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HEALTH DEVELOPMENT PROJECT

FACT FINDING MISSION

REPORT

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Report
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Dedication

Bonnie Kittle and Bineta Ba dedicate this report to Mr. NIARRE, Yossuf, the project chauffeur, whose superb driving skills were constantly in evidence during the nine day field trip over practically non-existent roads

Acknowledgement

We also acknowledge and thank Dr. Michel Gody and Mr. Adama Traore of the Local Project Coordinating Unit, for accompanying us on the long arduous journey and for helping us learn about this very complex project in such a short time. We are also thankful to them for making the field trip as enjoyable as it was.

The consultants alone take responsibility for any errors or misconceptions in this report as well as the opinion expressed herein.

Executive Summary

In December 1990, a fact finding mission was conducted of the World Bank funded Health Development Project (HDP). This project, which was implemented, in part, in the districts of Kita, Balfoulabe and Kenieba, proposed to assist the GRM by improving the quality of primary health care services to the populations in the three districts, as well as the population's health status. The project is now in its close out stage and preparations have been made for a follow on project, the Second Health, Population and Rural Water Supply Project. USAID/Mali, as well as several other donors, have been asked to participate in this project, and it is in consideration of this prospect that the fact finding mission was conducted.

Specifically, the mission was asked to collect, analyze and present information regarding the cost recovery schemes of the district health centers and the community health centers, the drug supply systems and the levels of service delivery at both the district and community health centers.

As part of the mission, a nine day field visit to the project zone was made, during which time data was collected. From analysis of that data and through interviews with various project-related people, the following findings, including strengths and weaknesses, statistical data, and recommendations were derived regarding the project.

Findings

The following strengths and weaknesses of the project were deemed worthy of note.

Strengths

- Training
- Cost Recovery System
- Multi-sectoral/integrated project
- Project flexibility/staff creativity

Weaknesses

- Supervision
- Parallel entities
- Vague project document
- Drug unavailability
- Low MCH service delivery

A review and analysis of the statistical data relating to the cost recovery schemes implemented by the district health centers revealed that the recurrent cost of in-patient medications plus many operating costs are being covered by the revenues generated by the fee for service scheme. In the community health centers, where the cost recovery scheme includes fee for services and the sale of drugs, not only are most operating costs being covered, but also the salaries of the CHC personnel.

Drug availability and affordability, despite the many efforts of the project staff at the district level, remains an unsolved dilemma. Efforts at the national level have also failed to resolve the issue in the project area to date.

Maternal and child health service delivery at the community health centers is very low. The number of MCH services offered, in practice, is minimal and the coverage of the sector is low. The CHCs, however, have been operational for only one year and with better supervision and support, there is reason to expect better productivity in the future. The CHC strategy is sound.

Recommendations

In light of these and other findings the mission makes the following recommendations:

- Improve the quality and the quantity of supervision at all levels by: creating a supervisory committee made up of donor representatives; providing special training in supervision; conducting a study of supervision needs and requirements.
- Up-grade training by making it more practical and improving trainers' skills.
- strengthen project management by enhancing the role of the regional advisors;
- investigate alternative means of supporting health costs;
- improve financial management skills of health staff and community representatives through training/supervision;
- develop guidelines for setting user fees;
- "officially recognize" the sector;
- take steps to facilitate, accelerate and ensure the Bamako Initiative and pharmaceutical reforms.
- increase the number of MCH services that are actually provided at the CHC by integrating vaccination and family planning services into the CHC program as well as re-enforcing the other MCH activities;
- improve the quality of health services through more regular, quality supervision and in-service training.

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ACROYNMS

CRS	Cost Recovery scheme
PHC	Primary Health Care
PPM	People's Pharmacy of Mali (Pharmacie Populaire du Mali)
UMPP	Usine Malian pour la Production des Pharmaceutiques (Malian Factory for Pharmaceutical Production)
CHC	Community Health Center
DHC	District Health Center (Centre de Sante du Cercle)
MC	Management Council (Conseil de Gestion)
EB	Executive Board (Bureau Executif)
HDP	Health Development Project (Project Developpement Sanitaire)
LDC	Local Development Committee
MOPHSA	Ministry of Public Health and Social Affairs
PCU	Project Coordinating Committee
LPCU	Local Project Coordinating Committee
WB	World Bank
MCH	Maternal and Child Health
HC	Health Center
BI	Bamako Initiative
ED	Essential Drugs
SRO/ORS	Oral Rehydration Solution
TT	Tetanus Toxoid
FP	Family Planning
RHT	Regional Health Team
TC	Technical Committee
SAPR	Semi-Annual Portfolio Review
DNPFSS	National Directory for Planning and Health and Social Training

1. PROJECT BACKGROUND

1.1 Project Overview

In January 1984 the World Bank-funded Health Development Project (HDP) was approved. This five year, 17.6 million dollar project has two components. Part A supports national level activities such as health manpower development, drug supply, and capacity building in planning and coordination, while part B focuses on the development of primary health care at the regional level, specifically in the districts (cercles) of Kita, Bafoulabe and Kenieba (KBK).

Major activities being carried out by the project include construction and renovation of health centers, training and re-training of various levels of health personnel, installation of water systems, strengthening the Ministry of Public Health and Social Affairs (MOPHSA) pharmaceutical planning and cost recovery capability, and strengthening the People's Pharmacy of Mali (PPM).

Under the project, a Project Coordinating Unit (PCU), based in Bamako and attached to the MOPHSA, was established to coordinate implementation of the project activities and authorize project related expenditures. Likewise, a Local Project Coordinating Unit (LPCU), located in Kita, was created to help implement the regional primary health care component.

The chart below shows how the project staff and groups established by the project correspond to the levels within the MOPHSA. It also indicates what percentage of the total expenditures at each level are covered by the MOPHSA's budget. The example here is Kita District.

Administrative Levels	Health Facility	MOH budget as % of total expend	Corresponding Project groups
Central	National Hospitals	100%	Project Coord. Unit
Regional	Regional Hospital	100%	
District (Cercle)	District Health Center	58%	Local Project Coord. Unit
Sub-district (arrondissement)	Sub-district Health Center	95%	
Sector	Community Health Center	0%	Managemnt.Coun./ Executive Board

With regard to the above table, it has been assumed that the MOPHSA budget covers 100% of the central and regional level expenditures. It is possible, however, that fees for services covers some small portion of operating costs. In the District of Kita, the World Bank project covers about 6% of the health center expenditures and fees for services covers some costs as well. Of the 58% cited above, 56.6% represents salaries of the health center staff and 1.4% operating costs. The sub-district figure is an estimate based on the knowledge that in Kita the local development tax pays several mid-wives, some of whom work at the sub-district level. The "sector" level (the one created by the project) is not officially a part of the MOPHSA structure, yet. With the exception of one CHC nurse, all of the CHC's expenditures are covered by the sector population. (see Annex 8 for a more detailed chart of the health care system proposed for the follow on project)

In 1988, the LPCU recognized that the project's strategy of working through the existing health structures would not enable the project to surpass its objective of "reaching maximum effective coverage of 45%" of the population. It therefore developed an alternative plan that called for the establishment of community-run, self supporting health centers. The strategy required that these Community Health Centers (CHC) be located in more densely populated areas (where between 5,000 and 10,000 people were grouped within a radius of 15 km) and where the villages within that area agreed to join together to establish and support a health center. This grouping was called a "sector" and the process, "sectoralization".

According to the plan, the CHCs would have a minimum staff of three (nurse, assistant nurse and midwife), and would serve as the most peripheral source of modern medical care. The CHCs would provide an integrated package of services including basic curative care; diagnostic and referral services for malaria, tuberculosis and leprosy; maternal and child health care including pre- and post natal consultations, birthing facilities, diarrhea disease control, malnutrition prevention and family planning; childhood diseases prevention through vaccinations; and health education. Furthermore, all of the recurrent costs, including staff salaries, would be covered by the community.

This strategy was tested in three sectors: Badinko, in the district of Kita; Selinkegny, in the district of Bafoulabe; and Darsalam, in the district of Kenieba, where community health centers were opened in July 1989, July (December) 1989 and June 1989 respectively.

1.2. An Overview of the Community Health Centers

The three Community Health Centers (CHC) at Badinko, Selinkegny and Darsalam have their similarities and differences. Both Badinko and Selinkegny had a functioning private clinic before the project launched its "sectoralization"/CHC scheme. These clinics were built by the communities with funds provided by private foreign donors. Medications were also periodically provided as donations to the centers. The nurse at Badinko was paid by the MOPHSA, otherwise the health center staff were supported by the community. First aid and simple curative care comprised the services provided at the clinic. Unlike Badinko and Selinkegny, before the CHC was established in Darsalam, the closest health facility was a sub-district health center, at one hour's drive (some 27 kilometers) distance across one river and two seasonal streams. Darsalam is inaccessible by car at least half of the year.

In 1988 the three test sectors were identified by the project staff using socio-demographic selection criteria, such as total number of inhabitants within a 15 km radius and long term commitment to establishing and supporting a PHC facility. The three Community Health Centers were opened in mid-1989, after about nine months of awareness raising, and community organizing activities. These activities, which also included the formation of a Management Council (Conseil de Gestion) with representatives from each of the participating villages, and an Executive Board (Bureau Executif), were conducted primarily by the Community Development Technician (CDT), a member of the Technical Committee (Comite Technique) of the District Health Center.

Although the CHCs were officially opened in June/July 1989 one CHC was not fully staffed until December, and it wasn't until the CHC Annual Program Plans were prepared in April 1990 that service delivery got underway in earnest. During a visit of the District Medical Doctor (Medecin Chef) and a LPCU advisor, each of the CHC nurses learned to prepare an Annual Program Plan, complete with objectives for each of the services provided, strategies for implementation, schedule etc. The following MCH objectives, taken from the Selinkegny CHC, typify the objectives of the other CHCs.

Community Health Center MCH Objectives

- provide 80% of the pregnant women with pre-natal exam (64 women)
- follow (conduct) 100% of the deliveries from Selinkegny and Darsalam (80 women)
- respond to demands for family planning
- follow (ie. weigh) 40% of the children ages 0-6 years (128 children)
- completely vaccinate 75% of children ages 0-24 throughout the sector
- vaccinate 100% of the pregnant women (TT) in Selinkegny (64 women)
- conduct group health lessons twice per week in Selinkegny and once a month in each of the other sector villages
- make SRO packets available and teach home solution

At the time when these Annual Program Plans were prepared it was expected that the CHCs would be able to provide all of the services indicated in the Plan. In reality, however, two of the key programs, notably vaccination and family planning, were never initiated.

The Expanded Program for Immunization (EPI) was never integrated into the services of the CHC, basically because it had already been initiated as a vertical program and because the cold chain had not been established at the CHC. Likewise, the family planning program was never initiated at the CHCs for what can only be described as "policy reasons".

Each of the three Community Health Centers, their staff and supporting groups have their strengths and weaknesses. In Selinkegny, the CHC staff, a nurse, nurse's assistant and a midwife, are technically very competent, and seemingly well motivated. The health center itself is large and well kept and the level of service delivery, particularly in comparison with the Annual Program Plan objectives, is high. The pharmacy is clean and neat and the stock of medications (thanks to private donations) is significant. On the other hand, the relationship between the 8 villages that make up the rest of the sector and Selinkegny is very poor. Services are provided primarily to the people of Selinkegny with people from outside the sector using the CHC services more than people from distant villages in the sector. Motivation to take action to resolve differences and ensure the provision of PHC service to all members of the sector seemed low among the Executive Board members.

In contrast, while the CHC in Darsalam does not enjoy the same level of competency among its three health care providers (the head nurse is particularly unqualified and lacking motivation), this health center benefits from an unusually high level of enthusiasm and support from the sector. Since this sector is in such dire need of health care, the Management Council (MC) and Executive Board (EB) actively support the CHC staff and cooperate effectively to address the needs of the staff as well as the sector members. For example the Management Council organized the work of the various villages of the sector, not only to construct four large thatched huts ("cases") to house the CHC staff and the health center itself, but successfully coordinating the repairs and rebuilding effort when one of the huts was damaged by heavy rains. The motivation of the sector population is high, but their representatives (as well as that of the CHC staff) lack vision. Without continued awareness raising and regular supervision, the population will remain content with the meager level of service delivery currently being rendered, and the CHC staff will atrophy. If this happens, Darsalam will still be better off than it was before the CHC was opened but the full potential benefit of the CHC will not be realized.

The Badinko Community Health Center, located as it is along the Bamako-Kayes train line, has an air of sophistication about it. The large, spacious facility is staffed by two government-paid nurses, an assistant nurse, two mid-wives and a pharmacist. The level of service delivery is significant, though there is plenty of room for improvement. The Executive Council seems well organized and enthusiastic, and although this CHC started out as a private clinic, the EC now seems quite committed to the concept of "sectoralization".

Despite all of this, the Badinko CHC health information systems were the least organized of the CHCs with no cumulative figures readily available, making it very difficult to accurately determine the level of service delivery. Unlike the other two CHCs, Badinko had completed their Annual Program Plan for 1991. After some questioning, however, it became apparent that the objectives were not based on an analysis of the previous year's achievements and the head nurse does not really understand the purpose of program planning. Since this CHC receives a supervisory visit from the sub-district health center nurse every trimester, one can only assume that this nurse either doesn't know how to supervise or doesn't understand the role of health information systems and the purpose of program planning.

Detailed information regarding the services provided and the level of productivity at the CHCs and the district health centers are provided in Chapter 3.4 and Tables 3.8-14.

1.3. Project Objectives

The November 1983 Staff Appraisal Report (the World Bank's "Project Paper") for the Health Development Project cites the following objectives. These objectives are fairly general and not usually quantifiable. More detailed operational objectives are cited and discussed in the Implementation Reports (Rapport d'Execution Physique du Projet de Developpement Sanitaire) prepared periodically by the Project Coordinating Unit.

At the national level the project would:

- improve the quality of health manpower in medicine, pharmacy, dentistry, nursing, midwifery, allied technical fields and community development by strengthening the basic and in-service training;
- improve the drug supply and utilization by (a) strengthening the PPM's management, and drug procurement and distribution capabilities, (b) strengthening the MOPHSA's pharmaceutical planning and cost recovery capabilities;
- improve the MOPHSA's capability in planning, coordination and health education.

At the Regional level the project would:

- assist the GRM in improving the quality of primary health care services to the populations of Kita, Bafoulabe and Kenieba by (a) constructing or renovating health centers and sub-centers (total of 24 centers), (b) retraining the health personnel attached to these facilities (approx. 186 MOPHSA staff), (c) initiating the process of promoting primary health care, community health education and the hygienic use of water at the village level.
- improve the population's health status by reducing the incidence of major diseases through the provision of an integrated program of health services to a maximum of 45% of the target population.

To achieve these objectives the World Bank provided \$17.6 million worth of financial and material resources as well as 119 man months of technical assistance.

1.4. Purpose of the Mission

The purpose of this Fact Finding Mission was to collect, analyze and present in a report, information regarding the cost recovery systems of the district and the community health centers, the drug supply situation in the three project districts and the service and vital statistics in the project zone. The mission would also identify, analyze and present the major strengths and weaknesses of the project, particularly those involving or effecting the three test Community Health Centers. From the information gathered conclusions and recommendations would be drawn and included in the mission report. (see Annex 1 for Terms of Reference)

This Fact Finding Mission was commissioned by USAID/Mali in an effort to better understand certain aspects of the Health Development Project. The results of the study will be used by AID in developing strategies for AID's participation in the Second Health, Population and Rural Water Supply Project.

2. FACT FINDING MISSION METHODOLOGY

2.1. Mission Composition, Design and Preparation

The Fact Finding Mission, including orientation, field trip, findings analysis and report preparation, was conducted over a 6 week (36 days) period, from November 28, 1990 - January 14, 1991. Two consultants, a primary health care specialist and a health care financing specialist, were engaged to conduct the mission. The mission was divided into four segments: 1) orientation to the mission and the project, preparation for the field trip; (2) the field trip; (3) analysis of the findings and preparation of the first draft report and; (4) revisions and writing final report. (see Annex 2 for mission schedule).

During the first part of the mission, the consultants collected and reviewed the various documents about the project and other relevant background material (see bibliography). They also met with the AID backstopping team and interviewed Bamako-based project staff, and the World Bank representative. Time was also spent making arrangements for the field trip and preparing general questionnaires for field-based interviews. (see Annex 3 for list of people encountered)

The field trip was conducted from December 10 - 19, 1990. The consultants were accompanied by two members of the Local Project Coordinating Unit (LPCU), Dr. Michel Gody and Mr. Adama Traore. A project vehicle and chauffeur were used once the consultants arrived in Kita by train. The field trip consisted of three half-day visits at each of the District Health Centers (Kita, Bafoulabe, Kenieba) and whole day visits at each of the three Community Health Centers (Badinko, Selinkegny and Darsalam). The team also briefly visited the sub-district health centers at Kokofata (Kita District) and Falea (Kenieba District). Upon arrival at Kita, a half day was also spent planning the trip and discussing various issues with the LPCU.

At the District Health Centers, the consultants met briefly with the medical doctor in charge (medecin chef). They then divided the tasks and met separately with the health center accountant and the pharmacist and the statistician. Following these interviews the consultants then met together with the Technical Committee. They also visited each pharmacy to inspect the stock and note storage conditions.

At the Community Health Centers the consultants interviewed the CHC staff together. Then the health care financing consultant worked with the treasurer of the Executive Bureau while the PHC consultant gathered service delivery information from the CHC records and reports. This done, the two consultants interviewed the entire Executive Bureau.

During the two visits at the sub-district (arrondissement) health centers, the consultants briefly toured the facilities, met the staff and got a general idea of the level and quality of service delivery.

Upon return to Kita, the headquarters for the Primary Health Care Component of the Project, the consultants also interviewed the Local Project Coordinating Unit.

In Bamako, additional information was gathered through interviews with Mr. Sidibe, of the Project Coordinating Unit, and some control statistics were collected at the National Center for Immunization and the National Directorate of Planning (DNPFS). On December 26, the consultants de-briefed Mr. Dennis Brennan, the AID Director, and the AID backstop team and received clarifications regarding the focus of the report.

2.2. Information Gathering Tools

The tools used by the consultants consisted primarily of interview questions and a list of statistical or otherwise quantifiable information collected from various financial reports or progress reports. Mid-way through the field trip the PHC consultant designed a table to facilitate the collection of standard information. (see Annex 4 for interview questions and other tools used.)

The consultants anticipated being able to use the various financial and progress reports as tools for information gathering. The fact that some of these reports are either not standardized, as in the case of the district health centers' accounts and the CHC's financial reports, or that they are poorly maintained, hampered information gathering. With regard to health information systems, while some standard forms do exist, particularly at the district level, these are most often monthly reports with no year-to-date, trimester or annual totals, not to mention life-of-project statistics. There was also some confusion about the population covered by each service, particularly since the expanded program for immunization (PEV) was implemented according to its own schedule as a separate vertical program.

To complement and complete the information gathered, and to confirm certain statistics, the consultants have also made use of information published by other consultants. Two sources, R. Vogel's "Cost Recovery in the Health Care Sector" and the PCU's June 1989 draft of the "Projet de Developpement Sanitaire: Etat d'Execution de la Composante Locale", were most useful. The DPNFSS's "Rapport d'Evaluation du Systeme de Recouvrement des Coûts dans la Zone KBK du PDS" was also helpful. Other sources are cited in the text of this report.

2.3 Difficulties Encountered

Data analysis and interpretation was hampered by poorly maintained information systems, both with regard to service delivery statistics and financial management. At the District Health Centers, the forms for recording information have changed somewhat several times over the last few years. Some statisticians and District Medical Directors are so confused that they have either given up trying to collect some information, or are behind in compiling the data. Further to this, the target group for certain services sometimes differs. For example, some centers provide well baby services to children under 5 years of age, while others offer them to children 0-6. This lack of standardization makes it difficult to compare statistics accurately.

The consultants also encountered difficulties in obtaining up-to-date MCH service delivery statistics for the control district. Because of the delay in compiling and analyzing the data, the most recent statistics published by the National Directorate for Planning were for 1988.

The mission was not able to collect data that could be used to calculate such impact statistics as infant and maternal mortality. Because the data is not compiled in one central location such as the district health center, to obtain the data required would have required a visit to each sub-district health center, and even these statistics are very questionable since their coverage of the population is sometimes very scant. The team was also not able to gather vaccination figures for the sectors, because the vaccination campaign was conducted by sub-districts and not sectors. In the project area each sector is made up of villages from 3 - 5 different sub-districts.

3. FINDINGS AND CONCLUSIONS

3.1. Major Strengths and Weaknesses of the Project

The strengths and weaknesses cited here are those most often mentioned by the various groups and individuals interviewed during the mission and those perceived by the consultants.

Major Strengths of the Project:

1) The training component - Almost all groups interviewed cited the training as a major strength of the project. The fact that almost all MOPHSA personnel in the three districts participated in some kind of training or refresher course, seminar, or workshop was perceived as a great benefit of the project. Many people also mentioned that they especially appreciated the courses on program planning, budgeting and data collection, indicating that, as a result, program and financial planning and data collection in the three districts is better than ever. It was felt, however, that the higher placed personnel (ie. physicians) received the bulk of the training opportunities, especially those conducted overseas. One District Medical Director attended four different courses, short and long term, outside of Mali. (see Annex 6 for list of courses and people trained)

It should be noted that the comments concerning training were primarily with regard to the number of people trained and courses offered, and to a lesser extent about the subject matter of the courses. None of the respondents commented on the quality of the courses and the consultants were not asked to look specifically into this aspect of the project. From the various interviews and work with individuals it was apparent to the consultants that some of the courses were more successful than others in training their participants. (see section 4.1.B. for recommendations)

2) The Cost Recovery Schemes (CRS)- This strength was cited primarily by the project staff and some health center physicians who understand the broader implications of covering recurrent costs better than some of their colleagues. None the less, the cost recovery schemes implemented by each of the three district health centers are recognized by most as a major benefit, particularly to in-patients. The cost recovery scheme can certainly be regarded as a major achievement of the project, particularly in as much as the original goal of the cost recovery scheme was to cover the cost of medications for in-patient care, while in fact the revenues actually cover many other operating costs.

There are certain drawbacks and inequities associated with the CRS, however, such as the MOPHSA withholding some financial support to health centers in light of the HC's new source of revenues, and the fact that the fee for service system places the burden of health center support only on the moderately unhealthy segment of society rather than on the entire population.

3) Multi-Sectoral/Integrated Project - The fact that the Health Development Project facilitated the collaboration of several sectors to achieve common objectives is a very positive aspect of the project. With the exception of the construction workers, personnel from three different sectors (health, water and literacy) successfully joined forces to implement the project. Thus, in most instances the installation of the bore hole well and pump (a very strongly felt need) paved the way for less popular health activities. Likewise, community level literacy personnel helped to spread health messages, thereby raising the villager's awareness to the causes of their community's health problems and potential solutions. Consequently, many of the communities became aware that the incidence of diarrhea decreased in their area when clean well water was consumed.

Program planning was also strengthened in the project zone by identifying and coordinating the various non-government donor resources, such as local NGOs, religious groups, and international charities (twin city partnerships, for example). This coordination helped the decision makers and planners at various hierarchical levels understand the importance and benefits of controlling resource allocations.

4) Project Flexibility/Creativity - The concept of "sectoralization" (community health centers located in and supported by groups of villages called sectors) could not have been tried if the project had been too rigidly structured and the Local Project Coordinating Unit lacking in creativity, . This experiment enabled the project to address the problem of inadequate PHC coverage in a truly innovative fashion, thereby ensuring the delivery of primary health care services to populations heretofore un-served by the traditional health structure at little cost to the government.

Major Weaknesses of the Project:

1) Supervision: Quality and Quantity - The lack of quality supervision was apparent at each health facility. It was most evidenced by the low productivity , poor quality of work among the health personnel, lack of understanding of certain things (such as health information systems, procedures and protocols) and, in some cases, lack of motivation. Not only are supervision schedules not adhered to (sometimes for legitimate reasons, admittedly), but the lack of understanding regarding the purpose and means of supervision is notable.

This criticism cannot be directed at the project staff, however, because the organigram of the project is such that while the Project Coordinating Unit and the Local PCU have financial control over the project's resources, they do not have any official relationship with the health personnel in the project zone. Thus, while the project can provide goods and services which benefit the MOPHSA personnel, and it can facilitate supervision by providing vehicles, fuel and per diem, project staff has no authority to supervise MOPHSA personnel itself or to require MOPHSA supervisors to do their jobs.

The lack of supervision of the PCU and the LPCU, the World Bank's project "staff" in country, has also been cited as a significant weakness of this and most World Bank Projects. The World Bank does not have the staff in country to supervise it's project personnel, and, short of cutting off funds to the entire project when a component goes off track (which happened when the construction component ran into trouble), the Bank does not seem to have a monitoring mechanism which catches and rectifies problems before they become catastrophes.

2) Parallel Entities - The above described problem is caused by the fact that the PCU and LPCU are separate and independent entities with only "collaborative relationship" status with their key implementing partners. This parallel and vaguely defined relationship is a major weakness of the project which has caused misunderstandings and conflicts not only at the district and regional level but also at the national level, and has reduced the effectiveness of both the PCU and the LPCU and the project as a whole. (see point 4 below)

3) Vague, Over-Budgeted Project Document - The Staff Appraisal Report, the World Bank's "Project Paper", is very imprecise on many points, not the least of which are the project objectives and the responsibilities of the PCU and LPCU and their working relationships with their counterparts. For the most part no strategic frameworks are given in the report to indicate how objectives would be reached, or how the different implementing agencies would interact. The lack of clear, quantifiable objectives makes it difficult to evaluate the project or even monitor progress. At present, monitoring is limited to operational objectives and outputs which are described in an implementation report prepared by the PCU. Another similar document has been prepared by the LPCU regarding "progress" in the field, but this too is not very analytical. According to one PCU member, the project does not intend to conduct an end of project evaluation, because it is too early to expect to see any impact. Instead, an end of project status report will be prepared.

The World Bank project includes funding for many recurrent costs thereby increasing the risk that activities initiated under the project will not be continued after the project ends. The Staff Appraisal Report (November 15, 1983 section 5.04)) cites this as one of the two risks to the project (section 5.04) and says "if the government should prove unable to meet these incremental recurrent costs, the level of service provided at project health facilities will be less than optimal, and health benefits will be adversely affected".....

4) Essential Drug Availability - Without exception, the fact that the project did not succeed in making more essential drugs readily available in the project area at reasonable prices was seen as a weakness, even a failure of the project. At the local level, the project's efforts to address the problem by establishing drug sale agents in the sub-districts did not work. However, valuable lessons have been learned from the experience and other variations on the same theme seem to have better potential. This scheme addresses the problem of availability, however, and not cost.

The "parallel entities" problem described above is in part responsible for the failure of the project to make drugs available in the project area at reduced rates. In brief, when the PPM decided to test a new reduced price scale at 10 of its outlets, none of the 10 outlets chosen was in the project zone. Apparently the PCU had no authority to insist that the pharmaceutical reform required by the World Bank as part of the project be tested in the project area to the benefit of the target population. This failure of the PPM to take into consideration the needs of the field based activities of the project demonstrates a lack of coordination of the different aspects of the project and is indicative of weak project management and coordination.

5) Limited Child Survival Services at the Community Health Centers-

Although the CHC were established to extend PHC services to the most peripheral levels of society, the services one finds being offered are very limited. As the Table 3.8 in section 3.4 shows, the two services most often offered are curative care and delivery assistance. Pre-natal care, well baby consultations and nutrition, diarrhea disease control and health education activities are practically non-existent. Because there is little demand for these activities, and for lack of any other motivating force, most of the CHC staff are content not to meet the challenge of raising the communities' awareness to the benefits of these activities. Support, in the form of training and supervision, would help educate and motivate the CHC personnel, but unfortunately the health staff responsible for providing such support, the Technical Committee, suffer from the same malaise. As explained later, vaccination activities have been carried out by the vertical EPI and current family planning policy discourages peripheral level health personnel from providing contraceptives.

3.2. Cost Recovery Findings and Conclusions

3.2.1. An Overview of the Project's Cost Recovery Efforts

District Health Centers:

In the design stage of the Health Development Project, the problem of supporting the recurrent costs of health care were addressed, and it was decided that certain cost recovery experiments would be tried under the project to see what positive results, if any, would occur. Specifically, the November 1983 Staff Appraisal Report (Section 1.34) indicates that under the project the MOPHSA intends to: "... (iii) encourage the purchase of drugs prescribed on an outpatient basis; and (iv) develop and test a scheme to promote cost recovery by charging for hospitalization, deliveries, x-rays and laboratory examinations. Receipts under this experiment would be retained by the hospitals and health centers to purchase drugs through the PPM for in-patient needs. A portion of these funds at the health center level would, if available, be used to assist with infrastructure and equipment maintenance."

The experiment proceeded as planned and in June and July 1985 the District Health Centers of Kita, Bafoulabe and Kenieba initiated cost recovery schemes (CRS). These CRSs at the district level involved charging a set fee for services, as outlined below (figures in f cfa):

Services	Kita DHC	Bafoulabe DHC	Kenieba DHC
consultation	100 - 500	100	100
prenatal con.	500		
internal med.	1500-2500-5000	2500	7500
delivery	500 - 1000	1000 - 1750	1000
laboratory	300	500	500
ophthalmology	300 - 2500		
surgery	1000 - 5000	5000 - 10000	12500
dental consult.			500
inject./bandage		50	

The net result of the CRS was also as planned and over the years each of the three DHC has not only succeeded in covering the costs of in-patient medications but they have indeed begun to cover some operating costs as well. Table 3.1 summarizes the results of the cost recovery schemes.

TABLE 3.1

SUMMARY OF

RATE OF COST RECOVERY*
at the

District Health Centers
of

Kita, Bafoulabe and Kenieba

DHC	1985	1986	1987	1988	1989	1990
Kita	100%	100%	84%	78.5%	94%	95%
Bafoulabe	100%	84%	100%	95%	100%	76%
Kenieba	67%	100%	100%	91%	82%	92%

* percentage of all recurrent costs excluding salaries, out-patient medications and costs related to supervision, training and all vertical programs such as EPI.

Community Health Centers:

In 1988 with the start of "sectoralization" and the creation of Community Health Centers, a more comprehensive cost recovery scheme was required. Because the CHC don't receive any government support, this scheme called for complete coverage of all recurrent costs including salaries. Given the uniqueness of each CHC and sector and the different resources available to each, the cost recovery schemes adopted by the three sectors vary somewhat. Common to each of the CHCs is a fee for service and charge for drugs. In addition to this, one CHC has received 12 months of financial support for salaries from the Local Development Committee (allocation of local taxes), one sector's Management Council has organized communal work to generate income, and two CHCs receive drug donations from Twin City partnerships. Once again the rate of cost recovery has been very impressive, as Table 3.2 shows.

TABLE 3.2

SUMMARY OF

RATE OF COST RECOVERY**
at the

Community Health Centers
at

Badinko, Selinkegny, and Darsalam

CHC	1989	1990
Badinko	NA	100%
Selinkegny	92%	100%
Darsalam	100%	95%

** percentage of all operational costs covered by the CHC and the communities.

The Local Project Coordinating Committee of the Project has been instrumental in helping the DHCs and the CHCs to establish and manage their cost recovery schemes. The project has provided much needed training in accounting, financial management, and drug management, and has developed and written up different strategies for cost recovery at the sector level for consideration by the Management Councils. Further to this, the project provided each health facility in the project zone with a substantial supply of drugs, which served as the basis for a revolving supply of drugs and helped launch the CRSs. Also in support of the cost recovery scheme, which is so dependent on the availability of drugs, the project helped establish drug sale agents (depositaires) in each sub-district to ensure the availability of drugs in areas where the People's Pharmacy of Mali has no branches.

The following parts of this section on Cost Recovery provide the financial data which explain the mechanics of the cost recovery schemes in each of the three District and Sector Health Centers. Following a presentation of the revenue and expenditure figures for each district and sector, the value of the drug supply at the end of the reporting period is given. This drug-related information, together with the other statistics, allows the reader to have a more complete picture of the financial situation of each facility.

3.2.2. Detailed Cost Recovery Statistics for the Districts

A. Cost Recovery- Kita District Health Center

The following two charts (and those in parts B and C) were taken from the "Rapport d'Evaluation du System de Recouvrement du Coûts dans la Zone K.B.K. du PDS", prepared by the MOPHSA in September 1989. The tables indicate that with donations from non-governmental organizations and subsidies from the MOPHSA and the project, the health centers are able to maintain a positive accumulative balance. More importantly, however, the figures indicate that even without assistance, the DHC cost recovery rates (ctcov rate) are very high.

Kita
Financial Situation
including Donations and Allowances
(7/85 - 12/88)

ctcov rate	year	Revenues - fee for Serv.	Expenditure (excl.sal.)	Annual balance*	Accumulated balance
100%	1985	6,972,355	2,419,410	+ 4,552,945	4,552,945
100%	1986	5,688,150	4,270,555	+ 1,417,595	5,970,540
100%	1987	6,302,030	6,178,193	+ 123,837	6,094,377
94.5%	1988	6,175,110	6,528,792	- 353,682	5,740,695

Financial Situation
excluding Donations and Subsidies
(7/85 - 12/88)

ctcov rate	year	Revenues - fee for Serv.	Expenditure	Annual balance*	Accumulated balance
100%	1985	2,977,125	2,419,410	+ 557,715	+ 557,715
100%	1986	5,688,150	4,270,555	- 1,417,595	+1,975,310
84%	1987	5,203,990	6,178,193	- 974,203	+1,001,107
78.5%	1988	5,125,950	6,528,792	- 1,402,842	- 401,735
94%	1989	8,522.315*	9,080,615	- 558,300	- 960,035
95%	1990	5,672,990	5,949,957	- 276,967	-1,237,002

* The revenues in 1989 were considerably greater due to revenues generated by the drug sale agents who purchased their drugs at the DHC pharmacies from a special stock of drugs provided by the project for this purpose.

NB. The actual tables use the term "consumption" instead of

"expenditures" to make the distinction between products that were actually "consumed" during the reporting period and expenditures which were made either before or during the reporting period but not "consumed" during the period. The term expenditure is used throughout this report.

* mission consultant calculations

Tables 3.3 and 3.4 show the cost recovery details for years 1989 and 1990, bringing the above charts up-to-date. These figures indicate the continued high rates of cost recovery (94% and 95%), despite the negative accumulative balances. They also show the disproportionate expenditures made for drugs.

TABLE 3.3

Cost Recovery Statistics
for the
Kita District Health Center
(Jan. 1, - Dec.31, 1989)

Mths	Revenue fee for Service	Expenditures					mth bal- ance	Accum. bal- ance
		Diret@	Drugs	supply	prodt	combt*		
Jan	621860	80310	508024	77279	36385	116000	- 91738	- 91738
Feb	654650	56090	431542	32673	33050	31375	+ 69920	- 21818
Mar	621400	11400	318315	84333	18500	7750	+181102	+159284
Apr	901425	23650	665569	105200	64300	12350	+ 30356	+189640
May	711350	83000	534868	99740	26000	9000	- 41258	+148382
June	736320	18925	626494	37600	37300	16350	- 349	+148033
July	626520	21400	669738	85410	24035	14100	-188163	- 40130
Aug.	980100	79500	950985	21800	11325	7800	- 91310	-131440
Sept	906010	46750	838667	23271	13350	14550	- 30578	-162018
Oct	593000	42950	598752	79365	26500	17550	-172097	-334115
Nov	592560	127350	574881	17500	10425	9350	-146846	-480961
Dec	577120	26950	572053	30150	15406	9900	- 77339	-558300
TOT	8522315	618175	7289888	694301	316576	161675		

The cost recovery rate for 1989 is calculated at 94%

* combustibles = kerosene, gas etc.

@ direct expenditures are expenses that do not contribute to the inventory.

Summary figures for 1989:

cash on hand 2,780,300
 current inventory (drugs) + 3,410,912
 total balance for 1989 5,632,942

TABLE 3.4

Cost Recovery Statistics
 for the
Kita District Health Center
 (Jan.1 - Oct.20, 1990)

Mths	Revenue for Service	Expenditures					mth balance	Accum. balance
		Direct	Drugs	supply	prod	combt		
Jan.	576035	12125	511979	73095	20400	7150	-48714	-48714
Feb.	650140	64780	402846	69005	29780	11350	+72379	+23665
Mar.	622350	14450	391372	66552	11830	6300	+131796	+155461
Apr.	499000	124989	425378	78160	13680	12950	-156157	- 696
May	582735	39710	489644	71595	22150	5100	- 45464	- 46160
June	488845	66605	385992	89725	3550	11100	- 69127	-114287
July	501115	96775	434793	68549	10430	18650	-128132	-242419
Aug.	510500	63300	445835	76665	33975	9850	-119125	-361544
Sept	599110	90400	437902	101715	10025	10500	- 52432	-412976
Oct.	643160	22770	416041	50070	12250	6000	+136009	-276967
TOT	5672990	595904	4341782	745131	168190	98950	-276967	

@ Direct expenditures do not contribute to the inventory.

According to the above figures the annual rate of cost recovery at the Kita District Health Center for 1990 was 95%.

The "Revenue" columns of TABLES 3.3 and 3.4 do not reflect donations and subsidies from private and government sources which also contribute to the support of the DHC. These funds cover such costs as DHC staff salaries, operating costs, supervision costs, and represent in-kind contributions of drugs.

The sources of donations and subsidies for the Kita DHC from January through October 1990 are cited below:

<u>Source</u>	<u>Value</u>
MOPHSA- salaries	25,285,382
MOPHSA- operating costs	<u>705,104</u>
TOTAL MOPHSA SUPPORT	25,990,486
Local Development Committee (Local Tax)	2,250,000
World Bank Project	6,246,885
Twin City Partnership (Drugs)	4,167,200
Raoul Follereau Fund	<u>330,000</u>
TOTAL DONATIONS (incl WB loan)	12,994,085
TOTAL donations, subsidies, MOPHSA	38,984,571

If one considers the donations and local tax as "extra" income, then the annual balance for 1990 becomes +12,717,118 f cfa.
 ({- 276,967} + 12,994,085)

If all sources of "outside" funding were withdrawn, then presumably for service delivery not to be negatively effected, the government would have had to provide an additional 10,744,085 f cfa to Kita's 1990 budget.

B. Cost Recovery - Bafoulabe District Health Center

The financial situation from the beginning of the cost recovery scheme in 1985 to 1989 is provided in the following charts. Once again, a high rate of cost recovery is noted

**Bafoulabe
Financial Situation
including Donations and Subsidies
(7/85 - 6/89)**

ctcov rate	year	Revenues - fee for Serv.	Expenditure (excl.sal.)	Annual balance*	Accumulated balance
100%	1985	4,868,268	1,273,284	+ 3,594,984	+3,594,984
84%	1986	2,446,700	2,918,159	- 471,459	+3,123,524
100%	1987	3,527,700	2,263,458	+ 1,264,241	+4,387,766
100%	1988	2,857,246	2,363,905	+ 493,340	+4,831,106
100%	1989	2,181,671	1,008,872	+ 1,172,799	+6,053,905
97%	1990	2,266,800	2,336,535	- 69,735	+5,984,170

**Bafoulabe
Financial Situation
excluding Donations and Subsidies
(7/85. - 6/89)**

ctcov rate	year	Revenues - fee for Serv.	Expenditure	Annual balance*	Accumulated balance
100%	1985	1,347,350	1,273,284	+ 74,066	+ 74,066
84%	1986	2,446,700	2,918,159	- 471,459	- 397,593
100%	1987	2,327,200	2,263,458	+ 63,741	- 333,851
94%	1988	2,233,950	2,363,905	- 129,955	- 463,807
100%	1989	1,313,450	1,008,872	+ 304,577	- 159,229
76%	1990	1,783,300	2,336,535	- 553,235	- 712,464

* mission consultant calculations

The Bafoulabe DHC's revenues and expenditures for 1990 are not available in the same detail as those of Kita. Nevertheless the following figures enable one to calculate a cost recovery rate of 76% for 1990 and an average recovery rate ('85-'90) of 92.5%.

Bafoulabe
Financial Situation
(Jan - Oct. 1990)

REVENUES(fee for Service)

consultations	237,400
surgery	530,000
minor surgery	190,000
medicine	330,000
deliveries	343,750
laboratory	121,000
injections	27,150
bandages	<u>4,000</u>

TOT.REVENUES 1,783,300

EXPENDITURES

drug purchase	1,420,465
office supplies	343,600
DHC maintenance	61,220
transpt*/travel	71,610
combustibles(gas)	209,365
vehicle maint.	62,400
maintenance prdts	44,225
fuel	23,600
other expenditure	<u>100,050</u>

TOT.EXPEND.** 2,336,535

* includes 15,260 linked to drug purchase

** includes some expenditures incurred for the Bafoulabe sub-district health center.

The annual balance for 1990, excluding donations and subsidies, is, - 553,235 f cfa.

Drug consumption for the year, including drugs purchased prior to the reporting period, totaled 1,732,715 f cfa.

The total inventory at the end of the year was equal to 1,048,967 f cfa.

If the value of this inventory is taken into account a positive annual balance of 495,732 f cfa results. (1,048,967 + {- 553,235})

The balance would have been more significant had the total expenditures not included some expenses incurred on behalf of the sub-district health center.

Expenses not covered by the fee for services revenues include:

Operating Costs	200,000	MOPHSA
Salaries	14,400,000	MOPHSA
Supervision Costs (fuel,perdiem etc)	283,500	WB Project
EPI costs (fuel, per diem, veh.main)	<u>unknown</u>	WB Project
	14,883,500+	

C. Cost Recovery - Kenieba District Health Center

As in parts A and B of this report, the following charts show acceptable rates of cost recovery. Cost recovery in the first year of implementation was low because DHC personnel (and their extended families) were exempted from the fees for services. When the impact of this policy on the CRS become evident, the policy was rescinded.

Kenieba
Financial Situation
including donations and subsidies
('85 - '88)

ctcov rate	year	Revenues - fee for Serv.	Expenditure (excl.sal.)	Annual balance*	Accumulated balance
100%	1985	4,332,761	2,004,894	+ 2,327,870	+2,327,870
100%	1986	3,808,920	2,429,785	+ 1,379 135	+3,707,005
100%	1987	4,016,178	3,280,163	+ 736,015	+4,443,020
100%	1988	3,754,745	3,722,791	+ 31,954	+4,474,974
97%	1989	4,622,255	4,743,645	- 121,390	+4,353,584
100%	1990	4,679,708	4,309,234	+ 370,474	+4,724,058

Kenieba
Financial Situation
excluding Donations and Subsidies
('85 - '88)

ctcov rate	year	Revenues - fees for Serv	Expenditure	Annual balance*	Accumulated balance
67%	1985	1,335,350	2,004,891	- 669,541	- 669,541
100%	1986	2,861,100	2,429,785	+ 431,315	- 238,226
100%	1987	3,956,300	3,280,163	+ 676,137	+ 437,911*
91%	1988	3,383,700	3,722,791	- 339,091	+ 98,820*
82%	1989	3,913,300	4,779,183	+ 865,888	+ 964,708
92%	1990	3,963,450	4,309,234	- 345,784	+ 619,924

* mission consultant calculations

Once again the revenues cited in these charts do not include donations from private sources or government subsidies. For Kenieba these included the following:

Donations and Subsidies for the years 1985 -1990

Source	1985	1986	1987	1988	1989	1990
MOPHSA	7,900@	917,820	0	0	257,000	200,000
WB Pro.	2,965,511	0	443,978	812,545	0	214,500
R.Foll.	14,000	0	220,310	188,500	500,000	210,400
other	10,000	0	0	0	110,510	267,870
TOTAL	2,997,411	917,820	664,288	371,045	867,510	892,270

@ this figure seems unrealistically small. Perhaps a mistake in recording the figure was made.

The following costs were also not covered by the revenues generated by fees for services in 1990 but are not included in the chart above.

DHC Salaries	8,280,000	MOPHSA
12 midwife salaries	2,160,000	LDC
EPI(per diem,fuel, veh. main))	unknown	WBProj
TOTAL	10,440,000+f cfa	

In Kenieba the accountant makes the distinction between "expenditures", an outlay of funds, and "real consumption", those tangible items that were actually "consumed" during the reporting period. Because revenues (in the form of donations, for example) can be received in one year but not consumed until the next, real consumption can exceed expenditures and even revenues for a given reporting period. Likewise, expenditures could be more than real consumption, particularly if a large supply of drugs was purchased. Direct expenditures are expenses that don't contribute to the inventory.

From the figures given below, a cost recovery rate of 82% is calculated for 1989.

Kenieba
Financial Situation
(Jan - Dec. 1989)

<u>REVENUES</u> (fees for service)	<u>EXPENDITURES</u>	<u>REAL CONSUMPTION</u>
consult 501,300	Material 32,000	Drugs 3,385,145
surgery 1,950,000	Drug Pur. 2,335,075	Offsup. 484,800
medec. 1,130,000	Off.Sup.. 650,950	Main.Prdt 50,950
labor. 86,000	Main.Prdts 222,350	Dir.Exp. 822,750
deliv. 227,000	Fuel 109,200	
dental 19,000	Combust. 73,900	
	travel 25,345	
	post fees 74,815	
	veh.main. 88,690	
3,913,300	3,612,325	4,743,645

The balance for the year 1989, when calculated from the revenues generated from fees for services and the real consumption, totals 865,888 f cfa.

The value of the inventory at the end of 1989 was calculated to be 169,768 f cfa, excluding donated drugs and subsidies, and 906,026 f cfa, if donations and subsidies are included.

Kenieba
Financial Situation
(Jan - Nov. 1990)

<u>REVENUES</u> (fees for service)	<u>EXPENDITURES</u>	<u>REAL CONSUMPTION</u>
consult 484,700	Materials 0	Drugs 3,109,804
surgery 1,856,250	Drug Pur. 2,559,855	Offsup. 220,220
medic. 1,335,000	Off.Sup. 310,070	Main.Prdts 600
labor. 20,500	Main.Pr. 161,000	Dir.Exp 978,610
deliv. 244,500	Fuel 0	
dental 22,500	Combust. 137,000	
	travel 25,345	
	post fees 47,945	
	per diem 67,420	
3,963,450	3,579,565	4,309,234

The balance for the year without donations and subsidies and compared to the real consumption is - 345,784 f cfa. Including the assistance the year-end balance is - 77,914 fcfa.

The cost recovery rate is 92% in 1990

3.2.3. Cost Recovery Statistics for the Health Sectors:
Badinko, Selinkegny and Darsalam

As Table 3.5. indicates, the three sector CHCs are demonstrating highly favorable rates of cost recovery since their creation in 1989. Unlike the figures given for the District Health Centers, these rates refer to all recurrent costs, including salaries and operating expenses.

TABLE 3.5
RATE OF COST RECOVERY
at the
Community Health Centers
at
Badinko, Selinkegny, and Darsalam

CHC	1989	1990
Badinko	NA	100%
Selinkegny	92%	100%
Darsalam	100%	95%

Each of the three sectors has somewhat different sources of revenue and slightly varied expenditures, but there are a number of similarities as well. The following two charts show the personnel at each CHC and their respective salaries, and the fees for services set by each sector's Management Council.

CHC Personnel and Salaries

Personnel	Badinko	Selinkegny	Darsalam
Head Nurse	MOPHSA	25,000	30,000
Asst Nurse	12,500	17,000	20,000
Pharmacist/guard	20,000		-
Midwife (s)	10,000@	10,500	10,000
TOT.monthly sal.	52,500	52,500	60,000
TOT yearly sal.	630,000	630,000	720,000

@ there are two midwives at Badinko

Fees for Services at CHC

Service	Badinko	Selinkegny	Darsalam
ticket/consult.	100	100 - 200*	50
PreNat consult.	200 - 300*	300	300
Delivery-CHC	500 - 750*	1000	500
Delivery-home		2000	1750
sutures	750 - 1000*	500 - 1000*	
injection		50	
bandage		250 - 500*	

* higher rates are charged for people outside of the sector

It is apparent from this chart that Darsalam, with lower fees for services has a much lower revenue generating base than the other two CHCs. Darsalam also does not enjoy the added advantage of being able to attract patients from outside the sector, thereby increasing revenues even further. An added disadvantage is the high monthly expenditures, given the comparatively high salaries of the CHC staff.

Revenue levels differ not only because fees vary but because two of the sectors (Badinko and Selinkegny) have received support (in-kind donations of drugs) from private sources, while another, Darsalam, received 12 months of salary support from the local development committee (local taxes).

A comparison of the revenues and expenditures of each CHC follows:

Comm.H.Cen.	Revenues	Expenditures	To - Date Balance	Value of Drugs
Badinko- 15/4 -15/12, 1990	1,501,512	1,472,140	+29,372	1,337,530*
Selinkegny 7/89 -9/90	1,618,400	1,686,205	-67,805	1,639,465
Darsalam 6/89 -12/90	467,385	276,640**	+190,745/ -9,255@	205,485

* very rough calculation by mission consultant

** does not include salaries which were paid for by the LDC from 6/89-6/90, and only partial payment (110,000fcfa) between 7/90-11/90.

@ If salaries had been paid as usual, then the actual expenditures would have been 386,280 f cfa and the balance as of December 31, 1990 would have been -9,255.

The preceding table shows that while the majority of costs are covered by the cost recovery system, there is a shortfall in Selinigny for the two year period, and, there would have been a shortfall in Darsalam, had the CHC staff there not agreed to forgo their salaries since July 1990 and make due on small advances.

This mix-up with regard to salary payments in Darsalam is due to the sudden death (murder) of the sub-district Major (commandant) who had agreed to pay the salaries from locally (sub-district) collected taxes at the rate 200 f cfa/taxpayer. In the months following the major's death, no alternative means of payment was identified. As of the mission's visit, however, the Management Council had decided to take up a collection from the sector to pay the CHC staff salaries.

3.2.4. Supervision Costs

One of the attractions in experimenting with community-supported health centers was the presumed advantage of reducing the MOPHSA's recurrent costs while at the same increasing population coverage. While it is true that the CHC have been successful in covering most of their recurrent costs, one should not forget that the project has contributed significantly to the start up costs of these centers and has subsidized the costs of supervision of the three CHC as well as all of the sub-district health centers.

The project's estimated support of supervision, which covers per diem, fuel and vehicle repair and maintenance, in 1990 was:

Kita	- 283,500 f cfa
Kenieba	- 214,500 f cfa
Bafoulabe	- <u>283,500</u> f cfa
TOTAL	781,500 f cfa

Despite these subsidies it was all too apparent that the quality of services, level of productivity and the attitudes of personnel were, in many respects, less than satisfactory due to the lack of frequent quality supervision.

Therefore, while it may be safe to say that the CHC's cost recovery systems cover most of their operating costs, it is not accurate to say that the MOPHSA can afford not to support the CHCs. At the very least, they need frequent quality supervision, in-serve training and re-supply of HIS forms and reports. The MOPHSA's commitment (ability) to providing this minimal support, even when subsidized by the project, was not apparent.

3.3. Essential Drug Findings and Conclusions

3.3.1. Overview of the Situation and the Project's Activities

Traditionally the District Health Centers rely on three drug suppliers to maintain their stock of medications: the People's Pharmacy of Mali (PPM),; the Malian Factory for Pharmaceutical Production (UMPP); and private donors such as twin city partnerships, and the World Bank Project.

To the DHCs, each of these suppliers offers advantages as well as disadvantages. The PPM has the advantage of accessibility since it has branches in each of the district capitals. It also maintains a fairly large variety and regular supply of drugs. However the PPM only carries brand name drugs, with their correspondingly high prices. Most DHCs use the PPM reluctantly, but find they often have no choice when stocks in the DHC pharmacy run out.

The UMPP is the preferred source of procurement because it provides essential generic drugs at comparatively lower prices, and most pharmacists indicated that they made procurement trips to Bamako at least three times per year. Unfortunately, however, the UMPP does not have any branches outside of Bamako, so travel time and expenses add an additional cost to the drugs themselves. A trip to Bamako for drug procurement ranges in cost from 60,000 f cfa in Kenieba to 9,000 f cfa for Kita. The UMPP produces only a limited number of essential drugs and because production levels are low, the supply to buyers is erratic.

The big advantage of private donors is that the drugs are free, or at least at limited cost (assuming it comes in the form of a grant and not a loan). The donated drugs might include much needed medicines which are not available in-country. More often than not, however, donated drugs do not correspond to the needs of a rural African community, or the practicing nurse is not familiar with the drug under its brand name. The latter can result in drugs expiring before they are used. This occurred in Selinkegny where 300,000 f cfa worth of drugs expired. In Badinko, 4,000,000 f cfa worth of donated drugs were deemed unsuitable, but before they could be sold or exchanged, they were stolen! Donations rarely include generic brand essential drugs.

Faced with the constraints built into each of these suppliers, the various health facilities have had to deal with high prices and/or unavailability of drugs. To complicate the matter, the capital base of the District Health Center Pharmacies is so low that they cannot afford to buy a large enough supply of drugs to meet the needs of the district for a significantly long period of time.

In recognition of these problems, the project took action to improve the availability of drugs. (The issue of lower prices was supposed to be addressed by the Pharmaceutical Reforms part of the project. see section 3.1.Weaknesses) In 1985, the project trained and established drug sale agents (depositaires) in each of the sub-districts by giving them each a 400,000 fcfa loan in the form of drugs. These agents would sell their drugs at a profit of between 27%- 60% to patients of the sub-district health centers (with prescription). The loan was repayable in 25 months at the rate of 16,000 f cfa/month.

At the District level, the project added an additional supply of drugs to the existing inventory of each of the DHC pharmacies in order to increase availability and the capital needed to replenish the stock. Furthermore, a special stock of drugs (stock tampon) valued at 880,000 f cfa and earmarked for sale to the sub-district drug sale agents (see below) and Community Health Centers, was provided to the DHC by the project. As an added assistance, if the DHC experienced stock depletions and had to purchase drugs at the PPM at the higher rates, the project would reimburse the difference between the PPM price and the UMPP price.

When the Community Health Centers opened, the project also provided them with an initial supply of drugs valued at 520,000 f cfa.

Despite these efforts, for various reasons, drug availability (and affordability) still remains a major problem in the project zone. The drug sale agent scheme did not resolve the problem because the agents themselves had to pay, not only the costs related to re-supply but sometimes also the high prices of the PPM (when the stock tampon was insufficient). Furthermore, when purchasing from the PPM, these agents did not benefit from the 15% discount accorded the DHC pharmacists. In the end many of the agents discontinued their sale of drugs altogether. Some people attribute the failure of this strategy to the fact that the agents selected were all retired health workers who neither had great motivation to succeed nor management skills.

3.3.2. Drug Consumption in the Project Zone

Drug purchase constitutes the largest line item in each of the DHC budgets. For example in Kita, between 1985 and 1989, the rate of drug expenditures ranged between 60% - 82% ; in Bafoulabe the range was 56%-

69% and in Kenieba it was 63% - 73%. Table 3.6 shows the value of drug sales in the three district health centers between 1986 and 1990 and the corresponding figures for the three CHCs.

TABLE 3.6

Drug Expenditures

Facility	1986	1987	1988	1989	1990
DHC Kita	2,903,947	4,844,751.	4,712,099	7,289,888	5,488,716
DHC Baf.	2,320,270	2,554,563	2,038,321	NA	1,732,715
DHC Ken.	1,766,262	2,234,011	2,669,328	3,385,145	3,109,804
CHC Bad				NA	1,411,912
CHC Sel				775,375	563,375
CHC Dar				157,310	229,950

3.3.3. Drug Cost Comparisons

In each of the sites visited by the mission consultants, everyone agreed that had drugs been made available at the price scale being tested by the PPM in other districts, the effect on the project would have been significant. When pressed for details, however, no one was able to specify the exact price difference the new scale affords or the exact difference between the generic essential drugs available at the UMPP and the brand name non-essential drugs sold at the PPM. It's difficult to compare apples and oranges, agreed.

For the sake of speculation, figures from a study comparing an average PPM prescription with average prescriptions from Medicine Sans Frontieres and Medecins du Monde have been used. The two latter groups are known for having set up a parallel drug supply system in the areas of Timbukutu, Gao, Bankass and Koro which are said to have reduced prescription rates to the level that will prevail when (if) the Bamako Initiative is implemented. The results of the study are shown in Table 3.7.

TABLE 3.7

Comparative Drug Prices

Average PPM base prescription	2,690
Average Med.Sans Front.prescr.	
Timbuktu:	196
Gao:	243
Average Med. du Monde prescr:	
Bankass	364
Koro	426
Average of all three prescr:	307

Based on the information gathered during this mission regarding drug prescribing and procurement practices, one can assume that the average prescription of the three DHCs is much closer to the average PPM base prescription than to the others, and that implementation of the Bamako Initiative would reduce the average prescription rate, perhaps not as low as those listed here, since procurement costs would still have to be born, but by at least half.

In another effort to calculate the potential prices of the BI and to confirm the above findings, the most recent price list (August 1990) for essential drugs (ED) was consulted and the prices of 93 generic brand EDs were compared with 141 similar drugs products sold by the UMPP. The average price of the 93 generic brand ED was calculated at 268 f cfa, with a variance between 10 f cfa and 2,085 f cfa. The average price of the 141 drugs sold by UMPP was 1,184 f cfa with a range of 230 f cfa and 8,365 fcfa. The ED prices conform to those calculated above and the UMPP average price confirms our theory that average prescription rates will probably be halved with the Bamako Initiative.

3.4 Service Delivery Statistics and Conclusions

3.4.1. Discussion of Table 3.8, "Comparative Figures for Service Delivery at Community Health Centers"

Table 3.8 shows the service delivery statistics for the period June/July 1989 through September/November 1990 and compares them with the objectives set forth in the Annual Program Plan. It is not clear upon which basis the objectives were set to begin with so there is no way of knowing if the objectives are realistic or not. Presumably this knowledge will come with experience.

Of the three CHCs, Selinkegny has come closest to achieving some of its objectives, notably pre-natal and well baby consultations. Badinko's well baby program is particularly weak while Darsalam has not even initiated well baby activities. Likewise, organized health education seems a very unpopular activity among health workers, with all three CHC staffs complaining of the difficulties in getting women together. (It should be noted here that the project has worked primarily through the ODPAC functional literacy zone chiefs to organize its health information dissemination activities in the project zone.) Selinkegny, despite the limited number of seances, has managed to reach more women because the staff take advantage of the weekly market to assemble women.

None of the CHCs had ORS packets during the field visit of the Mission. Apparently in the entire Kayes region there has been no supply of packets in many months, leaving no alternative but to teach the home made version of oral rehydration solution. Both Darsalam and Badinko distributed all of the packets they had, while apparently Selinkegny never had any to give out.

The number of deliveries attended by the mid-wives in Badinko is particularly high and is significant (though low compared to their objectives) in the other two sectors. This willingness to pay for a mid-wife's service is a remarkable milestone on the road to more demand for professional health services.

From the table and other information gathered it's apparent that at present the two services most in demand and consistently provided by the CHCs are curative care/first aid and maternal health care. For reasons cited earlier, vaccinations and family planning services are not currently provided by the CHC, and there is no, or little, demand for other preventive MCH services.

These findings are consistent with those of other newly established health facilities, since historically people become interested in preventive services only after curative care is assured. Once the population has begun to see the results of the curative care and become aware of the measures they can take to prevent illness, the demand for preventive services increases over time. This of course is contingent upon the continued provision of quality health services which in turn requires proper supervision and support of the facility and its staff.

TABLE 3.8
COMPARATIVE FIGURES FOR MCH SERVICE DELIVERY
Community Health Centers
Badinko, Selinkegny, and Darsalam

In 1990

women pregnant/deliveries expected:

- Bad. - 233
- Sel. - 219
- Dar. - 260

total children 0-6 years:

- Bad. - 1,117
- Sel. - 1,048
- Dar. - 1,244

SERVICES	1990 Pop.	Community Health Centers at					
		Badinko 5,078		Selinkegny 4,765		Darsalam 5,655	
		OBJ.	ACT.	OBJ.	ACT.	OBJ.	ACT.
Fam.Planning Users			3*		no prog.		no prog.
Pre-natal consulta. new cases		235	83	64	56	289	20
deliveries followed -maternity -home		46	100 0	80	27 15	60	16 3
post natal consult.			0		17		1
well baby consult.		335	18	128	114+	132	0
# consultations children 0-6			321		192+		129
% child consult per total # consult.			24%		20%		50%
# cases diarrhea children 0-6			34**		8@		62
# group health education lessons		48	4	96	5	48	2
# women present for health lessons			49		271		18
# of SRO packets distributed			200		-		249

* began FP services in November 1990

@ April - Oct. 1990

** includes all cases of diarrhea

+ children 0-5 years

NB. Data gathered from CHC trimester reports, CHC registers and other CHC documents. Except where indicated, all figures are totals for the period June/July 1989 - November 1990.

TABLE 3.9

COMPARATIVE MCH SERVICE DELIVERY FIGURES

Project Districts of Kita, Bafoulabe, and Kenieba
and the Control District of Nioro du Sahel

In 1988

pregnant women/deliveries expected:

- Kita - 10,990
- Baf. - 6,507
- Ken. - 5,198
- Nio. - 5,984

total children 0-6 years:

- Kita - 52,550
- Baf. - 32,771
- Ken. - 22,458
- Nio. - 28,620

MCH SERVICES	'88 Pop.	Kita 238865	Bafoulabe 148962	Kenieba 102083	Nioro@ 130095
Pre-natal consult. new cases in 1988		1825	814	852	775
Post-natal consult. new cases		705+	-	9++	39
Deliveries followed in 1988		1753	675	876	716
Fam.Planning Users new cases		1313+	150**	586++	133
cases of diarrhea in children 0-4		1673+	248**	160++	NA
well baby consult. new cases		581*	-	350++	436
rate of well baby coverage for 1988@		1.2%	1%	1.2%	1.8%
rate of F.Plan use@		.2%	.2%	.3%	.5%
rate del. followed@		8%	8%	4%	11%
rate of PNConsult@		11%	9%	5%	12%

* Jan-Nov. '89

++ figures for 1990

** 1990 only

+ January 1989 - September 1990

@ figures are for 1988 and were provided by National Directory of Planning and Training

3.4.2. Discussion of Table 3.9, "Comparative MCH Service Delivery Figures for the Districts of Kita, Bafoulabe, Kenieba and Nioro du Sahel"

Table 3.9 shows statistics for various MCH services for the three districts in the project zone and compares them with those figures from Nioro du Sahel, a neighboring district in the Kayes regions outside of the project area. Nioro has approximately the same population as Bafoulabe and Kenieba and a little more than half that of Kita. Taken jointly the statistics show no significant difference between the level of service delivery in the project zone and that in the control district. The number of family planning users in Kita is the only figure that stands out as remarkably higher than the others, but true comparison with Nioro is hampered by the lack of up-to-date statistics for that district. The comparative family planning rates given for 1988 show a slightly higher user rate in Nioro, so it is possible that in the ensuing years Nioro has made as much progress as Kita.

If levels of service delivery have not increased as a result of the project (and this was not one of the project objectives), given the emphasis the project placed on training, it would be just to expect the quality of services to have improved. While the mission was not asked to look into this aspect specifically, one indicator of improved quality of services is the reduction in the number of referrals. Both the District Health Center staff and the sub-district center staff remarked that over the years the number of cases needing to be referred to the next highest level had decreased. Presumably this is because the health care staff felt competent enough to treat the case and because the facilities themselves had been up-graded.

3.4.3. Discussion of Tables 3.10,11,12,13,14; "Comparative Vaccination Rates and Vaccination Rates for Individual Districts"

As described earlier, the Expanded Program for Immunization (EPI=PEV) was the one program that continued to be conducted vertically, and was not integrated into the regular services of the district or sub-district health centers. At the district level the district health center does provide vaccinations to children and pregnant women within a certain radius of the center. Outside this area, the vaccination campaigns are carried out by a special mobile team whose efforts are directed by the vertical EPI program personnel. The project supported the EPI by providing vehicles, fuel and per diem for the mobile teams. Furthermore, the project supported efforts of various health personnel in the three districts who conducted awareness raising and EPI information dissemination meetings in 366 villages throughout the project zone. (see Annex 5 for Project Support to EPI)

TABLE 3.10

COMPARATIVE VACCINATION RATES

Control District of Niore du Sahel
and Project Districts of Kita, Bafoulabe and Kenieba
 (Children 0 -. 6 years)

Dist- rict.	BCG	Meas.	DPT/Polio			TETANUS TOXOID**		
			1	2	3	1	2	Booster
Niore '86-90	115%	126%	122%	74%	62%	29%	14%	2%
Kita '88-90	103%	100%	97%	57%	33%	77%	33%	0%
Bafou. '88-90	119%	106%	118%	68%	60%	61%	83%	0%
Kenie* '88-90	67%	67%	66%	21%	11%	76%	31%	.1%

* These figures are incomplete as nine months of data, April-December 1989, are missing. It can be assumed that the to-date coverage is in the range of the districts of Kita and Bafoulabe.

** The percentages of TT vaccine for Niore are based on number of women of reproductive age (14 - 44 yrs), whereas the TT calculations for the project zone are based on the number of pregnant women, a much smaller denominator. This helps explain the considerable difference between the rates of coverage.

N.B. in cases where more than 100% coverage is reported it is generally assumed that the figures include children/women vaccinated more than once or rate are based on inaccurate census figures.

TABLE 3.11
VACCINATION COVERAGE
THE CONTROL DISTRICT
District of Nioro of the Sahel
Region of Kayes

YEARS	Number of Children Vaccinated ages 0 - 6 years							
	BCG*	Meas*	DTP/Polio*			TETANUS TOXOID**		
			1	2	3	1	2	Booster
1986	2163	3014	3424	2175	2167	453	223	-
1987	848	626	881	2732	2493	689	514	1
1988	6904	9047	6981	3777	506	964	550	16
1989	12787	13731	12985	6218	8269	1665	886	115
1990	11189	10930	11782	6941	5041	4100	1687	420
TOTALS	33891	37348	36053	21843	18476	7871	3860	552
RATES	115%	152%	122%	74%	62%	29%	14%	2%

Est. 1990 population 134,005
* children 0-6 years = 29,481
@ children 1-6years = 24,522
** women of reproductive age = 26,619

NB. figures supplied by the National Immunization Center

TABLE 3.12

VACCINATION COVERAGE

District of Kita

Region of Kayes

YEARS	Number of Children Vaccinated ages 0 - 6 years							
	BCG*	Meas@	DPT/Polio*			TETANUS TOXOID***		
			1	2	3	1	2	Booster
1988	23358	20346	21781	10335	5647	1984	594	
1989	19511	15667	18180	17412	10840	3892	2564	-
1990	11873+	10140+	11491+	2956+	1368+	2865+	598+	5
TOTALS	54742	46153	51452	30703	17855	8741	3756	5
RATES	103%	100%	97%	57%	33%	77%	33%	0

* total population children 0-6 - 52,997
 @ total population children 1-6 - 45,763
 ** total population pregnant women - 11,320

NB. + these figures are for 10 months of the year. The June 1990 report had been misplaced and the data for December had not yet been calculated, therefore the actual coverage will be somewhat higher than indicated here.

TABLE 3.13

VACCINATION COVERAGE
District of Bafoulabe
Region of Kayes

YEARS	Number of Children Vaccinated ages 0 - 6 years							
	BCG*	Meas@	DTP/Polio*			TETANUS TOXOID**		
			1	2	3	1	2	Booster
1988	4924	5440						-
1989	13214	11634	18668*	12642*	9147*	2447*	1118*	
1990	20699	17775	19901	9542	10411	1638	5486	
Totals	38837	34849	38569	22184	19558	4085	5604	
Rates	119%	137%	118%	68%	60%	61%	83%	

* total population children 0-6- 32,600

@ total population children 1-6 - 28,160

** total population pregnant women - 6,702

NB. Figures provided by the District Health Center.

There are 8 sub-districts in the district. Of these, 5 sub-districts had been completely covered, 2 had been partially covered and 1 had not been covered at all

TABLE 3.14

VACCINATION COVERAGE

District of Kenieba

Region of Kayes

YEARS	Number of Children Vaccinated ages 0 - 6 years							
	BCG*	Meas@	DTP/Polio*			TETANUS TOXOID**		
			1	2	3	1	2	Booster
thru 3/89	11630	10006	11834	2746	1658	1409	240	-
4/89- 12/89	+	+	+	+	+	+	+	+
1990	3907	3461	3377	2124	983	2683	1463	89
Totals	15537	13467	15211	4870	2641	4092	1703	89
Rates	67%	67%	66%	21%	11%	76%	31%	.1%

* total population children 0-6- 23,054

@ total population children 1-6 - 19,915

** total population pregnant women - 5,354

+ Data for this 9 month period were inadvertently omitted from the study. Given the vaccination levels in the other two project districts, and the fact that vaccination campaigns were carried out during this period, it is safe to assume that the actual vaccination coverage for Kenieba is more in the range of Kita and Bafoulabe Districts.

Despite this support, the rates of vaccination cannot really be regarded as an achievement of the project. Certainly, if the rates were higher in the project zone, one might speculate that the awareness raising efforts organized by the project had increased turnout at the vaccination campaigns. Unfortunately, the figures show no significant differences between the control district and the project area.

4. RECOMMENDATIONS

4.1 General Recommendations

Many of the weaknesses and situations that were identified during this study for which we would have recommended alternative strategies, have already been recognized by project staff and other consultants and the solutions incorporated into the Staff Appraisal Report for the Second Health, Population and Rural Water Supply Project. (In fact the report itself is an improvement over the 1983 Staff Appraisal Report, as it is far more detailed and comprehensive.) To avoid too much repetition, this section will limit itself to recommendations that have not, to our knowledge, been made previously and ones that we feel are worth reinforcing.

A. Supervision

Actions on several fronts can be taken to help address the crucial issue of supervision. At the central level, each of the agencies participating in the project (ie. UNICEF, USAID, MMB, etc) should select a project coordinator from among their personnel. These coordinators should form a PCU supervisory committee, and on a quarterly basis review project implementation with specific focus on the actions of the PCU. In this way, the PCU would not just respond to the Bank, but would be accountable to each of the project donors as well. This type of supervision would be more geared toward troubleshooting and problem solving than, say, the more finance-oriented by-annual audits that the World Bank proposes.

With regard to training, a practical course, generic in nature, and suitable for all levels of health personnel and even village level committees, should be developed on Supervision. This course should be mandatory for all levels of supervisors and offered to such groups as the sector Management Councils and Executive Boards. To this end the Community Development Technicians should be given a training of trainer's course so they in turn can train supervisors.

A practical study should also be conducted to determine the exact supervisory needs at all levels. This study should identify and review the supervisory responsibilities of each person concerned (ie. from national to village level), the tools used to carry out supervisory visits and the time, materials, other resources, conditions and funds required for each person (group) to supervise effectively. Armed with this information, the study should then cite weaknesses and ways to strengthen the system. Lastly, but most important of all, the study would investigate the different ways to locally ensure (financially and otherwise) regular effective supervision.

One possible solution would be to designate a portion of local taxes (local development tax) for this essential activity. This would mean that the Local Development Committee, who control these funds, would need to be convinced of this need and given some means of assurance that the funds are indeed spent as intended.

B. Training

A review of the training courses, workshops, seminars, retraining sessions financed by and carried out under the Health Development Project should be conducted to determine the training needs of the follow on project. This study would include a review and evaluation of the course content (curriculum), the training methods, the qualifications of the trainers, and the overall impact of the training on the implementation of the project. The appropriateness of the courses (participants, content, methods, timing etc.) should also be considered. The selection process would be reviewed as well to identify and review the selection criteria used. Identification of the various strengths and weaknesses of the various aspects of training would lead to recommendations for training improvements for the follow on project, including suggestions for additional courses not offered under the first project.

As mentioned above, a practical course on supervision should be designed/adopted and offered to all levels of supervisors, starting with the PCU, and the various people from within the government implementing directorates.

As much as possible, all courses should be competency-based and practically oriented and each training session should have funds for follow-up built into the costs of the course. This is similar to but different from supervision, since it is done by the trainer, who may not be the supervisor, and is specifically geared toward verifying retention and correct application of the subject matter covered by the training course.

Special orientation "courses" should be designed and offered to the local leaders whose support of or participation in the project's activities would be useful or even essential. This would include sessions with the district major (commandant du cercle), the local development committee, and sector management councils and the executive board members. The latter two groups would also need special training in implementing cost recovery schemes including ways to determine fees for services and other prices.

C. Project Management and Implementation

Background:

In the Second Health, Population and Rural Water Supply Project, Regional and District Health Teams (RHT/DHT) would be formed to manage the activities in their respective areas and make sure that the annual program plans of each center in its jurisdiction are carried out. This system is quite similar to the structure which existed under the Health Development Project (HDP), except that the RHT is taking over for the LPCU, and the Technical Committee is called a District Health Team. While this new set up was probably devised to address the "Parallel Entity" problem described in section 3.1, it's chance of success is slim, due to the weaknesses inherent to it.

First of all, the Technical Committee (TC) was not very effective in carrying out its tasks, particularly with regard to overseeing and supporting the different activities at the sub-district and sector levels. The mission learned that the various TC members knew very little about what was happening in the various centers under its supervision and that supervisory visits were infrequent and ineffectual. The TC's explained that their regular responsibilities at the health center often prevented them from carrying out their tasks as TC members vis-a-vis the sub-districts and sectors. More importantly, the TC depends on the District Doctor (Medecin Chef) to direct them, and even if the TC members are motivated, capable and available, they are obliged to wait for the doctor to organize field visits etc. He, himself, is frequently overtaxed, preoccupied, absent or otherwise unable to organize the work of the Technical Committee.

In the HDP, the LPCU, whose sole raison d'etre was the support of the field activities of the project, sometimes compensated for the inadequacies of the TC by directly supporting the sub-district and sector health centers and their staff. Unfortunately, in the second project the Regional Doctor will bare the brunt of the responsibility for overseeing project implementation and will not have the luxury of having this as his only task. In all likelihood the Regional Doctors will find themselves too overextended to carry out their responsibilities toward the project in an effective, efficient manner.

In recognition of this fact, the Second Project has foreseen the need for qualified accountants in each of the five regions as well as five full time project advisors. These advisors, to be provided by UNICEF and the Kingdom of Belgium (see Section 3.18 of the November 1990 Staff Appraisal Report) will help "build regional capacities and establish the mechanisms needed to effectively support District health operations".

Recommendation:

In order to make these advisors as effective as possible, they should be given full recognition as the Regional Doctor's assistant in implementing the project and should be designated as chief coordinator of the RHT and accorded the authority and resources (vehicle, support staff, possibly, operating funds) necessary to ensure the effective functioning of the RHT and the DHTs. The relationships and responsibilities should be well defined and officially recognized in the agreements between the various donors (UNICEF etc.) and the GRM.

4.2 Financial Sustainability

A. Maintaining the Cost Recovery Schemes

As Tables 3.1 and 3.2 (section 3.2.1) show the rates of cost recovery at both the district health centers and the community health centers is quite high (between 76% - 100% for 1990), with the majority of the following costs being covered by the cost recovery schemes.

Costs covered by the Cost Recovery Schemes

- drugs for in-patients
- office supplies
- maintenance supplies
- "combustibles
- travel (drug procurement related)
- some fuel
- some vehicle maintenance
- salaries*

* CHC only

As successful as the CRSs have been in covering certain operating costs, one must not lose sight of the fact that there are many other costs involved in supporting a district health center. The contribution of the CRSs, while important, are only the proverbial drop in the bucket by comparison. The following figures taken from the Kita DHC for 1990 shows the relative contribution of the CRS to the whole.

<u>Source of Funds</u>	<u>Value (cfa)</u>	<u>Percentage</u>
CRS revenues	5,672,990	13%
MOPHSA salaries/oper.	25,990,436	58%
Twin city partnership	4,167,200	9%
Raoul Follereau	330,000	1%
Local Devel. Committee (tax)	2,250,000	5%
World Bank Project	<u>6,246,885</u>	<u>14%</u>
	44,657,611	100%

The mission found no reason to doubt that the rates of cost recovery would not remain the same or even improve as drug sales increase with the reduction of prices and increased availability of essential drugs (assuming the implementation of the Bamako Initiative).

B. Recommendations

The period following the termination of a project is very crucial, particularly if the level of funding has been substantial with many recurrent costs having been supported by the project, as is the case with the World Bank funded, Health Development Project. Although the CRS have been quite successful, there are still many recurrent costs that the schemes do not cover. Therefore, to make the health centers more sustainable, financially, health authorities need to:

- 1) continue to test new strategies to improve the quality of health care and extend health service coverage. Statistics show that currently the majority of patients, at both the DHC and the CHC levels, come from the village in which the health center is located.
- 2) investigate alternative means of raising support funds for the centers, such as health card sales, family membership, community income generating activities, etc.
- 3) improve financial management capacity of the health staff and community representatives by providing them training in financial management, budgeting and programming.

4) develop guidelines for setting user fees. At present prices are set arbitrarily. Rather, price setting should take into consideration the operating costs of the center as well as the population's willingness and ability to pay.

5) to facilitate programming and financial planning, identify the financial resources (MOPHSA, local government, external donors, population), determine their contribution and assign to each the responsibility of covering certain costs, or a percentage of the whole. Take steps to ensure that the repartition of financial support is respected by each of the donors.

6) increase and improve supervision of health staff at the national, regional, district, sub-district and sector levels.

7) advise community on how to invest the positive result of the annual financial situation (have a bank account and invest the money in small income generating projects, for example).

8) take steps to "officially recognize" the sector and its CRS (to protect them from misuse of funds, to allow the CHC pharmacies to benefit from the 15% discount at the PPM etc.)

9) consider sustainability issues in the design of projects, not just toward the end of implementation.

10) accelerate Bamako Initiative implementation.

11) accelerate the pharmaceutical reforms.

4.3 Sustainability of the Drug Supply

As we have shown, the issue of drug supply is very closely linked to the pharmaceutical reforms being made within the PPM and the implementation of the Bamako Initiative (BI). If the BI is implemented in practice as it is described in theory, then many of the drug problems which have plagued the health centers should be alleviated.

Not to put their eggs in one basket, however, the project has come up with several strategies for making drugs available at the peripheral levels, which if successful, will complement, even be enhanced by, the BI. These strategies include a variation on the drug sale agents discussed earlier and the establishment of a village pharmacy (the equivalent of a central medicine cabinet) equipped with simple first aid supplies and a few non-prescription essential drugs. These strategies are designed to be self-sustaining.

Other strategies for increasing drug availability include:

- legalizing the drug sale agents (or taking whatever steps necessary) so they can benefit from the 15% discount from the PPM.
- have health centers which receive drug donations notify the donors of the drugs they need. If unsuitable drugs are received make arrangements to exchange or sell the drugs using the proceeds to replenish stock of generic essential drugs.

With regard to the price of drugs, it is recommended that research into the impact of reduced drug rates on the CRS be conducted. Reduced drug prices will decrease revenues if sales do not increase proportionately. Furthermore, once the new price list is in effect, a policy regarding drug pricing for the old stock of drugs must be made.

4.4 Improving/Expanding Service Delivery

A. Supervision

The project staff of the HDP has suggested an alternative means of ensuring adequate supervision of sub-district and sector health center staff. This plan calls for designating one member of the district health team as "supervisor", giving him/her special training in supervision, the transport and operating budget necessary to supervise the peripheral levels of health personnel on a monthly basis. If this plan is implemented (or if supervision is otherwise improved dramatically), then the level of service delivery at the sub-district and community health centers will improve. For the most part, the CHC staff are capable enough and have the means to provide adequate primary health care services. Regular supervision would help maintain their motivation and level of competency through on-the job training.

B. Integrating MCH Services

Once the EPI has completed it's initial three vaccination campaigns in the project areas, maintenance of the vaccination levels should become one of the responsibilities of the CHCs. Likewise family planning services should be provided, not just in theory, but in practice. These activities have already been planned for in the Second Project, but detailed strategic plans for the integration of these services have yet to be worked out (to our knowledge). Preparation of these strategic plans, allocation of resources and training should be a priority for the ministerial directorates concerned and Regional Health Teams.

C. Up-Grading MCH Services

The Regional and District Health Teams along with the ministerial directorates concerned, should also look into the barriers and constraints that have resulted in such low numbers of post-natal and well-baby consultations as well as the lack of ORS packets. Strategies for improving these services should be devised and progress in implementing solutions, closely monitored. The provision of oral rehydration solution packets should also be ensured.

Awareness raising of Sector Management Councils should be reinforced to make certain that the sector leaders are aware of the services that the CHC should be providing and the benefits that these health services can bring. Awareness raising should not be limited to the start-up phase of "sectoralization" but should be conducted by the Community Development Technician of the DHT on an on-going basis.

5. SUBSTANTIVE ISSUES FOR PID MODIFICATION - Advice and Counsel

In light of the information gathered in the field and an enlightened understanding of both the Health Development Project and the Second Health, Population and Rural Water Supply Project, the Mission consultants offer the following suggestions regarding modifications to the Project Implementation Document.

5.1 World Bank/AID Strategic Framework

The PID and/or the PP needs to firmly and clearly define the working relationship (strategic framework) between AID/Mali and the Bank's implementing/monitoring body, the Project Coordinating Unit (PCU). To "assume" this relationship would only lead to miscommunication and conflict, similar to that which plagued the PCU and LPCU's relationship with the Government's implementing bodies in the first project.

AID will want to be more involved in the project, at least certain aspects of it, and AID's monitoring and reporting requirements can not be satisfied by taking the "hands off" posture the Bank assumes. The World Bank and the PCU should be made aware of AID's operating procedures and the various roles AID wants/needs to play in all aspects of the project. These should be detailed in the PP. One of the possible means of structured involvement, suggested in the Recommendations Section, 4.1 - Supervision, calls for the AID project coordinator to join a committee of other donor agency coordinators in supervising the PCU. Other such relationships or means of interacting with project implementers need to be identified and described.

5.2 CHPS LogFrame

AID/Mali wants to be considered a full partner in the Second Health, Population and Rural Water Supply Project and this collaborative attitude is very positive. Certainly if AID plays an active role in project monitoring and facilitates implementation efforts, the entire project will benefit disproportionately to AID's financial input.

Nevertheless, AID is funding three distinct components of the entire project which are characterized by their own objectives, indicators, outputs and inputs. These logframe elements need to be written up as the framework of the AID-funded portion of the World Bank project and used to monitor and evaluate the CHPS project. The AID monitoring and evaluation requirements (SAPR) demand that indicators be established which correspond to the AID-funded activities, even if these represent only a fragment of the whole larger project. Developing a separate logframe for the CHPS project does not mean that AID doesn't recognize the broader overall objectives of the WB project, nor does it preclude AID/Mali from participating in monitoring and/or evaluating activities.

ANNEX I

Attachment A

Terms of Reference

Background:

USAID/Mali is proposing to fund a major portion of a new primary health care project (PDS-II) designed by the World Bank, USAID, and the Mali Ministry of Health. The Mission submitted a Project Identification Document (PID) to AID/W in September, 1990. The AID/W review committee requested additional information be provided in a revised PID document. The information requested included a discussion of the experience of the ongoing World Bank funded PDS-I project currently being implemented in the Kayes Region of Mali, including the major strengths and weaknesses; recurrent costs and cost recovery experience; success of the community pharmaceutical component in making essential pharmaceuticals available to the community at an affordable price; measured impact if any on under five mortality; support provided to national immunization, oral rehydration, and MCH/family planning programs, and the possibility of replication of the project model on a greatly expanded scale. USAID/Mali seeks to hire two consultants for a four week period to collect information and prepare a report that responds to these issues.

Methodology:

The consultants will start with a short team planning meeting to review the scope of work, detail tasks and responsibilities, decide on the team leader and prepare an outline of the final report to present all this to the Project Committee. They will next conduct interviews and document reviews with USAID, World Bank, and MOH officials in Bamako. They will then visit all three regions covered by the existing PDS-I project and particularly the three pilot community health centers to collect information and conduct interviews with local project and community officials. They will then return to Bamako and prepare a draft report in English and/or French for discussion with USAID. Following these discussions, the team will incorporate USAID requested additions or changes into a final report and submit it to USAID. Transportation, secretarial, computer, and other logistical support will be provided directly by USAID or funded through the contracts where USAID facilities are unavailable.

Scope of Work:

The consultants will prepare and present a report in English to USAID which responds to each of the issues set forth in the Attachment which is part herein of this scope of work and specifically includes the following information:

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A) An overview of the major strengths and weaknesses of the ongoing PDS-I project in all three regions where it is being carried out, especially the pilot community health centers in Badiako, Darsalam and Selinkegny.

B) Presentation of recurrent cost and cost recovery statistics obtained from all three project sites including tabular and graphic illustrations. The team will access and record all of the recurrent costs encountered in each area of the ongoing project including the cost of medical supervision and backup services from the Cerele headquarters.

The report will then present all available information on costs recovered at the community level by the Project. Sources of cost recovery include client payments, community assessments, and locally generated tax revenues but do not include costs covered by the Ministry of Health or other GOM agencies nor costs covered by donors external to the community including the PDS-I project.

The team will then present their conclusions with supporting analysis on the question of the financial sustainability of the Project. Specifically, the team will include a calculation of the percentage of total recurrent costs that are currently being recovered by each community and present their views as to whether the MOH can cover any shortfalls on a continuing basis.

C) The team will collect and present data on the quantity, quality to the extent discernable, and monetary value of pharmaceuticals sold in each of the three community-run pharmacies. They will report the source of the pharmaceuticals, method of transport delivery, and calculate the cost of obtaining them including the costs of transportation and any discounts at a loss resulting from local MOH, PDS-I or PPM policies. They will compare these results to the prices which can reasonably be expected to result from the implementation of the Bamako Initiative and present their conclusions as to the viability of the system on an expanded basis.

D) The team will analyze all available service and vital statistics at the three project sites as well as one similar selected control community not currently covered by the project. The team will estimate if possible and document the effect of the project activities on under five and maternal mortality in the project sites.

E) The team will study and describe the role that each project area has played in supporting national MOH programs in vaccination against preventable childhood diseases, oral rehydration therapy for treatment of diarrhea, and MCH/family planning services. The team

will collect service statistics on number of vaccinations provided in the community areas covered by the project, percentage of infants under 23 months who are fully immunized as well as women of reproductive age provided with tetanus toxoid, number of cases of diarrhea in under fives treated with oral rehydration therapy, knowledge and acceptance of oral rehydration therapy within the communities, number of users of modern contraceptive methods, and estimated contraceptive prevalence of women in reproductive age. The team will analyze statistics at the Cerele level and in comparable regions outside the immediate project area and report on the extent of favorable impact the Project has had on the leading child survival indicators listed above.

F) The team will review and report on each of the other listed issues as experienced by the current PDS-I project.

G) The report will conclude with a lessons learned section and the team's recommendations to the Mission on the most effective ways to design and implement the proposed large-scale expansion of the existing PDS-I pilot model.

Timing:

The team will be contracted in November, 1990, and complete all work prior to December 22, 1990.

Qualifications:

The team members may be either English or French native speakers. One consultant will be experienced in health care financing and cost analysis. The other consultant will have experience with AID and other donor funded primary health care projects at the community level. Graduate degrees in the health or social sciences are preferred. Consultants must be locally available to complete the work in the allotted time frame.

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LISTING OF SUBSTANTIVE ISSUES

The concept of the CHPS project is a potentially innovative way to improve and expand the delivery of Health and Population Services in Mali within the constraints of limited USAID resources. Current project documents however, are focused on planned project activities and do not provide a descriptive analytical framework for the project design that supports the mission's decision to participate in the multi-donor World Bank (WB) project in the absence of this framework, it is difficult to comprehend how the CHPS project relates to current USAID Health and Population Projects and the proposed WB effort and, most importantly, how the multi-donor effort will improve Mali's extremely poor health status. At this point, the rationale for USAID/Mali's participation in the broader WB project is not yet explained and justified. A discussion of the WB's first Health and Population (H/P) project experience especially in terms of cost recovery is necessary in the development of a strong rationale for designing an AID project supporting the WB second H/P project. In addition, project documents do not fully address financial issues for the health sector, and equity of coverage by the project. These appear to be major issues for the project design.

1. Overall issues: Current Project Documents do not outline a strategy for USAID Health and Population (H/P) activities, or provide an analytical framework to illustrate how the CHPS Project will interface with WB efforts to improve and expand health service delivery in Mali. An expanded discussion of the strengths and weaknesses of Mali's health system and of previous foreign assistance programs in Health and Population is needed. Further, considering the problems of the past and current USAID funded H/P efforts in expanding services, elaboration in the following areas is needed on why the CHPS project has a better chance for success than those efforts.

A. Project coverage and equity issues: The five regions in Mali selected by the WB contain about 5.1 million people or 67 per cent of Mali's population. The WB project identifies to be served by the Community Health Centers. WB project indicators relate to these 1.4 million beneficiaries who represent 18 per cent of Mali's total population or about 27 per cent of the project target population.

The CHPS PID also focuses on services to be provided to the 1.4 million beneficiaries while making general references to the fact that CHPS will serve the other 73 per cent of the project area population as well as other populations beyond the project area. The PID however provides little detail of this coverage beyond programs for information, education, and communication (IEC) and social marketing for contraceptives which are expected to have national impact.

Mali has the highest under 5 mortality rates in Africa, and the second highest in the world. As the WB project is intended to be the major Health and Population Initiative for USAID and other donors over the next decade, the project design must consider efforts that will provide broader coverage to impact on the under 5 mortality rates. For example, in limiting the number of beneficiaries to the 1.4 million population, the output indicator of 60 per cent of children immunized in this area would represent about 10 per cent of children in a country that only has a 5 per cent national immunization rate at present.

The small number of direct beneficiaries for a 54.6 million dollars project raises questions of economic feasibility and equity which are not fully addressed. The PID provides little evidence that the other 3.7 million population in the project area receive adequate health care and does not explain how this population will benefit. Equity issues related to the capacity of poor communities to qualify for Community Health Centers (CHC) under the competitive criteria set up under the WB project, and the ability of the poor to pay for services in cost recovery programs need to be addressed.

B. Project logframe: This issue relates to the wholesale adoption of the World Bank purpose, outputs, and indicators for the project logical framework i.e. is it appropriate for the CHPS project in view of the project strategy/coverage issues? As noted previously, the magnitude of the output indicators and the number of direct beneficiaries raise economic feasibility/cost effectiveness issues considering the total cost of the multi-donor project and Mali's health needs. There is also a higher than average risk that service delivery will not be fully established in the 120 Community Health Centers in six years, given the complexity of the activities, and the GRM's track record. Under these circumstances the indicators, which have been questioned by some project Committee Members as being unrealistic in the project time frame, may not provide any significant measurement at the end of the project. The logical framework should reflect intermediate outputs and indicators related to USAID inputs in the total project region that are measurable and within AID's manageable interest to achieve over the life of project.

The Project Proposal needs to do the following:

(A). Develop a descriptive analytical framework which clearly describes Malian Health and health system problems; and how CHPS project will interface with the World Bank multi-donor project to address these problems. A strategy should be developed within this framework which provides a comprehensive view of the CHPS project activities at all levels of service in the five project regions and an overview of how this project relates to the total Malian Health Sector. The strategy should address how the CHPS project activities will impact on the major causes of under 5 mortality. This discussion should go beyond training and address how CHPS will support the management and implementation of immunization, oral rehydration therapy, and maternal care programs in addition to Population/Family Planning Services at the different levels of service extending to the Community Health Centers and the target population serviced by these centers.

(B). The strategy should also discuss the rationale for coordination with the WB; the strengths and weaknesses of the first WB project in Mali; and those of previous and ongoing USAID projects. The mission should also expand on why the multi-donor activity may be more successful than other alternatives. At this point, AID/W is unsure of the rationale for the broader WB program and requests mission to objectively assess this program in light of the issues raised herein. During PID revision mission should seriously consider revising the logical framework to develop purpose and output indicators that reflect the activities of the CHPS project revised pursuant to this guidance.

ISSUES/CONSTRAINTS
(C). Expand the discussion on issues, risks, and constraints. The parallel but co-dependent nature of the WB and CHPS projects requires an in-depth examination of potential risks and constraints at the PID stage to identify issues to be addressed in the final project design. These include:

→ (1) Issues for financial and economic analyses: Health and Population Projects are generally not subjected to economic rates of return analyses as it is very difficult to relate these activities to economic growth goals. We request however, that the revised PID provide preliminary indications of economic benefits and project sustainability. Issues to be addressed in the revised PID should include: recurrent costs and cost recovery; GRM health sector budget allocations; MOHISA/GRT recurrent cost support for decentralization; drug supply and financing; and health manpower training and employment in the public and private sector.

(A) Recurrent costs/cost recovery: The discussion of the estimated increase in GRT/MOPSA recurrent costs and a parallel increase in funds from cost recovery over the life of project should continue to be identified. As the establishment of an effective cost recovery system is identified as one of the major risk areas by the WB, the issue of increased MOPHSA recurrent costs without sufficient or timely cost recovery needs to be addressed.

(B) The Malian health budget allocation also needs clarification: The mission action plan has established a health sector benchmark of a 9 per cent GRM health budget allocation by 1993, which represents a 2.5 per cent increase in just three years. How will the GRM provide this increase? How does this increase relate to the goals in the mission program log frame and the PRED goal to decrease GRM expenditure as a percentage of GDP from 30 percent to 20 percent by 1996?

(C) Essential drug supplies: The success of the cost recovery effort as well as improvement in health service delivery is dependent on a regular supply system for affordable essential drugs. The latest WB project document calls for major reforms of two inefficient pharmaceutical parastatals in Mali to import and distribute the drugs for the project. This appears to be a high risk venture with strong implications for the cost recovery efforts that needs to be addressed in the revised PID.

(D) Equity: The Project Proposal needs to respond to the issue of devoting 54.6 million dollars, which represents most of A.I.D and other donor health funding over the next decade, to a project that is expected to have a direct impact on only 1.4 million beneficiaries or 18 per cent of Mali's population.

2. Concerns

The following concerns were expressed during the issues meeting and are included for consideration in planning for the project design.

A. Definitions of project interventions: The nature and scope of the CHPS interventions are not clear, although the Family Planning/Population interventions were more clearly defined than the "Family Health" interventions. With Mali's high under 5 mortality, the project design needs to address essential Child Survival (CS) interventions such as immunization and oral rehydration in a direct way and address strategies for more effective delivery of CS interventions. In addition, Project Document does not provide a discussion of vertical interventions for Child Survival in the PID as alternative strategies. In a country with Mali's low coverage, some consideration needs to be given to more direct means of intervention for CS services.

B. Project design research: The committee supports the studies now being undertaken prior to the finalization of the PP design. The project committee recommends that an in-depth institutional analysis of MOPHSA be undertaken prior to completing the project design given the past problems the Mission has had in developing workable lines of authority, and MOPHSA's poor performance in managing service delivery.

C. Health personnel training and deployment: Training is a major area for analysis preparatory to the project design. A.I.D. has invested considerable resources in health sector training in Mali over a number of years without much impact on the provision of health services. CHPS again emphasizes training, and the issues section acknowledges potential implementation problems. The potential of the CHPS project to improve health service delivery in Mali through additional training over the next six years is not convincing.

The Project Document should provide some assessment of training in Mali, responding to the following issues:

- Are health personnel who have been trained implementing programs?
- Are there serious barriers to implementation that prevent trained health personnel from performing effectively that need to be addressed in the project?
- Should the centrally funded contractors be asked to emphasize implementation more?
- Are the training modules for Child Survival and Population/Family Planning being integrated into basic medical and Nurse/Midwifery programs so that health personnel graduate with the training needed for effective performance in community programs?

D. Family health fund: The types of activities being considered for the family health fund are quite broad. This could lead to the support of activities that are not relevant to the project's Health and Population goals if the fund activities are not well developed and sharply defined during the PP design. The development of the criteria should also provide clear guidelines for selection, monitoring, and evaluation of the Grants to facilitate mission management.

Annex 2

Schedule of the Fact Finding Mission

November 28 - December 8, 1990

literature review;, questionnaire preparation; field trip planning; interviews with Bamako-based people.

December 10 - 19, 1990

field trip to Districts of Kita, Bafoulabe and Kenieba

December 20 - January 7 1991

data analysis; addition data gathering; preparation and submission of draft report.

January 8 - 10, 1991

AID reviews and comments on report.

January 11 - 14, 1991

final report prepared and submitted to AID

Annex 3

LIST OF PEOPLE ENCOUNTERED

BAMAKO

AID:

George Thompson
Neil Woodruff
Dennis Brennen
Richard Byess
John Breslar
Tata Sangare

Project Coordinating Unit:

Abdel Kader Sidibe

World Bank:

Monique Garrity

National Immunization Center:

Ibrahim Koulibali
Bennatia Zitouni

KITA

Local Project Coordinating Unit

Dr. Togola
Michel Gody
Adama Traore
Messoum Guindo
Abdoulaye Ganobe

Technical Committee (District Health Center Staff):

Dr. Diakalia Kone - Head Doctor
Zoumana Kane - nurse
Oussouby Fallaya Kouyate - Community Development Technician
Boubou Sidibe - Sanitation Technician
Ousamane Traore - ATS Laboratory
Kante Fatou - nurse - MCH division
Kane Assa - TAS Social Service
Sy Mariam Kamena - technician- pharmacy
Keita Hadiara - general medicine
Doumbia Kadiatou - midwife
Abdoulaye Dembebe - ATS consultation annex
Abdoulaye Ganaba - manager/accountant
Oumar Diakite - CSA central/statistics

KOKOFATA

Sub-District (Arrondissement) Health Center:

BRahima Traore - Chef de Poste

BADINKO (in the District (Cercle) of Kita)

Executive Bureau:

Fassirima Keita

Founike Keita

Baboy Kouyate

Mozou Koulibali

Balla Koulibali

other observers:

Abdoulaye Diakite

Malick Sangare

Flani Diakite Bolli Keita

Badinko Community Health Center Staff:

Mamadou Diarra - Nurse

Awa Diakite - midwife

Niaga Traore - midwife

Amadou Guido - assistant nurse

Amadou Kebe - pharmacist

BAFOULABE

Technical Committee (District Health Center Staff):

Mamadou Mamore Traore - Head Doctor

Issa Ouattara - Community Development Technician

Mamadou Canara - Health technician

Bandjougou Diallo - major

Ousmane Danioko - MCH agent

Sounko Diarra - Health technician - sub-district health center head

Mamadou Dembele - pharmacist

Mamadou Gustave Dembele - Grd. Endemics service

Diallo Diallo - nurse

Youba Begayoko - accountant

Selinkegny:

El Hadji Sekou Diaby - Village Chief

Executive Bureau:

Mamadou Idrissa Diaby
Mamajdou Dansokho
Mamadou Madiheridiaby
El Hadji Yacoumba Diab
Bacou Diaby

Community Health Center Staff:

Souleymane Sidibe - nurse
Nadia Assa Diaby - assistant nurse (aide Soignant)
Coura Diallo - midwife

KENIEBA

Technical Committee (District Health Center Staff):

Lansana Kaita - Head Doctor
Cheikou Oumar Ba - community development technician
Cheikou Oumar Magassoube - Head of MCH
Daouda Seyba - Head of Pharmacy
Lansana Koulibay - statistician
Boubacar Sidibe - Head of Hygiene Service
Samba Macalou - Accountant

FALEA

Sub-District Health Center:

Issa Diakite- Health Center Head

DARSALAM

General meeting with about 50 men from the entire village

Executive Committee:

Theirmo Ibrahima Diallo
Mody Ismaila Fofana
Theirmo Mbello Diallo
Mamadou Oury Mbelle Diallo

Community Health Center Staff:

Mouhamadou Fane - nurse
Boubacar Camara - assistant nurse and pharmacist
Goundo Nassago - midwife

Annex 4

Interview Questions

District Health Center Level

Technical Committee

1. Explain how you, as individuals, support the sub-district and community health centers?
2. What support in the way of supervision did you provide?
3. What difficulties did you encounter in supporting the S-D and CHC?
4. Explain the role of the CHC in supporting the national programs such as Family Planning, EPI, etc.
5. What were the strengths and weaknesses of the World Bank Project?
6. Describe the cost recovery scheme.
7. If the BI isn't implemented, what will be the impact on the project?
8. Based on your experience, what are your suggestions for the follow on project?

The Pharmacist

1. What drug procurement problems have you encountered?
2. Where do you procure drugs?
3. How many times in the year do you procure drugs?
4. Are the drugs in generic form usually?
5. What is your role vis-a-vis the village pharmacies and the CHC?
How do you supply them?
6. What needs to happen in the follow on project to improve drug availability and facilitate procurement?

The Accountant

1. What are the main problems you face in your job?
2. Are you responsible for the cost recovery scheme?
3. To what extent are costs related to hospitalization covered?

Community Health Center Level

CHC Staff

1. What are the services provided by the CHC?
2. What are the advantages and disadvantages of working in the CHC?
3. What are the suggestions you can give for the follow on project?
4. What do you think of the cost recovery scheme?

Sector Management Committee

1. What is your role vis-a-vis the CHC staff?
2. What problems, if any have you encountered and how have you solved them?
3. Are you satisfied with the services of the CHC?
4. How were the prices for services set?
5. How does the cost recovery scheme work? Are costs being covered?
6. What kind of training, if any, did the treasurer receive?
7. What are the strengths and weaknesses of the project?
8. What suggestions for the follow on project do you have?

Local Project Coordinating Unit

1. What are the strengths and weaknesses of the project?
2. Suggestions for the follow on project?

Mr. Abdel Sidibe of the Project Coordinating Unit

1. Under the PDS I, what responsibilities did the PCU have?
2. What difficulties were encountered in carrying out these tasks?
3. Whose responsibility was it to monitor and supervise activities? How was this done?
4. How many of the activities cited in section 2.11 -13 (PPM reform) of the Staff Appraisal Report were actually accomplished.
5. Could the project have functioned without the LPCU? What will be the structure in the follow on project? Do you think this strategy will work?
6. What were the main strengths and weaknesses of the project?

**Aspects du Projet PDS a recherche pendant
la visite sur le terrain**

- 1) En general, les points forts et les points faibles du projet.

- 2) Les Couts recourants a chaque secteur
 - les salaires du personnel du Centre de Sante Comm.
 - les couts des medicaments et leur gestions(transport) des medicaments au centre)
 - les frais lies a la supervision/formation continue
 - les frais administratifs de Centre de Sante Comm.
 - les frais lies au fonctionnement courant des service
 - les frais de maintenance des moyen de transport NA
 - les frais lies a l'entretien des batiments
 - les frais de fonctionnement de la chaine de froid NA

- 3) les sources et les montants de revenue a chaque secteur
 - les frais de consultations (tickets)
 - les prix des medicaments
 - les impots (development tax?)
 - cotisations communautaire?
 - autre (dons)

- 4) le pourcentage des couts (operationnelles) recourants couvert par chaque secteur

5) Possibilites pour couvrir toutes les couts
ou une plus grande partie.

6) Moyens pour reduire les couts recurrent

7) Les Medicaments

- Les quantites vendus a chaque secteur
- quality (la condition ?????)
- le valeur monetaire les medicaments
vendus a chaque secteur
- les sources des medicaments
- le moyen de transport des medicaments
aux centres
- les frais de transport des medicaments
- frequence des ruptures de stock des medicaments

8) Compare les prix de ces medicaments aux prix
des medicaments qui vont etre disponible sous
l' Initiative de Bamako.

Table 12, WB

9) Opinion sur viabilite du system d'approvisionnement
des medicaments.

L'impact du Project sur la Survie de l'Enfant

- 1) Taux de mortalite infantil (moins de cinq an)
et maternele dans chaque secteur
et dans une zone controle
- 2) Les statistques suivantes: (au niveau du cercle)
 - nombre de vaccinations dans chaque CSCom
 - pourcentage des enfants moin de 23 mois
completement vaccine
 - pourcentage de femme de l'age de procreation
vaccine avec TT
 - nombre de cas de diahree des enfants moins de
cinq ans traite avec le SRO
 - totale nombre de femmes dans le programme de
planning familial NA
 - nombre de femmes de l'age de procreation qui
utilisent un methode de PF NA
- 3) Compare ces statisques aux memes statisques d'une
region hors de al zone du projet.
- 4) Faire des conclusions sur l'impact du projet sur
la survie de l'enfant.
- 5) How have the activities in the test secteur supported
the preventive activities of the MOH?
- 6) Est-ce que on peut dire que ce projet est une success?
Oui/Non/inconclusive
Pourquoi/pourqoui pas?
selon quel critere?
- 7) Est-ce que ce projet peut etre generaliser de meme facon dans
120 CSCom en 5 regions?
- 8) Qu'est-ce que c'est la courverture du projet (population)?

Annex 5

Project Support of the Expanded Program for Immunization

Vaccin accumulateur autres Fournitures UNICEF	25,751,880
Ped-o-jet	15,905,000
chaîne de froid	17,820,575
vehicules	17,925,000
Materiels de Camping	2,513,480
Materiels et meubliers de bureau	643,950
Fournitures de Bureaux	5,343,310
Achat fut vide et frais de transport	376,500
Achat malles metalliques	190,000
Frais de Transport de manutention	418,350
Carburant et frais de expedition	260,300
alchol et coton	520,500
Frais d'installation 2 congelateurs	48,160
Formation (PEV) personnel	1,784,620
Per diem execution PEV	<u>3,181,000</u>
TOTAL	92,582,625

ANNEX 6

- -

STAGES DE PERFECTIONNEMENT

COUTS

(en F CFA)

Perfectionnement en Anesthésie/Réanimation à l'hôpital Gabriel Touré de 3 infirmiers de CSC en 1984	803.477
Perfectionnement en Ophtalmologie à l'IOTA de 2 médecins chefs de CSC en 1984	223.450
Perfectionnement en Ophtalmologie à l'IOTA de 9 chefs CSA en 1984	223.450
Perfectionnement en Chirurgie et Gynéco-obstétrique à l'hôpital du Pt.G. en 1984	384.477
Perfectionnement en Mécanique et Entretien de véhicules au garage Renault de 6 chauffeurs et de 3 médecins chefs en 1987.	145.640

TOTAL = 1.780.494

SEMINAIRES/ATELIERS SUR PLACE:

- En Santé Familiale à Kita et Bamako 2.111.985
9 infirmiers chefs CSA et 3 sages-femmes
et 1 IPC en 1984
- En Techniques d'Animation à Kita 307 membres 1.227.770
d'équipe d'animation composés de T.D.C., T.S,
chefs de ZAF, ATC, chefs CSA et Médecins chefs
CSC en 1985
- En Gestion de médicaments essentiels à Kita, 764.260
Bafoulabé, 18 dépositaires en 1985
- En Santé Familiale à Kita et Bko 12 infirmiers 2.484.500
chefs CSA , 3 sages-femmes et 2 IPC en 1985
- En Prescription de médicaments en DCI et sur 1.102.450
l'utilisation de manuels et formulaires,
thérapeutiques à Kita, 29 participants composés
de Médecins, Pharmaciens, Infirmiers CSC et
chefs CSA en 1986
- En organisation et supervision des activités de 1.325.790
SMI/PE à Kita 13 agents composés de Médecins,
infirmiers CSC, chefs CSA et sages-femmes en 1986
- En Information et Education pour la santé à 1.327.710
Kita, 59 agents composés de TDC, TS, chefs de
ZAF, ATC, chefs CSA et responsable de PMI et
Maternité en 1986.
- En Réforme pharmaceutique à Bko. 10 participants 310.360
comprenant Directeur et pharmaciens régionaux
Kayes, médecins et pharmaciens de la zone du Projet
en 1987
- Au cours supérieur FEV à Bamako. 4 agents composés 376.800
du Directeur Régional Kayes et des médecins chefs
de la zone du Projet en 1987
- En Recherche appliquée à Kita. 14 responsables de 2.821.440
Région de Kayes ce sont les Directeurs régionaux
de la région de Kayes, les médecins chefs et les
agents de l'ULCPDS en 1987

- En Formation du Personnel d'exécution PEV, 23 agents ce sont les médecins chefs, infirmiers des CSA et responsables PMI/Maternité 1.784.620
- En Formation des formateurs ASC à Kita, Bafoulabé Kéniéba 70 agents composés de médecins, infirmiers chefs CSA, sages-femmes, responsables de PMI/Mat et matrones rurales en 1987 2.574.470
- En gestion de médicaments essentiels à Qualia, 1 dépositaire 256.000
- Au recyclage des matrones, 18 femmes-responsables 940.200 des maternités rurales de Kita, Bafoulabé et Kéniéba en 1987
- En formation des AT de Kita, 64 femmes travaillant dans 32 villages de Kita, en 1987. 960.000
- En supervision cours de la formation ASC l'équipe de CSC de Kita, en 1987 191.500
- En formation de gérants de pharmacie villageoise de Kita 32 agents de 32 villages en 1987 486.345
- En formation des agents clés des BSA 147 secrétaires, 135, trésoriers 74 réparateurs de matériel à partir de 1986
- Formation en programmation budgétisation et suivi mobilisation des ressources locales. 27 agents de l'ODIFAD et de la Coopération depuis 1985. (Voir budget de ces deux derniers établissements dans le budget programme UICPDS)

<u>STAGES DE PERFECTIONNEMENT</u>	<u>COUTS</u>
- En supervision après la formation ASC, l'équipe de CCPDS en 1988	868.200
- En formation d'AT de Kita, Bafoulabé et Kéniéba 131 A.T de 66 villages en 1989	1.279.600
- En formation de gérants de pharmacie villageoise de Kita, Bafoulabé et Kéniéba 52 agents de 52 villages en 1989	1.130.400
- En supervision au cours de la formation ASC par les équipes de CSC du projet en 1989	666.400
- Séminaire sur la supervision et organisation de la consultation prénatale	432.750
	<hr/>
TOTAL SEMINAIRES ET STAGES DE PERF.	25.397.350

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FORMATION A L'EXTERIEUR :

- En Electromécanique à Lomé, le technicien de l'ULCPDS en 1986	1.043.000
- En Santé Publique à Bruxelles, le médecin chef de Kéniéba en 1986	4.690.000
- En Santé Publique à Bruxelles, le médecin chef de l'ULCPDS en 1986	1.305.600
- En Santé Communautaire à Lomé, 2 chefs CSA de Kita, Kéniéba en 1986	1.594.000
- En Santé Nutrition Economie Familiale à Douala, le TDC de Kita 1986	1.257.700
- En Santé Nutrition Economie Familiale à Douala, 3 chefs CSA Kita, Baf, et Kén en 1988	4.079.550
- En Santé Nutrition Economie Familiale à Douala, 2 chefs CSA de Bafoulabé et Kéniéba en 1989	3.182.972
- En Santé Publique à Bruxelles, le médecin de Bafoulabé en 1987-1988	4.799.900
- En Santé Publique à Bruxelles, le médecin chef de Kéniéba en 1988-1989	4.229.450
- En Gestion du Projet à Douala, le gestionnaire de CSC de Kita en 1988	2.686.281
- En Gestion approvisionnement en médicaments essentiels à Dakar, 3 pharmaciens de zones du projet en 1988	4.922.250
<hr/>	
TOTAL FORMATION A L'EXTERIEUR	33.790.703

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ANNEX 7

TABLE ..

PROPOSED DRUG REFORM MASTER PLAN

OBJECTIVE	PROPOSED MEASURES	DATE	RESPONSIBILITIES
A. MAKE ESSENTIAL DRUGS (E.D.) AVAILABLE	- FORMALIZE OFFICIAL LIST OF 109 E.D. (60 FOR THE DISTRICT LEVEL), INCLUDING CONTRACEPTIVES, AND BAN THE IMPORT OF EQUIVALENT SPECIALTIES	DISBURSEMENT CONDITION	MOPISA (DNPH)
	- CHANGE THE OUTPUT MIX OF UMPP IN LINE WITH THE E.D. POLICY	NOVEMBER 1991	MOPISA (DNPH)
	- DEFINE THE CONDITIONS FOR OPENING UP A MULTIPLE CHANNEL DRUG IMPORT AND DISTRIBUTION SYSTEM, DISCUSS WITH IDA AND IMPLEMENT IMMEDIATELY THE AGREED UPON RECOMMENDATIONS	NOVEMBER 1991	DNPH/CONSULTANTS
	- AT ALL TIMES, ENSURE THAT 55 OUT OF 80 E.D. ARE AVAILABLE IN THE DISTRICT DEPOTS (CRITERIA (C) IN PART III OF THIS ANNEX)	DISBURSEMENT CONDITION	PHARMACY DIVISION UNICEF
B. MAKE ESSENTIAL DRUGS AFFORDABLE	- PROCURE E.D. IN GENERIC FORM UNDER INTERNATIONAL COMPETITIVE BIDDING (ICB)	-DISBURSEMENT CONDITION	MOPISA (DNPH)
	- AGREE WITH IDA, AND APPLY, A PRICE FORMULA BASED ON THE BAMAQO CIF PRICE OF GENERICS PROCURED UNDER ICB, PLUS A MARGIN TO COVER DISTRIBUTION, THE OPERATING COSTS OF DEPOTS, AND A FIXED MARGIN ON QUANTITIES FOR PPM	DISBURSEMENT CONDITION	
	- DO NOT REVISE THE E.D. PRICE LEVEL MORE THAN ONCE A YEAR, FOLLOWING THE JOINT REVIEW WITH IDA	EFFECTIVENESS	.
	- AT ALL TIMES, MEET CRITERIA (A) AND (B) REGARDING THE BAMAQO ICB PRICE AND PPM'S MARGIN CRITERIA GIVEN IN PART III OF THIS ANNEX	EFFECTIVENESS	.
C. RATIONALIZE THE USE OF DRUGS	- ENSURE THAT THE PRESCRIBERS OF DRUGS ARE DIFFERENT FROM THE SELLERS	PROJECT YEAR 1	DNTs
	- TRAIN THE PRESCRIBERS IN PROPER E.D. USE BASED ON TREATMENT PROTOCOLS	.	
	- INFORM THE PUBLIC ON E.D. (PURPOSE, PRICING, ETC..)	AS COMHC OPENS	DNTs, RTHs, ...
D. IMPROVE THE EFFICIENCY OF PPM AND UMPP	- MONITOR AT THE COMHC, DMC, HOSPITALS LEVEL		
	- AGREE WITH IDA AND IMPLEMENT A DETAILED ACTION PLAN (CAHIER DES CHARGES), TO COMPLEMENT THE CONTRAT-PLAN, COVERING IN PARTICULAR: - PPM'S OWNERSHIP (TO REMAIN PUBLIC) - PPM'S MANAGEMENT (PRIVATE, PROTECTED FROM DAY TO DAY INTERFERENCE) - PPM'S GRADUAL WITHDRAWAL FROM RETAIL SALES (MODALITIES TO BE SPECIFIED) - PPM'S PERFORMANCE OBJECTIVES (SALES OF E.D., EMPLOYMENT, COSTS, ETC..) SPECIFIED	DISBURSEMENT CONDITION	MOPISA (DNPH)
	- AGREE WITH IDA ON AND IMPLEMENT A SIMILAR ACTION PLAN FOR UMPP, COVERING IN PARTICULAR: - THE MODALITIES FOR CHANGING UMPP PRODUCTION MIX - THE RIGHT OF DEPOTS TO PROCURE DIRECTLY FROM UMPP	DISBURSEMENT CONDITION	MOPISA (DNPH)
	- REVISE THE REGULATORY FRAMEWORK () INCLUDING THE MARGINS FOR PRIVATE PHARMACIES, IN A MANNER SATISFACTORY TO IDA	NOVEMBER 1991	MOPISA (PHARMACY DIVISION)
E. ENSURE THE DEVELOPMENT OF A PRIVATE PHARMACEUTICAL MARKET			
F. REDUCE DEPENDANCE ON A SINGLE SOURCE OF DRUG SUPPLY	- DEFINE THE CONDITIONS FOR OPENING UP AN OPEN, MULTIPLE (DRUG CHANNEL) IMPORT AND DISTRIBUTION SYSTEM	PROJECT YEAR 1	MOPISA/CONSULTANTS
G. ENSURE THE IMPLEMENTATION OF THE E.D. POLICY	- STRENGTHEN THE PHARMACY DIVISION TO ENABLE IT TO COORDINATE, MONITOR AND EVALUATE IMPLEMENTATION OF THE E.D. POLICY - USE UNICEF FOR ADDITIONAL CONTROLS	DISBURSEMENT	PHARMACY DIVISION

TABLE ..

PROPOSED DRUG SUPPLY SYSTEM

LEVEL	STOCK	PRICING	MANAGEMENT	CONTROL	REPLENISHMENT
COMHC	ONE YEAR SUPPLY OF E.D. (30 CENTS/PERSON)	SET BY HEALTH COMMITTEE	HEALTH COMMITTEE (WILL RECEIVE TRAINING)	NURSE AND TREASURER	- FUNDS DEPOSITED IN BANK - REPLENISHMENT FROM PPM DISTRICT DEPOTS OR PRIVATE SUPPLIERS
DISTRICT	DISTRICT DEPOTS = ONE YEAR INITIAL STOCK (30 CENTS/PERSON PLUS BUFFER STOCK 10 CENTS/PERSON AFTER 8 MONTHS)	UNIFORM COUNTRYWIDE, BASED ON AGREED PRICE FORMULA	MANAGEMENT COUNCIL (TRAINING)	NURSE AND TREASURER	- FUNDS DEPOSITED IN BANK - REPLENISHMENT FROM PPM CENTRAL DEPOTS
REGION	THE REGIONAL DIRECTORATES WILL FOCUS ON PLANNING, PROGRAMMING, ASSISTING THE DISTRICT IN MANAGING THE SYSTEM, TRAINING AND INFORMING AND INFORMING THE PUBLIC, ALL UNDER THE RESPONSIBILITY OF THE REGIONAL PHARMACIST. THERE WILL BE NO REGIONAL DEPOT, ALTHOUGH THE DISTRICT DEPOT IN THE REGIONAL CAPITAL WILL, IN SOME CASES, SERVE AS WHOLESALE POINT				
	TO PURCHASE PRIOR TO DISBURSEMENT, A ONE YEAR STOCK OF GENERIC E.D., UNDER ICB (USING EXISTING REVOLVING FUND OF US\$ MILLION)	CIF BAMAQO PRICE, SAME AS UNIPAC OR INTERNATIONAL DISPENSARY ASSOCIATION	MOPISA	DONORS' MONITORING GROUP, LED BY UNICEF	- FUNDS DEPOSITED IN BANK - YEARLY ICB PURCHASE BASED ON PROJECTIONS OF CONSUMPTION

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REPUBLIC OF MALI
SECOND HEALTH POPULATION AND WATER SUPPLY PROJECT

PROPOSED DISTRICT-BASED HEALTH CARE SYSTEM
ENTITY, STAFF, FUNCTIONS, INSTRUMENT

LEVEL	ENTITY	STAFFING	HEALTH CARE FUNCTIONS	COMMUNITY INVOLVEMENT	INSTRUMENTS
COMMUNITY	COMMUNITY HEALTH CENTER (COMHC) (AVERAGE 11 PER DISTRICT)	NURSE NURSE'S AIDE CLERK/PHARMACEUTICAL AIDE	PROVIDE BASIC HEALTH CARE PACKAGE - CURATIVE - VACCINATIONS - PNC - FAMILY PLANNING - HIV/AIDS - IDENTIFY COMHC STAFF - MEET WITH LOC ANNUALLY RE DHP - DISCUSS DISTRICT CONTRIBUTIONS TO COMHC PROGRAM	- LOCAL DEV. COMMITTEE - MANAGE THE COMHC - IEC TO PROMOTE SELF-CARE - OUTREACH TO IMPROVE RESPONSIVENESS TO LOCAL NEEDS	- CONTRACT WITH DISTRICT IN CONTEXT OF DHP - PROTOCOLS FOR DELIVERY OF HEALTH SERVICES - PERFORMANCE INDICATORS
SUB-DISTRICT (200 IN COUNTRY)	UNPAID COMHC (2-5 PER DISTRICT) UNDER THE PROJECT	SAME AS COMHC, PLUS ONE PRATICAL NURSE (IDE)	SAME AS COMHC PLUS: - LIMITED REFERRAL SERVICES E.G. - MICROSCOPIC EXAMS IDE: - RESPOND TO URGENT HEALTH CARE NEEDS OF POPULATION NOT YET COVERED BY A COMHC	- SAME AS FOR COMHC	- SAME AS FOR COMHC
DISTRICT (48 IN COUNTRY)	DISTRICT HEALTH CENTER (DHC) (1 PER DISTRICT)	15 - 20 STAFF	- DELIVER A MINIMUM PACKAGE OF REFERRAL SERVICES FOR THE ENTIRE DISTRICT INCLUDING: HOSPITAL SERVICES: - MEDICAL - SURGICAL - PEDIATRIC - GYN/GBS TECHNICAL SERVICES: - LAB & RADIO SPECIALIZED SERVICES: - DENTAL & OPTHOLOGICAL		- PROTOCOLS FOR PROVIDING PREVENTIVE AND CURATIVE CARE - PERFORMANCE INDICATORS - DISTRICT HEALTH DEVELOPMENT PLAN (DHP) - CONTRACTS BETWEEN COMHCs AND DHCs IN CONTEXT OF DHP - STAFFING PLAN, REPORTS - PROTOCOLS
	DISTRICT HEALTH TEAM (DHT)	- CHIEF MEDICAL OFFICER - DEPUTY MEDICAL OFFICER - FIN./ADM. OFFICER - PUBLIC HEALTH NURSE - PHARMACEUTICAL NURSE - 2 COMMUNITY DEVELOPMENT SPECIALISTS	- DEVELOP DISTRICT HEALTH DEVELOPMENT PLAN (DHP) - MANAGE DISTRICT HEALTH CARE SYSTEM, INCLUDING: - P & B - STAFFING PLAN - PROCUREMENT AND DISTRIBUTION ESSENTIAL DRUGS - TRAINING AND SUPERVISION THROUGHOUT DISTRICT - MONITOR PROGRAM ACCEPTANCE AND PERFORMANCE	DISTRICT HEALTH COMMITTEE: - IDENTIFY COMHC STAFF TO BE RECRUITED BY THE DISTRICT UNDER A LOCAL CONTRACT - INVOLVE THE GENERAL PUBLIC IN THE MANAGEMENT OF BASIC SERVICES AND THE COMMUNITIES IN THEIR FINANCING AND MANAGEMENT - INFORM PUBLIC ABOUT HEALTH CARE AND AVAILABLE SERVICES	- DISTRICT HEALTH DEVELOPMENT PLAN (DHP) - CONTRACT WITH COMHC AND BETWEEN COMHCs AND DHCs - STAFFING PLANS, REPORTS, PROTOCOLS
REGION (7 IN COUNTRY)	REGIONAL HOSPITAL (ALL REGIONS EXCEPT KOULIKORO)	20 - 50 STAFF	- PROVIDE FULL RANGE OF DHC LEVEL REFERRAL SERVICES		- FINANCIAL AUTONOMY
	REGIONAL HEALTH TEAM (RHT)	- DIR. OF PUBLIC HEALTH - CHIEF OF PUBLIC HYGIENE - CHIEF OF SOCIAL AFFAIRS - CHIEF OF FAMILY HEALTH (INCLUDING FP) - PHARMACIST - REGIONAL HEALTH ECONOMIST - MANAGER OF RESOURCES - HEALTH EDUCATOR (IEC SPECIALIST) - TRAINING SPECIALIST (PERIODIC SHORT-TERM)	- COORDINATE AND MANAGE PHYSICAL, PHARMACEUTICAL AND BUDGETARY RESOURCES FOR THE REGION - APPOINT MEMBER PD DHTS - REPLY STAFF (MIS) - MANAGE TRAINING OF IEC PROGRAMS - SUPERVISION OF PROGRAMMED ACTIVITIES AT THE DISTRICT LEVEL - REVIEW DISTRICT ANNUAL REPORT - RECOMMEND DISTRICT BUDGETARY ALLOCATIONS		- PERFORMANCE INDICATORS - MIS FOR CIVIL SERVANTS - PHYSICAL INVENTORY

CENTRAL	NATIONAL HOSPITALS MINISTRY OF PUBLIC HEALTH AND SOCIAL AFFAIRS (MOPSA)	90-100 STAFF	PROVIDE FULL RANGE OF TERTIARY REFERRAL SERVICES		FINANCIAL AUTONOMY
	<ul style="list-style-type: none"> - DAPRES DIRECTION NATIONALE DE LA PLANIFICATION ET FORMATION SOCIO-SANITAIRE - DNEP DIRECTION NATIONALE DE LA SANTE PUBLIQUE - DSE DIRECTION NATIONALE DE LA SANTE FAMILIALE - DAPPA DIRECTION NATIONALE DE L'HYGIENE PUBLIQUE ET DE L'ASSAINISSEMENT - DNAS DIRECTION NATIONALE DES AFFAIRES SOCIALES - DAE DIRECTION ADMINISTRATIVE ET FISCALISE - DNAS AND DAPPA INSPECTION DE SANTE (WITHIN DAPRES) - CEPRES CELLULE D'EXECUTION DU PROGRAMME DE RENFORCEMENT DES UNITS SANITAIRES - PROJECT COORDINATION UNIT - COORDINATION WITH OTHER MINISTRIES MEN (MINISTRY OF EDUCATION) RE SCHOOL OF MEDICINE AND PHARMACY, FEDERATION POLICIE (CIVIL SERVICE) RE (TRENDS IN EMPLOYMENT) 		<ul style="list-style-type: none"> - RATIONALIZATION OF SECTOR RESOURCES HEALTH SECTORAL PLANNING, P 1, 8 TRAINING, IEC AND PERSONEL ALLOCATION - DESIGNS AND IMPLEMENT TRAINING AND IEC - DESIGNS AND IMPLEMENT P, TRAINING AND IEC - TRAINING RELATED TO RURAL WATER SUPPLY - TRAINING FOR FAMILY PLANNING ACTIVITIES, WITH SIGNIFICANT SUPPORT FROM USAID - BUDGET MANAGEMENT - PERSONNEL MANAGEMENT - FINANCIAL ACCOUNTING - DEVELOP GUIDELINES FOR COMMUNITY MOBILIZATION BY THE DNT AND KEY ELEMENTS OF THE HEALTH EDUCATION STRATEGIES IN THE PROJECT REGIONS - CIVIL WORKS QUALITY CONTROL - LIAISE WITH DONORS - COORDINATE AND MONITOR PROJECT IMPLEMENTATION 		<ul style="list-style-type: none"> - OPERATIONAL WORKS/GUIDELINES - ANNUAL REPORTS - MOPSA BUDGET

SOURCE: MOPAS, 1989

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