Zakaria Maiga, Fatoumata Traoré Nafo and Abdelwahed El Abassi
Health Sector Reform in Mali, 1989-1996

D/2003/0450/1
ISBN 90-76070-24-5
ISSN 1370-6462

At the time of publication Zakaria Maiga occupied the post of Secretary General at the Ministry of Health. Fatoumata Traoré Nafo was Director of PSPHR during the major party of the period covered by this work. She is actually working for the resident mission of the World Bank in Mali. Abdelwahed El Abassi was in charge of the health programme at the UNICEF Mali office. At the time of this publication he occupied the post of Regional Adviser Health/Nutrition at the UNICEF regional office in Abidjan.

The translation and editing of the English version was made possible with UNICEF support.
Health Sector Reform in Mali, 1989-1996

Zakaria Maiga, Fatoumata Traore Nafo and Abdelwahed El Abassi

Studies in Health Services Organisation & Policy, 20, 2003
Acknowledgements

The authors particularly wish to thank Prof. Wim Van Lerberghe for his help and encouragement at different stages of the work; Prof. Joseph Brunet Jailly for his substantial contribution; Mr. Ian Hopwood for his contributions and encouragement; and Mr. Hubert Balique for having stimulated the thought process. Thanks go also to the reading group established by Mr. Salif Coulibaly, Director of the Planning and Statistics Unit, Prof. Moussa Maiga, Technical Adviser to the Ministry of Health and Dr. Lanseni Konate, National Director of Public Health; to the entire public health team of the Institute of Tropical Medicine of Antwerp for creating a welcoming and stimulating environment that enabled the authors to undertake this work; and to Dr. Jean Louis Lamboray, Dr. Andre Stroobant, Prof. Harry Van Balen, Mr. Bassery Ballo, Dr. Guy Clarysse, Dr. Jean Luc Duponchel, and Dr. Pierre Blaise for improving the document through critical reading. Finally, the work owes much to the productivity and achievements of the staff at the regional, district, and central level. The authors hope that this publication conveys the magnitude of everyone’s contributions towards change and the success of the reform.
A new health policy for Mali

Limits of past experiences

Mali has frequently reoriented its health policy since independence. The first seminar for health and social workers (1964) led to a decennial plan for the period 1966-1976. The plan focused on modernizing, expanding, and improving the capacity of hospitals and medical centres, setting up village infirmaries, creating mobile prevention units, and eradicating major epidemics. The second and third national health seminars, held in 1978 and 1983, respectively, demonstrated the commitment of health professionals to identifying problems.

Following the example of other African countries, Mali pursued the recommendations of the Alma-Ata International Conference on Primary Health Care. At the beginning of the 1980s, the one-party State developed a national health policy based on the primary health care principles defined at Alma-Ata. However, the decennial plan for health development that resulted from it was never implemented. The support Mali received was selective [national programmes such as Maternal and Child Health (MCH), Expanded Programme of Immunization (EPI), leprosy, onchocerciasis, and so on], or limited and confined to certain geographical areas, with provisions differing from one locale to the other. The multilateral and bilateral aid agencies backed only specific projects. Here and there, the range and amount of this support helped to develop capacity and obtain results. But the gains were too project-dependent and had no significant or lasting impact on the health of the population, in particular that of women and children.

Efforts to involve the community focused mainly on promotion and use of health services. During the 1980s, a few participatory bodies were created (e.g., management committees and boards for district health centres, or DHCs) to manage revenue from cost-recovery financing. But the representatives on these participatory bodies were local and regional administrative staff, not people from the community.

Mali is a big country - 1.2 million sq. km - with a highly dispersed population. Inhabitants number roughly 9 million, of whom more than 7 million live in rural areas (Fig. 1). At the end of the 1980s, one out of eight children died before the age of one year, and one out of four before the age
of five. Maternal mortality was around 1,000 per 100,000 live births.¹

Health care was inaccessible, and varied greatly from region to region. Barely 30% of the population lived less than 15 km from a health centre. Service at those centres was poor owing to inadequate training and qualifications of personnel, uneven regional distribution, and lack of motivation. With drugs and equipment in short supply, little treatment was available apart from that covered by vertical programmes and projects. People relied largely on traditional healers.

Figure 1. Regions and districts of Mali

Health sector allocations revealed a growing gap between what was needed to keep services running well and the resources available from the State budget.² Yet households were spending significant amounts of money to

¹ UNICEF-Mali (1992) La situation des femmes et enfants au Mali. 50p. UNICEF.
purchase drugs from the dispensaries of the Pharmacie Populaire du Mali (PPM). That represented US$ 3 per inhabitant per year throughout the country, and US$ 20 per inhabitant per year in Bamako District.1

Management of services was centralized and hierarchical, transparency was generally lacking, and compartmentalization was the rule. The community was not involved in managing health services. Faced with the limitations and frequent failures of primary health care projects directed by Village Health Workers, many Malian managers had few illusions about their outcome and sustainability. Despite the amount of available resources, the limited results of vertical programmes such as EPI, Control of Diarrhoeal Diseases, and MCH were obvious. They raised doubts about the efficiency and relevance of specific interventions without a solid base to develop and sustain them.

**New opportunities**

From the 1980s, decentralized health planning and programming received strong support in certain regions (e.g., Koulikoro and Mopti), contributing to development of real management capability. However, provision of services and their relative weight was still basically determined at the central level, through vertical programmes. The substantial funds allocated to each of these programmes considerably reduced the impact of decentralized planning exercises.

At the 37th World Health Organization (WHO) regional meeting in 1987, African ministers of health made a commitment to implement the Bamako Initiative. This commitment served to motivate external partners as well as countries themselves to involve people in managing their health, and to promote essential generic drugs.

Pioneering projects in creating community health centres (ComHCs) were developed by the Health Development Project (HDP)4 in Kayes policy options in three countries (Costa-Rica, Jamaica, Mali), 45-92. Geneva: World Health Organization. (WHO/SHS/NHP/89.10).


4 A World Bank-supported project, predecessor of the Health, Population, and Rural Water project (HPRWP), which will be addressed further on.
Region and in Bamako District following careful consideration by the Ministry of Health regarding the respective roles of the State and the community.

Towards the end of the 1980s, several projects launched cost-recovery experiments designed to ensure the availability of essential generic drugs. These experiments showed that people were ready to pay for better-quality service. The payments significantly contributed to the good functioning of services provided, and often allowed recruitment of additional qualified staff. For example, Djenne District succeeded in financing 44% of its operating costs from its own revenue. Moreover, substantial effort was made within the framework of the HDP to organize care effectively in a health centre.

Starting from the premise that the principle of free care had had its day, these trials and initiatives highlighted the importance of the community in creating and managing health centres. The efforts were particularly significant considering that the country was undergoing structural adjustment.

In Mopti, the Regional Health Directorate succeeded in coordinating health development partners (Médecins du Monde, UNICEF, and the Deutsche Gesellschaft für Technische Zusammenarbeit) to put in place an essential drugs supply system with cost recovery. From 1987, a series of


8 Ministère de la Santé et des Affaires Sociales (1990) Système de gestion des services de
workshops and specialized studies built on past experience to prepare new national orientations for health programmes and projects being planned with the principal partners of the sector (World Bank, UNICEF, USAID, and the Coopération Française). These activities helped to develop a convergence of views among an about-to-be critical mass of national health professionals.

Under the direction of an ad hoc group comprising key officials from the Ministry, and with the participation of health professionals at all levels (nationals and expatriates working in Mali), the Bamako Initiative was finalized in August 1989. It integrates and formulates the principles of health sector organization and development. Decentralization (with a new definition of roles at each level) and genuine community responsibility for managing health centres (storage of drugs in particular) were accorded the same importance as availability of essential drugs.

A new national policy

Presentation of the Bamako Initiative to the Council of Ministers at the end of 1989 testified to the extent and political importance of the changes envisaged. It was in this context that formulation or reformulation of programmes among partners such as the World Bank, UNICEF, USAID, and the European Development Fund (EDF) could be coordinated, notably, during joint World Bank-UNICEF evaluation missions. Finally, through the Health, Population, and Rural Water Project, or HPRWP, the principle of cofinancing and complementary support was retained as the vehicle for motivating and implementing the new health sector policy. The term project did not reflect the scale of change. However, basically for legal reasons, the World Bank was constrained to use the term at the time.

This process led to framing of a national health policy—solemnly declared by the government—that went far beyond statements of intent and reaffirmation of principles. The policy was based on elements defined by...

the Bamako Initiative. The major steps needed to reorganize the health sector were spelled out, and the government obtained the commitment of its principal partners to help mobilize the resources required to implement it. The components of the national health policy are summarized in Fig. 2.

**Figure 2. Process leading to the new health sector policy in Mali**

**Ambitious objectives and new orientations**

Mali proposed to extend health coverage, while improving its quality and ensuring its viability. The health care system would consist of two levels: the first a network of ComHCs, and the second the DHC, which, though not a hospital, had the same function and technical services of a first referral level hospital. It was clear that most of the ComHCs would have to be created from scratch, and that existing dispensaries (the sub-district health centres, or SDHCs) would have to be transformed—“revitalized” in the terminology used.

At the first level, the availability, geographical accessibility, and affordability of essential generic drugs were critical to achieving objectives.
Community participation in managing and mobilizing resources for health was also considered basic to implementing the new health policy. Planning for coverage by the ComHCs would no longer be done in a top-down fashion, but would take into account the distribution, commitment, and motivation of the community. Once these principles were established, implementation could begin, in particular, extending coverage and strengthening technical services at the first referral level hospitals. The decision was made to start where the conditions for success seemed best. A series of eligibility criteria were defined for candidate districts to satisfy in order to receive support (Table 1). The grouping of the criteria was innovative. Each taken separately derived from the experiences or lessons learned from various projects.

Table 1. Selection criteria for eligible districts

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>The district health team should include at least two doctors.</td>
</tr>
<tr>
<td>2.</td>
<td>The district should develop a five-year health plan.</td>
</tr>
<tr>
<td>3.</td>
<td>The district should have implemented a functioning ComHC, proof of its technical wherewithal, and ability to promote the organization and responsibility of communities for their health.</td>
</tr>
<tr>
<td>4.</td>
<td>The communities must commit themselves to contributing financially and/or materially to at least 25% of the renovation or construction cost of the ComHC, the rest coming from the State.</td>
</tr>
<tr>
<td>5.</td>
<td>The Local Development Committee should commit itself to devote at least 7% of the regional and local development tax to the health sector.</td>
</tr>
<tr>
<td>6.</td>
<td>The Regional Health and Social Action Office helps the districts to meet these conditions.</td>
</tr>
</tbody>
</table>

The conditions had to be met as a package to avoid certain mistakes of the past. This innovation created anxiety among a number of staff who perceived it as a barrier to obtaining financing. Involvement of all levels of health organization was essential for such a programme to work. And the tasks of the different levels needed to be re-examined from the vantage of decentralization. From now on, the district would take care of planning, management, and execution, and the regional level would provide technical support and regional coordination. For their part, central services were limited to defining policy, strategic planning, and evaluation. But the onus was equally on them to mobilize resources and to ensure coordination of support from external partners.
Table 2. New functions by level

<table>
<thead>
<tr>
<th>Level</th>
<th>Structures</th>
<th>Function</th>
</tr>
</thead>
</table>
| National         | • Ministry of Health, central office  
                    • National hospital            | • Orientation and strategic planning, definition of standards and procedures, evaluation  
                                             • On-going training  
                                             • Specialized care |
| Regional         | • Regional office  
                    • Regional hospital            | • Technical support to the districts  
                                             • Second referral level care |
| District          | • DHC (first referral level hospital) | • Planning/administration management  
                                             • Referral care  
                                             • Supervision of the first level |
| Village group, urban areas | • ComHC or SDHC              | • Minimum package of health care services with community management |

**Principal participants**

**PARTICIPANTS WITHIN MALI**

For a variety of reasons (linked to commitment and international visibility), politicians maintained a favourable attitude during this process. In particular, they signified their support for a policy of decentralization and of responsibility and involvement of the community in the health sector. The Bamako Initiative and the government’s declaration were both formally adopted by the government in the Council of Ministers.

Health professionals at all levels of the Ministry of Health were involved and contributed at each stage, particularly through numerous working committees. Although enthusiastic, they sometimes had reservations about specific points related to their position or responsibilities. Apart from the issue of drugs—which was dominated by contradictions and emotions—the overall response was very positive. However, a certain scepticism was evident with regard to community participation,
decentralization, and integration of a few of the vertical programmes. Some of these had become veritable institutions, benefiting from significant political support. A failure to reorganize central structures to fit new tasks occasionally led to perpetuation of the existing system, to the detriment of change.

Certain communities (e.g., municipalities and local development committees) had amply demonstrated their commitment by constructing health centres and paying salaries for support staff. They often allocated more than 7% of their development tax to the health sector. The community already met 75% of health expenditures. The ComHC trials, and the cost-recovery system under way in certain localities, demonstrated people’s willingness to pay for quality services. However, apart from areas that supported organization projects, such as village associations or the Ton, management capacities were weak.

EXTERNAL PARTNERS

WHO supported the efforts of national health professionals during all the stages of the 1980s, in particular those aiming to decentralize and integrate programme management. WHO also supported vertical programmes, including those undertaken on a large scale at the end of the 1980s, for example, EPI and MCH. At the decisive stages its role was less visible, though that did not imply distancing.

UNICEF developed one of the largest support programmes for the health sector. It played a dynamic role at all stages of development, and amended the 1988-1992 cooperation programme to provide financing under the Bamako Initiative. UNICEF integrated and later encouraged the process of cofinancing the national programme with other partners and participated in a joint evaluation mission with the World Bank to launch a new national programme (the HPRWP) in May 1990. Technical assistance was offered to the regional offices. While support of the organization towards government efforts for defining a national policy was adequate, it should be noted that the intensity and vigour applied to reinforcing the EPI, a vertical programme in itself, was not in harmony with the problems and local priorities of the time.

Between 1984 and 1988, the World Bank-supported HDP, in Kayes Region, focused on three districts. The HDP approach had been that of a

---

two-level health system.\textsuperscript{13} This project consisted of national components covering the supply of essential drugs, training of staff, and particularly the review of basic training courses. The first ComHC trials were begun under this project.

Many of the staff from the Ministry were very critical of the Kayes Region HDP. Training for staff was positively perceived, but other national components never materialized, and the civil engineering component was too ambitious and seriously delayed. The fact that the project was directly managed by a central unit in place of the usual mechanisms (national and regional directorate) contributed to the negative perception. Renewal of the project and its planned expansion offered an opportunity for discussion and careful thought given to decentralization, community participation, financing, and cost sharing for health services. The World Bank expressed interest in supporting the government under a cofinancing arrangement for implementing a national health policy whose core elements feature in the Bamako Initiative.

USAID intervened in Primary Health Care projects, based on the Village Health Workers, and most often in support of non-governmental organizations (NGOs). It backed an MCH reorganization programme for Bamako District and Koulikoro Region, and certain specific programmes (Control of Diarrhoeal Diseases, Family Planning). USAID was in favour of setting up a large national programme cofinanced by principal donors, which took into account the health concerns of the community at the time.

The EDF provided support for two districts in the first region (Nioro and Diema). It appeared genuinely interested in cofinancing a national programme where each partner, while making its own contribution, could benefit from the experience of others for the global success of the programme. Support for referral services was among the EDF's priorities.

The Fonds d’Aide et de Coopération Française primarily intervened in the area of training for health professionals, hospitals, and research. It provided technical assistance to several departments in the Ministry of Health and also provided support in the domain of primary health care in Koulikoro Region and through NGOs. The Fonds played a significant role in financial aid and in the context of decentralized cooperation between Malian and French towns and provinces. Technical assistants and French

researchers were often involved in drafting new policy. Strictly speaking, however, the organization's commitment under the HPRWP was limited to combating iodine deficiency.

The Deutsche Gesellschaft für Technische Zusammenarbeit joined the process and expressed its interest to participate in cofinancing the programme as a continuation of its cooperative project in Mopti Region.14 Bilateral assistance from the Swiss and Dutch, in particular, was occasionally provided through participation of their technical assistants at workshops or in committees. They were not exactly associated with the coordination that led to commitment of principal partners under the HPRWP. Still, their cooperation lent significant support to a number of districts.

NGOs were not involved in the process at this stage, but their indirect contribution through innovations and lessons learned was significant (e.g., Medicus Mundi Belgique through the HDP, Médecins du Monde France through a cost-recovery project in Mopti Region, Belgian Médecins Sans Frontières through the Health Shop project of the regions of the north, and Santé Sud in Bamako District). Several Malian health professionals enriched their knowledge, developed expertise, and acquired experience through their involvement in these projects.

The declaration of the health sector policy was signed on 15 December 1990. The loan agreement between the government and the World Bank was signed five months later, on 3 May 1991. Activation of the loan was conditional on progress being made on the issue of drugs, on the creation of a favourable legal environment for implementing the project, and on the government signing grant agreements with the EDF, the KFW, and USAID. The loan was scheduled to start 26 March 1992. By this date, only the grant agreement with USAID had been signed. In the climate of political transition that characterized Mali following the events of March 1991, some partners were slow to fulfil their commitments.

In fact, rather than joint cofinancing, what actually transpired was parallel financing, each partner following its own specific procedures. Fig. 3 clearly illustrates the process to execution of commitments of external partners (a total of US$ 84 million). The occasional long delay between commitment, agreement, and release of funds was a major difficulty that threatened progress.

15 Some financing varied considerably, as was the case for the USAID contribution, which triple its planned contribution. The additional support was oriented towards family planning.
Achievements and problems


The new policy defined a framework with objectives and strategies that go well beyond professions of faith. This framework became an instrument for mobilizing and coordinating interventions in pursuit of a national ambition. The coherence and clear strategic choices evident in the declaration increased its credibility for donors. The commitment of a number of principal partners to cofinance the programme made implementation of the reforms a plausible goal. The decennial plan at the beginning of the 1980s did not benefit from such a commitment, and in fact, little of it was ever realized.

Genuine enthusiasm was discernible among most of the participants; it was evident that their motivation was equal to the challenges. The convergence of views among committed health staff eased the way to initiatives and concrete actions.

Questions regarding implementation still had to be settled (Table 3). The important issue of supply of essential drugs was controversial, and in particular, the steps needed for the PPM—a quasi-commercial public enterprise—to assume this task. Everything that concerned availability of essential generic drugs moved slowly. In contrast, transfer of the PPM’s distribution network to the private sector happened remarkably quickly. Measures needed to create the legal and regulatory environment for new orientations (e.g., decentralization and community participation) were not yet in place. The means for managing the transition from a programme-
based organization to the new policy had not yet been found. Given Mali’s tradition of compartmentalization, impenetrability, and rivalry, it was crucial to have a coordinated and concerted implementation mechanism among several partners.

Table 3. Achievements and new problems

<table>
<thead>
<tr>
<th>Achievements</th>
<th>Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Past experiences and exchanges have strongly influenced new orientations</td>
<td>✓ The problem of essential drugs remains</td>
</tr>
<tr>
<td>✓ The new policy constitutes a framework and a coordination and mobilization instrument</td>
<td>✓ The legal and statutory environment does not yet exist</td>
</tr>
<tr>
<td>✓ Credibility is reinforced by the coherence and clarity of strategic choices</td>
<td>✓ The transition between decentralized and integrated management and vertical management of programmes has not been clarified</td>
</tr>
<tr>
<td>✓ Commitment of principal partners for implementation</td>
<td>✓ Insufficient coordinating experience of several partners</td>
</tr>
<tr>
<td>✓ Motivation and convergence of views in relation to a group of participants</td>
<td></td>
</tr>
</tbody>
</table>
1990-1992: towards a strategy for change

Mobilizing under unfavourable conditions

Political instability in the country prevented dissemination of the new health sector policy at the time desired, and it ended up being treated as just another new project. The entire vision for health system reform became marginalized. The practical implications for scheduling activities and implementing them in each region, and for the partners who supported the plan, were not clear, and were apt to vary according to the negotiator at the central level. The persistent disorder explains the lessened interest of some bilateral partners and NGOs. For its part, the community was not informed of the opportunities that the new policy offered, or the responsibilities it entailed.

ELIGIBILITY REQUIREMENTS FOR THE DISTRICTS

Some of the regional districts needed to meet the eligibility criteria given in Table 1 to receive support for programmes. The first priority was to prepare district social-health development plans and establish the first ComHC. Because the financing anticipated under the HPRWP did not take into account the preparatory stages, funds had to be sought from programmes already under way or those nearing completion. Yet programme managers (national or partners) were seldom inclined to adjust their support. The situation of blockage thus created was very frustrating for national managers, particularly because actual conditions were far removed from the criteria detailed in Table 1.

A district team with at least two doctors. The State was committed to endowing all the districts with the required personnel, but very few of the districts had two doctors available. The structural adjustment programme, together with the end of recruitment for public service, did not improve the situation. Only much later, following the devaluation of the FCFA in January 1994, did the government authorize recruitment to compensate for the shortage of personnel in the districts. Redeployment of existing personnel to poorly served districts had limited impact.

A plan for extending coverage. The method used to prepare plans had no provision for extending coverage. It was naturally oriented towards programming and budgeting available resources for national programmes,
rather than planning for district health development. A few regions were farther along in the detailed preparation and finalization of district health development plans, but these regions were not included in the programme (Sikasso), or were only included in the second phase (Ségou). In contrast, Kayes Region, which had no decentralized programming experience, became part of the first phase.

At least one functioning ComHC. The criteria for the ComHC test, which were supposed to be satisfied six months after inception, appear to have been difficult for many of the staff to fulfil in such a short time. The region that did manage to put some ComHCs in place (Kayes) did not have a detailed district health development plan, and it is not clear how well these ComHCs worked. Indeed, once these test cases were launched under the HDP, they were no longer supervised. The long and poorly organized transition between the HDP of Kayes Region and HPRWP unfortunately did not take this factor into account.

Seven per cent regional and local development tax. A major part of the local tax was allocated to health. This allocation was mainly used by the local development committee to reimburse salaries of matrons and auxiliary nurses. Tax recovery nevertheless varied from one region to another, and following the major political events of March 1991, it collapsed in all the regions. Only with the advent of the Third Republic in 1993 did it significantly improve.

Regional support. The regions were assigned a key role in decentralization and in developing a health system based on the principles of the health district. Close to the operational level, the region provided support to the district health teams. Implementation and transformation tools, however, were neither developed nor adapted. This was the case for the Health Information System (HIS) and in particular for the local information system, training methods and modules, standards and procedures, and methods and approaches to involve communities. All these tools still needed to be developed or finalized. In a country where distances are great and communication difficult, the regional level is essential in leading change in the health system. Not all the regional offices had the desired management potential and experience. Under the programme, the support capacities of the regions were reinforced by providing them with

---

17 Community investment in and management of the centre, MPS, coverage, and balanced operating accounts.
technical assistants who were experienced in primary health care management and district health systems. These advisers did not have any direct responsibility for managing financial resources. They had to use their experience to support the regional and district teams in implementing initial tasks. That meant training for all (local, district, and regional levels), and helping to bolster implementation.

**NEW ROLES FOR PARTICIPANTS AT THE CENTRAL LEVEL**

The new roles and responsibilities for the different levels were designed to overcome the obstacles of inadequate organization and central functioning. These roles were strongly influenced by the compartmentalized and direct management of programmes. For many participants, notably at the central level, the new policy was dismissed as an additional large project that would gradually assume its place among others already under way. They did not see it as a tool for organizing and decentralizing health development. Indeed, a decree assigned management of the Technical Committee to the director of HPRWP, instead and in place of the National Health and Social Action Department. This move reinforced the tendency of the latter to treat the new national health policy as just another project.

The lack of “ownership” of this project generated all the more problems because the health organization model was new throughout Mali; it had not been implemented anywhere. Existing milestones were either partial implementations in a few locales or similar models developed in other countries.18 It was still an idea awaiting concrete application: making it work could only happen in the field, by establishing ComHCs and the district health development plan.

---

An explicit implementation strategy

In 1991, a first step towards change was taken by redefining the ComHC.19 Ways of setting it up and its function were clarified, as well as the relationship of the ComHC with the State. Prepared by an ad hoc group comprising staff from the Ministry, architects of previous projects, and resource persons, the document was widely discussed by other institutions and authorities. It was adopted by consensus and contained major innovations: (i) the ComHC would be free to define its area of responsibility; (ii) the relationship with the State was to be a partnership based on a formal agreement; and (iii) the community association that managed the ComHC needed to be recognized legally.

The strategy was favourably received by politicians. It allowed planning for extension of health coverage in an original way, the administrative division becoming a factor to take into account and not a non-negotiable constraint.

The initial challenge was to translate the principles and orientations of the new health sector policy into coherent actions. And that was fraught with difficulty. Because the tasks of implementation were many and large, it was necessary to organize and to prioritize them to achieve steady, systematic progress. The participants had neither referral experience nor tools adapted to transform the status quo. In the two years following the events of 1991, the political climate of Mali was marked by successive changes at the head of the Ministry of Health and of heads of central departments (four ministers and four national directors of health in less than two years).

In contrast, the regions were encouraged to take initiatives. At the same time, they benefited from strengthening of their technical support capacities, allowing room for experience and innovation in the field. These advantages would prove useful during the following stages, when conditions for pressing ahead were more favourable.

Implementation turned out to be more the product of extensive dialogue than a deliberate move at the central level. Of course, some participants had broad visions and suggested steps to take; the problem was

making all the right decisions at the right time. The gap that existed between goals and actual experience prevented central management from rapidly formulating operational strategies.

Despite the many changes at the head of the Ministry and the fact that the health sector declaration was made under a previous government, the policy was ratified by each new Minister. But owing to the laggardly pace and emotional tenor of the debate over essential drugs, reconfirmation of the new policy was hesitant at first. Only on 8 June 1992, with the inauguration of the government of the Third Republic, did instabilities subside. The Minister named at this time was still in his post in 1997.

ORGANIZING REGIONAL SUPPORT

Implementing the new health policy in the regions was predicated on the districts fulfilling eligibility criteria so they could obtain support for extending coverage and backup of the referral level. That required the districts to develop their plans, create a ComHC test, and negotiate mutual commitments with partners. It also required the Ministry of Health to complete the social-health team right up to actual minimum requirements (Table 1).

To avoid dissipating central support and to rapidly learn from useful lessons for the benefit of other regions, the decision was made to work in phases. In principle, three regions were involved in a first phase (Kayes, Mopti, and Bamako); two others (Ségou and Koulikoro) were to follow two years later. However, all the regions needed to provide support to the districts to meet eligibility criteria.

Financing these preliminary stages posed a problem: even Kayes, the region of the previous World Bank project, was not able to mobilize the necessary resources at this stage. And as noted earlier, HPRWP only took into account financing for implementation. The problem was resolved with the assistance of flexible financing from UNICEF.

Among the three regions of the first phase, two (Kayes and Mopti) presented serious problems of isolation and human resources. In actual practice, the region of Koulikoro—where technical assistance was available only from March 1993—fulfilled the eligibility criteria a little later than the

---

others. The initial progress and experience of the early regions was an advantage to the ones following. The latter all the more rapidly caught on to the progress of their predecessors because they had fewer problems of human resources availability and field conditions were less difficult for them. There as a definite gap between good ideas (disseminated in stages to the regions) and the means and conditions to realize them. This observation highlighted the inadequacy of accompanying measures permitting the designated regions to achieve the desired objectives for the first phase.

The development of regional support strategies for the district generated a major debate: Should a district develop and test methods and then capitalize on the ones that worked by extending them to other districts? Or was it preferable to organize simultaneous support for all the districts in a way that gave each a real opportunity to meet eligibility conditions?

Funds budgeted under HPRWP corresponded to control of 21 districts or communes out of 35, which included the 5 regions covered by the programme. Normally, external partners negotiated their choice of intervention zone at the central level. Now, the regions needed to intervene themselves. The districts not yet involved continued to benefit from regular support from national programmes (EPI, Control of Diarrhoeal Diseases, leprosy, tuberculosis, and so on), thus enabling channels of multiple central support to coexist in the same region. The limitation of financing to 21 districts nevertheless gave the impression that the districts not chosen were to be excluded from the support. That gave a political dimension to the choice of priorities that was difficult for the national managers.

On another level, the support capacities of the Regional Directorates remained limited despite the reinforcement provided under the programme. Expanding support to regional teams with little working experience of tools and methods meant documents and instructions were being distributed without really involving participants at the operational level. That heightened the possibility of errors and deadlocks in all the districts, and it had consequences for collaboration between the regions and districts, and between the latter and their partners.

So a compromise had to be found. First off, a “transfer of methodology” would be needed. Preparation of district health development
plans started with a discussion of eligibility requirements among all the districts, with support from the central level in the form of a 10-day workshop. Thereafter, the region anticipated a schedule of support that depended on the district’s initiative and was determined by progress in developing the plan (description of the situation, stage of situational analysis and prioritization of needs, health map, and so on). Finally, the region had the authority to orient support towards the most dynamic district, thus enabling it to reach the different stages needed to become eligible.

With this last possibility, each region was able to advance and to develop its own experience in relation to an enterprising district team. These were the teams that first developed five-year health development plans with maps for extending coverage, planned and launched ComHCs with all the needed inputs, and conducted initial training of personnel and the management committee. After each of these initial achievements, the regional support teams used, adapted, developed, and appropriated the tools and methods, thus acquiring a capacity they did not possess before their initial field experience. Support to the other districts thus became less hesitant, and more concrete and effective. Apart from misfortunes (notably the deaths of the two most energetic chief doctors), the strategy advanced in each region with support focused on one district and support for the other districts modulated by the local initiative and the availability of regional support.

These initial experiences made clear the limits and, similarly, the impossibility of intensive and simultaneous support to all the districts. Many districts that had benefited from the transfer of methodology workshop still encountered considerable delays.22 Adaptation by district health development participants of the new health policy, tools, and methods was incompatible with indiscriminate distribution of regional support.

Kayes: Direction Régionale de la Santé.

Complementary field support was necessary to translate the proposed innovations into reality.

**THE HEALTH MAP: A NEGOTIATING TOOL**

A district in Mali has on average between 150,000 and 200,000 inhabitants, spread over 200-300 villages. It is composed of 4-6 sub-districts with each sub-district including 3-5 development zones. Many development zones had maternities or dispensaries managed by matrons or auxiliary nurses, locally financed by the population or the local development committee. Each sub-district had a health centre (the SDHC) belonging to the state care system and run by a nurse (Fig. 4). Each district had a DHC, generally equipped with a surgical block and with at least one vehicle solely for the field. The DHC was run by a doctor, often assisted by an associate. Other technicians completed the team: midwife, nursing personnel, sanitary engineer for environmental health activities, and a community development engineer for social activities.

*Figure 4. Administrative map of the district of Koulikoro: the sub-districts and their SDHCs*

This existing administrative division (sub-district) often did not meet the technical and financial criteria for ensuring the viability and the quality of services at the SDHC level. For these reasons, the administrative division was not considered to be the absolute standard in developing maps for
extending coverage. Initially, each district team disregarded administrative limits and proceeded to partition the entire district into health areas on the basis of geography, population, sociology, and economics. Each area included a number of villages likely to participate and become organized enough to create and run a health centre. The outcome of this initial phase was called “the theoretical coverage map for the district” (Fig. 5).

Figure 5. The theoretical coverage map for the district of Koulikoro, 20 June 1993; drawn from data gathered at the different levels (local administration, SDHC, DHC, Ministry of Health, and so on)

The initial version of the health map was already very different from the administrative map. It was submitted to the district local managers (e.g., administrative, political, and chiefs of villages), and became a planning and negotiating tool for all the district partners, and in particular for the community, which contributed to the final draft. Numerous interactions within the villages and intervillage consultations—sometimes lasting several
months—were necessary to produce a community health association (ComHA) and to launch a ComHC in a health area.

This process made it possible to modify the initial theoretical map. It was progressively improved through negotiations and changes of health areas in operational regions. For example, the health map of Koulikouro included some villages in neighbouring districts, and a good number of villages "changed areas" in the course of negotiations (Fig. 6). The map became an indispensable planning instrument, increasing the role of the district team in relation to partners.23

Figure 6. The health map of Koulikoro, after negotiation with the community in the theoretical region of Chola, October 1995

Partitioning the districts all at once was preferred over doing it gradually. That made it possible to have a view, albeit theoretical, of the global coverage of

the district, and to assess what human resources and materials were needed. It was also the only way to determine the impact of each health centre initiative on the neighbouring areas. Because each village necessarily belonged to one health area, it clearly defined the burden of responsibility for each existing or proposed health centre.

At first, this approach met with some resistance, which centred on the following questions: Why should the district team produce an overall map? Does this not just duplicate administrative thinking? Why talk of areas of responsibility and not of attraction sites or ranges of easy accessibility? Why risk viability by reducing the size of the urban population from 40,000 inhabitants to around 15,000 inhabitants? Isn’t there some way to establish the desired relationship between users and auxiliary nursing staff in urban areas without incurring this risk?

Opposition came from different sides: technical assistants of bilateral projects, chief doctors of Bamako ComHC, and NGOs, which had health centres or maternity hospitals in their intervention areas. The debate was complicated because many of the participants were critical of the State delegating responsibilities to a ComHA in each area of responsibility. The private medical network is underdeveloped in Mali: it is limited to Bamako and to certain big towns. In the Malian context, and particularly in the rural setting, the for-profit private sector developed very slowly and initially in cost-effective areas. Thus, it does not pose a credible alternative for health coverage for the near future. Insofar as its purpose was lucrative, it fell outside the contractual framework on which coverage plans were based. Nevertheless, some confusion arose between private-for-profit initiatives and contractual delegation to a ComHA.

Incertitudes notwithstanding, Table 4 illustrates the pragmatism and the concern for equity that characterized the approach.

While the health sector experience serves as an example for implementing the government’s decentralization policy, it is worth noting that uncertainty will continue to characterize planning of future rural communes. The criteria for administrative division are not necessarily the same as those used by the health sector.

24 The private pharmaceutical network has grown spectacularly, from several outlets to more than a hundred in less than two years. Although recent, the private pharmaceutical sector is organized into professional associations with very active interests. These associations always been involved in the driving process of health sector policy.
Will the rural communes ratify the negotiated division of the health map? Can they allow for one to three health areas without having to redraw the map? What will happen to the relationship between the communes and the ComHA if basic services devolve to the communes? These questions no longer depend only on the health sector. What has been achieved up to this point could still undergo major changes. Information gleaned in forming rural communes often seems to reinforce efforts made by the health sector. In a very few cases we will face a real problem. Concerning the relationship between the communes and the ComHA, one can imagine that in the future, ComHA will assume more the role of an association of commune partner users.

Table 4. Advantages and disadvantages of criteria used for the health map

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Inclusivity</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inclusivity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Allows formulation of plausible hypotheses about district health coverage for the medium and long term.</td>
<td>• The need to plan and budget improvements may create combined pressure to proceed much more quickly everywhere, despite insufficient support capacities and other unmet conditions.</td>
<td></td>
</tr>
<tr>
<td>• Replaces the isolated initiative of the health care establishment with a global context of district coverage, promoting rational decision making.</td>
<td>• Conflicts with participants—e.g., NGOs—who wish to target support to a particular village.</td>
<td></td>
</tr>
<tr>
<td>• Gives the district team the responsibility for negotiating with those who wish to support district health coverage.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Defined area of responsibility | | |
|• The ComHC has responsibility for the health of the community for all the villages comprising the health area—a different approach from simply responding to demands presented to the health centre. | • Involves additional operating costs and opportunity costs through itinerant activities for the villages far from the health centre | |
| • Local costs are transparent and controlled by the community. | • Invites criticism from (i) indiscriminate advocates of a market economy approach for health services in developing countries and (ii) those who contest responsibility at this level for | |
| • Focuses on a common tool for villages | | |

Guarantees a minimum package of services to the community of the area so long as the ComHC is financially sound and bound by agreement. Preventive care activities and favor their total subsidy by the State.

Strengthens a sense of “ownership” and, for village participants, of having a role in shaping the health area. Time-consuming

Agreement is often not unanimous

Villages may refuse to stick to the health map, or having signed on to it, may decide to withdraw

The actual map and its implementation (ComHC) evolves slowly owing to the fact that reciprocal commitments of partners (community and government) depend on the results of negotiations. The process makes the gains robust, and helps to anchor them. Negotiations can drag on.

Instability can threaten the plan’s viability if defecting villages find alternative solutions too quickly.

Modifications should cease with implementation to provide opportunity and time to expand the agreement to non-participating villages.

THE MPS

The situational analyses of the first districts to develop plans all focused beyond the diversity of their situations towards a unified structure for a curative, preventive, and promotional “package of health services”. Apart from the burdens and priorities attributed to each problem in a given area, the similarities were striking, even when the teams carrying out the exercise were different. The similarity was sufficient to define a minimum package of health care services (MPS): this definition had important consequences for planning and programming in all health areas (nature and importance of equipment, initial provision of drugs, training, support for management, structure of the premises, personnel needs, and so on).
Table 5. Components of the MPS

Curative activities: Control of current infections, including acute respiratory infections, diarrhoea, malaria, current sexually transmitted diseases (STDs), referral of serious cases, and prescriptions for essential generic drugs

Follow-up and early detection of some chronic illnesses: Leprosy, tuberculosis

Preventive activities: Vaccination of children and pregnant women; nutritional follow-up of children; prenatal and postnatal follow-up for pregnant women; assisted childbirth, and referral of at-risk deliveries and evacuation of complicated deliveries; family planning

Laboratory samples: Urine tests, sampling and fixing of sputum (tuberculosis) on slides, and other simple tests

Promotional activities: Environmental hygiene and sanitation, promotion of positive nutritional behaviour for mother and child, health education activities, supportive activities for community development

Itinerant activities in health area villages: Vaccination, nutritional follow-up, promotion and strengthening of relationships with the local network

Management activities: Management of the essential drugs depot, monitoring and control of elements of the local information system (management control data and use of the service by the village), epidemiological surveillance, schedule management, health centre account data management, minutes of ComHA meetings, production and transfer of the quarterly report to the DHC

Defining the components of the MPS was a major objective for the National Health Directorate, making it possible to seriously envisage integrating and decentralizing national programme activities. While the principle itself posed no problem, it took innumerable meetings and (sometimes) heated exchanges before the components were formally made part of the MPS. The debate concerned the following questions: Is it necessary to make a list? Why not include the components among the activities that could follow from the responsibilities and fields of consideration of managers at the central level? Is such a clearly defined MPS limiting, restricting, or indicative? Why not make two types of MPSs, one for the ComHCs managed by doctors, and one for the ComHCs managed by nurses? Why not distinguish the services that the ComHCs will perform anyway (curative care) from those linked to State contracts that provide reimbursement based on performance (vaccination or other preventive and promotional activities)?

The debate generated by these questions revealed contradictory concerns. The central managers wished to see the “magnificent tool” that was to be the ComHC carry out all the responsibilities of the Ministry of
Health (to such an extent that some versions strongly resembled the organizational chart of the Ministry of Health in miniature). Another point of discussion emphasized that curative activities are unavoidable but profitable. It would be preferable for the government pay for profitable preventive activities and for those considered not much in demand by the community.

While the first proposition risked sinking the “ComHC boat” with inappropriate overload, the second threatened the integration and globality of services, and linked essential activities to specific financing that often depended on outside aid.

The position that formed the basis of agreement—generally supported though not unanimous—presented the MPS as a global offer of integrated curative, preventive, and promotional care, taking into account all health problems for which the centre is able to propose solutions. There was no question of subordinating basic activities (considered opportunity cost in for-profit logic) to specific financing in order not to harm the integration and the totality of care. Table 6 compares the global approach with a specific contract approach. It is not just that specific contracts had drawbacks. The choice made in Mali supported an integrated MPS service and a universally reinforced community health network. The mechanisms required to manage a large number of specific contracts between the ComHC and the funding programmes would have been both complex and difficult to control.26

---

Table 6. The alternatives: global convention or specific contracts for each vertical programme

<table>
<thead>
<tr>
<th></th>
<th>Global convention</th>
<th>Specific contracts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to care coverage</td>
<td>Balanced for the MPS</td>
<td>Improvement for the specific activity of the contract</td>
</tr>
<tr>
<td></td>
<td>Lasting progress</td>
<td>Specific results more rapid, but not lasting</td>
</tr>
<tr>
<td></td>
<td>Specific performance may</td>
<td></td>
</tr>
<tr>
<td></td>
<td>be modest</td>
<td></td>
</tr>
<tr>
<td>MPS</td>
<td>Complete at the beginning</td>
<td>Incomplete if activities not covered by a contract</td>
</tr>
<tr>
<td>Quality of care</td>
<td>Favours global responsibility</td>
<td>Favours programme performance but lacks integration</td>
</tr>
<tr>
<td><strong>Development</strong></td>
<td>The community and its needs constitute the reference frame</td>
<td>Reference to programmes and their technicians becomes predominate</td>
</tr>
<tr>
<td></td>
<td>Partner</td>
<td>Programme target</td>
</tr>
<tr>
<td></td>
<td>The stakes are clear:</td>
<td>Threatened because linked to the successful execution of contracts</td>
</tr>
<tr>
<td></td>
<td>survival of the ComHC</td>
<td></td>
</tr>
<tr>
<td><strong>Continuity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Motivation of personnel</td>
<td>Through responsibility for the ComHC and the whole community</td>
<td>Double financing always possible owing to lack of transparency and isolated management reinforced by the perceived advantages a contract brings</td>
</tr>
<tr>
<td></td>
<td>Sense of ownership of the ComHC as a working tool</td>
<td>Possibility of undesired effects with anomalous results if remuneration is based on performance without local control</td>
</tr>
<tr>
<td></td>
<td>Premiums possible for performance and global quality of services</td>
<td></td>
</tr>
</tbody>
</table>
THE ISSUE OF ESSENTIAL DRUGS

From its creation in 1962, and until 1983, the PPM was responsible for importing and distributing drugs to the public. The hospital sector and public services network were supplied by the central pharmacy of the National Health Directorate. The private sector was confined to a single pharmaceutical dispensary in Bamako.

In 1984, following pharmaceutical reform, the PPM appointed itself to import and distribute drugs to hospitals and public services, effectively establishing a monopoly.

In 1985 and 1986, laws liberalizing the health professions and pharmaceuticals raised questions about this monopoly. But in 1987, the PPM moved in the opposite direction, signing a comanagement agreement with China that formalized the monopoly. The question came up again in agreements governing the structural adjustment of public enterprises. These agreements, concluded with the Bretton Woods Institutions, called for the PPM to be restructured and to cease from distributing drugs in favour of the private sector before December 1989. Negotiations with the World Bank to implement the new health sector policy put an end to the PPM monopoly, though it was still accorded a major role in importing and distributing essential drugs. The decision undercut a part of the Bamako Initiative conceptual framework defined in August 1989: the PPM had been expected to import and distribute essential drugs to the benefit of public and community structures.27

In other words, the PPM’s contract with the government required it to import and distribute essential generic drugs.28 Signing the contract was a condition of the World Bank loan. But now the PPM had to reduce the number of its personnel from 650 to 200, give up nearly all of its dispensaries to the private sector, stop importing brand-name specialty drugs in place of essential generic drugs, and compete with new private importers of drugs (rapidly put in place with credit assistance from French drug exporters). The PPM retained its commercial nature but lost all its

---

major assets (monopoly and distribution network) and was faced with the delicate business of negotiating a drastic reduction in workforce.

As a matter of fact, apart from essential drugs ordered under the framework of the IDA loan of 1986-87, the PPM never imported essential generic drugs for the public sector. It always favoured importation of “essential” brand-name drugs, equivalent to those on the official list of essential generic drugs. During this period generic drugs were available in Mali only in some zones where health cooperation projects benefited from a special exemption.

The availability of essential drugs was a major factor in health reform: it determined the quality of services and the credibility of health structures at all levels, and it was crucial in improving the financial accessibility of communities to care. The obstacles encountered added to the confusion over how the issue of drugs should be handled. Although the PPM no longer had a monopoly, it remained the privileged supply channel. Yet it failed to demonstrate either its effectiveness or its competitiveness, and it became evident that alternative strategies were necessary for importing the needed drugs.

Many national managers and partners did look for alternative solutions. They pursued and developed mechanisms already in place for certain projects to assure the supply of essential generic drugs (e.g., Ségou, Koulikoro, and regions of the North). The idea was to preserve functioning networks so long as the favoured (official) alternative had not proved its effectiveness or competitiveness. But managers and partners also seized the opportunity offered by liberalization of importation of essential drugs. It was in this context that the economic interest group Health for All was created, through the initiative of ComHAs of Bamako and with the support of numerous partners, in particular, the Coopération Française and UNICEF.29

These strategies were critical to maintain the momentum of regional and district managers, who were tired of losing face with the community by making promises that would not be kept. After the initial grants for the new ComHC (guaranteed especially by UNICEF at the start) were used up, resupplying was to be done within the framework of strategies cited above without creating new provisional networks.

---

The new strategies were developed with the cooperation of all the managers involved in implementing the new policy, and without opposition from politicians. PPM managers would have preferred less tolerance of projects that used alternative importation channels, but over and again it was demonstrated that at the regional level, the service given by the PPM was unsatisfactory both in terms of supply and price.

The path was undeniably fraught with difficulty, and would remain so as long as commercial thinking dominated a beleaguered enterprise in a market far from being saturated. Much later (at the end of the contract, when it was clear how hard it had been to carry out), the PPM was offered the chance to separate the accounting and supply functions of its role in providing essential drugs.

The growing number of private pharmacists contributed to formation of a pressure group opposed to implementing the essential drugs policy. As a matter of fact, and independent of what the various parties intended, the “pharmaceutical reform” ordeal served to bolster the commercial and private mentality prior to devaluation of the FCFA. The solution to the availability of essential drugs remained precariously “do-it yourself”.

UNITARY PROGRAMMING BY HEALTH AREA

The health sector policy anticipated improvement in quality of care with extension of coverage, a network of first referral level health centres, upgrading of the referral level, and building a capable district health team.

Support for the district health development plan played an integral part in implementing these strategies. But it was hard to steer clear of the traditional financing components of vertical programmes that staff were familiar with from previous regional programming exercises. The danger lay in having an approach emerge that would separate the content of the MPS (keeping its vertical technical and financial structure) from development and community management of services. For a large-scale national programme in favour of decentralization, such an approach would have harmed the unity, globality, and efficacy of implementation.

Considering all the interventions leading to transformation of a health area into a ComHC as a monolithic programme helped in reducing this risk. Doing that, however, required fulfilling the conditions listed in Table 7.
Table 7. Conditions required for unitary programming by health area

1. The health map is developed.
2. The MPS is defined and adopted in the context of the district.
3. The following inputs are feasible:
   • Process leading to the creation of the ComHA
   • Rehabilitation or construction of infrastructure
   • Standard equipment for the health centre and estimated depreciation
   • Initial provision of drugs and vaccines and estimate of annual consumption
   • Training of personnel and of the management committee
   • Supervision of start-up and of on-going training
   • Resources to cover salary costs and current operation
4. A broad outline is made of cost-sharing investment and functioning between the different partners in health development.

Each unit took into account the logical sequence of all the activities involved in transforming an entire functional health area, maintaining it (e.g., supervision and support for operations), and estimating costs. Costs were split into investment costs and operating costs. Under each section, the source of financing was specified as deriving from cost-sharing with the State, external partners, or the community (e.g., own revenue from the centre, contributions, and local taxes). A schedule for implementation was proposed according to the stage of negotiations and support capacity, to allow timely planning and programming of resource needs. One of the benefits of this approach was that apart from the traditional unit costs (e.g., infrastructure, equipment, and initial seed monies), all of the activities and inputs required to transform an area (creating a ComHC, revitalizing a health centre) were considered together. It would not be possible, for example, to consider isolated training in maternal health or for vaccination, nor community approaches without taking into account the material, technical, and financial support for the other parts of the transformation. Thus it was possible to avoid bottlenecks through lack of coordination and waste resulting from inappropriate implementation.

Of course, resources had to be available at the operational level according to the provisional planning, with effective decentralization of their management. The central level (all programmes intermingled) would mobilize resources so that the operational level (with the support of the region) could undertake the transformations.
That may appear simple and obvious, in conformity with the new roles of each level. In reality, it was totally different from the way the central level usually operated. Indeed, besides the partitioning that characterized its administration, the central level naturally was more concerned with its own priorities and position than coordinating with other programmes and levels. The development of the Mali-UNICEF health cooperation programme from 1993 to 1997 was the first opportunity for national managers to familiarize themselves with the new method.30

Points for discussion about the new programming approach were the following: How can vertical programmes that contribute to the MPS evolve, especially since changes in the practical organization of their activity is not foreseen and the new health policy would take a long time to cover the whole country? Should it refuse financing that is not within the scope of the arrangement and priorities of the plan? Is it at liberty not to take national programme priorities into account or to carry out the activities associated with them (training and seminars, supervision)?

The questions affirmed the need for negotiations to strengthen the coherence of central level interventions. It was obvious that for social and political reasons, no one would try and stop the flow of support flowing to the regions under the programmes, particularly since effective implementation was only in its infancy.31 Thus it was almost inevitable that old and new would coexist somewhat uncomfortably.

The new policy advocated decentralization, integration, and making the community more responsible. That would take time, and required promoting clear and positive transitions—certainly not an easy thing.

Central level managers were often very favourable to change: these included planners, central services officers, and regional directors. Others were indifferent or hesitant: vertical programme officers and some chief doctors. But the structuring and programming of stages became widespread without explicit objections. Validation of the change had to await experience with the initial district plans and installation of the first

ComHCs. It was an example where actual use built confidence in the methods without clearly resolving the underlying problems (evolution and transition in the management of certain vertical programmes), which became increasingly apparent.

A TRAINING STRATEGY

Between 1989 and 1992 the Family Health Division introduced new training strategies, under a programme that reorganized services for MCH activities. The reorganization proceeded from health centre to health centre with on-the-spot facilitators, in a process that led to the desired change. The limitation of this intervention was that it only concerned MCH, even though the health centres had other needs (e.g., essential drugs, effective curative care, financial and material management, and community participation). Training could not be offered by the specialized service of the central level but required staff or a team in the field with more flexible responsibility and abilities.

Whatever its shortcomings, the programme proved the basic utility of on-site training. In the interest of continuation, the staff conducting the training were those in charge of supervising the centre. The district team, including the chief doctor, became indispensable for the training activities associated with the ComHC. The region provided support to the district teams to initiate the process and to develop expertise. They also specified suitable standards and procedures, developed training modules, strengthened regional managers' teaching skills, and evaluated the results of training.

The HPRWP Interinstitutional Group for Training, originally traditional in its approach to training trainers, saw its role evolve in the context of these new responsibilities. A problem to resolve was how to tailor the training programme to the first ComHCs. It was also important to adapt or create the appropriate medium (e.g., integrated questionnaire for mother and child follow-up, schedule, outline for microplan development,

---

managerial instrument tools for follow-up and evaluation of activities, and so on).

In the interest of common sense, it was decided that the duration of initial training should not exceed one month, to avoid interfering with plans for extending coverage. A preliminary list of training fellows was inspired by Guinean\textsuperscript{33} and Tunisian\textsuperscript{34} experiences. In addition to organizing effective curative care and major prevention activities, and prescribing essential drugs, training emphasized

- healthy infant care as an integrated activity in itself (nutritional follow-up, vaccination, breastfeeding promotion, vitamin A supplementation, child spacing and promotion of family planning)
- using operational questionnaires to support training and for developing instructions for principal activities
- organizing and managing the human, material, and financial resources of the centre
- microplanning activities, in particular, itinerant activities in the villages and developing and interpreting management control data and monthly reports.

Taking into account the insufficiency or inadaptability of some of the modules and tools from vertical programmes, the National Health Office gave the green light for the regions to test new formulas in the ComHCs. This freedom was helpful in implementing the initial ComHCs. Regional and district staff felt they had a stake in the tools they produced and the modules they adapted. Ultimately, experiences could be exchanged in a way that allowed the central level to exercise its role as harmonizer. The autonomy carried two risks: first, centrifugal tendencies—the variability among regions was troubling to a centre uncertain of its new role; second, the loss of time and money, leading to the frequent reinvention of the wheel. The question was one of optimizing the price to pay for staff commitment and sense of investment in the programme.

Practical training was the principal method used in building ComHC teams. It began with developing the plan and continued up to supervising the first centre. Strengthened regional office technical support capacities, support and enthusiasm at the central level, and increased exchanges between districts and regions made this approach possible.\textsuperscript{35}


\textsuperscript{34} Stroobant A (1979) Expériences de soins de santé intégrés au Cap Bon, Tunisie. \textit{Annales de la Société belge de Médecine Tropicale} 59 (Supplement).

\textsuperscript{35} Direction Nationale de la Santé Publique (1993-1996) Série de rapports de missions
### Table 8. Example of the training curriculum for ComHC, Segou Region 1995

<table>
<thead>
<tr>
<th>Date</th>
<th>Module</th>
<th>Duration</th>
<th>Trainer</th>
</tr>
</thead>
<tbody>
<tr>
<td>7-12 March</td>
<td>Planning decision making for curative care, Flow chart and measures to take: malaria, diarrhoea, leprosy, tuberculosis</td>
<td>5 days</td>
<td>Dr. F. Fofana</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 day</td>
<td>Dr. M. Traore</td>
</tr>
<tr>
<td>14-19 March</td>
<td>Prescribing essential drugs, The perinatal period: prenatal care (PNC), deliveries (partograph), labour outcomes, postnatal care</td>
<td>3 days</td>
<td>Dr. H. Mamadou</td>
</tr>
<tr>
<td></td>
<td>Family planning: clinical and management of contraceptives</td>
<td>2 days</td>
<td>Dr. M. Colibaly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 day</td>
<td>Mrs. R. Sidibe</td>
</tr>
<tr>
<td>21-26 March</td>
<td>Information, education, communication, Control of children’s health, nutritional follow-up, exclusive breastfeeding, nutrition Vaccinations</td>
<td>1 day</td>
<td>Mr. S. Moussa</td>
</tr>
<tr>
<td></td>
<td>Integration of follow-up tools and care: action-oriented medical records, schedules, home visits, monthly visits to the villages</td>
<td>2 days</td>
<td>Dr. M. Traore</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 day</td>
<td>Dr. Anafa Ag</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 days</td>
<td>Dr. G. Clarysse</td>
</tr>
<tr>
<td>28-31 March</td>
<td>Microplanning activities, Quarterly reports, instruments and monitoring</td>
<td>2 days</td>
<td>Mr. A. Toure</td>
</tr>
<tr>
<td>Early April</td>
<td>Practical internship in a working centre using the tools and methods learned during training</td>
<td>10 days</td>
<td>Head doctor</td>
</tr>
</tbody>
</table>

**USING THE LOCAL HIS AS ANCHOR**

The existing health information system (HIS) did what was expected of it: it transferred data required by the programmes to the central level. Decentralization imposed new demands on the HIS, including an emphasis on self-evaluation and help in decision making at each level.

In this way, the local HIS developed in step with the initial experiences of the ComHC, without having to abandon transfer of information to the higher level. In addition to support for regular activity reports, a variety of tools also took into account resource management, and included items such as schedules to aid smooth running of the centre.
operational forms to facilitate integration and uniformity, files classified by village of origin, and management control data to facilitate self-evaluation.

The local HIS thus defined helped to anchor the processes of decentralization and change in district functioning. It formed the basis for global reform of the HIS to ensure better integration with the new health policy.\(^{36}\) This ambitious goal impacted well-entrenched networks and services and was not easy to carry out.

**EXCHANGES AND COORDINATION**

“Instructions” for implementing the new health policy were left to the initiative, creativity, and negotiating skill of the participants. The uncertainty and inevitable trial and error typical of an undertaking of this magnitude make exchange of experiences and consultation at the different levels essential.

Development of tools and methods for change was done together with national and regional staff, taking advantage of past experiences. Regional staff were formally assigned initiatives to test and extend where merited, an opportunity for diversity that was considered enriching. Still, harmonization was sought at each stage. This way of proceeding created a cohesive group of “pioneers”, irrespective of the level to which they belonged (central, regional, or district). Solidarity stimulated a healthy competitiveness between regions. Each of the participants found satisfaction in expanding its field of activities and of the number of new participants it was able to involve (which served as indirect proof of the validity of choices and methods). There was never any question of a closed or elitist lobby.

Implementing such extensive reform doesn’t only take political will and skills, tools and appropriate methods, and experienced participants and beneficiaries. It also takes resources.

Generally external partners are looked to, especially to mobilize funds. That is certainly appropriate, but the reality is more complex. External partners can have varying degrees of influence on all the other factors affecting reform, helping or hindering implementation either globally or locally. It was therefore important for the Ministry of Health to

coordinate support to verify conformity with the strategies of the new policy. The government of Mali possesses a powerful tool in the HPRWP. Co-financed by a group of multilateral and bilateral partners, it was able to stimulate and energize a convergent process.

The Ministry of Health organized regular meetings of donors, sometimes in the presence of the Minister himself. At the beginning, donors were chiefly partners directly involved in the HPRWP (e.g., the World Bank, UNICEF, EDF, USAID, KFW, and the Fonds d'Aide et de Coopération Française). This group rapidly expanded to include all partners of the Ministry to clearly signify that it was a matter of implementing a new policy and not just one “large project” among others. The formal framework was indispensable in making everyone’s position known, and in creating an environment where progress could be made with partners whose commitments were explicit. A need for follow-up dialogue through either more restricted or less formal meetings was also recognized, to give a hearing to partners who preferred to air their reservations privately.

No sooner had implementation begun than criticisms from some of the external bilateral partners and NGOs grew louder. “This is a World Bank project; it has been imposed in the country.” “With so much financing, it will turn into a ‘white elephant’ and will all collapse along the way.” These comments implied a lack of information, but especially the anxiety of partners insufficiently familiar with the previous stages. Concerning the content of the new policy, few specific objections were made, though scepticism was sometimes voiced about the viability of ComHCs in certain regions of Mali, and doubt frankly expressed about the pharmaceutical reform’s chances of success. On the other hand, genuine distress was apparent over the gradual change and role of regional and central projects managed by bilateral and non-governmental bodies.

Decisions taken to address the situation included (i) increasing information meetings with NGOs, associations, and bilateral partners at the central and regional level; (ii) explicitly giving first priority to each traditional partner of a district or a region to contribute, within the limits of financing, to implementing the new policy—HPRWP monies would then be used as additional and supplementary resources; and (iii) involving all partners, in particular their technicians, in developing implementation tools through working committees and regional and central workshops.

These overtures did not entirely resolve the problems; however, they did create a climate conducive to positive developments. On-going projects
that were largely committed did not have the flexibility to adapt to new directions. Some of the expatriate technicians were understandably frustrated when it came time to reconsider projects they identified with very strongly. Time, dialogue, and firmness were needed to reach a positive convergence.

The regular meetings organized by the HPRWP coordination unit to exchange information involved a number of external partner technicians in Mali (project officials and technical assistants). These technicians had a characteristic role that added a further component to partners’ decision-making processes. This role often responded more to personal than to institutional logic. Sometimes it helped matters, but it could also complicate them. The organization of these meetings led to better understanding of the principal technical problems of implementation, a comparison of points of view, respect for differences, and especially minimized risk of bottlenecks. Notably, coordination of external partners initiated after the events of March 1991 occurred without objection. The policy defined in December 1990 was similarly uncontested: the problem was not to reorient it, but to implement it.

**Achievements of the mobilization phase**

The declaration of the new health policy was made on 15 December 1990. In 1992 implementation was still only at the mobilization and trial stage. Nevertheless, one could already point to a number of major achievements.

The strategy of regional support and training was defined so districts could meet eligibility criteria. This strategy was different from training trainers in series, and highlighted the significance of support in the district itself to the principal stages of development and implementation of the district health development plan.

The minimum that each ComHC needed to provide to demonstrate good financial accessibility—costs of curative care not to exceed FCFA 600 (before the FCFA was devalued)\(^37\)—were defined by the MPS. Creation of

---

Health for All was a major asset in the fight for availability of essential generic drugs. It reduced the risk of delays and deadlocks in setting up ComHCS.

Techniques for developing the health map were devised and shared with all the managers in each region. Negotiating with the community on the basis of theoretical maps helped to ensure the economic viability of the ComHC at the time and to develop a good dialogue between the auxiliary nursing staff and the community.

The debates about the health map and the MPS nevertheless highlighted differences in thinking. These differences converge towards two principal positions: one that increasingly connected ComHA with the private for-profit industry despite it being a not-for-profit association; and a decentralizing mentality that saw ComHA as a form of autonomy recognized by a specific community for having organized and managed the ComHC in its health area under the terms of its partnership relationship with the State. Insofar as it was simply one component of the new health system, development of the private sector posed no problem, and might help to build pluralism in the system. Still, it had a tendency to expand at the heart of the public and community health structures, rather than to develop its own system.

Unitary programming by area to improve quality of care and to extend health coverage became a precious tool in a context where vertically managed programmes were on the rise. Nevertheless, the insufficient involvement of vertical programme officers in the process made it difficult to coordinate interventions at central level.

Frequent formal and informal exchanges generated a positive spirit of collaboration among all participants and with external partner technicians. This spirit did not exclude differences, but it helped to manage them better.
### Table 9: Achievements and problems of the strategy for change

<table>
<thead>
<tr>
<th>Achievements</th>
<th>Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Support strategy in the districts defined</td>
<td>• Confusion between ComHA-ComHC and the private for-profit sector</td>
</tr>
<tr>
<td>• MPS defined</td>
<td>• Similarities and differences between civil and government initiatives</td>
</tr>
<tr>
<td>• Creation of the economic interest group Health for All</td>
<td>• Insufficient involvement of managers of vertical programmes</td>
</tr>
<tr>
<td>• Method for developing the health map and using it as a negotiating tool</td>
<td></td>
</tr>
<tr>
<td>• Unitary programming by area</td>
<td></td>
</tr>
<tr>
<td>• Collaborative spirit</td>
<td></td>
</tr>
</tbody>
</table>
1993-1995: first achievements

District health development plans

In October 1993 four regions (Kayes, Ségou, Mopti, and Bamako) submitted their first district health development plans to the follow-up committee of HPRWP for financing. The proposed plans had as many similarities as differences. The latter were linked to the context, but also to the scope for creativity left to the regions by the central level.

Developing the plans provided a training opportunity for the social-health team of each district. Participants learned how to perform district health situational analyses—inventoring and choosing priority problems, inventorling means and available or mobilizable strategies, discussing and choosing appropriate strategies, familiarizing themselves with the functional organization of the district, gaining experience in developing health maps, and learning community approaches. The social-health team was also able to practice defining, organizing, and managing the MPS (particularly if the ComHC test was implemented), and principles of referral organization and support for the district team.

Implementing a first ComHC represented an opportunity for the team to familiarize themselves with a programming and budgeting tool, and later, with follow-up and evaluation tools. It was also an opportunity to consult and negotiate with the community and with local partners about adopting and implementing the plan. Finally, this achievement constituted an opportunity to negotiate with upper-level managers and external partners to mobilize the resources and conditions required for implementation.

Obvious differences notwithstanding, these opportunities were as much training opportunities as an information resource for local partners.

The process was long, and perceived as such: it could last from 12 to 19 months (Fig. 7). In extreme cases it pushed the bounds of reasonableness. Nor was it the exercise itself that took the most time. Negotiations with local partners, limited availability of regional support, and the burden of routine work allowed the district teams very little time to draft and finalize the planning document. Figuring in the time needed for local negotiations, developing the plan could be expected to take 6-9
months. The actual time allocated to the district health team was only 6-8 weeks.

Some development activities were not budgeted because they did not require travel. Often this was less motivating for the local staff, and gave rise to a few significant delays.

In the districts where the extended coverage map and the first ComHC were already in place, finalization of the plan was most rapid: the exercise became less abstract for the district team since an essential element of the plan (the ComHC) was able to draw on real experience.

These experiences made it possible to reduce the scope of the initial survey and to orient it more towards a search for pertinent information for health interventions. That avoided the tendency to produce endless monographs.

The planning stage was not without its critics: “What is the use of all these planning efforts? The initiative should be left to expand and not be crushed by complicated and unfeasible plans.” “The financing for the plans does not benefit the community; it produces documents that have no follow-up.” These comments had merit, not in raising doubts about the relevance of plans, but to ensure that the emphasis was on the practical side of things, and to put the importance of the document vis-à-vis effective implementation into perspective. In addition to clear differences in sympathies, the debate was marked by the position of officials responsible for planning in the Ministry of Health. In any case, the plan was not an end in itself or the prerogative of specialists, but a tool to help initiators of change to achieve their objectives.

In the event, the trial strategies turned out to be the right ones. The support strategies really were designed to help regional staff understand the tools and methods developed, to train district health teams in using them, and to strengthen the interaction between partners and the health teams. At each opportunity, the district and regional teams demonstrated good understanding, thus confirming the appropriateness of the methods. The health maps were useful in illustrating the methods' advantages and disadvantages. For the doctors, this was often their first in-depth look at their districts. They also had the opportunity to interact with the community outside of consultations and health education sessions.
The first ComHCs

At the beginning of 1993 Mali already had numerous experiences with ComHCs in the regions of Bamako, Kayes, and Sikasso. This first generation of ComHCs were largely credited with having demonstrated that there was a place outside of state structures where initiative could satisfy unmet needs. Still, in addition to the controversy surrounding the communal nature of these initiatives, the reality is that among these ComHCs, there was no example that combined all the elements one might wish to find in it: a community with real responsibility for a defined area, a satisfactory MPS, genuinely autonomous management, and a partner relationship with upper-level public services.

The first model ComHCs were based on achievements and lessons learned from past experiences. They depended on the government encouraging their creation in the context of a partner relationship. Accordingly, significant benefits were agreed to by the State together with ComHAs (Table 10). In return, the ComHA was expected to ensure that the ComHC would offer the full range of MPS components for the community of the health area, and that it would manage the ComHC with rigour and efficiency. The initial implementations of the ComHCs, first
Dougoulo (Bla District), then Guétéma (Nioro) and Gagna (Djenne), made these principles a reality. ³⁸

<table>
<thead>
<tr>
<th>Table 10. The ComHA benefits agreed to by the State</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Cofinancing civil engineering work</td>
</tr>
<tr>
<td>✓ Equipment financing</td>
</tr>
<tr>
<td>✓ Financing the initial provision of drugs</td>
</tr>
<tr>
<td>✓ Financing initial training</td>
</tr>
<tr>
<td>✓ Providing vaccine, contraceptive, and specific treatment supplies under terms similar to State health centres</td>
</tr>
<tr>
<td>✓ Technical support by district health team</td>
</tr>
<tr>
<td>✓ Exemption from taxes on income of the ComHA as well as taxes on the activities of the health centre</td>
</tr>
<tr>
<td>✓ Contribution to equipment depreciation.</td>
</tr>
</tbody>
</table>

THE COMMUNITY APPROACH: PAVING THE WAY FOR NEGOTIATION

The first ComHC had no explicit “set of instructions” adopted at the central level for approaching the community. Instead, a few general directions were provided based on past experiences. “Environmental evaluation” was required in any case, but its significance varied depending on the speaker. According to some proposals, “scientific” sociological and anthropological research needed to be performed in each area before doing anything. Yet studies carried out in this vein have not contributed all that much to decision making.

The skills needed to launch a community approach were obviously lacking, but it was thought that the community development technician on the district team had the profile required to accomplish the task. Given the difficulty of reaching precise agreement about potential training and which procedures to follow, the regional teams were left alone to set up the first trials. Later, in July 1994, these trials underwent critical examination. The

evaluation of the approaches was positive, and their diversity attested to their appropriateness. 39

Over time, the community approach became more pragmatic (Table 11). A minimum of preliminary information needed to be gathered by local and regional resource persons. This was done as soon as contacts were developed between the district team (doctor, community development technician, health technician) and the different villages and neighbourhoods. In fact, the information was often collected at the district description stage, and used in developing the theoretical map for extended coverage.

With a few exceptions, spontaneous initiatives to create a modern care service were rare. It usually took the enthusiasm of the administration or of an external partner, or, as in the case of Bamako, doctors in search of work. The initiative to establish first ComHCs generally arose in the district team for totally different reasons than in the past.

Table 11. Elements and stages of the community approach

| ✓ Feasibility study a precondition for establishing a ComHC |
| ✓ Information as complete as possible about the opportunities that the new sectoral policy offers: partner relationship to resolve health problems and need to group villages and sometimes neighbourhoods to assure viability and adequate technical performance |
| ✓ Information from all the villages and neighbourhoods of the area |
| ✓ Sufficient time in intravillage and intervillage consultations before obtaining their agreement to the principle, and verification in each of the villages |
| ✓ Expansion of contacts and discussions beyond the chief of the village and advisers (heads of families, women, youth, and so on) |
| ✓ As soon as the majority of villages affirm their commitment, support formation of a ComHA (status, rules, constitutive assembly, election of the committee, legal approval from administrative authorities) |
| ✓ Negotiation of the contract with specified commitments of each party for the establishment and operation of the ComHC |
| ✓ Execution of commitments of each party and establishment of the ComHC. |

These principles were not actually put into effect until after the adoption of an interministerial order\textsuperscript{40} and the restoration of State authority following the political changes of March 1991.

The process had a variable duration, rarely less than 9 months. When building was needed, the duration could be much longer. Collecting contributions from the community then became more difficult, and managing the construction caused delays due to the persistent centralization of this component (Fig. 8). At times it was necessary to press forward even when one or two villages were still undecided in their support; in other cases, the map was modified to take changes into account: villages signing on, for example, or defections of villages that wanted to belong to another area.\textsuperscript{41}

Often reservations concerned the physical site of the ComHC, and originated either with a rival village of the proposed site or with a relatively large village distant from the ComHC site. Since there is no miracle solution to satisfy everyone, well-defined criteria were systematically discussed. This process helped to lessen the frustration of undecided villages and sowed the seeds for their future participation.

Indeed, the process was validated insofar as some villages ended by joining. But there were also cases of villages that decided to withdraw after having initially signed on. For example, in the health area of Dougouolo one major village revoked its participation in the hope of implementing its own ComHC with support from an NGO. In such cases, NGOs considered efforts to develop equitable access to health care services to be an administrative constraint, and their behaviour was not always above reproach. Too much flexibility in modifying the maps once commitments were made could weaken the planning process and threaten the survival of functioning ComHCs.

Initial efforts demonstrated that it was possible to introduce a fruitful dialogue between the health teams and the population and to initiate an


approach through negotiations, without losing or being caught up in endless details. The starting point was clear. Based on a partner relationship, the community would be offered an opportunity to participate in managing its health problems and to use the health map as a negotiating tool for regrouping villages and creating a viable ComHC. In this way, an intervillage process—not imposed by the administration—began with the promise of new active solidarity in a context broader than a single village.

LAUNCHING A COMHC

Although benefiting from critical analysis of past experiences and from new tools and methods (clearly defined MPS, standard equipment list, specified initial training field), detailed instructions for launching the ComHC remained to be devised. The fear of erring or of not meeting a multitude of expectations sometimes inhibited initiative.

Figure 8 illustrates the successive stages for establishing a ComHC: duration varies between 29 and 59 weeks.

*Figure 8. Stages and their average duration for implementing a ComHC*
PERFORMANCE

The performance of the first ComHCs differed from previous first level services in Mali. There were distinct improvements, particularly in the quality and coverage of care more than in organization and management of health centres. The inadequacies—and the constraints—were evident, but the ComHCs showed that significant progress was possible.

Three types of activities (curative care, prenatal care, and vaccination of children less than 1 year of age) were evaluated before and after transformation of the health area. The differences were more pronounced in areas benefiting from an established ComHC (Fig. 9) than in areas that had undergone “revitalization” of their existing SDHC\(^{42}\) (Fig. 10). The contrast is obviously more significant in the health area of Mozambala, seeing that previously it was deprived of a health centre. Before the establishment of a ComHC, services were provided by a distant sub-district health centre about 15 km away.

The range of MPS services. While the MPS necessarily comprised a group of curative, preventive, and promotional activities, it was recognized as minimal: besides the control of current and priority diseases (malaria, acute respiratory infections, diarrhoea), an integrated care for infant nutrition was organized (nutritional follow-up, vitamin A supplementation, vaccination, and promotion of child spacing for mothers). Normal deliveries, prenatal care, and family planning were also included. In contrast, STDs were not yet benefiting from adequate support, and the control of chronic diseases was limited or not developed outside of existing vertical programmes (e.g., leprosy and tuberculosis).

The basic training of health personnel was unsuitable, inconsistent, and generally weak; it made rapid development of the MPS during the training that preceded the launch of new ComHCs more problematic.

\(^{42}\) As we will see further on, there are some areas where it was preferable to transform (“revitalize”) the SDHC rather than to create a new ComCH.
Figure 9. Performance in the health area of Mozambala before and after establishment of the ComHC (use and coverage rates)

Figure 10. Performance in the health area of the SDHC of Kalabankoro before and after “revitalization” (use and coverage rates)
Quality of curative care. Supervisions have demonstrated that initial training was effective.\textsuperscript{43} Prescription of drugs improved. The percentage of injectable prescriptions, formerly almost automatic, was reduced by 5 to 10%. In more than three out of four cases, prescriptions included three drugs or fewer. The flow charts appeared to be used correctly in more than 90% of the cases. Still, the diversity and accuracy of diagnoses remained weak.\textsuperscript{44} The referral rate, rarely greater than 1%, suggests that nurses only evacuated obvious emergency cases and rarely referred cases in advance.

Organizing and microplanning activities. All the ComHCs provided microplanning and a schedule both of centre and itinerant activities in the villages. Microplans were finalized with ComHA, and the villagers were then informed on what day the nurse would visit.

A scorecard enabled participants to visualize progress towards objectives, and appropriate tools allowed ComHA to resume coverage of certain activities by village to improve the usefulness of discussions about village participation in the different activities of the centre.

In a major innovation over the old “forward strategies”, the nurse now provided this activity. Previously it was left to less-qualified auxiliary nurses, who had neither the credibility nor the competence to develop promotional activities in the villages.

The regular visits of the nurse not only improved the quality of services in the villages (vaccination, nutritional follow-up, vitamin A supplementation, follow-up of high-risk pregnancies, continuity of care), but they also strengthened solidarity and the sense that the villages had a stake in the health area. In Guétéma, the villages subscribed and renewed their contributions before the expiry date to assure financing of itinerant activities.

In other health areas, including a large number of villages and hamlets (Monzambala), discussions were particularly lively when a schedule of visits had to be stopped in favour of continuity at the health centre. All the villages, whatever their size, required a monthly visit by the nurse.


In Dougouolo, a survey\textsuperscript{45} revealed that in small remote villages the population was often better informed about the activities of the centre than the population living near it. This phenomenon can be explained by the fact that the regular visit of the nurse to the village constituted a real social event. It is even likely that this activity contributed to better use of the ComHC.

**Attendance and coverage achieved.** Performance was very encouraging. Coverage by preventive activities in ComHC health areas was good—indeed, very good—in the first year of activities. Vaccination coverage for children of 0-11 months of age exceeded 80% in many ComHCs and revitalized SDHCs, even while self-financing local costs.

Figure 11 illustrates good or very good coverage for prenatal care and vaccination of children less than 1 year of age (DPT3) in ComHCs operating longer than one year. Prenatal coverage clearly remained lower in rural environments than in outlying environments (in numerous ComHCs prenatal care was not part of the itinerant activities of the nurse).

Use of curative care was higher than the average achieved in Mali, but it remained low, often between 0.2 and 0.3 new cases per inhabitant per year. Centres with personnel combining clinical skills and good relations with the population often achieved the best performance.\textsuperscript{46}


In rural settings geographical accessibility strongly influenced use of the health centre. Use of curative care by village communities where a ComHC existed or was located nearby was clearly higher—0.8-1 new case per inhabitant per year—than for communities living far from the centre. Good performance of certain preventive activities (in particular vaccination) was possible due to the itinerant activities of the nurse in the local villages. But this strategy of regular nurse visits to the villages could not compensate for the distance factor in responding to needs for curative care or increasing its use at the health centre.

In urban settings, the frequency of curative care at the ComHC also remained very modest, often fewer than 0.2 new cases per inhabitant. Other factors arose (Table 12), namely, the range of informal and formal offers of care services that prevailed in the city. In a commune of Bamako in 1994, four out of five consultations in modern care were sought in the informal sector.47

---

REACTION

Establishing the MPS with community management indisputably improved the performance of health coverage, while reinforcing autonomy for ongoing operation. Subsequent discussions about the initial achievements were marked by contradictions:

- increased enthusiasm and motivation of actors to achieve, and greater confidence and determination to go forward
- positive appreciation by some external partners, though not free of scepticism, about the replicability of the initial trials
- systematic hunting for weak points by other parties.

The criticisms focused on the inability of communities to competently manage the centre; the impossibility of self-financing fixed costs, in particular, the monthly visits to the villages; the support given to the early trials in each region, which makes them hard to reproduce; gaps with regard to the organization and procedures used in the vertical programmes (especially tools).

These criticisms did not take into account the fact that the process was only beginning and needed to continue if the goal of change was to be reached. That was particularly true for development of ComHA capacities, where it was necessary to capitalize on experience and disseminate the results. Several months to a year following initial launching of the ComHCs, the criticisms were put into perspective and laid aside.

Clear and reiterated support from the central level for these initial trials helped to lessen apprehensions. The support was also intended to drive home the fact that procedures in the existing health centres were not absolute constraints. That allowed maintenance and development of new tools and methods compatible with integrated management of the MPS, despite objections and reservations on the part of national programme managers.

For sure, the difference between the initial trial results and the former situation was now evident. ComHA and the regional staff explained and enthusiastically defended their projects. They were in the best position to compare current results with the previous situation rather than with unattained utopias. The continued improvement in quality of care and coverage of preventive care, and in the managerial expertise of nurses and
ComHA highlighted the fact that mastering the ComHC tool is a process that requires time and perseverance.

Considerable progress was also made with regard to the hypotheses and focus on a strategy: (i) it was actually possible to set up a complete MPS at the first go and to ensure acceptable local management; (ii) the quality of services and the performance of preventive coverage improved rapidly enough to make a difference at traditional health centres; (iii) rural health centres considered the itinerant activities of the nurse as critical in reinforcing the sense of investment in the ComHC by remote villages despite additional costs; and (iv) poor basic training for nurses was the limiting factor in quality of services, notably for curative care. The brief initial training provided for launch of the ComHCs is only a partial response to this problem.

“Revitalizing” the SDHCs

Prior to emergence of the ComHC, the primary care network was organized by the SDHCs. There were 286 of these centres, one per administrative sub-district. In general they were managed by a qualified government civil servant nurse. The staff included two or more workers. The auxiliary nurses and the matrons who were attached to the centre were most often funded by the Local Development Committee. A single SDHC serviced between 30,000 and 60,000 inhabitants. Theoretically, it had the responsibility of supervising structures and health activities at the village level; in practice, it did not have the means and did not do it.

The debate over these government centres centred on a series of questions posed with concern and sometimes urgency by staff at all levels: These are the only structures through which the government shows its presence in the health sector beyond the main district towns. Will the State have to withdraw further? The Bamako Initiative envisaged revitalization of these centres; does community responsibility apply only to management of drugs (community depot, or to global management of the health centre? Will we have two different ways of organizing the community to manage first level health centres: ComHC-SDHC? Is it possible to transform a SDHC into a ComHC? What will the relationship between the civil servant nurse and the ComHA be? Does the SDHC have responsibilities beyond the health area that will definitively be its own? Who will assure preventive services for the rest of the sub-districts if the SDHC is
transformed into a ComHC? Should the State withdraw its personnel as soon as a SDHC is managed by a ComHA?

Decisions were based on a group of principles. To begin with, whether ComHC or SDHC, the first level must provide the MPS and refer directly to the DHC. That helped to avoid an artificial hierarchical relationship between ComHC and SDHC. Second, it was expected that in all cases, the community would organize itself to provide global management of the health centre, and not only the drugs depot, as had been envisaged at the beginning under the Bamako Initiative. Finally, the health map served as the basis for organizing the community approach and the impetus for negotiations; it differentiated between SDHC area and ComHC area neither in principle nor in method.

For a SDHC to begin to work this way, it needed to be “revitalized”. ComHCs and revitalized SDHCs (R-SDHCs) thus existed side by side, working according to the new principles, with non-revitalized SDHCs functioning poorly, as before. During the long transition period, the SDHC network continued to provide services for areas still not covered by the ComHCs. During this whole period the government kept up support, which it accorded to the SDHC.

In reality, it was the initial revitalization trials, and in particular those of Touna in 1993, that got the debate moving towards concrete proposals. Revitalization of the SDHC of Touna followed exactly the same process as that for establishing a ComHC. The village communities that made up the health area were organized in a ComHA and contributed to the initial investment. A civil servant nurse technically managed the centre. The nurse provided continuous preventive activities for the sub-district villages outside the area (with financing from the district), and was accountable to the committee for managing the centre and evaluating activities for the villages in the health area.

The early stages of cohabitation were not easy. The nurse was not invited to the regular meetings of ComHA, but took part in discussions before and after the meetings. The committee wanted to assure itself that it had real power. This way of going about things was unsettling for the nurse,

48 Directions Régionales de la Santé et de l’Action Sociale de Bamako, Mopti, Ségou, Kayes, Sikasso, Koulakoro, Mali (1993-1996) Etat d’avancement, études de cas, séries de notes techniques et de rapports de supervision des centres de santé de cercle et CScm/CSAR.

Bamako: Ministère de la Santé, de la Solidarité et des Personnes Agées.
who observed that the chairman of the committee became the favoured partner of the head doctor for global management of the centre. Only six months later did the committee invite the nurse to regularly attend the meetings.49

While in principle a community with a ComHC benefited from the same package of care, a problem of equity between health areas remained. Those with a ComHC had to pay staff salaries, while those with a SDHC benefited from a nurse paid by the State. For the medium term, the solution to this problem lay in distributing the support provided by each district. An alternative would be to redeploy all staff to the benefit of the DHC. In that case, the R-SDHC would no longer have had an advantage. But it would complicate the situation of areas where viability was already tenuous.

In any case, everyone was conscious that despite the uniqueness of the principles and methods it shared with the ComHC, SDHC revitalization distinguished itself by (i) its historical relationship with the community; (ii) the fact that the centre was run by a civil servant who had to learn to be accountable to a ComHA and to accept changes in job description (especially the regular visits to the villages); (iii) the fact that the financial contribution of the community was less significant than that for the ComHC, and that the amount of the appropriation was less certain.

These principles were only really embraced by all from the beginning of 1994. Thereafter, the number of revitalizations increased rapidly in the regions.

Specific problems in the urban context

Twenty per cent of the Malian population live in an urban setting. The capital, Bamako, is Mali’s major health market, constituting 75% of health expenditures. The big hospitals of the capital report directly to the central level. The central powers and external partner offices so dominate that it is difficult for a regional health office to accomplish the tasks that theoretically are assigned to it.

It is clear that the specifics of the urban setting as shown in Table 12 influenced the process of implementation in Bamako and strongly

contributed to the debate at the national level. One could also add to this table the fact that in Bamako, the communes have elected mayors, whereas in rural settings there is no equivalent. The planned rural communes have not yet been created.

The initial formation of ComHCs in Bamako began in 1989, well before the Ministry of Health defined the framework for the community sector (April 1994). Often at the initiative of doctors that the public sector was unable to absorb, ComHCs developed unbeknownst to regional staff, who often were not even invited to the inaugurations. Urban ComHC doctors had the tendency to develop unduly technical services. It is worth noting that offers of support and donations from NGOs were numerous.

The risk of over-technological development was that it reduced the financial accessibility of services for the community. On the other hand, the automatic and inflexible transfer to the urban setting of the two-level health model, as developed in the rural setting, was also risky and difficult to implement.

The social-health development plans of Bamako communes did not envisage developing a referral service in each commune: they already had three hospitals to provide first level services for the six communes in the capital. The role of a health team devoid of referral technical services was very different from that of rural DHC teams.

---

<table>
<thead>
<tr>
<th>Table 12. Characteristics of health systems in rural and urban settings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rural setting</strong></td>
</tr>
<tr>
<td><strong>Population</strong></td>
</tr>
<tr>
<td>Traditional organization. Generally stable.</td>
</tr>
<tr>
<td>Population dispersed.</td>
</tr>
<tr>
<td><strong>Community participation</strong></td>
</tr>
<tr>
<td>Relies on traditional organization. Little management capacity. Initiatives difficult without support from administration or external partners.</td>
</tr>
<tr>
<td><strong>Health map</strong></td>
</tr>
<tr>
<td>Stable regrouping of villages. Negotiation poses logistical problems for multiple and regular contacts.</td>
</tr>
<tr>
<td><strong>Mobilization of resources</strong></td>
</tr>
<tr>
<td>Qualified human resources rare. Financial and material resources difficult, even impossible, to mobilize beyond a certain threshold.</td>
</tr>
<tr>
<td><strong>Service offered</strong></td>
</tr>
<tr>
<td>MPS by nurse.</td>
</tr>
<tr>
<td><strong>Referral</strong></td>
</tr>
<tr>
<td>The DHC is in general the referral and often the only possible one.</td>
</tr>
<tr>
<td><strong>Management team</strong></td>
</tr>
<tr>
<td>Authority and technical support essential of developing the district health system.</td>
</tr>
<tr>
<td><strong>Pluralistic system of care</strong></td>
</tr>
<tr>
<td>Private sector undeveloped. Traditional. Virtually a monopoly. Alternative sector undeveloped.</td>
</tr>
</tbody>
</table>
Organizing and developing referral in the rural setting

THE FIRST LEVEL

The DHC—the equivalent of a first referral hospital—had a special status in the district. At the time, it provided first referral level care. The relationship with the periphery was essentially administrative and hierarchical. The DHCs most often had a surgical block, but the premises were unsuitable, the equipment insufficient, and the staff inadequate or unqualified. In its relationship to the community, the reputation of the DHC largely depended on its successes and surgical failures.

While it was hoped that an effective referral level would strengthen the quality and the global credibility of the system, it was necessary to rehabilitate, strengthen the technical services, and improve staff skills. These requirements formed part of the district health development plans.

Initial programming foresaw the parallel evolution of the first stage and the referral level. The difficulties of mobilizing financial resources to achieve the technical services referral stage (donor and administrative procedures) were such that substantial progress was made only in the developing the first stage. In fact, the workload for the first stage kept the district teams from being in any way able to simultaneously address development of the referral level. An external evaluation team confirmed this observation.51 It would take many more than the two doctors currently stipulated as the minimum. Three to five doctors would be needed to develop the two levels at the same time. It was therefore decided to start by improving and extending accessibility to the first level.

A MULTIPURPOSE TEAM FOR MANAGING THE DISTRICT

Considering the level of need in clinical and surgical skills, it was proposed that doctors totally devote themselves to these functions in order to maintain and develop their competence, and to leave the public health roles (supervision of health centres at the periphery) to other staff. Taken to its extreme, this philosophy led to the structural separation of the hospital from its role in public health and the first level.

However, the decision was made to keep the principle of a single service and a single team. The arguments were the following:

---

It is in the DHCs that one finds medically qualified personnel in Mali; this situation will continue for a long time. For the foreseeable future, the first level will be provided by nurses. Under these conditions, the level where situational analysis can be carried out, with all its implications, remains the district level.

Under this scheme, it would be detrimental to have the chief doctor take on an administrative role as head of the public health office rather than that of a multipurpose medical manager of a team. Separating functions could not help but be reflected in the quality of supervision at the first level and in the relationships between health team members and their relationship with the community.

This division of functions and roles does exist in Mali at the regional level (the regional hospital is a separate institution from the regional health office), but at this level, referral is specialized, and the regional health office provides administrative and technical support, not operational support.

DISTINGUISING BETWEEN FIRST LEVEL AND REFERRAL

While the ComHC and R-SDHC obviously needed to be strengthened, the fact that the DHC was at times providing first and second level care posed a problem. In addition to chipping away at the prestige of the first level, which one was hoping to reinforce, it affected the quality and efficiency of referral care. Participants agreed on the principle of distinguishing these two functions of the DHC, but support became more muted and even lukewarm as soon as the problem of financial viability arose. The DHCs assured the stability of their everyday operations largely thanks to their first level activities, which sometimes provided more than half the income.

Simulations carried out as part of feasibility studies set expected income needed to balance accounts at such a level that it would seem very unwise for a district team to cut this source of financing, especially if the State contribution was not increased.

Two formulas were then tested: total separation with community management of the first level in Djenne District, and separate operations and book-keeping, but a single account at Bla. The results are still not in

---


on these experiments, but in both situations, the separation is believed to benefit the organization and quality of services. In Djenne, a considerable increase in use of the first level by the community has been observed, with a decrease in revenue from the hospital without producing an operational deficit. In both situations, the medical team gained precious time that it was able to invest in more complex activities and in supervision.

While the general recommendations (annual reviews of the HPRWP and report of the commission on referral) clearly leaned towards separation of activities, the problem of financing referral health centre activities also need to be addressed. An appropriate and lasting solution necessarily had to take into account real costs, subsidies, and the community’s ability to pay. The latter could significantly improve financing of certain events (such as obstetrical and surgical emergencies) by establishing mutual aid or insurance funds (ComHA funds, in relation with the district health community board). Substantial efforts were made in this direction and were well received by the population. Assessment of the financing of the district health system at the end of 1996 supported not only that trend but also combining mobilization of local capital, State subsidies, and the possibility for internal adjustment. At the time, the delay in attracting funds for technical services was used to learn from trial projects in districts with significant referral capacity (Djenne, Bla, Commune V of Bamako District, Koulikoro, Kolondieba), however modest that capacity with respect to minimizing risks in the event of appreciable investment.

STRENGTHENING REFERRAL FOR OBSTETRICAL CARE

If only for reasons of credibility, it was not possible to completely ignore the referral function of the DHC. The issue was tackled using “perinatality” as the entry point.

Coverage of emergency obstetrical care is very weak in Mali. The number of caesareans performed comes nowhere near covering obstetrical needs. Outside Bamako District caesareans are performed in less than 0.2% of deliveries. In Koulikoro District, for example, rates of caesareans for women living in health areas beyond 40 km from the first level hospital were very low (Fig. 12). Thus even the least intervention needs went

54 Blaise P, Kegels G & Van Lerberghe, ibid.
unmet: for maternal absolute values alone, the expected rate ranges from 1 to 2%.\textsuperscript{56} The high mortality among the emergencies handled contributed to the enormous maternal health problems of the country.\textsuperscript{57}

Tragic obstetrical mishaps were in principle avoidable through care at the DHC. As in many countries, the main strategy for handling pregnancy problems was a combination of prenatal care and rural maternities. The latter were often created by the community, showing just how badly they were needed. In the absence of professional care—in other words, surgery—for complicated deliveries, these strategies only slightly reduced the gravity of the situation.

Delivery poses a real and common problem; it offers a genuine opportunity to organize referrals.\textsuperscript{58} Funds readily procured for a perinatal programme provided the opportunity, though the financing for the whole of the referral level was available only from 1996.


Figure 12. Obstetrical emergencies seen and caesareans performed in the hospital, according to origin (Koulikoro, 1995)

SOURCE: Data collected by F. Guidetti, G. Kanako and A. El Abassi

It was evident that the factors related to staff expertise, however significant, were not the major bottlenecks. In terms of situational analysis district by district, other elements seemed more significant: organization of work of peripheral health teams and at the DHC, communication between the centre at the periphery and the referral service, logistics and communication channels between the periphery and the hospital, financial accessibility, as well as evacuation for emergency care.

It was clearly necessary to involve communities in resolving problems when solutions were nontechnical. The referral problem needed to be taken into account in the community approaches. Especially, removal of financial

obstacles at the referral level and improved functioning were crucial to
developing the health system and strengthening its impact.60

A significant degree of progress was made. Development of the
ComHCs and R-SDHCs led to improved communication between the first
level and the DHCs using a radio-communication system. The organization
and financing of evacuations and referrals was negotiated with all partners.

### Table 13. Rates of caesareans performed according to origin, Bla District, 1995

<table>
<thead>
<tr>
<th>Distance from the DHC</th>
<th>Expected deliveries</th>
<th>Functional health area (%)</th>
<th>Non-functional health area (%)</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;30 km</td>
<td>4535</td>
<td>1</td>
<td>0.5</td>
<td>0.8</td>
</tr>
<tr>
<td>30-50 km</td>
<td>1689</td>
<td>0.5</td>
<td>0</td>
<td>0.5</td>
</tr>
<tr>
<td>&gt;50 km</td>
<td>3243</td>
<td>-</td>
<td>0.3</td>
<td>0.3</td>
</tr>
<tr>
<td>Total</td>
<td>9467</td>
<td>0.85</td>
<td>0.35</td>
<td>0.55</td>
</tr>
</tbody>
</table>

**SOURCE:** F. Guidetti, G. Kanoko, and A. El Abassi

Apart from the classical differentiation of coverage according to
distance from the hospital, analysis of the source of caesareans performed in
Bla (Table 13) shows a marked difference between areas with ComHCs or
R-SDHCs and health areas not yet transformed.61 In Koulikoro District
(Table 14), improving the quality of the technical services in terms of both
equipment and staff expertise led to a considerable increase in needs met in
1994. Organizing the referral system and transforming four health areas
contributed to maintaining growth.

### Table 14. Caesareans in Koulikoro District 1993-1995

<table>
<thead>
<tr>
<th>Year</th>
<th>1993</th>
<th>1994</th>
<th>1995</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expected births</td>
<td>7000</td>
<td>7150</td>
<td>7300</td>
</tr>
<tr>
<td>Caesareans performed</td>
<td>6 (0.1%)</td>
<td>56 (1%)</td>
<td>71 (1%)</td>
</tr>
<tr>
<td><strong>SOURCE:</strong> District Socio-Health Services supervision reports of 1993-1996</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To make evacuations financially feasible (their cost sometimes
exceeded FCFA 20,000), some of the district teams developed cost-sharing
schemes. In Bla, FCFA 4,000 constitutes the lump sum required for

60 Gouvernement de la République du Mali et UNICEF (1994) Programme Santé Mali
Health Service Organisation & Policy 5, 1-130.

61 See District Socio-Health Services supervision reports of 1993-1996.
ambulance evacuation by the health service. In Djenne, the ComHA prefincanced evacuations with grants for renewable fuel after discussion in the management committee, thus removing any financial obstacle to evacuating patients. A biannual review of progress and problems is conducted with ComHAs and the whole district health team.

Figure 13. Emergency obstetrical evacuations according to distance, Kolondieba District, 1994, 1995, and 1996

The costs of surgical management, even when streamlined (FCFA 25,000-40,000 for one caesarean), still constituted a significant hurdle, difficult for marginalized groups in the community to overcome. To finance surgical emergencies and particularly obstetrical emergencies, initiatives

---


were developed to create mutual health organizations. In Kolondieba, 14 ComHAs have committed themselves in this way and established insurance schemes to manage obstetrical emergencies, considerably reducing the financial obstacle. The number of emergency obstetrical evacuations carried out at the hospital has clearly increased. Since the increase is even higher for areas reasonably far away from the hospital, the referral system is the likely cause.

Regulations and contracts: crystallizing the debate

The interministerial order establishing the modes for managing socio-health services was signed on 15 March 1991. It was a precondition to signing the loan agreement with the World Bank. The regulations concerned the organization and functioning of management boards and committees at different levels (e.g., community, sub-district, and district), and for programming and managing resources. It exempted revenue generated by the provision of services from all duties and taxes. While clearly a step forward, the document still supported the traditional hierarchy (village or neighbourhood chief) and the administration (e.g., sub-district chief, district commander) in the composition of councils.

The management committee was appointed, not elected by the management board. The technical managers at each level were not proper members with a real say, but advisors. At the lower level, the doctor belonged to the sub-district health board, and the sub-district nurse belonged to the community level health board.

The regulations were vigorously criticized and contested during the institution of multipartyism, following the political events of March 1991. The criticisms essentially had to do with designation of board members, non-membership of technical managers on the board, and the fact that the order linked measures agreed to in the context of the project (HPRWP) instead of presenting them as the general product of a national policy (as was anticipated in the conceptual framework of the Bamako Initiative).

The ComHA-BA—the community health association of the Bankoni neighbourhood in Bamako—was the first to be created in Mali. It managed a ComHC in a neighbourhood in Bamako. As a not-for-profit association, made up of members living in the neighbourhood, it benefited from official authorization that gave it the moral authority to manage a non-State public health centre.

This form of organization and autonomy in managing a health centre (which is neither sectarian nor private for-profit) was a major innovation. Nevertheless, no mention was made of it in the interministerial order of March 1991, which was more geared towards decentralization within the limits of the one-party system. It was necessary to wait until April 1994 for adoption of the new interministerial order, which took into account the political changes that had occurred in Mali, and the new experiments in innovation.

Based on the experience of ComHA-BA, brain trusts for the ComHCs established by the Ministry of Health recommended institutionalizing community management of health centres and organizing the community in ComHAs.

The rapid development of the ComHA and ComHC in Bamako did not formalize a partner relationship with public services. The regional health department was outmatched by a process that had the direct support of external partners and from the energy of young doctors looking for jobs (recruitment into the public service was no longer assured for outgoing medical students, and private medical practice was undeveloped).

Test projects under the HPRWP adopted the same principle of organization. In addition, however, they forged agreements linking ComHAs to the public health services. The agreements highlighted the obligation to guarantee the full range of MPS components and the specific commitments of each party, with the ComHA given explicit responsibility for the health of the community of a defined area.

The political changes that occurred in Mali with the advent of multipartyism and democratic elections indisputably influenced the debate and favoured creation of non-State spaces for the organization and provision of health care. The community sector and private sector

---


(especially in the area of drugs) developed significantly, several steps ahead of the regulations then in force. Varying interpretations of how management should be organized and the objectives of the community sector generated substantial confusion.

Was non-State simply private or was it a hybrid of private not-for-profit and private for-profit? Doesn’t the distinction between for-profit and not-for-profit objectives have a tendency to evaporate? Wasn’t the community a form of decentralized and collective responsibility rather than a private sector association? Was the relationship of State services with the other sectors going to be a relationship of pure regulation and control, or a partnership for public intervention in the area of health? Was the State in a position (financially and technically) to manage a relationship in a conventional framework with a multitude of specific contracts to carry out activities of national priority programmes? Was it necessary to link the activities of public and not-for-profit institutions, which respond to needs that are real and increasingly expressed by the community themselves (such as vaccinations), to supplementary financing (aside from the usual inputs)? Would the risk shatter the global and integrated approach of care at the expense of giving priority to cost-effective activities (curative) and making other activities dependent on availability of specific financing (uncertain), from the public service (State or external partners)?

This debate was at times very heated, in particular in Bamako District. Several associations and many ComHCs run by young doctors were more inclined to private enterprise than a ComHA. The result was to drain supplementary resources from existing financing structures at the central level (national programmes) to the benefit of the ComHCs.

But these positions had nothing to do with providing care according to the needs and demands of a well-defined population. They lacked the long-term vision needed to negotiate support, and to plan based on the real cost of services and equitable sharing of those costs among the community, users, decentralized populations, and the State. Thinking long term also avoided the trap of linking ComHC support to financing structures at the central level, which could change with time and depend strongly on external partners.

Paradoxically, in rural settings where preventive activities involved significant additional costs (forward strategy), the ComHAs sometimes provided financing from contributions for itinerant prevention services (e.g., in Guétéma and Gagna) and to ensure their frequent use, all the while
maintaining the centre’s capacity to restock drugs. These cases are not legion, but they illustrate very well the difference in attitude from urban settings.

Drawing up regulations, and fixing the terms for creating ComHCs and the modes for managing social-health services, heightened the debate. Regulations were consequently delayed, which affected implementation of the new policy. Some of the staff pulled back on their initiatives to avoid finding themselves at fault with the provisions of the new policy and losing face with the community or local partners.

The new regulations not only concerned development but also made constitution of a ComHA a major condition for setting up a ComHC. The latter was defined as a first level health establishment, created on the basis of the commitment of a defined population and organized within a ComHA. Thus the association necessarily emanates from a defined population to which it is accountable (which differentiates it from a classical association). This specification entails more of a vision of effective decentralization than a process that sees the population only as targets or customers. In the context of other developing countries like Mali, the problems are equally complex.

According to the interministerial order of 21 April 1994, the ComHC must comprise a dispensary, a maternity, and a depot of essential drugs. The nurse needed to have a minimum first-stage qualification. The functions of the ComHC included the obligation to distribute the entire MPS. To create a ComHC, the ComHA had to conform to the district health map, to include at least 10% of the population among its members, and to sign an agreement with the Ministry of Health. That clarified the choices and made the relationship with the government more one of partners.

Even better, the regulations required each ComHA to be represented on the district health board, consisting of all the district ComHAs and/or of the commune, and presided not by an administrative manager, but by the chairman (elected) of the district development board or the mayor (elected) of the commune. Each ComHA was thus entitled to vote on a board that managed the entire district health system. Technical and administrative

---

managers (chief doctor, representatives of the local administration, NGO representatives, and ComHC technical managers) participated on the district health board only as consultants. In the interest of consistency, the SDHCs were to be organized and managed in the same way as DHCs. The administration therefore ceased from directly managing first level structures, but kept the resources and reserved the right to verify that the ComHC was aiding in effectively resolving the health problems of the community and to improve health coverage in the country. At the same time, management of the DHCs and of communes was effectively decentralized with the participation of the ComHA on the management boards of referral health centres.

These principles clearly distinguished not-for-profit organizations from classical private organizations that are not bound by conventional commitments and develop in a competitive environment. It was probably illusory to believe that the private sector could contribute significantly to these objectives in a country without adequate financial means or health insurance funds to support it. Experiences of other countries confirm the tendency of the private sector to develop only in zones where the climate is conducive to cost-effectiveness and profit.67

With increased direct financing by the communities, the State responded by giving the private sector the possibility of managing first level health centres and comanaging the referral level. The relationships and commitments of each party were specified under an agreement linking the public services and the ComHAs. This agreement was to undergo regularly scheduled review. In this context, the non-profit aim was a condition to ensure geographical and financial accessibility of health services.

A problem remained nevertheless, and that was financial motivation of staff. In addition to considerations discussed in the following chapter, the more motivation of personnel depends on financing from central programmes, the less local control the ComHA will have. In the Malian context, specific programme contracts offered salary supplements for staff. Global agreement for the MPS may also affect staff motivation (Table 15). There is still scope for testing mechanisms to motivate staff and protect them without reducing the responsibilities of the ComHA or producing other undesirable effects.

Table 15. Effects of contractual modes between the State and the ComHC on the motivation of personnel

<table>
<thead>
<tr>
<th>Factors affecting staff motivation</th>
<th>Global MPS agreement</th>
<th>Specific contracts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having a model (to know where one is going)</td>
<td>ComHC with MPS and management control data</td>
<td>Specific objectives in activities where one is under contract</td>
</tr>
<tr>
<td>Genuinely being able to do what is expected (being on top of things)</td>
<td>Specific training, supervision, referral, and feedback for the entire MPS</td>
<td>For activities under contract</td>
</tr>
<tr>
<td>Having adequate tools for the job</td>
<td>Simultaneously put in place all the tools needed for the range of MPS activities</td>
<td>Puts in place specific tools each time a contract is signed for an activity; takes no or almost no account of unrelated activities</td>
</tr>
<tr>
<td>Being in a position to protect one’s family</td>
<td>Assure the financial health of the ComHC contracts</td>
<td>Depends on continuation of contracts</td>
</tr>
<tr>
<td>Feeling validated</td>
<td>Appropriate payment for personnel</td>
<td>Validated by the technicians in charge of the program based on specific results</td>
</tr>
<tr>
<td></td>
<td>Validated by the community and by the local health authorities depending on the quality and global results achieved</td>
<td></td>
</tr>
</tbody>
</table>

Achievements and problems after initial implementation

The initial achievement was indisputably the implementation of functional models in each region. The various participants had acquired experience and skills. The implementation became clearer, and the policy less abstract for the regions and the central level. Subsequent stages were envisaged with more confidence and much more realism.

The interaction between health personnel and the community was no longer that of direct provision of care or of “health education”. The perceptions of some of the people had changed, notably owing to a desire not to disappoint others. The teams that participated in the community approaches, from negotiating the health map to opening the ComHC, were
not the same teams as before; they had changed, and were more qualified to pursue their committed path.

The tools and methods used to introduce the changes were tested and enriched. They were more readily adopted by managers, especially owing to central services being careful not to insist on a foolish uniformity.

The health map was recognized by all as the tool needed to negotiate extension of coverage in the districts; it even aroused the interest of the Ministry of Territorial Administration, which worked on the issue of the decentralization and establishment of rural communes. Beyond the village unit, a non-administrative intervillage space was shown to be feasible and suitable for basic development. It seemed appropriate for building the rural communes envisaged by the policy of decentralization.

The models put into place clearly differed from past experiences, more so from the point of view of the quality of coverage than of financial accessibility to care. They confirmed a genuine ability to self-finance fixed costs in rural areas, including local costs of preventive activities and part of the investment. The frequently muscular debate reinforced attitudes of tolerance, openness, and a process of real synthesis. Regulations for creating the ComHcs and operating the social-health services were a successful innovation that benefited especially from field experience and widespread, supportive consultations.

The adequacy of basic training, with new roles assigned to the doctors and nurses, posed an acute problem. Even the quality of the basic training, particularly that of nurses, remained a pressing preoccupation. Neither the initial training for launching the ComHcs nor continued training could totally alleviate it.

Motivation of health staff received little attention. The modes of motivation, in particular those of ComHCs and revitalized SDHCs, have still to be developed and tested, though some attempts were made. The new relationships between the technical managers of health centres and the ComHAs were also insufficiently consolidated. Non-technical authority was now the province of the ComHAs, and the nurses relied on their technical skills and dialogue with the community to assert their authority. The nurses had not been constrained this way in the past, having been accountable only to the chief doctor and deriving administrative authority from their functional status. Some have been able to adapt; for others, it has clearly been more difficult.

A further problem was the persistent confusion over the support modes of external partners when they systematically favoured the use of NGOs and brought them into conflict with the administration. Often the criticism was justified. The administrative bureaucracy served as an excuse to put in place intervention mechanisms directly controlled by NGOs. It is unlikely that these mechanisms promoted development, especially when they did not contribute to achieving a critical mass of knowledge and skills. The shortcomings of the administration were reproduced to various degrees.

<table>
<thead>
<tr>
<th>Table 16. Achievements and problems after initial implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Achievements</strong></td>
</tr>
<tr>
<td>Working models exist in the regions</td>
</tr>
<tr>
<td>Fruitful interaction and support between health personnel and the population</td>
</tr>
<tr>
<td>Tools and methods tested</td>
</tr>
<tr>
<td>Health map tool adopted and tested</td>
</tr>
<tr>
<td>New intervillage non-State space</td>
</tr>
<tr>
<td>The ComHCs in place make the difference</td>
</tr>
<tr>
<td>Positive atmosphere for exchange and debate</td>
</tr>
<tr>
<td>Regulations the result of experience and consultation</td>
</tr>
</tbody>
</table>

The complex situation in the urban setting, where a plurality of formal and informal health systems coexisted, created a tension that was
difficult to handle. The obligation for the ComHAs to sign an agreement with the Ministry of Health was considered by some to be very restrictive. The response of staff from the Ministry was that by the agreement, the ministry committed itself to a leading role in public health, especially since it was no longer directly in charge of first level health structures. The publication of regulations nevertheless unblocked the situation and helped to relaunch the implementation in the regions and districts.

The viability of the ComHCs remained a concern in all respects: with regard to the structure of responsibilities (doctor or nurse employed by the ComHA) and with regard to the context (urban, rural, rural with low-density population). Helping the ComHAs to assume their new responsibilities remained a challenge, particularly in rural settings.69

Financing of the sector and viability of ComHCs

Doubts about the viability of ComHCs

In 1990, operational health expenditures were financed by the State (20%) and external aid (5%). Household budgets accounted for 75% of the total. The purchase of drugs remained the most significant item, comprising more than 60% of total operating expenditures. The average health expenditures per inhabitant and per year were estimated at FCFA 2,700 (around US$ 10) at the end of the 1980s, but with significant variations according to the region (Table 17).

Table 17. Average expenditures per inhabitant according to the region

<table>
<thead>
<tr>
<th>Place of residence</th>
<th>Average expenditures per inhabitant per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bamako</td>
<td>FCFA 16,760 (US$ 61)</td>
</tr>
<tr>
<td>Sikasso</td>
<td>FCFA 1,300 (US$ 4.75)</td>
</tr>
<tr>
<td>Sekou</td>
<td>FCFA 1,000 (US$ 3.65)</td>
</tr>
<tr>
<td>Other regions</td>
<td>FCFA 900 (US$ 3.28)</td>
</tr>
</tbody>
</table>

Note: US$ 1 = FCFA 273.58 (1990)

The average expenditures on drugs by region from PPM sales in 1990 confirm the existence of significant regional disparities and the considerable spending of the capital for health expenditures (Table 18).

Table 18. Average expenditure on drugs per inhabitant per year

<table>
<thead>
<tr>
<th>Region</th>
<th>Average expenditure for drugs per inhabitant per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kayes</td>
<td>FCFA 461 (US$ 1.7)</td>
</tr>
<tr>
<td>Koulikoro</td>
<td>FCFA 617 (US$ 2.25)</td>
</tr>
<tr>
<td>Ségou</td>
<td>FCFA 467 (US$ 1.7)</td>
</tr>
<tr>
<td>Mopti</td>
<td>FCFA 211 (US$ 0.77)</td>
</tr>
<tr>
<td>Tombouctou</td>
<td>FCFA 138 (US$ 0.50)</td>
</tr>
<tr>
<td>Gao</td>
<td>FCFA 376 (US$ 1.37)</td>
</tr>
<tr>
<td>Bamako</td>
<td>FCFA 5,272 (US$ 19.2)</td>
</tr>
</tbody>
</table>

Note: US$ 1 = FCFA 273.58 (1990)

---


Like most developing countries, in the 1980s Mali went through an economic and financial crisis. Social sectors such as health and education were particularly affected by the crisis. The health budget portion of the State budget dropped from more than 8% in the 1970s to 4% at the end of the 1980s. Growth picked up again in 1989-1991\(^2\) (Fig. 14)\(^3\).

**Figure 14. Evolution of the health budget portion of the State budget**

SOURCE: CPS Ministry of Health

In response to the diminution of financial resources, it was necessary to find alternative financing. Towards the end of the 1980s, pilot projects for fixed-cost recovery were conducted in several regions of the country, with some success.\(^4\) However, when in 1989-1990 virtually complete self-

---

\(^2\) The devaluation of the FCFA in 1994 was followed by a drop, that was in turn followed by a net revival in 1995 with the health budget portion representing 6.68% of the State budget. This revival was due in large part to accelerated implementation of the health sector policy.


financing of the ComHCs was considered, it hardly appeared a risky hypothesis. That was because the question was one of extending coverage assured by the SDHCs, and the feasibility studies assumed rates of FCFA 500 per curative episode (drugs not included). These scenarios did not take into account the direct contributions to curative care made by users through charges. The scenarios came in for a fair share of criticism.75 Appearing as an annex to the HPRWP programmatic framework, they were perceived as the official option. Serious doubts were cast on the viability of future ComHCs.


drugs as a contribution to operations, subsidizing the local development committee, annual contribution from the community) in addition to charging services to individual users of the centre. There are drawbacks to developing health centres based solely on market laws. Such an approach would have led to the closure of many existing health centres and the development of more of them in viable areas (urban setting and some rich rural zones).

The State did not totally disengage from financing the first level health network. Its contribution remained significant through national programmes such as the EPI. Nevertheless, the problem of viability of the ComHCS remained real in a country where geographical accessibility to health services is very modest.

**New cost-sharing**

For several reasons, external partners of Mali and the government shared a genuine desire to improve and extend health coverage in the context of a redefined role for the State, decentralized communities, associations, and the population. The new health policy advocated a new cost-sharing for the health system. The users and the decentralized communities would assume a significant part of fixed costs at the first level (often through payment of salaries), and the State took charge of fixed costs for referral structures. The population contributed directly to financing fixed operating costs and the purchase of drugs at both the first and second levels (Table 19).

This new cost-sharing took into account the fact that for a long time, the State had been in no position to finance the health system or to automatically recruit school leavers for basic training. The government’s limited means, even though strengthened, needed to be oriented more towards investment and depreciation of structures at the first level and towards the district management teams. The State paid particular attention

---

to placing the complex and costly referral structures to make them more accessible and to increase the overall efficiency of the health system. Finally, the State was instrumental in ensuring the availability of essential generic drugs with a view to guaranteeing good financial accessibility to care.

### Table 19. Principles of cost-sharing

<table>
<thead>
<tr>
<th>District management team</th>
<th>Depreciation</th>
<th>Salaries</th>
<th>Operation</th>
<th>Drugs</th>
<th>Clientele</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government Partners</td>
<td>Government</td>
<td>Government</td>
<td>-</td>
<td></td>
<td>Government</td>
</tr>
<tr>
<td>Referral level partners</td>
<td>Government</td>
<td>Government</td>
<td>User fees</td>
<td>Users</td>
<td>Government</td>
</tr>
<tr>
<td>First level partners</td>
<td>Government</td>
<td>Users and local institutions</td>
<td>User fees</td>
<td>Users</td>
<td>Users and local institutions</td>
</tr>
<tr>
<td>Communities and local institutions NGOs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The fact that the State no longer paid ComHC health staff salaries introduced an obvious inequity within the community in ComHC areas. It also made ComHC staff accountable to the community through the ComHA as their employer. These changes in cost-sharing appeared to many as the State pulling back. Inarguably, it presented a difficult burden for the community in many health areas. But given the situation, the only realistic alternatives would have reintroduced the welfare state.

Revenue derived from two separate accounts: drugs and charges. This separation was intended to protect the resupply of drugs and to avoid the false impression of liquidity that sometimes arises from a common account. In the past these false impressions led to bankruptcy of a number of cost-recovery projects by diluting capital. Generally speaking, the proposal involved deducting a fixed percentage (between 10 and 15%) of the “drug account” to contribute to the overall operations at the centre. The “charge account” collects revenue from fees leveled on transactions (by event) and subsidies, in particular those originating from local and decentralized communities.
From simulation to a provisional operating budget

All things considered, establishing a ComHC seemed a difficult and risky venture; it could not be done without a feasibility study that took into account the responsibilities, preliminary revenue, and negotiation of subsidy programmes (e.g., by the State and the local development committee). A simple software package was developed for the feasibility studies based on observations from other cases. Using the software, one could simulate the viability of health areas according to the configuration of the health area (total population and population living within 5 km of the centre, number of villages), fixed charges, expected attendance for communities living near the centre and those living more than 5 km from the centre, preventive coverage, and range of fees as well as the margin on sale of drugs.

Population living within 5 km of the health centre. Fig. 15 shows hypothetical attendance for communities living within 5 km of the centre as 0.45 new cases per inhabitant per year, and 0.20 new cases per inhabitant per year for communities living more than 5 km from the health centre. Beyond 5 km from the health centre, attendance for curative care is very low and contributes only marginally to revenues.

It turned out that hypothesizing 0.20 new cases per inhabitant per year was too optimistic. The actual figure was closer to 0.10. On the other hand, assuming 0.45 cases for communities living within 5 km of the health centre underestimated the situation in a number of rural health centres. The simulation tested different hypotheses according to the size of the total population of the health area and its distribution, expressed as the percentage of the population living within 5 km from the health centre (30, 50, and 70%, respectively). Revenues from operations became positive for communities of 10,000 inhabitants, 50% of whom were living within 5 km of the centre. In reality, and considering the fact that the State needed to cover depreciation, a critical mass of 3,000-4,000 inhabitants living within 5 km was sufficient to assure the viability of the area.


Profit on drugs. Another aspect tested in the simulations was the influence of profit margins expected on the sale of drugs. In the rural setting, the global result only became positive with a 40% margin on 29% attendance (Fig. 16). That showed the influence of the profit margin on drugs for the viability of the ComHCs and also the possible side effects of high profit margins.

Fixed charges and appropriateness of the workload for available staff. Salaries in both the rural and urban setting needed to be adjusted to fit the volume of work (curative, preventive, and promotional activities). Estimation methods were developed to determine the optimal charges compatible with the financial equilibrium of the centre and a financial accessibility of the service for the community. One of the obvious revelations of the simulation exercises was that having to pay doctors’ salaries made it impossible for most of the rural community health centres to balance their accounts. Fig. 17 presents the workload expected at a centre comprising two workers and providing all MPS activities (including itinerant services). It shows the factors affecting the number of contacts according to the proportion of the population of the area living within 5 km of the centre (30%, 50%, and 70%) due to greater use of curative care. Attendance rates are the same as those used for Fig. 15.

Figure 15. Balance sheet of a rural ComHC according to the proportion of the population living within 5 km of the centre (simulation)
Figure 16. Influence of the margin (factor of 1-1.8) on drugs on the ComHC balance sheet; three hypotheses for attendance: 0.23, 0.29, and 0.35 of consultations for curative care (simulation)

Figure 17. Workload of a rural ComHC according to the size of the population living within 5 km (simulation)
These simulations deliberately favoured global determination of operating costs over the alternative option of determining them activity by activity. This choice was intended to limit the negative consequences of a rigid cost structure on integrating the different components of the MPS. The idea was to prevent the ComHC from being tempted to favour profitable activities to the detriment of others.

Microplanning itinerant activities in the villages was essential to applying the simulation to the provisional budget of a particular health centre and estimating the cost of the forward strategy. The structure of the area, the number of villages and their distribution, as well as the frequency of visits affect that cost (e.g., fuel and motorcycle maintenance). By integrating this concrete information into the model, the provisional budget could assign responsibility to different parties for providing MPS activities and for balancing the actual budget. Together with the microplan, it constituted an essential tool for establishing the partnership agreement linking the ComHA and the State and for evaluating the performance of the centre through regular reviews.

Careful scrutiny of the provisional operating budget was a crucial step, allowing the parties concerned (ComHA, decentralized communities, the State) to determine their respective responsibilities and reciprocal commitments. Very soon, however, the first simulations gave way to actual costs. These served to remove doubts about the viability of the ComHCs.

From provisional to balanced budget
Investment costs were estimated to be US$ 17,000, without construction, and US$ 40,000 when construction costs were included (Table 20). For a ComHC serving a community of 10,000 inhabitants, that translated to US$ 1.7 and US$ 4 per inhabitant, respectively.

The direct contribution of the population and of decentralized communities to investment was estimated at about US$ 0.7 per inhabitant. This contribution could be in cash or in kind (e.g., labour or construction material). Costs were far lower when no construction was required (e.g., renting, or old premises in good condition).

The annual operating costs of a ComHC varied greatly between the urban and rural settings. Table 21 lists costs for a rural health centre. In the rural setting, the ComHC is generally run by a nurse and rarely includes
more than three workers, nurse included. The population of the area is also very variable, generally comprising between 5,000 and 15,000 inhabitants, more than half of whom live more than 5 km from the health centre.

In the urban setting, the ComHC is generally run by a doctor and includes at least five other workers. The population of the area generally numbers more than 15,000 inhabitants. For urban ComHCs, estimates of costs are US$ 35,000 per year (an average of US$ 2.5 per inhabitant per year), and for rural ComHCs, US$ 13,000 per year (an average of US$ 1.3 per inhabitant per year).

The State and its partners continue to finance part of the fixed costs of ComHCs. This contribution sometimes goes unnoticed and is often not calculated. It may represent up to 25% of the fixed costs. For a health area of 10,000 inhabitants, this contribution amounts to around US$ 3,000 per year (vaccines, anti-tuberculosis and anti-leprosy drugs, materials, supervision). The local development committee generally subsidizes salaries (e.g., the salary of a matron or auxiliary nurse).
### Table 20. Distribution of investment costs

<table>
<thead>
<tr>
<th>Item</th>
<th>Community</th>
<th>Government</th>
<th>Average cost (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community approach: negotiation and demonstration</td>
<td>Inauguration of the ComHC</td>
<td>Community approach</td>
<td>300</td>
</tr>
<tr>
<td>Building</td>
<td>25% construction</td>
<td>75% construction</td>
<td>25,000</td>
</tr>
<tr>
<td>Human resources</td>
<td>-</td>
<td>Seed money for • training personnel</td>
<td>500</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• training the ComHA</td>
<td>300</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• supervision</td>
<td>150</td>
</tr>
<tr>
<td>Consumables</td>
<td>Initial provision of power</td>
<td>Initial provision of • drugs</td>
<td>4,780*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• vaccines</td>
<td>1,112</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• management support</td>
<td>250</td>
</tr>
<tr>
<td>Material and equipment</td>
<td>Local furniture</td>
<td>Medical equipment</td>
<td>6,350</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Logistics</td>
<td>1,400</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Furniture</td>
<td>120</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>40,072</td>
</tr>
</tbody>
</table>

**Source:** HPRWP and UNICEF  
**Notes:** US$ 1 = FCFA 520  
*The allowance of drugs takes into account the contribution to the district distribution depot.

### Table 21. Distribution of operating costs of a rural ComHC (including depreciation)

<table>
<thead>
<tr>
<th>Community</th>
<th>Government and external partners</th>
<th>Average costs (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Building</td>
<td>• Maintenance, charges</td>
<td>• No commitment</td>
</tr>
<tr>
<td>Furniture and equipment</td>
<td>• Maintenance</td>
<td>• Depreciation of large equipment, and EPI materials and supplies</td>
</tr>
<tr>
<td>Consumables</td>
<td>• Drugs</td>
<td>• Vaccines</td>
</tr>
<tr>
<td></td>
<td>• Vaccines</td>
<td>• Contraceptives, anti-tuberculosis drugs</td>
</tr>
<tr>
<td></td>
<td>• Reagents and medical</td>
<td></td>
</tr>
<tr>
<td>Category</td>
<td>Items</td>
<td>Budget</td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Consumables</td>
<td>• Provision of power</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Materials</td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
<td>• Salaries</td>
<td>4,694*</td>
</tr>
<tr>
<td></td>
<td>• Housing</td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td>• Fuel and maintenance</td>
<td>656</td>
</tr>
<tr>
<td>Communication</td>
<td>• Maintenance</td>
<td>360</td>
</tr>
<tr>
<td></td>
<td>• Supervision</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Continuing education</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Depreciation for motorcycles (?)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Depreciation for radio communication</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>3,047</td>
</tr>
</tbody>
</table>

* Includes the salary for four workers

Figure 18. Financial outlook for rural ComHC based on simulation

![Graph showing financial outlook for rural ComHC based on simulation]
Results for the first ComHCs projected balanced operational accounts or surpluses, even when they offered the full range of MPS activities. Figs 18 and 19 show the size of the population living within 5 km of the health centre, which was a determinant of the viability of the centre. Three health areas showed a surplus balance that clearly exceeded projections (Monzombala, Kalabankoro, and Fanga, with 52, 49, and 81%, respectively, of their total population living within 5 km of the centre). Three health areas fell below projections without incurring deficits (Touna and Dia, and Guétéma, with 51, 63, and 58%, respectively, of the population living within 5 km of the health centre).

The remaining two areas are close to projections corresponding to the proportion of their population living within 5 km of the health centre (Dougoulo and Gagna, with 55 and 49%, respectively, of their population living within 5 km).

Overall, none of the eight areas showed a deficit, and six closely matched the projections or had a surplus. But these encouraging results also underscored the limits of the method. Simulations do not take into account variables such as the competence and people skills of the auxiliary nursing staff or the motivation and degree of commitment of the community. Moreover, the ComHAs did not always follow the pricing schemes used in the simulations.
Figure 19. Financial results observed in eight areas ("%" indicates the proportion of the population living within 5 km)

Points for discussion

Presentation of these results in annual reviews and other meetings sparked many questions. Doesn’t increasing the profit margin on drug risk reducing their affordability? Why not standardize margins and selling prices for drugs? Some centres do not explicitly provide mechanisms to cover the poor; shouldn’t the same mechanisms apply to everyone? Why not use contracts to finance activities of national priority programmes? It really is a question of government priorities, and it would help to avoid deficits and to motivate staff based on results. The forward strategy is very costly; shouldn’t the EPI continue to finance it? Why run the urban ComHCs using doctors given the effect it has on the centre’s fixed charges? Why stop at nurses when the country produces dozens of doctors each year? What can be done for non-viable areas?
The answers to these questions emerged through a mutually enriching process of debate and practice. Generally, good sense prevailed, and impasses were sidestepped—though sometimes with difficulty.

**Profit on drugs.** The profit on drugs was essential to the ComHCs and the private dispensaries. In terms of helping to operate the health centres, it was socially and economically justifiable. Of course, the contribution needed to be reasonable and not to exceed a certain percentage to avoid becoming an obstacle to affordability. The determining factors in the affordability of drugs are their availability and actual prescription. For health centres disadvantaged by distance or dispersed populations, applying a single profit margin and selling price for every product throughout the country in the interest of equity could be counterproductive if standardization mechanisms were not taken into account and if they were not effectively managed. Case-by-case adjustment of the profit margin within a reasonable bracket was required in each situation to determine a fair selling price and to avoid the undesirable effects of different prices in the same market. In the end, this was the approach taken in Mali.

**Care of the poor** was left to the discretion of the ComHAs. Some made formal provisions for it (e.g., funds and authorizations by the committee). Others omitted it, arguing that the family or the extended family and eventually the village solidarity fund were sufficient to provide support. It was considered unwise and premature to complicate management of the centre with this risky proposition and to endanger the centre’s sustainability. Whatever the philosophy, the rates of unused prescriptions give some indication of the inability to pay among those referred to the health centres. Often less than 5%, this percentage exceeds 10% in the region of Mopti (particularly after the devaluation of the FCFA) and in places where essential drugs are not still not really available.

The problem of the poor was more serious in emergency referral situations, where patients needed to cover costs amounting to several tens of thousands of FCFA. Efforts are under way to develop insurance mechanisms to meet the cost of evacuations and emergency surgical care. These efforts are positively perceived both by individuals and the ComHAs. It is likely that the low rate of case referrals, which affects the overall efficiency of the health system, was due at least in part to the difficulty in paying the increased cost of referrals. In any case, it became important to distinguish efficient management of the centre from the mechanisms...
needed to increase access for the poor. Each dimension requires action, but they should not be confused.

**Itinerant services.** Depreciation of the refrigerator, and shipment and supply of vaccines made up nearly 90% of the actual costs of vaccination and itinerant services. The State covered these costs and seemed ready to meet the total or partial cost of depreciation of the motorcycle. The local costs of the forward strategy were of the order of FCFA 160,000 per year for maintenance and fuel (US$ 320 at the average exchange rate for 1995), and FCFA 90,000 per year (US$ 180) for fuel for the refrigerators. That represents less than FCFA 20 per inhabitant per year and hardly more than 3-4% of the total operational cost of the health centre. It is obviously modest with regard to a budget of more than FCFA 6 million. The advantage of having the ComHCs bear the local costs is that the health centre has greater autonomy vis-à-vis inputs available in all the regions, and in local and community control of these expenditures. An example is the R-SDHC of Touna, where the nurse had to stop vaccination services for one month. The programme had failed to supply petrol, despite the fact that the centre funds were adequate, petrol was available, and the village and committee were perfectly capable of assuring continuity of vaccinations.

The rural ComHAs place great importance on itinerant services (which are not limited to vaccinations, but do not include curative care), and they ensure that the nurse performs them in accordance with the schedule fixed through microplanning. It is a solution of sorts to equalizing access to the health centre and of strengthening the solidarity of the group of villages around their centre. This involvement would be meaningless if the financing of local costs remained under the responsibility of vertical programmes, for the health staff would not be accountable to the community. Some ComHAs have even organized annual renewable contributions to guarantee these services; others have recommended that three sessions per week be devoted to itinerant activities at the risk of affecting the continuity of curative care in the health centre.80

---

Specific contracts had no justification if the activity to be carried out was part of the MPS. The agreement and regular reviews were an occasion to examine the reciprocal commitments of each party (Minister of Health and ComHA) and to take into account particularly structural problems. The introduction of the concept of separate contracts for basic activities would have risked taking responsibility from the ComHAs and causing negative effects related to the quest for funds linked to these contracts.

Bonuses and benefits. Staff could not be financially motivated using the ComHA as the driving force without calling into question the principles of decentralization and community participation. Some ComHAs negotiated bonuses, whereas others helped with housing arrangements; the community traditionally gives money to staff who come to the village to perform services. But these initiatives do not constitute an adequate response to a problem that is becoming increasingly serious.

Medicalization of the first level. Recruiting a temporary doctor costs significantly more for a ComHA than recruiting a nurse. Sooner or later, however, the urban first level will be medicalized, and in the foreseeable future, some of the relatively rich rural areas will also inevitably host a number of doctors in training. On the other hand, to be appointed by a ComHA is not often the first choice for a doctor or even for a nurse. Indeed, the rural ComHCs encountered difficulties in recruiting nurses, who prefer the informal prosperous sector in the cities and towns while waiting for eventual recruitment to public service. In some cases a ComHC failed to launch because a nurse could not be found.81 The urban ComHCs are not always able to retain their doctors, who also would rather be employed by the public service, even if the pay is two times lower, or working for an NGO. The public sector’s commitment to assure the availability of the required number of doctors per district (three to five doctors per district) is far from being met. The constraint of the structural adjustment programme in recruiting staff in the health and education sectors remains a reality.82 It may be a long time before doctors rush to the rural ComHCs seeking employment.

de la Solidarité et des Personnes Agées.

81 Mali does not produce enough nurses to satisfy the plan for extended coverage. Centralized training for middle level managers in Bamako does not favour allocating them to rural regions.

82 Even thought devaluation of the FCFA helped to alleviate it.
What are the solutions for the non-viable areas? With barely 30% of the population living within 5 km of a health centre (stable proportion for more than 15 years), it was not reasonable to expect total coverage in fewer than five years. So it made sense to give priority to the areas which appeared structurally viable at the outset. Revitalization of SDHCs would change the accessibility and quality of care in Mali in the coming years. By the year 2000, more than 45% of the population lived within 5 km of a health centre offering a MPS and managed by the community. It is time to evaluate the areas that this initial effort contributed to changing to better assess implications, mobilize resources (financial and human), and use those resources to organize solidarity at all levels to assure the establishment of ComHCs in areas not yet covered.

According to available health maps at the central level in December 1995, out of a total of 614 health areas comprising 6,350,000 inhabitants, 425 were programmed by the year 2000. They included 4,675,000 inhabitants and represented 74% of projected health areas.

The number of programmed areas containing fewer than 7,500 inhabitants was 133 (31%). Out of the 189 areas not yet programmed, 104, or 55%, had fewer than 7,500 inhabitants. These numbers imply the use of financial viability criteria in the programming, but they also suggest that these criteria are not absolute. Other criteria were taken into account locally, including the commitment and determination of communities in the area.

Devaluation

THREATS TO REFORM

On 12 January 1994 the FCFA was devaluated by 50%. It was clear that this event could compromise implementation of the health sector policy and reduce the viability of the ComHCs. Should priorities in the health sector be reconsidered in light of devaluation, or should reform be pursued? Should drugs be subsidized? How could generic drugs be made available to the whole population? What would the effect of devaluation be on the frequency of services and on their viability?

The response to devaluation—virtually unanimous, though with some hesitation—was to accelerate implementation of the new policy and,
better still, to do it in a way that the accompanying measures strengthened rather than weakened it. The main problem was drugs.\textsuperscript{83} The implication for the selling price of drugs was that devaluation would lead to a price increase of more than 60%. This would have put drugs out of reach for a significant segment of the population. There was a strong temptation to insulate provision of drugs to health centres from the process of on-going technical and community management, or at least, to subsidize the drugs.

At the time, there were no more than 10 centres using generic drugs. For most of the Malian population, improving the availability of generic drugs was a better solution than subsidizing them. Subsidies nevertheless proved useful to avoid diluting the capital of existing drug depots, given that the government had decided to freeze selling prices. Finally, the Canadian government granted Mali FCFA 1 billion through the PPM.\textsuperscript{84} The funds were used to stabilize the sale price of 15 essential drugs for one year and to supply private dispensaries under favourable conditions. These measures were very controversial. They did not prevent dilution of capital at the peripheral health centres, nor did they resolve the problem of availability of essential drugs.

The contract between the State and the PPM never met expectations. Massive subsidies had allowed the PPM to order considerable quantities of generic drugs (more than FCFA 2 billion). The availability of these drugs in the regions was overwhelming. It was possible to conclude that the ComHCs would never lack drugs in the future. But the problem of sustaining the supply remained. The market was very far from being saturated despite devaluation.

\section*{VIABILITY OF ACCESS}

After an initial dilution of capital, the ComHCs reflected the effect of devaluation in the sale price of drugs. In contrast, fees for consultations did not change. There was no drop in attendance, but notably, the number of


unused prescriptions increased. The financial situation improved following the increase in sale prices, but to the detriment of affordability for the population. Viability thus prevailed over affordability.

In 1995, the year following devaluation, only 3 out of 39 health centres for which detailed operational accounts were available showed deficits (depreciation of the refrigerator and medical equipment being the responsibility of the State) (Table 22). Most of the ComHCs were established after devaluation and had not faced the same risk of dilution of capital for their drug depots.

These centres continued to offer well-regarded services with balanced accounts, indeed, surpluses. They were able to cover all local operating costs (including petrol for the cold chain and fuel for logistics). The cost of services had certainly increased in the old centres (in particular in the region of Mopti). But the new centres (the majority) constituted a new opportunity and important progress for a population devoid of easy access to care services and which, in emergencies, had to pay a fortune to obtain brand-name drugs.

This phenomenon is especially notable in Mopti Region, where implementation of the new health policy included assuring continuity of a system for distributing essential drugs already in place through a regional project. This system had been destabilized by the devaluation, but also by restocking in PPM stores. When they were available, the generic drugs were clearly more expensive than those of the former round of stocking under the project, or even those of the GIE Santé pour Tous. In Mopti, the average cost of prescriptions was more than FCFA 1,200, as opposed to FCFA 700 in other regions. One patient in five could not afford to buy the drugs prescribed to them. See Berche T & Mariko M (1991) Le financement des coûts recurrents de la santé dans le cercle de Bandiagara; analyse économique et santé publique. Report. 112p, Bamako: Institut National de Recherche en Santé Publique. Oopen C, Coulibaly F & Neuhaus E (1997) Combien pourraient coûter des soins de qualité. In: Brunet-Jailly E (ed) Innover dans les systèmes de santé. Expériences d’Afrique de l’Ouest, 257-270. Paris: Editions Karthala. Diarra K & Robez-Masson D (1992) Le financement des coûts recurrents de la santé dans le cercle de Djenné au Mali. Initiative de Bamako. Technical Report No. 14 34p. New York: UNICEF.

### Table 22. Operating account for 23 ComHCs and 16 R-SDHCs the year following devaluation

<table>
<thead>
<tr>
<th></th>
<th>ComHC</th>
<th>R-SDHC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Surplus</td>
<td>Balanced</td>
</tr>
<tr>
<td>Kayes</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Koulikoro</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Ségou</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Mopti</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Sikasso</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
<td>11</td>
</tr>
</tbody>
</table>

**Source:** S. Samake, F. Giudetti, and A. El Abassi.

**Note:** The R-SDHCs have a nurse paid by the State; the ComHCs pay the nurse’s salary themselves.

A price increase of FCFA 50 would have significantly improved the account’s chances of remaining balanced (Fig. 20). But it would have reduced affordability and assumed elasticity of demand. In truth, the major consequences of devaluation are still to come, and concern depreciation of equipment (practically all imported) and logistics. Paying back a fuel refrigerator costing close to US$ 2,000 and a motorcycle costing US$1,000 became difficult for the rural health centres, even though some had hoped to do so at the start. For the ComHCs to be able to cover deprecations would have required a level of attendance much higher than 0.35 (Fig. 20). The rates of attendance observed before devaluation ranged between 0.15 and 0.25 in the ComHCs and R-SDHCs; elsewhere, it was often less than 0.10. It is unthinkable that the ComHCs, in particular the rural ones, can survive and respond to the demands on them without the State guaranteeing (with the support of external partners) depreciation of equipment or contributing to logistics. After devaluation this commitment from the State was inevitable. It was necessary to act very quickly to avoid bottlenecks when the time came for replacement.
Figure 20. Depreciation and devaluation: effects on the financial equilibrium of a rural ComHC

Note: ComHC with a population of 9,631 inhabitants of which 55% live within 5 km of the health centre. Depreciation accruing to ComHC: Depreciation 1 = refrigerator over five years, small tools over three years, mobillette over three years. Depreciation 2 = small tools over three years, mobillette over three years. Option = rate increase of FCFA 50.

Financing the district health system

In the districts where a cost-recovery system was organized, close to 50% of the operating budget came from local revenue, with the State continuing to pay salaries. The non-functional health areas were and remain covered by the SDHCs, at least for preventive care. For this the R-SDHC receives a modest subsidy. In the framework of the new programme, the State needed to increase the health portion of the State budget from 4% in 1991 to 9% in
1995. Even though begun, this evolution remained short of objectives (6.56% in 1996) (Fig. 14).

The increase was aimed at improving the basic functioning of the system and in particular that of referral. The problem at this level is more fluidity and flexibility in mobilizing resources at the decentralized level. It was not rare to observe that in the third quarter, the health budget showed a significant delay in execution, though the needs were far from being covered. Here, the problem was one of structuring and effective decentralization of budgets. In many countries the Ministries of Finance do not always look favourably on decentralization. And staff responsible for finance are not easily inclined to modify procedures and material. Nevertheless, a solution is needed so that referral centres and the district management team can respond to programme demands with budgetary resources sufficient to guarantee basic operations. Otherwise, users will have to pay high prices for each hospitalization or surgical intervention, especially since there is still no solidarity mechanism to take care of referral cases, other than a few promising projects.

An evaluation of the costs and financing of the district health system was undertaken in 1996. It covered three districts and one Bamako commune. The operational costs, less depreciation, of the first referral varied from FCFA 530 per inhabitant for Commune V of Bamako to FCFA 108 per inhabitant for Djenne. The evaluation systematically reviewed the different mechanisms for financing the district health system with an eye to equity. The conclusion was that there are only two ways to assure the viability of first referral hospitals: subsidies from the State and the ability of communities and health teams to create new forms of solidarity. For this second dimension to develop, it will be necessary to avoid top-down and one-size-fits-all approaches. Efforts to progress towards a consolidated budget by district and to put in place new solidarity mechanisms (premutual and mutual funds) will permit better understanding of the complex, overall financing of the district health system.

A major problem remaining is that of the structure of financing of the ComHC, which depends on how much of the community has easy access. If the State guarantees depreciation for all items, as appears to be the case, it will be necessary to put in place solidarity mechanisms by level (e.g., district, region and central), to extend coverage of the country by the ComHCs. The non-viable areas or areas with uncertain viability will soon constitute the large majority of ComHCs to be planned. One could make current progress conditional on finding a solution for the non-viable areas. But common sense encourages progress in the implementation of viable areas, negotiation on a case by case basis in the limited areas, and keeping the door open for non-viable areas with energetic communities and making inroads through reciprocal agreements. It will mean organizing the district health system and its financing to bring about a very different situation in terms of quality and access to care. That being the case, it should be possible to mobilize resources and solidarity to extend coverage to areas presumed to be non-viable.

The problem of non-viable areas is an important one. More equitable mechanisms of resource allocation have to be found without demobilizing those who made efforts under trying circumstances, or returning to centralization, which has failed before. To learn from on-going experiences, to bring each partner to respect all their commitments, to organize and develop a base of solidarity will undoubtedly lead to progress in establishing ComHCs in difficult areas. A few a priori non-viable health areas have shown the way: Kaara in Sikasso Region, with fewer than 5,000 inhabitants and Gagna in the floodplain of Mopti Region assured viability of their ComHCs using annual contributions from the community.89

Pressures to accelerate

Most contributors appreciated the achievements of the early 1990s. District development plans were drawn up in consultation with local partners and regional support. The coverage plans took into account demographic, geographic, sociologic, and economic elements. These flexible maps were used as tools to negotiate district health coverage and development. The ComHCs provided the MPS through itinerant activities in the villages, thus meeting underlying health sector policy objectives (financial accessibility, improved quality of care, good preventive coverage, community management, viability not dependent on external financial aid) in their area of responsibility.

The replicability and fragility of the commitments of each party (State and community), particularly following devaluation were of course a matter of concern. But people recognized that there was no real alternative, certainly not using the methods of the past.

Pressure to move faster and to extend coverage to the whole country began to be felt. While approving quality and performance, some parties placed too much emphasis on the time it took for each of the activities: for example, 18 months for the district health development plan, and around 12 months for a ComHC. While some ComHCs had been able to start up 6 months after the start of negotiations, others took up to 24 months (Table 23).

Some people requested that strategies be revised to better respond to their concerns, in terms of coverage, disbursement, or political satisfaction. Obviously, if the time required for each implementation in every region were laid end to end, it would have been necessary to wait well beyond the year 2000 for substantial differences in coverage. This perspective was clearly not acceptable to all, in particular those committed to attaining institutional and political objectives.
### Table 23. Time to launch of the ComHCs and R-SDHCs in Koulikoro Region

<table>
<thead>
<tr>
<th>No. of months</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
<th>17</th>
<th>18</th>
<th>19</th>
<th>20</th>
<th>21</th>
<th>22</th>
<th>23</th>
<th>24</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tougouni*</td>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>i</td>
<td>a</td>
<td>m</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baguinéda*</td>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>i</td>
<td>a</td>
<td>m</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boron*</td>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>i</td>
<td>a</td>
<td>m</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moundiah*</td>
<td>n</td>
<td>c</td>
<td>i</td>
<td>a</td>
<td>m</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ilali*</td>
<td>n</td>
<td>c</td>
<td>i</td>
<td>a</td>
<td>m</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monzombala</td>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>i</td>
<td>a</td>
<td>m</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nossembougou*</td>
<td>n</td>
<td>c</td>
<td>i</td>
<td>a</td>
<td>m</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kalabancoro</td>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>i</td>
<td>a</td>
<td>m</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Koula*</td>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>i</td>
<td>a</td>
<td>m</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cheln</td>
<td>n</td>
<td>c</td>
<td>i</td>
<td>a</td>
<td>m</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sirakorola*</td>
<td>n</td>
<td>c</td>
<td>i</td>
<td>a</td>
<td>m</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Massantola*</td>
<td>n</td>
<td>c</td>
<td>i</td>
<td>a</td>
<td>m</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Didéré*</td>
<td>n</td>
<td>c</td>
<td>i</td>
<td>a</td>
<td>m</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nangola</td>
<td>n</td>
<td>c</td>
<td>i</td>
<td>a</td>
<td>m</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sabouga</td>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>i</td>
<td>a</td>
<td>m</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kolébougou</td>
<td>n</td>
<td>c</td>
<td>i</td>
<td>a</td>
<td>m</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Niyamina*</td>
<td>n</td>
<td>c</td>
<td>i</td>
<td>a</td>
<td>m</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Motshougou*</td>
<td>n</td>
<td>c</td>
<td>i</td>
<td>a</td>
<td>m</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kanitaye</td>
<td>n</td>
<td>c</td>
<td>i</td>
<td>a</td>
<td>m</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Madina Sako*</td>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>i</td>
<td>a</td>
<td>m</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Narina*</td>
<td>n</td>
<td>c</td>
<td>i</td>
<td>a</td>
<td>m</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goumbou</td>
<td>n</td>
<td>c</td>
<td>i</td>
<td>a</td>
<td>m</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dilly*</td>
<td>n</td>
<td>c</td>
<td>i</td>
<td>a</td>
<td>m</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kerouné</td>
<td>n</td>
<td>c</td>
<td>i</td>
<td>a</td>
<td>m</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cola Bamanam</td>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>i</td>
<td>a</td>
<td>m</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Massigui*</td>
<td>n</td>
<td>c</td>
<td>i</td>
<td>a</td>
<td>m</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*SDHC

Legend: n = beginning of negotiations; i = training ComHC workers; c = setting up the ComHA; a = training the ComHA.

**Notes:** Tougouni (SDHC), 1995; Baguinéda, 1996; Boron, 1995; Moundiah, 1996; Ballé, 1996; Monzombala, 1994; Nossembougou, 1995; Kalabancoro, 1994, the ComHA predated the community approach; Koula, 1995; Chola, 1995; Sirakorola, 1996; Massantola, 1995; Diéni, 1996, ComHA refused to keep the SDHC’s nurse; Nangola, 1995, problems recruiting nurses; Sabouga, 1995, problems with negotiations; Kolébougou, 1994, problems recruiting staff; Niyamina, 1995, rainy season and delay of the district health team; Motshougou, 1995, negociated maternity conversion into ComHC; Keriégué, 1995, delay in mobilizing resources by SNV (an NGO from Netherlands); Madina Sako, 1995, delay of the ESSC; Naréna, 1995, negotiation difficult and nurse problems; Goumbou, 1995, support difficult because of distances; Dilly, 1995, support difficult because of distances; Kerouané, 1995, problem recruiting nurses; Cola Bamanam, 1995, difficult negotiations; Massigui, 1996, delay in mobilizing resources by SNV.

**Within Mali** a push came from the political level, which wanted the community to benefit rapidly from the new policy. The government was committed to attain its objectives in a national and international context. It wished to demonstrate the progress achieved in this direction and to advance towards implementation of its objectives. The results of the first
implementations and their acceptability by the community led the health authority to support the operationalization strategies while applying pressure to move faster.

The ComHA of Bamako and the economic interest group Health for All included many upper-level staff, some of whom were members of political parties. Thus it is not surprising that the problems with implementation and the debate over the strategies resonated at high political levels and contributed to pressure. Another source of internal political pressure was the determination to effectively mobilize resources allocated by donors, notably in a macroeconomic framework.

Pressure also came from the community. Following training, discussions about the health maps, and especially through word of mouth as the first ComHCS emerged, people increasingly appealed to the chief doctors and to the regional offices for rapid opening of ComHCSs in their areas. Through their citizens living in Bamako, they made direct requests to external partners, for example, small French NGOs or through twinning arrangements.

External pressures. The World Bank and UNICEF expressed the most anxiety and impatience over delays in implementation. Other partners showed their frustration to a lesser degree, or not at all.90 While it is true that USAID developed mechanisms to help in eradicating dracunculiasis and increasing contraceptive use, the agency hoped the objectives would not be a detriment to establishing ComHCSs. That was much easier said than done.

At the launching seminars of the HPRWP in November 1992 and implementation in February 1993, there was a strong temptation to accelerate development of district plans and to multiply them rapidly. There was certainly pressure from the World Bank in this direction. The preparatory stage of putting in place a foundation for the new health system did not disburse large amounts of money, and its achievements were not very visible. The message was clear: in the absence of significant results in the following months, the HPRWP was in jeopardy owing to inadequate disbursement, in accordance with Bank procedures. Still, this message was moderated by the clear show of sympathy by successive Bank missions to

90 At this stage the other external partners had still not begun disbursements towards implementation (EDF, KFW) or remained on the fringe, indeed outside of cofinancing (FAC, UNFPA).
Mali. The Bank and UNICEF alike followed with interest the link between evolution of access to the MPS and achievement of programme coverage objectives.

The new capacities of the chief doctors during these seminars, and the mastery and commitment the regional staff showed reduced the challenges and criticisms. Letting time take its course proved a viable proposition by creating opportunity for self-training and adaptation. The central level managers resisted the temptation to “bulldoze”, and respected the process under way in the field.

UNICEF played a major role first in universal immunization during 1990, then in demonstrating and mobilizing at the time of the World Summit for Children. The organization was preoccupied with verifying that the implementation strategies constituted the best means of attaining its objectives. Having played a key role in defining and implementing the national policy, it wished to rapidly demonstrate that the proposed strategies were pertinent and that the coverage was progressing in a steady and significant way. The pressure of the organization was exerted through different channels, particularly at meetings and international gatherings. Well informed due to its field presence (UNICEF technical advisors in the five regional health offices), the UNICEF office in Bamako was careful not to disturb the process of implementation. With regard to headquarters, however, this type of concern did not carry the same weight as points for vaccination coverage gained or lost.

It was expected that matters would accelerate after the first trials in each of the regions. But that didn’t mean the challenge shouldn’t be taken seriously. Those aware of realities in the field knew that the policy of “burying one’s head in the sand” did not alleviate the constraints.

**Real constraints**

Offering the whole population of Mali accessibility, quality, and the level of health coverage achieved by the first ComHC was a legitimate and necessary objective. It was highly desirable that it happen quickly.

In particular, getting all the inputs in place required effective control by participants. Rushing the process risked compromising the minimum level of quality and could lead to major failure. Focusing on these failures risked calling the entire enterprise into question.
Extension of coverage had to be accelerated to increase scope and gain credibility, which was essential with respect to national programmes. In this way, the stage would be set to integrate them into the on-going process. Acceleration was also politically necessary to find a definitive and sustainable solution to the essential drugs problem.

There were several objective constraints to acceleration that were too often ignored by those who advocated speeding implementation along. Still, what it ultimately boiled down to was a profound transformation of health services and relationships between the community and services. That required competent, experienced, and motivated staff.

**Staffing problems.** Many districts only had one doctor, and nurses for the ComHCs were difficult to recruit in the rural areas. That may appear paradoxical in a country where young graduates go unemployed. But there are limited opportunities to recruit doctors into public service, inequities in the way staff are deployed, and a thriving informal sector in the city of Bamako. Increasingly, nurses prefer to remain in the capital where they have been trained rather than to work in the rural areas, which does not confer civil servant status.

Managing a ComHC required at least a certified nurse qualification. Basic training consisted of an initial month’s training on managing the centre and the MPS, followed by monthly supervision for one year.

The initial training sessions for nurses and matrons revealed wide ranges in competence, which was generally low. Serious shortcomings were observed during supervisions, including in the ComHCs. The basic training of nursing staff was not at all adapted to the role of “doctor” which they were asked to assume in the middle of nowhere. Many matrons were incapable of reading or writing correctly. One or two months’ training was not enough to alleviate serious deficiencies. It is then not surprising that certain diagnostics never appeared on the consultation records, and that referrals were rare (often less than 1% of consulting) and essentially involved emergency evacuations.

While short courses of retraining and supervision can improve the skills of on-site staff, over the medium and long term the effort would be

---

91 Credibility had to be reestablished, not only with regard to the extreme poverty of the public sector health centres, but also vis-à-vis experiences with Village Health Workers in the 1980s.

ineffective and inefficient without revising nurse training school programmes, and without standardizing recruitment of matrons at an acceptable level. Some proposals for revamping health school training programmes were formulated (in particular in the nursing school of Sikasso which actually implemented them). But the years go by, and the preparatory phases endure at the Bamako secondary health school, the main training institution for paramedical managers.

The problem of basic training for doctors also arose, but less critically. The new context demanded versatility. Doctors needed surgical and management skills that were generally not taught in medical schools.

In certain districts, and after the team had been through the crucial stages (e.g., developing the plan and negotiating the map), transfers were made without taking into account their impact on the team. That brought some districts back to square one. In other circumstances there were unfortunate cases of serious illness and death. In countries where managers are rare in rural areas, these phenomena need to be taken into consideration.

Limited logistical capacity and support. The early implementations enjoyed significant logistical support from UNICEF. Government logistical support capacities were not appropriate and constituted a serious obstacle to moving forward quickly. The pace of development, which was slow at the beginning, concealed these problems. Soon the logistical problems became a rate-limiting factor.

The support capacities of regional teams were inadequate. They were supposed to develop the whole district health system, which included not just the ComHC but also the referral hospital service. Automatically reverting to external technical assistance to meet this need would run the risk of compromising adaptation. The natural tendency of technicians to reinvent the wheel would have generated more problems than solutions.

Decentralization was one of the essential orientations of the new sectoral policy. There was a consensus about its need and justification. But doesn’t wanting to move quickly ultimately risk strengthening the case for centralization?

Time available for staff at the operating level was divided among follow-up activities related to implementation of the new policy, vertical programme activities (seminars, central supervisions, national workshops, and so on), and community care services. In this situation of competition,
priority was always given to the service imposed or even paid for at the expense of continuity of services. The shortage of human resources, in particular in rural areas, underscored this phenomenon.

Guaranteeing quality of care and appropriate management of the new ComHCs, as well as their effectiveness and viability, required minimum support. This support consisted of a series of successive stages: community approach, provision of inputs, training and the launching the new centre (ComHC or R-SDHC), technical supervisions, follow-up, and evaluation. Eighteen months (including the six months of initial functioning) proved sufficient to establish a ComHC and bring it to an acceptable operating level. The performance thus obtained was compatible with attainment of fixed objectives. The workload for the district team was estimated at a minimum of 10 full weeks of work for each ComHC. This constituted a bottleneck could only be reduced to the detriment of the quality of support and potential adaptation by the participants.

Few managers had acquired enough experience during the first two years of implementation. Their number increased progressively according to the progress achieved in the chosen districts. They benefited from the support of those who had already had experience.

The limits of budgetary decentralization. Budgetary decentralization is not part of and does not strengthen the process (Fig. 21). It is projects such as the HPRWP that underpin the current effort. Previous years demonstrate that the global increase in the health budget has essentially benefited the financial transactions made at the central level and not those of the regions. It appears that at the time, there was more budgetary recentralization than decentralization.
The persisting problem of integrating vertical programmes

The new policy was not implemented all at once; the old vertical programmes continued to operate, and others were even added to them (e.g., dracunculiasis and distribution of contraceptives at the community level). Officially this was supposed to be an interim arrangement while waiting for decentralization and progressive integration. The desire for seamless change concealed a range of problems; the reality was the status quo, or even a reversal.

Confusion persisted concerning the integration and effective decentralization of the services comprising the MPS. None of the vertical programmes had begun an explicit transition. Hesitating to question methods of management and integration, programmes continued to benefit from financing of external partners who were not always approving of the on-going process. Preoccupied with their programmes or specific projects, the latter were concerned about maintaining an influential partner.
When achievements started to mount up, the chief doctors and regional managers began to criticize the excessive demands of vertical programmes. The National Health Directorate then took formal measures to prioritize execution of district health development plans. Still, external partners and managers of programmes at the central level used the pretext of insufficient coverage to justify their parallel interventions.

Despite the will of some, problems of coordination and harmonization of interventions at the central level were not easy to resolve. At the beginning of 1994 the National Health Directorate organized consultation days with the participation of all the divisions and regional offices. The differences in levels of information and reasoning were strikingly apparent. These consultations helped to make progress, but without resolving all the problems. The thinking behind the divisions and programmes of the National Health Directorate was strongly influenced by tradition and the involvement of external partners. The people most closely involved in implementing the new policy had no miracle solution to propose. Nevertheless, they were able to correct the major inconsistencies and to resolve conflicts of priority.

Beyond closed arbitration at the central level, the field could hardly best the challenge without an alternative solution. Consequently, programmes were urged to channel their support towards launch of the ComHCs. Once the number of operational health areas exceeded 100, a new, strong relationship was established. External partners and managers of national programmes had a more positive attitude with regard to the new health system. Now the trick was to manage the new risk arising from a flood of proposals for integration originating from projects and programmes.

Accelerating without derailing

The national technical staff and expatriates all expressed doubts about the chances of success for rapid acceleration. Their convergent positions mitigated the demotivating effect of pressure.

It was possible to plan a few measures for speeding things up. Establishing the first ComHC was a nucleus that allowed the district team to be formed gradually and to avoid possible apathy (including from within), when transforming a State health centre. Thereafter, it was possible to revitalize SDHCs more rapidly than to set up other ComHCs: the infrastructure and the staff were already in place.
The combination of initial training for three to four centres of two to three regional districts had advantages. The support process was shortened, and it created a group dynamic and competitiveness among the people being trained as well as the chief doctors. This seemed a good way to bring the newcomers together. The concentrated training carried risks, and specific solutions needed to be envisaged. To make up for the risk of neglecting the launch of the centre, a cushion of one week was explicitly foreseen in the opening of each centre as well as in-service-training for several days in a working ComHC (Table 8). Another risk concerned management of priorities by the regional and district staff. Some of the centre openings did not follow rapidly enough on group training. A long delay between training and launch considerably reduced a centre’s efficacy. Finally, from the start close supervision remained an integral complement to all these measures.

The measures were necessary to avoid laxity and the problems of classical training in series. Practical training, self-evaluation with support from those who had acquired experience, and exchange of experiences all were decisive for bringing about change.

The new HIS supported decision making at each level. Its implementation proved to be particularly difficult owing to resistance from projects and national programmes, which each had their own system. Despite a prevailing consensus throughout development of the new HIS (which lasted more than three years), implementation was at a standstill. Maintenance of the old system as a transitional arrangement became an obstacle to developing the new HIS. As a result, the National Health Directorate decided to generalize it to the whole country, even though some components still had to be completed. This measure was intended to support the acceleration process: it was possible to do monitoring thanks to the new HIS.


94 And to the software program DESAM, a geographical and cartographical database that relates information about resources to HIS data on care and morbidity.
Faced with increasing pressure, technical staff developed coverage scenarios using the performance of the first ComHC to show that it was advisable to wait for completion of district plans. These illustrations proved to be very useful for supporters and major participants by providing arguments that confirmed the strong basis of the strategies. It was no longer a question of whether it was possible to achieve such coverage or such results. It was clear that it was possible. The question was rather one of setting more reasonable deadlines.

In December 1994 an external evaluation preceded the mid-term review of the HPRWP. It determined the significance and quality of progress achieved. In particular, the risks of moving too quickly and certain obstacles (drug issue and availability of staff at the operational level) were identified. Development of community capacities required sustained attention. The process was not ending, but beginning. The pressures diminished, and external partners were anxious to express a position at one with the government in recognition of progress achieved. This show of unanimity was the first of its kind since the declaration of the new health sector policy in December 1990. It involved the principal external partners who supported the health sector.

Visible results

Things were moving forward. A genuine acceleration was in progress. It was estimated that 900,000 people benefited from health centre services offering the MPS. This constituted more than one-tenth of the Malian population.

---


Figure 22. Proportion of the total population with access to a health centre which offers the MPS with community management: planning and achievements

![Proportion of the total population with access to a health centre which offers the MPS with community management.](image)

Source: DESAM/HIS Ministry of Health

Figure 23. Number of health areas transformed: planning and achievements

![Number of health areas transformed.](image)

Source: DESAM/HIS Ministry of Health
Figure 24. Performance achieved in 18 health areas, before and after transformation

Figure 25. Evolution of the access to the MPS and performance in Bla District, 1993-1995
According to the programming for health development plans, the percentage of the population living within 15 km of a health centre managed by the community and offering the MPS needed to rise from 3.35% in 1993 to 65% in the year 2000. In fact, from 1993 to 1996, it progressed only to about 24.5%. The number of areas transformed progressed to 173 units during the same period.

This progression was certainly lower than projected. But it was effective, and supported. The gap between implementation and programming was real, but a real acceleration was also in progress from the second half of 1994. The momentum had to be maintained until the beginning of 1997, the period during which all the SDHC programmes were effectively revitalized (Figs 22 and 23). Beyond this deadline, increased access to the MPS depended on the capacity to establish new ComHCs in health areas whose viability was not assured.

Performance achieved by health areas transformed into ComHCs or revitalized SDHCs demonstrated a few very significant improvements compared with the previous situation.

Fig. 24 compares the performance levels for 195,000 inhabitants in 18 health areas, before and after the introduction of a ComHC or revitalization of a SDHC. Improvements were made at acceptable cost. The average cost of a prescription in these health areas in 1995 was FCFA 734.97.

In the districts of Bla and Djenne, where the accessibility to the MPS increased with community management, this progression had a very significant impact on the global performance of the whole district (Fig. 25).

The case of the sub-district of Mozambala illustrates the impact of the new system. This sub-district was divided into two health areas: one remained under the responsibility of the SDHC; in the other, a ComHC was launched. Fig. 26 shows the differences between the services for the community covered by the ComHC and the community still dependent on the SDHC (non-revitalized, and operating as before).

Fig. 26. Services to the population in the sub-district of Mozambala: on the left, the part of the sub-district (17,401 inhabitants) that remained under the responsibility of the

---

Increasing access to the MPS depended on the ability to overcome difficulties in the health areas for which financial viability is not assured. The other difficulty was finding qualified staff prepared to work in rural areas without the status of a civil servant. Mechanisms of solidarity had to be more explicit to ensure that the resources (existing staff included) were equally divided in each district. Structural conditions required to balance accounts of operational health areas had to be taken into account, and every temptation of proceeding forward had to be resisted if the resources were not adequate to transform all the areas anticipated by the health map. Sometimes, it is better to leave well alone. Progress achieved had to be
consolidated, and the new rules of the game established to be able to tackle the final phase: extending coverage. Otherwise, one risked weakening all achievements, and waste from clearly foreseeable failures.

The initial acceleration did highlight certain weaknesses. Very few achievements involved the referral system. Its effective organization and strengthening remained essential to guarantee the quality and efficacy of the whole district health system. The HIS was put in place, but it needed sustained attention at all levels to effectively carry out its designed task. The quality of services remained insufficient. The problem of basic training of health staff was still unresolved.

**From a strategy for extending coverage to a changing relationship between services and users**

The problem of training was not the only one. The health civil servants were often criticized for emphasizing their administrative role at the expense of their professional work of health care. Civil servants were not accountable to the local community nor to their own administration apart from providing statistical reports.

The disruption introduced by the ComHCs in this traditional relationship was considerable: health staff were no longer necessarily civil servants; they had to answer to the ComHA that managed the centre and often was the employer. The ComHA was advised by the chief district doctor but was also able to seek other expertise. The nurse no longer monopolized access to health authorities.

In this new situation, the relationship of the health personnel with the population was more balanced. The health staff thenceforth had to rely on their competence and capacity to listen in order to “impose themselves”.

The new role played by the population in managing its health represented a major achievement for the new health sector policy. The new

---

98 Some tools facilitate self-evaluation and performance review for certain services (e.g., preventive coverage, type of prescriptions, average cost of prescriptions, number of cases referred, causes and feedback, and so on). Aside from providing a subject for discussion at ComHA meetings, their utility is uncertain. An obstacle to overcome from this perspective is the poor suitability of the tools for off-the-shelf use by ComHA, especially when staff are illiterate. Materials and tools cannot appropriately assess quality of care if the point of view of beneficiaries is not an integral part of a whole set of criteria to be established and reviewed regularly.
situation opened prospects for intervillage development that went beyond health. Of course, as promising as the new situation is, it also has weaknesses, and the constraints are many. Management capacities and the literacy rate are very low in rural Mali. The on-going experience offers an entry point to improve community capacities, but at the same time shows the present limits of change and the risks that surround it.

The decisive move towards giving more responsibility to the community was made possible thanks to the new relationship with the health staff. The communication thus developed supported this evolution. Some progress was made in the domain of participation, but mainly confined to aspects of management, or coverage of certain preventive services by the village. More work needed to be done to develop appropriate tools, encourage new attitudes among staff, and to take advantage of improved community capacities.

It has often been observed that the ComHA does not account for the activities of the management committees and boards to their respective villages. There is a risk that ComHA could reduce itself to a new bureaucratic link between the health services and the community. Its role as counterbalance is no less important vis-à-vis health services technical staff.99

The inadequacy of the models is a consequence of the weak development of the relationship between the ComHC and the village population. The forward strategy activities alone will not be enough to maximize impact and diversify opportunities. Efforts were undertaken using lessons learned from nutrition projects to strengthen community-based activities. There also, definite steps need to be taken to see that haste does not become counterproductive. By the fact of its existence, the health area and the process of organization it entails could be used as an entry point for much wider community development beyond health issues.\footnote{Fassin D, Jeannee E, Salem G et al. (1986) Les enjeux sociaux de la participation communautaire. Les comités de santé a Pikine (Sénégal). \textit{Sciences Sociales et Santé} \textbf{4}, 205-221.}

That is the principle underpinning the ComHC strategy. It is too premature to evaluate it, and it will not happen spontaneously. It will take the support and oversight of people who have a clear perception of the potential advantages to this new situation to overcome the inherent obstacles and difficulties.\textsuperscript{101}

Progress in this domain will depend on the overall evolution of Malian society, and effective and realistic decentralization—not hollow idealism and dull theories. There is no doubt that the greater the community’s skills in negotiating with the health services and the administration, the more the community will assume responsibility.

To promote a healthy partner relationship, the ComHA must be autonomous. Regrouping into a federation reinforced the ComHA’s negotiating capacity. The Federation of Community Health Associations held its inaugural conference in July 1994. It constituted a significant achievement, but was not immune to artificial politicization.

Defining the relationship between the ComHAs and future rural communes will be very important in developing the sector. Contractual delegation of ComHC management by the State and the community to the associations represented by the ComHAs are what makes the Malian experience original. This approach is based more on effective decentralization and autonomy of communities than privatization in the liberal sense of the term. These ComHCs have a public service role. The ComHAs should be accountable to the community from which they emanate and to the administration in the context of regular reviews of agreements.

Managing change

Without the projects and experiences of the 1980s and their contribution to training field staff, it would not have been possible to envisage implementation or even to formulate a new health sectoral policy in Mali. The latter was all the more credible because it was supported by achievements and lessons from the past, and because the need for change was obvious to all participants. The design of the health system and the role that the State was expected to play made the present different from the past. Completion of several parallel and often contradictory actions to achieve coordination among all parties was equally important.

For a policy to succeed, it has to have resources. In Mali, the commitment of principal partners of the sector clearly constituted a success factor in its effective implementation. This commitment was different from the disparate and non-coordinated support of the 1980s. The involvement of diverse national participants was also determinant. The health system in Mali was too weak to support change imposed by the administration and half-hearted collaboration.

The consecutive changes in the new policy disrupted established traditions and interests. The motivation of some participants and the inertia or the resistance of others all had to be reckoned with. Experience demonstrated that the positions were not immutable. They changed from one stage to the other.

Each stage—and there were four of them—had its stakes and alliances. The first stage was that of policy definition, from 1989 to the beginning of 1991. The second stage was the period of trials and of developing strategy. This was a phase of researching methods, tools, and approaches to implementing and realizing the first ComHC and district health development plans. It began in 1991 and ended in 1993. The third stage was the first results: actual implementation of the first ComHC and approval of financing for the first district health development plans. This stage began in the middle of 1993 and continued up to the end of 1994. It was followed, at the end of 1994, by scaling up implementation and was marked by external evaluation and mid-term review by the HPRWP.

At the beginning there was little opposition to the principles of the sectoral policy, apart from the active resistance of certain professional
organizations, especially on the question of drugs (Figs 27-30). The referral framework was politically acceptable, and the details remained vague to avoid creating concern. That changed as soon as people began to experiment and formulate a strategy for change. Some lost their enthusiasm owing to fear of the unknown, others out of fear of losing power.

The preparatory stages for implementation were much longer and more complex than initially anticipated. The fact that there was an explicit reference model facilitated design of the strategy for change. Experience and innovation were decisive in pursuing dialogue at the strategic level. This implied proximity to the field, expertise, experiences, and exchanges, in other words, an excellent vocational school and capacity building approach. Initial planning, detailed as it was, did not take into account the realities of a complex and dynamic situation. Its rigid application would have led to a deadlock. In fact, nothing was fixed in advance, and the major regulatory measures often followed rather than preceded the first steps.

Even at the heart of the Ministry reservations were perceptible as strategies were being developed (Fig. 28). The low enthusiasm of regional staff who were not involved in the first stages shows how it is important to ensure good circulation of information and to have constructive discussions. A major difficulty encountered in implementation consisted in positively managing the coexistence between the new organization of the health system and the traditional support of vertical programmes. New developments (e.g., MPS, community management, decentralization, and integration) needed to gradually expand to assure national coverage. Therefore, areas still not covered continued to benefit from traditional support of vertical programmes.

Implementation was not supposed to be a juxtaposition of existing programmes. Negotiations to decentralize management and integrate programme activities into the new system proved to be a true test of strength where the technical and efficiency elements rarely existed at the first level. The stakes and influences of this test were not only a product of the Malian context. Decentralization and integration advanced against the current, and the challenge that arose was to resolve new problems caused by new programmes offered in the classical format of previous ones.102

Process stages (fig. 27,28,29 and 30)

Stage 1: Policy definition
Stage 2: Implementation strategy development
Stage 3: First results
Stage 4: Scaling up

Commitment scores used in the figures 27,28,29 and 30

<table>
<thead>
<tr>
<th>Score</th>
<th>Actor’s position</th>
<th>Score</th>
<th>Actor’s position</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Active commitment</td>
<td>-1</td>
<td>Sceptical</td>
</tr>
<tr>
<td>3</td>
<td>Supportive</td>
<td>-2</td>
<td>Systematic critical</td>
</tr>
<tr>
<td>2</td>
<td>Support with some reservations</td>
<td>-3</td>
<td>Active opposition</td>
</tr>
<tr>
<td>1</td>
<td>Neutral</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 27. The position of national participants throughout the four stages
Figure 28. The position of health managers throughout the four stages

Figure 29. The position of bilateral partners throughout the four stages
Initial field implementations have had a levering effect. The capacity of staff to defend and promote their new findings mobilized indecisive participants while rallying opponents. They had some effect on the evolution of the position of external partners, broadened alliances, and favoured much greater mobilization. They also allowed better management of pressure while reassuring partners and giving them more confidence in the actors themselves. Over time, word of mouth following initial experiences succeeded in changing the climate.

The positions of external partners were themselves far from being homogeneous. It is only at the mid-term review that there was a consensus on support. As for national participants, the stage of development of strategies for change and, to a lesser degree, of first results did not provoke enthusiasm. It is very likely that even if political transition had not
occurred, the concerns, impatience, and institutional interests of different parties would have been cause for attempting change. The interest manifested by many partners provided time to establish the new policy in the field.

The multiplicity of centres and decision levels among the external partners\(^{103}\) constituted a serious constraint in coordinating support for implementation. Financial procedures varied from one partner to the other, which does not always favour operational coordination of cofinancing. The latter became a system of parallel financing, with each partner looking to develop its own areas to achieve a coherent and independent project. Instead of strengthening convergence, complementarity, and flexibility, parallel financing was a setback. It is true that centralization of national budgets on the one hand, and the absence of a consolidated budget by the districts on the other did not favour the desired evolution.

When areas of intervention are well defined, the group of external partners can play a useful pivotal role for all and above all for the government and the country, while ensuring the coherence and the complementarity of total support. Effective coordination of external partners whose delegations have real power in the country facilitates negotiations and allows decisions to be made at the site of implementation. Negotiation apart from financial agreements did not always maintain initial cohesion.

The coordination and complementarity of support from the government of Mali, the World Bank, and UNICEF was decisive for concretizing the new policy. The flexible design of the Mali-UNICEF Health Programme allowed preparation of different elements, and in particular district development plans and establishment of the first ComHCs.

\(^{103}\) Is it not the insistence of external partners that contributions go through NGOs rather than the administration simply a panacea? No one can deny the significance of NGO contributions, but they should be set in the context of the national policy. It is hard to see how external partner-NGO relationships can make this arrangement work without taking into account the role of public administration in control and orientation. There is certainly a happy medium to be found here that avoids the bureaucratic constraints, and encourages innovation and initiative, while still being part of a national development process. The sectoral policy offered the Ministry of Health a suitable framework for such coordination. And the successes in implementation gave it the credibility it needed to negotiate external support provided by the NGOs.
Joint central supervision\textsuperscript{104} played a very important role in the process of change and its diffusion. These field visits were undertaken by the National Health Directorate, with the HPRWP and UNICEF. They also often involved one of the external partners, in particular the WHO. The supervision missions allowed the central level to have a better appreciation of the field. Through their participatory approach they also involved all the participants (e.g., ComHA, ComHC health team, district health team, and regional team). Corrections were made in the field, and a consolidated report was systematically shared with all the regions and central offices. In this way, problems in implementation could be handled and sometimes resolved. The approach was shared with regional teams who provided continuous support in the field. Leadership was represented by a critical mass of staff sharing the same principles and a good sense of collaboration, negotiation, and partnership, in Mali’s overall favourable political context of democratization. The necessary alliances among external partners were created to overcome obstacles.

It takes time to put a reform of such magnitude in place. Negotiations, adaptation, and learning all proceed slowly. Moreover, the critical mass of health professionals is limited, and transforming the health system is a lengthy process. Each situation has its own best pace for advancing without losing ground. The involvement of representatives from civil society can help in reconciling the health services and the community, allying them side by side to face the challenges of development.

# Table of contents

Acknowledgements ........................................................................................................... 1

A new health policy for Mali .............................................................................................. 3
   Limits of past experiences ....................................................................................... 3
   New opportunities ................................................................................................. 5
   A new national policy ........................................................................................... 7
   Ambitious objectives and new orientations .......................................................... 8
   Principal participants ............................................................................................ 10
      PARTICIPANTS WITHIN MALI ................................................................... 10
      EXTERNAL PARTNERS ............................................................................. 11
   Achievements and problems .................................................................................. 15

1990-1992: towards a strategy for change ................................................................. 17
   Mobilizing under unfavourable conditions .......................................................... 17
      ELIGIBILITY REQUIREMENTS FOR THE DISTRICTS ......................... 17
      NEW ROLES FOR PARTICIPANTS AT THE CENTRAL LEVEL ........... 19
   An explicit implementation strategy ...................................................................... 20
      ORGANIZING REGIONAL SUPPORT ..................................................... 21
      THE HEALTH MAP: A NEGOTIATING TOOL ....................................... 24
      THE MPS ................................................................................................. 29
      THE ISSUE OF ESSENTIAL DRUGS ...................................................... 33
      UNITARY PROGRAMMING BY HEALTH AREA .................................... 35
   A TRAINING STRATEGY ................................................................................. 38
   USING THE LOCAL HIS AS ANCHOR ...................................................... 40
   EXCHANGES AND COORDINATION .......................................................... 41
   Achievements of the mobilization phase .............................................................. 43

1993-1995: first achievements ...................................................................................... 47
   District health development plans ........................................................................ 47
   The first ComHCs ................................................................................................. 49
      THE COMMUNITY APPROACH: PAVING THE WAY FOR NEGOTIATION ... 50
      LAUNCHING A COMHC .......................................................................... 53
   PERFORMANCE ................................................................................................. 54
   REACTION ........................................................................................................... 59
“Revitalizing” the SDHCs ................................................................. 60
Specific problems in the urban context ........................................... 62
Organizing and developing referral in the rural setting ..................... 65
THE FIRST LEVEL ........................................................................... 65
A MULTIPURPOSE TEAM FOR MANAGING THE DISTRICT ............. 65
DISTINGUISHING BETWEEN FIRST LEVEL AND REFERRAL .......... 66
STRENGTHENING REFERRAL FOR OBSTETRICAL CARE ................ 67
Achievements and problems after initial implementation .................. 77
Regulations and contracts: crystallizing the debate ......................... 72
Financing of the sector and viability of ComHCs ......................... 81
Doubts about the viability of ComHCs ............................................. 81
New cost-sharing ........................................................................... 84
From simulation to a provisional operating budget ......................... 86
From provisional to balanced budget ............................................ 89
Points for discussion ....................................................................... 94
Devaluation .................................................................................... 98
THREATS TO REFORM ...................................................................... 98
VIABILITY OF ACCESS ....................................................................... 99
Financing the district health system ............................................. 102
1994-1995: Scaling up and improving quality ............................ 105
Pressures to accelerate ................................................................. 105
Real constraints ............................................................................. 108
The persisting problem of integrating vertical programmes ............. 112
Accelerating without derailing ..................................................... 113
Visible results ................................................................................ 115
From a strategy for extending coverage to a changing relationship
between services and users .......................................................... 120
Managing change .......................................................................... 123