Putting communities in charge of health services in Benin, Guinea, and Mali

In some of the world’s poorest countries, putting communities in charge of health services, and allowing them to charge fees and manage the proceeds, increased the accountability of local health staff and improved health services for the poor.

The Bamako Initiative

In these three countries, serious disruptions to the situation of health services had occurred during the 1980s as a result of a severe economic recession and financial indebtedness. The health budget in Benin went from $3.31 per capita in 1983 to $2.69 in 1986. In Mali, rural infrastructure was almost nonexistent, and in Guinea, health services had almost totally disappeared—except in the capital city, Conakry—during the last years of the Sekou Touré regime. The vast majority of poor families in the three countries did not have access to drugs and professional health services. National immunization coverage was under 15 percent, and less than 10 percent of families used modern curative services.

The approach focused on establishing community-managed health centers serving populations of 5,000 to 15,000 people. An analysis of the main constraints in the three countries led to emphasis on service delivery strategies focusing on the poor. Priorities included:

- Implementing community-owned revolving funds for drugs with local retention and management of all financial proceeds.
- Revitalizing existing health centers, expanding the network, and providing monthly outreach services to villages within 15 kilometers of facilities.
- Stepping up social mobilization and community-based communication.
- Pricing the most effective interventions below private sector prices, through subsidies from the government and donors and through internal cross-subsidies within the system. Local criteria were established for exemptions (table 1).
- Having communities participate in a biannual analysis of progress and problems in coverage with health services—and in the planning and budgeting of services.
- Tracing and tracking defaulters—and using community representatives to increase demand.
- Standardizing diagnosis and treatment and establishing regular supervision.

Scaling up incrementally

The Bamako approach was implemented gradually, with the support of UNICEF, WHO, and the World Bank, building on a variety of pilot projects. Since the early 1980s, it was progressively scaled up in the three countries—from 44 health facilities in Benin to 400 in 2002, from 18 in Guinea to 367, and from 1 in Mali to 559. This raised the population with access to services within 5 kilometers to 86 percent in Benin, 60 percent in Guinea, and 40 percent in Mali, covering more than 20 million people. Importantly, a legal framework was developed to support the contractual relationship with communities, the cost-sharing arrangements, the availability of essential drugs, and community participation policies. Community associations and management committees were registered as legal entities with ability to receive public funds.

Better health outcomes for poor people

Over the 12 or so years of implementation in Benin and Guinea, and more than 7 years in Mali, health outcomes and health service use improved significantly. Under-five mor-

Table 1 Reaching out to benefit the poorest groups

<table>
<thead>
<tr>
<th>Disease targeting</th>
<th>Geographical targeting</th>
<th>Cross-subsidies</th>
<th>Exempting the poor</th>
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<tbody>
<tr>
<td>Focus on the burden of diseases of the poor: malaria, diarrhea, respiratory infections, malnutrition, reproductive health</td>
<td>Focus on rural areas. Larger subsidies to poorer regions</td>
<td>• Higher markup and co-payments on diseases with lower levels of priority</td>
<td>• Exemptions left to the discretion of communities</td>
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<td></td>
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<td>• High subsidies for child health services</td>
<td>• Exempted categories include widows, orphans</td>
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<td></td>
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<td>• Free immunization and oral rehydration therapy as well as promotion activities</td>
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fied with the quality of care, although 48 percent were not “fully” satisfied. Health care users found the availability of drugs to be high (over 80 percent said drugs were available) and the overall quality of care to be good (91 percent).

Greater access reduced travel costs, and the availability of drugs reduced the need to visit distant sources of care. Prices have been kept below those of alternative sources. In Benin the median household spending on curative care in a health center was $2 in 1989, less than half that at private providers ($5) or traditional healers ($7).217 Poor people still saw price as a barrier.218 And a large proportion of the poor still do not use key health services in all three countries. In Benin and Guinea the health system allowed for exemptions, and most health centers had revenue that they could have used to subsidize the poorest, but almost none did. Management committees typically valued investment over redistribution.

Immunization levels increased in all three countries.214 They are very high in Benin, close to 80 percent—one of the highest rates in Sub-Saharan Africa. Immunization rates are lower in Guinea and Mali, largely because of problems of access (figure 3). Coverage of other health interventions also increased. The use of health services by children under five in Benin increased from less than 0.1 visit per year to more than 1.0. In Mali exclusive breast-feeding and the use of professional services for antenatal care,215 deliveries, and treatment of diarrhea and acute respiratory infections increased for all groups, including the poorest (figure 4).216

In an independent evaluation in 1996 in Benin, 75 percent of informants were satisfied with the quality of care, although 48 percent were not “fully” satisfied. Health care users found the availability of drugs to be high (over 80 percent said drugs were available) and the overall quality of care to be good (91 percent).

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Community financing—a seat at the table

The community financing of key operational costs bought communities a seat at the table. Donors and governments had to systematically negotiate new activities with community organizations. Governments in all three countries, with the support of donors, continued to subsidize health centers, particularly to support revolving drug funds in the poorest regions. In Benin and Mali today the public subsidy to health services is about the same per capita for rich and poor regions. In Guinea, however, public spending has benefited richer groups most. But all three countries face the challenge of emphasizing household behavior change and protecting the poorest and most vulnerable. Establishing mechanisms to subsidize and protect the poor remains a priority of the current reform process.