PD-BAQ 276

File Mali

CLASSIFICATION

PROJECT EVALUATION SUMMARY (PES) — PART I

Report Control Symbol U-447

1. PROJECT TITLE	2. PROJECT NUMBER	3. MISSION/AID/W OFFICE
MALI RURAL HEALTH SERVICES DEVELOPMENT	666-0206	USAID/BAMAKO

4. EVALUATION NUMBER (Enter the number maintained by the reporting unit e.g., Country or AID/W Administrative Code, Fiscal Year, Serial No. beginning with No. 1 each FY)

☒ REGULAR EVALUATION ☐ SPECIAL EVALUATION

5. KEY PROJECT IMPLEMENTATION DATES	6. ESTIMATED PROJECT FUNDING	7. PERIOD COVERED BY EVALUATION
A. First PRO-AG or Equivalent FY 77	A. Total $~~4.76 mil~~	From (month/yr.) June 1978
B. Final Obligation Expected FY 81	B. U.S. $ 3.89 mil	To (month/yr.) April 1982
C. Final Input Delivery FY 82		Date of Evaluation Review 26 April 1982

8. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR

A. List decisions and/or unresolved issues; cite those items needing further study. (NOTE: Mission decisions which anticipate AID/W or regional office action should specify type of document, e.g., airgram, SPAR, PIO, which will present detailed request.)	B. NAME OF OFFICER RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED
1. Prepare PIL closing out project.	Thomas Park	May 1982
2. A follow-on project is recommended which would focus on strengthening the MOH support system at the national level in order to lay the foundation for the future expansion of primary health care.		
3. A funding bridge is required to support activities in Koro until the follow-on project is put in place.	Thomas Park	May 1982
4. Prepare PID.	Thomas Park	June 1982

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS

- ☐ Project Paper
- ☐ Financial Plan
- ☐ Logical Framework
- ☐ Project Agreement
- ☐ Implementation Plan e.g., CPI Network
- ☐ PIO/T
- ☐ PIO/C
- ☐ PIO/P
- ☐ Other (Specify) _____
- ☐ Other (Specify) _____

10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT

- A. ☐ Continue Project Without Change
- B. ☐ Change Project Design and/or ☐ Change Implementation Plan
- C. ☒ Discontinue Project

11. PROJECT OFFICER AND HOST COUNTRY OR OTHER RANKING PARTICIPANTS AS APPROPRIATE (Names and Titles)

Thomas E. Park, Public Health Advisor, USAID/Bamako

12. Mission/AID/W Office Director Approval

Signature

Typed Name David M. Wilson

Date May 3, 1982

AID 1330-15 (3-78)

13. SUMMARY

The Mali Rural Health Project began in June 1978 for a four-year period at a cost to AID of $3,890,000 (grant). The purpose of the project is to develop an affordable and replicable primary health care service system bringing both curative and disease preventive services to the village level. The system includes training, supervision, technical and logistical support and referral activities linking village health workers (VHWs) to trained health personnel at higher levels in the MOH hierarchy. After 46 months of experience, the project has more than amply demonstrated that, given the means and incentives, MOH personnel are capable of operating a primary health care system in Koro, where a team based at the cercle health center has been trained to support and supervise approximately 155 VHWs in 56 villages covering about 70,000 people.[1/] The Koro experience has produced a wealth of information, particularly in the selection, training, and supervision of VHWs, which is being used by MOH planners at the national level.

In Yelimané, the project was not able to establish a demonstration primary health care (PHC) system. High personnel turnover, erratic contractor performance, difficulty of access, and other structural constraints combined to prevent a demonstration system from being achieved.

While the PSR has not produced epidemiological data proving the efficacy of VHWs, the descriptive reports of VHW activities, their use of a limited range of drugs and village support for them suggests there is a modest impact on health status. Improving the referral system would do the most to increase VHW efficacy.

One of the key assumptions in the design of the project was that out of the budget available for health, the MOH could afford to pay the recurring costs of a PHC system. The per capita recurring costs of the Koro project are estimated to be 98 FM or 16¢ at a 600 exchange rate (Gray, Awantang Reports). While this is a remarkable accomplishment and represents an enormous economy, the sad truth is this figure is at least 20 times greater than the Koro MOH operational budget, which had to be reduced 25% in 1981 (Awantang). The steady deterioration of GRM finances since 1976 was not envisaged by the project designers. For this reason alone, there is no escaping the conclusion the project is not affordable.

14. EVALUATION METHODOLOGY

The purpose of this evaluation is to measure progress toward attainment of a demonstration rural health system, to identify and evaluate constraints to such attainment, and to determine whether such a demonstration system is replicable and affordable. Based on an assessment of major project issues, the information produced by the project, and on the evaluation reports, the results should provide guidance for the continuation of AID-funded health activities in Mali.

The final evaluation was divided into three different scopes of work:

1) the management of the project, to include an analysis of recurring costs, of the logistical system (drug supply, equipment use, transportation, communication), of the information system, and of the planning, organization, and integration of project activities within the MOH structures;

[1/] Population coverage is defined as being within 5 km of a VHW.

2) an analysis of the VHWs' role and performance, to cover diagnostic and treatment skills, referrals, health promotion activities, record keeping functions, use of drugs and training material, the VHW support system, training, the effectiveness of supervision, and an assessment of the health impact of project activities;

3) an assessment of project activities in terms of villagers' needs, to cover the extent of village participation, VHW selection criteria, degree of participation of MOH personnel, and collaboration with other organizations.

The joint GRM/USAID evaluation team consisted of a GRM sociologist, an AID public health physician, and an AID health management specialist.

The evaluation was based on a study of project documents, reports, surveys, and on interviews with key personnel. Field visits were made to Mopti, Koro, and Yelimané for interviews with local personnel and with a sample of VHWs and villagers.

15. EXTERNAL FACTORS

The most important external factor having an impact on the project has been the steady deterioration of government finances which is reflected in the MOH's incapacity to support even the barest minimum of recurring costs. The project's first quarter 1981 budget for Koro was $2,469 while the MOH Koro budget for the same period was $188. This MOH budget is all that's available to pay the operating costs of a health system which is supposed to cover about 100,000 people[1/] ($752/100,000 = 3/4 of a penny per person per year!) While the project's achievement to reduce its annual per capita recurring costs to o/a 16¢ is remarkable, it nevertheless remains more than 20 times what the MOH could reasonably expect to support in the foreseeable future.

The GRM's drug pricing policy is another external factor. The project is required to sell its drugs at official "Pharmacie Populaire" prices, which are uniformly very high. This policy has had an adverse impact on the project in that some drugs, e.g., oral penicillin, are probably priced beyond the reach of most villagers. This not only limits the number of consultations, but, perhaps more importantly, increases incomplete drug utilization, thus contributing to drug resistance.

Thirdly, the very large out-migration of males in the Cercle of Yelimané and the social/economic consequences have rendered invalid the Yelimané-Koro comparative approach, as outlined in the PP and ProAg.

Fourthly, the resistance by local officials to approve of full service delivery in one arrondissement while providing only the sale of drugs to neighboring ones has rendered invalid the comparative arrondissement approach, as outlined in the PP and ProAg.

1/ 100,000 is the estimated total population of the Koro Cercle, of whom about 70,000 are covered by project activities.

16. INPUTS

In the area of technical assistance, deficiencies in the contract team's planning, organizing, and implementing of activities have been noted. There have been personality conflicts within the team, disputes over contractual arrangements, high turnover rates and, in some cases, poor performance. At the end of the first two years, the entire contract team of 5 was replaced. A bright spot was the performance of the first contract advisor based in Koro.

These deficiencies could have been prevented, or at least minimized, with better preparation. The first cycle of contract advisors arrived with an extremely brief and inadequate orientation by the home office. Several of them had barely skimmed through the PP and ProAg and one of them had never even heard of these documents.

There has also been a lack of continuity in MOH personnel assigned to the project. By the end of the first three years, the entire MOH team at the cercle, regional, and national level, including the project director, had changed. At one point, Yelimané was without a Medecin-Chef for eight months. The status of the Koro Medecin-Chef has been unclear since December 1981.

These problems have resulted in communication breakdowns between the contract team and the MOH as well as in lapses in the continuity of project direction.

In part, these problems are structural. The remote and harsh Sahelian environment, the heat, and the lack of creature comforts make adjustment a constant struggle for Americans and Europeans. As is true in other projects, finding candidates who are fluent in French, technically qualified, experienced, and willing to work in the Sahel has been enormously difficult. At the end of the mid-term evaluation, there was agreement that Yelimané's particularly harsh living conditions, its remoteness, and difficulty of access all meant that full-time technical assistance was not viable there. Consequently, Yelimané has not benefited from a full-time contract advisor since May 1980. Before then, two different advisors resigned without having developed an operational PHC system. (The second cycle of contract personnel, with the hiring of native French-speaking physicians, has resulted in improved performance).

The MOH has had an equally difficult time finding and keeping competent Malian health personnel who are willing to stay two years or more in a rural health post. The staff suffers the additional hardship of being poorly and irregularly paid. Until the MOH has the means to provide incentives to its personnel who do the work of primary health care, high personnel turnover is unlikely to change and health activities will continue to be handicapped because of it.

Under commodities, there were problems in the use of U.S. drugs. They come in different dosages from what is generally available from European sources. (For example, U.S. chloroquine comes in 150 mg doses, European in 100 mgs). Regulations to purchase U.S. drugs have created a training and prescription situation which will cause confusion when the project ends.

Project-purchased Land Rovers are extremely expensive to operate. These costs would increase geometrically were activities to begin in more distant arrondissements. Given the heavy proportion of transportation-related costs in the project's recurring costs (approximately 70%), cheaper supervision methods need to be developed.

The project was called on to train five MOH physicians at the MPH level. Although such U.S. based training was offered to all the physicians involved in the project, only one accepted. The apparent reason for the lack of interest is that MOH personnel see little financial security or professional satisfaction in public health and limited career ladder opportunities in an unrecognized MPH degree.

During the life of this project, 13 Peace Corps Volunteers were selected, trained and assigned to work in the two project zones. With one or two exceptions, the quality and quantity of their work has been good.

17. OUTPUTS[1/]

Most of the outputs recorded by the project come from the Koro zone. Of the 211 VHWs trained, 155 (73%) come from Koro, of whom 50 are traditional birth attendants (TBAs). In a 10 day training period, VHWs are taught to diagnose and treat malaria (chloroquine), diarrhea (oral rehydration), childhood malnutrition (weaning foods), miscellaneous aches and pains (aspirin), conjunctivitis (opthalmic solution), and cuts and scrapes (first aid). VHWs learn how to provide nutritional surveillance for the under 5's (arm circumference measurement) monitor measles cases, and refer to higher levels the following health problems: convulsions, bloody diarrhea, respiratory infections, acute malnutrition, meningitis, birth complications, serious accidents, TB, leprosy, guinea worm, and schistosomiasis. In addition, VHWs are taught to keep records of consultations, births, deaths, and the inventory and sale of medicines. Training in health promotion consists of guinea worm prevention, the explanation of water hygiene and fecal contamination, and in the use of stories with other health education messages.

The diagnostic and treatment performance of most of the VHWs in Koro has been judged to be from adequate to good (Brown, White), although problems in chloroquine and penicillin utilization have been noted (LeTarte). Yelimané, on the other hand, has trained only 56 poor quality VHWs who are very infrequently supervised (Brown, Daulaire). Assessment of the VHW performance in Yelimané are difficult to make because of the lack of records on consultations and on drug utilization. In neither zone were VHW health promotive activities judged adequate (Brown, Cissé, White).

Most of the villages reached (70%) and population covered (82%) are in Koro. The difficulties encountered in Yelimané are responsible for the PSR being unable to reach the planned project total of 240 trained VHWs in 120 villages.

The ProAg calls for a detailed work plan that would spell out, among other activities, the community diagnosis process. This process, or information system, should be developed for each zone, according to the ProAg, and should contain base line data from which to identify health problems and to measure changes in health status. Despite constant reminders

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[1/] The number of VHWs trained, villages reached and population covered have increased since the final evaluation was completed in November 1981. This accounts for the discrepancies in output figures between this document and evaluation reports.

Outputs	ProAg Objectives	Attained
Trained VHWs, including TBAs	240	211
Trained Arrondissement level health personnel	9	13
Trained Cercle level health personnel	3	10
Trained Regional level health personnel	3	0
Trained National level health personnel	5	1,3 1/
Villages reached	120	80
Population covered	60,000	85,000
Community diagnosis reports (one from each zone)	2	0
Training manuals (one from each zone)	2	1
Establishment of a demonstration program (one from each zone)	2	1
Recurring costs	$2/person/yr 2/	$.16/person/yr

1/ 1 MPH participant in the U.S.; 3 trained to manage PHC programs at national level.

2/ See the discussions of recurring costs on pages 7, 9 and 12.

from both the GRM and USAID, the project functioned for three and a half years without an overall, acceptable work plan. (For causes, see Input Section). The lack of such a work plan has been a major flaw in the project and one of the consequences is that there is no information system with which to measure health impact nor to be used as a model for replication. Nonetheless, the Koro project has produced a wealth of useful information on PHC in Mali.

Lack of planning also resulted in the late development of the final training manual (a guide to the setting up and carrying out of VHW training programs), which was not made available until the 42nd month of the project, leaving very little time for adequate testing. The manual exists, nonetheless, and it represents the most complete work to date on organizing and carrying out a PHC training program in Mali.

As discussed elsewhere, the project was able to establish a demonstration program only in Koro.

The project's extremely low recurring costs is a notable accomplishment. Recurring costs are calculated from the project expenses for vehicle gas and maintenance, per diems, office supplies, training program expenses, and miscellaneous costs. The total of Koro expenses for the one year period October 1980 through September 1981 was 6.358.000 FM. Divided by the estimated 65,000 population covered by VHW activities during that time period, the recurring costs come to 98 FM, or 16¢ at a 600:1 exchange rate. (Note these calculations do not take into consideration overhead costs at the regional and national levels, which may be substantial).

There are possibilities to further reduce these costs in Koro through increased local financing and decentralized supervision. The prospects, however, for significant cost reductions below 16¢ are remote. Training more VHWs probably will not result in reduced per capita recurring costs because the Koro health staff is operating at or near maximum capacity. Any horizontal expansion, therefore, will require additional MOH staff, requiring in turn additional staff and logistical support, all of which is constrained by extremely small health budgets.

18. PURPOSE

Statement of project purpose: to design, implement, and evaluate a demonstration rural health program which the GRM can adopt as the basis for replication elsewhere. The system will:

a) bring health services to the village level, emphasizing health promotive and disease preventive activities;
b) be managed by trained MOH personnel at the national, regional, cercle, arrondissement, and village levels;
c) result in a measurable change in the health status of the target populations;
d) have annual operating costs of $2 or less per capita (in order to make GRM expansion and replication feasible).

The project has established a demonstration program in Koro (EOPS 1), which has more than held up its side of the bargain in VHWs trained (155), villages reached (56), and population covered (approximately 70,000). Of the 7 arrondissements in the cercle, 5 are covered by the PHC system. Achieving full horizontal coverage in the more distant arrondissements

would require increased transport resources and additional staff, because the cercle staff capacity is at or near the saturation point. Due to extremely limited financial resources, the MOH is not in a position to provide either.

There are constraints to vertical expansion as well. It is extremely unlikely the VHWs will accept any more tasks or responsibilities in the absence of remuneration. This problem was discussed at the mid-term evaluation. While acknowledging that their work was appreciated by the villagers, VHWs have mentioned that it has not been supported financially or in-kind. Lassitude in the performance of some VHWs in their present tasks has already been noted (Cissé).

An equivalent demonstration program was not attained in Yelimané. Poor project planning and high personnel turnover had an adverse effect on the continuity of project direction; staff performance suffered as a result, and an already difficult situation worsened. There was a 20-month period without any increase in coverage. The Yelimané VHWs have inadequate diagnostic and treatment skills, they do no health promotion, and receive little or no supervision. Consequently, it is not surprising that many of them are not functional. (The lack of information on the number of functional VHWs in Yelimané, for example, is an indication of an inadequate information system). Given the problems in finding qualified and experienced technical assistance, the difficulty of access, and the constraints in MOH finances, to achieve a demonstration program in a place as hard to work in as Yelimané is not feasible.

The project's training programs (EOPS no. 2) have been a mixed success. The evaluation reports note the curative orientation of the VHW, which is a reflection of how they were selected, trained and supervised. VHWs have brought a few basic health services to villagers previously outside the health system. These villagers felt needs are for curative services. Recognizing this, and also recognizing that disease prevention was the goal, it was decided nonetheless to focus training programs on curative care. The rationale was that by first providing a few simple curative services successfully, and thereby gaining credibility for the health system, the VHWs would be better placed to move into health promotion. However, to organize and make operational a series of activities (sensitization, training of trainers, curriculum development, training material production, selection and training of VHWs, setting up a village pharmacy system, defining and scheduling supervision and referrals, recordkeeping) and to keep it all going so that VHWs could perform a few, simple diagnostic and treatment tasks proved to be much more difficult and time consuming than anyone expected. It has also proved to be much more difficult to change than anyone expected. The project, despite the best of intentions, has gotten stuck in a largely curative mode. To reorient activities to preventive care requires not only the retraining of VHWs and possibly redefining their selection criteria, but also the redevelopment of training materials and curriculums, and the reorganization of supervision. Even more importantly, it means the fundamental reorientation of the existing MOH personnel. Not surprisingly, the project has encountered built-in resistance to doing this.

The capacity of trained MOH personnel to manage all aspects of the PHC system is not yet clearly established. The organization of VHW training activities in Koro, for example, still requires the presence of contract personnel. The technical issues, on the other hand, seem to be well handled by the MOH staff in Koro.

Strictly speaking, the project did not develop an information system (EOPS no. 3), defined as identifying a set of indices to measure change over the life of the project and to assess costs and benefits. At the beginning of the project, it was decided that conducting base line mortality and morbidity surveys would be too time consuming and too expensive to be feasible. It was also recognized that to expect a measurable impact on disease incidence within 4 years was unrealistic. Although there are measurements other than final outcome to evaluate health projects, such as the intermediate measures of health consumption, behavioral and attitudinal changes, etc. these sorts of evaluation indices were not adequately incorporated into the project's data-gathering activities. The lack of an information system is attributed to poor planning, lack of direction, and high personnel turnover during the first three years of the project. Having said this, the fact remains this project has produced more practical information on PHC than any other project to date in Mali. There are excellent reports on setting up a PHC system (Kelly-Sissoko), on recurring costs (Gray), and on VHW performance and training (Dulaire, Letarte, Baudouy). Health surveys have also been conducted on nutrition, infant mortality, malaria, and conjunctivitis.

An adequate flow of affordable basic medicines to the project zones has been achieved (EOPS no. 4). The project's drug sytstem, however, is still dependent on contractor personnel for management (for example, for customs clearance and transport to the project zones). This, coupled with GRM unfamiliarity with U.S. procurement and with different U.S. drug dosages (see Input Section), means the drug system is not yet replicable.

While the project succeeded in delivering health services at 16¢ per capita in Koro, it did not develop a system for defining recurring costs at the regional and national levels. Examples of these costs are the management of drug distribution, budgeting and accounting, planning and supervision associated with the Koro PHC system. Consequently, it is not known what these cost are. As a result, cost projections of personnel and logistical requirements for total cercle coverage are not known.

19. GOAL

Statement of project goal: to provide improved health services to the rural poor.

85,000 people in the two project zones now have access to a few simple curative services where previously none existed. Although the impact of these improved services cannot be demonstrated in terms of decreased morbidity and mortality, there is presumptive evidence of consumer satisfaction which may indicate improved health status.

The project has also demonstrated that MOH personnel can be trained to carry out a PHC program under very difficult Sahelian conditions, provided the following conditions are met:

- they have the means of transport (vehicles, gas, maintenance);
- there are adequate supplies of medicines;
- there is an adequate operating budget;
- there are financial incentives (per diems, salary supplements, etc.).

The project's hypothesis was that these minimum conditions could be met at the end of the project. Unfortunately, the MOH is probably further from providing minimally adequate financial support to health care now than five years ago.

In short, the project has probably accomplished much of what was expected of it, and under normal circumstances, it would have been affordable.

20. BENEFICIARIES

The direct beneficiaries of the project are the 85,000 people living in the two project zones who have access to a few basic health services. Although it can't be proven, infant mortality is presumed to have gone down due to oral rehydration, improved birth delivery, and curative and preventive malaria services. It was pointed out in both evaluations that adult males make up a disproportionately large share of the VHW clientele.

In direct beneficiaries are the 26 MOH personnel at various levels of the health system whose knowledge and practice of primary health care has been improved as a result of the project activities.

21. UNPLANNED EFFECTS

There were no significant unplanned effects of project activities.

22. LESSONS LEARNED

There are several points to be made with respect to use of contractors.

- The Chief of Party and back-stop officer should be managers/administrators rather than physicians.

- French-speaking and reading ability of all contractors including back-stop officers should not be compromised no matter what the level of technical expertise. If one's knowledge of French is not excellent from the beginning, misunderstandings will result, and the quality of work and the rapport with counterparts will be handicapped, perhaps irrevocably.

- Relevant field experience rather than credentials should be the second most important selection criteria.

- Contractors should spend considerable time in the U.S. being briefed before beginning project activities. In order to understand how to work with each other, there should be team-building exercises. They should be briefed on the operating procedures of the home office and its back-stopping functions so there is more clarity on mutual expectations.

- It should be insisted the contractors study carefully, not simply read, the project documents (PP, ProAg, and other relevant materials). Once arriving in country, the contractors and the project manager should spend at least a week together going over these documents with the purpose of developing a mutually acceptable work plan.

There are several points to be made on PHC in Mali.

- Site selection is very important. PHC programs are radical and ambitious enough without having to do them in remote, isolated corners of the country. If the site is more than one day's drive from the capital, it's probably too far. Difficulty of access and harsh living conditions result in contract personnel spending more time on creature comforts than on the work.

- MOH finances should be carefully studied during the design stage. Exactly what amounts are available for personnel, commodities, travel, operations, etc., in a given area need to be known. Annual per capita health expenditure is a far too simplistic yardstick of MOH resources.

- PHC programs require a minimally functioning health system. To get a sense of whether a health system is functioning, the following questions are among those which need to be asked:

Are MOH staff being regularly and adequately paid? Are there enough of them?
How many hours a day do they work?
Are they supervised? By whom? How regularly?
What are their training needs? How long since they have been retrained?
What drugs/medicines are available regularly at affordable prices?
What is the condition of the health facilities in the zone? What are their needs?
What are the transportation resources and needs?
How are gasoline and kerosene made available? Costs?
What are the maintenance capabilities? Availability of spare parts?

The purpose of asking these questions is to determine to what extent project resources are going to be used to put a health system on its feet before one can expect it to effectively train, supervise, support, and receive the referrals of a number of VHWs. If it is decided to invest project resources in the health infrastructure (at acceptable recurring cost levels), then planners should be aware that the outcome will be the provision of more or less static health services. This may be a perfectly valid outcome, and in fact may result in increased health coverage, but its unrealistic to expect an outreach PHC system. Most PHC programs <u>are</u> unrealistic because they are expected to reanimate and radically reform the health system at the same time and at replicable recurring costs within a 4 to 5 year period. It needs to be understood that PHC often represents an approach alien to the health establishment. It offers few, if any, professional rewards, depends heavily on managerial skills and personal sacrifice, and requires working under difficult conditions.

Finally, the project has shown that:

- villagers will accept a VHW's diagnoses of their ills and purchase his medicines;
- VHWs will stay on the job without pay provided they are adequately supervised;
- when a VHW-based program is set up to provide mainly curative services, it tends to get stuck there;
- MOH personnel will train, supervise, and support VHWs, provided they themselves are adequately trained, have the means, and are given the incentives.

23. SPECIAL COMMENTS

The conclusion of this evaluation is that the project's efforts to improve health care at the periphery have not been affordable within the GRM's currently available resources. The conclusion is not that AID should withdraw from the health sector or from primary health care. The corollary is that without a minimal training, planning, management and support base at the national level, sustainable health care cannot improve in Mali. The expansion of PHC at the periphery requires support for it at all levels in the health care system. The need is to strengthen the support system at the national level in order to lay the foundation for the future expansion of primary health care.

An example of support to the national level is curriculum development, where AID has been approached to assist in a major revision of teaching curriculum of the two nursing schools. Another example is the provisions of affordable and appropriate medicines. There are already efforts underway to develop a new national pharmaceutical system. A third example is the need to strengthen the maternal and child health/family planning service and training base in Bamako, so that there can be more effective supervision and support to such centers at the regional levels. A fourth is to assist the MOH in adopting policies which place health services on a sounder financial basis. It may well be true that an investment in the strengthening of the existing health infrastructure may result in as much or more benefit than an equivalent investment in the horizontal expansion of a deteriorating infrastructure. The need for national level support is recognized by the MOH and by other donors.

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