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**Health Problems in Areas of Human Vulnerability:
Field Experience of *Médecins Sans Frontières* (MSF)
in the Sahel Region**

by

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KEYWORDS. — Access to Care; Food Insecurity; Malnutrition; Sub-Saharan Africa; User Fees.

SUMMARY. — During the nutritional crisis of 2005, malnutrition rates reached very high levels in certain regions of Niger and neighbouring countries. In Niger, 40,000 severely malnourished (Weight/Height (W/H) below 70 %) children were treated in MSF's therapeutic feeding centres. In spite of the severe crisis, general free food distribution did not happen. As alternative, subsidized food was brought on the local market, but this remained out of reach of most of the already completely destitute families. This year, a similar crisis announces itself, with many months of continuing high levels of malnutrition. The question begs whether one can still speak about a temporary crisis situation or rather can label this an endemic state of malnutrition and associated child mortality.

In most Sahel countries, basic health care services are paid for by patients, also in public structures. Patient fees need to be paid before care can be obtained. MSF conducted epidemiological surveys in several of these low-income countries, to assess the impact of these patient fees in terms of exclusion of patients in need of care and in terms of further impoverishment of households. The results of the survey in Mali illustrate the degree of the problem. Thirty per cent of people did not seek any care during their last episode of illness, mainly because of lack of money to pay for care. Moreover, using the public health centre signified for an important proportion of patients the need to borrow money or sell goods to mobilize the cash. This led to delays in health care and carries risks of further impoverishment of the family. The median price paid for care was the equivalent of 6 \$US, representing twenty days of an average income. Less than 2 % of the patients were exempted from payment, in spite of the national policy on protection of those unable to pay. Patient fees in a context of generalized poverty jeopardize access to essential health care and are counterproductive within the framework of the international commitment of poverty reduction and the Millennium Development Goals.

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1. Introduction

Médecins Sans Frontières, a medical humanitarian organization, is active in different countries of the Sahel belt, and in some of them for many years. The main focus of MSF's intervention is put on health problems in vulnerable population (groups). From our field experience of recent years, we would like to highlight two particular issues: 1. recurrent or continuously high levels of acute malnutrition on a large scale; 2. access barriers to paying health care in public health services among an impoverished population.

2. High Levels of Malnutrition: the Case of Niger

During the nutritional crisis of 2005, malnutrition rates reached very high levels in certain regions of Niger and neighbouring countries. Table 1 shows malnutrition rates measured during population-based surveys in selected contexts.

Table 1
Malnutrition rates as measured by MSF through population-based surveys in selected contexts during the year 2005

Acute malnutrition (Weight/Height)	Total (below $-2SD$)	Moderate (between $-2 SD$ and $-3 SD$)	Severe (below $-3 SD$)
Mali, Goundam	17.0 %	15.5 %	1.9 %
Chad, Kanem	15.1 %	10.5 %	4.6 %
Niger, Maradi (April)	19.3 %	17.4 %	2.9 %
Niger, Maradi (Sept.)	19.2 %	15.1 %	4.1 %

We focus on the specific experience of MSF in Maradi in Niger (fig. 1). Maradi is a densely populated area (2.5 million inhabitants, with 65 inhabitants per sq. km on average). Twenty per cent of the population live on 3.3 % of the surface, concentrating in the south, where agriculture is most developed. In contrast with an overall relatively good agricultural production in the area, an important degree of food insecurity exists, mainly caused by extreme poverty. Food production per inhabitant is deficient and in particular during the lean period (May to October) there are problems.



Fig. 1. — Map of Niger with location of Maradi.

Since 2001 MSF is present in the area and has provided nutritional care for severely malnourished (below -3 SD) children in therapeutic feeding centres and for moderately malnourished children (below -2 SD) in supplementary feeding centres. MSF teams have experienced a worsening of the situation, with increased numbers of malnourished children and an expansion of the lean period duration over longer periods of time.

In 2005 an extreme crisis appeared. The number of severely malnourished children admitted to MSF feeding centres increased significantly. In response, extra facilities were opened, allowing to admit more children closer to their homes. Compared to the seasonal rise in previous years, the number of malnourished children skyrocketed, with up to 2,000 children per week admitted because of severe malnutrition (fig. 2).

In spite of the severe crisis, general free food distribution did not happen. As alternative, subsidised food was brought on the local market, but this remained out of reach of most of the already completely destitute families. Market prices did not diminish sufficiently to allow people to have access to it. Therefore, the measures injecting food subsidies may have increased the availability of food on the market, but did not tackle their unaffordability, thus blocking households to have access to the available food. In figure 3 the

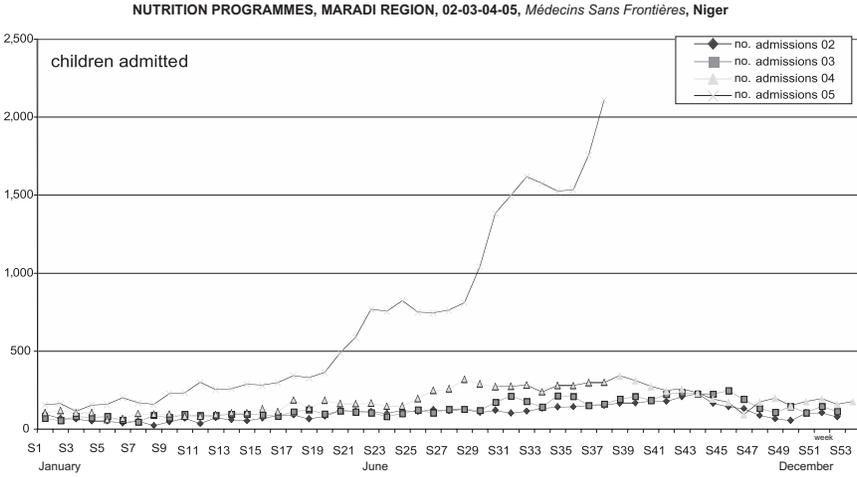


Fig. 2. — Evolution of the number of malnourished children admitted to MSF feeding centres from 2002 to 2005.

relation is shown between the price increase of millet — the main staple food — and the increase in malnourished children admitted. The two curves are strikingly similar, separated by an average period of five weeks.

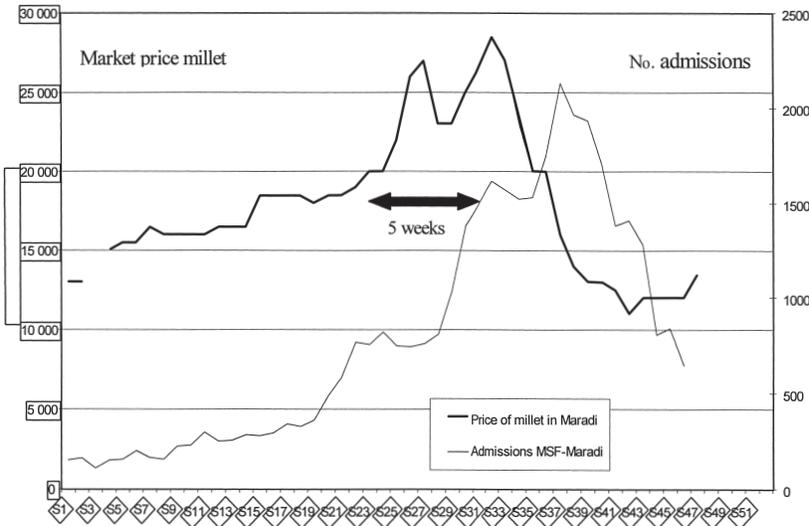


Fig. 3. — Comparison between market prices for millet and number of severely malnourished children admitted in Maradi region, Niger (2005).

The intensity, the recurrent nature of the nutritional crisis, and the extent of the population affected by the crisis, beg also the question if one can still speak about a temporary crisis situation or rather can label this an endemic state of malnutrition and associated child mortality. Are the usual development interventions still adapted to this type of situation?

The classic interventions based on food subsidies and market support seem to have failed in these circumstances (MSF 2006). Subsidised food remains inaccessible to households because they still must be paid for, whereas most households have no cash and have run out of assets to sell. "Food for work" is also questionable as measure, as the net caloric gain remains low and many households cannot provide the necessary labour force. There is clearly a need for free food distribution in order to guarantee access to food. Otherwise the most vulnerable households remain excluded.

The refusal by development actors to recognize the depth and extent of the nutritional crisis and their clinging to market support as sole measure are closely linked and raise the question when exceptional measures are considered justified. Overall, 40,000 severely malnourished (W/H below 70 % or below -3 SD) children were treated in the MSF's therapeutic feeding centres in 2005. Should we consider them as the acceptable side effect of failing development programmes?

3. Primary Health Care Unaffordable due to User Fees: the Case of Mali and Chad

As in most of the sub-Saharan African countries, basic and essential health care services are paid for by patients in most Sahel countries. Payment is generalized, including in public health structures. The introduction of user fees was considered justified as a response to the crisis in the health sector of low-income countries in the 1980s. This policy was endorsed by the World Bank within social adjustment reforms and — although from a different perspective — in 1987 promoted by the WHO and Unicef for Africa, through the 'Bamako Initiative'. Although raising hope at that time, experience has shown many negative effects on equity, effectiveness and efficacy of health services (ARHIN-TENKORANG 2000, GILSON 1997, RUSSELL & GILSON 1997). Moreover, health care expenses pose serious risks for further impoverishment for patients and their family (MEESSEN *et al.* 2003, XU *et al.* 2003). However, in the absence of an adequate state health budget and sufficient international funding for health, user fees remain the most important financing strategy for health care (WHITEHEAD *et al.* 2003).

With the objective to care for patients, where possible through public structures, MSF has documented the existing financial barriers to essential care and investigated the consequences of user fees for the population. MSF has conducted epidemiological surveys in several of these low-income countries to assess the impact of these patient fees in terms of exclusion of patients in need of care and in terms of further impoverishment of households. MSF has investigated access to care during the most recent illness episode among those households living at a reasonable distance of health centres applying user fees for primary health care. This suggests that exclusion is likely to be even higher in households living further away from a health centre, as geographical barriers become more stringent. We will discuss the results of surveys done in Bougouni (Mali) and in Bongor (Chad).

3.1. BOUGOUNI, MALI

The results of the survey in Bougouni, Mali, illustrate the degree of the problem (MSF 2006). Overall, less than half of the ill persons consulted the nearest health centre (46 %). Thirty per cent of people did not seek any care during their last episode of illness, and two in three failed to do so for lack of money to pay for care. Some 17 % of ill people sought care from the informal sector, with one in three giving lack of money as main reason.

The median price paid for care obtained at the nearest health centre was the equivalent of 6 \$US, representing twenty days of an average income. Less than 2 % of patients were exempted from payment, in spite of the national policy on protection of those unable to pay. Thirty-five per cent of patients had to borrow money or sell goods in order to mobilise cash to pay the required fees.

Moreover, using the public health centre signified for an important proportion the need to borrow money or sell goods to mobilise the cash. This led to delays in health care and carries risks of further impoverishment of the family. Ninety-eight per cent of households lived with less than 1 \$US per person per day (the international threshold of extreme poverty), with rural households facing more cash problems. At the moment of the survey, 40 % of households declared a debt and one in six had a debt related to health care.

3.2. BONGOR, CHAD

In Chad, investigating episodes of malaria in Bongor revealed similar consequences of user fees (MSF 2006). Overall, only 56 % of all reported malaria

patients received complete treatment for malaria in the nearest health centre. Among the people who reported illness, 16.3 % did not consult anybody during the last episode of suspected malaria. Lack of money was reported as the major reason for not attending (76 %).

Instead, 21 % of people consulted the informal sector, mainly drug peddlers. For patients consulting the nearest health centre, the median fee paid was 1,500 FCFA (equivalent to \$US 3.1), and 4,535 FCFA in hospital. In the informal sector, people paid less, a median fee of 700 FCFA. The price in the nearest health centre was the equivalent of a median twelve days of revenue; for the poorest quintile it was equivalent to one month's revenue. Fees were waived for only 1.7 %, and for only one in a hundred and three users in the poorest quintile.

Among those who used the nearest health centre, only 32 % had cash available to pay for care. Others obtained the money by selling goods or incurring a debt; for 48 % this risked (further) impoverishment. Ninety per cent of the study population were living on less than \$US 1 per person/day; 50 % on less than \$US 0.23; the poorest 20 % on less than \$US 0.12. Given the widespread poverty of this population, these prices for essential health care are unaffordable for most; other costs, such as transport, and lost earnings reduce access even further. Our results highlight the general difficulties in ensuring accessible and affordable malaria treatment through health services that apply cost recovery, even when treatment is heavily subsidised. Donors, NGOs and health authorities need to ensure that the introduction of a new, more expensive treatment, such as ACT, goes hand in hand with measures to guarantee that this treatment is accessible and affordable. Table 2 and table 3 give an overview of these findings.

We conclude that patient fees in a context of generalized poverty, such as investigated in Mali and Chad, jeopardize access to essential health care and are counterproductive within the framework of the international commitment of poverty reduction and the Millennium Development Goals. The financial barriers caused by patient fees at primary health care levels have also negative consequences for the effectiveness of any medical intervention through these health structures, as they restrain coverage, limit effective use of resources and might place a financial burden on vulnerable patients.

Table 2
Overview of survey results on access to care in two contexts:
Bougouni (Mali) and Bongor (Chad). Both surveys were conducted in 2005

	Bongor (Chad)	Bougouni (Mali)
Use of nearest health centre	57 %	46 %
Use of informal sector	21 %	17 %
<i>Reason lack of money</i>	49 %	30 %
No care beyond home	16 %	30 %
<i>Reason lack of money</i>	76 %	65 %

Table 3
Prices paid by patients and proportion of patients exempted among those attending public
health centres in two contexts: Bougouni (Mali) and Bongor (Chad)

	Bongor (Chad)*	Bougouni (Mali)*
Total price paid by patient as equivalent \$US	3,1 \$US	6 \$US
Total price paid by patient as equivalent to days of total expenditure	12 days	20 days
Proportion of patients exempted from payment	1,7 %	2 %

* Both surveys were conducted in 2005.

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