

Health Care in Mali: Building on Community Involvement

THE ASSISTANCE PROVIDED BY THE WORLD BANK TO the health sector in Mali has contributed to improved access to rural health services and increased availability of affordable essential drugs, according to a recent Operations Evaluation Department (OED) study. Lessons learned through an early, unsuccessful health project in the country helped the Bank and its partners identify key strategies—including establishing a community-managed health sector with services financed through cost recovery, reforming the state pharmaceutical agency, and creating a regulatory framework to promote essential generic drugs. Remaining challenges include increasing the utilization of health services, addressing malnutrition, alleviating staff shortages in the community sector, and improving the equity of government health expenditures.

Background

Mali is one of the poorest countries in the world. Most of the population engages in rain-fed cultivation of subsistence crops, but the country's climate is harsh and unpredictable, with an ever-present threat of drought. The adult literacy rate is less than 20 percent, among the lowest in the world. Education services are poorly developed, particularly at the primary level. School enrollment among girls is less than one-

third the Sub-Saharan average, and up to 80 percent of school-age children in rural areas do not attend primary school.

These indicators are important because poor economic conditions and low incomes depress demand for health services, and foster conditions that make the population susceptible to disease and ill health. The low level of education, particularly among girls, exacerbates health and nutrition indicators for chil-



dren and contributes to low contraceptive use and high fertility rates.

As in most other Sub-Saharan countries, the main health problems are infectious and parasitic diseases, and the leading causes of death are such preventable diseases as malaria, measles, tetanus, acute respiratory infections, and diarrhea. The burden of disease falls disproportionately on children and women of reproductive age, and health indicators are worse in rural areas than in urban centers. Malnutrition is a severe problem; one-third of children under age 5 and one-fourth of infants under 6 months of age are stunted. And the emerging problem that must now be targeted is the spread of the HIV virus, which currently infects 5 percent of the population, a figure that is on the rise.

When the Bank first embarked on health sector operations in Mali 20 years ago, the country was faced with a centralized health system that was unresponsive to the population. Government policy was biased toward urban, curative health care, leaving a splintered and inaccessible system for the rural majority of the population. A state-owned monopoly controlled the distribution and cost of drugs, rendering them inaccessible to all but a few. Although the government in the mid-1980s ended guaranteed employment for medical school graduates and opened up the sector to private practice, it fixed fees at rates that most could not afford, and created a pool of unemployed practitioners. An added influence was the prevailing attitude toward health care: the population was accustomed to tending to its own needs with the guidance of indigenous practices and beliefs.

The Bank's assistance in addressing these problems has yielded substantial dividends, but stubborn obstacles remain. The Bank's policy dialogue and sector analysis helped the government develop a national health policy, which established a framework for expanded access to rural health services and increased availability and affordability of essential generic drugs. At the same time, the government still has not let go of its urban bias, and does not devote an appropriate share of expenditures to primary health care or the rural sector. The Bank's lending and project operations also helped the government create a workable community-based health care system that has extended coverage to rural areas through a more coordinated network of donors and NGOs, but overall utilization remains low, and it is difficult for clinics to recruit practitioners and provide a clear career path for health professionals. The Bank, government, and other partners are well aware of these unresolved issues, and are now engaged in a comprehensive Sector Investment Program (SIP) to address them.

The Bank's Work in the Mali Health Sector

The policy dialogue and preparatory work leading to the approval in 1983 of the Bank's first health project in Mali—the Health Development Project (PDS)—represented the first time that government had participated directly in the preparation of a donor project. The project and its strategy drew on a 1981 epidemiological study that showed that villagers visited government dispensaries only an average of once every two years. Three-quarters of the sample population had not visited at all during the year preceding the survey. It also found that the average number of visits was a function of the distance from the dispensary—critical in a country that is predominantly rural.

The survey suggested that the population at greatest risk—children and pregnant women—was not receiving priority in treatment. People relied primarily on traditional healers and herbal medicines for the treatment of illnesses. Although modern drugs were sold by the government pharmaceutical parastatal, they were overpriced and in chronically short supply. Moreover, donor agencies and NGOs were attempting to expand services at the rural level, but lack of coordination, staff shortages, and inadequate financing for recurrent costs reduced their impact and sustainability.

The PDS was designed to enhance service delivery by working with the existing government health system to construct additional health centers and train new staff. But significant implementation delays hindered nearly every component. Among other problems, the NGO contracted to construct facilities performed poorly. The project piloted community-managed revolving drug funds to help address chronic drug shortages in rural areas. But because efforts to reform the pharmaceutical parastatal and reduce drug prices were unsuccessful, drugs provided by village pharmacies remained unaffordable for most, and the pharmacies could not achieve financial viability. Although a disappointment for both the government and the Bank, the PDS—together with pilot programs sponsored by other partners—provided valuable lessons that prepared the way for a significant shift in Bank and government strategy in the early 1990s.

Cost Recovery

The failure of the Bank's first project and an international shift in the development model for health prompted a reconsideration of the country's health sector strategy. The principles of the new strategy were based on models of community participation and cost recovery articulated in the Bamako initiative, endorsed by the

African ministers of health in 1987. Under the initiative, the Ministry of Health began work with UNICEF in 1989 to develop an action plan for Mali that would include community-managed cost recovery to enhance the availability of health care services. The first step was to develop a national plan for the decentralization of health planning and management, the provision of essential drugs, and community involvement in the management and financing of local health centers.

Based on the PDS experience, Bank staff were 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 proceeded by developing strong alliances with government policymakers and with UNICEF and other donors. The Bank provided advice and technical assistance during policy development, but, perhaps more significantly, it made the approval of a well-defined national health policy a condition for further support. This condition gave additional momentum to the policy development process, and tied the policy to the new project.

Although the national policy was developed by a small team of technocrats from the Ministry of Health, the government's strong ties with the Bank led some donors to call it a "Bank policy." Yet the policy survived the civil unrest and political transitions of the early 1990s—including four ministers of health and the transition to a democratically elected government in 1994—because of the strong support of senior civil servants at the Ministry of Health.

The new policy shifted the organizational model for rural service delivery away from the administrative structures of the state. It introduced the partnering of the public sector with the communities to broaden access to health services, including community management of health centers and revenues from cost recovery. The policy also called for reform of the pharmaceutical sector, including the restructuring of the pharmaceutical parastatal (PPM) to supply only essential and generic drugs, and allowing the private sector to import and sell drugs.

Confronting Essential Issues

The Health, Population, and Rural Water Project (PSPHR), initiated in 1991, set out to resolve the conundrums of rural access, drug cost, and health care coordination. It 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 and technical support from UNICEF. The involvement of UNICEF—particularly the presence of a senior UNICEF technical specialist in each region—was crucial in the development of district health plans and the supervision of the new community clinics.

Reform of the Pharmaceutical Sector

WHEN THE BANK BECAME INVOLVED IN MALI'S health sector in the early 1980s, it was recognized that pharmaceutical reform was essential. The PPM earned profits in spite of inefficient purchasing policies because the demand for drugs was strong. But the drugs that PPM imported were expensive, brand-name specialty drugs, often in short supply. Over-staffed, PPM was rife with opportunities for illicit drug sales and other 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 government was initially reluctant to lose the profits from PPM, and, not surprisingly, PPM was strongly resistant to any kind of reform. But by the late 1980s, the failure of the Bank's PDS and other similar initiatives helped convince senior officials within the Ministry of Health that pharmaceutical reform was necessary.

The Bank realized that the obstacles to reform were not simply a lack of capacity, and in the policy dialogue for the PSPHR it emphasized the need to change the regulatory framework. Other donors and NGOs had grown sufficiently frustrated with PPM's inefficiency to call for its abolition. But Bank staff resisted, suggesting that it would be politically infeasible to do so, and that the large drug procurements planned for the PSPHR could not be handled immediately by an NGO.

As part of the National Health Policy, government, the Bank, and other partners developed a "contract plan" that would guide the pharmaceutical sector toward four reforms—private competition in retail drug sales, the introduction of a larger share of generics into the government and community health sectors, limits on sales mark-ups, and the restructuring of PPM, including the elimination of 200 positions.

In the early 1990s, liberalization gained support as alternative channels for drug imports emerged, creating competitive pressures in the sector. As the PSPHR began to expand the community health sector, the demand for generic drugs increased, putting additional pressure on the government to fully implement the reforms.

By 1993 the PPM had begun purchasing essential generics through international competitive bidding (ICB). By the mid-1990s, drug prices had fallen to as little as 20 percent of their previous levels, and they continued to decline, even after the 1994 CFA devaluation.

Although civil unrest initially delayed project implementation, the 1994 democratic transition gave additional momentum to health service decentralization, increased community participation, and weakened entrenched opposition to pharmaceutical reform.

The project significantly increased access to health facilities and, with pharmaceutical reform, increased the supply of affordable drugs. By 1998, nearly 300 new community health centers had been established, one-third of which were financed by PSPHR, and the percentage of the population living within 15 kilometers of a health facility increased from 17 percent in 1995 to 39 percent. The community clinics have been largely successful in improving service coverage and client satisfaction, and have been able to use cost recovery to finance most wage and non-wage recurrent costs. In addition, community management committees were established for some established government clinics, although staff continue to be employed by the government. About half of all clinics nationwide continue to be owned and managed by the Ministry of Health.

The Bank pressed for the restructuring of PPM, removal of constraints to private competition, and a shift by the PPM toward the purchase of essential generic drugs as conditions for project approval. Although progress was initially slow, the eventual introduction of international competitive bidding (ICB) sharply reduced official prices for drugs, and prices have continued to decline, even with the CFA devaluation in 1994. Generics are now widely available, and prices are low enough to allow community health centers to cover recurrent costs from drug sales. Most specialty drugs are now provided by the private sector.

Finally, the decentralized planning process initiated under the project allowed services to be planned and delivered closer to the beneficiaries, and reduced the burdens 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 coordination of donor and government activities.

The Challenges Ahead

Since the first community-managed clinics were established in the mid-1990s—just before the most recent Demographic and Health Survey (DHS)—it is too soon to correlate the PSPHR with changes in health indicators in Mali. Evidence suggests some modest improvements in the past decade, however. Both child and infant mortality declined slightly, but still remain high, even in the context of the substantial regional rates. One-fourth of children still die before age five. The percentage of children fully vaccinated in rural areas increased from 0 to 24 percent, largely

because rural DTC3 coverage increased. The percentage of women with at least one prenatal visit during pregnancy increased from about one-third in 1987 to half in 1995, and tetanus vaccination coverage increased from 18 to 50 percent. Data also suggest that some health practices—including birth attendance by trained medical personnel and the percentage of children treated for diarrhea—have improved.

The prevalence and severity of malnutrition among children provides a notable contrast to the successes cited. The number of children suffering from malnutrition is daunting—23 percent of Mali’s children are wasting according to the 1995/96 DHS—and prevalence of malnutrition is comparable to that found in countries just emerging from famine or civil conflict (see table below). Both stunting and wasting have been common since the late 1980s, and may have increased in the past decade (although the data from the 1987 DHS may not be reliable). An analysis of the 1995/96 DHS data suggests that more than half of mortality among children under age 5 could be attributable to malnutrition (15 percent to severe malnutrition, and 42 percent to mild to moderate malnutrition). It is abundantly clear that increasing access to health services without improving nutrition will not significantly improve child health.

Why Progress Is So Critical: The Increase in Malnutrition in Mali

	1987	1998–89	1995–96
Stunting (ht/age)	24%	27%	30%
Wasting (wt/ht)	11%	18%	23%
Undernourished (wt/ht)	31%	43%	40%

Utilization Must Follow Accessibility

Although the Bank and the government have made substantial progress in improving physical access to health services in rural areas and increasing the use of curative and preventive services in the catchment areas of the community health centers, utilization rates remain low. In 1996, Malians visited a government or community health center for curative services only 0.16 times on average. Utilization rates are somewhat higher at community-managed health centers, but they remain well below the expected average rate of one visit per year.

While the PSPHR also included efforts to strengthen the first-level district referral system, several constraints remain in the referral system between the community centers and districts, including unavailable or very expensive transport; inadequate training for clinic staff on referral protocols; and, sometimes, inadequate skills at the district level to deal with referrals.

The stubbornly low utilization rates, which have resisted efforts to improve geographic access, are the product of several factors. Costs remain a deterrent for many, despite the reduced prices for essential generic drugs. Physical access is still a problem, particularly during the rainy season, because much of the population must still walk more than a few kilometers to get to the clinics. Community outreach remains weak—health center staff often wait for users to come to them. The family planning component of the PSPHR (sponsored by USAID and relying on service delivery by NGOs) was not well integrated with the community health center component. Many potential consumers still prefer traditional medicine, and attitudes change slowly in a traditional rural society. And, finally, the decision to seek care depends on who controls household resources—often, the man.

Staff Recruitment Is Essential

Because government clinics continue to function in parallel with community clinics, a major constraint in the community health sector is the difficulty of attracting and retaining qualified health staff. There is currently no job security, pension benefit, or opportunity for career advancement, and the centers are often located in remote areas. While staff employed by community health centers are often more responsive to community needs, most health professionals express a strong preference for government service. For all these reasons, 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, potential staff members are drawn to the urban areas or the better-off regions. In addition, professional training emphasizes curative services rather than public health promotion.

Government Health Spending Is Still Biased Toward Urban Areas

The financing of basic and preventive health services in Mali faces several fundamental challenges and constraints. The foremost is the ability of the government to mobilize resources for health, given a per capita annual income of US\$250. The government has historically generated only about 10 percent of GDP in revenue.

Government provides less than one-fifth of total resources for health—far less than households (at 50 percent) or external aid (25 percent). But even the money that the government does allocate to health spending is not being used efficiently or with equity. The majority of the government's limited resources are spent for urban-based tertiary care and central administration. Public subsidies remain highest, and cost recovery lowest, at urban tertiary facilities; the opposite obtains at rural facilities. Although public subsidies for higher-level care could be considered a

form of social insurance for serious illness, those benefiting from these services are largely from the upper-income brackets. And despite an increase in donor support to rural areas in the past decade, the growing dependence on donors is creating its own problems. Most strikingly, primary health care and health education programs were funded entirely by donors in 1997.

Next Steps

With the right framework in place—an accessible, coordinated service delivery system in rural areas, and the broader, increased availability of essential generic drugs—the government can now pursue the broader goal of providing a responsive, practical health care system for all. The prospects are sound. The government has taken the lead role throughout project and policy preparation, which has enhanced capacity-building at the Ministry of Health and “learning by doing” throughout the sector.

In 1998, the 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 Bank support—the Sector Investment Program (SIP)—which will support the government's strategy and address the remaining sectorwide issues. The SIP will form the framework for several donor programs, although most donors will continue to manage funds separately.

The SIP includes four broad components. The first is the construction, renovation, and equipping of community health clinics at the village and district level, and some renovation and equipping of regional and national hospitals. The second comprises management and technical training of the health sector workforce. The third calls for expanding health insurance and cost-sharing mechanisms, and the fourth will entail restructuring government hospitals to improve cost recovery, cost-effectiveness, and technical efficiency. The program also seeks to improve district health management, including referral services; strengthen management information systems; increase community involvement in health centers, and develop management modules for hospitals.

Lessons to Guide Future Initiatives

The Bank's support has progressed over the past 20 years from a (unsuccessful) health pilot project in a single region, to a nationwide “umbrella project” that embodied a new national health policy and was cofinanced by several donors, to an SIP under a national strategy that is to encompass all investment in the sector. This progression has corresponded with increased government willingness to establish sectoral strategies and priorities.

Although the Bank strongly encouraged government to take a sectorwide approach, government has full ownership of the program. Among donors, the Bank has taken a leadership role, but has worked to bring in other partners. Government officials have reported that the Bank has been effective in linking its support to key sector reforms and issues. Some donor-partners have expressed concerns, however, that the policy development and SIP appraisal processes were unduly influenced by the Bank's timetable and agenda. Given the Bank's influence in Mali's health sector, it must be cautious and collaborative to ensure that it does not dominate the policy process. The Bank must also engage in more rigorous monitoring and evaluation, particularly when new service delivery mechanisms are piloted for nationwide replication.

Other lessons from experience in Mali may also be helpful to the Bank's new SIP project work:

- Curative services alone will not improve health outcomes. They must be combined with appropriate health education and outreach programs, family planning promotion, and nutritional surveillance and intervention, and they must be integrated effectively with those offered by NGOs.
- The cost-recovery mechanism of community-based facilities for curative care does not create incentives for locally based health promotion activities. Strengthening these activities will be necessary to achieve further improvements in health and nutritional status.
- Incorporating health sector concerns effectively into macroeconomic and budgetary dialogue will continue to require regular communication between Bank macroeconomic and sector specialists, and sufficient sector work to match priorities with sector budgets and staffing patterns.
- The community-based agenda must move beyond access—by targeting continued cost barriers, inadequate outreach, and preferences for traditional medicine or self-treatment.
- Establishing a community sector outside government may have made providers more responsive to community centers, but uncertain job security and career paths must be addressed if community-based facilities are to attract and retain a full cadre of health professionals.

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