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Development Discussion Papers

REALITIES IN IMPLEMENTING DECENTRALIZATION,
COORDINATION, AND PARTICIPATION: THE CASE
OF THE MALI RURAL HEALTH PROJECT

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DEVELOPMENT DISCUSSION PAPER No. 105

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Harvard Institute
for International Development

H A R V A R D U N I V E R S I T Y

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Abstract

Decentralization of operation, coordination and integration with existing services, and participation are three principles commonly identified as contributing to successful implementation of development projects. Less common, however, is a clear understanding of what is actually involved in implementing a project in a decentralized, coordinating, and participatory manner. This paper analyzes the implementation experience of the Rural Health Project in Mali, West Africa, a project that has attempted to operationalize these three often-cited implementation criteria. The case of the Mali Rural Health Project illustrates that the extent to which decentralization, coordination, and participation contribute to project success rests largely upon how implementation is defined.

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**REALITIES IN IMPLEMENTING DECENTRALIZATION,
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OF THE MALI RURAL HEALTH PROJECT***

Introduction

Changes in the definition of development have given rise to "New Directions" in technical assistance.¹ Policy statements of the international donors advocate development projects that fulfill the basic needs of the rural and urban poor, focusing upon means to increase food production, levels of health, employment, access to adequate shelter and water supplies, and education. Included in these policy statements are implementation principles for carrying out these "New Directions" projects. Three of the most common are: 1) decentralization of operation, 2) coordination and integration, and 3) participation.

However, the translation of these principles into practice has been problematic. Despite a growing body of research that has emphasized the need for new project structures and procedures in order to implement poverty-focused development successfully,² the tendency has been to graft new principles onto existing operating mechanisms. Development projects may be traveling in "New Directions"; but for the most part they are making the trip in old implementation vehicles, albeit with different labels. The result has frequently been project failure in generating benefits and/or failure in getting benefits to the poor,

*An earlier version of this paper was presented at the American Society for Public Administration, Panel on Public Sector Implementation in Developing Countries, 41st Annual Conference, April 13-16, 1980, San Francisco, California.

leading to what is commonly referred to as the "implementation gap." Why has this been the case? What are the difficulties involved in employing structures and procedures that are decentralized, integrated, and participatory?

This paper provides one set of answers to these questions by analyzing one project's experience in attempting to bridge this gap. The "Projet de Santé Rurale" (the PSR, translation: Rural Health Project) in Mali, West Africa, is an example of a project that has tried to operationalize and apply the principles of decentralization, integration, and participation. The PSR's experience sheds some light on the realities involved in implementing a project according to these often-cited principles.*

The Projet de Santé Rurale

The Setting: Mali is one of the large, landlocked nations of the African Sahel. With 6.1 million people and a GNP per capita of US \$110, it is among the poorest countries in the world.³ Approximately one quarter of the population is nomadic; 80 percent of the population lives in rural areas. Eighty-nine percent of the work force is engaged in agricultural production, and the adult literacy rate hovers around ten percent.

Life expectancy at birth is 42 years; infant mortality rates vary from about 150 per 1000 births in the cities and towns to around 200 per

*Case data were collected while the author served as a consultant to the PSR on documentation and evaluation. The views and interpretations presented here are solely those of the author and should not be attributed to the Malian Ministry of Health or to the Harvard Institute for International Development.

1000 in the rural areas. The major health hazards in Mali are communicable diseases and nutritional deficiencies. Malaria is endemic, and especially serious in children aged one to five. Other prevalent diseases include: measles, diarrheas, meningitis, tuberculosis, bronchopulmonary infections, schistosomiasis, onchocercosis, and venereal diseases. Health services are minimal. Those that exist are chronically understaffed and undersupplied; there are about 170 doctors in the entire country. The urban-biased distribution of existing services means that rural residents have no effective sustained contact with the government health system.

Project Purpose: The PSR came into existence with the signing in June of 1978 of an agreement between the Government of the Republic of Mali (GRM) and the Harvard Institute for International Development (HIID). Funded with U.S. Agency for International Development (AID) monies through a host country contract, the PSR is slated to operate over a four year period. The project is a central component of the GRM's effort to provide improved health services to the rural poor.

The purpose of the PSR, as stated in the Project Paper (PP), is twofold:⁴

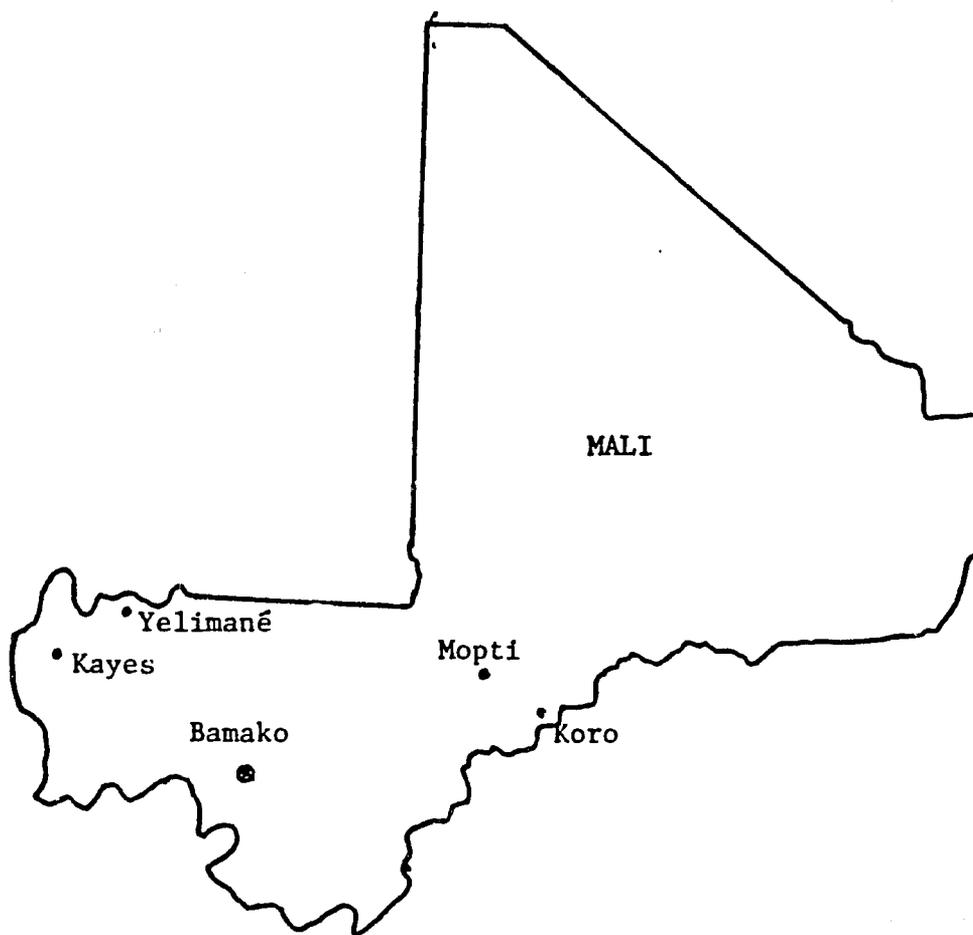
- 1) To design, implement, and evaluate a demonstration rural health system that will
 - a) bring health services to the village level, emphasizing health-promotive and disease-preventive activities;
 - b) be integrated with other community and economic development activities;

c) function with an annual budget of US \$3 per person, of which \$1 per person will be recovered through the sale of drugs in the villages.

2) To achieve GRM adoption of the demonstration project as the basis for a national rural health system, and to assist the Ministry of Health (MOH) with preparations to implement such a system nationally.

Based on joint discussions among MOH, USAID, and the PP design consultants, two demonstration sites were chosen for project activities: the "cercle" of Koro in Region V (Mopti) and the cercle of Yelimané in Region I (Kayes).⁵ Within each cercle one "arrondissement" was to be selected to receive the full complement of PSR services: village health workers (VHWs), supervision and support services, plus medicines and other supplies. Other arrondissements in the cercle were to receive medicine and supplies only. The target arrondissement in Koro is Toroli; and in Yelimané, Tambacara. The 1976 census put the populations of Toroli and Tambacara arrondissements at approximately 20,000 and 17,000 respectively. Toroli and Tambacara were not selected until after the arrival of the PSR advisors in the field. The choice was made on the basis of: interest in the project expressed by health personnel, accessibility within the cercle, field team assessment of interest in the population, and baseline surveys carried out by Peace Corps volunteers. Another factor entering into the choice of demonstration sites was the presence in Koro of other organized development activities (Opération Mils, Opération Pêche, DNAFLA), and their absence in Yelimané. Thus, the PP established the framework for a quasi-experimental design in which two levels of effort in primary health care (VHWs plus medicines vs. medicines only) could be compared in the

Figure 1. Location of PSR Operating Sites



Scale: 1 inch = 227 miles

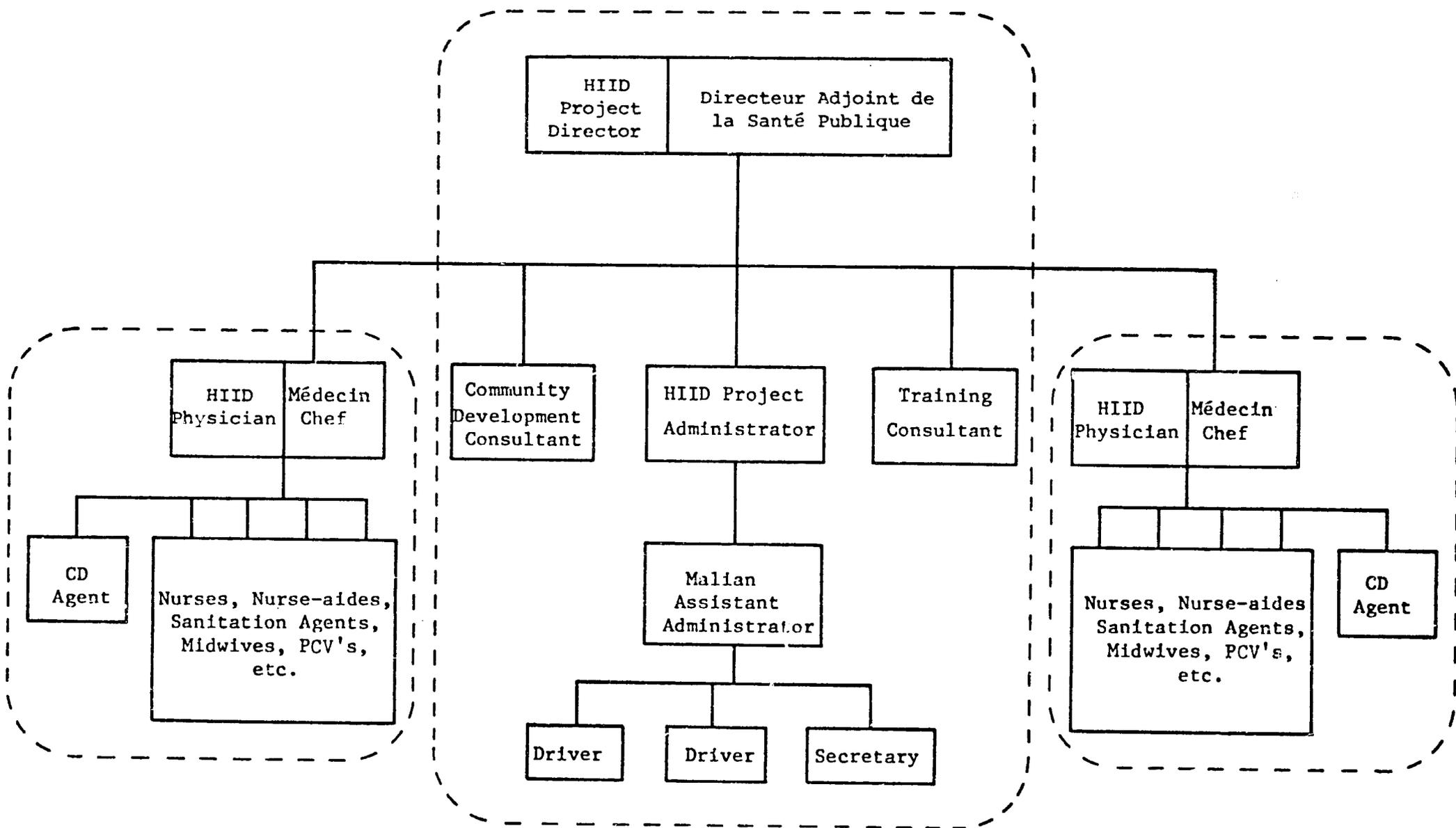
context of two configurations of potentially complementary development activity ("grandes opérations" vs. none).

Within this framework, the PSR has undertaken activities in the following categories: 1) the training of public health workers at the village, arrondissement, and cercle levels; 2) the gathering of data profiles of health and health-related information for community diagnosis and monitoring of project activities; 3) the implementation of supervised health promotive, disease preventive, and simple curative services; 4) the provision of medicines and equipment needed for the operation of the rural health services system; and 5) preparation at various levels within the MOH for the acceptance and ultimate expansion of the project on a national scale.

Project organization: The following schema provides a graphic representation of how the PSR is organized (see Figure 2, page 7).

The PSR operates as a sub-unit of the MOH directed jointly by the head of the Harvard Technical Assistance Team and the Directeur Adjoint de la Santé Publique. Both are physicians. At the field sites the Médecins-chef du Cercle are the counterparts to the Harvard physician advisors. At the Region level, there are no expatriate advisors, according to the expressed wishes of the GRM; though the Regional Directors in Kayes and Mopti are linked to the project through their supervisory relationship to the Médecins-chefs. Also forming part of the public health teams in the cercle have been Peace Corps volunteers (PCVs). At present, there are three volunteers in Koro, and two in Yelimané. They report directly to the Médecin-chef in each cercle.

Figure 2. PSR Organization Chart



PSR/Yelimané

PSR/Bamako

PSR/Koro

In addition to its network of reporting relationships, the PSR has established functional links with a variety of other units and projects of the Malian government that are concerned with rural health and development. These links take the form of consulting, coordinating, and advisory relationships. The bulk of the linking process has been carried out by the community development advisor and the training consultant, both positions filled by expatriates from Education Development Center (EDC), a subcontractor to HIID for the training component of the project.

PSR Programs

The PSR, in designing and operating the demonstration rural health system, covers basically three program areas: 1) village health workers, 2) village pharmacies, and 3) community development projects. These are all intimately related, but for discussion purposes will be treated sequentially.

The Village Health Workers: A major element of the PSR is the use of part-time volunteer village health workers (VHWs) as a means of extending the reach of the primary health care (PHC) system. To bring the VHW role from concept to reality meant that the project had to address the following questions: Who would become VHWs and how would they be selected? Who would train and support the VHWs? How would these trainers be trained? How would a VHW curriculum be developed and what would it encompass? Devising answers to these questions constitutes the cluster of PSR activities subsumed under the VHW program. This

program comprises: 1) training of trainers and supervisors, 2) training of VHWs, and 3) the development of appropriate educational materials.

As a way to begin to find answers to these questions, the project team made contact with Malians within the MOH and related services in Bamako and with health and development officials in Koro and Yelimané. The team solicited their ideas on training, supervision, and job content, and assessed possibilities for collaboration among various services on planned project activities. It quickly became apparent that simply grafting VHWs onto the lowest administrative level of the existing health system (the arrondissement dispensary) was not a workable proposition. The general staffing pattern at that level consisted of one or two nurses or nurse-auxiliaries serving 40 to 60 villages. These personnel alone could not be expected to train and supervise the VHWs. Therefore, the team made efforts to enlist as many health staff as possible from the next higher administrative level (the cercle medical center). In addition, based on the conviction that PHC is but one piece of a village's development needs, the team contacted representatives of other services in order to "test the waters" of collaboration. Many of these personnel expressed interest in linking up with the project in some way; but how this might be done, and what sort of commitment of time and resources it would involve, could not be fully worked out at these initial meetings.

The training consultant prepared a preliminary plan for training activities and assembled a work group made up of PSR staff plus members of Education Pour la Santé (EPS), the Community Development section of the MOH, the Service d'Hygiène, DNAFLA (the literacy agency), and the

materials production division of EPS. This work group prepared an outline for a training workshop, to be held in the main village of the target arrondissements in Yelimané and Koro, and discussed its plan with officials in the regions and with representatives of potentially collaborating services.

The workshops were designed to serve two purposes. First, they offered a structured forum where health and other development workers in the rural areas could think through the project for themselves and arrive at a clear conception of its goals, principles, and methodologies. And second, they provided a mechanism to bring together workers of all the related services at the cercle, arrondissement, and village levels so as to begin the process of building a team that could effectively train and support VHWs. The first workshop took place at Tambacara in Yelimané Cercle in late October of 1978; the second, in Toroli, Koro Cercle, followed one month later. Each lasted approximately two weeks.

The principal activity in each of the workshops was the assembly of multi-disciplinary teams in order to study a single village in each arrondissement as a training exercise. The teams were composed of members of various government services with responsibility for rural development. Many of the participants had had very little actual dealings with villagers, and it was felt that only by coming into close contact with the realities of village life would it be possible for field level workers to gain an understanding of how they could combine their agencies' resources with those available in the village itself to address some of its health and development problems. The workshop schedules consisted of discussion and study sessions during the day

plus informal evening meetings with the village chief, elders, and other residents to discover villagers' perceptions of their problems and their priorities.

Based on the information provided by the villagers and by several community diagnosis surveys, participants debated program options and methodologies. From the discussions emerged the following: 1) an assessment of village willingness to choose and support VHWs and purchase basic medicines; and 2) identification for each arrondissement of a set of health problems that a) were perceived by the villagers as problems, b) were prevalent, c) had significant debilitating effects, e.g., prevented people from working, made them vulnerable to other diseases, etc., and d) were treatable with simple and inexpensive drugs. On this basis the PSR field teams in Koro and Yelimané, with back-up from the Bamako-based work group, began to develop a training curriculum and methodology for VHWs.

The first training session took place in Yelimané Cercle in January 1979. In Koro Cercle, the first cohort of VHWs was trained in March 1979. From the end of May through early June the second cohorts of VHWs were trained in both cercles. A third training session took place in Koro in September. So far, a total of 59 VHWs have been trained.

The PSR has developed: 1) a flexible VHW training curriculum based on village perceptions of health problems and on sample surveys of disease patterns; 2) a problem-oriented pedagogy that starts from the trainees' knowledge of prevalent diseases, and through discussion, introduces basic curative and preventive techniques; and 3) a set of

visual aids, treatment manuals, and recording forms that are easily understood by their intended users.

In keeping with the notion that the VHW is a member of the village and should be responsible to the village, selection of trainees in both target arrondissements has been left to the villagers themselves. The project has defined several criteria for the choice of VHWs for the villages to consider: a candidate respected by other villagers who has and can maintain their confidence; and also someone who intends to stay in the village. Literacy and minimum educational levels were purposefully not suggested as selection criteria because, at the outset, the PSR had no basis for deciding that literate and educated villagers made better VHWs.

Indeed, the decision to institute a VHW and a pharmacy in a village in the first place has been left up to the villagers themselves. In Koro Cercle, as part of the initial contact with a village to present the project, team members meet with the village chiefs and others to lay out both the potential benefits and the problems involved in having a VHW and a pharmacy.

Another important part of the VHW program of the PSR is the follow-up and supervision of the VHWs once they are trained and functioning in their villages. The visits to check the consultation records, control the finances of the pharmacies, and restock the supply of medicines provide opportunities for the members of the PSR teams to offer counseling, on-the-job training, and encouragement to the VHWs. In the course of going over the consultation notebooks, the supervisor asks about any diagnostic or other problems, and usually requests that the

VHW examine and diagnose several cases while he is there. These one-on-one sessions are intended to keep up the skills the VHWs learned during their training, to give them the chance to improve their skills and add to them, and to provide the back-up support necessary to the successful functioning of service delivery in remote rural areas. However, the process of changing the generally authoritarian interaction patterns between government workers and villagers has been a slow one.

The Village Pharmacies: The network of village pharmacies in the cercles of Koro and Yelimané forms the basis of operations for the VHWs' primary health care activities and, equally important, serves as the source of the PSR's potential for self financing resupply. The pharmacies program has been concerned with: 1) establishing pharmacies in the villages that have elected to participate in the program so that they are in place when the VHWs have been trained; 2) developing within the village of the capacity to manage and operate the pharmacies successfully; 3) assuring a continuous flow of drug supplies to the pharmacies, utilizing as much as possible the existing MOH structures for resupply; and 4) establishing appropriate methods for supervision, financial control, and record keeping.

Under Malian law, the Ministry of Health is not allowed to sell drugs; medicines made available through the national health care system are distributed through the Pharmacie d'Approvisionnement (known as PharmaPro) to state hospitals, medical centers, and dispensaries throughout the country. PharmaPro supplies are free of charge, but the system is plagued by chronic shortages. Drugs available on a retail basis are sold through the Pharmacie Populaire, a parastatal

organization with a legal monopoly. Therefore, in order to devise a legal means of operating village pharmacies, the PSR set them up as cooperatives with the prices charged falling within the price structure of the Pharmacie Populaire.

In order to satisfy U.S. law relating to disbursements for drugs and medical supplies, the PSR was required to submit to AID/Mali a plan for an inventory control and distribution system. The project administrator submitted a proposed plan in late November of 1978. AID subsequently rejected the proposal as unsatisfactory, stating that it dwelled more on problems than specific solutions. This action initiated a series of discussions between AID and PSR management over a four-month period. An acceptable plan emerged, and was approved in early April 1979.

In the meantime, so as to minimize delaying the onset of VHW training in the field, the project worked out an interim agreement with AID allowing a small initial purchase of medicines. Part of these supplies were used during the training sessions, and the rest formed the basis for stocking the first village pharmacies. The sample surveys done of village health conditions (some undertaken by PCVs before the arrival of the PSR teams and some undertaken by project staff) and subsequent discussions with village chiefs, notables, and others during the course of the planning/training workshops provided the information used to select both the content of VHW curricula and the specific drugs to be carried by the village pharmacies.

The first pharmacies in each cercle were opened directly after the completion of the first training cycles. At present nine pharmacies in

Yelimané Cercle are operating, and sixteen are functioning in Koro. Some attrition has taken place. Originally nineteen pharmacies were set up in Koro, but three have since closed because the VHWs left their villages. One of the pharmacies in Yelimané has been closed several times over the past year due to the departure of the village vendor in charge.

The process for establishing a pharmacy in a village is the same as for a VHW; in fact, the concepts are introduced together. When the PSR team members enter a village to talk about villagers' health and development problems, they introduce the VHW and pharmacy ideas and explore with the villagers their willingness to participate in the program. The teams have tried to bring to the villagers' attention potential problems in having a VHW and a pharmacy in their village as well as the benefits. The intent is to allow the village itself to make an informed, intelligent decision based upon its perceived needs and priorities. Each pharmacy has a treasurer and a management committee made up of residents selected from and by the villages served by the pharmacy. In Koro, some of the pharmacies have treasurers, but for a number of them, the VHWs are in charge as part of their work. In both cercles, the PSR has devised recording forms, some with pictures for non-literates, in which type, quantity, price, purchaser, and date are noted for each sale.

Arrangements for restocking the pharmacies and managing the accounts fall under the drug distribution schema. On the distribution side of the system, the drugs ordered from the United States are cleared through customs by PharmaPro officials, and are then stored

in the PharmaPro warehouse and at the PSR storeroom in Bamako. When orders for resupply come in from the field, the drugs travel by project or MOH vehicle as available directly to the cercle level, where they are stored at the medical center under the control of the médecin-chef. He and his staff fill orders from the arrondissement and down to the villages.

On the accounting side of the system, monies collected through the sale of drugs in the village pharmacies are kept by the pharmacy treasurer or the VHW (depending on each village's arrangement) under the supervision of the management committee or the village chief and his council. The PSR team collects these funds on its supervisory visits to check the account notebooks and the consultation records, and to provide further training and support for the VHW. These visits occur at least monthly, though the teams try to circulate on a more frequent schedule. Once collected from the villages, the team transfers the monies either to the head of the medical post at the arrondissement or directly to the médecin-chef at the cercle level. From there the funds are moved by project or MOH vehicle to Bamako. Though technically there is a regular schedule for the transfer of funds from field to center, given the limitations of the transport situation, actual transfers take place when vehicles are available and other project business requires travel.

Community Development: The PSR's community development (CD) program is a function of the project's perspective on: 1) the relationship between the curative and preventive aspects of primary health care, and 2) the relationships between the villagers as health service recipients

and the members of the national government bureaucracy as health service providers. The first perspective has led the project to address environmental issues in the village that have an impact on health status. So far, major activities have centered around access to, and quality of, water supply.

The second perspective relates to the changes in the roles of villagers and of national health system staff implied by the PSR's goals. The community development activities stemming from this center around the creation of new forms of interaction between villagers and government personnel. The PSR has sought to organize and support villagers for the immediate purpose of managing the VHW program, but with the longer-range goal of providing the village with a mechanism by which it can discuss and decide upon its own development priorities and exercise some control over how village development activities take place. In addition, CD in the PSR has aimed at facilitating a change in the way national government personnel relate to the villagers, trying to move them toward a client-responsive mode of operations and away from an expert-imposed mode.

As had been done in the VHW program, the project's first steps in community development entailed discussions with personnel of various government agencies both within and outside of the health sector in order to exchange ideas and gain a sense of potentially fruitful avenues of collaboration. Resulting from these initial meetings, the National Center for Community Development assigned two of the first graduates of its new training school to the project field teams, one for Yelimané and one for Koro. These two CD agents have been integral

members of the PSR, participating in the planning workshops and training programs, traveling to the villages to discuss community needs and the VHW role, writing reports, making supervisory rounds of VHWs and pharmacies along with the health staff, as well as seeking to sensitize villagers to their needs, etc.

With the arrival of a CD technical advisor in January 1979 (initially for a three month contract, but then extended to a long-term one), the PSR began more actively to seek out opportunities for small subprojects that would complement the work of the VHWs. The Peace Corps volunteers (PCVs) and the CD agents had carried out several surveys in villages in both arrondissements that collected information on health and development problems as perceived by the villagers. One item surveyed was the number and condition of wells in the villages.

In Koro, several villages expressed an interest in having wells dug. Subsequent meetings with PSR staff, engineers from the national wells service (Opération Puits) and village representatives clarified technical requirements, siting arrangements, and the extent of village contribution to construction (labor, gravel and sand, lodgings for the well team, and some money). The technical advisor sought and secured funding from CARE/Mali for these two wells, and has arranged for a larger program, jointly undertaken by Opération Puits and the MOH, to construct twenty more wells within the arrondissement over a two-year period. Funding sources for this expanded effort are in the process of being sought. At present, the first two wells are under construction.

In Yelimané, due to soil and water characteristics, water problems are technically more difficult to deal with. The main CD activity in

this area has been an effort to explore with the village of Diongaga the possibility of installing a well using a pump purchased and donated to the village by migrant laborers in Europe in 1969. The PSR CD agent helped the villagers make contact with the appropriate government agencies, assess their options, and discuss possibilities. Ultimately the village decided not to finance the technical studies needed to determine the feasibility of using their pump.

Other water-related CD activities include work on dams and testing of water quality. In Koro, repair and reconstruction work has begun on a small, village-built dam that provides water for irrigation and livestock (funded by CARE). Other similar efforts are being planned in additional villages in the cercle. In cooperation with the Service d'Hygiène, a division of the MOH, a program of well water testing and purification is underway using equipment ordered from the U.S.

Decentralization

In general, decentralized project operation entails attending to three areas: 1) achieving a balance between local spheres of action and central authority; 2) managing dispersed organization members and programs effectively and efficiently; and 3) maintaining project coherence and unity of purpose among dispersed operating units. For the PSR, decentralization as an operating mode has been a matter of both necessity and choice. As a result, the project has had to seek solutions to the problems contained in these three areas.

Balance Between Center and Field: Functioning in two remote field sites has led the PSR to delegate substantial authority and responsibility to project members closest to actual operations. Decisions about how to organize the field teams, when to hold VHW training sessions and how to structure them, what pharmaceuticals to stock, and what data to collect have all been taken by the teams in Koro and Yelimané.

The PSR has also employed a decentralized methodology for developing program content. On the assumption that effective health interventions are based upon client perceptions of their problems and needs, the PSR began activities by getting out into the field soon after the arrival of the HIID advisors in-country. The training/planning workshops served as mechanisms to introduce Malian health professionals to community perceptions and to provide them with an opportunity to engage in a dialogue with their clients. Similarly, the VHW training sessions have proceeded from the trainees' level of health knowledge, and have been based on dialogue rather than rote learning.

In seeking an appropriate center-field mix, the PSR has contended with a system heavily weighted toward the center. The project's approach to design and operations—basing programs on client-derived perceptions of need and delegating close to total operating responsibility for those programs to the field—is at variance with the traditional mode of MOH functioning. This fact has generated several problems for the project in its efforts to move more decision-making authority toward the field.

First, the process of re-orienting health professionals toward a perspective on their work that treats client participation in problem definition as something valuable has been a slow one. They

have been schooled in a system that rewards the faithful application of centrally-designed programs and procedures and discourages local-level initiative. The training/planning workshops were a first step in the re-orientation process.

Second, the level of discomfort in the MOH associated with the delegation of substantial authority to the field has fluctuated throughout the life of the project. This situation has created ambiguity around exactly what kinds of decisions the field teams are allowed to make, despite PSR efforts to push for specification and clarity. In several cases, for example, hiring of a part-time secretary and mobylette allocation, decisions taken in the field have been questioned and/or reversed at the center. These, and other similar exchanges, have resulted in morale problems for the field teams, and have bred a certain amount of caution in the team leaders, both Malian and expatriate.

Management of Dispersed Members and Programs: Operating programs in two remote parts of Mali has proved to be a major challenge for the PSR. Communication channels are few and uncertain; telephone service within Bamako is very erratic, telegrams and letters are slow and often are lost. However, the project has recently installed a radio system which has greatly increased the ease and frequency of field-center communications.

Transportation is as problematic as communication. To reach Yelimané requires an eight to twenty-four hour train ride (the variation depending upon breakdowns) followed by six to eight hours in a Landrover. During the rainy season it is completely cut off for

weeks at a time. Getting to Koro is only slightly easier: a twelve to eighteen hour drive depending upon the season. The PSR is heavily dependent upon its vehicles, both for getting to and from the field sites and for carrying out its programs in the target arrondissements.

In assessments of rural development projects, communications and transportation constraints are almost always cited in passing. For the PSR at least, their impact upon implementation has been more than just passing. The difficulties and delays in transporting supplies and equipment to the field, the slowness and infrequency of written communication in both directions, and the lack of regular and frequent face-to-face contact between PSR field and center personnel have had important management implications.

Almost from the start, the PSR developed a substantial field-center rift. In acting upon their commitment to client-responsive program content, PSR members took to the field before substantive agreement had been reached on the appropriate mix of field-center responsibilities, scheduling and sequencing of program activities, etc. It was felt that questions regarding these issues could not be answered before the teams had had some experience at their sites. Once that experience had been gained, however, the lessons learned were not shared among the entire team. Pressures to start programs quickly kept the field teams at their sites and allowed few opportunities to come to Bamako to meet.

Quarterly meetings have been held with the entire staff in attendance, but because of their infrequency the agendas have been too long to do much more than raise issues and state positions. The lack of opportunity for frequent discussions, coupled with the differing perceptions of the project held by PSR members, has meant that field and center have come to these

meetings with a backlog of concerns that require attention. In the limited time available for the meetings, it has occasionally been difficult to move beyond discussion of past issues to address current problems. Major issues upon which there has been disagreement include unresponsiveness on the part of the center to field requests, and reluctance on the part of the field to furnish the center with needed information. In some respects, however, because of the tendency for field and center to develop fixed ideas about each other in the absence of continuous communication, the extent of unresponsiveness and reluctance has been more apparent than real.

Maintenance of Project Coherence: In spite of the HIID project director's efforts to institute regular and consistent reporting procedures between field and center and to visit the field sites as often as possible, PSR activities in Koro and Yelimané have taken place basically as separate operations. The result has been a lack of overall project coherence.

The effects of this situation have been particularly strong on the data gathering and evaluation activities of the PSR. As mentioned above, the project's decentralized approach to program design led to a decision to post the advisors to their field sites as soon as possible. Once there they would work out what information was appropriate and also feasible to collect. This was to be the first step in an iterative process whereby data needs and procedures would be derived from actual experience, and be fed back into planning activities, thereby producing choices for action that were situationally relevant and adapted to client needs.

The anticipated sequence of steps consisted of: 1) reaching an assessment of data gathering needs and constraints specific to each

cercle (e.g., is it possible to collect stool samples among Dogon adults in the face of cultural barriers?); 2) communicating findings to the rest of the PSR; 3) working out the specifics of what data to gather using comparable indicators and methodologies, and of which constituencies need what types of information; and 4) producing a set of information gathering and monitoring procedures adapted to each field site and also sufficient for overall project requirements. However, the reality was that each field team went through a separate process, closed off for the most part from the center and the other field team, in reaching decisions regarding information. Therefore, most of the field data collected by the PSR has been based on differing methodologies, assumptions reflecting individual priorities, and specialized interests.

The PSR, through changes in procedures and personnel, has tried to remedy some of the effects of this autonomy. Data-gathering efforts in Yelimané by the new advisors are being undertaken with particular attention to methodology and comparability.

Coordination and Integration

Coordinating primary health care with other rural development activities and integrating this new approach to PHC into the Ministry are among the PSR's stated objectives. In addition, all the expatriate advisors are committed to coordination and integration with Malian agencies. They consider that the ultimate success of the PSR hinges upon the extent to which the Malians see it as theirs, rather than Harvard's or USAID's. Acting upon the principles of coordination and integration implies responding to the Malians' priorities and going

at their pace. In some situations the PSR has been torn between its commitment to these principles and its desire to meet its own performance targets.

Coordinating PHC Delivery: Building a coordinated approach to the delivery of PHC has required a tremendous amount of PSR staff time, most of it spent in meetings with members of various other units of the Malian government. The initial series of meetings at the start of the project informed these other units of the PSR's purpose and investigated possible avenues of collaboration. Most officials expressed support for and interest in the PSR's proposed activities. The next steps involved exploring concrete possibilities for working together. Table 1 lists the government services that the PSR has initiated some sort of collaboration with in PHC. Most involved with the PSR have been Education Pour la Santé, DNAFLA, and the CAC. Mainly in Koro, members of these services have worked closely with the field team in VHW training and setting up of pharmacies.

A major problem in developing a coordinated approach to PHC has been the general scarcity of material resources that characterizes most Malian agencies. Few services possess sufficient resources to carry out their own mission, much less allocate some for coordination with others. This situation is particularly acute in Yelimané, which lacks the large-scale development efforts that have been undertaken in Koro. For example, one service succeeded in acquiring a Landrover only to find its gasoline allotment sufficient for a mere ten miles per week. Thus, in many cases, efforts at collaboration can rarely move beyond paper statements.

Table 1. PSR Collaboration with Other Services

- Within the MOH:
 - Health Education Division (Education Pour la Santé)
 - Nutrition Division (Division de Nutrition)
 - Hygiene and Sanitation Service (Division d'Hygiène et d'Assainissement)
 - Division of Social Affairs (Affaires Sociales)
 - National Center for Community Development (Centre National Pour le Développement Communautaire)
 - National Institute for Research in Traditional Medicine (Institut National de Recherches sur la Pharmacopée et la Médecine Traditionnelle)
 - Supply Pharmacy (Pharmacie d'Approvisionnement)
 - Baguineda Primary Health Care Services (Dispensaire de Baguineda, Programme de Soins de Santé Primaire)
 - School of Medicine and School of Nursing (Ecole de Médecine)

- Outside the MOH:
 - Functional Literacy Division, Ministry of Education (Direction Nationale d'Alphabétisation Fonctionnelle et de la Linguistique Appliquée, DNAFLA)
 - Ministry of Rural Development (Ministère de Développement Rural)
 - Operation Millet (Opération Mil)
 - Operation Wells (Opération Puits)
 - Rural Cooperatives Service (Centre d'Animation et de la Coopération, CAC)

Integrating with the MOH: Working with existing MOH structures and personnel has meant that to some extent the project has inherited MOH problems besides having its own to deal with. In several cases, these two sets of problems became intertwined. Particularly affecting the communications difficulties cited above, for example, has been the policy of sharing the MOH secretarial pool. Slow turnaround time of letters, memos, and reports has caused delays and frustrations in meeting deadlines, getting material to the field, and carrying out day-to-day office functions. In November, 1979, the PSR hired its own secretary in an effort to ameliorate the situation.

Other problems have occurred with vehicles, office supplies, and phone service. All of these are in short supply at the MOH (and throughout the Malian government), and thus affect the PSR. Project vehicles have been shared with MOH personnel in the spirit of integration, though often to the detriment of project business. Although contractually the MOH is to furnish some of the office supplies used by the project, the reality of the situation is that the MOH's limited budget is barely sufficient to cover its own needs in this area. The PSR's response has been to share its office supplies with the Ministry. The continual breakdown of phone service has necessitated increased vehicle use, given the isolated location of the MOH in an administrative suburb of Bamako. All of these problems have resulted in higher than anticipated support expenditures and also a large amount of staff time devoted to resolving conflicts and smoothing relations.

The high degree of centralization characteristic of the MOH has also generated problems for the project. As is the case in government

bureaucracies in much of the developing world, authority at the MOH is concentrated in the hands of a small group of overworked executives situated at the top of the Ministry. Often responsible for several program areas involving large numbers of personnel, these executives rarely have time to follow through on any single problem or decision set before them. Subordinates, though possessing nominal responsibility for tasks, do not in fact have the ultimate authority to carry them out. The PSR, as part of the MOH, is confronted with a dilemma common to all MOH operating units: having responsibility for program outputs, but with limited and often nebulous lines of authority to take action.

For the PSR, this dilemma has been further compounded by the fact that the Malian project director is often out of the country. As a member of the small cadre of highly trained health professionals in Mali, he is often called upon to attend international seminars and conferences. In keeping with the centralized management practices just described, many decisions must simply be delayed until his return because of unwillingness to delegate sufficient authority to subordinates to act. This situation has created a pattern of administrative decision-making characterized by periods of intense and hurried action followed by lulls of managerial limbo.

Another personnel issue related to PSR integration with the MOH is staff turnover. Its effects have been felt most directly in the field. The project deliberately chose to work with what personnel were in Koro and Yelimané rather than attempting to assemble teams of atypical superstars. Thus, the field teams are comparable in skills and length of assignment to the average cercle and arrondissement. This situation has meant, however, the loss of some highly effective trainers and some delays in meeting program targets. In the Koro team, for example, the percentage of health personnel

reassigned since VHW training began is 17 percent. An added feature of using existing personnel has been that the project has worked with *médecins-chef* whose primary interests are in medical specialties rather than public health. This situation arises because a rural assignment is a prerequisite to consideration for advanced training. Although the doctors involved have worked actively toward the achievement of PSR goals, their participation is restricted by the fact that their commitment to rural PHC will last only as long as their current posting.

In seeking to address any of these systemic issues, the PSR has had to tread a fine line between pointing out the effects of current practices and giving the appearance of insensitivity or arrogance toward the difficulties the Malian health establishment faces. As is the case in most projects where a special organizational entity is created for implementation purposes, members of the sponsoring organization hold varying opinions about the desirability of the new unit. Views held by MOH personnel on the PSR are far from unanimous. Several officials at the MOH are uneasy with the existence of a Ministry operating unit containing expatriates. Some see the PSR's presence as a cost associated with obtaining AID's financial assistance rather than a benefit to the MOH. However, despite occasional misgivings, both the PSR and the MOH remain committed to the principle of integration.

Participation

The term, participation, is subject to a confusing variety of definitions. To reduce the confusion, participation can be thought of as encompassing several classes of activities engaged in by various sets of actors.⁶ The following grid (see Table 2, page 30) displays the dimensions of participation in the PSR to be discussed here.

Client Participation: Increased participation of rural residents in the national health delivery system is a major goal of the PSR. The

Table 2. Participation in the PSR

<u>Participation</u> in	Decision- Making	Implementation	Program Benefits
by			
Clients	X	X	X
MOH and other government personnel	X	X	
USAID and HIID	X	X	
PSR personnel	X	X	

project has sought to extend PHC to the village level through the use of paraprofessionals supported by a network of village-based pharmacies. These devices, as the above description points out, include a large component of client participation in implementation and decision-making.

At the start, the PSR consulted the villagers in Koro and Yelimané so as to base programs on local perceptions of need. The VHW and pharmacy programs (or the community development efforts) were not pushed onto any village. The village residents made the decisions to participate; in some cases they did not wait to be visited by the field teams, but sent delegations to the arrondissement medical centers requesting that their village be included in the programs.

Once a village made the decision to participate, it chose a candidate(s) from among its residents for VHW training and/or membership on the pharmacy management committee. Participation has involved monetary commitment as well. Villages purchase a metal box used by the VHW to store the pharmaceuticals, and, of course, all villagers buy the drugs prescribed by the VHW. In addition, the PSR is in the process of working out a remuneration scheme for the VHWs whereby they will be paid in kind (millet, rice, or assistance in tilling or harvesting their crops, etc.).

The implications for implementation of the substantial client participation present in the PSR have been touched on above. Decentralization of operations has been necessary in order to gain sufficient flexibility to respond to clients. These operations are both staff-intensive and vehicle-intensive. The Harvard advisor in Koro estimated that on the average it takes five visits per village to:

- 1) present and discuss the VHW program with the village, 2) select a

trainee, 3) transport the trainee to the trainers and back or vice-versa, and 4) deliver the pharmaceuticals to the village. This estimate does not include the supervisory visits or pharmacy resupply associated with continued program functioning.

Participation by MOH and Other Government Personnel: The PSR's goal of integration and coordination is predicated upon participation in project decision-making and implementation by members of the MOH and of other government services. As mentioned above, the project has tried to foster a sense of ownership in the PSR by the Malians by involving them in project decisions, responding to their sense of PHC needs, and taking into account their operating constraints.

While participation by MOH and other government personnel is basic to the purpose of the PSR, it has resulted in substantial pressure upon the project's resources, both material and human. By involving a wide group of organizational actors, all with their own agendas, in its internal workings, the PSR has been subject to competing claims on those resources. Inability to satisfy all claims has regularly embroiled the PSR in conflicts ranging from policy questions to such mundane (but crucial) issues as who gets to use project vehicles when for what purposes. Many of these conflicts have created "no-win" situations for the PSR, where acceding to one set of participants' desires leads to accusations of insensitivity or even ineptitude from others.

Participation by USAID and HLID: Involvement of the PSR's contracting agency and international donor has occurred mainly in

decisions related to operation and evaluation. AID's participation in implementation has been through the Health Officer, who trained the first group of Peace Corps volunteers (PCVs) assigned to the project. Due to delays in selecting a contractor, the PCVs arrived a year ahead of the Harvard team.

Concerning decision-making, the Health Officer and/or his Malian representative have participated in the weekly staff meetings held in Bamako and in the quarterly project-wide meetings as well. HIID's involvement has mainly been indirect, via cable and letter, though home office staff have made several visits to Mali to help resolve specific issues.

The participation of AID has brought yet another set of organizational actors inside the PSR. AID's concerns have had a contract focus, concentrating upon variance from the PP and proper accounting procedures. The regular participation of the Health Officer at the staff meetings has meant that questions related to these concerns are continually raised, necessitating steady attention by the project director, other project personnel, or HIID. Resolution of the issues involved has been complicated by the occasionally adversarial nature of PSR-AID relations.

Participation by PSR Personnel: While PSR personnel are participants in project decision-making and implementation by definition, how they participated has important implications for the project's implementation. As discussed above, the decentralized nature of the PSR required that project field staff possess a high degree of decision-making discretion given that they were most closely in touch with day-to-day operations. Several staff members, and not just

Maliens, wanted less discretion and more direction from the center. A long-standing issue for the PSR is the difference of opinion over whether decentralization represents a conscious policy coming from the center or a policy by default.

Paradoxically, one of the reasons for this disagreement stems from the project director's commitment to principles of participative management. In instituting discussion of almost every aspect of project purpose and functioning with all team members and soliciting of their views on a regular basis, the project director established the first part of a participatory management process. Unfortunately, the next steps of reaching agreement on the issues discussed, allocating responsibility for accomplishing specified tasks, and setting a time frame were only imperfectly realized. Besides the logistical constraints on project operation arising from the remoteness of the field sites and the difficulties in communication, the pattern of participation in decision-making by PSR personnel contributed substantially to the over-decentralization that has hampered the project.

Implementation Models in Conflict

The experience of the PSR demonstrates that the relationship between decentralization, integration, and participation and successful implementation is not a simple additive one. Applying increased amounts of these three operating principles does not necessarily sum to make better implementation. Decentralization in the rural development context is difficult to manage; where communications links are tenuous

and uncertain, field operations can easily "get away" from the center, resulting in a loss of unity of effort. Integrating with existing units of government means to some extent sharing the deficiencies and problems of those units, as well as gaining access to their experience and competence. Incorporating participation of various actors—from clients to donors—into project operations necessitates dealing with their concerns, going at their pace, and adjusting to their perceptions and administrative requirements.

The appropriate mix of decentralization, integration, and participation depends largely upon how successful implementation is defined. In the case of the PSR, two conflicting perspectives on what implementation means have resulted in disagreement over whether the project has been successful or not. AID's perspective is that the PSR's major responsibility is to carry out as closely as possible the plans and activities described in the PP. As required by AID regulations, the PP contains a comprehensive implementation plan covering scheduling of activities, success indicators, monitoring arrangements, an approach to evaluation, and contractual specifics. Deviations from this plan must be justified, put into writing, and approved by all parties before any changes can be made. This compliance-oriented viewpoint is in conflict with the PSR team's adaptive approach to implementation. The project has treated the PP as a set of guidelines for action, arguing that implementing a project by definition means going through a process of modification and adaptation of plans in response to an ever-changing task environment. The team members also consider their primary responsibility to be to the MOH, with AID secondary, by virtue of the host country contract arrangement.

While theoretically AID procedures provide for flexibility in implementation, the manner in which the regulations have been applied has emphasized compliance with what is stated in the PP.⁷ Though AID has approved of the PSR's technical accomplishments with the VHWS and the pharmacies, the project's deviations from the PP have been taken as evidence of administrative incompetence rather than creative problem-solving. As others have noted, AID's procedures have yet to catch up with its "New Directions" mandate.⁸ In fact, AID/Mali has been so concerned with attention to proper procedures by the PSR that it has played a much more active role in the project than is usually the case under a host country contract. One result of this situation has been confusion over reporting relationships between the PSR and the MOH.

The case of the PSR illustrates the complexity of the project implementation process. The project has sought to operationalize decentralization, integration, and participation in its approach to PHC. These are difficult principles to apply, and it would be an oversimplification to argue that any single set of factors accounts for what has taken place. Internal managerial deficiencies, conflicts with AID, problems with the MOH, and logistical constraints all have had an impact upon outcomes. Varying interpretations of these outcomes have led to a substantial amount of controversy regarding the degree of success achieved by the PSR.

However, much of the controversy surrounding the PSR's experience arises from the conflicting models of implementation held by project staff and by AID. The conflict is clouded by the fact that both parties use the "New Directions" terminology, that stresses the importance of

decentralization, coordination and integration, and participation. The underlying difference of perspective is that procedurally AID treats these three as elements of a pre-planned implementation blueprint, whereas the PSR considers them as processes facilitating adaptive implementation.⁹

As of this writing, after approximately twenty-one months of operation, the PSR is in a transition period. The HIID project director, the administrator, and the Koro physician advisor are all leaving at the expiration of their contracts. In addition, the AID Mission Director is due for an assignment rotation. More new directions are in store as a different set of actors enters the scene.

Conclusion

The PSR's experience demonstrates the need for funder and contractor to develop a mutual understanding of what it means to implement a project. This meeting of the minds is especially crucial in projects whose plans call for the use of such difficult-to-apply principles as decentralization, integration, and participation. At present, most funding agencies' procedures permit no more than lip service to these principles; projects seeking to act upon them risk falling into the gap separating espoused commitment and contractual reality. While urged to decentralize, integrate, and be participatory, projects at the same time are expected to meet pre-planned targets on schedule.

It has been argued that the only way to carry out the "New Directions" mandate effectively is to scrap altogether the development

project as an implementation mechanism.¹⁰ While this position may be valid, the nature of the political and bureaucratic environments of most funding agencies, which require short-run fiscal accountability, makes such action only a remote possibility. Given the likelihood that the development-by-project structure of technical assistance will be retained subject to continual readjustments, contractors and funders are faced with the need to further their understanding of the project implementation process. This requires less emphasis upon adherence to planned specifics and more openness to learning and change as a project unfolds.

Notes

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2. See the review of the literature on implementation in Marcus D. Ingle, Implementing Development Programs: A State-of-the-Art Review, Washington, D.C., USAID, Paper prepared for the Office of Rural Development and Development Administration under contract AID/ta-147-612, Final Report, January 1979.
3. Background data on Mali are from World Bank, World Development Report, 1979, Washington, D.C., World Bank, August 1979; and United Nations Fund for Population Activities, Mali: Report of Mission on Needs Assessment for Population Assistance, New York, UNFPA, Report No. 8, December 1978.
4. See David Cole, Steven Joseph, and Hanell'ore Vanderschmidt, Consultants' Technical Report: Mali Rural Health Project, January 1976; AID Project No. 688-11-590-208, Project Paper: Mali Rural Health Services Development, August 1976; and AID Project No. 688-11-590-208, Project Grant Agreement between the Republic of Mali and the United States of America for Rural Health Services Development, 13 May 1977.
5. Mali is divided into seven regions, 46 cercles, and 280 arrondissements. Each region is administered by a governor, and each cercle has a commanding officer. The cercle is the nucleus for government services, serving as the focal point for police, courts, army, and health care. The arrondissement is the basic administrative unit. At its center are the school and the medical dispensary.
6. See Norman T. Uphoff, John M. Cohen, and Arthur A. Goldsmith, Feasibility and Application of Rural Development Participation: A State-of-the-Art Paper, Ithaca, Cornell University, Rural Development Committee, Monograph No. 3, January 1979.
7. This is not only AID practice in Mali, but characterizes donor agencies' orientation to implementation, AID's included, in general. See Ingle, op. cit.
8. See Coralie Bryant, "Organizational Impediments to Making Participation a Reality: 'Swimming Upstream' in AID," Rural Development Participation Review, Vol. 1, No. 3, Spring 1980, pp. 8-11; and Harry W. Strachan, "Side-Effects of Planning in the Aid Control System," World Development, Vol. 6, No. 4, April 1978, pp. 467-478.

9. See Charles F. Sweet and Peter F. Weisel, "Process Versus Blueprint Models for Designing Rural Development Projects," in George Honadle and Rudi Klauss, eds., International Development Administration: Implementation Analysis for Development Projects, New York: Praeger Publishers, 1979, pp. 127-145.

10. See David C. Korten, "Community Organization and Rural Development: A Learning Process Approach," Public Administration Review, vol. 40, No. 5, September/October 1980, pp. 480-512.

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