

Public Disclosure Authorized

**Report No. 18112**

# The World Bank and the Health Sector in Mali

## An OED Country Sector Review

**June 30, 1998**

Sector and Thematic Evaluations Group  
Operations Evaluation Department

## Currency Equivalents

Currency unit = Mali CFA  
US\$1.00 = CFA 600

## Abbreviations and Acronyms

ARI	Acute respiratory infection
ASACO	Association de santé communautaire
CBD	Community based distribution
CSA	Centre de santé d'arrondissement
CSC	Centre de santé de cercle
CSCOM	Centre de santé communautaire
CPR	Contraceptive prevalence rates
DHS	Demographic and Health Surveys
DNHE	Direction National de l'Hydraulique et de l'Energie
FASEF	Fonds d'Action Sociale Pour l'Education Familiale
GDP	Gross domestic product
GNP	Gross national product
HNP	Health, Nutrition, and Population
ICB	International Competitive Bidding
IEC	Information, education, and communication
IMF	International Monetary Fund
IMR	Infant mortality rate
MCH	Maternal and child Health services
MOH	Ministry of Health
MSSPA	Ministere de la Santé, de la Solidarité et des Personnes Agées
NGO	Nongovernmental organization
OED	Operations Evaluation Department
ORT	Oral rehydration therapy
PCR	Project completion report
PER	Public Expenditure Review
PDS	Projet de Développement Sanitaire
PHC	Primary health care
PMA	Paquet minimum d'activités
PPM	Pharmacie Populaire du Mali
PSPHR	Projet Santé, Population et Hydraulique Rurale
SIP	Sector investment program
SSA	Sub-Saharan Africa
TBA	Traditional birth attendant
TFR	Total fertility rate
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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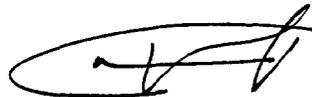
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**MEMORANDUM TO THE EXECUTIVE DIRECTORS AND THE PRESIDENT**

**SUBJECT:** The World Bank and the Health Sector in Mali - An OED Country Sector Review

Attached is the Operations Evaluation Department (OED) report entitled *Case Study of World Bank Support in the Health Sector in Mali*.

The report evaluates the performance of the Bank in supporting projects to expand rural health services, and the influence Bank policy dialogue and sector work on sector performance, both at the macroeconomic and sectoral levels. The report illustrates the important role the Bank can play in facilitating the development of a national health policy, and considers the extent to which the policy—based on community-financed rural health centers—is likely to result in improved health outcomes. Based on lessons learned the report indicates a number of areas in which emphasis should be placed in forthcoming activities.

A handwritten signature in black ink, consisting of a large, stylized initial 'A' followed by a vertical line and a diagonal stroke.

Attachment



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## **Preface**

Over the past two decades, the World Bank has emerged as the world's largest lender in the health, nutrition, and population (HNP) sector. In addition, the Bank plays a major role in providing advice on national health policies. This Country Sector Impact Study is one of four studies being undertaken by the World Bank's Operations Evaluation Department (OED) as part of a comprehensive assessment of the Bank's development effectiveness in the HNP sector. The other study countries are Brazil, India, and Zimbabwe. Mali was selected as one of the country case studies because it represents the challenges of health sector development in a low-income environment with limited health infrastructure.

This study is based upon review of World Bank project documents, interviews with World Bank staff, government officials, and health workers, focus group discussions with health center clients, and analysis of available facility and household data. The research team visited Mali three times over the course of a year, first to discuss study design, next to conduct interviews and field research, and a final visit to hold a workshop to discuss preliminary findings with government and civil society. Drafts of the study were reviewed by both World Bank staff and officials at the Ministry of Health, and their comments were incorporated into the final text.

Ms. Susan Stout directed the overall OED assessment. Ms. Laura Raney and Mr. Timothy Johnston were task managers for this study. Ms. Sheila Dohoo Faure, Ms. Laura Raney, and Dr. Sanoussi Konaté were the principal researchers, and the report was written by Mr. Timothy Johnston, Ms. Sheila Dohoo Faure, and Ms. Laura Raney. Mr. William Hurlbut edited the report. Mr. Benjamin Crow and Ms. Marcia Bailey provided administrative assistance.



## Executive Summary

1. This Sector Impact Study evaluates the World Bank's contribution to the development of the health sector in Mali over the past 20 years. In that time the Bank has financed three projects and undertaken policy dialogue that contributed to the development of a national health policy for the country. The Mali case represents some of the challenges faced by the Bank and its partners in attempting to improve health and health system performance in a low-income country with a poor and widely-dispersed population.

2. The health system in Mali historically focused on curative urban-based care, with limited basic curative or preventive health services in rural areas. Various donor agencies and NGOs attempted to provide rural services, but inadequate coordination, staff shortages, and inadequate financing for recurrent costs reduced impact and sustainability. A parastatal drug agency maintained a monopoly on drug imports and sales, and sold only high-priced specialty pharmaceuticals, making drugs unaffordable for the majority. In addition, the low levels of girls' primary education contributed to weakened health indicators—including high fertility rates, low contraceptive prevalence rates, and high child mortality. Child malnutrition is also a serious problem.

3. The Bank's first lending to the health sector was in the early 1980s for a pair of projects, Health Development (PDS) and Rural Water Supply. The objective of PDS was to extend primary health care services to the village level, and to improve the supply and reduce the cost of drugs. The rural water project worked in concert with PDS to achieve improved health by installing water pumps and wells, and organizing communities to maintain them. While Rural Water Supply achieved its objectives, PDS failed to achieve most of its objectives. That failure, together with promising results from pilot community-managed health clinics, led to Bank participation in the development of Mali's national health policy and to the implementation of that policy through the 1991 Health, Population, and Rural Water project (PSPHR).

4. The policy restructured Mali's health sector to establish a new community health system that would deliver primary health care services at the village level. Responsibility for planning and supervising local health services was decentralized to district health teams. The success of this strategy depended on improved planning and supervision at the district level, and on ensuring a reliable supply of low-cost essential drugs. The World Bank, UNICEF, and other partners advised in this policy process, but it was led by government.

### Principal Findings

5. The Bank's emphasis on meeting the basic health needs of the country's rural population was appropriate, and the establishment of the community health sector was a strategic response to financial and structural constraints prevailing in the Mali health sector. The Bank's efforts to improve the supply and affordability of essential drugs also addressed a major constraint to the effectiveness and efficiency of the Mali health system, and was key to the viability of the community health sector. The community health strategy, however, left unaddressed significant constraints to improved health for the majority rural population. Despite progress in expanding rural health services, overall utilization remains low. In addition, inefficiencies, inequities, and

urban bias remain in the government health sector. Yet starting first with the community sector--and not trying to fix everything at once--was probably the right strategic choice.

6. In the 1980s, the World Bank and IMF macroeconomic dialogue focused on restraining government spending and internal adjustment. Together with fiscal stringency and continued economic stagnation, this inattention to social sector concerns contributed to a decline in government health financing. By the early 1990s, communication between sector and macroeconomic staff improved, and the Bank included in its macroeconomic dialogue calls for increased budget allocations to health and basic education. The Bank also began to raise concerns regarding the equity and efficiency of government health spending and health staffing patterns. The civil service reduction targets in the structural adjustment program, however, depleted basic health staff and senior health policy positions, with negative repercussions for the health sector and project implementation. Government significantly increased funding for health by the mid-1990s, and the Bank eventually relaxed its restrictions on recruitment for the social sectors.

7. The Bank's health financing policy dialogue in the 1990s focused on increasing overall budget allocations to health, reducing the cost of drugs, encouraging cost-recovery for health services, and improving the efficiency and equity of government budget allocations within the sector. The Bank's dialogue on the latter was constrained by difficulties in interpreting government health budget categories, and inadequate support for sector work and operational research. The forthcoming Sector Investment Program plans to address health staffing and sector efficiency issues.

8. The Bank's initial efforts to reform the pharmaceutical sector failed because the problem with the Pharmacie Populaire du Mali (PPM) was perceived as inadequate capacity, rather than an inappropriate regulatory and incentive structure. The Bank subsequently made restructuring of PPM and removing constraints to private competition a condition for PSPHR support, and required that PPM shift toward the purchase of essential generic drugs. Progress was slow initially, but with the introduction of international competitive bidding, official drug prices dropped sharply, and continued to decline despite the 1994 CFA devaluation. Generics are now widely available, and prices are low enough to allow community health centers to cover recurrent costs from drug sales. Shortages persist at the regional distribution depots, however, and many community health centers rely on a recently established nonprofit drug agency to maintain their stocks. Bank conditionality may have focused excessively on reform of PPM, however, rather than on essential drug availability.

9. The PSPHR project helped establish and expand the new community health system in four districts and in the capital, and was cofinanced by several other donors, with parallel financing from UNICEF. Technical support from UNICEF was particularly crucial to help districts develop health plans and supervise the new community clinics. The project significantly increased access to health facilities and, with pharmaceutical reform, increased the supply of affordable drugs. The community clinics mostly have been successful in improving service coverage and client satisfaction and are able to cover much of the recurrent costs of running the clinics through cost-recovery.

10. The new system has several limitations. First, despite some improvements, utilization rates remain low, apparently because of financial barriers to access and continued preference by many clients for traditional services or self-medication. Second, the clinics provide primarily

curative health services, with little involvement in provision of family planning, promotion of clean water and sanitation, nutritional monitoring, or health and nutrition education and preventive activities. Local NGOs provide some of these services, but they are not integrated with the health centers. Third, the clinics are not linked to the traditional sectors, including traditional healers. Fourth, there is currently no clear career structure for health professionals at the clinics, and the community clinics have had difficulty attracting and retaining staff. Finally, although most of the clinics show a "surplus," revenues are not sufficient to cover long-term maintenance and other costs such as replacement of equipment. Although government and the World Bank have acknowledged that continued subsidies will be necessary, the recurrent implications for national budget allocations have not been adequately assessed.

11. By encouraging government to take a lead role in project and policy preparation, the Bank has contributed to capacity building and "learning by doing." The MOH's capacity to plan and manage health projects and services has improved since the Bank's first investments in the early 1980s. The key role of the Project Coordinating Unit within the MOH in both policy and project implementation, however, sometimes has resulted in a blurring of responsibilities within the ministry.

12. The Bank's contribution to monitoring and evaluation has been mixed. The PDS was unsuccessful in establishing a regional project monitoring system, and the project was never evaluated, which meant that PSPHR design proceeded without the benefit of hindsight. With support from USAID, the PSPHR helped establish a national monitoring system in 1996—a three-year process that rationalized and consolidated a variety of vertical information systems. This was an important achievement, but because it was not initiated earlier, it is difficult to assess the impact of the project over time. Periodic PSPHR review meetings provided a useful forum for discussing a variety of project and sector issues among government and partners. PSPHR provided no funding for operations research, however, so that a number of key sector issues were not investigated until preparation began in 1996 for the next phase of support.

13. In 1998, government completed a 10-year strategic plan for the sector, together with a 5-year investment program, which are to guide both government and donor programs. These plans were prepared in conjunction with the next phase of World Bank support, a sector investment program (SIP), which supports the government's strategy and addresses a number of sector-wide issues. In preparation for the SIP, the Ministry of Health prepared a number of studies with support from the Bank and other donors. The SIP plans to further expand the community health sector, improve hospital efficiency and autonomy, and expand private health insurance, among a variety of initiatives. The SIP will form the framework for several donor programs, although most donors will continue to manage funds separately.

14. The SIP attempts to address a number of issues raised in this evaluation, including human resources, sector efficiency, and nutrition, and sets ambitious targets for improvements in health system and HNP indicators. In trying to address so much at once, however, the program runs the risk of excessive complexity. The Bank, government, and partners may need to prioritize as implementation proceeds, and continue to monitor whether the proposed interventions are the most efficient and effective means to improve HNP outcomes. Some donors also expressed concern that Bank timetables and agenda excessively influenced the policy process and program design. Although government has retained its leadership role, the Bank must be cautious and collaborative to ensure that it does not excessively drive the agenda.

## Lessons

- Community-financed health centers, combined with a reliable supply of essential generic drugs, can help extend basic care to previously underserved populations and improve responsiveness to local consumers. Yet improving physical access to health services does not necessarily lead to increased service utilization.
- During fiscal adjustment, the Bank and government must pay attention both to protecting overall allocations to the social sectors and to the efficiency of expenditures within the social sectors.
- While rural cost recovery can be important to sustain local services, the funds raised typically are small relative to overall government health spending, which often remains focused on urban curative care.
- Pharmaceutical reform and improving the availability of essential generic drugs requires first a careful diagnosis of the institutional and political constraints to change, followed by negotiated agreements to shift the regulatory and incentive structure for the public, private, and nonprofit sectors.
- Shifting a previously-centralized health delivery system to one based on district-level planning and community participation requires changing incentives together with intensive technical support both for districts and communities.
- Establishing a community sector outside of the government civil service can help make providers more responsive to community concerns, but can also create problems with attracting and retaining staff if job security and career paths are unclear.
- The Bank should give greater emphasis to rigorous monitoring and evaluation, and operations research, particularly when piloting new service delivery mechanisms that are then scaled-up nationwide.
- In aid-dependent countries, the Bank can help increase the coherence of donor activities by supporting the development of national health strategies and through funding instruments such as umbrella projects or sector investment programs.

## 1. Introduction

1.1 Over the past 20 years the World Bank has undertaken a variety of activities in Mali intended to strengthen the performance of the country's health system. This study of those activities has two objectives: first, to assess the Bank's contribution to improving the performance of the health system; and second, to draw lessons from that experience that can be used to improve future Bank and borrower activities in the health sector in Mali.

1.2 The study addresses several broad questions. First, were Bank HNP strategy and project interventions relevant to the epidemiological and institutional context of the Mali health system (did the Bank "do the right things")? Second, did Bank interventions improve the effectiveness, efficiency, and institutional capacity of the Malian health system? Finally, are the results likely to be sustainable?

### World Bank Activities in Mali

1.3 The World Bank's earliest health sector activities in Mali were in the 1970s, when it funded a health component in the Mali Sud Agricultural project to support village-level primary health care in one region. It also supported the introduction of health themes into the functional literacy programs conducted in western Mali through the First Education project and a Rural Development project. The government of Mali first approached the Bank for funding specifically for health activities in 1977. This coincided with the Bank's first forays into health sector lending.<sup>1</sup>

1.4 The Bank's health sector lending to Mali consisted of three projects: Health Development (1983); Rural Water Supply (1983); and Health, Population, and Rural Water Supply (1991) (see Table 1.1). A sector investment program (SIP) is currently under preparation. In addition, from 1977 to the present, the Bank has had ongoing dialogue with the government on such HNP policy issues as the structure of health service delivery, health financing, pharmaceutical policy, population and family planning, and macroeconomic issues, such as structural adjustment (beginning in the early 1980s). Most notably, in the late 1980s the Bank worked closely with the government on the development of the current national health policy. The Bank's economic and sector work during this time consisted of epidemiological surveys (1978), a needs assessment (1979), two public expenditure reviews (1985, 1995), a population study (1987) and a poverty study (1993). Preparation for the SIP included support for studies in health finance, human resource development, nutrition, and a beneficiary assessment, among others.

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1. Although Mali was the first country to enter negotiations with the Bank for specific health sector funding, the loan approved in 1983 was not the first World Bank health sector loan. Preparations in Mali took a long time; in the meantime, a loan was negotiated and signed with Indonesia in 1980.

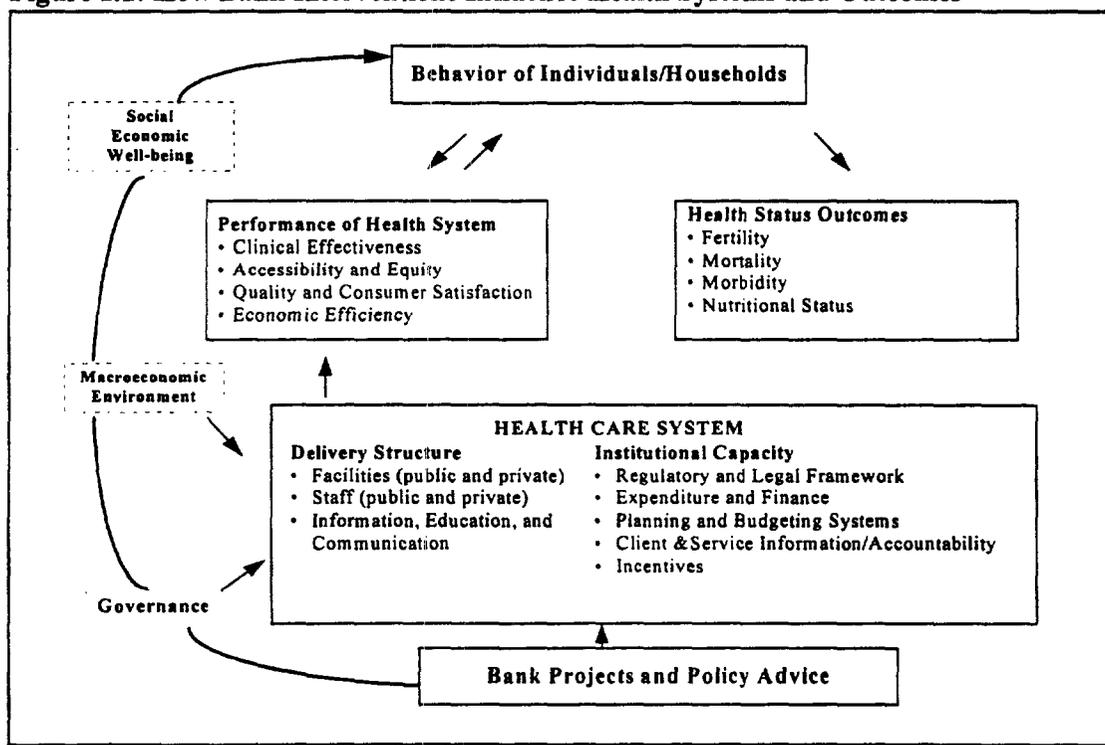
**Table 1.1: Bank Health Sector Lending to Mali**

<i>Project</i>	<i>Credit No.</i>	<i>Approved</i>	<i>Credit Amount (US\$ million)</i>
Health Development	1422-MLI	December 6, 1983	16.7
Rural Water Supply	1431-MLI & SF7-MLI	December 20, 1983	10.9
Health, Population, and Rural Water Supply	2217-MLI	May 3, 1991	26.6

### Study Framework

1.5 The World Bank's health sector lending, which finances facilities, health staff development, and the institutional arrangements that govern the health sector, affects the *supply* of services. Shifts in health-related behavior affect the *demand* for health services. Socio-economic factors, such as income and education are among the key determinants of demand. Therefore, Bank activities outside the health sector, particularly its macroeconomic work, can influence the demand for services. The structure and institutional capacity of the health system, including indirect as well as direct efforts to provide services and information to consumers also influence health behavior and hence outcomes. Figure 1.1 illustrates this concept. One important message of this study is that the Bank has focused primarily on influencing health outcomes through increased access to health services, but has not given sufficient attention to health-related behavior change. The influence of the Bank's macroeconomic work on the health sector in Mali is discussed briefly in Chapter 3.

**Figure 1.1: How Bank Interventions Influence Health Systems and Outcomes**



Source: Stout and others 1997.

## **Case Study Methodology**

1.6 This study is based upon review of World Bank project documents, interviews with World Bank staff, government officials, and health workers, focus group discussions with key stakeholders, and analysis of facility data.

1.7 The case study field work was conducted between March and October 1997 by a team consisting of an OED staff member, an international consultant, and a Malian public health physician. Health sector specialists from the *Centre de Santé Publique de Québec* advised the team. The study team visited Mali three times:

- The first visit was a planning mission to interview key stakeholders in the health sector, including staff of the government, the World Bank, and other development partners.
- The second mission conducted interviews with government officials and other development partners in Bamako, government health staff in three of the eight regions, and visited a number of community centers to interview health staff and members of the community health associations. Two Malian consultants also conducted focus groups with women in nearby villages.
- The third mission conducted a workshop with key stakeholders to present preliminary study findings. Participants from the ministry, the Bank, and other development partners were invited to comment on the findings and develop recommendations.

1.8 The paper is divided into five chapters. Chapter 2 discusses the relevance of World Bank policy dialogue and project lending in the context of the Mali health sector during the 1980s and 1990s. Chapter 3 focuses on the influence of World Bank policy dialogue on the Mali health sector, with separate discussions of health and structural adjustment, health financing policy advice, and the dialogue on pharmaceuticals. Chapter 4 examines in detail the PSPHR project and the community health sector it helped establish, including its influence on access and equity, the role of community participation, and the sustainability of the community sector. The final section draws lessons from Bank experience in Mali.



## 2. The Relevance of World Bank HNP Strategy in Mali

2.1 To what extent has World Bank strategy in the Malian health, nutrition, and population sector been relevant to the country's epidemiological, socio-economic, and institutional context? The discussion will focus in particular on the explicit and implicit strategy underlying the Bank's support for the current national health policy, including the promotion of essential drugs and the establishment of the community health sector based on community management and cost-recovery. This strategy resulted in part from the disappointing results of the Bank's first project in the sector (the PSD), and was embodied in the subsequent PSPHR project.

2.2 This chapter will argue that the Bank's emphasis on meeting the basic health needs of the country's rural population was appropriate, and that the establishment of the community health sector was an innovative response to financial and structural constraints prevailing in the Mali health sector. The Bank's efforts to improve the supply and affordability of essential drugs also addressed a major constraint to the effectiveness and efficiency of the Mali health system, and was key to the viability of the community health sector. Yet the current community health strategy did not address a number of significant constraints to improved health for the majority rural population, including malnutrition, financial barriers to access, and the need for health education and outreach for preventive services. In focusing attention on establishing a community health sector outside the civil service, the Bank largely left unaddressed the significant inefficiencies, inequities, and urban bias prevailing in the government health sector. Yet starting first with the community sector—and not trying to fix everything at once—may have been an appropriate strategic choice.

2.3 This chapter begins with a brief description of the socioeconomic context. It then turns to the health system, including the delivery structure, health manpower, and health financing, to consider whether Bank-sponsored interventions have addressed key constraints to system performance. Finally, it examines trends in HNP indicators and available evidence regarding the factors underlying health, nutrition, and fertility outcomes, to assess whether the current strategy is addressing key constraints to improved health.

### Socioeconomic Context

2.4 Mali, a landlocked country in the Sahel, is one of the poorest countries in the world (World Bank 1997). The estimated per capita income (US\$250 in 1995) is well below the average for sub-Saharan Africa (US\$490) and for the Sahelian countries (US\$386).<sup>2</sup> The World Bank's *Assessment of Living Conditions* (1993) estimated that nearly 75 percent of the population of nine million lived below poverty level. This poverty is also unequally distributed, with more of it occurring in the less arable lands of northern Mali. Rural areas account for 75 percent of the population and 86 percent of the poor. The population, although low in density, is doubling every 22 years. This rapid growth erodes the purchasing power of households and gains in economic

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2. Sahelian countries include Burkina Faso, Cape Verde, Chad, The Gambia, Guinea-Bissau, Mali, Mauritania, Niger, and Senegal.

growth. The young age of Mali's population (nearly half is under 15 years of age) adds to the burden of poor households.

2.5 The prospects for economic improvement are poor: a majority of the population engages in rain-fed cultivation of subsistence crops, primarily millet and sorghum. The country's climate is harsh and unpredictable; drought is an ever-present threat. Agriculture, including livestock and fisheries, accounts for nearly 50 percent of the gross domestic product (GDP) and for all the country's export earnings. Modern employment, dominated by government and state enterprises, accounts for only about 6 percent of the labor force (World Bank 1994). Mali's economic performance thus depends on the vagaries of rainfall, soil condition, world markets, and population growth.

2.6 The adult literacy rate in Mali, at less than 20 percent, is among the lowest in the world. Education services are poorly developed, particularly at the primary school level. Until recently, nearly 60 percent of the government's education budget was spent on secondary tertiary education, including scholarships for university students, and households have tended to favor boys' education over girls'. Not surprisingly, therefore, school enrollment for girls remains low—one-third of the sub-Saharan African average—and remained static at around 17 percent for two decades. The current government, in partnership with donors, parents, and NGOs, has placed greater emphasis on primary education, and gross enrollment rates have increased in the past five years, from 28 percent in 1992 to 46 percent in 1996. Disparities remain, however, among regions and by gender, with only 30 percent of girls enrolled in school (OECD 1998). In rural areas up to 80 percent of school-age children do not attend primary school. Despite some improvements, government still spends only 37 percent of its education budget on basic education, which remains heavily dependent on donor and NGO financing.<sup>3</sup>

**Table 2.1. Education Statistics: Mali, Average for the Sahel, and Average for Sub-Saharan Africa, 1995**

	<i>Mali</i>	<i>Sahelian Average</i>	<i>Sub-Saharan Average</i>
Primary school enrollment <sup>a</sup>	43	56	73
Girls' primary school enrollment	30	35	—
Secondary school enrollment	7	12	22
Girls' secondary school enrollment	4	6	—

a. Percent gross enrollment rates. The most recent data for education statistics is 1990.

Source: World Bank; OECD 1998.

2.7 The creation of an effective health system and improved health outcomes in Mali therefore face many challenges. Poor economic conditions and low incomes depress demand for health services, and foster conditions conducive to disease and ill-health. The low population density hinders efficient service delivery. A low level of education, particularly for girls, contributes to weakened health and nutrition indicators for children, and to low contraceptive prevalence rates and high fertility (Subbarao and Raney 1993).

3. The Bank has supported several projects in the education sector in the past 2 decades, mostly aimed at increasing access to primary education. These efforts had limited success until recently, when the new government began to demonstrate greater commitment to basic education.

2.8 As in most sub-Saharan countries, the main health problems are infectious and parasitic diseases, with the leading causes of death being preventable diseases such as malaria, measles, tetanus, acute respiratory infections, and diarrhea. Diseases related to contaminated water and sanitary practices are also significant contributors to the disease burden (Duflo and others 1986). The burden of disease disproportionately falls on children and problems related to women's reproductive health, and health indicators are worse in rural areas than in urban. Malnutrition is also a serious problem, affecting one-third of children under five and one-fourth of infants under six months (Macro International 1996). The projects supported by the World Bank have focused on rural areas and the provision of basic health services, and as such were generally relevant to the health needs of Mali. They have not, however, targeted nutrition or effectively promoted family planning or health education. Approximately 5% of the adult population is infected with the HIV virus, so AIDS is a growing concern for the Bank and the government.

### **Evolution of the Health System in Mali**

2.9 Before independence in 1960, the French, in cooperation with other colonial powers, had developed in Mali a preventive health program carried out by mobile teams operating independently of curative services being developed by the colonial administration. After independence, the new socialist government of Mali banned private medical practice and developed a health services structure that was almost entirely curative and limited largely to urban areas. It was characterized by low service quality and low utilization. A parastatal pharmaceutical company was given a monopoly on drug importation and sales in Mali, and sold only high-priced specialty drugs.

2.10 Until 1990, the Ministry of Health (MOH) had a pyramidal health system down to the subdistrict level. Health services were organized according to the country's administrative structure, which includes seven regions<sup>4</sup> plus the capital area, 46 districts (*cercles*), and 286 subdistricts (*arrondissements*).

2.11 All regions (except Koulikoro in 1980) had a hospital, and Bamako was served by three national hospitals. Each district had a small, 80-bed hospital. Most subdistricts had a health dispensary, typically staffed by a three-person team (a nurse, an aide, and a rural midwife) serving 20 to 40 villages. In 1977, Mali had adopted the principle of the provision of primary health care (PHC) services at the community level through volunteer health workers, and in theory, large villages had a health post with a village health worker and a traditional birth attendant.

2.12 The district health center was self-contained, capable of providing emergency surgery and most types of basic care. The center staff also provided technical support to the subdistricts and the volunteer village health workers, although shortages of vehicles, medical equipment, and drugs, and lack of an operating budget made this more theoretical than real. The provision of village-level PHC required a credible district and subdistrict support system, but in less developed regions, such as the western region of Kayes, the system was ill-equipped to meet the challenge.

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4. An eighth region (Kidal) was later created through the subdivision of the region of Gao.

2.13 Until 1985 the private practice of medicine was illegal in Mali, and all doctors graduating from medical school were guaranteed government employment. Government health workers, along with other civil servants, were relatively well-paid and politically influential. The training system encouraged specialization, and job postings were determined more by the desires of health professionals than the needs of the populace (WHO and USAID 1989).

2.14 In response to the lack of rural health services in Mali, and the international consensus regarding the primary health care model established at the 1978 Alma Ata conference, international donor agencies attempted to fill the gaps in government health services. Increased reliance on international donors and nongovernmental organizations created other problems, however, including a proliferation of projects and procedures, vertical programs that were poorly integrated, geographical division of the country among various donors, and excessive emphasis on new investments at the expense of recurrent costs. Donors tended to design and manage programs themselves, and government had limited capacity to coordinate these various efforts. The interest of donors and NGOs in rural service provision also allowed government to spend most of its resources on inefficient and inequitable urban health services.

### **Initial World Bank Strategy and Support**

2.15 The Bank's first lending specifically for the health sector in Mali was for a pair of projects that were developed concurrently but delivered separately: the Health Development Project and the Rural Water Supply Project. As noted in Chapter 1, the government first approached the World Bank with a request for health sector assistance in the late 1970s. The Bank had previously supported only population activities, but a change in Bank policy in 1980 allowed direct lending for health. The Health Development Project (known by its French acronym, PDS) was therefore only the second health project approved by the Bank.

2.16 The policy dialogue and preparation work leading to the approval of the Bank's first health project took six years. During this time, the Bank undertook sector work and produced a document entitled *Basic Health Needs in Mali* (March 1979). The government of Mali used project preparation facility funding to set up a planning directorate within the MOH, finance studies, and prepare the project. This was the first time government had participated directly in preparation of a donor project.<sup>5</sup> Among the studies conducted were a pharmaceutical sector study and socioeconomic and epidemiological studies in the project area.

2.17 The 1981 epidemiological study in the Kayes region showed that villagers visited a government dispensary on average only once every two years. Three-quarters of the sample population had not visited at all during the year preceding the survey. The average number of visits per year by inhabitants of a village correlated negatively with distance from the dispensary. The survey also suggested that the population at the highest risk—children and pregnant women—was not receiving priority in treatment. People primarily relied upon traditional healers and herbal medicines for the treatment of illnesses. Modern drugs were sold in pharmaceutical parastatal outlets in district headquarters towns and retail outlets at the subdistrict level, but they were high-priced and in chronically short supply.

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5. At the end of preparation, the MOH wrote the Bank that even if the project did not receive funding, the preparation process had been an extremely valuable learning experience.

2.18 The Health Development Project introduced the government's basic health service program through a pilot in the Kayes region. Following the Alma Ata model, the project aimed to extend PHC services to the village level. The activities were to be integrated with other community and economic development activities. Thus, the PDS worked with the existing government health system to enhance service delivery through the construction of additional health centers and the training of health staff. The project emphasized the selection and training of volunteer village health workers and traditional birth attendants (TBAs), provision of basic maternal and child health (MCH) services, creation of village pharmacies, reform of the parastatal pharmaceutical company to improve the supply of drugs and strengthening the planning and implementation capacity of the Ministry of Health.

2.19 The project objectives therefore were generally relevant to the prevailing epidemiological context and health system needs, and consistent with the development thinking of the time. Significant implementation problems hindered nearly every component, however, and the project failed to achieve its objectives. Among other problems, the NGO contracted for facility construction performed poorly, and efforts to reform the pharmaceutical parastatal and reduce drug prices were unsuccessful. As a result, drugs provided by the village pharmacies remained unaffordable for most, and the pharmacies could not achieve financial viability. Using alternate drug supplies, however, the project in the late-1980s helped pilot several community-managed health centers that were able to cover most of their recurrent cost through the sale of generic drugs (MSSPA and OMS 1995).

2.20 In contrast, the Rural Water Supply project exceeded its objectives of establishing new village water sources. More important, it demonstrated the feasibility and effectiveness of community management and maintenance of local water sources. The project also provided health education on sanitation and appropriate water use. Although developed separately, the projects coordinated health and clean water activities to some degree, although they did not achieve the full benefits of an integrated approach.

2.21 The failure of the PDS project was an embarrassment for both the Bank and the government of Mali, and provided several important lessons. First, reducing drug prices was essential to improve sector efficiency and for the viability of rural health services. Second, if PHC facilities were to be used, they needed to be located near their catchment population, and involve communities in the establishment and management of the centers. Third, community-managed health centers based on cost-recovery from the sale of essential drugs could help mobilize additional resources for rural health services. Finally, the prevailing *ad hoc* approach with various donors supporting different vertical programs and regions was inefficient, and a national policy framework was needed to provide some coherence for the sector.

### **Development of the Government's 1990 Health Strategy**

2.22 Meanwhile, several changes took place both in the international policy context and in the economic and political situation in Mali. Poor internal economic policies under the former socialist regime, combined with the droughts of 1982–83 and 1987, worldwide recession, and unfavorable terms of trade for cotton contributed to economic stagnation in the 1980s. This stagnation led to adoption of a series of World Bank and IMF-sponsored structural adjustment programs beginning in 1983. The reforms had only limited success in stimulating growth and exports, however, largely because the CFA franc remained overvalued. In 1994, a 50 percent devaluation of the CFA franc helped restore the external competitiveness of the economy, and the

World Bank and other donors provided additional assistance to help reduce the shock of the devaluation. Civil disturbances in 1991 led to the resignation of the dictatorial government that had ruled since independence, and paved the way for the election of a new democratic government in 1993.

2.23 As part of a civil service reform program (initially sponsored by USAID), government ended guaranteed employment for graduates of health professional schools in 1985. For the rest of the 1980s, of the 60 annual graduates of medical school in Mali, only about 10 were offered positions in the government service. To provide opportunities for numerous unemployed physicians created by this policy change, government liberalized the profession hoping to encourage physicians to set up private practices. Yet the new regulations fixed private sector charges that were unaffordable for most of the populace. As a result, in 1988 Mali had only nine registered private physicians, four nurses, three midwives, and 29 pharmacists, most of them in Bamako.<sup>6</sup> Informal private practice by government health workers, however, remains widespread. The growth in unemployment among health professionals contributed to the push for additional employment opportunities outside of the civil service. The first community-managed health centers were established in Bamako by unemployed physicians.

2.24 The effect of these exogenous factors on the health sector, the failure of the Bank's first health project, and an international shift in the development model for health prompted a reconsideration of the health sector strategy. The principles of the new strategy were based on the community participation model and cost recovery model articulated in the Bamako Initiative, which was endorsed by the African ministers of health in 1987.<sup>7</sup>

2.25 Under the Bamako Initiative, the MOH began work with UNICEF in 1989 to develop an action plan for Mali that would include cost recovery (UNICEF 1990). The first step was to develop a national plan that included the key components of decentralized health planning and management, provision of essential drugs, and community involvement in management and financing. The government's decision to implement cost recovery also was heavily influenced by the successes of various pilot programs supported by donors and nongovernmental organizations (NGOs) and by the country's tradition of self-reliance.

2.26 MOH officials in Mali became interested in moving to cost recovery as a result of declining central budget allocations and the realization that the lack of financial resources had impaired their ability to function effectively. Cost recovery was seen as a means of capturing additional voluntary resources to enhance the availability of health care services. Mali began cost recovery at targeted national hospitals after new legislation was passed in 1983. Cost recovery at the local level began in several externally assisted pilot projects in various regions of the country,

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6. The number of registered private physicians had increased only to 57 in 1997 with the majority still in Bamako (Ringuedé 1997).

7. The Bamako Initiative is based on recovering a multiple of the cost of essential drugs and thereby generating a margin sufficient to finance certain PHC activities. By ensuring an essential drug supply and appropriate training, health workers are able to provide the improved care sought by the population. Community financing is the key to empowering people to be involved in managing their health care services.

including the Bank's PDS project.<sup>8</sup> Results of these projects indicated the population's willingness to pay for health services.

2.27 Meanwhile, based on the PDS experience, Bank staff became convinced that the community-financed health center approach could work, assuming that a reliable supply of low-cost essential drugs could be guaranteed. The Bank also had released a 1987 policy paper advocating the expansion of cost-recovery for health services in Africa, which was consistent with the basic principles of the Bamako Initiative (World Bank 1987). Although Bank guidelines did not require the establishment of a national health policy prior to project support, staff felt that such a policy could help bring coherence to the project and overall activities in the sector.

2.28 Bank staff developed strong alliances with the government technocrats developing the policy, and with UNICEF and other donors. The Bank provided important advice and technical assistance during policy development, but perhaps more critically, it made the approval of a well-defined national policy a condition for further support. This condition gave additional momentum to the policy development process, and tied the policy to the new project and the Bank's project cycle. Bank staff and government worked to convince other donors to either cofinance or provide parallel financing for the PSPHR project. PSPHR thus became the vehicle for implementing the new health policy (UNICEF 1998).

2.29 Preparation of the PSPHR by the government and Bank staff therefore proceeded in parallel with the development of the new national health policy. The policy itself was developed by a small team of technocrats from the MOH, in the context of growing public opposition to the ruling regime. As such, it did not incorporate widespread public participation. In addition, government signed the new national health policy in Washington during negotiations for the PSPHR project. Even though government played a lead role in its development, the strong ties with the PSPHR project and the World Bank led some donors to call it a "Bank policy," and used this as justification for not aligning their support with the policy. Yet the policy survived the political transition in the early 1990s—including four ministers of health—because of strong support for the policy by senior civil servants in the MOH.

2.30 The new policy shifted the organizational model for the health sector away from the administrative structures of the state and introduced the partnering of the public sector with communities to broaden access to health services, including community management of health centers and revenues from cost recovery. The policy also called for significant reforms in the pharmaceutical sector, including reforming the PPM to supply essential and generic drugs, and allowing the private sector to import and sell drugs (See chapter 3).

2.31 The success of this community health management approach depended upon strengthening the capacity of communities to take responsibility for health and the implementation of more decentralized, community-based planning and management of health services and facilities, as well as a reliable supply of low-cost drugs. Each health area in the system would have a community health facility, staffed by health professionals but managed by a community association representing the population served. The new decentralized approach also required strengthening the capacity of district health teams to plan, manage, and supervise district health services.

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8. This early experience included a project in the northern regions managed by the NGO Médecins Sans Frontiers (MSF); a Médecus Mundi project in the Mopti region; and a UNICEF program also in the Mopti region.

2.32 Under the new policy, the public sector continued to provide services at the national, regional, and district levels as it did previously, but the roles and responsibilities have been more clearly defined. Responsibilities for planning, budgeting, and delivery of local health services were decentralized to the district level, including supervision of the new community health sector. The regional level provides technical support for the districts, and the central level became responsible for strategic planning, maintaining standards and equity, and resource mobilization from the government and donors.

2.33 The PSPHR became the primary vehicle for implementation of the national strategy. As discussed in chapter 4, the project achieved most of its immediate objectives, including increasing access to basic health services through the establishment of community-managed health centers, and improving the supply and lowering the cost of essential drugs. The process of establishing community health centers has taken time, however, and gaps still remain in coverage and services provided.

2.34 The establishment of a community health sector was an innovative response to the problems of rural service provision, and the emphasis on lowering the cost and increasing the supply of essential drugs addressed a key constraint to sector efficiency. The decentralized planning process initiated by the project allowed services to be planned and delivered closer to the beneficiaries, and reduced the burdens on and bottlenecks at the central level. The PSPHR provided an "umbrella" for the support of several donors along with the Bank, and together with the national policy helped improve the coherence of donor and government activities.

2.35 The 1990 policy and the PSPHR, however, left some important issues unaddressed. They did not deal with the continued problems of inefficiency in government tertiary facilities and in the training and deployment of health professionals, or significantly reorient government spending toward primary health care. Government continued to spend most of its resources on urban curative care—as such, the 1990 policy did not deal with the majority of government spending. With so many constraints facing the sector, the Bank's and government's implicit strategy was to focus first on essential drugs and improving access to rural basic health services. Not trying to do everything at once was probably appropriate given the context and constraints, and the government's new health plan and the Bank's next phase of support will attempt to address some of these issues. The issue of health staffing for the local clinics is critical, however, and although the Bank and government plan to address the issue, it probably should have been addressed more directly in the initial project design and policy dialogue.

2.36 In addition, the design and implementation of the project and of the community sector itself did not sufficiently address a number of important issues. These include the problems of retaining health staff; continued low utilization and problems of financial access by the poor; inadequate integration of health services with family planning and nutrition activities; and the limited provision of health education and preventive outreach services. Although the project combined clean water provision with health service expansion, the activities were not adequately integrated on the ground. The government's Ten Year Health Plan and the follow-on five-year investment program are attempting to address many of these issues.

**Table 2.2. Health Indicators for Mali**

	1987	1995-96
Infant mortality	108*	134
Neonatal mortality	53*	68
Postnatal mortality	54*	65
Junior mortality (1-5 years)	159*	137
Total fertility rates	6.9	6.7
ARI prevalence <sup>a</sup>	7	15
Diarrhea prevalence	34	25
Children malnourished (wasting) <sup>b</sup>	11*	23
Vaccination rates		
BCG	89	76
DTC3	27	38
Polio 3	21	39
Measles	80	51
Completely vaccinated	16	32
Urban	25	54
Rural	0	24

a. Children under three years of age with specific illness in previous two weeks.

b. Children under three years of age, using weight for height.

\* The mortality data from the 1987 DHS are likely underestimates due to sampling problems in the survey.

Sources: 1987 and 1995/96 Mali Demographic and Health Surveys.

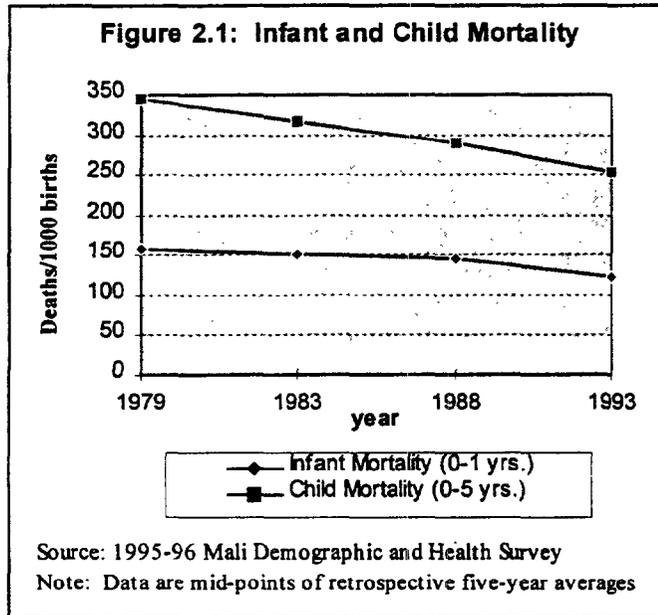
### Health Trends and Epidemiological Relevance

2.37 Trends reflected in Demographic and Health Surveys (DHS) indicate modest improvements in health indicators over the past decade, but overall mortality levels remain high, and child malnutrition (wasting) is very high and may have increased in the past decade (Table 2.2). The most recent DHS survey, however, was conducted just as implementation of the PSPHR project commenced. The preceding PDS project failed to meet its objectives and focused in only one region, so no impact on national indicators would be expected, although the water project did contribute to increased access to potable water. Examination of these national data therefore provide insights into the evolution of HNP indicators and health system performance, and whether the Bank has supported the types of interventions needed to improve health outcomes.

2.38 Retrospective data from the 1995/96 Demographic and Health Survey for Mali show a slow decline in both child and infant mortality, but mortality remains high even by African standards (Macro International 1996) (Figure 2.1). Comparisons with the 1987 DHS can be confusing, however, since infant mortality rates appear to have increased. The 1987 survey probably underestimated infant and child mortality, however, as well as child malnutrition.<sup>9</sup> The

9. Figure 2.1 shows the 5-years averages of infant and child mortality recall data collected for the 1995-96 Demographic and Health Survey (for example, average mortality for 1991-95 is plotted as 1993). The 1987 survey was among the first Demographic and Health Surveys conducted, and experienced problems with the sampling framework, and a significant percentage of women selected were not located, particularly in rural areas, which biased the results toward urban and higher socioeconomic households. The northern region was not covered because of civil conflict.

percentage of children fully vaccinated improved between the two surveys, particularly in the rural areas. For individual vaccine coverage, the picture is more mixed, with declines in coverage for measles and BCG, but increases in DTC3 and polio 3. The percentage of children fully vaccinated in rural areas increased from 0 to 24 percent over the period largely because of an increase in rural DTC3 coverage. The percentage of women with at least one prenatal visit during pregnancy increased from about a third in 1987 to half in 1995, and the percentage receiving tetanus vaccinations increased from 18 percent to 50 percent.



2.39 The DHS data also suggest that diarrhea prevalence has declined in the past decade and that acute respiratory infections increased. The decline in diarrhea prevalence could be attributable to the expansion of clean water, although field investigations have found that poor sanitary practices are undermining the health benefits of improved water sources (World Bank 1997).

2.40 Health behavior and health service statistics (Table 2.3) indicate improvements regarding some health practices: attendance at births by trained medical personnel, percentage of children with diarrhea who receive treatment, and most notably, the

percentage of women with knowledge of at least one modern contraceptive method. The prevalence rates for modern methods have improved slightly. The increase is mainly due to increased prevalence in rural areas, albeit from an extremely low, almost nonexistent base. In urban areas, the rate for modern methods more than doubled.

**Table 2.3. Health Behavior Indicators for Mali**

	1987	1995-96
Average length of time mothers breast feed (in months)	21.6	21.6
Birth assistance		
Trained medical personnel	32%	40%
Traditional birth attendant	30%	20%
Other	21%	30%
None	13%	12%
Children with diarrhea who received treatment	68%	77%
Knowledge of one modern contraceptive		
Women	28%	65%
Men	54%	86%
Contraceptive prevalence rates <sup>a</sup>		
Any method	4.7%	6.7%
Modern method	1.2%	4.5%
Contraceptive prevalence rates: Urban		
Any method	11.4%	16.2%
Modern method	4.7%	11.6%
Contraceptive prevalence rates: Rural		
Any method	2.3%	3.3%
Modern method	0.1%	1.9%

a. Women in a union.

Sources: 1987 and 1995/96 Mali Demographic and Health Surveys.

2.41 Government and its partners have also made substantial progress in improving physical access to health services in rural areas, starting from a very low base, and the use of curative and preventive services has increased in the catchment areas of community health centers. But even with the successes in establishing community clinics, utilization rates of modern health services remain low. In 1996, Malians visited a government or community health center for curative services only 0.16 times per year on average (MSSPA 1997). The continued low utilization rates despite efforts to improve geographic access are a consequence of several factors, including low quality of services at government facilities, inadequate outreach services, and client preferences for traditional medicine and self-medication. As discussed in chapter 4, the fees charged at health centers also represent a deterrent for potential clients.

2.42 Evidence from Mali and neighboring countries suggest that the most important determinants of infant and child mortality include household income, the mother's education level, child nutritional status, fertility (including child spacing and the mother's age), and the availability of basic health services, particularly prenatal care and child vaccination. Household incomes have not improved significantly over the past decades, female education remains low with only slight increases in recent years, fertility has changed little, and child malnutrition appears to be increasing. The improvements in child health are therefore most likely the result of improved vaccination coverage, and possibly the modest improvements in access to and use of basic health services.

2.43 The DHS data on child malnutrition, particularly 23 percent of children wasted, is remarkably high, and is comparable with countries emerging from famine or civil conflict, even though the survey took place in a good harvest year. The 1987 survey may actually have underestimated the levels of malnutrition. Table 2.4 below shows DHS results together with

with those from a 1988-89 income and consumption survey, suggests that both stunting and wasting have been high since the late 1980s and may have increased in the past decade (Enquête Budget et Consommation 1990 cited in Mali 1995/96 DHS). In addition, an annual survey conducted over five years in the Sikasso Region (which is relatively well-off agriculturally) from the late 1980s found that child wasting was increasing over time.<sup>10</sup> Statistical analysis of the Sikasso survey data found that stunting was associated with parental education and socioeconomic status, but the high levels of wasting were consistent across socioeconomic groups (Bouvier and others 1995). A secondary analysis of the DHS data estimated that over half of under-5 mortality in Mali could be attributed to malnutrition (15 percent to severe malnutrition, and 42 from mild to moderate) (Mali 1995/96 DHS). As such, increasing access to health services without improving nutrition is unlikely to lead to significant improvements in child health.

**Table 2.4: Child Malnutrition 1987-1996**

	1987 <sup>a</sup>	1988-89 <sup>b</sup>	1995-96 <sup>c</sup>
Stunting (ht/age)	24%	27%	30%
Wasting (wt./ht)	11%	18%	23%
Undernourished (wt/ht)	31%	43%	40%

a. Macro International 1987, for children 3-36 months

b. Enquête Budget et Consommation, 1990

c. Macro International 1996, children 3-35 months

2.44 Although the design document for the PSPHR noted the problem of high malnutrition and its consequences for child health, the program did not address nutrition directly. The government and Bank have agreed, in light of recent data, to include a nutrition component in the next phase of Bank support, and sponsored a community-based investigation of the causes of child malnutrition (Moore 1998). The study found that high levels of child malnutrition in Mali was a consequence of several factors, including child feeding practices, traditional beliefs regarding health and nutrition, and disparities in the allocation of food and resources within households, with young children receiving the lowest priority. Most strikingly, the study found that among the rural populace surveyed, malnutrition was not associated with inadequate food intake--children with signs of kwashiorkor were given pills, and children who were very thin often are not given additional food or special attention. Household heads in Sikasso region often did not consider improved child health and nutrition to be among their highest expenditure priorities (Moore 1998).

2.45 Research elsewhere in Africa has found that child malnutrition can worsen even in the context of increasing household incomes if agricultural policy changes result in a shift toward food or cash crops that are controlled by men, and the men tend not to use their income to improve child welfare (Kumar 1994). Community data suggest that the latter may be the case in Mali, but further research would be needed to assess whether changes in agricultural policies and prices have in fact contributed to increased child malnutrition.

2.46 In general, household behavior and traditional beliefs represent a significant constraint to improved health and nutrition in Mali. Some NGOs and donor-sponsored projects are engaged in

10. The survey found wasting averaged 12 percent over the survey period, but concluded that even this level constituted a serious child malnutrition problem (Bouvier and others 1995).

community education, which may account for increases in knowledge of ORT and family planning methods. But the public health system, including the community health centers, currently provide little in the way of health, nutrition, or family planning education and community outreach.

### **Summary**

2.47 In sum, the Bank support has generally targeted appropriate diseases and constraints on system performance, and properly emphasize increased access to basic rural services. The Bank's long-term effort to improve the availability of essential drugs addressed a major sector constraint and eventually yielded positive results. From an epidemiological perspective, the major unaddressed issues were child malnutrition, health education and behavior change. Without improvements in these areas, the curative services offered in the community clinics are unlikely to achieve significant impact on health outcomes. Although the community sector approach ignored the continued problems at higher levels in the health system, this may have been an appropriate strategic choice in the context.



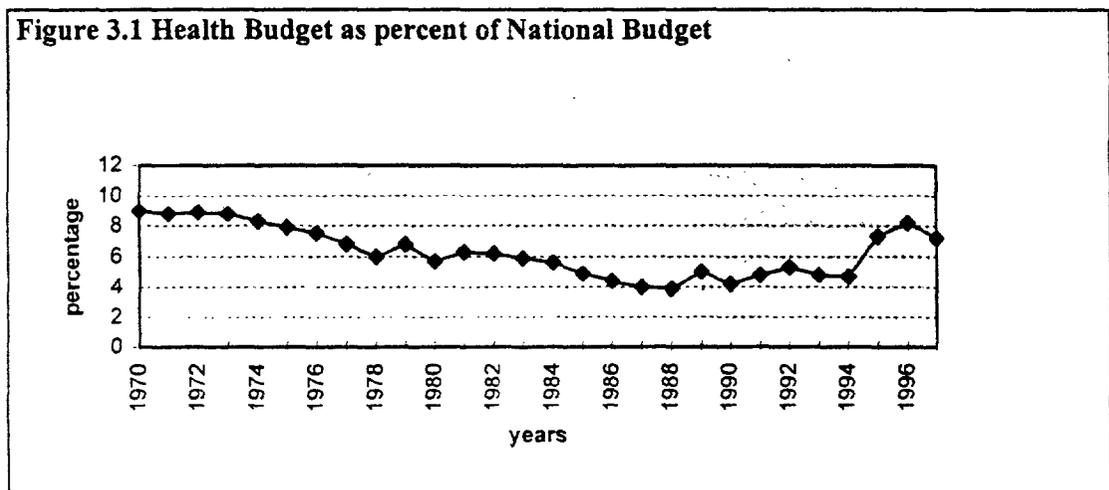
### 3. World Bank Policy Dialogue

3.1 The World Bank's influence on health sector and macroeconomic policies can be equally or more important than the direct impact of project support. The Bank's role in the development of the 1990 National Health Policy was discussed in Chapter 2. This chapter first addresses the influence of the Bank's advice on economic structural adjustment and civil service reform on the health sector. It then considers the Bank's advice and influence on health financing and the Mali pharmaceutical sector.

#### Economic Structural Adjustment and the Health Sector

3.2 The post-independence government in Mali established a variety of controls on the economy consistent with its socialist orientation. By the early 1980s, the country faced a serious economic crisis resulting from recurrent droughts, declining terms of trade, and inappropriate economic and financial policies. With support from the World Bank and IMF, the government launched a series of stabilization and adjustment programs starting in 1982, which sought to reduce budget deficits and improve the efficiency of resource allocations. In 1986, a sharp drop in the international price of cotton--the country's major export--combined with inadequate stabilization measures again plunged Mali into a major economic crisis by 1987.

3.3 In these initial adjustment operations, the Bank focused on the macroeconomic aspects, including reducing public spending, with limited attention to the social sector consequences (World Bank 1987). Communication and coordination between health sector staff and Bank macroeconomists were poor. Continued economic stagnation, combined with lack of measures in the adjustment program to protect the social sectors, contributed to a steady decline in government health spending through the 1980s (see Figure 3.1). Private health expenditure and donor financing increased over this same period, but were not effective substitutes for government financing (World Bank 1995).



Sources: Brunet Jailly 1993; Coulibaly and Keita 1993; NSPAS 1982; and MSSPA 1997.

3.4 In the late 1980s, government renewed its adjustment efforts, and negotiated Policy Framework Papers for 1988-90 and 1990-92.<sup>11</sup> The World Bank-supported Structural Adjustment Loan (US\$70 million), which was approved in 1990 and cofinanced by several other donors, focused on improving the economic incentive system and public resources management (World Bank 1990). Specific measures included tax and tariff reforms, reducing regulatory constraints on the private sector, restructuring current expenditures, reform of the civil service, and improving public investment management.

3.5 Several adjustment conditions directly affected the health sector. To reverse the declines in government health funding in the 1980s, government agreed to increase the share of health expenditures to 8 percent of the budget by 1992, and to increase the percentage of non-wage recurrent spending. Yet the adjustment agreement also called on government to freeze the nominal wage bill at 1989 levels, and to reduce the number of employees on the government payroll from 42,400 in 1990 to 34,000 by the end of 1992. The civil service reduction targets did not fully exempt the social sectors, however, and the expenditure targets did not discuss allocations within the sector.

3.6 Despite the civil disturbances of 1991 and the subsequent democratic transition, the adjustment program met most of its immediate objectives, with the major exception of civil service reform. On the positive side, government increased the percentage allocation to the health sector to 8 percent by 1995, although spending remained heavily biased toward urban services and tertiary care. The civil service reform program reduced the number of civil servants and controlled the public wage bill (although below the original targets) but did not improve the efficiency of the civil service.

3.7 The social sectors, including health, were negatively affected for several reasons. First, the reform program resulted in significant reductions in health and education staff, including at the primary levels, which were already understaffed. Essential social sector staff were to be ineligible for a voluntary departure program, but the severance package was so generous (four years salary plus pension) that the civil service union pressured government to make the package available to all staff. Government relented, and 10 percent of those who ultimately took the package worked in basic health and education. Second, the wage bill reduction target was met only in part by staff reductions, the rest came from real wage declines, which contributed to low morale among health workers. Finally, efforts to reduce the size of the central MOH administration resulted in the loss of experienced high-level staff, which undermined efforts to improve government's planning and management capacity in the sector.

3.8 The civil service reduction targets and freezes on new hiring initially affected the PSPHR, which was project approved in 1991. In order to qualify for funding under the project, districts were to have a minimum of two doctors on staff to prepare the district health plan. These stipulations were established during project design, however, without close consultation with Bank macroeconomists or the Ministry of Finance. The hiring restrictions created delays for a number of districts that were unable to obtain the needed staff.<sup>12</sup> Hiring freezes and declining

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11. The key focus areas were: i) improved economic incentives for private sector development; ii) improved public resource management; iii) reform of the cotton sector; iv) restructuring of public enterprises; and v) reform of the financial sector.

12. The project essentially began in 1993 after the districts met the conditionalities of the project.

real wages also made it more difficult to hire and retain staff for rural health facilities. By the early 1990s, the Bank and IMF relaxed these hiring restrictions for the social sectors, which allowed project implementation to proceed more smoothly.

3.9 Continued overvaluation of the CFA initially kept the adjustment program from restoring economic growth and external competitiveness. From 1982 to 1992, real GDP per capita declined by an average of 0.7 percent annually (World Bank 1995).<sup>13</sup> Following the 50 percent devaluation of the CFA in January 1994, economic growth increased (GDP grew by 2.3 percent in 1994 and over 6 percent in 1995). The renewed growth was the result of heightened external competitiveness in export-oriented sectors, particularly the cotton sector, and in import-substitution. The Bank and other donors also provided emergency loans and grant assistance to help ease the impact of CFA devaluation. Increased growth in exports and the formal sector, however, have not yet translated into significant poverty reduction or increases in rural income (World Bank 1993).

3.10 A major problem in the design of the 1990 adjustment program was the absence of communication and coordination between Bank macroeconomic staff and those in the health and education sectors. Bank health staff became aware of the negative impact of the civil service reduction targets on the sector, but did not have the expertise or institutional channels to integrate these concerns into macroeconomic dialogue. By the early to mid-1990s, the Bank became more aware of the importance of integrating social sector and poverty concerns into adjustment programs, and communication between social sector staff and macroeconomic staff working on Mali improved. The placement of a social sector specialist in the resident mission in 1992 also contributed to dialogue and policy coordination on social sector financing and staffing.

3.11 The World Bank's 1993 Public Expenditure Review (PER) for Mali identified declining public financing of health as a major sector concern, which was aggravated by inefficiencies in drug expenditures and low cost recovery at higher-level facilities. It recommended a doubling of public financing for the sector; providing an appropriate legislative and institutional framework to improve private sector procurement of generic essential drugs; improving cost recovery at tertiary levels; and redirecting resources from defense to health. In addition, the Bank's 1994 Country Assistance Strategy listed increases in health and education expenditures as "triggers" that would partially determine the scale of the overall lending program (World Bank 1994). Regarding civil service efficiency, the concerns expressed in the PER included: poor staff distribution across and within individual sectors; low staff morale due to low pay and lack of transparency in remuneration; inadequate staff training; subjectivity in appointments to higher level positions; and insufficient emphasis on staff accountability to superiors and to the public (World Bank 1995).<sup>14</sup>

3.12 The 1996 Economic Management Credit provided more specific conditions for improving health sector financing and staffing, although the conditions for the education sector

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13. The completion report for the 1990 adjustment program listed four major factors negatively affected implications of the program: the sociopolitical disturbances of March 1991 and the political instability and transition that ensued; continued declines in the world market cotton price; the economy's lack of competitiveness due to the over-valuation of the CFA; and weaknesses in the country's administrative capacities.

14. For example, it noted that in the health sector, about 60 percent of all professional staff, 64 percent of midwives and 39 percent of state registered nurses were located in the Bamako region, with only ten percent of the population. In agriculture, staff numbers exceeded staffing norms, while the health sector was considerably understaffed.

are much more specific. The credit repeated the PER call for doubling of health spending, and included specific targets for the health sector regarding new personnel recruitment and sector maintenance spending allocations (recruit an additional 550 medical and paramedical staff over 1996-98). Unlike the education sector conditions, it specified neither where staff would be deployed nor the composition of spending by level. The health targets were less specific for several reasons. First, although the Bank sponsored sector studies in the early 1990s on health financing and staffing, the budgeting system for health in Mali made it difficult to determine levels of expenditure for basic health and other key areas. Second, Bank health staff did not spend as much time as education colleagues in detailed discussions on budget priorities. Preparation for the Sector Investment Program has sponsored background papers on sector financing, health staffing and training policies, among others (MSSPA 1998).

### Health Financing

3.13 The financing of basic and preventive health services in Mali faces several fundamental challenges and constraints. First, the ability of the government to mobilize resources for health is limited. In addition to being one of the world's poorest countries, government has historically generated only about 10 percent of GDP in revenue. The current government is trying to improve on this performance, but with a small formal economy and limited state capacity, increasing revenue without creating excessive economic distortions is difficult. Of this total revenue, government spending for health services has ranged from 4 to 9 percent of the national budget (see figure 3.1). The World Bank's 1994 publication *Better Health in Africa* recommended that countries needed to spend US\$9-12 per capita to provide a minimum package of primary health care. With a GDP per capita of US\$250, at current levels of government revenue collection, this would require the equivalent of one-third to nearly one-half of all government revenues to be spent on basic health care alone--a clearly unrealistic level.

3.14 Government is not the only, or even the largest, financer of health services. As Table 3.1 shows, in 1997 the state provided less than one-fifth of total resources for health, behind households (half) and external aid (one-quarter). Total health spending from all these sources amounts to about US\$7 per capita. In a context where the state has limited capacity for both revenue collection and service provision, the high levels of household spending can be an appropriate response. But this brings us to the second problem: the high degree of inefficiency in health spending, both public and private. At the household level, 85 percent of private health

**Table 3.1: Sources of Health Financing, 1997 (FCFA billions)**

<i>Source of Health Financing</i>	<i>Amount</i>	<i>Percentage</i>
State	10.0	17.5 %
Others (NGOs)	3.3	5.8 %
External aid	14.2	25.0 %
Households	29.2	51.5 %
Total	56.7	100 %

*Source:* MSSPA 1997.

spending is for modern drugs (Table 3.2). Prior to the early 1990s, nearly all of this expenditure was for high-cost brand-name specialty drugs purchased through the parastatal drug company, or for drugs purchased on the informal market, most of which are of dubious quality.

**Table 3.2 Private Health Expenditures, 1997 (FCFA billions)**

	<i>Amount</i>	<i>Percentage</i>
Fees in public sector	0.9	3.1 %
Care in private or informal sector	1.5	5.1 %
Illicit private fees	1.0	3.4 %
Traditional medicine	1.0	3.4 %
Modern drugs	24.8	84.9 %
Total household health expenditures	29.2	100 %

*Source:* MSSPA 1997.

have concentrated their resources on providing basic rural health services. The growing dependence on donor aid has created other problems, however, including poor coordination, difficulties in funding recurrent costs, and donor programs substituting for government support for the most critical interventions (OECD 1998). Most strikingly, primary health care and health education programs were entirely funded by donors in 1997 (see Table 3.3).

3.16 In this context, the Bank's health financing strategy--as embodied in its projects, particularly the PSPHR, and policy dialogue--took a multi-faceted approach. First, in the mid-1980s, the Bank (along with other donors and NGOs) sponsored several pilot projects to test whether community-financing could be an effective means to mobilize additional resources for basic health care and extend service provision into rural areas. The results of these experiments were drawn upon in the establishment of the national health strategy of 1990 and the PSPHR

**Table 3.3: Intrasectoral Distribution of Health Expenditure by Source, 1997 (FCFA billions)**

	<i>Internal</i>	<i>External</i>	<i>Total</i>	<i>Percentage</i>
Primary Care	0	4,292	4,292	16 %
Secondary Care	755,809	1,909,400	2,665,209	10 %
Tertiary Care	1,375	376	1,751	7 %
Training	675,210	37	712,210	3 %
Central Administration	3,740,725	0	3,740,725	14 %
Decentralized Administration	1,822,129	0	1,822,129	7 %
Health/Environment Education	0	8,343,167	8,343,167	32 %
Vertical Programs	0	2,072,621	2,072,621	8 %
Logistics	792,472	93,320	885,792	3 %
<b>Total</b>	<b>9,161,345</b>	<b>17,123,510</b>	<b>26,284,850</b>	<b>100 %</b>
<b>Percentage</b>	<b>35%</b>	<b>65%</b>	<b>100%</b>	

*Source:* MSSPA 1997.

project. Second, the Bank encouraged government to reform the parastatal drug company to lower costs and introduce essential generic drugs into the public and private markets (see below). The goal was that together, these measures could shift household resources away from inefficient drug purchases toward provision of basic primary care. Third, the Bank sought to improve the overall efficiency of public and donor resource mobilization by encouraging government to develop a health strategy, and working to bring donors under a common program framework (first in the PSPHR, and currently in the Sector Investment Program). Fourth, after neglecting the problem of public resources for the social sectors in the early to mid-1980s, the World Bank

3.15 The allocation of government health spending also has not been efficient or equitable. The majority of the government's limited resources are spent for urban-based tertiary care and for central administration. Donors have increased their support to health in the past decade, and

began to encourage government, through policy dialogue and explicit macroeconomic conditions, to increase health spending as a percentage of the national budget. Finally, from the early 1990s, the Bank began to raise concerns regarding the efficiency and equity of resource allocations within the sector, with some of these concerns to be addressed in the new program.

3.17 Overall, these strategies were appropriate, and as discussed in subsequent chapters, have yielded some important results. The Bank could be faulted for not bringing focused attention earlier to the inequities and inefficiencies of government's health spending, although it could be argued that this was an appropriate strategic choice. The Bank's 1993 Public Expenditure Review (PER) raised a number of issues regarding the efficiency and equity of government health expenditures, some of which are being addressed in the SIP.

3.18 From a health financing and equity point of view, however, the Bank's strategy has had several basic constraints. First, it has not fully confronted the equity issues inherent in a community-financed basic health care strategy. This has two dimensions. Although improvements in the availability of essential and generic drugs has significantly reduced the price of drugs at health centers, the cost of drugs and service fees remain a deterrent to use by the poor, and communities do not appear to be widely providing exemptions (see Box 4.6). In addition, public subsidies remain highest and cost recovery lowest at urban tertiary facilities, with the reverse situation at rural primary care facilities. Although it could be argued that public subsidies for higher-level care represent a form of social insurance for more serious illness, those benefiting from these services are mostly from upper-income brackets. The 1993 Public Expenditure Review discussed the problems of inequities in cost recovery (World Bank 1995), but this concern has not been fully transferred to program design or sector strategies (for example, the Bank has sponsored little research on the health-seeking behavior of the very poor).

3.19 Second, the community-financing approach faces a fundamental problem with the provision of public goods, particularly preventive programs and health education. Since the community centers rely on drug sales to meet recurrent costs, they tend to under-provide health education services (Chapter 4), which are among the interventions most critical for improving public health. Third, although community financing can provide an important means to mobilize local resources, in the context of overall expenditures, the amount raised is currently only about 3 percent of total household expenditures (Table 3.2), which translates into 1.5 percent of total sector expenditures. This does not mean that the community health sector should not continue to expand, but that expectations for resource mobilization should remain modest.

### **Reform of the Pharmaceutical Sector**

3.20 The World Bank identified pharmaceutical reform as a major objective during preparation of The Health Development Project, and supported a sector study in 1981 to help guide reform efforts (the study was cofinanced by USAID, the European Union, and government). The importation and sale of drugs were the responsibility of a parastatal--the Pharmacie Populaire du Mali (PPM)--that had a monopoly on the importation of medicine and pharmaceuticals. It earned profits, despite inefficient purchasing policies, because demand for drugs was strong. The drugs imported were specialty, brand-name drugs, however, and drugs were often unavailable and, when available, were expensive. PPM was inefficient and over-staffed, and its monopoly position and sole-source contracts provided opportunities for illicit drug sales and other forms of corruption. Drugs were sold at a subsidized discount to government

facilities, but at full price elsewhere. Together with illegal imports, this contributed to a thriving black market in drugs, often of dubious quality. The combination of a weak public health system and proliferation of black-market drugs contributed to a growing practice of self-medication.

3.21 In addition, despite its inefficiencies, PPM was one of the few state enterprises making a profit because of the high demand for drugs, despite the high prices. Government was reluctant to lose these profits (USAID-WHO 1989). Despite the significant institutional and political obstacles to reform, the Bank addressed the problem as technical and managerial in the 1983 Health Development Project. Through technical assistance and "capacity building," and establishment of a revolving drug fund for PPM, the Bank hoped to improve the efficiency of the PPM and introduce lower-cost essential and generic drugs.

3.22 Not surprisingly, PPM strongly resisted all efforts at reform, and made few changes despite the project inputs. The failure to improve the supply and affordability of essential drugs hampered experimentation with cost recovery at the community level, since the drugs remained unaffordable and the health centers were unable to cover their recurrent costs. The Project Completion Report for the PDS concluded that the project design had not adequately assessed government "commitment" to pharmaceutical reform, and that the success of the entire project had relied too heavily on the expectation of significant reforms (World Bank 1989).

3.23 By the late 1980s, however, several factors began to build impetus for reform. The failure of the PDS and other similar initiatives helped convince some senior officials within the Ministry of Health and elsewhere in government of the need for pharmaceutical reform. At the international level, essential drugs were a central component of the Bamako Initiative, and the development of Mali's national plan for implementation of the Initiative included plans for the introduction of essential drugs. The World Bank also realized that the obstacles to reform were not simply lack of capacity, and in the policy dialogue leading to the subsequent project, the Bank emphasized that changes in the regulatory framework for the pharmaceutical sector should be implemented before project effectiveness. Other donors and NGOs had grown sufficiently frustrated with the PPM's inefficiency that they began to call for its abolition. Bank staff, however, felt that it was important to improve the functioning of existing government institutions, and that abolishing the PPM was not politically feasible. In addition, they were concerned that a recently-established NGO would not have the capacity to handle the large drug procurements planned for the PSPHR.

3.24 In the months prior to negotiation of the PSPHR, Bank staff differed regarding the appropriate conditions to encourage pharmaceutical reform and improve the supply of essential generic drugs. Sector staff initially planned to tie project disbursements directly to the regional availability of essential drugs at a price "affordable" to districts and health centers. Macroeconomic staff wanted to emphasize opening up the market to private competition and restructuring of the PPM. Just before negotiations, macroeconomic staff convinced their counterparts, and the conditions emphasized liberalization and restructuring.

3.25 As part of the National Health Policy, government, World Bank, and other partners worked together to develop a "Contract Plan" that would guide reforms of the pharmaceutical sector. The 1991 Plan was a contract between government (represented by the Ministry of Finance) and PPM, and included a number of major reforms. First, the PPM was to sell its retail outlets, and government was to legalize private sector importing and retailing of drugs. Second,

PPM was to phase out procurement of specialty drugs, which would become the responsibility of the private sector, and shift to procurement and distribution of essential and generic drugs for the government and community sectors. In 1991, government adopted an essential drugs list, which was attached to the Contract Plan. Third, PPM was allowed to charge real costs, but with limited mark-ups. Fourth, all large procurements were to be awarded by open international bidding. Finally, PPM was to introduce a number of measures to improve efficiency, including the elimination of 200 positions from its total staff of more than 600 in the first 18 months, with further reductions subsequently. PPM retained its regional supply depots, however, and districts and community health centers were expected to purchase their drugs from these regional depots. The Plan also called for PPM to participate in a campaign to improve prescribing practices among doctors (MSSPA n.d.).

3.26 Reforms proceeded slowly in the early 1990s, both because of the political transition, and because of continued resistance within PPM. The liberalization of the sector, however, allowed the establishment of private and nonprofit drug suppliers. To ensure a supply of essential generic drugs to the initial community health centers, several donors and NGOs supported the establishment of a local nonprofit organization--G.I.E. Santé pour Tous--that procured essential generics and sold them directly to districts and health centers. These alternative channels created some competitive pressures, and the expansion of the community health sector increased demand for generic drugs and generated further political pressure for implementation of the PPM reforms. By 1993, as part of the World Bank project, PPM began purchasing essential generics through international competitive bidding (ICB), which further reduced drug prices.

3.27 By the mid-1990s, most of the provisions of the Contract Plan were implemented, particularly the shift toward procurement of essential drugs and the use of ICB. These measures alone helped drive down drug prices to as little as 20 percent of their previous levels. As a result, even after the 1994 CFA evaluation, drug prices continued to decline. The devaluation itself also put further pressure on PPM to reduce cost and contain drug prices. The reduced prices and improved availability allowed the community health centers established as part of the National Health Policy to maintain drug availability, and to use proceeds from drugs sales to cover most of their recurrent costs. In response to public demand, private pharmacies also began to sell generic drugs. As of 1997, the percentage of generic drugs sold in Mali was higher than in most other West African countries (World Bank 1998). The reforms and essential drug policy were therefore largely successful.

3.28 The reforms, however, encountered strong resistance. Government initially reduced PPM staff somewhat, but efforts at further reductions sparked union protests, and government relented. The introduction of generic drugs cut into the profit margins not only for PPM but also for the new private pharmacies and drug importers, who launched a newspaper advertising campaign accusing generic drugs of being of inferior quality. The election of a new democratic government in 1993 gave new impetus to the reform process. The new government continued the streamlining process, and eventually reached the target of 200 total staff. By 1998, PPM had achieved its goal of financial viability.

3.29 Stock-outs of essential drugs still occur at the regional depots, even when the drugs are available at the main warehouse. The stock-outs are partly due to continued problems in the distribution network, but may also be the result of weak incentives for the regional depots to maintain adequate supplies of essential drugs. To maintain drug stocks, some districts and

CSCOMS have begun to procure drugs through a nongovernmental supplier, but this often requires a trip to a major city, which not all districts or health centers can afford. Finally, the problems of a large black market for pills, self-medication, and poor understanding of appropriate drug use remain.



## 4. PSPHR and the Community Health Sector

4.1 The Health, Population, and Rural Water Supply Project (known as PSPHR) introduced several concepts into Mali's health system. First, the project helped establish the community health sector, separate from government health services, where local committees run the centers and staff are employed by the community, not the civil service. Second, PSPHR awarded funding on a competitive basis to districts, contingent on their meeting criteria for a five-year district health plan. Finally, the project helped break the tradition of geographical zoning based on donor interests by bringing most donors under a single project guided by a national policy (see Chapter 2). Since the project encompassed most of the investments in the sector and multiple donors (see Box 4.1), this section will focus primarily on rural health services and the establishment of the community health sector.

### Box 4.1 PSPHR Objectives

The main objective of PSPHR was to implement the government's new national health policy and to increase the availability of health services in four of the five southern regions of the country (Koulikoro, Ségou, Mopti, and Kayes). The project was jointly funded by the Bank (43 percent), local communities and government (7 percent), and other development agencies. These included the European Union (20 percent), France (3 percent), Germany (10 percent), and the United States (17 percent). Its implementation was also supported heavily by UNICEF. The total project budget was US\$61.4 million.

The quantitative targets of PSPHR were to:

- increase the coverage and quality of health services in four regions of the country and in Bamako;
- integrate family planning into MCH services and support IEC activities to increase contraceptive prevalence; and
- provide access to safe water for about 180,000 people.

The population components of the project were implemented nationwide. The water component was implemented in Kayes region; feasibility studies were conducted in the other project regions.

*Source:* World Bank 1991.

### Decentralized District Planning and Management

4.2 The 1990 national health policy and the PSPHR project sought to promote decentralized district planning and community management of health services in a country with a tradition of centralized administration, which was emerging from decades of dictatorial rule. This called for significant changes in the relations between central MOH administration and districts, districts and local health centers, and health center staff and local communities.

4.3 Before the 1990 policy, districts had limited planning responsibilities, and often had multiple vertical programs in their districts, each separately managed from headquarters. The new policy created significant changes in responsibility. To qualify for funding under PSPHR, districts had to develop a five-year health plan, which required consultation with communities

regarding service priorities and the location of the health center. The plans had to meet established criteria to qualify for funding. District health officials also were to facilitate community organization and establishment of the community management committee (known as the ASOCO) for the health center. Yet, district health services were mostly run by doctors with limited experience in health service planning or community mobilization. Furthermore, these new tasks were additional to their responsibilities for running the district hospital.

#### **Box 4.2 The Community Health Sector**

Before implementation of the new health policy, decisions about where to offer health services were based primarily on the administrative status of the locality. Under the new policy, decisions are based on health needs and population criteria. Each district develops a health map that identifies priority health needs and defines the population to be served and the siting of the community health facility.

A contractual agreement is then signed between the communities and public health officials, whereby the government and the communities each agree to contribute toward construction or rehabilitation costs for a health facility. Initially, communities were to contribute half of the construction costs, but the amount was lowered to 25 percent following the 1994 CFA devaluation. (Communities are expected to contribute only 10 percent of construction costs funded under the planned sector investment program, given the limited resources available in most rural communities.) In addition to its initial contribution for the facility, the government is responsible for equipment, the initial stock of drugs, and periodic supervision of the professional staff to ensure the provision of a minimum package of services (including both preventive and curative services).

The community owns and manages the health center. An elected management committee is responsible for mediating between the health center staff and the villages. The intent of the policy is for the community health centers to become self-financing of recurrent costs, except in the poorest areas. This is accomplished through the collection of user fees. The health committees set fees, and all fees are retained at the community level. Under the health policy, local development committees are also committed to spending at least 7 percent of local development taxes on health.

About two-thirds of the community health centers are true community centers (CSCOMs), in that they are new health facilities, in sites selected by the community and operating with staff paid for by community resources. The remaining third are centers that were previously owned and operated by the state but for which the community now takes management responsibility (CSA-Rs), although they may still operate with public sector staff.

4.4 Bank staff believed that district officials could handle these responsibilities if given the opportunity and the incentives, but the Bank underestimated the intensive assistance that would be required to help them adapt to these new roles. UNICEF stepped in and used its parallel financing to place a senior technical specialist in each region of the country, who helped the district health teams and communities as they developed their district plans and organized health associations. As a result, in the first years of the project, instead of 60 percent of districts qualifying (as originally expected), over 90 percent met the criteria for funding.

4.5 Not surprisingly, the quality of management and leadership varies among districts. But an important remaining constraint is that although responsibility for planning has been decentralized, budgets are still mostly controlled centrally. Devolving budgetary authority, together with training and financial management, will be an important next step in the decentralization process. In addition, decentralization within the Ministry of Health has occurred ahead of the government's overall decentralization program. As the national program proceeds, a number of important issues will need to be resolved, including differences between the geographic boundaries used for health planning and those used by local district governments.

## Community Participation

4.6 The community participation process required extensive negotiations between district health teams and communities, and numerous visits to communities by the district health teams. District officials first met with community leaders to explain the partnership between the government and the community under the new national health policy, and asked if the community wished to contribute toward the construction of a new facility and take responsibility for management and funding recurrent costs. Community leaders then spoke with their villages to clarify the proposal and answer questions.

4.7 If communities agreed to establish a health center, the district health teams, with support from the regional health teams, undertook theoretical mapping exercises to determine what they thought would be appropriate locations for new health centers. They began the process of consulting and negotiating with communities, which often resulted in changes in the facility map, with communities deciding the final grouping of villages belonging to a health area. Communities chose representatives (two from each village) for the management committee (ASACO) of the health facility, which became responsible for mediating between the health staff and the village leaders, determining the prices of various services, and managing the cost recovery and day-to-day functioning of the health facility. The district health team and the ASOCO then signed a contract specifying respective responsibilities for the management, supervision, and financing of the health center. The district teams are expected to continue supervisory visits to ensure that the ASOCOs are able to carry out health promotion activities and to provide health center staff with required support.

4.8 Given the inexperience of most rural communities with management of health services, and the government's inexperience in organizing participation, the process worked reasonably well and many centers are functioning effectively. The PSPHR provided several lessons, however, in community participation. First, the community organization process took longer than originally anticipated—typically more than a year. Even then, in some cases the process was rushed, without allowing time for building strong consensus among the various villages involved. Some observers have therefore labeled the process as “top-down participation.” Second, district doctors were not always the ideal community organizers and did not always have skills in, or even see the value of, community participation. Technical assistance from UNICEF was critical both in helping district staff assume this new role and in convincing health staff of its importance. Still, a 1998 survey found that many health professionals viewed “participation” as clients paying for services (Moore 1998). NGOs might have been more effective at mobilization, assuming qualified organizations were available. Third, although the management committees were supposed to be elected, the democracy of the process varied—with traditional authorities sometimes appointing the committees—and the committees are dominated by men. In focus group discussions, women sometimes complained that their concerns were not adequately represented. Those in surrounding communities were not necessarily aware of the community management structures (Maiga and Dicko 1997).

4.9 At centers with effective management committees, providers were responsive to community concerns. Yet, most health clinics are still part of the government health system, with staff employed by the civil service (50 percent in the PSPHR region and 40 percent nationally). Although some management committees have been established for government centers, they often have relatively little influence over the staff. The management committees for the most part

have proved capable of managing the basic health services, cost recovery, and the revolving drug fund, but do not engage in long-term financial or work program planning. Few committees appear to be active in health promotion. A national federation of community health associations was established in 1994, and the Bank supported its expansion to regional levels to help provide support to community management committees. The federation and solidarity among committees are still in the early stages, however; strengthening the support process will be important for future sustainability. Even as government and partners focus on expanding the community health system as part of the next five-year investment program, the existing ASOCOs and community health centers will require continued attention and support.

#### **Box 4.3 Minimum Health Services Package**

The government defines the minimum package of health care services to be offered at the community level in a statement entitled “Paquet minimum d’activités” (PMA). The PMA is a two-page statement of curative and preventive services to be offered at health centers. Activities include:

- Curative activities—diagnosis and treatment of common ailments (including local endemic diseases).
- Preventive activities, including vaccinations for children and pregnant women, pre- and postnatal consultations and assisted deliveries, healthy child services, hygiene and sanitation activities, IEC, information on contraceptives, and community development activities.
- External clinical activities—urine and sputum tests.
- Management activities, including distribution of essential drugs; holding of regular community association meetings; collection, analysis, and transmission of health information; referral to district level of cases requiring further attention.

These services are appropriate for a country with such high levels of infant, child, and adult mortality related to preventable diseases that have low-technology, low-cost solutions.

### **Service Provision and Coverage**

4.10 The PHC services to be provided at the community level are defined by the government in a minimum package of health care services (*paquet minimum d’activités*). The services outlined in the PMA (Box 4.3) are appropriate for a primary care clinic. Although the PMA describes for local providers and communities the services to be offered, it does not provide guidance as to how these services should be delivered—for example, who is responsible for outreach and health education. Community health staff did not always have adequate documentation to help them determine which services to provide, and have been given limited guidance on when to refer a case.

4.11 The main problem, though, is that some of the most important interventions—including health education, IEC, family planning, and outreach—are provided rarely or *ad hoc*. Field visits conducted for this study, as well as other surveys and MOH data, confirm that family planning services are provided infrequently at most community health centers (Moore 1998; MSSPA 1997; Ringuedé 1997). The community-based provider program established as part of the USAID-funded population component initially was not integrated with the community health centers (see Box 4.4). Efforts are now underway to improve linkages between CBDs and health centers, and possibly to expand the CBD mandate to include general health promotion activities. These activities are crucial in the battle to halt the progression of AIDS in the country (World Bank 1995).

#### **Box 4.4 Population Component**

The population component of PSPHR consisted of two parts, i) institutional support to assist the government in finalizing its population policy and to strengthen planning, management, and evaluation of national family planning programs; and ii) investments to increase demand for family planning through IEC campaigns, and improve the availability and quality of family planning services.

USAID financed the majority of the population component through its Community Health and Population (CHPS) project, the budget for which was nearly doubled in 1994 to US\$40 million. USAID's activities focused on four major areas: i) community-based distribution of contraceptives (CBD); ii) social marketing of various contraceptive methods; iii) contraceptive logistics and management; and iv) training in mother/child and reproductive health. Most of these activities were implemented by international and local NGOs. Although formally part of PSPHR, in practice these activities were managed independently and were not closely coordinated with the community health centers. The substantial investments under this component have led to modest increases in contraceptive prevalence (see Table 2.3), and may have established a base for more substantial gains in the future.

The United Nations Fund for Population Activities provided support for completing and distributing the national population policy. The World Bank supported the national IEC component, which has shown mixed results. This component provided institutional support for the National Center for Health Information, Education, and Communication (CNIECS), including staff training in IEC development, health communication, and community mobilization. These actions appear promising, but it is not clear that the CNIECS has the capacity to conduct a major national IEC effort, which will be critical to bring about improvements in HNP outcomes.

4.12 Centers have few resources and materials for IEC and health education activities, and staff lack incentives to carry out these activities. In villages where these activities were reported, they tended to be done by NGOs or district-level health teams, not by community-level health personnel.<sup>15</sup> Some health center staff plan regular discussions on health themes when clients are at the centers for vaccinations or prenatal consultations, but the themes generally do not go beyond vaccination and prenatal consultation issues. In some centers visited, the nurses or ASACOs are involved in outreach for vaccination, or following up children who do not receive immunizations. Immunization coverage rates appeared to be higher at these centers. These activities need to be extended to other centers and broadened to include community health education.

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15. The lack of priority given to health-promotion activities was also echoed in the Population Council's study of health center operations (Ringuedé 1997).

### **Box 4.5 Water Supply Component**

The rural water supply component of PSPHR is well on its way to meeting its targets for establishment of community water committees, drilling of new wells, installation of pumps, repair of existing pumps, and establishment of repair mechanisms (Table 3.1). The village committees participated in site selection, and the project trained village pump repairmen and village pump caretakers, and helped establish a network for spare parts. Community development agents from the project health villages created village water committees, and conducted community activities focusing on sanitation, maintenance, cost recovery, and the health benefits of safe drinking water.

Even though the project was to integrate clean water and health activities, most of the activities of the water component were conducted outside areas where the health component was establishing health centers. As a result, the links between access to safe water and health, established in PDS were less evident in PSPHR. Following the PSPHR mid-term review, the project increasingly focused on providing new water installations near health centers being established under the project. Although the project, together with its predecessor, has substantially improved access to clean water, the Bank has conducted no surveys or other assessments to determine whether improved water supply has led to better health. Community education and IEC provided by both the PDS and PSPHR projects may have improved water-related health practices, but a 1995 audit of PDS by the Bank's Operations Evaluation Department found that the IEC activities have not been sustained in most communities. Various community surveys in Mali have found that sanitary practices remain poor; the contribution of clean water is often undermined through carrying and storing the water in unsanitary conditions (Moore 1998).

### **Accessibility, utilization, and equity**

4.13 The most visible achievement of PSPHR is the increase in physical access to community health care facilities. As of early 1998, nearly 300 community health centers had been established. About one-third of the new health centers (103) were constructed with funding from PSPHR; the remainder were built with support from other donors and government. Nationally, the population living within 15 km of community health facility rose from 17 percent in 1995 to 39 percent as of December 1997 (World Bank 1995; MSSPA 1998). In the PSPHR zone, the figure is 44 percent (MSSPA 1998). When the improvements in geographical access by region are examined, they are even more striking, as shown in Table 4.1 below. A recent external review of development assistance to Mali found that expanded access to rural health services was considered by the Malian public as one of the major accomplishments of aid in Mali (OECD 1998)

4.14 Has increased physical access resulted in increased use of health services? The ministry's management information system has information on utilization rates for only 1996. Table 4.2 combines information from this system with information collected during the field visits to show the utilization levels of various services at selected CSCOMs and districts,<sup>16</sup> and figure 4.1 shows aggregated national data comparing utilization at community health centers (CSCOMs), government health centers under community management (CSA-Rs), and government health centers (CSAs). Several conclusions can be drawn from the table and figure. First, the establishment of new community health centers has led to increased utilization of both curative and preventative services. Figure 4.1 shows that the consultation rates for curative services, prenatal care, family planning, and vaccinations are all higher at CSCOMs and CSA-Rs than at government health centers, and that with the exception of vaccination coverage, attendance for

16. Comparison of this information with information on health service coverage before PSPHR is impossible because of inconsistencies in the way in which rates are calculated.

CSCOMs is higher than CSA-Rs. There is no significant difference, however, in the percentage of women giving birth at health facilities.

**Table 4.1. Percentage of the Population with Physical Access to PHC Facilities<sup>a</sup>**

<i>Region<sup>b</sup></i>	<i>1993</i>	<i>1994</i>	<i>1995</i>	<i>1996</i>
Kayes	1.8	4.3	11.1	16.1
Koulikoro	0.0	3.8	14.5	34.0
Sikasso	0.0	1.9	15.9	28.2
Ségou	2.2	10.8	31.8	39.7
Mopti	0.9	10.6	20.6	42.1
Bamako <sup>c</sup>	21.6	33.5	41.8	41.8
Total (rural areas only)	0.9	6.1	18.7	32.1
Total—Mali	3.4	9.5	20.1	33.4

a. Access to a health facility within 15 kilometers that provides the minimum package of services

b. Only the five southern regions and Bamako, in which the national policy is currently being implemented, are covered in the NSIS data.

c. The whole population of Bamako is within 5 kilometers of a health center; however, not all residents are officially the responsibility of a center. This number reflects the percentage of the population that is under the responsibility of a center.

Source: MSSPA 1997.

4.15 Second, curative consultation rates remain low, both nationally and in the catchment areas of the new community health centers. The CSCOM curative consultation rate of 0.19 new consultations per inhabitant per year is double the rate at government-run health centers, but is well below the expected average of one consultation per year. The consultation rates for family planning are only 3.4 percent for CSCOMs; although 50 percent higher than the rate at government centers, this is still low. Although most of the community centers visited had utilization rates above the district averages, not all did. Based on this small sample, the factors affecting the different utilization rates appear to include the effectiveness of center management, the extent of community outreach services, staff quality, and whether another health facility with better perceived quality was located nearby (typically run by a religious mission).

#### **Box 4.6 Access to community health services by the very poor**

In the spirit of community-managed health, the definition of poverty and mechanisms for providing health services to the very poor has been left to the determination of the communities. However, the response to this issue in all communities visited for this study was identical. In theory, when the very poor come to the health center for treatment, they are referred to the community association (or its representatives, the president or treasurer) for a determination of whether their costs will be covered by the association. Each health center had established a register for recording treatment provided to the very poor for whom the costs were covered by the association. Yet no center visited by the evaluation team for this study had any such treatment recorded in the register.

This suggests at least three options: either there are no people so poor that they cannot afford treatment, that they are not declaring themselves to be very poor, or that they are not coming to the health centers. A study in the Koulikoro region proposed that because of the embarrassment associated with being very poor, those without the resources to pay for themselves prefer to ask a family member or friend to cover the costs or forego treatment rather than depend on the charity of the community association.

**Table 4.2. Selected Utilization Rates, 1996<sup>a</sup>**

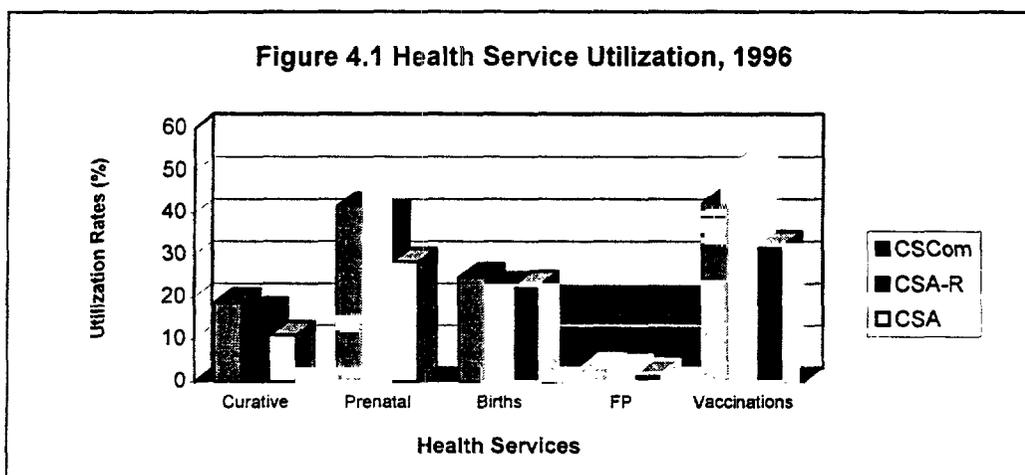
<i>National</i>	<i>District<sup>b</sup></i>	<i>Community Health Center<sup>a</sup></i>	<i>Curative consultations (new cases/inhabitant/year)</i>	<i>Assisted deliveries (coverage rate, %)<sup>c</sup></i>	<i>Family planning (contact rate, %)<sup>c</sup></i>
	Bla		0.16	27.80	2.00
		Kémini	0.24	n.a.	0.08
		Touna	0.36	0.04	n.a.
	Tominian		0.38	22.60	1.30
		Yasso	0.22	n.a.	0.01
		Timissa	0.40	n.a.	0.08
	Kolokani		0.08	21.50	1.10
		Massantola	0.21	n.a.	0.03
<b>Mali</b>			<b>0.16</b>	<b>31.20</b>	<b>2.90</b>

a. Data collected directly from the centers visited for this study from their health record information submitted in their trimestrial reports to the districts.

b. Aggregated from project- and non-project centers in the district. Figures adjusted to account for centers that did not submit health record information.

c. Includes only coverage rates for the population in health facility catchment areas, not total population of the district or region.

Source: MSSPA 1997.



Source: MSSPA, DAF 1997.

4.16 Why are many people not using the health services? The community health system is only a few years old, and it is reasonable to expect that use might improve as clients become better acquainted with the improved services. The focus groups conducted for this study, together with other recent beneficiary assessments, however, point to several other reasons for continued low service use (Maiga and Dicko 1997; MSSPA 1997; Ringuedé 1997). First, cost remains a deterrent for many, despite the reduced drug prices achieved through the introduction of essential generic drugs. Second, physical access is still a problem, particularly during the rainy season, but also because walking to the centers has a time cost for those more than a few kilometers away. Third, community outreach remains weak at many centers, with health staff waiting for users to come to them. The ASACOs are supposed to promote healthy practices and

encourage use of the centers, but they do not always do so. Fourth, the family planning component of the PSPHR (sponsored by USAID) relied on NGOs for service delivery and was not well integrated with the community health center component. Fifth, many potential consumers still prefer traditional medicine or self-treatment depending on the disease and prevailing local beliefs. Although government, donors, and NGOs are sponsoring a variety of IEC and social marketing campaigns to promote family planning, attitudes change slowly in a traditional rural society. Finally, the decision to seek care depends on who controls household resources. The issue of user charges is therefore not just a question of affordability, but also the cost relative to the preferences of the decision-maker (who is often not the woman) and compared to available alternatives (Moore 1998).

#### **Box 4.7. Social fund for population activities**

The democratic transition in 1993 facilitated improved relations between government and the NGO community, and created a more supportive environment for local NGOs. The PSPHR established a demand-driven social fund, *Fonds d'Action Sociale Pour l'Education Familiale* (FASEF), to fund projects proposed by NGO and the private and public sectors in support of the national population policy. The fund was set up as a flexible tool to finance innovative activities by the public, private and NGO sectors in the areas of population, IEC, family planning, and promotion of women. FASEF was the first fund in Mali to channel funds from government to NGOs.

FASEF initially encountered several problems, however. With a total budget of US\$3.2 million, FASEF initially established a maximum of US\$20,000 for each project. But, as noted in a 1996 interim evaluation, the management unit of the fund was too small to effectively administer and monitor a large number of small projects. As a result of the evaluation and some complaints from NGOs about the limited budget available for projects, the funding maximums were subsequently increased, and the number of projects to be funded has been limited to 50. Government and the Bank also shifted FASEF's focus toward funding larger NGOs that would in turn fund and supervise projects implemented by smaller NGOs. In addition, although USAID initially agreed to cofinance FASEF, it instead launched an independent NGO funding organization—the Groupe Pivot—which provided direct financing to local organizations. The Groupe Pivot is well-financed and has contributed considerably to the strengthening of the local NGO community, but local NGOs that might have sought funding from FASEF initially found it easier to access funds through the Groupe Pivot. USAID eventually also provided funding for FASEF, and the two organizations have begun to develop complementary roles.

As of December 1997, FASEF had received 213 applications, and financed some 46 projects. Despite its initial difficulties, FASEF has emerged as a flexible tool that provides the Ministry of Health with mechanism for assisting NGOs and the private sector (Külker and Diarra 1996). Equally importantly, it fostered improved relations between the MOH and the nongovernmental sector, which had previously been characterized by mutual suspicion.

4.17 A major constraint in the community health sector is the difficulty in attracting and retaining qualified health staff. The community health sector currently offers no job security, pensions, or opportunities for career advancement, and the centers are often located in remote areas. Most health professionals therefore express strong preference for government service. As a result, the vacancy rate for professional staff is high; some centers have remained without a nurse for more than a year. Since the salaries are determined by the communities, staff in the community sector are also more attracted to work in urban areas or in the better-off regions. In addition, professional training emphasizes curative services rather than public health promotion. Staff training and health workforce issues are therefore a major challenge, which government and the Bank will attempt to address in the next phase of support.

4.18 PSPHR also included efforts to strengthen the first-level district referral system, including funding to upgrade district hospitals and staff training and the installation of a communications network linking the community health centers with district hospitals. When

cofinancing for district hospital upgrades from the European Union was delayed, the World Bank reallocated funds to complete this component. A number of constraints remain in the referral system between the community centers and districts, however, including unavailable or very expensive transport, inadequate training for clinic staff on referral protocols, and sometimes inadequate skills at district level to deal with referral cases. Some districts have negotiated a cost-sharing formula for evacuations, with contributions from the state, patients, and the ASOCOs, which may help reduce the cost barriers to referrals.

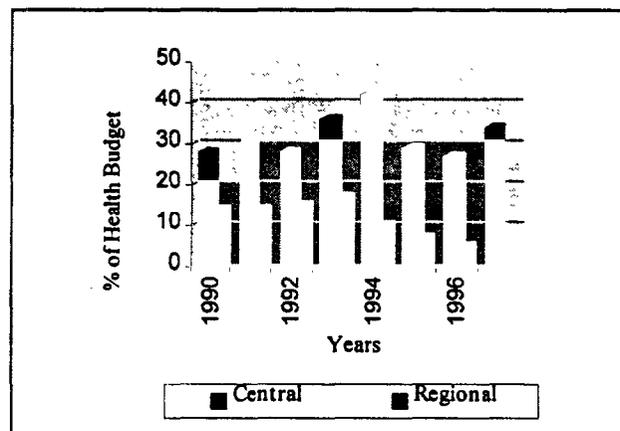
### Community Financing and Sustainability

4.19 Most community health centers established under PSPHR are able to fully cover their recurrent costs—including wages for staff—through user charges and drug sales (MSSPA 1997). The community management committees determine the fees charged for various services and the prices for drugs. Drug sales generate most of the centers' income (around 75 percent), although centers also charge for basic preventative services, including vaccinations and antenatal care (MSSPA 1997; data collected from health centers). One of the project's major successes has been to ensure the availability and affordability of essential drugs. The average cost of a prescription in the community health centers has been maintained between 400 and 700 CFA (US \$0.75-1.25) despite the 1994 currency devaluation (Nafu 1998).

4.20 The revenues are insufficient to cover all long-term costs, however, including replacement of equipment and building maintenance<sup>17</sup>.

Government policy and Bank staff state that the centers were never intended to become financially self-sufficient, although solidarity mechanisms still need to be developed to help compensate centers in poor or more sparsely populated areas. It is not clear, however, that government or the Bank have fully assessed the long-term requirements of sustaining and expanding the community health system. For example, government data show that the percentage allocation to regions from the health budget has declined significantly since 1993 (see Figure 4.1). This seems to imply that the government has been reducing support for rural services with the expectation that these will become increasingly self-sustaining.

**Figure 4.2. Central and Regional Recurrent Health Budgets Allocations**



Source: MSSPA/DAF 1997.

Note: The investment budget, which is almost entirely donor financed, is not included in this figure.

17. The government's 10-year plan for the health sector specifies that government will cover 75 percent of the replacement costs of the building and large equipment with the remaining 25 percent the responsibility of the community health center (MSSPA 1997).

## **Donor coordination**

4.21 The PSPHR provided a framework for coordination of health sector development partners, not only those who were cofinancing the project. The national health policy provided a framework for coordination, but the government's own mechanisms for donor coordination were weak. The project coordinating unit also organized informal meetings with partners about once a month that focussed on one theme, and discussed possible solutions. Most partners agree that prior to the PSPHR donor coordination was limited, and that its coordination mechanisms have been a key contribution of the project. A consequence of the project coordination unit's lead role, however, is that other units of the MOH have not strengthened their coordination capacity. In addition, it has resulted in a sense among some donors that, through the project, the Bank at times was pushing its agenda and time frames on the government.

4.22 The major success story was the relationship established between the Bank and UNICEF. Although UNICEF was not a cofinancer, the organization realigned its five-year program to support the implementation of PSPHR. The flexibility of the UNICEF assistance and the strong local field presence was critical in overcoming key project constraints. For example, the project design required that, in order to be eligible for project funding, districts had to develop a district health plan and have implemented one community-managed health facility. The project did not include support for these activities, however. UNICEF provided this support for some districts and enabled them to meet the requirements for project funding.

## **Monitoring and Evaluation**

4.23 In the 1970s and 1980s, various donors established independent project monitoring systems, either regionally-based or focussed on particular vertical programs. Government's own monitoring and evaluation systems were weak or nonexistent, but the World Bank and donors gave limited attention to increasing government capacities or consolidating competing systems. The World Bank's First Health Project (PDS) attempted to establish a regional project monitoring system, but the system never became operational. Although the PDS was supposed to be a pilot, it was not evaluated until after PSPHR was designed and approved.

4.24 The PSPHR sought to establish an integrated national health information system (with support from USAID). Because of delays due to the political transition, work on this component did not begin until 1993, and was not completed until 1996. During this three-year process, government and partners agreed to rationalize and consolidate a variety of vertical information systems. Establishing this national system was an important achievement, but because data are only available for one year (1996), it is not possible to assess the impact of the project over time. With the system now in place, remaining challenges include improving data quality and strengthening incentives for the use of data at the district level.

4.25 Periodic PSPHR review meetings provided a useful forum to discuss a variety of project and sector issues among government and partners. The Bank provided no funding for operations research under PSPHR, however, so that a number of key sector issues—such as staffing problems in the community sector, or accessibility by the very poor—were not investigated until preparation began for the sector investment program.

## 5. Prospects and Lessons

5.1 In anticipation of PSPHR completion, government, the World Bank, and other development partners began preparation for a comprehensive sector investment program. The Health Sector Investment Program (SIP) would expand the community health sector and address broader sector issues not included under PSPHR, including health staffing and increasing the efficiency of higher-level care. To provide a policy framework for the program, government assembled in 1995 an *ad hoc* group, consisting mostly of government officials (some former officials seconded from donors) to develop a 10-year sector strategy and a five-year investment program. The documents were completed in 1997, and all government and donor resources are to be guided by the strategy and investment program. Government also convened meetings to consult with regional health officials, and engaged NGO representatives in the discussions to help build consensus around the strategy.

5.2 The SIP is designed to support the implementation of the government strategy and investment program. The planning process for the SIP include extensive analytical work in the areas of health finance, human resource development, institutional capacity assessment, and further reform of the health system.

5.3 The SIP was appraised in June 1998, with 16 co-financers pledging US\$143 million, with \$40 million from the World Bank. The program encompasses a wide array investments and policy and institutional reforms. The objectives of the SIP are to assist the government in its efforts to accelerate fertility decline, expand access to basic care, improve the efficiency and effectiveness of the health system, and improve internal resource mobilization. The program components are i) construction, renovation, and equipping of PHC clinics at village and district level, and some renovation and equipping of regional and national hospitals; ii) management and technical training of the health sector workforce; iii) expansion of health insurance and cost-sharing mechanisms; and iv) restructuring management of government hospitals to improve cost recovery, cost effectiveness, and technical efficiency. The program also aims to strengthen district health management, including referral services; strengthen management information systems; increase community involvement in health centers; and develop management modules for hospitals.

5.4 The SIP agenda is both comprehensive and ambitious, and attempts to address many of the issues raised in this evaluation. In trying to do so much, however, the program runs the risk of excessive complexity, particularly given the continued constraints on the financial and human resources in the Ministry of Health. The SIPs illustrates a fundamental dilemma in strengthening health system performance in poor countries. On the one hand, much needs to be done to improve the coverage, efficiency, and effectiveness of the health system; on the other hand, trying to do everything at once can lead to partial or inadequate implementation. As program implementation proceeds, government and its partners will need to ensure thorough monitoring and evaluation to periodically assess and revise priorities among the various components and objectives.

5.5 The Bank's support has progressed over the past 20 years from an (unsuccessful) health pilot project in one region, to a nationwide "umbrella project" that embodied a new national health policy and was cofinanced by several donors, to a sector investment program under a

national strategy that is to encompass all investment in the sector. This progression has corresponded with increased government willingness and ability to establish sectoral strategies and priorities. The Mali SIP differs from others, however, in that many donors will continue to manage their own projects and funds separately, and not all funds will be channeled through government.

5.6 Although the World Bank strongly encouraged government to take a sector-wide approach, government has full ownership of the process. Among donors, the Bank has taken a leadership role, but has made efforts to bring in other partners (for example, by encouraging the European Union to fund some of the sector studies, even though Bank funds were available). Government officials report that the Bank has been effective in linking its support to key sector reforms and issues. Some donor partners have raised concerns, however, that the policy development process and SIP appraisal were unduly influenced by the World Bank's timetable and agenda. Given the Bank's influence in the Mali health sector, it must be cautious and collaborative to assure that it does not dominate the policy process.

### Lessons

5.7 The study provides a number of lessons for the Bank's HNP work in low-income countries and for government and its partners as they proceed with the implementation of the new health strategy and the sector investment program.

- *Community-financed health centers, combined with a reliable supply of essential generic drugs, can help extend basic care to previously underserved populations and improve responsiveness to local consumers.* In a country such as Mali, however, curative services alone will not necessarily lead to improved health outcomes. They therefore must be combined with appropriate health education and outreach programs, family planning promotion, and nutritional surveillance and interventions. To some extent NGOs are providing these services although they are not as yet well integrated with health services. There is a risk that community-based approaches will, through their emphasis on self-financing of curative care, create disincentives for locally-based health promotion activities, which will need to be monitored through time.
- *During fiscal adjustment, the Bank and government must pay attention both to protecting overall allocations to the social sectors and to the efficiency of expenditures within the social sectors.* In addition, excessive emphasis on meeting global targets for reducing the size of the civil service can negatively affect the social sectors and reduce sectoral efficiency. Effectively incorporating health sector concerns into macroeconomic and budgetary dialogue requires regular communication between macroeconomic staff and sector specialists, and sufficient sector work to identify priorities for changes within sector budgets and staffing patterns.
- *While rural cost recovery can be important to sustain local services, the funds raised typically are small relative to overall government health spending, which often remains focused on urban curative care.* Questions remain as to how best to provide for public goods, such as health education and preventive services, and improve access for low-income clients, when the financial viability of the health centers depends on profits from drug sales.

- *Pharmaceutical reform and improving the availability of essential generic drugs requires first a careful diagnosis of the institutional and political constraints to change, followed by negotiated agreements to shift the regulatory and incentive structure for the public, private, and nonprofit sectors. Highly inefficient parastatals are capable of significant reforms given sufficient political support and pressure, but private and nonprofit competition is important to provide alternative supply channels and to sustain pressure for reform.*
- *Shifting a previously-centralized health delivery system to one based on district-level planning and community participation requires changing incentives together with intensive technical support for both districts and communities. The Bank initially underestimated the time and human resources required, but parallel financing of technical assistance from UNICEF made the process largely successful. In retrospect, using NGOs instead of district doctors as community mobilizers might have been more effective. Decentralizing to districts responsibilities for planning but not budgets also limits the benefits of decentralization, although it can be the first step in the process.*
- *Improving physical access to health services does not necessarily lead to increased service utilization. Utilization can remain low because of continued cost barriers, inadequate outreach, and preferences for traditional medicine or self-treatment. The Bank should give greater attention to utilization and equity in assessing the impact of community-financed health programs.*
- *Establishing a community sector outside of the government civil service can help make providers more responsive to community concerns, but can also create problems with attracting and retaining staff if job security and career paths are unclear.*
- *The Bank should give greater emphasis to rigorous monitoring and evaluation, and operational research, particularly when piloting new service delivery mechanisms that are then scaled-up nationwide.*
- *In aid-dependent countries, the Bank can help increase the coherence of donor activities by supporting the development of national health strategies and through funding instruments such as umbrella projects or sector investment programs. Given the Bank's influence, however, it must be cautious to ensure that its agenda and timetables do not dominate the policy and coordination process.*

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