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Full Length Research Paper

Equity and access to health care services: the experience of the Bamako initiative programme in Nigeria

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Abstract

This study examines attempts by the Nigerian government to increase the access of the poorest people to modern health care services, through the Bamako Initiative programme. Responses obtained from health service providers and consumers, as well as community leaders selected from across the four health zones in Nigeria, showed a conclusion that although the operational structures to accomplish the Bamako initiative objectives are in place, access to health services by the poorest is still difficult. The operation of the programme in this direction also runs parallel to existing Nigerian traditional structures to accommodate the indigent in the community. The study suggests that both structures need to be integrated to increase access to health care services.

Keywords: Access to health care, Bamako initiative, Equity, Nigeria, Primary health care.

INTRODUCTION

The third National development plan (1975-1980) (FMOH, 1991) of Nigeria focused, in part, on the inequality in the distribution of medical facilities and health human resources in the country. The fourth development plan (1981 – 1985) (FMNP, 1985) emphasized the need for more equitable distribution of health facilities and manpower in all parts of the federation. In both, unrestricted health system performance (WHO, 2000) and equity in distribution and treatment were emphasized. A recent study compared the extent of maintenance of the principles of "equal treatment for equal need" (Lu *et al*., 2007) and emphasized that the distribution of services is a major axis on which health systems are commonly judged. The study by Travis *et al*. (2004) suggests that weak health systems are one of the main bottlenecks in achieving the health in millennium development goals. The health system in Nigeria is still faced with the problem of inequality. As noted by Iyun (1988) just as Wagstaff *et al.* (1991) observed for England and Wales, despite the desire of state government to ensure a more equitable distribution of health resources, glaring disparities are still evident.

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Reasons offered by Iyun (1988) included the exodus of trained health care practitioners out of the country, poor remuneration of health care professionals which discourage them from staying and working in rural areas, and dwindling government resources, which resulted in lower investment in health care services. Many scholars have also noted the implications of inverse relationship between socio-economic status and health (Iyun, 1988; Egunjobi, 1993; Jegede, 1995; 1998) as affecting illness behavior of the people.

Ojanuga *et al.* (1982) noted that peoples' illness behaviour has negative effects on successful delivery of medical services in Nigeria as scarce resources are wasted through duplication of services and personnel. The implication, as noted by Ojanuga *et al.* is that there is a competition between modern and traditional health care systems which is heightened by the defection of patients to the alternative system. In many parts of the Nigerian society, the question of cost (Onwujekwe *et al*., 2007; 2010), willingness to pay (Onwujekwe *et al*., 2008; 2010) and ability to pay (Onwujekwe *et al*., 2010) are important determinants of access to and utilization of health care systems. The need to make health care delivery not only affordable but also accessible accounted for the introduction of the Bamako Initiative programme in 1987. It was in response to the deep political and economic

crisis which Sub-Saharan African found herself which also culminated into child mortality rate exceeding 200/1000 live births in several countries, yet national budget for health among others were declining despite a rapidly increasing population (Paganini, 2004).

The Bamako Initiative

The Bamako initiative sponsored by UNICEF and WHO and adopted by African ministers of health in 1987 was a movement pioneered towards proper adoption and implementation of the principles of Primary health care (PHC) and maternal and child health care (MCHC) in African countries. The initiative was based on the realization that, despite accepting in principle the core tenets of comprehensive primary health care, by the late 1980s many countries – especially in sub-Saharan Africa – were burdened by a lack of resources and practical implementation strategies. In particular, many health facilities lacked the resources and supplies to function effectively. In response, health Ministers from several African countries met in Bamako, Republic of Mali in 1987, to fashion out strategies to accelerate and improve the delivery of the PHC and other issues revolving around MCH in Africa. Some of the specific issues examined included governments' commitment to universal accessibility of PHC/MCH, decentralization of decision making in health to local communities, equity of access, and the provision of exemption of the poorest from charges for their health care. The meeting led to the development of the Bamako Initiative (BI) programme. Bamako initiative was quickly adopted in 1987 in Benin and Guinea for improving effectiveness, optimizing efficiency, ensuring financial variability and promoting equity (Knippenberg *et al.*, 1997). In Kenya, a model of Bamako initiatives adopted addresses problems of geographical accessibility rather than quality in existing services (McPake, Ajuong, Forsberg, Liambilla and Olenja (1993). With the model, most urgent health service problems in Kenya were responded to. In Benin and Guinea, dividends of the Bamako Initiative program, was referred as a reason for availability of drugs and other essential resources, increase in regular contract between the community health service providers and communities, and efficiency and improvement in the quality of care (Knippenberg *et al*. (1997). The programme is designed with targets as shown in the figure below.

In an attempt to achieve its main targets, the programme stipulated that the Village Development Committee (VDC) should determine exemptions for drugs payment while the District Development Committee (DDC) should provide guidelines for exemptions from drug payments. Knippenberg *et al*. (1997) even reported same that community health resources are managed locally through joint microplanning and monitoring, involving health personnel and village committees. The VDC is a group of people selected by village members to discuss and work in support of the initiative while the DDC is a conglomeration of VDCs in a district usually representative of VDCs. It was expected that such exemptions from drug payment will encourage and enable those who cannot afford the cost of health care to utilize PHC services. The BI programme started actual full implementation in Nigeria in four Local Government areas in April 1990 and as at July 1995 the initiative expanded its implementation to 53 LGAs covering a population of approximately 11 million Nigerians. In Enugu State, Nigeria, Uzochukwu, Onwujekwe and Akpala (2002) compared the level of availability and rational use of drugs in PHC where BI drug revolving fund programme had been operational, with PHC centers where the BI-type of drug revolving fund programme is not yet operational, findings showed that the BI facilities had a better availability of essential drugs both in number and in average stock. However, the BI has given rise to more drugs prescribing which could be irrational (Uzochukwu et al., 2002). Another study (Uzochukwu, Onwujekwe and Akpala, 2004) that determine the utilization of maternal and child healthcare services in health centers before and after the introduction of the Bamako Initiative program in Southeast Nigeria found that although the utilization of immunization, antenatal and delivery services improved, curative service utilization worsened. The study concluded that the potential exclusion of some socioeconomic groups from utilizing services due to financial reasons, distance and non-availability of medical doctors are major factors militating against the use of these services.

As similar efforts by the government and foreign donors are in pipeline focusing on the eradication of disease of poverty through accessibility to adequate healthcare services in Nigeria, the purpose of this article was to examine the extent to which the Bamako Initiative programme has been able to promote equity in access to health services, and the extent to which the strategies adopted in this regard impact on existing traditional welfare systems in the community, especially to see whether these strategies run parallel to existing traditional welfare systems or attempt to integrate them into the programme; and finally to suggest ways by which equity may be promoted in health care service delivery in Nigeria.

METHODS

The study was undertaken in eight selected local government areas (LGAs) in the four health zones in Nigeria-namely Enugu (zone A); Ibadan (zone B); Kaduna (zone C); and Bauchi (zone D). These LGAs started implementing the Bamako Initiative programme at different times - two in 1990, one each in 1991 and 1992,

- Promote self-reliance in the supply of essential drugs to the population by introducing self-help projects as cost recovery systems and drug revolving funds which are locally supported and funded
- Use funds realized from such schemes to replenish drug supplies and to support other primary health care activities
- Develop and promote health management capacity at Village and District levels. The programme was, in a sense, also a reaction against perceived individualistic Western type of social organization. This is reflected in a description of the programme features which says that the BI aims at 'bringing into the fore-front of the African consciousness the traditional ways of life which often had been taken for granted and which the effects of modernization was beginning to erode (FMNP, 1975). Consequently the BI programme also had the objectives of making Nigerian community consciously pursue the development and establishment of community financing for sustaining the programme
- The development and establishment of equitable methods of ensuring that the services provided are received by all members of the community who may need the services, especially the poorest members.

Figure 1: Designed programmes with targets

and two each in 1993 and 1994. Five of these LGAs were funded by the federal government of Nigeria (FGN) in collaboration with UNICEF, one exclusively by the FGN and one each by the Overseas Development Association (ODA) and the United Kingdom Committee (UKC). To purposively select these LGAs from among the others, considerations were given to their spatial location in the country, year of establishing the programme, and types of inputs into the programme determined by sponsorship since different sponsors provided unequal resources for the implementation of the programme. However, in order to have a comparative basis to evaluate the programme, two LGAs that was not implementing the BI programme as at time of study were randomly selected, one each from the north and south respectively. The selected LGAs are as shown in Table 1.

In each of the selected LGAs, the following categories of people were interviewed: Health workers at the community level, community and district development committees, health service consumers at both the health facilities and at home; and local and state government officials. Two methods were utilized to select respondents at the LGA levels. Community health workers and health services consumers were randomly selected and interviewed, while community and district development committee members and local and state government officials were purposively selected based on their involvement in the PHC delivery system. In all, 543 respondents were interviewed at the district, local and state government levels.

Respondents were asked questions that pertain to awareness of and attitudes to policies guiding health service utilization, the services that people were utilizing, their assessment of the cost of health services and its influence on the ability or inability of consumers to pay for such services. Consumers were also asked questions about their responses to inability to pay for health care cost. Finally respondents were asked questions relating to how the indigents in their community were taken care of; this was with a view to understanding whether the strategy proposed by the BI programme runs parallel with existing traditional welfare systems or integrates them to health care delivery system. Generated data from respondents were collated on daily basis by the field supervisor. Data collected were discussed with investigators and later cleaned, coded where necessary and processed into computer for analysis. Analysis of quantitative data was processed using SPSS to generate descriptive statistics while Atlas.ti programme was used for qualitative data. The findings are reported in this paper showing the variations, where they exist, among rural and urban respondents; and also between BI and non BI respondents.

FINDINGS

Awareness and attitude to payment for health services

Results showed that people appeared generally willing to pay for health service, except in urban non BI communi-

Table 1. Selected LGAs for the study.

LGAs	States	Year of BI generation	Zones
Yala	Cross River	1992	A
Etinam	Akwa Ibom	1994	A
Ife central	Osun	1990	B
Owan East	Edo	1993	B
Oyun	Kwara	1990	C
Zuru	Kebbi	1993	C
Barkin Ladi	Plateau	1991	D
Misau	Bauchi	1992	D
Non_BI LGAs			
Ohafia	Abia	-	A
Chanchaga	Niger	-	C

Table 2. Health care Services at the community level as at time of study

Services being paid for	Rural N=151				Urban N=105				Total	
	BI * (N=118)		NBI** (N=33)		BI (N=87)		NBI (N=18)		BI	NBI
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	Freq
General consultation	18	15	7	21	13	15	2	11	31	9
Immunization	21	18	1	3	9	10	1	6	30	2
Family planning	92	78	15	45	66	76	9	50	68	24
Ante natal care	91	77	15	45	53	61	13	72	144	28
Child Deliveries	92	78	19	58	70	80	17	94	162	36
Post natal care	63	53	12	36	31	36	14	78	94	26
Child health	66	56	12	36	43	49	15	83	109	27
Drugs	113	96	32	97	84	97	18	100	197	50
Laboratory	38	32	15	45	26	30	11	60	64	26
X – Ray	28	24	6	18	30	34	10	56	38	16
Others	18	15	-	-	34	39	10	56	52	10

BI*=Bamako Initiative
NBI=**Non Bamako Initiative

munities where peoples' ability was not favourably disposed to paying for health care services. There was an affirmative response that there exists universal awareness that people should pay for health care services received even though people's ability to pay differed. For example, while 89% (of forty-five) and 87.5% (of 23) respondents at the local and State government levels respectively believed that people should pay, others objected the payment due to low ability to pay. These were mainly policy makers. At the community level, where the BI programme exists, 52.5% (of 217) and 79.3% (of 217) respondents in rural and urban areas respectively believed in making payment for health care service utilization. These findings alternate in non BI areas, for instance, while 81% (of 54) of rural respondents agreed, a much lower proportion of urban dwellers (39% of 55) believed in payment for health care services. By implication, people were generally well disposed to the policy that the cost of health care services should be the joint contributions of the government and consumers.

Services Utilized by Consumers

Accessibility of the poorest of the poor to health care services was also a major concern in this study, hence respondents were asked to indicate the type of services people were currently utilizing and paying for. Table 2 shows the different types of services that people paid for as at time of this study. Drugs dispense and maternal and child health related activities like child delivery, antennal care and child health topped the list in that order. Others are post-natal care and family planning services.

Table 3. General assessment of the cost of PHC services

Cost of services	Rural N = 144		Urban N = 119	
	BI N = 111	NBI N= 33	BI N = 102	NBI N = 17
High	19 (17.1)	6 (18.2)	20 (19.6)	4 (23.5)
Moderate	75 (67.6)	24 (72.7)	62 (60.7)	12 (70.6)
Low	17 (15.3)	3 (9.1)	20 (19.6)	1 (5.9)

Table 4. Number of instances recalled by those unable to pay for drugs and other **Services**

Number of instances	Rural N = 160				Urban N = 164			
	BI N = 125		NBI N = 35		BI N = 132		NBI N = 32	
	Freq.	(%)	Freq.	(%)	Freq.	(%)	Freq.	(%)
1 – 4 times	17	(13.6)	4	(11.4)	14	(10.6)	5	(15.6)
5 – 9 times	10	(8)	4	(11.4)	19	(14.4)	2	(6.3)
10 and above	-		4	(11.4)	4	(3)	-	

Assessment of cost of services

When peoples' opinion was assessed as to the cost expended on the services they received, 67% respondents from BI and 61% from non-BI LGAs believed that the cost of services was moderate as in table 3. As shown in table 3, moderate indicates that the cost was neither too high nor too low but rather considered reasonable, and to a large extent affordable. In the non-BI areas, a higher proportion (70%) considered the cost as affordable, but a higher proportion (22%) also considered the cost as high and unaffordable compared with 18% in the BI areas.

There was no much difference in people's assessment of the cost of PHC services across locality as shown in table 3. However, relatively higher proportion of respondents from the BI areas considered the cost of PHC services as low compared with non-BI areas hence 15.3% of respondents in the BI rural areas felt the cost was low, while only 9.1% of respondents from the non-BI rural areas share same views. The distinction was sharper in the urban areas where 19.6% of respondents in the BI areas considered the cost as being low compared with only 6% in the non-BI areas. One reason for this is the relatively lower cost of drugs in BI areas.

Access of the poorest to services

The access of the poorest people in the community towards utilizing health care services hinged on factors such as their "ability to pay for drugs and for other health services", and their "knowledge of available measures to ensure such access and utilization either through policy provisions or through community efforts". Specifically, when questions about accessibility of the poor to health care services were asked from respondents (324 health service consumers), 23% and 28% of consumers in the BI and non BI areas respectively were sometimes unable to pay for drugs prescribed while 16.3% and 17% of the consumers were unable to pay for other services rendered. Results also revealed that slightly more consumers in the non BI areas were unable to pay for drugs than consumers in the BI areas. This difference, though not very significant, is noteworthy for its consistence in both the urban and rural areas. It is possible to attribute this to the relatively lower cost of BI drugs. On the other hand, while only 14.4% of consumers in the BI rural areas reported that they sometimes found it difficult to pay for other services, twice that different picture was obtained in the urban area where more people from the BI areas reported inability to pay for other services than respondents from non BI areas.

The inability of some of the respondents to pay for health care services was not an isolated or uncommon occurrence as respondents reported that they, sometimes, were unable to pay for these services several times. Results show that such occurrences had sometimes been up to 5 times or more. In BI and non BI areas, 12% and 13% respectively of the respondents reported inability to pay for health services between one and four times in the recent past as shown in table 4.

When respondents were asked to explain how they were able to obtain health care treatment, results indicate that some of the patients were offered the privilege of deferring payment as shown in table 5. Others were assisted by health staff either through health workers' contribution to pay for the patient's medical cost or somebody offered to pick up the bill (9%) in both areas.

Table 5. Means of obtaining treatment when people were unable to pay for healthcare

Means of obtaining treatment while unable to pay	Rural N = 160		Urban N = 164	
	BI N = 125 Freq. (%)	NBI N = 35 Freq. (%)	BI N = 132 Freq. (%)	NBI N = 32 Freq. (%)
Through Community fund	4 (3.2)	4 (11.4)	4 (3)	-
Individual assistance	3 (2.4)	1 (2.8)	7 (5.3)	1 (3.1)
Relations of patients requested to pay	4 (3.2)	1 (2.8)	7 (5.3)	1 (3.1)
Deferred payment	15 (12)	3 (8.5)	15 (11.3)	5 (15.6)
Health staff assistance	4 (3.2)	1 (2.8)	8 (6)	2 (6.2)
Treatment refused	4 (3.2)	2 (5.7)	10 (7.5)	3 (9.3)
Other ways	3 (2.4)	1 (2.8)	14 (10.6)	2 (6.2)

Table 6. Instance when People were unable to pay for Health Care Services

Means of payment	Rural N = 160				Urban N = 164			
	BI N = 97		NBI N = 23		BI N = 120		NBI N = 40	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Through community fund	6	6.2	8	34.8	15	12.5	9	22.5
Individual assistance	8	8.2	1	4.3	8	6.7	4	10
Relations of patients requested to pay	2	2.1	16	69.6	2	1.7	23	57.5
Deferred payment	10	10.3	4	17.4	9	7.5	5	12.5
Health staff assistance	3	3.1	1	4.3	9	0.8	2	5
Treatment refused	4	4.1	5	21.7	1	6.7	4	10
Other ways	10	10.3	1	4.3	7	5.8	3	2.5

About 10% in BI areas and 15% in non BI areas were refused treatment, while the relatives of others were contacted and asked to pay for the treatment.

The responses of consumers as reported above were also corroborated by those of community health workers. In their own interviews, health workers' responses indicated the extent of the inability of some people to pay for drugs and other services. The proportion of health workers that reported people's inability recollecting instances when to pay for health services ranged from 28% in the urban BI areas to 65% in the rural non BI areas; indicating more health workers in the non BI areas reported this occurrence than in the BI areas. Table 6 indicates health workers' responses about the different ways by which people's inability to pay for services were resolved. From the table, it reveals that in the non BI areas, relations of patients were often requested to pay for such charges or payments often effected through community funds. Much lower proportion of health workers in the BI areas reported these approaches. This finding could mean that in the non BI areas, existing traditional welfare systems are used more frequently in the absence of official prescriptions.

Measures to ensure universal access to PHC services

In order to ensure universal access, different facilities were designed by communities to enable the indigent receive health care. According to respondents, three general methods were utilized to ensure universal access. The most frequently mentioned measure was community fund as shown in table 7. Most communities in the country usually have developmental, social, cultural or any other associations established to develop their community. As part of the measures to enable universal access, health and development committees often utilize part of the money collected for other purposes to assist the indigent to receive health care. The traditional social structures, the well known African communal philosophy of being one's brother's keeper generally ensured that in close knitted communities, especially rural communities, the indigents are taken care of by the entire community. The non BI rural communities utilized the community fund facility more than any other category. This was reported by 29 (51.8%) respondents in those areas and followed by the urban BI areas with 62 (36.5%). Result also shows that the BI communities have facilities for exemp-

Table 7. Existing facilities to ensure universal access at the community level

Process of encouraging accessibility	Rural N = 271				Urban N = 216			
	BI N = 215		NBI N = 56		BI N = 170		NBI N = 46	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Exemption from payment	48	22.3	3	5.4	51	30	6	13
Community fund for those who cannot pay	53	24.7	29	51.8	62	36.5	7	15.2
Payment-in-kind	27	12.6	17	30.4	39	22.9	14	30.4
Other measures	7	3.3	3	5.3	9	5.3	7	15.2

Table 8. Methods by which the Indigent are taken care of in the Community

Methods	Rural N =271				Urban N =216			
	BI N=215		NBI N=56		BI N=170		NBI N=46	
	Freq.	(%)	Freq.	(%)	Freq.	(%)	Freq.	(%)
Through Community Funds	57	(26.5)	28	(50)	65	(38.2)	5	(10.9)
Individual Assistance	22	(10.2)	12	(21.4)	36	(21.2)	9	(19.6)
Relatives/Friends	74	(34.4)	23	(10.7)	71	(41.8)	17	(36.9)
Deferred Payments	5	(2.3)	4	(7.1)	22	(12.9)	-	
Health Staff Assistance	12	(5.5)	1	(1.8)	23	(13.5)	3	(6.5)
Community Farm	5	(2.3)	3	(5.4)	2	(1.2)	1	(2.2)
Others.	20	(9.3)	13	(23.2)	21	(12.4)	3	(6.4)

tions from payment more than non BI communities. Table 7, revealed that while 22.3% of respondents in the BI rural communities reported the availability of exemptions for payment, only 5.4% of the respondents in the non BI areas reported similar exemption facilities. A similar result was obtained from the urban areas. One of the functions of Village Development Committee was to determine the criteria for exemptions and ensure that the poorest in the communities were taken care of. Some communities appeared to be undertaking this function seriously.

Universal access was also ensured through payment in kind whereby those who cannot afford to pay for health care services were allowed to undertake some community services in exchange for receiving free treatment. Some of these services include gardening, farming, road repairs and other menial jobs. These methods are in most cases not different from the traditional methods by which the indigents in Nigerian communities are taken care of. Even before the introduction of PHC, Nigerian communities have traditional, long established mechanisms by which they ensure that the poorest in the community have access to social welfare. Apart from community funds (table 8) one of the recognized duties of village and district heads was to provide for the poor.

Consequently, the attempt to ensure universal access in health care delivery can only be successful if it understands existing traditional measures and integrated them into the health care policy. Given this consideration, information on the ways by which the various communities take care of the indigent was obtained. The responses show that individuals, especially the relatively affluent ones, community leaders and even health workers often provide assistance to the indigent in the community. These patterns of activities are often not officially reported. Indeed, as some respondents emphasized, the extent to which informal, traditional, primordial relationships ensure the success of government health programmes cannot readily be appreciated by those who are not directly involved in service provision. The fact that many of the patients are members of the community, known to health workers ensure that, to a reasonable extent, patients are rarely refused treatment, even if the health workers might have to contribute some money to pay for such treatment.

DISCUSSION AND CONCLUSION

The concern about inequity access to health care services remains a major challenge in health care delivery in developing nations. Overall health systems in Nigeria was ranked 187th among 191 member states by the WHO in 2000 (NSHDP, 2009). It has also been noted that health indices have been deteriorating by every health system evaluation carried out in Nigeria (Reid, 2008). The desire to ensure universal access to

health care services is a commendable aspect of the PHC (WHO, 1978) especially through the Bamako Initiative Programme. In places where such programme were launched, assessment study like this have a paramount importance for ascertaining programme potential and proper intervention. By design, Bamako initiative is modeled to empower communities to move towards more equitable and sustainable healthcare system. McPake *et al*., (1993) admonished that in the longer term, the Initiative should be used to support efforts to strengthen quality and improve accessibility at higher levels.

However, Reid (2008) expressed unsatisfactory concern that to date, Nigeria has never learnt or developed any system of authentic and full-scale community health care before Alma-ata or after it.

The present study showed no much difference in people's assessment of the cost of PHC. About 15.3% and 9.1% of respondents in the BI and non-BI rural areas respectively felt the cost was low. In the urban areas 19.6% and 6% of respondents in the BI and the non-BI areas considered the cost as being low. One reason for this is the relatively lower cost of drugs in BI areas. Such experience was reported in a study that documented result from the six-monthly monitoring sessions from approximately 400 health centres conducted from 1989 to 1993 (Soucat *et al.,* 1997) and compared the costs and revenue between regions and individual health centres revealed that in Benin, some centres recovered more than twice the local costs targeted for community financing. Twenty-five per cent of centres in Guinea did not manage to cover their designated local recurrent costs. In a process whereby there is disparity in cost of any product, it affects demand and hence affects the sales thereby fault the cost recovery.

Findings in this study indicate clearly that community empowerment through decentralization of decision making and community co-management should be given policy backing. In consequence, by harnessing local voices through community participation, experience and research evidence as it is in this study to public and private sector policy processes, it is possible to inform debates and shape better policies and institutions of health. The health Bill (2008) in Nigeria expressed that without prejudice to the prescription by the health Minister as indicated in the bill, all Nigerians shall be entitled to a guaranteed minimum package of services. This study noted a substantial population who were unable to pay for qualitative treatment and likewise noted that even where facilities to provide the service were made available, proximity was a challenge. The national health promotion policy (2006) observed that poverty is keeping more and more people in poor health, just as the poor health of an increasing number of Nigerians is retaining them in poverty. In many places evaluated, the structural arrangements to ensure that the poor also have quality health care are available. The various health development committees (HDC) were aware of this aspect of the programme. The health workers were also generally aware of this. It is however debatable the extent to which those who were targeted to benefit from such exemptions were aware of this facility. In spite of the difficulty in accurately determining whether the indigent are actually benefiting from the program the participatory approach in implementing the initiative at the community level could be taken up as a framework for designing and implementing future health programmes. The commitment of the social system in self maintenance and productive activity is important. The people's activities in the system must carry some intrinsic rewards, some instrumental or extrinsic rewards or some combination of the two (Katz and Kahn, 1966).

Those who provided information were either health workers or health service consumers who have actually gone to the health facility for treatment. Those who are really indigent may not even go to the health facilities at all. In this case, access cannot be accurately determined. What is required is for the Village Development Committees (VDC) to encourage all those who are ill in the community to visit the health facilities or health workers, after which decisions for exemptions can be made. There is also the need to educate the people on the criteria for exemptions from drug payment. By doing this, those who qualify for exemptions will know beforehand and can then confidently seek for health care.

In another dimension, the grassroots components of the PHC programme guarantees, to a certain extent, that the lowest cadres in the health delivery system, the VHW and the TBA, know those who are truly poor in the community. These stakeholders must be trained to encourage the indigent to receive adequate health care treatment. However, as earlier explained, existing traditional welfare structures provide avenues for taking care of the indigent. What is required at this stage is to integrate these traditional mechanisms adequately into health care delivery systems. The support of LGA budgetary director is indispensable here in order to factor in Bamako initiative programme. Fortunately, along the line as many communities have taken up the challenges; they only need to be adequately motivated and encouraged.

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