

AGENCY FOR INTERNATIONAL DEVELOPMENT
PROJECT IDENTIFICATION DOCUMENT
FACESHEET (PID)

1. TRANSACTION CODE
A = Add
C = Change
D = Delete
Revision No. _____
DOCUMENT CODE 1

2. COUNTRY/ENTITY
Mali

3. PROJECT NUMBER
688-0248

4. BUREAU/OFFICE
USAID/Mali
A. Symbol AFR
B. Code 688

5. PROJECT TITLE (maximum 40 characters)
Community Health and Population Services

6. ESTIMATED FY OF AUTHORIZATION/OBLIGATION/COMPLETION
A. Initial FY 91
B. Final FY 96
C. PACD 97

7. ESTIMATED COSTS (\$000 OR EQUIVALENT, \$1 =)
FUNDING SOURCE LIFE OF PROJECT
A. AID DFA 12,900
B. Other U.S. 1. _____
2. _____
C. Host Country _____
D. Other Donor(s) _____
TOTAL 12,900

8. PROPOSED BUDGET AID FUNDS (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. 1ST FY 91		E. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) DFA				11,100		12,900	
(2)							
(3)							
(4)							
TOTALS				11,100		12,900	

9. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)

10. SECONDARY PURPOSE CODE

11. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)
A. Code _____
B. Amount _____

12. PROJECT PURPOSE (maximum 480 characters)
To increase the sustainability and effectiveness of family health service delivery in Mali.

13. RESOURCES REQUIRED FOR PROJECT DEVELOPMENT
Staff: PDO, 2 pm; HPN Officer, 2pm. PHC/MCH/FP Training Specialist, 1.5 pm; FP and IEC Specialists, 1.5 pm; Institutional Analyst, 1.5 pm; Health Economist, 1 pm; WID Specialist, 1 pm.
Funds Program Development and Support, \$100,000

14. ORIGINATING OFFICE CLEARANCE
Signature: [Signature]
Title: USAID/Mali Mission Director
Date Signed: MM DD YY 02 28 91

15. DATE DOCUMENT RECEIVED AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION
MM DD YY

16. PROJECT DOCUMENT ACTION TAKEN
S = Suspended
A = Approved
D = Disapproved
CA = Conditionally Approved
DD = Decision Deferred

17. COMMENTS

18. ACTION APPROVED BY
Signature _____
Title _____

19. ACTION REFERENCE

20. ACTION DATE
MM DD YY

MEMORANDUM

Date: 28 February 1991

To: John Hicks, Director, AFR/SWA

From: Dennis Brennan, Mission Director, USAID/Mali

Subj: The Community Health and Population Services Project (CHPS) (688-0248): Submission of the Revised PID

Attached please find the revised PID for the Community Health and Population Services Project (CHPS). Since the September review we have broadened our analysis of Mali's health and population sector with special studies and consultancies keyed to the issues and concerns expressed by the ECPR. The results directly address these concerns.

As you know, we are planning to obligate \$11.1 million this year for CHPS. To facilitate this obligation and ensure that Project Paper design goes ahead as planned, I would very much appreciate your scheduling the PID review at your earliest convenience.

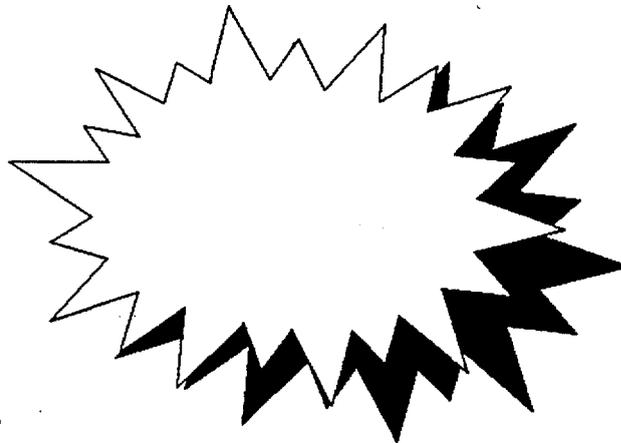
Thank you for your help. Best regards.

B

USAID/MALI
PROJECT IDENTIFICATION DOCUMENT
THE COMMUNITY HEALTH
AND POPULATION SERVICES PROJECT

688-0248

FEBRUARY 1991



**COMMUNITY HEALTH AND POPULATION SERVICES (688-0248)
PROJECT IDENTIFICATION DOCUMENT**

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ACRONYMS AND ABBREVIATIONS

AID	Agency for International Development
AMPPF	Association Malienne pour la Protection et la Promotion de la Famille
CERPOD	Centre d'Etudes et de Recherches sur la Population pour le Developpement
CFA	Communaute Financiere Africaine (FCFA)
CHC	Community Health Center
CPR	Contraceptive Prevalence Rate
CS	Child Survival
DHS	Demographic and Health Survey
DHC	District Health Center
DHT	District Health Team
DNAFLA	Direction Nationale de l'Alphabetisation Fonctionnelle et de la Linguistique Appliquee
DSF	Division de la Sante Familiale
EPRP	Economic Policy Reform Program
FHI	Family Health Initiatives
FSN	Foreign Service National
FP	Family Planning
FY	Fiscal Year
GDP	Gross Domestic Production
GRM	Government of the Republic of Mali
IDA	International Development Agency
IEC	Information, Education, and Communication
IFHAS	Integrated Family Health Services Project
IMF	International Monetary Fund
IPPF	International Planned Parenthood Federation
IUD	Intra-Uterine Device
JHU/PCS	Johns Hopkins University/Population Communication Services
LOP	Life of Project
M&E	Monitoring and Evaluation
MCH	Maternal Child Health
MIS	Management Information System
MOPSHA	Ministry of Public Health and Social Affairs
NGO	Non-Governmental Organization
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
PID	Project Identification Document
PP	Project Paper
PPM	Pharmacie Populaire du Mali
PRED	Policy Reform for Economic Development
PSC	Personal Services Contract
RHT	Regional Health Team
SOMARC	Social Marketing for Change
UMPP	Usine Malienne de Produits Pharmaceutiques
UNFM	Union National des Femmes du Mali
UNICEF	United Nation's International Children's Fund
UNIPAC	UNICEF Packing and Assembly Center
UNJM	Union National des Jeunes du Mali
USAID	United States Agency for International Development
USDH	United States Direct Hire
WHO	World Health Organization

Community Health and Population Services

I. PROJECT SUMMARY

Health conditions in Mali are among the poorest in the world. Only 20 percent of Malians have access to health services, most of which are concentrated in urban areas. One in four children dies before age five; those who live have a life expectancy of 47 years. Determined to turn this situation around, the Malian government has conceived and is beginning to implement a "Health for All" strategy that is grounded in the delivery of quality primary health care services. Key to its implementation is a recently issued National Health and Population Policy which focuses on expanding child survival and maternal child care nationwide, while at the same time integrating family planning services at all levels. Reinforcing this policy are critical macroeconomic and sectoral reforms that promote the continuous supply of affordable essential drugs, rationalize the use of health sector resources, decentralize health care delivery, and encourage private initiatives among health professionals.

Government and private resources cannot finance such an effort alone. For this reason the GRM has requested donors to put in place a program that would bring integrated family health care delivery to local communities, in the optic of increasing both the sustainability and effectiveness of Mali's health delivery system. Several donors have responded positively, agreeing to invest in the \$60 million World Bank-lead "Second Health, Population, and Rural Water Supply Project" (PDS-II). Through a comprehensive strategy that integrates policy, institutional and program reforms, this 7-year multi-donor effort will bring affordable decentralized quality health care to some 1.4 million Malians living in four regions and the District of Bamako. Key to its success is weaving the components of primary and maternal child health, voluntary family planning, and potable water systems into a strategy anchored in population-based planning, community participation and empowerment, and the separation of primary care, referral care, and management functions.

USAID's role in this multi-donor effort is the \$12.9 million Community Health and Population Services Project (CHPS). Within the strategic framework of the PDS-II program, CHPS activities will cross-cut the three components above and provide resources for human resource development for integrated family health care delivery; information-education-communication (IEC) programs for health and family planning; core population/family planning activities; operations research for family health initiatives; and contraceptive procurement and distribution. These activities best reflect USAID's comparative advantage and experience in Mali's health sector, and best address the Mission's strategic objectives and health and population strategy. Also, with its objectives of integrating child survival and family planning services, creating sustainable delivery systems, improving management of the Malian economy, and coordinating the program with other donors and PVOs, CHPS fully supports the DFA mandate.

The PDS-II/CHPS program addresses Mali's most critical health problems and provides a workable solution to them. USAID/Mali firmly believes that CHPS has the most potential for sustainable broad-based impact of any investment the Mission could make in Mali's health and population sector at this time.

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II. PROGRAM FACTORS

A. *Conformity with Mali's Country Strategy*

Mali's national development program is in the midst of a gradual but profound reorientation from the socialist and statist principles which guided national planning during the first 20 years of independence. These principles, which promoted centralized management and control, left some deep scars which Malian policymakers are grappling with today -- extensive macroeconomic difficulties, a stagnant non-agriculture productive sector, and an overgrown public sector lacking basic resources. The government (GRM) acknowledges these problems and, with assistance from the international donor community, is putting the economy on more solid footing through wide-ranging policy and program reforms.

In the health sector these reforms are based on a "Health for All" strategy grounded in the promotion of primary health care (PHC). Recognizing that the public service provision of basic services has not produced desired results, the GRM recently issued a draft "National Health and Population Policy" whose purpose is to improve the overall health status of the population, especially children and women of child-bearing age. This policy reorients the GRM's role in basic health care to strategic, policy, management, and support services; improvements in quality and efficiency of referral care; and the promotion of public health policy. Its key elements, which have emerged through policy discussions with the World Bank, USAID and other donors, promote (a) the "Bamako Initiative", and the need to supply affordable essential drugs to the entire population; (b) the rational use of resources, and the capability to integrate private health practitioners while recovering costs for basic health care; (c) the decentralization of health care delivery, with reliance on local capacities and new public-private partnerships; and (d) the expansion of PHC, maternal child health (MCH) and family planning (FP) coverage.

Equally noteworthy on the child survival (CS) front is the GRM's February 1991 issuance of a draft "Plan pour la Survie, la Protection, et le Developpement de l'Enfant", a direct outcome of Mali's catalytic role in the September 1990 World Summit on Children. This document, which is currently being reviewed within the GRM, advocates the full integration of CS interventions into PHC/MCH services, including family planning and birth-spacing activities.

In the population and family planning sector, the Population Policy openly recognizes the adverse social and economic implications of rapid continued population growth (2.8% annually) in the face of a limited resource base. What it proposes is a reduction in Mali's total fertility rate (TFR) from 6.8 to 4%, and an increase in the contraceptive prevalence rate (CPR) from 1 to 40%, by the year 2020; the development of FP and Information, Education and Communication (IEC) targeted at specific groups; the introduction of family health information in the formal and non-formal educational systems; and the promotion of an efficient FP delivery system, in part through the systematic integration of FP into MCH. Based on this policy and with USAID assistance, the GRM issued a draft FP/IEC strategy in November 1990 which sharpens the focus and timeframe of the above interventions, particularly with respect to short-term CPR targets, geographic and beneficiary targets, and complementary channels and options

for expanding demand of FP through IEC. Formal adoption of this strategy, which is expected in March 1991, is a precondition to the World Bank PDS-II and USAID CHPS Projects.

B. Relationship to AID Policy and Priorities

The GRM sectoral objectives and priorities correspond with those of USAID. As discussed in the Mission's 1990-1994 CDSS and further elaborated in the 1990 Program Logframe, USAID/Mali's program goal of promoting economic growth is grounded in a three-pronged development strategy designed to increase the productive capacity of the Malian people and the Malian economy. Strategic objectives which (a) encourage private initiatives that promote private sector participation and a more efficient use of public funds; (b) increase incomes in sectors of high productive potential; and (c) improve delivery of health and educational services, form the framework for bringing about an acceptable quality of life in Mali. Indeed, the last of these objectives and the purpose of CHPS, which is to increase the sustainability and effectiveness of Mali's family health service delivery system, are synonymous.

CHPS also conforms to the priorities of the DFA Action Plan, particularly those which form the basis for recent increased allocations to social sectors. The DFA strategic objective of "Improving the Management of African Economies by Redefining and Reducing the Role of the Public Sector and Increasing its Efficiency" is the essence of the World Bank and USAID health care initiative. Improved equity and efficiency in providing key public services, particularly health and family planning services, will be achieved through increased access to and availability of health and child survival services. Program directions include integrating child survival and family planning services; creating the demand and multiple-channel services for voluntary family planning, while at the same time integrating FP programs into other GRM development efforts (e.g. education, private industry); putting in place sustainable health financing and health management systems; and developing data collection and analysis systems capable of monitoring key CS and FP benchmarks and indicators.

The U.S. Congress, in its authorization of the DFA, encourages AID "to coordinate its programs closely with those of the Multilateral Development Banks, United Nations agencies, other bilateral donors, and private voluntary organizations." In CHPS, USAID will collaborate closely with each of these.

C. Perceived Problem

Despite a country health and population policy which now has all the right elements and priorities, the state of health in Mali is deplorable. Life expectancy hovers around 47 years and the infant mortality rate at 170/1000, the highest IMR in Africa and the second highest in the world. Over half of Malian women and children are exposed to health risks associated with early and late childbearing, closely spaced births, and high parity. Prenatal care, the single most important determinant of infant survival, reaches only 31% of Mali's pregnancies. A mere 6% of children under five have health cards, and none of these children is fully immunized. The

majority of their deaths are caused by malaria, measles, respiratory infections and diarrheal diseases -- all of which are treatable or preventable by simple available technologies.

All this has its socioeconomic consequences as well. An unhealthy population is an unproductive one. And a burgeoning unhealthy population cannot make the economic gains needed to keep pace with population growth. Despite the GRM's willingness to restructure the economy and devote additional resources to the social sectors, productivity must be at higher levels in order to do so.

Why are health conditions in Mali so poor? The principal reasons are:

- *Limited Access to Health Care:* Mali's existing organized health care system reaches approximately 20 percent of the population, a situation which is particularly acute in rural areas and in more remote regions.
- *Poor Quality of Health Care:* The health care reaching those 20% is characterized largely by inadequate facilities, insufficient attention to local health needs, a lack of essential medical supplies, poorly trained and unmotivated staff, and poor supervision and management. All this has contributed to the declining use of public health facilities.
- *Lack of Affordable Essential Drugs:* Drugs are neither affordable nor available in 70% of Mali. This is primarily due to poor policies and management of parastatals ("Pharmacie Populaire du Mali"; "Usine Malienne de Produits Pharmaceutiques") responsible for production, distribution and sales. Mismatches between needs (affordable, essential generic drugs) and supply (costly, non-essential brand-named drugs) are endemic.
- *Inefficient Use of Sectoral Resources:* Poor sectoral planning, lack of donor coordination, management inefficiencies from centrally-directed disease-control programs, non-integrated public health approaches, lack of attention to decentralized and private alternatives for basic health care, reliance on inefficient parastatals, poor deployment of trained and skilled health care professionals, and a lack of sustainable health financing systems have prevented the rational use of health resources.
- *Limited Demand for and Availability of Family Planning Services:* Only 50% of urban and 15% of rural women have heard of one modern method of contraception. With a CPR of 1%, hearing does not mean using. Stalling FP services are a lack of facilities, staff capable of prescribing and distributing contraceptives, a lack of appropriate FP messages and IEC campaigns, and restrictive policies on contraceptive use.
- *A Policy Vacuum:* Family health programs operating in a policy vacuum, or in a poor policy environment, cannot be successful. It is only with the Health and Population Policy (1990), the FP/IEC Strategy (1990), and the Child Survival, Protection, and Development Plan (1991) that the GRM has focused on broadening access to or

improving the quality of health care, making essential drugs available, promoting rational use of health resources, and expanding the availability of family planning services.

Solving these problems cannot be done through a piecemeal approach covering a little bit of one problem here and part of another one there. Nor can it be done by everyone doing his own thing, or by addressing everything everywhere at the same time. All these approaches have been tried in Mali, with varying degrees of unsuccess. At this stage in the evolution of Malian health care, the solution which will bring short-term results and long-term impact lies in an integrated, coordinated and focused effort by all those who want to improve health conditions in Mali. It lies in a global approach that addresses policy and program, that builds on existing talents and capacities, and that nurtures innovative public and private partnerships involving a wide cross-section of the population. The Second Health and Population Sector Program offers such a solution.

III. THE SECOND HEALTH AND POPULATION SECTOR PROGRAM

A. *The Project Purpose and Strategy*

The GRM/World Bank Second Health, Population and Water Supply Project (PDS-II) provides a policy and programmatic framework that will best enable the GRM to bring about sustained improvement in Mali's health and family planning sector. It also provides the framework for the CHPS project. Through an integrated and comprehensive program of policy and institutional reforms and investments, this project will support the GRM's efforts to improve the health status and well-being of the Malian people, notably women and children; implement its emerging population policy, and FP/IEC Strategy; and broaden the access of rural communities to health services and safe water.

An integrated and mutually reinforcing set of policy and program interventions is the crux of a strategy that will lead to sustainable growth and improvement in Mali's health care delivery system. On the policy side, the Bank and GRM have already made significant strides in key areas targeted for reform. As a result of the December 1990 Project Negotiations, the GRM and the Bank have agreed that the following must be accomplished prior to Board Presentation:

- *Pharmaceutical Reforms:* Approved decrees exempting 189 essential generic drugs (ED) from taxes, while taxing specialty drugs. The PPM will not import speciality drugs that compete with the 60 most essential drugs. The GRM has revoked the import monopoly of the PPM (February 1991) and will soon create conditions enabling private pharmacists to import and distribute drugs. PPM and UMPP restructuring is a condition for Project Effectiveness.
- *Privatization Reforms:* Approved decrees liberalizing conditions for private health practitioners, i.e., medical/paramedical professionals, health technicians and pharmacists, to set up private practices. Current regulations mandating fee structures will be abolished.
- *Family Planning and IEC Reforms:* Formal adoption of the National FP/IEC Strategy, and texts authorizing trained health workers to distribute all contraceptives down to the community level. An official note will state that there exists no legal basis for refusing family planning services to unmarried women or to married women who do not have spousal consent.
- *Service Delivery Reforms:* Approved decrees establishing the framework for planning, financing, and implementing a local health care delivery systems. Decrees will support the GRM decentralization initiatives and enable communities to control and finance their health care facilities.

This health-specific policy framework dovetails with macroeconomic reforms being implemented through the SAP, ESAF, and EPRP/PRED programs, particularly those designed to improve

sectoral resource use, increase GRM's capacity to manage public investments, and promote participation of the private sector.

Health policy reforms, which will be in place before the World Bank and USAID projects begin, fill the "policy vacuum" discussed above and reinforce a PDS-II program strategy grounded in five strategic objectives:

- o *Increase Access to Health Care:* Through a population-based strategy that maximizes health care coverage at the local level. The goal is effective coverage, not complete coverage. Expanding services to 120 delivery points will provide services to 1.4 million Malians.
- o *Improve the Overall Quality of Health Care:* Through a program focusing on child survival and integrated PHC/MCH/FP interventions, supported by trained and motivated personnel, adequate facilities and supply systems, and proper supervision and management.
- o *Provide Essential Drugs:* Through multiple-channel procurement and sale systems that make essential drugs available at the community level and at an affordable price. IEC will increase knowledge of generic drugs.
- o *Maximize the Efficient Use of Resources:* To be achieved by integrated and coordinated sectoral planning, private and decentralized provision of services, locally-adapted sustainable health care financing systems, coordinated donor investments, and increased GRM investments in health.
- o *Increase Demand for and Availability of Family Planning Services:* To be achieved by PHC/MCH/FP health care delivery programs which maximize the public and private channels for FP services and IEC campaigns. Multiple channels and social marketing will help promote contraceptive use.

It is this strategy that will provide the framework for GRM, World Bank, and other investments in Mali's health sector over the next decade.

B. *The Project Outline and How it Will Work*

PDS-II builds on successes and lessons learned from the Bank's initial Health Development Project (HDP), implemented in the Kayes Region since 1984. HDP's first phase supported training, drug supply, and planning and coordination at the national level; the second focused on village health service delivery. World Bank and subsequent USAID assessments (cf. Annex H, Kittle & Ba, 1990) gave the project good marks in the areas of staff training, creativity and flexibility, integrated and adaptive approaches to health care delivery, district-community coverage, and effective cost recovery for services and pharmaceuticals. These elements, now proven effective, are incorporated in the PDS-II Project.

Population-based planning, community participation and empowerment, and the separation of primary care, referral care, and management functions are the underpinnings of PDS-II. Population-based planning calls for a critical mass of 5,000-15,000 people within a 15 kilometer radius of a Community Health Center (CHC) -- a condition considered sufficient to warrant basic family health care delivery and to support sustainable health care financing systems (cf. Section V on Financial & Economic Considerations). Local participation and empowerment will encourage communities to take an active role in managing and financing their CHCs. Following 1990 Decentralization Decrees specifying use and control of the Local Development Tax Fund (FDRL), communities may use a portion of their taxes to finance health care construction and operating costs. The separation of primary care, referral care and management functions will promote an efficient division of labor, rational investments, and focused technical and administrative expertise at all levels of the health system.

These principles and the strategic objectives above provide the basis for a seven-year \$60.6 million PDS-II effort. Targetted for assistance are Bamako and the Kayes, Mopti, Koulikoro and Segou Regions. Districts and communities within this geographic area do not automatically receive project support, but must qualify by meeting selection criteria designed to maximize coverage and the potential for achieving results. At the referral level, the estimated 21 District (17 from the four Regions and 4 from Bamako) and 25 Sub-District Health Centers to be selected must first have a five-year District Health Development Plan (DHDP), at least one operational CHC, a commitment by the Local Development Committee to spend at least 7% of the Local Development Tax on the Health Plan, and a fully-staffed District Health Team. At the primary health care level, CHCs must be selected by the District for project support. They must also establish a Health Committee representing 5,000-15,000 people, and contribute up to 50% of the construction or rehabilitation costs for CHCs. Once selection is made, the Project Coordination Unit will work with MOPSHA central divisions, Regional and District Health Teams, Local Communities, NGOs and private health practitioners to develop a sustainable integrated District-based family health care system. The three components envisioned are:

- *A Health Component:* A combination of construction, staff training, and essential medical-pharmaceutical inputs will establish (a) PHC/MCH/FP services at CHCs, focusing on child survival interventions (ORT, growth monitoring, immunizations, malarial prophylaxis), FP (contraceptives and IEC), and curative services; (b) basic referral services at District Clinics, and full referral services at Regional and Central levels; (c) planning and management systems to maximize resource use at all levels.
- *A Population and Family Planning Component:* Training, IEC, operations research and adequate supplies of quality contraceptives will be used to (a) make operational the National FP/IEC Strategy, and strengthen the institutions responsible for implementation; (b) increase availability and use of FP services, and initiate innovative activities to complement standard service delivery; and (c) strengthen the Ministry's and others' capacity to plan, manage, and evaluate FP and IEC programs.

- *A Rural Water Component:* Construction, IEC and iodination activities will (a) increase the supply of safe drinking water and eliminate iodine deficiency for the rural population; (b) support community participation in the financial and technical management of the potable water supply; and (c) sensitize users to the benefits of integrated health services.

\$60.6 million of project inputs consisting of construction services, technical assistance, pharmaceutical-medical supplies, training, operations research and a grant program for population activities (POPFUND), furniture and equipment, and operating expenses, will be shared by the GRM, local communities, and a number of donors. Donor interventions are coordinated and capitalize on program interests, experience and comparative advantages (cf. Section V on "Relevant Experience" and "Estimated Costs"). Inputs will be provided in phases: Kayes-Mopti in Phase I (1991-93), and Koulikoro-Segou in Phase II (1993-95). This will promote management efficiency and enable project staff, private groups, and practitioners to profit from experiences along the way. Inputs to Bamako facilities and MOPSHA will be continuous.

C. *Expected Achievements*

The PDS-II strategy and program will enable the GRM to effect a significant positive impact on the health status of 1.4 million Malians. Assessing this impact is best done by measuring achievement in attaining set targets for key family health indicators. For this project they are as follows:

- Increasing the treatment of disease episodes from 30-60%
- Increasing immunization of children under 1 from 5-40%.
- Increasing pregnancies receiving pre-natal care from 38-60%
- Increasing diarrhea episodes treated with ORT from 3-50%.
- Increasing growth monitoring for children under 2 to 50%.
- Increasing the Contraceptive Prevalence Rate from 1-10%.
- Decreasing the number of women and children facing potential health risks from early or late childbearing, closely-spaced births, and high parity from 65-30%.

Specific project outputs that contribute toward achieving these targets are outlined in the "PDS-II Output" Section of the Logframe (cf. Annex B). More specific and related project achievements will be

- District and Community Health Centers delivering integrated family health services on a cost effective and sustainable basis;

- District Health Development Plans adapted to local conditions and based on coordinated planning and rational resource allocations;
- Regional and District Health Teams providing adequate management and supervisory support to health care personnel; and
- Monitoring and Evaluation and MIS/HIS systems capable of tracking project inputs and outputs, and measuring performance and impact.

IV. USAID'S COMMUNITY HEALTH AND POPULATION SERVICES PROJECT

A. *Project Goal, Purpose and Strategy*

Within the framework of the PDS-II project, USAID's Community Health and Population Services Project (CHPS) has the goal of promoting economic growth in Mali, the subgoal of improving the quality of life of Mali's poor, and the purpose of increasing the sustainability and effectiveness of Mali's family health service delivery system.

The CHPS project strategy embraces the policy reforms and strategic objectives elaborated for PDS-II. Where CHPS demonstrates both its complementarity and uniqueness is in the selection of components and assistance mechanisms it will use to achieve the above purpose. Key to the selection are three programmatic conditions which USAID established early on in project preparation discussions with the GRM and other donors. The first is that USAID's intervention in this program will be only in those areas which reflect both its strategic interests and on-the-ground experience. Though there is certainly room for experimental activities, USAID's comparative advantage lies in 12 years of experience in Mali's health sector, and lessons learned from its past and ongoing programs. Second, there must be no duplication of effort among the development partners. The PDS-II program net is wide yet focused enough so that donor interventions can be complementary and mutually reinforcing. Finally, although there is no "going it alone" in a multi-donor coordinated program, USAID's activities will be implemented through grant agreements and implementation procedures that contribute to the global effort while safeguarding our investment.

B. *Project Outline and How It Will Work*

CHPS' contribution to this program cross-cuts the PDS-II health, population/ family planning and rural water components and focuses on five key areas: (1) human resource development for integrated family health service delivery; (2) IEC programs for health and family planning; (3) core population and family planning initiatives; (4) operations research and innovative family health activities; and (5) contraceptive procurement and distribution. The content of these components is as follows:

● *Human Resource Development*

Providing decentralized integrated family health care services will require extensive human resource development, both in technical and managerial areas. A major challenge, and critical factor in the success of this program, is to change attitudes and practices of health personnel, getting them "on board" in the transition from a centralized to a decentralized delivery system, and from a curative and largely reactive individualistic approach to a proactive public health and community service approach. USAID will assume this challenge and take major responsibility for training public and private medical, paramedical and administrative staff in integrated family health concepts and techniques.

Training, of which about 90% will be in-country, will focus on (a) integrated health care technologies (PHC/MCH/FP) and essential drugs, targetting regional and district health teams (physicians, nurses), CHC staff (nurses, midwives, aides) and pharmacists; (b) resource management (health, family planning and pharmaceutical systems management; financial and personnel management; health information systems) for central, regional and district managers; and (c) the training of trainers for MOPSHA staff and NGOs, and curriculum development for in-service training and medical/nursing/midwifery school courses. Annex C gives a preliminary training plan for PDS-II, the USAID-assisted components of which will be further refined during Project Paper design.

USAID has assisted MOPSHA in developing modules and conducting training in several of these areas, based on operational guidelines developed under the World Bank HDS and USAID/IFHAS projects. The results have been positive.

- *Information/Education/Communication*

Getting people to use PHC/MCH/FP services once they are in place requires either creating a demand where it is weak, or satisfying an unmet demand where it exists. This is the objective of the IEC component. CHPS will support integrated family health care education and community sensitization campaigns, developing targeted materials and approaches for both national and local use. Critical to the success of IEC will be using multiple channels for design and dissemination. MOPSHA and AMPPF (Association Malienne pour la Protection et la Promotion de la Famille), a local IPPF-affiliated NGO, will play key roles in conceptualizing and implementing IEC activities -- MOPSHA through Regional, District and CHC Health Teams, and AMPPF through its Regional staff and local ONG and private affiliates. Media campaigns will be launched and, with help from the Ministry of Education's (MEN) functional literacy units (DNAFLA), these IEC concepts will be incorporated into community development curricula. CHPS will also work through the MEN and the USAID Basic Education Expansion Project (BEEP) to introduce family health education into the core curriculum at the primary and secondary school level.

Messages will be spread at all levels of the central, referral and primary health care delivery systems. In addition to health care professionals and technicians, targeted for sensitization and training are key decision-making groups, community leaders, Village Cooperatives and Associations, businesses and trade unions, PVOs/NGOs, service organizations (e.g., the National Women's (UNFM) and Youth (UNJM) Unions, religious organizations, and scientific and technical committees and groups (e.g., the Malian National Committee on AIDS Research.)

- *Core Family Planning Activities*

In addition to the integrated PHC/MCH/FP activities described above, CHPS will invest in core FP activities aimed mainly at strengthening AMPPF's capability to further develop its training, IEC and delivery services. As the leader for many years in raising Malian awareness of family planning options and issues, AMPPF provides services in Bamako and outlying urban areas.

The Association has pioneered clinical FP services of the highest medical standards (IUD/VSC) and, with assistance from AID's Enterprise Project, a cost recovery system for contraceptives. It has also instituted a fee structure for client payments.

AMPPF can provide specialized FP training and IEC services to primary and referral care deliverers in the project area. They also have the expertise to organize a national FP/IEC campaign. To help support these activities, and to enable AMPPF to expand its coverage to the Sixth and Seventh Regions, CHPS will supplement existing AMPPF staff with three family health trainers and seven IEC professionals.

- *Operations Research*

Given the newness of the Population Policy and the FP/IEC Strategy, and the need to find flexible and responsive ways to implement them, CHPS will finance operations research activities aimed at encouraging private and public groups to find innovative and sustainable ways for bringing quality family health care delivery to Malians. USAID's experience with the Enterprise, SOMARC and JHPIEGO activities (cf Section V "Relevant Experience with Similar Projects"), as well as small grants to the AMPPF and UNFM, are reference points for some successful small-scale and focused interventions in family health. It is this kind of experimentation, and particularly targeted to reduce constraints and increase participation in program activities, that will be sought through buy-ins and small grants to local institutions and groups.

Part of CHPS operations research will be for the PDS-II "POPFUND", which will finance innovative service delivery, IEC, WID, and action research activities within the population/family planning sector, through various public, private and non-governmental entities. Though criteria and modalities for this fund are currently being worked out in a joint USAID/Bank-supported consultancy, it is likely that the implementation and operational guidelines will follow those of the BEEP "FAEF" (Fonds d'Appui a l'Enseignement Fondamentale") component which, in its concept and structure, is immediately relevant.

- *Contraceptive Procurement*

CHPS will continue USAID's activities in contraceptive procurement (condoms, pills, IUDs, injectables, vaginal tablets, spermicides, Norplants), in support of the CPR targets and essential drugs policy articulated in IEC/FP Strategy. Procurement will be complemented with assistance to expand the DSF's stock management and distribution monitoring systems to the project area, so as to assure the timely provision of quality contraceptive products. To satisfy the unmet demand particularly in urban areas, CHPS will help create additional community-based channels and alternative distribution points, and broaden the choice of contraceptives as appropriate. The project will also continue its social marketing campaign, through the PPM and private pharmacists.

CHPS share of the \$60.6 million PDS-II program will be approximately \$12.9 million, of which \$10 million is for core activities and \$2.9 million for additional technical assistance (a family health specialist, a FP/IEC training specialist, and short-term TA). The project, which will be obligated through a bilateral grant to the GRM and a separate grant to the AMPPF, will contain conditionalities parallel to those elaborated for PDS-II Board Presentation, Effectiveness and Disbursement of Funds (cf. Annex D "Aide Memoire of 18 December 1990). The principal implementing agencies will be the MOPSHA and AMPPF. Procurement will be carried out directly or through a technical assistance contract, to be determined during the Project Paper design. The provision of all training, IEC, core family planning, operations research, and commodity inputs will be coordinated within the PDS-II framework.

C. *Expected Achievements*

CHPS activities will contribute to fulfilling targets for key family health indicators as outlined in the PDS-II project description (cf. Section III(C) above). The CHPS outputs, as detailed in the Project Logframe (cf. Annex B), cross-cut and reinforce outputs elaborated for PDS-II. As such, achieving results and impact through CHPS interventions will achieve results and impact under PDS-II. More specific and related CHPS achievements will be

- Trained local-level leaders, groups, and NGOs delivering PHC/MCH/FP information to communities and other targeted beneficiaries;
- A set of IEC and training materials and strategies easily adapted to non-project areas, and which demonstrate a spill-over effect; and
- Activities funded under operations research which are replicated within the project area, and replicable beyond the project area.

V. FACTORS AFFECTING PROJECT SELECTION AND DEVELOPMENT

A. *Social Considerations*

1.4 million Malians or 18% of the population will directly benefit from the PDS-II/CHPS program. The primary target group will be women, and children to age 5. Malian women are severely compromised during their childbearing years, with nearly half their deaths occurring during childbirth. Emphasis on pre-natal and preventive health care, trained midwives in the CHCs, and access to FP/IEC services will help alleviate this problem and, along with a full range of child survival interventions blending vertical programs into primary health care, will address the principal causes of child and infant mortality.

MOPSHA staff will benefit from management and technical training programs, as will several NGOs and health care practitioners in the private sector. The latter will also benefit from the easing of restrictions on acquiring drugs and establishing private practice with the framework of sectoral and economic policy reform. Additional benefits for the entire population will derive from increased awareness of population issues, through the nationwide operations of the FP/IEC strategy. There will also be substantial spread effects resulting from the FP/IEC interventions through AMPPF and other NGOs, as well as the Ministry of Health's reinforced capacity to plan and manage sectoral programs.

Equity, a serious concern for the CHPS project, cannot be disassociated from quality service delivery. On the public health investment side, \$60.6 million for 1.4 million beneficiaries over six years represents an annual per capita investment of \$7.20. With the cost recovery and private investment strategies proposed under PDS-II (cf. Section C below), \$7.20, which is about the cost of treating three disease episodes, is sufficient to bring quality health care to the targeted population. To spread this \$60.6 million among more people would dilute the quality of health care. While the experience with HDP (see below) warrants the effort, and the need demands it, this remains a high-cost broad experimental program to address a fundamental health/FP issue which does not admit of lesser costs or rates.

Providing quality health services to 18% of Mali's population who do not have them is a substantial accomplishment, fully supportive of the GRM's goal of providing quality family health care to all Malians by the end of the decade. But regardless of the amount of public, donor and private support, the process must be phased. There is a capacity-building and learning process that must be accomplished first. What is important at this point is that this effort to provide quality health care to 1.4 million Malians in four of seven regions and Bamako does not undermine the existing programs and planned investments in other areas and regions. The national vertical programs, for example, will retain GRM and donor support in those regions, as will the numerous PVO/NGO development activities. Indeed, it is the remote 6th and 7th regions which served as the "testing ground" for the innovative essential drug program, and the laboratory for some of the most impressive gains in child survival. It is and will remain an integral part of USAID's and several other donors' health investment strategies, development policies, and equity concerns to broaden our activities in those regions which can be well

serviced through NGO and private channels, especially those where MOPSHA services are minimal. What we count on is that this expansion will profit from the intensive four-region effort under this program. That primary effort is essential.

B. *Institutional Considerations*

The PDS-II program relies on a much larger institutional web than the previous project. Among the key players will be (1) the Ministry of Health and Social Affairs (MOPSHA), under whose umbrella fall the Project Coordination Unit, six line divisions, Regional/District/Communal/Community Health Teams and Clinics, the PPM and the UMPP; (2) the Ministry of Industry, Hydrology, and Energy, for the rural water supply activities; (3) AMPPF and other NGOs, for core FP/IEC, family health activities, and operations research; (4) the Local Development Committees at the District and Sub-District levels, for financial and logistical support; and (5) private health practitioners.

The job of coordinating and managing this cast will not be easy, especially since coordination under the HDP project was problematic. Notes the World Bank PDS-II Appraisal Report, "Under HDP, the Project Coordination Unit has functioned in parallel with MOPSHA, thereby alienating itself from many authorities with whom it was supposed to collaborate." Adds Kittle and Ba, "This parallel and vaguely defined relationship is a major weakness of the project which has caused misunderstanding and conflict (at all levels), and has reduced the effectiveness of the project as a whole" (cf. Annex H).

The Ministry and the Bank are aware of the above problems and have taken steps under PDS-II to correct them, notably (1) creating a high-level ministerial committee for overall program coordination, support and monitoring functions; (2) giving implementation responsibility to those line divisions and NGOs most directly implicated in the activity; and (3) assigning the PCU responsibility for project coordination and management, focusing on financial and procurement systems, workplans, etc. This is a promising division of labor, and one which favors intra-ministerial and public-private collaboration. In order to better understand the structure, function and dynamics of all concerned actors, the Mission agrees with AID/W (cf. Annex A) that a comprehensive institutional analysis of the project be undertaken prior to completing the project design.

On the donor side there is considerable experience in program planning and management coordination, as evidenced in the macroeconomic policy reform, cereals market restructuring, and basic education expansion programs. Donor coordination has been excellent during project preparation, resulting in a series of commitments among the Bank, USAID, the European Community, UNICEF, and the German, French, and Belgian assistance programs that complete the \$60.6 million envelope. Although the specific interventions are still being worked out, overall program support is shown in Table 2 below (cf. Section H on "Estimated Costs and Methods of Financing"). The type of Coordination Committee and review processes established under the BEEP project will likely serve as a starting point for CHPS.

C. *Financial and Economic Considerations*

The overall impact and sustainability of the PDS-II program will depend to a great extent on the ability of communities to self-finance all CHC and some DHC health services, and of the Ministry to increase its share of incremental operating expenses at the central, regional and district levels. There are positive indications that this will happen on both fronts.

The most convincing evidence for self-financing comes from pilot activities undertaken in the HDP/PDS-I District and Community Health Centers, whose user population is among the poorest in the country. Kittle and Ba ((Annex H) document that the cost recovery strategies implemented in the three targeted CHCs of Badinko (Kita District), Selinkegny (Bafoulabe District) and Darsalam (Kenieba District) covered 100%, 96% and 98% of their respective operational costs in 1989-1990. Common to all three was a fee for service, which averaged FCFA 50 per visit; and charge for drugs, which were supplied by the project through PPM distribution points. One Local Development Committee allocated FDRL tax funds for salary support of the 3 CHC staff; another CHC's Management Group organized communal work to generate income. The project also provided needed training in accounting, financial management, and drug management. District Health Center strategies were equally successful - not only covering costs of medications for in-patient care as initially intended, but also costs (and unexpectedly) other operating expenses as well. Both schemes, which show the importance of local initiative, locally adapted strategies, and comprehensive management support, are unprecedented in Mali.

Had these Districts had the benefit of essential drugs at affordable prices, the achievements would probably have been even greater. The "Medecins sans Frontieres" project in the 7th Region (Tombouctou and Gao), and the "Medecins du Monde" project in the 6th Region (Bankass and Koro), for example, accessed essential drugs at international market prices and held prescription costs to FCFA 220 and FCFA 395 per visit, respectively, in comparison to the average PPM-based prescription of FCFA 2,690. Availability of affordable essential drugs was a major factor in increasing their users' clinical utilization rates 300% at the primary level and 50% at the referral level.

Another lesson learned from the Tombouctou/Gao experience is that the "poorest of the poor" were not denied health care services. Common practice was for communities to identify its poorest members and make them eligible for free health care. This group never totalled more than 4% of the community -- an indication of the affordability of PHC when essential drugs are available. Given the social fabric of Malian society, and the web of family and community networks that exist, we expect a similar number of and treatment for the poor in the PDS-II project area. As the appraisal report notes, any community meeting minimal population criteria and demonstrating a commitment to self-help will be eligible for project assistance. Disadvantaged communities will have options that project personnel and local leaders will help them explore.

The principles for financing the District-based health care system under the PDS-II program are laid out in Table 1 on the following page. What this shows is that CHCs will be totally self-financing for all aspects of health care, and DHCs self-financing for non-salary operating and essential drug costs. Noting that additional sensitivity analysis will be provided during PP design, the current estimate for the cost of services and essential drugs per episode ranges from FCFA 465-705 - a cost affordable for the vast majority of Malians.

The Bank estimates that project incremental operating costs will amount to \$2.6 million, or about 5% of the total cost, of which \$0.7 will be financed by the GRM. The project will keep incremental costs at a minimum by emphasizing health care delivery adapted to community needs, and the cost-efficient use of sectoral facilities, personnel, and drugs. Incremental operating costs equal about 1% of the 1990 MOPSHA sectoral recurrent budget, which will

UNIT	INVESTMENT	SALARIES	NON-WAGE OE COSTS	DRUGS	MISC.
DISTRICT HEALTH TEAM	GRM THRU EXTERNAL FINANCING (PROJECTS)	GRM	GRM	N/A	GRM
DISTRICT HEALTH CENTER (REFERRAL)	GRM THRU EXTERNAL FINANCING (PROJECTS)	GRM	USER FEES	USERS	GRM
COMMUNITY HEALTH CENTERS (PHC)	GRM THRU EXTERNAL FINANCING: 50% COMMUNITY THRU TDRL AND NGOS: 50%	NURSE : TDRL NURSE'S AIDE & PHARMACY CLERK: COMMUNITY	USER FEES	USERS	COMMUNITY

Table 1: Principles for District-Based Health Care Financing

grow to 3% once the DHCs are fully operational. The GRM is committed, through the SAP and ESAF agreements with the World Bank and IMF, to raising MOPSHA's share of the GRM's central budget from 6.5% to 9% by 1995. Budgetary norms have been prepared which require a 25% real per capita increase in the health budget during the 1990-1996 period, which will improve family health care delivery nationwide. At the same time, and by means of rational resource allocations across sectors, the GRM will decrease expenditures as a percent of GDP to 20% by 1996. User fees will also increase annual cost recovery to about 30% of total recurrent expenditures by 1996. These initial estimates, which will be refined during PP development, point toward a sustainable and effective family health care delivery system.

D. *Relevant Experience with Similar Projects*

In addition to the innovative cost recovery schemes discussed above, the first phase of the HDP/PDS Project had success with (1) multi-sectoral integrated activities, which brought together health, water and literacy personnel in a focused and coordinated effort; (2) training courses, particularly in program planning, budgeting and data collection; and (3) innovative approaches, which lead to population-based sectors and quality PHC services for a previously unserved population. Where the project encountered difficulties were in (1) the quality and quantity of supervision at the health facilities, which were largely insufficient; (2) the independent and parallel nature of the Project Coordination Unit and its implementing partners, e.g. MOPSHA line divisions and the PPM; (3) an imprecise and over-budgeted project document, which was unclear on how objectives would be reached and how working relationships would be established; and (4) an inability to make the most critical essential drugs readily available in the project area (for details see Kittle & Ba, Annex H). Lessons from these strengths and weaknesses are being incorporated in PDS-II.

USAID's decade in Mali's health sector has also been instructive. Beginning with the bilateral Rural Health Services Development Project (RHDP) in 1978, USAID has intervened at all levels of health care and through many different delivery channels. RHDP, which had objectives similar to those of PDS-II, showed that working with line agencies in remote areas will not work without central support, basic infrastructure, and management capability. The Mission brought that lesson back to Bamako in 1986 with the Integrated Family Health Services Project (IFHAS). Designed to assist the Ministry in developing an integrated MCH/FP program, IFHAS has made good progress in reorganizing the management of urban and district-level clinics, training professional staff in administration and supervision, and developing treatment protocols. The project also supports AMPPF's FP/IEC activities. Both sets of activities are integral to the PDS-II/CHPS program.

Since 1987 the Mission has moved back to remote rural areas, this time through a major child survival effort involving seven American-based PVOs. Activities include a range of CS interventions, such as immunizations, ORS education and treatment, improved feeding practices through Vitamin A education, malarial control, birth spacing, and growth monitoring. Results, as measured through coverage rates and service quality, have been impressive. Beneficiaries of the CARE/Mali Child Survival Project in Macina, for example, recorded the highest level of knowledge nationwide in the preparation and utilization of ORT (cf. 1989 PRITECH KAP Survey), with 24% of children aged 12-23 months and 65% of those aged 24-71 months completely vaccinated. As for PVO coordination with national vertical programs, our conclusion thus far is that where there is local-level sensitization, and the necessary IEC, medical and logistic support, vertical programs are better received and achieve more fully their desired results. At present PVOs have the "comparative advantage" in this community-mobilization approach than do MOPSHA line agencies.

Complementing these urban and rural efforts are national level interventions which support ORT and the National Diarrhea Control Program, AIDS prevention and the National Committee for

AIDS research, contraceptive social marketing and community-based distribution with the PPM and DSF, and malarial research which will eventually fund the National Malaria Research Laboratory. Most of these activities have an important but localized impact on the provision of health services. USAID support to the Regional Population Policy Development Project (CERPOD) was also instrumental in launching the Malian Population Policy Initiative, from which stemmed the National IEC/FP Strategy.

Also relevant to CHPS are the USAID Basic Education Expansion Project (BEEP), the Economic Policy Reform Program (EPRP), and the upcoming Policy Reform for Economic Development (PRED) -- all of which are coordinated multi-donor financed activities. Together they show that it takes a combination of macroeconomic and sectoral reforms to make a reform effort work, and that coordination among donors - for all its positive results - demands time, effort, and persistence.

The experience gained from these activities has enabled the Mission to develop a proactive, responsive and mature family health strategy, one whose elements converge in the CHPS Project. It is not an "all-or-nothing" strategy which supports either vertical or horizontal programs, rural or urban populations, line agencies or PVOs, or central or community interventions. It reflects a combination of all of these, and a belief that it takes this combination to bring quality health care to the Malian people. The integrated family health approach of CHPS, which cross-cuts all of the above dichotomies, combines the policy strengths of our regional population and national macroeconomic reform programs, the technical strengths of our national health support programs, the managerial and human resource development strengths of our district clinical programs, and the integrated and participatory strengths of our local-level PVO development programs. It is this convergence of sectoral expertise, along with USAID's experience in working with the GRM through multi-donor financed programs, that give the PDS-II/CHPS initiative its strength.

E. *Monitoring and Evaluation*

The Ministry of Health and participating donors will have a critical need for family health information both for planning and budgeting resources, and for tracking performance and impact. These will be major challenges. Currently available information in the health sector, especially at the local level, is deficient. Reporting on health data for national programs has a compliance level less than 50%. Not only is MOPSHA's capacity to analyze and make use of the health data weak, but there is no centralized location for receiving and collating information from the PDS Project and other Divisions.

USAID and the World Bank are committed to improving the Ministry's management capability, and their systems for gathering and reporting project information. The focal point for gathering primary data will be the 5-year District Health Development Plans, which will be updated annually. These will guide resource allocations and give preliminary indications on the performance of the family health and child survival indicators detailed in the Logframe. Data will be gathered through the CHC/DHC/RHC network, and analyzed at district, regional, and

national levels. Decentralized analysis is critical if timely feedback is to be given to health care managers and technicians. Depending on results, information will be supplemented with periodic surveys, assessments and rapid field appraisals. Key social and economic indicators will also be tracked independently through the Bank's "Social Dimensions of Adjustment" program.

The Mission is currently putting in place a "Program Monitoring and Impact Assessment System" for internal monitoring and as well as a resource for the Africa Bureau's Assessment of Program Impact (API). This system will be incorporated into the CHPS Monitoring and Evaluation Plan PP design.

F. *AID Support Requirements and Capabilities*

USAID can provide CHPS with competent management and leadership. The project, which is clearly within the Mission's management interest and capability, will be managed by existing USDH staff in the General Development Office's Health Division, with assistance from a local-hire PSC. The current health staffing includes a Senior Health/Population Development Officer, a Technical Advisor in Child Survival, two experienced FSNs in population and child survival, and a USPSC to manage the CERPOD Project. The first two years of CHPS will draw on considerable support and assistance provided by seven full-time technical advisors working with IFHAS (MOPSHA/DSF), PRITECH (MOPSHA/DSF), SOMARC (PPM), NIH (National School of Medicine Malaria Research Lab), as well as a number of TDY support staff. When IFHAS phases out in 1993, CHPS technical assistance will be in place and an orderly transition will have been made. The Mission will undoubtedly need complementary program support in a number of family health areas, and will be examining closely the Bureau's new Africa Public Health and Population Support Project (698-0483) for assistance.

G. *Estimated Costs and Methods of Financing*

The total cost of the PDS-II program is estimated at \$60.6 million, of which the World Bank's share is \$26.6 million. The remaining financing comes from the European Community (\$13.6 million), USAID (\$10 million core contribution), France (\$3 million), Germany (\$3 million), Local Communities (\$2.8 million), and the Government of Mali (\$1.6 million). Table 2 shows the allocation of World Bank and USAID funds by project element. Other donors will bridge the \$23.9 million complement as shown.

PROJECT COMPONENT	\$IDA	\$USAID	\$OTHER	\$TOTAL
Construction	7.8	---	6.6	14.4
Furniture and Equipment	4.3	0.3	2.3	6.9
Medical Supplies/Equipment	2.5	2.0	3.6	8.1
Technical Assistance	4.9	1.2	2.3	8.4
Training	1.1	2.2	0.5	3.8
POPFUND/Operations Research	0.6	2.0	2.1	4.7
Core FP/IEC Program	---	1.6	---	1.6
Operating Costs	2.6	---	2.0	4.6
Contingencies/Inflation	2.8	0.7	4.8	8.1
TOTAL	26.6	10.0	23.9	60.6

Table 2: Donor Financial Support for the PDS-II Program

Note: USAID's contribution for TA contains \$300,000 for Evaluation and Audit.

Also, USAID's core FP/IEC funds represent essentially a grant to AMPPF.

The estimated budget for the CHPS Project is \$12.9 over six years (cf. Annex E for details), which will be obligated through a bilateral grant agreement with the GRM and a separate grant to the AMPPF. The \$2.9 million above core funds represents additional technical assistance (long-term family health specialist and FP/IEC training specialist; 30 PM of short-term assistance) which the GRM, USAID, and the Bank agree is essential for project implementation.

H. *Alternative Approaches to the Project*

In arriving at the current CHPS approach, the Mission weighed a number of alternatives, many of which were reviewed with AID/W staff. They include:

- *Program Assistance*

In the early phases of PDS-II design, it was thought that program assistance would help encourage the GRM to adopt several difficult policy reforms. The Bank then determined that rational resource allocations and decentralization of ministerial operations would result in substantial savings in the annual cost of providing health care services -- an adequate incentive for the GRM to adopt the necessary reforms. This incentive, together with the macroeconomic policy reforms in the SAP/ESAF programs, have moved the health sector reforms through PDS-II negotiations and close to Board Presentation (cf. Annex D).

- *Non-Governmental Grantees*

Implementing this project exclusively through PVO channels would result in the direct provision of family health services in selected locations. This kind of approach has worked well in many areas, and has provided MOPSHA with new ideas for expanding health services to the community level. But it would not lead to those policy, program and institutional reforms needed to build a sustainable system of health care delivery nationwide. PVOs have a critical role in this project, one which both complements and reinforces activities implemented through MOPSHA.

- *The AID-Only Approach*

USAID has seen first-hand that multi-donor programs, targeted on macroeconomic policy or sectoral reforms or both, can have major impact if they are focused, integrated, coordinated, and have the backing of the Malian Government. The PDS-II/CHPS promises to be one such program. For USAID to use its limited funds for a stand-alone bilateral project, knowing that the above elements are in place and that our core investment would result in significantly greater impact, would represent a missed opportunity that simply would not make sense.

- *Vertical Interventions*

Mali has good nationwide vertical programs in immunization, malaria, and ORT. Experience to date, much of which comes from the HDP and PVO child survival projects, shows that vertical programs achieve their most successful results when they are incorporated into integrated PHC/MCH delivery systems at the local level. This approach minimizes the risk of duplication and promotes self-sufficiency and management efficiency at the delivery points. The GRM has made this integration part of their health policy. UNICEF has agreed to take the lead in incorporating vaccinations into the CHC health care programs.

- I. *Design Strategy*

The CHPS PID has been prepared by Mission staff in cooperation with the World Bank design team and with AID/W assistance. Since the initial PID review in September 1990, USAID has financed several activities designed to respond to ECPR issues and concerns, and further PDS-II/CHPS development. They include (1) assistance to the GRM to develop a National Strategy for Family Planning and Information/Education/Communication (September 1990); (2) assistance to the MOPSHA/DSF to develop training modules and treatment protocols (September 1990); (3) a study on performance to date of the World Bank Health Development Project, focusing on cost recovery, drug supply, and health care services (cf. Kittle and Ba, January 1991); (4) a marketing plan for the Bamako Initiative (cf. Parlato, January 1991); (5) a willingness-to-pay study for contraceptives (to be completed in March 1991); and (6) assistance to the PDS Project Unit to specify the content and modalities of the "Fund for Population Activities" or "POPFUND" (to be completed in March 1991).

Four additional analyses, which will take place between March and May 1991, are necessary for PP development. As discussed earlier, they include (1) a plan for implementing the National FP/IEC strategy; (2) a training needs assessment and implementation plan that elaborates on the training plan outlined in PID Annex C; (3) an institutional analysis of the family health care sector; and (4) a follow-on analysis of the Kittle & Ba report (Annex H) which further specifies GRM recurrent costs over time and refines the PDS-II cost recovery strategies. The Mission will also examine issues with regard to the privatization of health care services, and decentralized finance and management within the health sector. \$100,000 in FY 1991 PD&S funds has been reserved for these activities.

The timeframe for PP design and approval coincides with the PDS-II approval schedule, which currently sets Board Presentation for April and Effectiveness for September. CHPS design will proceed as follows:

Complete and Submit Revised PID	February 1991
AID/W ECPR Review and Approval	March 1991
Complete Design Analyses	May 1991
Complete Project Paper Design	June 1991
Prepare Grant Documents	July 1991
Authorization and Obligation	August 1991

J. *Issues Affecting Project Design*

Issues which could affect successful achievement of project objectives are:

● *What if the PDS-II Project start is delayed?*

World Bank-GRM negotiations proceeded well in December, with expectations for Board Presentation in April and Effectiveness in the Fall. Since the initial USAID disbursements will be conditioned on PDS-II effectiveness, any slippage in the Bank's schedule would affect CHPS activities. We estimate that a six-month delay, for example, would have limited substantive consequences for CHPS. Our current support to central and district programs through IFHAS and AID/W projects, along with our grant to AMPPF, would enable training, management, procurement, and FP/IEC activities to continue. These are service delivery and capacity-building activities that would strengthen the PDS-II/CHPS program. The Mission would also be able to proceed with the procurement of long-term TA. Running parallel will be UNICEF's recruiting of five advisors who by mid-1991 will be stationed in the four PDS-II regions and Bamako. Their job is to assist District Health Teams develop health plans and meet selection criteria -- a key task for the project start-up.

- *What if the proposed policy reforms are not carried out?*

The main policy reforms which affect the program are (a) macroeconomic reforms on GRM budgetary allocations to the health sector over the next 5 years, and (b) sectoral reforms on essential drugs and related liberalization measures. The former, which the GRM have accepted in principle, are being negotiated with the IMF and World Bank under an Extended Structural Adjustment Facility. Failure to implement these would seriously undermine proposed cost recovery strategies. Regarding drug reform, we do not see the restructuring of the PPM and UMPP as the major stumbling block at this point. No longer holding the monopoly for drug importation and distribution, the PPM has sold off many of its outlets to private concerns, and anticipates a useful role as a drug wholesaler. And the UMPP is looking forward to manufacturing essential drugs. What is more critical at this point are the incentives for integrating the private sector in the drug procurement and distribution process, ensuring that they can compete with the PPM on equal footing. Mali has a nascent but vibrant private sector which could quickly assume greater responsibility.

- *What if local communities cannot contribute their fair share?*

The underlying philosophy of the PDS-II selection process is facilitative, not punitive. It is designed to include users, not exclude them. However, in the event that the critical population mass needed for the CHC cannot rehabilitate a building, come up with 7% in tax funds, or interest an NGO or private party to cover some of the operating costs, the project would have to explore other means to ensure qualification. This would be done, and in a way that does not compromise cost recovery and sustainability. In our view the element most "at risk" at this point is the degree to which local decision-makers will be able to access their local tax fund (FDRL). USAID, which has been instrumental in assisting the GRM to revamp their decentralization policies, has been assured that the new codes permitting allocations at the local-level are in effect. How they work will be monitored closely in the targeted project areas.

- *What if the key implementing parties don't work together?*

Differing priorities within the Ministry of Health, which now includes the PPM and UMPP, and between the Ministry and the private sector, could make it difficult to implement a program whose very essence depends on cooperation and coordination. However, with strong commitment and direction at the ministerial level, with effective mechanisms in place for program coordination and conflict resolution, and with donors united and sending similar messages, this program can work. Indeed, there are numerous pressures and incentives to make it work. World Bank negotiations for PDS-II have placed a premium on the key aspect of implementation, and all present signs are positive and responsive. The test will be more difficult, of course, but in this instance the inauguration of a strong donor coordination group (the BEEP model) will help reinforce the likelihood of working through these inevitable issues.

K. *The Potential for Impact*

Having reviewed the current state of Mali's health, the opportunities and the strategies for improving it, and the risks and constraints that surface along the way, USAID/Mali firmly believes that the PDS-II/CHPS program has the most potential for sustainable broad-based impact of any investment we could make in Mali's health and population sector at this time. There are many reasons for this, the most important being, quite simply, that this program addresses Mali's most critical health problems and provides a workable solution to them. Key to this effort is responsiveness. PDS-II and CHPS give Malians what they want -- affordable quality family health care services close to home. It does so in a way that gets people working together, building on their involvement and commitment while at the same time transferring knowledge, awareness and skills. It also encourages self-sufficiency, dignity, and choice - ingredients without which policy reform, clinical interventions, and donor coordination have no anchor.

Equally important is attention to sustainability, namely pulling together and integrating all elements of the solution. Creating a policy and institutional environment that will make critical drugs and other health services available at all times, at affordable prices and through different channels; providing technical inputs that will keep children and their mothers alive and healthy; developing skills and offering incentives that motivate people to do quality work; establishing delivery systems adapted to social and economic conditions; educating people to make informed decisions about their lives; and letting communities decide how to invest their own resources -- these are the major elements of the PDS-II/CHPS solution, and ones that will make a difference in Malian health care.

Finally comes experience. The PDS-II/CHPS program represents an understanding of Mali's health sector, a response backed by several years experience working with the Malian government, PVOs and NGOs, and private groups to effect major changes in policies and programs. It is this expertise that will help guide and support GRM efforts to revamp Mali's health care system and make the kind of changes needed for sustained economic growth and development.

L. *Recommended Environmental Threshold Decision*

The Initial Environmental Examination (IEE) attached as Annex F recommends a categorical exclusion for all activities under CHPS.

M. *Gray Amendment Considerations*

o *Mission Involvement with Socially and Economically Disadvantaged Enterprises*

USAID/Mali has made a firm commitment to involve socially and economically disadvantaged enterprises, private voluntary organizations, and individuals in designing, implementing and evaluating our development activities. During the past several years our health and population

program in particular has been a leader in this partnership. Under the IFHAS Project (688-0227), for example, the Mission contracted services from a socially and economically disadvantaged enterprises on three separate occasions (1) to assist in a major evaluation, (2) to develop innovative training modules, (3) to assess the national FP/IEC program, which included preparing a five-year Action Plan. Under FHI (698-0462), the Mission has executed a \$235,000 buy-in with a disadvantaged firm for support to various population and family planning activities.

These consultancies, and many others across our portfolio, indicate that incorporating socially and economically disadvantaged enterprises, PVOs, and individuals into our development activities is already part of our ongoing Mission contracting strategy. They have proven to be a valuable resource and an integral part of the way USAID does business in Mali.

- *The Community Health and Population Services Project (CHPS)*

CHPS has already contracted the services of two socially and economically disadvantaged business and an individual for assistance in project design, specifically to prepare training modules and health protocols, and to assist the GRM in developing a National FP/IEC Strategy. The Mission will make every effort to ensure maximum consideration of disadvantaged enterprises for the remaining design activities. Upon project authorization, USAID will contract for approximately \$3.8 million of technical assistance in the areas of public health training, family planning, and project management support; \$2.3 million for the procurement of contraceptives and other commodities; and \$300,000 for evaluations and audits. There is potentially an important role for socially and economically disadvantaged enterprises and individuals in all of these activities. USAID/Mali will actively encourage the participation of such entities or contractors and/or sub-contractors in each of these areas. These efforts will comply with AID requirements and all substantive and procedural items. At PP preparation a final determination will be made with respect to the set-aside of all or part of the technical assistance and other components of the project, as these elements are more clearly defined. Our expectation is that a substantial portion of the technical assistance may be appropriate for such an assignment.

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 DOLLAR 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 PID LOGICAL FRAMEWORK. WHILE THE PROJECT COMMITTEE UNDERSTANDS THIS WAS DONE IN THE BEEP (EDUCATION) PROJECT, 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 MEASUREABLE AND WITHIN AID'S MANAGEABLE INTEREST TO ACHIEVE OVER THE LIFE OF PROJECT.

2. GUIDANCE FOR PID REVISION: ECPR PROVIDES THE FOLLOWING GUIDANCE FOR MISSION IN PID REVISION:

(A). DEVELOP A DESCRIPTIVE ANALYTICAL FRAMEWORK WHICH CLEARLY DESCRIBES MALIAN HEALTH AND HEALTH SYSTEM PROBLEMS; AND HOW THE 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.

(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;

COMMUNITY HEALTH AND POPULATION SERVICES PROJECT

PID ANNEXES

- A. CHPS PID Review Guidance Cable (90 STATE 351606)
- B. Project Design Summary: Logical Framework
- C. PDS-II Training Plan
- D. World Bank/GRM Aide Memoire of 18 December 1990
- E. Project Budget
- F. Recommended Environmental Threshold Decision
- G. PID References
- H. Kittle/Ba Fact Finding Mission on HDP (January 1991)

ACTION: AID-2 INFO: CHARGE ECON

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PP RUTABM
DE RUEHC #1606/01 2900536
ZNR UUUUU ZZH
P R 170530Z OCT 90
FM SECSTATE WASHDC
TO RUTABM/AMEMBASSY BAMAKO PRIORITY 2462
INFO RUEAIIA/ CIA WASHDC 7567
RUEKJCS/ JCS WASHDC 6349

LOC: 145
17 OCT 90
CN: 35805
CHRG: AID
DIST: AID

ANNEX A

BT
UNCLAS SECTION 01 OF 04 STATE 351606

AIDAC

E.O. 12356: N/A

TAGS:

SUBJECT: PID REVIEW - MALI COMMUNITY HEALTH AND
POPULATION SERVICES (CHPS) 688-0248

SUMMARY AND BASIC GUIDANCE

THE EXECUTIVE COMMITTEE FOR PROGRAM REVIEW (ECPR) CHAIRED BY DAA/AFR E.L.SAIERS MET ON SEPTEMBER 11, 1990, TO REVIEW THE SUBJECT PID. OFFICES REPRESENTED INCLUDED AFR/SWA; AFR/PD; AFR/TR/HPN, AFR/DP; GC/AFR; SET HEALTH; AND SET POP. USAID/MALI MISSION DIRECTOR BRENNAN ALSO PARTICIPATED AND PROVIDED ADDITIONAL INFORMATION FOR THE ECPR.

IN SUMMARY, THE COMMITTEE VIEWED THE CONCEPT OF THE CHPS PROJECT AS A POTENTIALLY INNOVATIVE WAY TO IMPROVE AND EXPAND THE DELIVERY OF HEALTH AND POPULATION SERVICES IN MALI WITHIN THE CONSTRAINTS OF LIMITED USAID RESOURCES. THE PID, HOWEVER, IS FOCUSED ON PLANNED PROJECT ACTIVITIES AND DOES 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, THE COMMITTEE HAD DIFFICULTY COMPREHENDING 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, WOULD BE USEFUL IN THE DEVELOPMENT OF A STRONG RATIONALE FOR DESIGNING AN AID PROJECT SUPPORTING THE WB SECOND H/P PROJECT. IN ADDITION, THE PID DID 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.

THE COMMITTEE AGREED THAT THE PID SHOULD BE REVISED TO ADDRESS THE ECPR ISSUES. THE MISSION IS REQUESTED TO

DUE DATE	10/20
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PROG	<input checked="" type="checkbox"/>
DEO	<input checked="" type="checkbox"/>
MGT	<input checked="" type="checkbox"/>
CONT	<input checked="" type="checkbox"/>
ADD	<input checked="" type="checkbox"/>
GDO	<input checked="" type="checkbox"/>
JAO/DIR	<input checked="" type="checkbox"/>
JAO/CD	<input checked="" type="checkbox"/>
JAO/PER	<input checked="" type="checkbox"/>
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CHRON	<input checked="" type="checkbox"/>
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REVISE THE PID TO RESPOND TO THE GUIDANCE THAT FOLLOWS IN THIS CABLE FOR RESUBMISSION TO AID/W. THE ECPR PREFERS TO REVIEW THE REVISED PID IN AID/W, AND MAKE THE DECISION REGARDING PP AUTHORIZATION VENUE AT THAT TIME. A DISCUSSION OF THE ECPR ISSUES AND GUIDANCE FOR THE PID REVISION FOLLOWS.

1. OVERALL ISSUES: THE PID DOES 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 IS NEEDED ON WHY THE CHPS PROJECT HAS A BETTER CHANCE FOR SUCCESS THAN THOSE EFFORTS. THE FOLLOWING GUIDANCE IS PROVIDED TO ASSIST THE MISSION IN THE PID REVISION.

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 1.4 MILLION OF THIS POPULATION AS THE DIRECT BENEFICIARIES 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 AREA 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

GRM HEALTH SECTOR BUDGET ALLOCATIONS; MOPHSA/GRM 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 GRM/MOPHSA RECURRENT COSTS AND A PARALLEL INCREASE IN FUNDS FROM COST RECOVERY (PID PAGES 18-19) OVER THE LIFE OF PROJECT SHOULD CONTINUE TO BE IDENTIFIED IN THE REVISED PID AND SHOULD BE FULLY ADDRESSED IN THE PROJECT PAPER ANALYSES. 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 (PID PAGE 3) ALSO NEEDS CLARIFICATION IN THE REVISED PID. THE MISSION ACTION PLAN HAS ESTABLISHED A HEALTH SECTOR BENCHMARK OF A 9 PERCENT GRM HEALTH BUDGET ALLOCATION BY 1993, WHICH REPRESENTS A 2.5 PERCENT 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 REVISED PID 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.

3. CONCERNS

THE FOLLOWING CONCERNS WERE EXPRESSED DURING THE ISSUES MEETING AND WERE INCLUDED IN THE ECPR ISSUES PAPER. THEY ARE INCLUDED FOR CONSIDERATION IN THE PID REVISION AND 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, THE PID DID 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 AS DESCRIBED ON PAGE 33 OF THE PID. THE REVISED PID WILL LIKELY IDENTIFY OTHER FACTORS BEARING ON PROJECT DESIGN AND ANALYSIS. THE PROJECT COMMITTEE WAS UNANIMOUS IN RECOMMENDING 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 PID ISSUES SECTION ACKNOWLEDGES POTENTIAL IMPLEMENTATION PROBLEMS. WITH THESE PROBLEMS, THE PID IS NOT CONVINCING IN THE POTENTIAL OF THE CHPS PROJECT TO IMPROVE HEALTH SERVICE DELIVERY IN MALI THROUGH ADDITIONAL TRAINING OVER THE NEXT SIX YEARS.

THE REVISED PID 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. SUCH CRITERIA SHOULD BE INDICATED IN THE REVISED PID.

4. ACTION REQUESTED: - THE MISSION IS REQUESTED TO REVISE THE PID AS OUTLINED IN GUIDANCE FOR PID REVISION PARA 2 AND TO ADDRESS THE AREAS AS INDICATED UNDER CONCERNS PARA 3. PLEASE ADVISE AFR/PD/SWAP WHEN REVISED PID IS EXPECTED TO BE RESUBMITTED AND IF THERE IS ANY WAY THAT AFR/PD/SWAP CAN ASSIST THE MISSION. BAKER

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ANNEX B
Project Design Summary
Logical Framework

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Goal : To promote economic growth in Mali</p> <p>Subgoal : To improve the quality of life of Mali's poor</p>	<p>1. Per capita GDP and Income Figures</p> <p>2. GDP increases due to decrease in sick days</p> <p>1. Infant and child mortality rates</p>	<p>GRM statistics; MOPSHA reports; IBRD, IMF and USAID reports; macroeconomic assessments and income surveys; performance evaluations</p>	<p>Government remains stable</p> <p>Economic policy reforms are implemented according to the ESAF</p>
<p>Purpose:</p> <p>To increase the sustainability & effectiveness of family health service delivery in Mali</p>	<p>1. 1.4 million people receive good family health services, for whom</p> <p>a. Disease episode treatment increases from 30-60%</p> <p>b. Under-1 child immunizations increases from 5-40%</p> <p>c. Pregnancies receiving pre-natal care increase from 38-60%</p> <p>d. Diarrhea episodes treated with ORT increase from 3-50%</p> <p>e. Under-2 growth monitoring increases to 50%</p> <p>f. Women & children with potential health risks from early or late child-bearing, closely-spaced births or high parity drop from 65-30%.</p> <p>g. CPR rate increases from 1-10%</p>	<p>Project M&E reports and performance evaluations; WHO, UNICEF and other donor/GRM surveys; sector analyses</p>	<p>Drug policy, population policy, and FP/IEC strategy are approved in 1991</p>

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NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><u>PDS-II Outputs:</u></p> <ol style="list-style-type: none"> 1. Increased access to primary health care services at 120 Comm. Health Centers 2. Improved health referral services at 21 district and 25 sub-district health centers 3. Strengthened health admin. & management at Regional and District levels 4. Improved planning and management of resources at national level 5. Increased demand for, and quality and availability of, FP services 6. Increased supply of safe drinking water in Kenieba and Bafoulabe 	<ol style="list-style-type: none"> 1. Patient visits, type and quality of PHC services, staff & financing at CHCs; drug availability 2. Patient referrals; type and quality of surgical & diagnostic equipment available; drug availability 3. Resources and good supervision provided on time and based on approved health development plans 4. Coordinated planning & management among implementors; resources allocated according to local needs and capacity 5. Contraceptive distribution & sales rates; number of FP consultations & IEC activities at clinics and in villages. 6. People with access to safe drinking water increases to 50% 	<p>Project reports audits and evaluations; data from private clinics and pharmacies, ONGs; household surveys; rapid appraisals</p>	<p>No major delays in procurement of technical assistance, commodities, and construction services</p> <p>CHCs receive adequate tax funds from Local Devel. Committee</p> <p>There exist sufficient incentives for trained health care personnel to remain in the PDS-II system</p>
<p><u>PDS-II Inputs:</u></p> <ol style="list-style-type: none"> 1. Construction 2. Furniture & Equipment 3. Medical Supplies 4. Technical assistance 5. Training 6. Population Fund 7. Operating Expenses, Contingency, & Inflation 	<ol style="list-style-type: none"> 1. \$14.35 million 2. 6.85 million 3. 8.08 million 4. 8.12 million 5. 3.81 million 6. 4.67 million 7. <u>14.71 million</u> <p>\$60.6 million</p>	<p>Project Audit Reports; GRM financial statements</p>	<p>Inputs are provided in a timely manner by the GRM and all donors</p>

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NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>CHPS Outputs:</p> <p>1. Competent health care professionals providing quality MCH/FP/IEC services at district and community health centers; and FP/IEC services at private clinics and pharmacies</p> <p>2. Competent health care administrators providing quality supervision in planning and management to clinic staff and local health committees</p> <p>3. Increased demand for, availability and awareness of modern contraceptive methods</p> <p>4. FP/IEC services are adapted to local conditions and available through public and private channels</p>	<p>1. Patient and customer visits; type, quality and frequency of training provided to health care professionals</p> <p>2. Periodic meetings to assess and plan health care programs; type, quality and frequency of training provided to management personnel; HRD plans updated and tied to health sector priorities</p> <p>3. Contraceptive awareness increases to 75 % in urban areas and 50% in rural areas</p> <p>4. Distribution, sales and service points; quantity, quality and affordability of contraceptives available through local clinics, ONGs, and pharmacies</p>	<p>Project training records; MIS reports; information from private clinics, pharmacies, and ONGs; village surveys and rapid appraisals</p>	<p>GRM and local development committees will make available a sufficient qualified health practitioners for training in priority areas</p> <p>Trained health staff are assigned to positions based on technical and management expertise</p> <p>Private sector has incentives for involvement in FP/IEC activities</p>
<p>CHPS Inputs:</p> <p>1. Training</p> <p>2. Core Family Planning</p> <p>3. Operations Research</p> <p>4. Technical Assistance</p> <p>5. Contraceptives</p> <p>6. Commodities</p> <p>7. Evaluation and Audit</p> <p>8. Inflation & Contingency</p>	<p>1. \$2.25 million</p> <p>2. 1.60 million</p> <p>3. 2.00 million</p> <p>4. 3.75 million</p> <p>5. 2.00 million</p> <p>6. 0.30 million</p> <p>7. 0.30 million</p> <p>8. <u>0.70 million</u></p> <p>\$12.90 million</p>	<p>Project and Controller's reports; GRM financial statements</p>	<p>Inputs are provided in a timely manner</p> <p>Allowances are received from AID/W</p>

SECOND HEALTH, POPULATION AND RURAL WATER SUPPLY PROJECT

PROJECT-RELATED TRAINING									
PROJECT COMPONENT	STAFF	NO	SUBJECT	LOCAL/FOREIGN	TRAINING FROM TO	TOTAL TIME MAN-MONTHS	TRAINER	PLACE	FTW CIP
A. HEALTH COMPONENT									
1. IMPROVING THE COVERAGE AND QUALITY OF HEALTH CARE									
- COMMUNITY HEALTH CENTERS (MHC)	COMMUNITY STAFF (NURSES, MIDWIVES, AIDS)	260	(A) INTEGRATED HEALTH CARE AND ADMINISTRATION (DISTRICT TRAINING)	LOCAL	01/91 12/96	360	DHT	DISTRICT	USA
- COMMUNITY HEALTH COMMITTEES	COMMUNITY STAFF	480	(B) INTEGRATED HEALTH CARE (IN SERVICE TRAINING)	LOCAL	01/91 12/96	480	DHT	COMM	USA
- QUALITY OF REFERRAL CARE	PARAMEDICAL STAFF OF THE DHCs	64	- MINIMUM REFERRAL CARE PACKAGE	LOCAL	01/91 12/96	192	DISTRICT TRAINER SUB-DISTRICT STAFF	COMM	USA
- DISTRICT HEALTH SYSTEM MANAGEMENT	DISTRICT MEDICAL OFFICERS	21	(A) PUBLIC HEALTH	FOREIGN	01/96 12/96	84	T.A.	DHC	USA
			(B) OBSERVATION VISITS	FOREIGN	01/91 12/96	21	SCHOOL OF PUBLIC HEALTH	TO BE DETERMINED	USA
	DISTRICT HEALTH MANAGERS AND PHARMACISTS	48	(A) HEALTH AND PHARMACEUTICAL SYSTEMS MANAGEMENT	FOREIGN	01/96 12/96	144	SCHOOL OF PUBLIC HEALTH	TO BE DETERMINED	USA
			(B) OBSERVATION VISITS	FOREIGN	01/96 12/96	21	-	TO BE DETERMINED	USA
	COMMUNITY DEVELOPMENT AGENTS	24	- IEC ON ENVIRONMENT	LOCAL	01/96 12/96	288	BAGUIDERA	MALE	IDA
	LOCAL AUTHORITIES	80	- PROJECT LAUNCH SEMINARS TO DISSEMINATE THE PROJECT'S UNDERLYING PHILOSOPHY	LOCAL	01/91 12/96	8	DHT	DISTRICT	IDA
	COMM. DHC AND DHT REPRESENTATIVES	160	- YEARLY WORKSHOPS PREPARE JOINT ANNUAL JOINT REVIEWS WITH IDA	LOCAL	06/91 06/96	16	DHT & T.A.	DISTRICT	IDA
- REGIONAL MANAGEMENT SUPPORT (RMT)	RMT STAFF	360	(A) INITIAL WORKSHOPS TO DISSEMINATE THE PROJECT'S PHILOSOPHY AND TECHNICAL APPROACHES	LOCAL	01/91 12/92	60	DHT	REGIONAL CAPITALS	IDA
			(B) YEARLY WORKSHOPS TO MONITOR IMPLEMENTATION OF THE PROJECT, IN PREPARATION FOR THE JOINT ANNUAL REVIEWS	LOCAL	06/91 06/96	100	RMT & TA IN PYS AND PHARMACY MANAGEMENT THEREAFTER	REGIONAL CAPITALS	IDA
	IEC STAFF	16	- COMMUNITY DEVELOPMENT	LOCAL	01/91 12/96	16	REGIONAL INSTITUTE	TO BE DETERMINED	UNIC
	DEVELOPMENT COMMITTEE MEMBERS	160	- YEARLY WORKSHOPS TO DEFINE, EVALUATE AND REFINED THE IEC STRATEGY	LOCAL	01/91 12/96	60	RMT	REGIONAL CAPITALS	IDA
	ACCOUNTANTS AND BUDGET OFFICERS	16	- BUDGET PREPARATION AND MONITORING, ACCOUNTING PRACTICES AND CONTROLS (SEMINARS)	LOCAL	01/91 12/94	48	ITALIAN INSTITUTE (SMA 7)	-	USA
	PERSONNEL OFFICERS	10	- PERSONNEL MANAGEMENT, INCLUDING MANAGEMENT OF TRAINING (YEARLY)	LOCAL	01/91 12/96	10	SHORT TERM T.A.	-	USA
	ADMINISTRATIVE OFFICERS	100	- TRAINING IN ADMINISTRATION, CLERICAL SKILLS, DM, ACCOUNTING, COMPUTER SKILLS (SEMINARS)	LOCAL	01/91 12/96	100	ITALIAN INSTITUTE	-	USA
2. IMPROVING SECTORAL RESOURCE MANAGEMENT									
DRUGS	STAFF OF PHARMACY DIVISION IN ROTVSA	6	(A) TRAINING IN PHARMACEUTICAL SYSTEMS DESIGN MANAGEMENT AND CONTROL SEMINARS	FOREIGN	01/91 12/96	72	SCHOOL OF PHARMACY	TO BE DETERMINED	IDA
B. POPULATION COMPONENT									
1. INSTITUTIONAL SUPPORT									
- HUMAN RESOURCE DEVELOPMENT	STAFF OF ADMINISTRATIVE AND FINANCIAL UNIT	3	- TRAINING IN PERSONNEL ADMINISTRATION AND MANAGEMENT (FOUR-MONTH)	FOREIGN	06/91 06/92	12	TO BE DETERMINED	TO BE DETERMINED	IDA
- PHYSICAL RESOURCES	STAFF OF CEPRIIS	2	(A) PHYSICAL FACILITIES PLANNING, INVENTORY MANAGEMENT	FOREIGN	01/91 12/92	18	SPECIALIZED DISTRICT	TO BE DETERMINED	IDA
		80	(B) THREE-TIERED TRAINING FOR FACILITIES PLANNING, INVENTORY AND MANAGEMENT (FOR REGIONAL AND DISTRICT STAFF, INITIAL SEMINAR PLUS TWO REFRESHERS)	LOCAL	01/91 06/96	36	CEPRIIS, THEN REGIONAL STAFF	BAHANG, THEN REGIONAL CAPITALS	IDA
2. INCREASING THE AVAILABILITY FOR AND USE OF FP SERVICES NATIONWIDE									
- DISTRICT LEVEL AND BELOW	HEALTH AGENTS (NURSES AND MIDWIVES)	300	FP PROGRAMS MANAGEMENT (INITIAL AND REFRESHER SEMINARS, ONE EACH YEAR)	LOCAL	06/90 06/91	1800	CEPDA (TRAINING ARRANGEMENT)	BAHANG	USA
	MIDWIVES AND UNPW	200	(A) FERTILITY AND FAMILY-PLANNING HEALTH CARE AS PART OF THE INTEGRATED MINIMUM PACKAGE, INCLUDING SCREENING OF G.C.	LOCAL	01/91 12/96	200	DEF. WITH SHORT-TERM T.A. & ANPPP	DISTRICTS	USA
			- SEMINARS ON TRADITIONAL DANGEROUS PRACTICES (E.G. FEMALE CIRCUMCISION)	LOCAL	01/91 12/94	80	DEF. UNPW & ANPPP	DISTRICTS	USA POP PLAN

SUMMARY OF TRAINING	MAN-MONTHS	% OF TOTAL
FOREIGN	8.48	7%
LOCAL	71.52	93%
TOTAL	80.00	100%

S.E.M.
Abdoulaye Diallo
Ministre de la Santé Publique et
des Affaires Sociales de la
République du Mali

ANNEX D

le 18 décembre 1990

AIDE MEMOIRE

DEUXIEME PROJET DE SANTE, POPULATION ET HYDRAULIQUE RURALE

Le présent aide-mémoire résume les mesures légales qui doivent être prises par la République du Mali afin: (I) que le Projet sus-mentionné soit présenté aux administrateurs de l'Association; (II) que l'Accord de Crédit et les documents y afférents puissent être signés; (III) que l'Accord puisse être déclaré en vigueur; et (IV) que les demandes de retrait au titre du Crédit puissent être acceptées par l'Association.

I. MESURES A PRENDRE AVANT QUE LE PROJET NE PUISSE ETRE SOUMIS AUX ADMINISTRATEURS DE L'ASSOCIATION

1. L'Association devra recevoir l'approbation écrite par le Gouvernement sur les documents juridiques tels que négociés. Un telex envoyé par vous-même serait satisfaisant.

2. L'Association devra recevoir les documents suivants:

(a) un texte approuvé en Conseil des Ministres:

- (i) abrogeant le décret 90-318 P-RM du 6 juillet 1990, et précisant que seuls 189 Médicaments Essentiels ("ME") seront exonérés de droits et taxes douanières;
- (ii) abrogeant le décret 3422 MSPAS du 26 juin 1985 pour préciser que les spécialités essentielles ne sont plus exonérées de droits et taxes douanières; et
- (iii) abrogeant l'article 3 du décret 85/PG-RM du 2 mai 1984 sur le monopole d'importation des médicaments et réactifs par la PPM et réglementant l'importation des médicaments par d'autres opérateurs;

(b) un texte interne au MSPAS approuvé et diffusé prévoyant l'élimination des 350 "spécialités essentielles" correspondant aux ME du catalogue de la PPM en deux phases, l'une à effet immédiat et la seconde d'ici novembre 1991.

Le mécanisme de prix interne à la PPM prévu dans le décret No. 90-2156 du MFC/MSPAS du 20 juillet 1990 s'appliquera jusqu'à ce que le contrat-plan, qui précisera la nouvelle formule de prix, ait été approuvé;

- (c) deux lettres circulaires approuvées et diffusées relatives, la première à l'autorisation de prescription et de distribution de contraceptifs et la seconde, à l'autorisation maritale et parentale reflétant les modifications convenues;
- (d) trois décrets approuvés en Conseil des Ministres libéralisant les conditions pour l'exercice privé des professions médicales et paramédicales, pharmaceutiques et sanitaires;
- (e) un décret approuvé en Conseil des Ministres formalisant le cadre administratif et juridique du système de santé de cercle reflétant les modifications convenues;
- (f) un texte approuvé créant le Comité de Suivi du Projet;
- (g) un texte approuvé créant et organisant la Cellule de Coordination du Projet et désignant de son personnel;
- (h) la stratégie approuvée de Planification Familiale, Information, Education, Communication; et
- (i) le contrat d'emploi au MSPAS d'un spécialiste en gestion du secteur pharmaceutique.

II. MESURES A PRENDRE AVANT LA SIGNATURE DE L'ACCORD DE CREDIT

L'Association devra recevoir les pouvoirs du Gouvernement désignant un représentant, avec faculté de substitution, pour signer, au nom de la République du Mali, l'Accord de Crédit ainsi que tous documents y afférents, notamment les lettres supplémentaires. Un telex envoyé par le Ministre des Affaires Etrangères et de la Coopération Internationale serait satisfaisant.

III. MESURES A PRENDRE AVANT QUE L'ACCORD DE CREDIT NE PUISSE ETRE DECLARE EN VIGUEUR

1. Conformément à la Section 12.01 (a) des Conditions Générales de l'Association, la République du Mali devra remettre à l'Association:
 - (a) une copie de la loi autorisant la ratification de l'Accord de Crédit ou de l'ordonnance de même effet prise en Conseil des Ministres;

- (b) une copie du décret du Président de la République du Mali ratifiant l'Accord de Crédit;
- (c) une copie du Journal Officiel publiant les textes envisagés aux paragraphes (a) et (b) ci-dessus;
- (d) une copie de l'instrument de ratification; et
- (e) le document accordant les pouvoirs au signataire de l'Accord de Crédit et documents y afférents au cas où l'Association n'aurait reçu qu'un telex avant la signature de l'Accord (voir (II) ci-dessus).

2. Conformément à la Section 12.01 (b) des Conditions Générales et à la Section 6.01 de l'Accord de Crédit l'entrée en vigueur de ce dernier est également subordonné aux conditions suivantes:

- (a) l'Accord de Don du FED A été signé au nom de l'Emprunteur et du FED;
- (b) l'Accord de Don de l'USAID a été signé au nom de l'Emprunteur ~~de l'USAID, et~~
- (c) le Contrat-Plan de la PPM jugé satisfaisant par l'Association a été signé au nom de l'Emprunteur et de la PPM.

3. Conformément à la Section 12.02 des Conditions Générales, l'Association devra recevoir un avis juridique de la Cour Suprême établissant:

- (a) que l'Accord de Crédit a été dûment autorisé ou ratifié par la République du Mali et qu'il remplit toutes les conditions requises par sa Constitution et ses textes législatifs et réglementaires;
- (b) que l'Accord de Crédit a été dûment signé et remis au nom de la République du Mali; et
- (c) que l'Accord de Crédit a pour la République du Mali force obligatoire conformément à ses dispositions.

4. Conformément à la Section 6.02 de l'Accord de Crédit, les mesures à prendre avant l'entrée en vigueur de ce dernier devront être remplies et l'Accord devra être entré en vigueur au plus tard 90 jours après la date de sa signature.

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IV. MESURES A PRENDRE AVANT QUE LES DEMANDES DE RETRAIT AU TITRE DU CREDIT NE PUISSENT ETRE ACCEPTEES

La République du Mali devra fournir à l'Association les pouvoirs des personnes autorisées à signer les demandes de retrait au titre du Crédit ainsi qu'un spécimen de leurs signatures.

Au cas où vous auriez des questions au sujet du présent aide-mémoire, n'hésitez pas à me le faire savoir. Veuillez agréer, Monsieur le Ministre, l'expression de ma plus haute considération.

Gian Domenico Spota

Gian Domenico Spota
Conseiller Juridique Principal

cc. S.E.M.
Mohamed A. Touré
Ambassadeur de la
République du Mali
Washington

MEMORANDUM

THE SECOND HEALTH, POPULATION AND VILLAGE WATER PROJECT

This memorandum summarizes the legal measures to be taken by the Republic of Mali so that: (I) the above referenced project could be submitted to the Association Executives; (II) credit agreement and related documents could be signed; (III) the agreement could take effect; and (IV) drawing requests under the Credit Agreement could be accepted by the Association.

I. MEASURES TO BE TAKEN BEFORE THE PROJECT CAN BE SUBMITTED TO THE EXECUTIVE ASSOCIATION

1. The Association should receive a written approval of the government on all legal papers as negotiated. A telex from you in person would be sufficient.
2. The Association should receive the following documents:
 - (a) a document approved in Council of Ministers
 - (i) superseding Order 90-318-P-GR of July 6, 1990, and specifying that only 189 Essential Drugs (ED) will be exempted from custom duties and taxes;
 - (ii) superseding Order 3422 MSPAS of June 26, 1985 and specifying that Essential Specialties are no longer exempted from custom duties and taxes; and
 - (iii) superseding article 3 in Order 85/PG-RM of May 2, 1984 on import monopoly of drugs and reactants by the PPM and regulating the import of drugs by other business operators;
 - (b) an internal paper in the MSPAS approved and circulated the removal of 350 "essential specialties" corresponding to ED in the PPM catalog in two phases, one taking effect immediately and the other by November 1991. The mechanism of internal prices at the PPM provided for in Order No. 90-2156 of the MFC/MSPAS of July 20, 1990 will be effective until the protocol of agreement which will specify the new price formula is approved;
 - (c) two memoranda approved and circulated relating the first one to the authorization to prescribe and distribute contraceptives and the second one, to the spouse or parental authorization reflecting the agreed changes;

- (d) three orders approved in Council of Ministers liberalizing requirements for the private practice of medical and paramedical, pharmaceutical and health professions;
- (e) an order approved in Council of Ministers formalizing the administrative and legal frame of the health system at cercle level reflecting the agreed changes;
- (f) an approved paper creating the project monitoring committee;
- (g) an approved paper creating and organizing the Project Coordination Unit and designating its staff;
- (h) the approved strategy for Family Planning, Information, Education, Communication; etc.
- (i) the employment contract at the MSPAS for a specialist in pharmaceutical sector management.

II. CONDITIONS PRECEDENT TO SIGNATURE OF THE CREDIT AGREEMENT

The Association should receive the powers from the Government for designating a representative, with potential substitutes, for signing, on behalf of the Republic of Mali, the Agreement of Credit as well as all related documents, especially additional letters. A telex sent by the Minister of Foreign Affairs and International Cooperation would be sufficient.

III. CONDITIONS PRECEDENT TO EFFECTIVENESS

1. In compliance with Section 12.01 (a) of the General Provisions of the Association, the Republic of Mali should give the Association:
 - (a) a copy of the Act authorizing the ratification of the Credit or of the Order with the same effects approved by the Council of Ministers;
 - (b) a copy of the Presidential Decree ratifying the Credit Agreement
 - (c) An issue of the *Journal Officiel* displaying the texts mentioned in paragraph (a) and (b) above:
 - (d) A copy of the ratification document; and
 - (e) The document transferring authority to the signatories of the Credit Agreement and related documents in case the Association would have only received a Telex before the signature of the Agreement (See (II) above).

2. In accordance with Section 12.01 (b) of the General Provisions and Section 6.01 of the Credit Agreement, implementation of the latter is also subordinated to the following conditions;
 - (a) The EDF Grant Agreement was signed on behalf of the Borrower and ED;
 - (b) The USAID Grant was signed on behalf of the Borrower and USAID
 - (c) The PPM Performance Contract, deemed satisfaction by the Association, was signed on behalf of the Borrower and PPM;

3. In accordance with Section 12.02 of the General Provisions , the Association should received a legal notice from the Supreme Court establishing:
 - (a) that the Credit Agreement was duly authorized and ratified by the GRM and that it complies with all the conditions required by its Constitution and its legal and regulatory texts;
 - (b) that the credit agreement was duly signed and delivered on behalf of the Republic of Mali; and
 - (c) that the Credit Agreement has a binding power for the Republic of Mali in conformance with its provisions.

4. In accordance with Section 6.02 of the Credit Agreement, the condition fulfilled prior to the enforcement of the latter should be satisfied and the agreement should be implemented within 90 days after the date of signature.

IV. MEASURES TO BE TAKEN BEFORE THE CREDIT TITLE REQUEST FOR DRAWING CAN BE ACCEPTED

The Republic of Mali should provide the Association with the credentials of the persons authorized to sign the Credit Title drawing request, as well as a specimen of their signatures.

In case you have questions about the present memorandum, please feel free to contact me.

ANNEX E: PROJECT BUDGET

COMMUNITY HEALTH AND POPULATION SERVICES PROJECT

BUDGET LINE ITEM	AMOUNT (In dollars)	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	TOTAL
1. TRAINING	2,245,348	216,984	417,028	457,700	486,672	402,116	264,848	2,245,348
2. CORE FAMILY PLANNING	1,593,820	808,240	436,240	260,240	30,000	30,000	30,000	1,593,720
3. OPERATIONS RESEARCH	2,000,000	300,000	300,000	300,000	400,000	400,000	300,000	2,000,000
4. TECHNICAL ASSISTANCE	900,000	300,000	150,000	150,000	150,000	150,000	0	900,000
5. CONTRACEPTIVES	2,000,000	333,000	333,000	333,000	333,000	333,000	333,000	2,000,000
6. COMMODITIES (vehicles & equipt)	300,000	200,000	100,000	0	0	0	0	300,000
7. EVALUATION	150,000	0	0	75,000	0	0	75,000	150,000
8. AUDIT	150,000	0	50,000	0	50,000	0	50,000	150,000
9. CONTINGENCY & INFLATION	711,547	53,964	86,780	113,534	142,647	169,447	145,175	711,547
TOTAL	10,050,615	2,212,521	1,872,381	1,689,807	1,592,653	1,484,896	1,198,357	10,050,515
TECHNICAL ASSISTANCE/FAMIL	1,425,000	510,000	315,000	240,000	240,000	120,000	0	1,425,000
TECHNICAL ASSISTANCE/FAMIL	1,425,000	510,000	315,000	240,000	240,000	120,000	0	1,425,000
TOTAL	2,850,000	1,020,000	630,000	480,000	480,000	240,000	0	2,850,000
GRANT TOTAL	12,900,615	3,232,521	2,502,381	2,169,807	2,072,653	1,724,896	1,198,357	12,900,615

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ANNEX F
INITIAL ENVIRONMENTAL EXAMINATION

- Project Location: First (Kayes), Second (Koulikoro), Fourth (Segou), and Fifth (Mopti) Regions; and the District of Bamako
- Project Title: The Community Health and Population Services Project (688-0248)
- Funding: FY 1991-1996 US \$12,900,000
- Life of Project: 7 years
- IEE Prepared by: Wayne McDonald, Acting Mission Environmental Officer WM
- Recommendation: Categorical Exclusion

Project Description:

USAID's strategic objectives are aimed at improving health and education, increasing incomes, and encouraging private sector participation in the economy. It is in this strategic framework that we propose the Community Health and Population Services Project (CHPS). This project is integrally linked to the Second Health, Population and Rural Water Supply Program of the World Bank (WB), whose goal is to help the Government of Mali increase the sustainability and effectiveness its family health service delivery. This will be done by increasing access to health care, improving the quality of health care, providing essential drugs, maximizing the use of resources, and increasing the demand for and availability of family planning services.

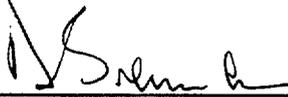
USAID's participation in this collaborative effort cross-cuts the Bank's health, population and water supply components, focusing on human resource development for integrated family health service delivery; (2) Information-Education-Communication programs for health and family planning; (3) core population and family planning initiatives; (4) operations research and innovative family health activities; and (5) contraceptive procurement and distribution.

No construction or water supply systems will be funded by USAID. Only technical assistance, training, equipment, and health and family planning commodities will be provided.

- Discussion of Environmental Issues: None of the interventions described above have any conceivable effect on the environment and qualify for a categorical exclusion under 216.2(C)(1)(i) and 216.2(C)(2)(i)&(viii): programs involving technical assistance, training, nutrition, health care, population and family planning. A categorical exclusion is therefore appropriate.

- Recommendation: Based on the above discussion, I have determined that per 216.2(c)(1)(i) and 216.2(C)(2)(i)&(viii), the CHPS Project is not subject to environmental procedures and I therefore recommend a categorical exclusion.

Approved by:



Dennis J. Brennan
USAID/Mali Mission Director

Date:

2/28/91

Concurrence:

Bureau Environmental Officer:

Approved: _____

Disapproved: _____

Date: _____

Clearance:

General Counsel: _____

Date: _____

ANNEX G

PID REFERENCES

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ANNEX H

HEALTH DEVELOPMENT PROJECT

FACT FINDING MISSION

REPORT

Submitted by:

Bonnie L. Kittle - PHC Consultant
Bineta Ba Diagne - Health Care
Financing Advisor/REDSO/WCA
January 14, 1991

Report
Commissioned by:
USAID/MALI

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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

SS

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 DNPFS'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.

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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

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"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	prod	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.

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Summary figures for 1989:

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

TABLE 3.4

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

Mths	Revenue for for Service	Expenditures					mth bal- ance	Accum. bla- ance
		Diret@	Drugs	supply	prodt	combt		
Jan.	576035	12125	511979	73095	20400	7150	-48714	-48714
Feb.	650140	64780	402846	69005	29780	11350	+72379	+23665
Mar.	622350	14450	391372	66552	11880	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	10480	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.

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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.

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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	+4,881,106
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)

<u>REVENUES</u> (fee for Service)		<u>EXPENDITURES</u>	
consultations	237,400	drug purchase	1,420,465
surgery	530,000	office supplies	343,600
minor surgery	190,000	DHC maintenance	61,220
medicine	330,000	transpt*/travel	71,610
deliveries	343,750	combustibles(gas)	209,365
laboratory	121,000	vehicle maint.	62,400
injections	27,150	maintenance prdts	44,225
bandages	<u>4,000</u>	fuel	23,600
TOT.REVENUES	1,783,300	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))	<u>unknown</u>	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	
<u>3,913,300</u>	<u>3,612,325</u>	<u>4,743,645</u>

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	
<u>3,963,450</u>	<u>3,579,565</u>	<u>4,309,234</u>

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 sutures	750 - 1000*	2000	1750
injection		500 - 1000*	
bandage		50	
		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.

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The preceding table shows that while the majority of costs are covered by the cost recovery system, there is a shortfall in Selinkegny 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:	total children 0-6 years:
- Bad. - 233	- Bad. - 1,117
- Sel. - 219	- Sel. - 1,048
- Dar. - 260	- Dar. - 1,244

SERVICES	Community Health Centers at						
	1990 Pop.	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.

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TABLE 3.9

COMPARATIVE MCH SERVICE DELIVERY FIGURESProject Districts of Kita, Bafoulabe, and Kenieba
and the Control District of Nioro du Sahel

In 1988

pregnant women/deliveries expected:	total children 0-6 years:
- Kita - 10,990	- Kita - 52,550
- Baf. - 6,507	- Baf. - 32,771
- Ken. - 5,198	- Ken. - 22,458
- Nio. - 5,984	- 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 Nioro 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
Nioro '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 Nioro 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 Nioko 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

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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

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TABLE 3.14

VACCINATION COVERAGEDistrict of KeniebaRegion 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.

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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

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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 Devl. 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 its 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 1
Terms of Reference

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 Cercle 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.

ANNEX 1

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:

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 Cercle 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 GRM 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

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 the 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.

*RISKS
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; MOPHSA/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 Diaby
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 Mbelli 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?

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

List of Courses Conducted and People Trained under the HDP

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<u>STAGES DE PERFECTIONNEMENT</u>	<u>COUTS</u> (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

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SEMINAIRES/ATELIERS SUR PLACE:

- En Santé Familiale à Kita et Bamako 2.111.935
9 infirmiers chefs CSA et 3 sages-femmes
et 1 IPC en 1984
- En Techniques d'Animation à Kita 307membres 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
chefs CSA , 3 sages-femmes et 2 IPC en 1985 2.486.520
- En Prescription de médicaments en DCI et sur
l'utilisation de manuels et formulaires, 1.102.450
thérapeutiques à Kita, 29 participants composés
de Médecins, Pharmaciens, Infirmiers CSC et
chefs CSA en 1986
- En organisation et supervision des activités de
SMI/PE à Kita 13 agents composés de Médecins, 1.325.790
infirmiers CSC, chefs CSA et sages-femmes en 1986
- En Information et Education pour la santé à 1.327.710
Kita, 58 agents composés de TDC, TS, chefs de
ZAF, ATC, chefs CSA et responsable de FMI et
Maternité en 1986.
- En Réforme pharmaceutique à Bko. 10 participants
comprenant Directeur et pharmaciens régionaux 310.240
Kayes, médecins et pharmaciens de la zone du Projet
en 1987
- Au cours supérieur FEV à Bamako. 4 agents composés
du Directeur Régional Kayes et des médecins chefs
de la zone du Projet en 1987 376.500
- En Recherche appliquée à Kita. 14 responsables de
Région de Kayes ce sont les Directeurs régionaux
de la région de Kayes, les médecins chefs et les
agents de l'ULCPDS en 1987 2.821.440

- 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 256.080
- 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 181.500
- En formation de gérants de pharmacie villageoise de Kita 32 agents de 32 Villages en 1987 468.365
- En formation des agents clés des OVA 147 secrétaires, 135, trésoriers 74 réparateurs de pompes à partir de 1986
- Formation en programmation budgétisation et suivi mobilisation des ressources locales, 27 agents de l'ODIFAC et de la Coopération depuis 1985.
(Voir budget de ces deux dernières opérations dans le budget programme ULCFDS)

STAGES DE PERFECTIONNEMENT

COUTS

- 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
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

TOTAL FORMATION A L'EXTERIEUR	33.790.703

Annex 7

Proposed Drug Reform Master Plan

OBJECTIVE	PROPOSED MEASURES	DATE	RESPONSIBILITIES	
A. MAKE ESSENTIAL DRUGS (E.D.) AVAILABLE	- FORMALIZE OFFICIAL LIST OF 100 E.D. (60 FOR THE DISTRICT LEVEL), INCLUDING CONTRACEPTIVES, AND BAN THE IMPORT OF EQUIVALENT SPECIALTIES	DISBURSEMENT CONDITION	MOHSA (DPM)	
	- CHANGE THE OUTPUT MIX OF UPPP IN LINE WITH THE E.D. POLICY	NOVEMBER 1991	MOHSA (DPM)	
	- 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	DPM/CONSULTANTS	
	- AT ALL TIMES, ENSURE THAT 56 OUT OF 60 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	MOHSA (DPM)
		- AGREE WITH IDA, AND APPLY, A PRICE FORMULA BASED ON THE BAHAWO 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 BAHAWO 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	DPM
		- TRAIN THE PRESCRIBERS IN PROPER E.D. USE BASED ON TREATMENT PROTOCOLS		
- INFORM THE PUBLIC ON E.D. (PURPOSE, PRICING, ETC..)		AS CONC. OPNS	DPM, KPM, ...	
- MONITOR AT THE COMM, DHC, HOSPITALS LEVEL				
D. IMPROVE THE EFFICIENCY OF PPM AND UPPP	- AGREE WITH IDA AND IMPLEMENT A DETAILED ACTION PLAN (CAHIER DES CHARGES), TO COMPLEMENT THE CONTRACT PLAN, COVERING IN PARTICULAR:	DISBURSEMENT CONDITION	MOHSA (DPM)	
	- 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)			
E. ENABLE THE DEVELOPMENT OF A PRIVATE PHARMACEUTICAL SECTOR	- PPM'S PERFORMANCE OBJECTIVES (SALES OF E.D., EMPLOYMENT, COSTS, ETC..) SPECIFIED			
	- AGREE WITH IDA ON AND IMPLEMENT A SIMILAR ACTION PLAN FOR UPPP, COVERING IN PARTICULAR:	DISBURSEMENT CONDITION	MOHSA (DPM)	
	- THE MODALITIES FOR CHANGING UPPP PRODUCTION RISK			
	- THE RIGHT OF DEPOTS TO PROCURE DIRECTLY FROM UPPP			
F. REDUCE DEPENDENCE ON A SINGLE SOURCE OF DRUG SUPPLY	- REVISE THE REGULATORY FRAMEWORK () INCLUDING THE MARGINS FOR PRIVATE PHARMACIES, IN A MANNER SATISFACTORY TO IDA	NOVEMBER 1991	MOHSA (PHARMACY DIVISION)	
	- DEFINE THE CONDITIONS FOR OPENING UP AN OPEN, MULTIPLE CHANNEL DRUG IMPORT AND DISTRIBUTION SYSTEM	PROJECT YEAR 1	MOHSA/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	DISBURSEMENT	PHARMACY DIVISION	
	- USE UNICEF FOR ADDITIONAL CONTROLS			

TABLE ..

PROPOSED DRUG SUPPLY SYSTEM

LEVEL	STOCK	PRICING	MANAGEMENT	CONTROL	REPLISHMENT
COMM	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 - REPLISHMENT FROM PPM DISTRICT DEPOTS OR PRIVATE SUPPLIERS
DISTRICT	DISTRICT DEPOTS = ONE YEAR INITIAL STOCK (30 CENTS/PERSON PLUS BUFFER STOCK 10 CENTS/PERSON AFTER 6 MONTHS)	UNIFORM COUNTRYWIDE, BASED ON AGREED PRICE FORMULA	MANAGEMENT COUNCIL (TRAINING)	NURSE AND TREASURER	- FUNDS DEPOSITED IN BANK - REPLISHMENT 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 BAHAWO PRICE, SAME AS UNIPAC OR INTERNATIONAL DISPENSARY ASSOCIATION	MOHSA	DONORS' MONITORING GROUP, LED BY UNICEF	- FUNDS DEPOSITED IN BANK - YEARLY ICB PURCHASE BASED ON PROJECTIONS OF CONSUMPTION

Annex 8

Proposed District-Based Health Care System
Second Health, Population and Water Supply Project

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 (CDHC) (AVERAGE 11 PER DISTRICT)	NURSE NURSE'S AIDE CLERK/PHARMACEUTICAL AIDE	<ul style="list-style-type: none"> PROVIDE BASIC HEALTH CARE PACKAGE <ul style="list-style-type: none"> - CURATIVE - VACCINATIONS - FHC - FAMILY PLANNING - PHARMACY - IDENTIFY CDHC STAFF - MEET WITH LDC ANNUALLY RE DHP - DISCUSS DISTRICT CONTRIBUTIONS TO CDHC PROGRAM 	<ul style="list-style-type: none"> - LOCAL DEV. COMMITTEE - MANAGE THE CDHC - IEC TO PROMOTE SELF-CARE - OUTREACH TO IMPROVE RESPONSIVENESS TO LOCAL NEEDS 	<ul style="list-style-type: none"> - CONTRACT WITH DISTRICT IN CONTEXT OF DHP - PROTOCOLS FOR DELIVERY OF HEALTH SERVICES - PERFORMANCE INDICATORS
SUB-DISTRICT (268 IN COUNTRY)	ENHANCED CDHC (2-8 PER DISTRICT) UNDER THE PROJECT	SAME AS CDHC, PLUS ONE PRATICAL NURSE (IDE)	<ul style="list-style-type: none"> SAME AS CDHC PLUS: <ul style="list-style-type: none"> - LIMITED REFERRAL SERVICES E.G. - MICROSCOPIC EXAMS (IDE) - RESPOND TO URGENT HEALTH CARE NEEDS OF POPULATION NOT YET COVERED BY A CDHC 	- SAME AS FOR CDHC	- SAME AS FOR CDHC
DISTRICT (46 IN COUNTRY)	DISTRICT HEALTH CENTER (DHC) (1 PER DISTRICT)	15 - 20 STAFF	<ul style="list-style-type: none"> - DELIVER A MINIMUM PACKAGE OF REFERRAL SERVICES FOR THE ENTIRE DISTRICT INCLUDING: <ul style="list-style-type: none"> HOSPITAL SERVICES: <ul style="list-style-type: none"> - MEDICAL - SURGICAL - PEDIATRIC - GYN. GMS TECHNICAL SERVICES: <ul style="list-style-type: none"> - LAB & RADIO SPECIALIZED SERVICES: <ul style="list-style-type: none"> - DENTAL & OPHTHALMOLOGICAL 		<ul style="list-style-type: none"> - PROTOCOLS FOR PROVIDING PREVENTIVE AND CURATIVE CARE - PERFORMANCE INDICATORS - DISTRICT HEALTH DEVELOPMENT PLAN (DHP) - CONTRACTS BETWEEN CDHCs AND DHCs IN CONTEXT OF DHP - STAFFING PLAN, REPORTS - PROTOCOLS
	DISTRICT HEALTH TEAM (DHT)	<ul style="list-style-type: none"> - CHIEF MEDICAL OFFICER - DEPUTY MEDICAL OFFICER - FIN./ADM. OFFICER - PUBLIC HEALTH NURSE - PHARMACEUTICAL NURSE - 2 COMMUNITY DEVELOPMENT SPECIALISTS 	<ul style="list-style-type: none"> - DEVELOP DISTRICT HEALTH DEVELOPMENT PLAN (DHP) - MANAGE DISTRICT HEALTH CARE SYSTEM, INCLUDING: <ul style="list-style-type: none"> - P & B - STAFFING PLAN - PROCUREMENT AND DISTRIBUTION ESSENTIAL DRUGS - TRAINING AND SUPERVISION THROUGHOUT DISTRICT - MONITOR PROGRAM ACCEPTANCE AND PERFORMANCE 	<ul style="list-style-type: none"> DISTRICT HEALTH COMMITTEE: <ul style="list-style-type: none"> - IDENTIFY CDHC 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 	<ul style="list-style-type: none"> - DISTRICT HEALTH DEVELOPMENT PLAN (DHP) - CONTRACT WITH CDHC AND BETWEEN CDHCs AND DHCs - STAFFING PLANS, REPORTS, PROTOCOLS
REGION (7 IN COUNTRY)	REGIONAL HOSPITAL (ALL REGIONS EXCEPT KOUKOURA)	20 - 30 STAFF	<ul style="list-style-type: none"> - PROVIDE FULL RANGE OF 2ND LEVEL REFERRAL SERVICES 		<ul style="list-style-type: none"> - FINANCIAL AUTONOMY
	REGIONAL HEALTH TEAM (RHT)	<ul style="list-style-type: none"> - 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) 	<ul style="list-style-type: none"> - COORDINATE AND MANAGE PHYSICAL, PHARMACEUTICAL, AND BUDGETARY RESOURCES FOR THE REGION - APPOINT MEMBER PD DHTS - REDEPLOY STAFF (MIS) - MANAGE TRAINING OF IEC PROGRAMS - SUPERVISION OF PROGRAMMED ACTIVITIES AT THE DISTRICT LEVEL. - REVIEW DISTRICT ANNUAL REPORT - RECOMMEND DISTRICT BUDGETARY ALLOCATIONS 		<ul style="list-style-type: none"> - PERFORMANCE INDICATORS - MIS FOR CIVIL SERVANTS - PHYSICAL INVENTORY

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

<p>CENTRAL</p>	<p>NATIONAL HOSPITALS MINISTRY OF PUBLIC HEALTH AND SOCIAL AFFAIRS (MOPHSA)</p> <ul style="list-style-type: none"> - DNPSS DIRECTION NATIONALE DE LA PLANIFICATION ET FORMATION SOCIO-SANITAIRE - DNGP DIRECTION NATIONALE DE LA SANTE PUBLIQUE - DNF DIRECTION NATIONALE DE LA SANTE FAMILIALE - DNPA DIRECTION NATIONALE DE L'HYGIENE PUBLIQUE ET DE L'ASSAINISSEMENT - DNAS DIRECTION NATIONALE DES AFFAIRES SOCIALES - CAF DIRECTION ADMINISTRATIVE ET FINANCIERE - DNAS AND DNPA INSPECTION DE SANTE (WITHIN DNPSS) - CEPRI CELLE D'EXECUTION DU PROGRAMME DE RENFORCEMENT DES INFRA- SANITAIRES - PROJECT COORDINATION UNIT - COORDINATION WITH OTHER MINISTRIES MOPH (MINISTRY OF EDUCATION) RE SCHOOL OF MEDICINE AND PHARMACY, FONCTION PUBLIQUE (CIVIL SERVICE) RE TRENDS IN EMPLOYMENT) 	<p>50-100 STAFF</p>	<ul style="list-style-type: none"> - PROVIDE FULL RANGE OF TERTIARY REFERRAL SERVICES - RATIONALIZATION OF SECTOR RESOURCES HEALTH SECTORAL PLANNING, P & B TRAINING, IEC AND PERSONNEL ALLOCATION - DESIGN AND IMPLEMENT TRAINING AND IEC - DESIGN AND IMPLEMENT FP, TRAINING AND IEC - TRAINING RELATED TO RURAL WATER SUPPLY - TRAINING FOR FAMILY PLANNING ACTIVITIES, WITH SIGNIFICANT SUPPORT FROM USAID - BUDGET MANAGEMENT - PERSONNEL MANAGEMENT - PROCUREMENT, ACCOUNTING - DEVELOP GUIDELINES FOR COMMUNITY MOBILIZATION BY THE DHT AND KEY ELEMENTS OF THE HEALTH EDUCATION MESSAGES; STRENGTHEN PROGRAM STRATEGIES IN THE PROJECT REGIONS - CIVIL WORKS QUALITY CONTROL - LIAISE WITH DONORS COORDINATE AND MONITOR PROJECT IMPLEMENTATION 		<p>FINANCIAL AUTONOMY</p> <ul style="list-style-type: none"> - OPERATIONAL MONS/GUIDELINES - ANNUAL REPORTS - MOPHSA BUDGET
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SOURCE: MSPAS, 1988

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