Primary Health Care in Africa

A Study of the Mali Rural Health Project

Clive Gray, Jacques Baudouy, Kelsey Martin, Molly Bang and Richard Cash

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Preface

The present volume seeks to draw lessons for the strategy of improving rural primary health care in sub-Saharan Africa from a multi-disciplinary account and evaluation of a foreign donor-aided project conducted in Mali during 1978-1982. The project, known in French as the Projet Santé Rurale (PSR) and in English as the Mali Rural Health Project, was assisted by the United States Agency for International Development, which financed a contract for the purpose between the Government of Mali and the Harvard Institute for International Development (HIID). The Education Development Center (EDC) of Newton, Massachusetts, served as a subcontractor to HIID.

The team of authors comprises physicians (Richard Cash of HIID and Jacques Baudouy, then on contract to HIID, currently with the World Bank); a development economist (Clive Gray of HIID); a writer and illustrator (Molly Bang, then on contract to EDC); and an editor/writer (Kelsey Martin, then on contract to HIID). Authorship of the book may be allocated as follows: first drafts of all or part of Chapter 1 (Cash), Chapter 2 (Martin), Chapter 3 (Baudouy), Chapter 4 (Baudouy and Bang), Chapter 5 (Gray), and Chapter 6 (Cash). The final versions of all chapters were prepared by Clive Gray. In addition, Kelsey Martin did substantial editing work on the first drafts of Chapters 3 and 4.

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Introduction

Well before the World Health Organization's 1978 conference in Alma Ata enunciated the widely publicized goal of "Health for All by the Year 2000," but to an increasing extent in the wake of that event, governments of less-developed countries have promoted activities carrying the generic title of primary health care. These programs have the stated goal of extending rudimentary health services to the rural areas where most of the population lives. In many cases the programs are aided by official donors and voluntary agencies, who in turn participate to a greater or lesser extent in project design.

Few of these programs have fulfilled their initial targets of population coverage and service quality, and providing a meaningful level of health services to the majority of the world's population by the year 2000 is becoming an increasingly elusive target. Not surprisingly, this is particularly true in the poorest of these countries, a category that includes Mali, the subject of the present study.

A variety of health care models have been tested in the effort to discover how to make health care accessible to the rural population. Thus far, no single model has emerged as the final answer. A population's health depends on a complex and changing web of political, cultural, geographic, biological, and economic factors, all of which vary dramatically from society to society.

The experimentation that has taken place has, however, helped narrow the range of policy options both by highlighting approaches that bear promise of success and, perhaps more frequently (certainly the case described in the present volume), by identifying approaches that cannot be supported by local resources in the foreseeable future and should therefore be modified or even abandoned. At least in this sense the work that has gone on heretofore, including the Mali Rural Health Project, has helped pave the way for initiatives that should ultimately improve health conditions for rural dwellers in poor countries.

The Projet Santé Rurale in Mali

The present volume describes an effort to develop a primary health care program that could ultimately be replicated, under highly adverse conditions of geography and economics, throughout rural Mali. The project arose from a request in 1973 by Mali's Ministry of Public Health [Ministère de la Santé Publique (MSP)] to the U.S. Agency for International Development (USAID), and was executed by the Harvard Institute for International Development (HIID) in collaboration with the ministry under a USAID-financed contract with the ministry.

The design concept of the Projet Santé Rurale (PSR) called on the implementing team to identify those health problems which the public health service, operating through non-salaried village health workers, could help meet subject to a per capita expenditure ceiling. This latter was computed by dividing the central government's current health budget by the national population, yielding a figure close to two U.S. dollars. As the project progressed the relevance of this calculus in defining the level of budget resources available to finance rural primary health care came increasingly into question.

The project ended by concluding that the effective limit on available resources was a tiny fraction of the government's overall public health expenditure per capita. Hence the service model tested by the project with USAID financial support could not be maintained in the two sites where it was implemented, let alone replicated in other rural areas of Mali.

The USAID-MSP discussions that were to culminate, four years later and after many site visits by design teams, in launching the PSR, began in 1974. At that time attention focused on identifying service models that would have a positive impact in one or more of three subsectors of health care – maternal and child health, training of subprofessional health care providers, and drug procurement. Issues of cost and sustainability were not at the center of attention.

With the passage of time, ideas and concepts changed and all parties – the Ministry of Public Health, USAID, and HIID – came to recognize that the first priority was to determine what if any activities in the field of rural primary health care could become a permanent part of Mali's public health system.

In this light, the Mali Rural Health Project (PSR) was ultimately conceived to address two core questions:

1. What improvement in village health can be expected to follow when rural public health staff recruit local volunteers and give them a few days of training? and

2. Can the program be mounted and maintained at a financial cost low enough to be absorbed in the government budget or covered through supplementary local sources?

Determinants of Foreign Influence

The story of the PSR includes a wealth of observations of transactions among Malian public health officials, rural health workers, and villagers, but it is much more than just a Malian story. No less important are the interactions that took place between Malian public officials and the foreigners, including officials of USAID and an assortment of other health professionals, social scientists, and administrators, who helped design, implement, and evaluate the PSR, most of them under the auspices of HIID or its subcontractor, the Education Development Center (EDC) of Newton, Massachusetts.

The initial request from the Ministry of Public Health to USAID was for some hard cash to enable it to carry on and expand, for a

few years, a set of pre-existing public health services that the Malian government's welfare-state precepts called upon it to provide, *gratis*, to its population. It was the foreigners' dominant voice in design and implementation that transformed this request into an ambitious demonstration project that saw about two-thirds of the PSR's $3.9 million of USAID support go into a contract with HIID to supply expatriate advisors and consultants.

This outcome was heavily determined by a philosophy of social engineering in LDC rural areas that came to dominate USAID's project-based activity in the early 1970s. To a significant extent – though by no means exclusively – this philosophy was imposed by the Congressional committees controlling the agency's funding, out of a concern that much of the foreign aid, where not being siphoned off by corrupt officials, was indirectly benefitting upper income groups in the developing world. Accordingly the 1974 Foreign Assistance Act required that project aid be oriented towards assisting what in USAID parlance soon came to be known as the "poor majority." In most developing countries that meant, of course, the peasantry.

At the same time USAID was under a long-standing mandate not to dissipate its technical assistance resources in short-term relief programs but rather to fund activities that would yield an economic return. In the social sectors, notably education and health, this meant projects that would establish human capital which could be maintained out of local savings or taxes.

Responsive to these mandates, the local USAID mission in Mali took the occasion of the Ministry of Public Health's aid request to, in effect, try to sow seed capital that would develop into a new system of health care delivery and, even more important, provide mass health education and preventive services eventually covering most of rural Mali.

Critique of Foreign Influence

In hindsight, one can say that USAID's judgment was heavily influenced by the tempting prospect of establishing the route to fulfillment of the Alma Ata resolution. The same can be said of outside

professionals who participated in the PSR's design, and of American contractors who enthusiastically accepted it in their proposals, including HIID as the successful bidder. Had the various participants looked more closely at the ministry's fiscal constraints, they might have questioned a demonstration project whose maintenance and replication would have required additional annual public expenditure, per resident of the target area, equivalent to Mali's per capita national health budget.

It is instructive to reflect on what such an assumption would imply under American conditions. According to the *1986 World Almanac*, United States national health expenditure in 1983 totalled $355.4 billion, only a small fraction of which is funded through the federal budget (i.e., the reverse of Mali's situation). Dividing this figure by a population of 235 million yields $1,512 per capita. Assuming a rural American township of 1,000 inhabitants that does not have reasonable access to primary health care, who would take seriously a proposed project for the township that involved net additional expenditure of $1.5 million per year?

The principal reason why this figure strikes one as outlandish is that per capita expenditure at the national level includes the relatively high cost of care at the tertiary level (city hospitals). Indeed, the same source assigns 41 percent of the $355 billion figure to hospital care. To be sure, American hospitals cost many times as much to run as Malian ones, but the ratio between unit costs of tertiary care and such primary health care as is currently provided in rural Mali is if anything probably higher than any analogous ratio in the United States.

Implementation and Documentation

Two demonstration sites were chosen for the PSR: Koro district (*cercle*) of Mopti Region in east central Mali, and Yélimané district in Kayes Region, near Mali's western border with Senegal. Additionally, a central office was set up in the headquarters of the Ministry of Public Health in the capital, Bamako.

Many individuals, featuring a wide range of backgrounds, participated in the project. The Malian team included officials of the