estimated, but it seems likely to be significant. Case-based payments, which do not require detailed supporting documents, could reduce this burden, and so—while not immediately reducing the direct costs of Gratuité—could improve cost-efficiency.

What options exist to increase the health impact of Gratuité?

Quality improvements will be key to converting utilization into improved outcomes. In the *Lancet Global Health commission on high-quality health systems in the SDG* era (Kruk et al. 2018), Margaret Kruk argues convincingly that, "Poor-quality care is now a bigger barrier to reducing mortality than insufficient access." Burkina Faso performs poorly against some indicators, such as maternal mortality, despite relatively high rates of coverage. This link between poor outcomes and quality is recognized in the 2018 national strategy

document on the quality of integrated care and services focused on the person and patient safety (Ministère de la santé du Burkina Faso 2018d).

Gratuité is designed to improve access, but could also be leveraged to improve quality (Philibert et al. 2014)**.** Service quality is a significant underlying challenge to health in Burkina (Millogo et al. 2020), and the fact that Gratuité is not explicitly linked to quality may be a missed opportunity. Approaches to leveraging Gratuité to incentivize quality need not require the development of wholly new systems but might be achieved by more effective links between existing mechanisms. The MOH, through the Direction de la qualité des soins et de la sécurité des patients,[34] is in the process of developing a new quality framework, with the intention to use this framework to measure and incentivize health facilities through a PBF approach. At the same time, the MOH has endorsed (but not implemented) a proposal to move Gratuité payments from fee-for-service to case-based payments, and to modify these payments based on a one-, two-, or three-star quality score for each facility. Harmonizing these approaches and perhaps linking them to the control and validation functions subcontracted to NGOs offers potential efficiency gains as well as improved clarity of signals for quality.

Recommendation 3: Link gratuité to quality

Reward facilities that achieve higher quality standards. Improving the quality of health services is a fundamental challenge for Burkina Faso. Gratuité has improved access, but frontline staff tell us that they feel that they are expected to manage more clients with uncertain facility income, and so quality is certainly at risk. More effective links between Gratuité and schemes designed specifically to improve quality, such as performance-based financing, will improve operational efficiency and reinforce both schemes.

[34] Quality of care and patient safety department

VI. CONCLUSION

Burkina Faso's Gratuité policy represents a valiant effort to remove financial barriers for key health services and so to improve health care access in one of the world's poorest countries. Gratuité has been built through the passion and commitment of many talented people over the last decade, and is technically well aligned to the principles of strategic purchasing; it is a purposeful attempt to align funding and incentives with promised health services.

Gratuité has been most successful when sufficient funding has been available but has faltered when budget constraints interrupted payments and undermined providers' confidence in the system. Gratuité can also be strengthened through improved coherence with other elements of Burkina Faso's health system. Indeed, Gratuité has the potential to be an organizing principle around which other interventions align, for example by providing a mechanism through which to incentivize service quality, or by demonstrating the effectiveness of separating responsibilities for purchasing and provision of services. If funding difficulties can be resolved, Gratuité can provide a key pillar of a more resilient health system.

ThinkWell and RESADE remain committed to supporting the MOH in its efforts to develop and refine the Gratuité. We hope that this report will provide a useful reference and will promote constructive discussion and debate. We look forward to working together to support Burkina Faso on its path to UHC.

REFERENCES

Barroy, Hélène, Francoise Andre, and Abdoulaye Nitiema. 2018. "Transition to Programme Budgeting in Health in Burkina Faso: Status of the Reform and Preliminary Lessons for Health Financing." Geneva.

Bassani, Diego G., Paul Arora, Kerri Wazny, Michelle F. Gaffey, Lindsey Lenters, and Zulfiqar A. Bhutta. 2013. "Financial Incentives and Coverage of Child Health Interventions: A Systematic Review and Meta-Analysis." *BMC Public Health* 13 (SUPPL.3): 1–13. https://doi.org/10.1186/1471-2458-13-S3-S30.

Bonkoungou, Justine. 2020. "Secteur de La Santé Au Burkina : 2019, Une Année Mouvementée !" Lefaso.Net. 2020. https://lefaso.net/spip.php?article94144.

"Burkina Faso: Prime Minister and Cabinet Resign from Office." n.d. BBC News. Accessed June 4, 2020. https://www.bbc.com/news/world-africa-46930537.

Chuma, Jane, Janet Musimbi, Vincent Okungu, Catherine Goodman, and Catherine Molyneux. 2009. "Reducing User Fees for Primary Health Care in Kenya: Policy on Paper or Policy in Practice?" *International Journal for Equity in Health* 8: 1–10. https://doi.org/10.1186/1475-9276-8-15.

Dabire, S.J., Bruno Nebie., S Panzani-Ancellin, F Bamogo, A Ouedraogo, I Ky, B Ouedraogo, S Sama, K Kabore, and A Nacoulma. 2017. "Capitalisation de l'expérience Accumulée Par Terre Des Hommes En Contrôle Médicale Des Prestations Sociales Entre 2008 et 2016." Ouagadougou, Burkina Faso.

Dake, Fidelia A.A. 2018. "Examining Equity in Health Insurance Coverage: An Analysis of Ghana's National Health Insurance Scheme." *International Journal for Equity in Health* 17 (1): 1–10. https://doi.org/10.1186/s12939-018-0793-1.

Doetinchem, Ole. 2010. "Hypothecation of Tax Revenue for Health: World Health Report (2010) Background Paper, No 51." Geneva.

Independent Evaluation Group. 2011. "Social Safety Nets: An Evaluation of World Bank Support, 2000–2010." Washington, DC. https://doi.org/10.1093/acprof:oso/9780199689248.003.0046.

Institut National de la Statistique et de la Démographie, and ICF International. 2012. "Enquête Démographique et de Santé et à Indicateurs Multiples Du Burkina Faso 2010." Calverton, Maryland. https://doi.org/february 2008.

Kafando, Yamba, Joel Arthur Kiendrébéogo, and Charlemagne Tapsoba. 2020. "Evaluation Du Système de Paiement de La Politique Nationale de Gratuité Des Soins Au Burkina Faso." Ouagadougou, Burkina Faso.

Koulidiati, Jean-Louis, Sarah Straubinger, Pierre-Marie Metangmo, and Matt Boxshall. 2020. "Removing User Fees for Family Planning Services in Burkina Faso: A Review of the Gratuité Pilot Program." Ouagadougou, Burkina Faso.

Kruk, Margaret E., Anna D. Gage, Catherine Arsenault, Keely Jordan, Hannah H. Leslie, Sanam Roder-DeWan, Olusoji Adeyi, et al. 2018. "High-Quality Health Systems in the Sustainable Development Goals Era: Time for a Revolution." *The Lancet Global Health* 6 (11): e1196–1252. https://doi.org/10.1016/S2214-109X(18)30386-3.

Kruk, Margaret E., Godfrey Mbaruku, Peter C. Rockers, and Sandro Galea. 2008. "User Fee Exemptions Are Not Enough: Out-of-Pocket Payments for 'free' Delivery Services in Rural Tanzania." *Tropical Medicine and International Health* 13 (12): 1442–51.

https://doi.org/10.1111/j.1365-3156.2008.02173.x.

Kutzin, Joseph, Winnie Yip, and Cheryl Cashin. 2016. “Alternative Financing Strategies for Universal Health Coverage.” *World Scientific Series in Global Health Economics and Public Policy*, 267–309. https://doi.org/10.1142/9789813140493_0005.

Lagarde M, Palmer N. 2011. “The Impact of User Fees on Access to Health Services in Low- and Middle-Income Countries.” *Cochrane Database of Systematic Reviews*, no. 4. https://doi.org/10.1002/14651858.CD009094.

Langenbrunner, John C., Sheila O’Duagherty, and Cheryl S. Cashin. 2009. *Designing and Implementing Health Care Provider Payment Systems*. Washington: World Bank. https://doi.org/https://doi.org/10.1596/978-0-8213-7815-1.

Leone, Tiziana, Valeria Cetorelli, Sarah Neal, and Zoë Matthews. 2016. “Financial Accessibility and User Fee Reforms for Maternal Healthcare in Five Sub-Saharan Countries: A Quasi-Experimental Analysis.” *BMJ Open* 6 (1): 1–8. https://doi.org/10.1136/bmjopen-2015-009692.

McPake, Barbara, Kara Hanson, and Anne Mills. 1993. “Community Financing of Health Care in Africa: An Evaluation of the Bamako Initiative.” *Social Science Medicine* 36 (11): 1383–95.

Meda, I.B., A. Baguiya, A. Coulibaly, T. Millogo, and S. Kouanda. 2019. “Les Effets Du Changement Du Mode de Paiement Des Centres de Santé Sur Les Coûts Des Accouchements Au Burkina Faso : Une Étude Avant-Après.” *Revue d’Épidémiologie et de Santé Publique* 67 (February): S47. https://doi.org/10.1016/j.respe.2018.12.017.

Millogo, Tieba, Marie Laurette Agbre-Yace, Raissa K. Kourouma, W. Maurice E. Yaméogo, Akoua Tano-Kamelan, Fatou Bintou Sissoko, Aminata Soltié Koné-Coulibaly, Anna Thorson, and Seni Kouanda. 2020. “Quality of Maternal and Newborn Care in Limited-Resource Settings: A Facility-Based Cross-Sectional Study in Burkina Faso and Côte d’Ivoire.” *BMJ Open* 10 (6): e036121. https://doi.org/10.1136/bmjopen-2019-036121.

Ministère de la fonction publique du travail et de la protection sociale, and Secrétariat Technique pour la Couverture Maladie Universelle. 2018. “Plan Stratégique de Développement 2018-2027 Du Régime National d’assurance Maladie Universelle: Rapport Définitif.” Ouagadougou, Burkina Faso.

Ministère de la Santé, and Direction Générale des Etudes et des Statistiques Sectorielles. 2014. “Enquête Nationale Sur Les Prestations Des Services de Santé et La Qualité Des Données Sanitaires (EN-PSQD/SARA II).” Ouagadougou, Burkina Faso. apps.who.int/healthinfo/systems/datacatalog/index.php/ddibrowser/50/download/152.

Ministère de la santé du Burkina Faso. 2003. “Prise En Charge Intégrée Des Maladies de l’enfant: Une Stratégie Pour Réduire Le Taux de Mortalité.” Ouagadougou, Burkina Faso.

———. 2011a. “La Politique Sanitaire Nationale.” Ouagadougou, Burkina Faso.

———. 2011b. “Plan National De Développement Sanitaire 2011-2020.” Ouagadougou, Burkina Faso.

———. 2016a. “Enquête Nutritionnelle Nationale 2016.” Ouagadougou, Burkina Faso. https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/file

s/documents/files/smart_2016.pdf.

———. 2016b. “Plan National De Développement Sanitaire 2011-2020, Phase 2016-2020.” Ouagadougou, Burkina Faso.

———. 2017. “Plan National d’acceleration de Planification Familiale Du Burkina Faso 2017-2020.” Ouagadougou, Burkina Faso.

———. 2018a. “Comptes de La Santé 2017.” Ouagadougou, Burkina Faso.

———. 2018b. “Directive Pour La Dispensation Gratuité Des Medicament et Consommables Medicaux Par Les Agents de Santé à Base Communautaire Dans Le Cadre de La Gratuité Des Soins Communautaires.” Ouagadougou, Burkina Faso. https://doi.org/10.1145/2505515.2507827.

———. 2018c. “Document d’Orientation de l’Achat Stratégique Pour Le Secteur de La Santé.” Ouagadougou, Burkina Faso.

———. 2018d. “La Stratégie Nationale de La Qualité Des Soins et Services Intégrés Centrés Sur La Personne et La Sécurité Des Patients Au Burkina Faso.” Ouagadougou, Burkina Faso.

———. 2018e. “Stratégie Nationale de Financement de La Santé Pour La Couverture Sanitaire Universelle de 2018-2030.” Ouagadougou, Burkina Faso.

———. 2019. “Dossier d’investment En Santé Communautaire Au Burkina Faso.” Ouagadougou, Burkina Faso.

———. 2020. “E-Gratuité.” Gratuité Des Soins. 2020. http://e-sante.gov.bf:8080/gratuitédessoins/.

Ministère de la santé du Burkina Faso, and Institut national de la statistique et de la démographie. 2018. “Annuaire Statistique 2017.” Ouagadougou, Burkina Faso.

———. 2019. “Annuaire Statistique 2018.” Ouagadougou, Burkina Faso.

———. 2020. “Annuaire Statistique 2019.” Ouagadougou, Burkina Faso.

Ministère de la santé du Burkina Faso, and Ministère de l’économie des finances et du développement. 2018. “Manuel de Procédures Descriptives Des Modalités de Gestion, de Suivi et de Contrôle Des Mesures de Gratuité Des Soins Au Profit Des Femmes et Des Enfants de Moins de Cinq Ans Vivant Au Burkina Faso.” Ouagadougou, Burkina Faso.

Ministère de la santé du Burkina Faso, Ministère de la fonction publique du travail et de la protection sociale, and Ministère de l’économie des finances et du développement. 2017. “ARRETE CONJOINT N° 2017- MS/MFPTPS/MCIA/MINEFID/ Portant Tarification Des Actes Des Professionnels de La Santé et Des Hospitalisations Dans Les Formations Sanitaires et Établissements Hospitaliers Publics Du Burkina Faso.” Ouagadougou, Burkina Faso: Ministère de la santé du Burkina Faso.

Ministère de la santé du Burkina Faso, and Organisation mondiale de la Santé. 2017. “Profil Sanitaire Complet Du Burkina Faso.” Ouagadougou, Burkina Faso.

Nebie., Bruno, and Fabrice R. Guissou. 2017. “Exemption de Paiement : Pour Un Accès Universel Aux Soins de Santé Des Enfants de Moins de Cinq Ans et Des Femmes Enceintes. Guide Du Contrôleur.” Ouagadougou, Burkina Faso.

Nebie., Bruno, Lassina Ouattara., Sam J. Dabrie, and David Taminy. 2017. “Exemption de Paiement : Pour Un Accès Universel Aux Soins de Santé Des Enfants de Moins de 5

Ans et Des Femmes Enceintes. Manuel Du Commissare Aux Comptes Coges." Ouagadougou, Burkina Faso.

Nguyen, Hoa Thi, David Zombré, Valery Ridde, and Manuela De Allegri. 2018. "The Impact of Reducing and Eliminating User Fees on Facility-Based Delivery: A Controlled Interrupted Time Series in Burkina Faso." *Health Policy and Planning* 33 (8): 948–56. https://doi.org/10.1093/heapol/czy077.

Parmar, Divya, Manuela De Allegri, Germain Savadogo, and Rainer Sauerborn. 2014. "Do Community-Based Health Insurance Schemes Fulfil the Promise of Equity? A Study from Burkina Faso." *Health Policy and Planning* 29 (1): 76–84. https://doi.org/10.1093/heapol/czs136.

Philibert, Aline, Valéry Ridde, Aristide Bado, and Pierre Fournier. 2014. "No Effect of User Fee Exemption on Perceived Quality of Delivery Care in Burkina Faso: A Case-Control Study." *BMC Health Services Research* 14 (1). https://doi.org/10.1186/1472-6963-14-120.

PMA2020, Institut Supérieur des Sciences de la Population, Démographie, and Institut national de la statistique et de la démographie. 2019. "PMA2020/Burkina Faso: Family Planning Brief." Ouagadougou, Burkina Faso.

Primary Health Care Performance Initiative. 2018. "Burkina Faso: Primary Health Care Vital Signs Profile." Washington, DC.

Resilient & Responsive Health Sytems. 2014. "What Is Strategic Purchasing?" London, United Kingdom.

Ridde, Valéry. 2015. "From Institutionalization of User Fees to Their Abolition in West Africa: A Story of Pilot Projects and Public Policies." *BMC Health Services Research* 15 (Suppl 3): S6. https://doi.org/10.1186/1472-6963-15-S3-S6.

Ridde, Valéry, and Florence Morestin. 2011. "A Scoping Review of the Literature on the Abolition of User Fees in Health Care Services in Africa." *Health Policy and Planning* 26 (1): 1–11. https://doi.org/10.1093/heapol/czq021.

Ridde, Valéry, and Pierre Yaméogo. 2018. "How Burkina Faso Used Evidence in Deciding to Launch Its Policy of Free Healthcare for Children under Five and Women in 2016." *Palgrave Communications* 4 (1). https://doi.org/10.1057/s41599-018-0173-x.

Secrétariat Technique pour la Couverture Maladie Universelle. 2020. "No Title." Ouagadougou, Burkina Faso.

Sombie, Issiaka, Ziemlé Clément Méda, Gueswendé Blaise Léon Savadogo, Gwladys Sanou, and Moussa Dadjoari. 2017. "Trends in Caesarean Section Rates and Places of Delivery in Burkina Faso." *Sante Publique* 29 (1): 133–39. https://doi.org/10.3917/spub.171.0133.

Tangcharoensathien, Viroj, Woranan Witthayapipopsakul, Warisa Panichkriangkrai, Walaiporn Patcharanarumol, and Anne Mills. 2018. "Health Systems Development in Thailand: A Solid Platform for Successful Implementation of Universal Health Coverage." *The Lancet* 391 (10126): 1205–23. https://doi.org/10.1016/S0140-6736(18)30198-3.

ThinkWell Strategic Purchasing for Primary Health Care. 2020. "Burkina Faso: Strategic Purchasing Strategies and Early Results." Washington.

Track20. 2019. "Burkina Faso: FP2020 Core Indicators Country Fact Sheet." Glastonbury.

———. 2020. “Exploring Opportunities for MCPR Growth in Burkina Faso.” Glastonbury.

United Nations Development Programme. 2019. *Human Development Report 2019: Beyond Income, beyond Averages, beyond Today*. New York: United Nations Development Programme.

United Nations High Commissioner for Refugees. 2019. “Burkina Faso: Country Operation Update November-December 2019.” Geneva. http://reporting.unhcr.org/sites/default/files/UNHCR Burkina Faso Operational Update - December 2019.pdf.

———. 2020. “Refugee Situations: Burkina Faso.” Operations Portal: Refugee Siuations. 2020. https://data2.unhcr.org/en/country/bfa.

United Nations Office for Coordination of Humanitarian Affairs. 2020. “Burkina Faso Situation Report.” Ouagadougou, Burkina Faso.

Witter, S., C. Boukhalfa, J. A. Cresswell, Z. Daou, V. Filippi, R. Ganaba, S. Goufodji, I. L. Lange, B. Marchal, and F. Richard. 2016. “Cost and Impact of Policies to Remove and Reduce Fees for Obstetric Care in Benin, Burkina Faso, Mali and Morocco.” *International Journal for Equity in Health* 15 (1): 1–19. https://doi.org/10.1186/s12939-016-0412-y.

World Bank. 2020. “World Development Indicators | DataBank.” World Bank Data. 2020. http://datatopics.worldbank.org/world-development-indicators/.

World Bank Group. 2018. “Project Appraisal Document: Burkina Faso - Health Services Reinforcement Project.” Washington, DC.

World Health Organization. 2000. “The World Health Report 2000.” Geneva. https://doi.org/10.1111/1758-5899.12212.

———. 2010. “The World Health Report 2010.” Geneva.

———. 2019. “Global Health Observatory.” Global Health Observatory. 2019. https://www.who.int/gho/database/en/.

———. 2020a. “Global Health Expenditure Database.” Global Health Expenditure Database. 2020. http://apps.who.int/nha/database/Select/Indicators/en.

———. 2020b. “Health Expenditure Profile: Burkina Faso.” Global Health Expenditure Database. 2020. https://apps.who.int/nha/database/country_profile/Index/en.

Yameogo, Pierre, Adeline Kagonesalou, and Claudine Lougue Sorgho. 2019. “Note Conceptuelle Santé Communautaire.” Ouagadougou, Burkina Faso: Ministère de la santé du Burkina Faso.

Yazbeck, Abdo S., William D. Savedoff, William C. Hsiao, Joe Kutzin, Agnès Soucat, Ajay Tandon, Adam Wagstaff, and Winnie Chi-Man Yip. 2020. “The Case Against Labor-Tax-Financed Social Health Insurance For Low- And Low-Middle-Income Countries.” *Health Affairs* 39 (5): 892–97. https://doi.org/10.1377/hlthaff.2019.00874.

Zombré, David, Manuela De Allegri, Robert W. Platt, Valéry Ridde, and Kate Zinszer. 2019. “An Evaluation of Healthcare Use and Child Morbidity 4 Years After User Fee Removal in Rural Burkina Faso.” *Maternal and Child Health Journal* 23 (6): 777–86. https://doi.org/10.1007/s10995-018-02694-0.

ANNEX A: KEY INFORMANT INTERVIEW GUIDE

1) Can you explain how health care providers are paid for delivering Gratuité services, including family planning?
2) Can you explain the financial circuit of Gratuité, including family planning?
    a. At central level?
    b. At hospital level?
    c. At district level?
    d. At community level?
3) Can you tell me what are the tools available to follow-up and report data/information related to Gratuité, including family planning?
4) Can you tell me what procedures are in place for monitoring (supervising/overseeing) Gratuité, including family planning? Explain how they operate.
5) Can you tell me what procedures are in place for the control of Gratuité, including family planning? Explain how they operate.
6) Can you tell me at what stage are the discussions for the transfer of Gratuité to CNAMU?

ANNEX B: LIST OF ARTICLES, REPORTS, AND DOCUMENTS ON THE GRATUITÉ POLICY

N°	Authors	Title	Publication References	Document Type
1	V. Ridde and P. Yaméogo	How Burkina Faso used evidence in deciding to launch its policy of free healthcare for children under five and women in 2016	2018. Palgrave Communications 4 (119) ; http://dx.doi.org/10.1057/s41599-018-0173-x	Article
2	T. Druetz, A. Bicaba, T. Some, S. Kouanda, A. Ly, S. Haddad	La Gratuité des soins améliore grandement l'accessibilité aux services de santé, mais les gains demeurent fragiles	L'Université de Laval (2018)	Report
3	I.B. Meda, A. Baguiya, V. Ridde, H.G. Ouédraogo, A. Dumont, S. Kouanda	Out-of-pocket payments in the context of a free maternal health care policy in Burkina Faso: a national cross-sectional survey	2019. Health Economics Review. 9 (11) ; https://doi.org/10.1186/s13561-019-0228-8	Article
4	I.B. Meda, A. Baguiya, A. Coulibaly, T. Millogo, S. Kouanda	Les effets du changement du mode de paiement des centres de santé sur les coûts des accouchements au Burkina Faso : une étude avant-après appariée	2019. Revue d'Épidémiologie et de Santé Publique. 67. https://doi.org/10.1016/j.respe.2018.12.017	Article
5	D. Zombré, M. De Allegri, R.W. Platt, V. Ridde, K. Zinszer	An Evaluation of Healthcare Use and Child Morbidity 4 Years After User Fee Removal in Rural Burkina Faso	2019. Maternal and Child Health Journal. 23:777–786. https://doi.org/10.1007/s10995-018-02694-0	Article
6	S. Nikiema	Charge de travail du personnel soignant dans un contexte de Gratuité des soins : Cas du district sanitaire de Bogodogo au Burkina Faso	2018	Masters Thesis

7	S. Kouanda, A. Bado, I.B. Meda, G. S.Yameogo, A. Coulibaly, S. Haddad	Home births in the context of free health care: The case of Kaya health district in Burkina Faso	2016. International Journal of Gynecology and Obstetrics. 135: S39–S44. http://dx.doi.org/10.1016/j.ijgo.2016.08.009	Article
8	Ministère de la santé	Plan national de communication sur la stratégie de Gratuité des soins et des services de planification familiale	May 2019	Report
9	Ministère de la santé	Plan d'opérationnalisation de la stratégie nationale de Gratuité des soins et services de planification familiale	February 2019	Report
10	Ministère de la santé	Stratégie nationale de mise en œuvre de la Gratuité des soins et des services de planification familiale	February 2019	Report
11	Ministère de la santé, Ministère de l'économie des finances et du développement	Arrêté conjoint N° 2018-1211 portant adoption du manuel de procédures descriptives des modalités de gestion, du suivi et du contrôle des mesures de Gratuité des soins au profit des femmes et des enfants de moins de cinq ans vivant au Burkina Faso.	November 2018	Joint Order
12	Gouvernement du Burkina Faso	Décret présidentiel N°2016-311/PRES/PM/MS/MATDSI/MINEFID portant Gratuité des soins au profit des femmes et des enfants de moins de cinq ans vivant au Burkina Faso	April 2016	Decree

ANNEX C: SUMMARY OF ARTICLES, REPORTS, AND DOCUMENTS ON THE GRATUITÉ POLICY

The articles and documents analyzed in this section relate largely to the Gratuité policy, which has been implemented since 2016, but also to previous experiences of free health care experienced in certain health districts of Burkina Faso.

In general, the articles have focused on the effects of the policy outside of a study that traces the process of formulating and developing the national user fee removal policy.

Indeed, the study conducted by ***V. Ridde and P. Yaméogo (2018)*** takes stock of the long process that led to the implementation of the Gratuité policy. It indicates that, unlike other countries, the decision to implement the Gratuité policy in Burkina Faso was based both on evidence (results of pilot projects by NGOs), but also on strong, continuous advocacy by a number of actors. There was also a window of political opportunity with the popular uprising in October 2014, which accelerated the policy process.

The authors selected a few key lessons from this process. These include:

- Formalizing knowledge transfer activities.
- The rapid and regular identification and establishment of partnerships with political entrepreneurs.
- The production of rigorous and useful knowledge; independent evaluation of the process using mixed methods.
- Training researchers in decision-making processes and decision-makers in knowledge production issues.
- Adaptation (content, format, vocabulary, language, etc.) of the data to the needs of knowledge users in close collaboration with researchers and disseminating them to target audiences.
- Regular analysis of political decision-making processes specific to the national context.
- Consideration of social and political contexts favorable (or not) to decision-making.

The other articles dealt with the effects of the Gratuité policy on additional health care costs, the workload of nursing staff, the morbidity of populations, and home deliveries.

T. Druetz et al. (2018) have shown that the effects of free policies or measures remain fragile if the implementation is not continuous and lasting. The authors analyzed the experiences of the Kaya health district, which had several phases of introduction and user fee removal between 2011 and 2016. The results of the study reveal that the visits to health in urban or rural areas in the Kaya health district doubles immediately after the introduction of the free service. But the suspension of the measure also results in an immediate drop in the use of health services. This suggests that to guarantee long-term effects, the sustainability of the implementation and of the funding of user-fee removal policies are necessary.

I.B. Meda et al. (2019) looked at the expenses made by the beneficiaries of the Gratuité policy, despite care being free. The study, which only covered women, shows that they pay between $ 0.08 and $ 98.67 for care at the health facility level. Almost a third (29.6%, n = 174) of women said they paid for their care; among them, 17.5% of women had bought medicines in private pharmacies and 11.4% had bought cleaning products for a room or equipment. The study shows that out-of-pocket payments were higher among older, more educated women in urban areas and in hospitals.

The effects of the transition from reimbursement to pre-positioning of funds at health facilities on the costs of childbirth were also analyzed in ***I.B. Meda et al. (2019)***. The results of the study show that the average costs of deliveries (eutocic, dystocic, and cesarean) in 2016 were higher than in 2014. The method of pre-positioning funds to health facilities has contributed to better success of the Gratuité policy by avoiding shortages of medicines and consumables linked to late reimbursements. However, by removing the risk associated with late reimbursements, there have likely been fewer rational medical prescriptions for health care personnel.

D. Zombré et al. (2019) makes the connection between health care and the probability of occurrence of illnesses or the morbidity of beneficiaries as a result of the Gratuité policy. This study shows that free health care is effective in maintaining the use of health services by children under the age of 5, but the policy has no effect on the probability of developing the most common childhood illnesses. Similarly, the Gratuité policy reduces geographic inequalities in access to health services, but its effect is zero on inequalities of access according to socioeconomic status.

The effects of the policy on the workload of nursing staff were discussed by ***S. Nikiema (2018)*** in his master's thesis. The study was carried out using the WISN method in 11 health centers in rural, peri-urban and urban areas of Bogodogo health district in the central region of Burkina Faso. The results show that the health facilities located in peri-urban and urban areas had enough nursing staff to cope with the sharp increase in attendance induced by the Gratuité policy. At this level, Gratuité did not induce a high workload pressure in comparison with the availability of nursing staff. However, the health centers located in rural areas had fewer nursing staff to cope with the high demand for care caused by the Gratuité policy. The workload for the nursing staff was higher. This suggests a poor distribution of nursing staff between rural, peri-urban, and urban areas.

S. Kouanda et al. (2016) looked at deliveries that take place in homes despite the implementation of the Gratuité policy. The results of the study show that almost one in eight women (12%) surveyed in the health center of Kaya district in central northern Burkina Faso continued to give birth at home, despite free cost of delivery in public health centers, thus exposing many to the risk of death. The main reasons noted by the authors are immediate delivery, previous experiences of home birth, negative experiences with health centers, fear of cesarean deliveries, and lack of transport. In addition to free care, other additional measures are needed to significantly reduce the rate of home births.

The study reports and other documents concern the laws and decrees implementing the Gratuité policy and the joint decree of the manual of procedures that specify the functioning of the policy. Communication and operational plans for free health care and family planning were also analyzed.

The communication plan presents the potential of the audiovisual space in Burkina Faso and defines the actions and strategies to be implemented for harmonized and successful communication of the Gratuité policy. It aims to contribute to the successful implementation of free measures by increasing the visibility of policy actions and also increasing the awareness of populations on the policy.

The operational plan describes how to implement free care services strategy in Burkina Faso. It also presents the main stages of operationalization of the policy, which are planning, launching, execution, and evaluation.

ANNEX D: GRATUITÉ MANAGEMENT AND REPORTING TOOLS

I. The *individual care sheet,* which mainly specifies:

   a. The medical "acts" performed (date, type of service, amount, and observations).

   b. The medicines and consumables prescribed (date and time and prescription, name/first name of the prescriber + signature and stamp of the service, drugs and/or contraceptives and/or consumables prescribed with dosage, quantity prescribed, quantity served, amount, and identity and signature of the dispenser).

   c. The additional examinations prescribed (date of prescription, name/first name of the prescriber + signature, examinations requested, amount, and observations).

   d. Hospitalization, if applicable, specifying the day of entry, the day of discharge, the length of hospitalization in days and the amount.

   e. Evacuation, if applicable, indicating the amount of fuel.

II. The paraclinical examination bulletin, which specifies the diagnostic tests prescribed.

III. The medical prescription sheet, indicating the type of care/service and the target population, the drugs and/or contraceptives and/or consumables prescribed, the medical "acts" performed, and observation/hospitalization, if applicable

IV. The exit ticket from the health facility, which is established to keep the patient informed of the care/services he/her benefitted from and for the monitoring and control needs. It specifies the type of care/service and the target population, the day of entry, the day of discharge, the length of stay, and the summary of care/services provided.

V. The free medication booklet for ASBCs, indicating the drugs and/or contraceptives and/or consumables concerned, the quantity served, their unit cost, and the total amount.

VI. The Gratuité TLOH, a weekly report on the implementation of Gratuité. It indicates the number of children under 5 treated medically, children under 5 treated surgically, newborns treated, vaginal deliveries, cesarean sections, women treated during pregnancy, imaging examinations performed, inserted IUDs, IUD withdrawals, inserted implants, implant removal, pill packs dispensed, women received for injectables, necklaces dispensed, male condoms dispensed, and female condoms dispensed. Drugs shortages at the pharmaceutical depot should also be reported, as well as difficulties encountered, and the solutions found to deal with them.

VII. The Gratuité monthly activity reports, specifying the details of activities performed in each of the following major components: (i) deliveries and major obstetric interventions, (ii) care during pregnancy, (iii) family planning services, (iv) care for children under 5 (outpatient and inpatient curative care), (v) screening and treatment of precancerous lesions of the cervix (VIA/VILI, cryotherapy, diathermy loop excision), (vi) Gratuité services provided by ASBCs (curative care for diarrhea, pneumonia, and non-severe malaria; pre-transfer care of severe malaria; RDTs for malaria; family planning). Moreover, goods and services accompanying these activities (medical "acts", drugs and consumables, observation/hospitalization, fuel for medical evacuations, and additional tests) are also reported.

GRATUITÉ INDIVIDUAL CARE SHEET

MINISTERE DE LA SANTE

SECRETARIAT GENERAL

DIRECTION REGIONALE DE LA SANTE DU....

DIRECTION PROVINCIALE DE LA SANTE DU.....

HOPITAL DE.....

BURKINA FASO
Unité – Progrès - Justice

DOSSIER N° : .....

FICHE INDIVIDUELLE DE PRISE EN CHARGE
Hospitalisations

1. INFORMATIONS GENERALES

NOM et PRENOMS DU PATIENT : .....N° enregistrement : .....

2. ACTES

DATE	PRESTATIONS	MONTANT	OBSERVATIONS
TOTAL 1			

3. MEDICAMENTS PRESCRITS

Date et heure	Nom/prénom du prescripteur, signature et cachet du service	Médicaments prescrits et posologie	Quantité prescrite	Quantité servie	Montant	Identité et signature du dispensateur

TOTAL 2		

NB : Cocher les produits non servis au DMEG

4. EXAMENS COMPLEMENTAIRES

Date	Nom/prénom prescripteurs/signature	Examens demandés	Montant	Observations
TOTAL 3				

5. HOSPITALISATION

Entré le :..... Sortie le :.....Durée :.....jours Montant total :.....FCFA

6. MODE DE SORTIE : Guéri/__/ Décédé/__/ Référé/__/ Décharge/__/ Transféré/__/ Evadé /__/

7. RECAPITULATIF

Désignation	Montant
1. Acte (= T1)	
2. Médicaments et consommables (=T2)	
3. Examens complémentaires (=T3)	
4. Hospitalisation	
5. Carburant	
TOTAL dépensé par la FS	

Visa du responsable des guichets de paiement

GRATUITÉ PARACLINICAL EXAMINATION BULLETIN

DRS DE :.....
FS/Unité de soins : .....

Burkina Faso
Unité – Progrès – Justice

BULLETIN D'EXAMEN

Nom, prénom (s) : ..... Age : .....Sexe : ..... Profession : .....

N° dossier : .....

Nature de l'examen	Résultats de l'examen
Date : ..... Identité, visa du prescripteur	Date : ..... Identité, visa du spécialiste

GRATUITÉ MEDICAL PRESCRIPTION SHEET

Date : .....

N°

(série).....

DRS : .....

FS : .....

UNITE DE SOINS : .....

Nom & Prénom :.....Village/secteur.....

Enfant<5ans /__/ Femme enceinte /__/ Accouchement /__/ Dépistage lésions pré cancer (*Col de l'utérus*) /__/

Age : ..... Sexe : M /__/ F /__/ N° *(sur le Registre de consultation)*.....

Nom du père/mère *(pour enfants<5 ans)* .....Téléphone .....

ORDONNANCE MEDICALE

Désignation	Quantité	Montant
Actes (*préciser*)		
Mise en observation (*niveau CSPS*)		
Total		

Nom & Prénom du Gérant
Signature et cachet

Nom & Prénom du prescripteur
Signature et cachet

GRATUITÉ HEALTH FACILITY EXIT TICKET

MINISTERE DE LA SANTE

SECRETARIAT GENERAL

DIRECTION REGIONALE DE LA SANTE DE.....

HOPITAL DE .....

BURKINA FASO
UNITE - PROGRES - JUSTICE

Date : .....

BILLET DE SORTIE N°.....

Nom & Prénom : ..... **Village/secteur**.....
Enfant<5ans /__/ Femme enceinte /__/ Accouchement /__/ Dépistage du cancer (*Col de l'utérus et du sein)* **/__/**
Age :.....**Sexe : M /__/ F /__/** **N°** *(sur le Registre hospitalisation)*.....
Nom du père/mère *(pour enfants<5 ans)* ..... Téléphone : .....

Date d'entrée :..... **Date de sortie :**..... **Durée de séjour :**.....
Mode de sortie : guéri /__/ décédé /__/ évacué / référé /__/ SCAM (*Sortie Contre Avis Médical***) /__/**

RECAPITULATIF DES PRESTATIONS OFFERTES

Désignation	Montant
1- Consultation	
2- Hospitalisation	
3- Médicaments	
4- Examens complémentaires	
5- Carburant évacuation	
Montant total	

NB : Ce billet est établi à titre d'information pour le bénéficiaire et pour des besoins de suivi et de contrôle.

Etabli par la caisse, Nom Prénom, signature et cachet	*Le Bénéficiaire ou son représentant, Nom Prénom et signature*

Date : .....

N° *(série)*.....

Commune : .....

Formation sanitaire : .....

Nom & Prénom(s) : ..... Village.....

Age (en mois): /_____/

Sexe : M /__/ F /__/ N° *(sur le Registre ou cahier de consultation de l'ASBC)*.....

Nom du père/mère : ..... Contact .....

Carnet de dispensation gratuite de médicaments et consommables médicaux

Désignation	Cocher si servi	Quantité	Coût unitaire	Montant total
1. KIT SRO_ZINC				
2. Amoxicilline dispersible				
3. Artémether + Luméfantrine (AL)				
4. Amodiaquine + artésunate (ASAQ)				
5. Dihydroartémisinine + Pipéraquine (DH-PPQ)				
6. Artésunate suppositoire				
7. Paracétamol				
8. TDR paludisme				
9. Préservatifs				
10. Pilules				
11. Sayana Press				
Total				

Nom & Prénom de l'ASBC

Signature

GRATUITÉ WEEKLY ACTIVITY REPORT FORM

Région:..... Formation sanitaire :.....

Unité de soins:

RAPPORT HEBDOMADAIRE DE MISE EN ŒUVRE DE LA GRATUITE DES SOINS

SEMAINE :___/___/ DU ___/___/201... AU ___/___/201...

Items	Nombre	Observations
1. Nombre d'enfants de 0 à 5 ans traité médicalement		
2. Nombre d'enfants de 0 à 5 ans opérés		
3. Nombre de nouveau-nés pris en charge		
4. Nombre d'accouchements par voie basse		
5. Nombre de césariennes réalisées		
6 .Nombre de femmes soignées pendant la grossesse		
7. Rupture d'au moins un médicament au DMEG (1 = OUI ou 0 = NON)		
8. Nombre total d'examens de laboratoire réalisés		
9. Nombre total d'examens d'imagerie réalisés		

Commentaires, difficultés, solutions:

GRATUITÉ MONTHLY ACTIVITY REPORT FORM

MINISTERE DE LA SANTE
****
SECRETARIAT GENERAL
****
DIRECTION REGIONALE DE LA SANTE DE .....
****
DISTRICT DE .....
****
CSPS DE .....

BURKINA FASO
UNITE - PROGRES - JUSTICE

Date d'établissement du rapport : .....

RAPPORT MENSUEL D'ACTIVITES SUR LA GRATUITE DES SOINS

Mois de : ..... **Année :** .....

PRESTATIONS	QUANTITE	COUT
I.Gratuité des accouchements et des interventions obstétricales majeures		
I.1. Prestations		
I.1.1. Accouchements eutociques		
I.1.2. Accouchements dystociques par voie basse		
I.1.3. Césariennes		
I.1.4. Soins obstétricaux d'urgence		
I.1.5. Soins curatifs du post partum		
I.1.6. Soins d'urgence aux nouveau-nés		
I.1.7. Laparotomie pour rupture utérine		
I.1.8. Laparotomie pour GEU		
I.1.9. Cure de fistules obstétricales		
Sous-total I.1.		
I.2. Biens et services		
I.2.1. Carburant évacuation		
I.2.2. Montant total des médicaments et consommables médicaux		
I.2.3. Examens complémentaires		
I.2.4. Actes (Consultation, accouchement)		
I.2.5. Mise en observation/Hospitalisation		
Sous-total I.2.		
II. Gratuité des soins pendant la grossesse		
II.1. Prestations		
II.1.1. Soins préventifs		
II.1.2. Soins curatifs en ambulatoire		
II.1.3. Soins curatifs en interne		
Sous-total II.1.		
II.2. Biens et services		
II.2.1. Carburant évacuation		
II.2.2. Montant total des médicaments et consommables		

médicaux		
I.2.3. Examens complémentaires		
II.2.4. Actes (consultations)		
II.2.5. Mise en observation/Hospitalisation		
Sous-total II.2.		
III. Gratuité de la Planification Familiale		
III.1 Prestations		
III.1.1 Personnes vues pour PF		
Sous-total III.1		
III.2 Biens et services		
III.2.1 Montant total des médicaments et consommables médicaux		
III.2.2 Examens complémentaires		
III.2.3 Actes (consultation, pose/retrait implant, pose/retrait DIU)		
Sous-total III.2		
IV. Gratuité des soins chez les enfants de moins de 5 ans		
IV.1. Prestations		
IV.1.1. Soins curatifs en ambulatoire		
IV.1.2. Soins curatifs en observation		
Sous-total IV.1.		
IV.2. Biens et services		
IV. 2.1. Carburant évacuation		
IV. 2.2. Montant total des médicaments et consommables médicaux		
IV. 2.3. Examens complémentaires		
IV.2.4. Actes (consultations, chirurgies)		
IV.2.5. Mise en observation/Hospitalisation		
Sous-total IV.2.		
V. Gratuité du dépistage et du traitement des lésions précancéreuses du col de l'utérus		
V.1. Prestations		
V.1.1.Dépistage par IVA/IVL		
V.1.2. Cryothérapie		
V.1.3. Résection à l'Anse Diathermique (RAD)		
Sous-total V.1.		
V.2. Biens et services		
V.2.1. Montant total des médicaments		
V.2.2. Examens complémentaires		
V.2.2. Actes (consultations, mise en observation)		
Sous-total V.2.		
Total formation sanitaire		
VI. Gratuité des soins ASBC		
VI.1. Soins curatifs contre la diarrhée		
VI.2. Soins curatifs contre la pneumonie		
VI.3. Soins curatifs contre le paludisme simple		

VI.4. Soins pré-transfert du paludisme grave		
VI.5. TDR paludisme		
VI.6. Planification familiale		
Total ASBC		
TOTAL GENERAL (Formation sanitaire + ASBC)		

Le responsable du poste

ANNEX E: TYPE OF INFORMATION COLLECTED AND STORED IN THE "*E-GRATUITÉ*" PLATFORM

1. Data
    a. Indicators (cost of health services delivery, cost of goods and services, satisfaction rate)
    b. Data elements (medication orders, NGO control data, data provided by health facilities, amounts of health facilities bill payments, TLOH data, number of staff by category, and level of care)
    c. Data sets (reporting rates, reporting rates on time, actual reports, actual reporting rates on time, expected reports on drug orders and deliveries, NGO verification data, health facilities monthly activity reports, monitoring of CAMEG's debts, monitoring of expired medications)
    d. Event data items (no sub-categories)
    e. Program indicators (no sub-categories)
2. Periods
    a. Data can be extracted by day, weeks, months, bi-months, quarters, six-months, years
3. Organization units
    a. Data can be extracted according to the level of care (community level, CSPS, CM, CMA, CHR, CHU), by district, by region, and also at national level
4. CAMEG debts
    a. Matured debts
    b. Unmatured debts
    c. Amount paid
5. Quantity of material
    a. Functional, in good condition
    b. Functional, in fair condition
    c. Service needs
    d. Available in store in new condition
    e. Not functional, broken and repairable
    f. Not functional, out of use
6. Monthly material quantity
    a. Functional, in good condition
    b. Functional, in fair condition
    c. Service needs
7. Quantity and cost of Gratuité services
    a. Quantity
    b. Cost

ANNEX F: HEALTH FACILITIES STATUS OF INVOICES VS. PAYMENTS BY QUARTER FROM 2016-19

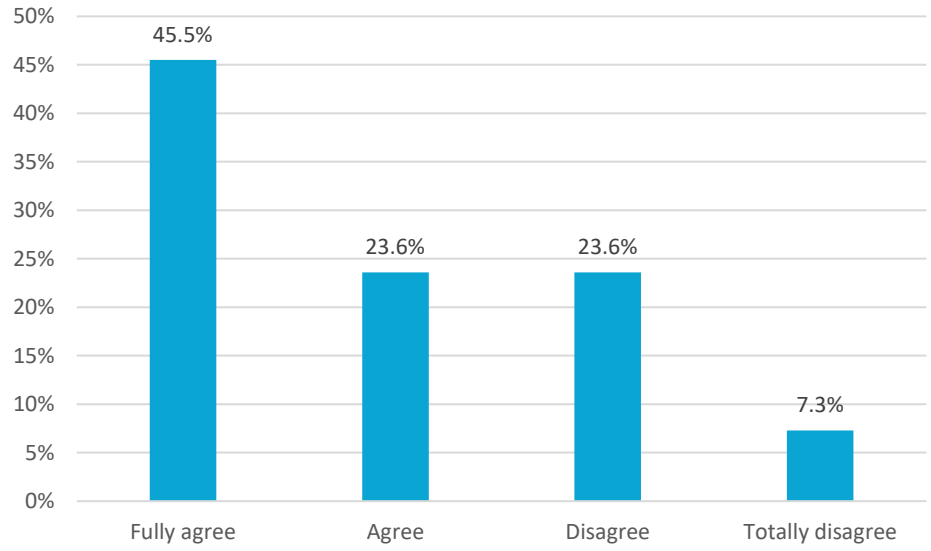
Period	CHU 1			CHU 2			CSPS			CSPS 2			CSPS 3			CSPS 4		
	Bills issued	Payments received	Gap (%)	Bills issued	Payments received	Gap (%)	Bills issued	Payment received	Gap (%)	Bills issued	Payments received	Gap (%)	Bills issued	Payments received	Gap (%)	Bills issued	Payments received	Gap (%)
T2 2016	17,563,613	0	-00	148,970,305	57,291,199	38	641,810	0	-00	429,425	0	-00	10,726,670	11,019,877	103	251,490	420,355	167
T3 2016	95,378,679	88,762,960	93	276,307,579	171,873,598	62	3,278,480	3,201,681	98	2,572,235	1,480,586	58	16,811,945	17,189,381	102	474,400	617,186	130
T4 2016	94,917,742	88 541 968	93	295,970,343	386,782,691	131	2,733,840	4,029,857	147	2,235,110	4,263,299	191	16,925,795	9,045,760	53	327,260	0	-00
T1 2017	87,017,547	92,682,655	107	214,612,872	302,733,811	141	1,989,200	1,713,486	86	2,564,455	1,295,808	51	8,825,780	20,237,788	229	274,300	315,505	115
T2 2017	102,031,819	117,972,838	116	240,832,466	242,429,074	101	2,025,076	1,751,854	87	2,351,110	3,819,856	162	12,319,665	5,126,500	42	248,825	349,004	140
T3 2017	106,933,245	106,288,779	99	264,711,124	235,521,960	89	3,574,300	2,208,459	62	3,521,320	2,392,170	68	15,363,350	15,147,114	99	307,480	139,170	45
T4 2017	101,401,945	114,711,530	113	235,467,472	291,271,482	124	2,776,175	3,533,352	127	2,564,080	3,265,451	127	11,922,930	14,396,014	121	408,020	352,746	86
T1 2018	91,351,240	105,917,096	116	93,771,107	238,884,794	255	2,826,190	3,456,689	122	2,353,700	2,773,628	118	10,517,450	14,174,792	135	321,364	441,565	137
T2 2018	111,059,719	52,805,060	48	175,382,974	100,872,244	58	2,625,540	2,591,118	99	2,573,018	1,166,540	45	12,920,550	6,904,521	53	450,335	303,089	67
T3 2018	110,196,627	62,569,048	57	300,149,483	168,272,516	56	3,044,736	1,983,908	65	2,856,685	2,461,925	86	12,702,070	11,325,536	89	551,145	508,431	92
T4 2018	122,707,976	0	-00	350,366,603	0	-00	2,519,378	0	-00	2,222,370	0	-00	11,963,860	0	-00	562,745	0	-00
T1 2019	113,409,652	137,521,096	121	251,141,645	268,528,651	107	2,020,455	2,337,962	116	1,992,175	2,180,487	109	13,366,525	10,778,831	81	405,410	479,038	118
T2 2019	93,415,679	145,861,521	156	297,548,376	436,012,378	147	2,136,578	1,879,088	88	1,560,830	1,834,182	118	12,084,450	10,538,675	87	297,070	404,621	136
T3 2019	46,866,210	93,313,664	199	276,850,320	283,502,539	102	1,967,140	1,839,556	94	2,116,185	1,750,069	83	12,300,350	12,540,741	102	530,380	398,394	75
T4 2019	90,805,417	0	-00	314,859,893	169,962,958	54	1,718,860	0	-00	1,772,770	0	-00	10,747,595	0	-00	546,656	0	-00
TOTAL	**1,385,057,110**	**1,206,948,215**	**87**	**3,736,942,562**	**3,353,939,895**	**90**	**35,877,758**	**30,527,010**	**85**	**33,685,468**	**28,684,002**	**85**	**189,498,985**	**158,425,531**	**84**	**5,956,880**	**4,729,103**	**79**

Source: Ministère de la santé du Burkina Faso 2020; Kafando, Kiendrébéogo, and Tapsoba 2020

ANNEX G: SURVEY RESULTS OF PUBLIC SECTOR HEALTH WORKERS ON UNDERSTANDING THE GRATUITÉ MECHANISM

The online survey indicated that most people interviewed linked the stockout and shortage of drugs and consumable in health facilities to the current "payment mechanism." This association of drugs stockouts with Gratuité was fully agreed by 45% of the respondents (109 of 243) and another 24% agreed (see Figure 19). Only a small number of respondents believed that the stockouts are instead due to the shortcomings noted in the order placed for drugs and commodities as well as the management of available stocks at the level of health facilities.

Figure 19: Stakeholders' opinions on the influence of payment methods to drug stockouts



Source: Kafando, Kiendrébéogo, and Tapsoba 2020

Results of the online survey on payment methods show that not all health workers in the field knew the requirements and procedures for the flow of payments and the reporting of claims for Gratuité (see Table 7). For example, only 44% (106 out of 243) of the respondents knew that the payment mechanism was a pre-positioning of funds in advance in the special Gratuité account at district level for them to use as needed during the quarter. Also, up to 12% (31 out of 243) had no idea of the reimbursement mechanism.

Table 7: State of knowledge of health workers on the Gratuité payment method

According to you, what is the payment mechanism for Gratuité?	Number of respondents	%
Correct Answer: Full pre-positioning of the amount in the special Gratuité accounts of the districts and hospitals, followed by the transfer of 29% to 30% to health facilities and 70% to 80% to CAMEG for drugs and consumables to be used during the quarter	106	44%
Incorrect: Reimbursement of expenses made to each health facility at the end of each quarter	82	34%

Incorrect: Full pre-positioning of the amount in the special Gratuité accounts of districts and hospitals followed by the transfer of the total amount to health facilities	19	8%
Incorrect: Full pre-positioning of the amount in the district and hospital special Gratuité accounts	5	2%
None of these options / Do not know	31	12%
Total	**243**	**100%**

Source: Kafando, Kiendrébéogo, and Tapsoba 2020