Health Policy and Development
Department of Health Sciences of Uganda Martyrs University
ISSN: 1728-6107 EISSN: 2073-0683
Vol. 2, Num. 1, 2004, pp. 11-13

Health Policy and Development Journal, Vol. 2, No. 1, April, 2004, pp.11-13

THE BAMAKO INITIATIVE WAS NOT ABOUT MONEY

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Code Number: hp04004

Abstract

The Bamako Initiative (BI) was a pragmatic strategy to implement primary health care (PHC) in the era of economic structural adjustment. Championed by UNICEF's charismatic leader, James Grant, it sought to fill the gap created by WHO's open-ended approach to health for all and a hard-nosed economic reform pursued by the World Bank and International Monetary Fund. Economic reforms virtually destroyed social services and safety nets. The idea of BI was to select a few critical elements of PHC for child survival, which would be funded partly through community contributions. These contributions were expected to be in addition to donor and Government expenditure. But this approach was rejected by public health experts. And in the end the initiative did not make a significant impact on the deteriorating conditions of child welfare. Therefore it was abandoned. But it sowed the seeds for communities to seek for accountability for social services.

Introduction

In 1987 Sub-Saharan Africa was in a deep political and economic crisis. In several Countries child mortality rates exceeded 200 per 1,000 live births. The debt service obligations were crashing stagnant economies. National budgets for health, education and other social services were declining, despite a rapidly increasing population. The Government financial allocation to public health, in the best cases, was barely enough to pay the salary of the staff. As a result the availability of public health services was deteriorating fast.

UNICEF, then under the leadership of Mr. James P. Grant, had embarked in a strong advocacy effort (Adjustment with a Human Face) to call the world's attention to the need of rescheduling the debt and of guaranteeing that under the adjustment program imposed by the International Monetary Fund (IMF) and the World Bank (WB) social safety nets were solidly in place (Jolly et al. 1992). Mr. Grant was in the middle of the controversy triggered by the launch of the Child Survival Revolution, accused by the WHO of lacking the comprehensiveness of Primary Health Care and thus missing the sustainability component.

Pragmatism versus entrenched process

While everyone was basically paying lip service to the PHC philosophy, its implementation was, with notable exceptions like Cuba, Sri Lanka and few others, bogged down by the lack of resources and of practical implementation strategies.

In the WHO itself, the champion of PHC, the real stars were the vertical programs: EPI, CDD, ARI, Essential Drugs. PHC as a program was mainly a talk shop dealing with Traditional Birth Attendants and Village Health Workers.

So much so that, in many Ministries of Health, PHC became one of the several, externally financed, vertical programs. At that time, the World Bank was tentatively moving into the health sector with little experience, a strong ideological framework based on privatisation, cost recovery and big loans (World Bank 1987).

Mr. Grant must have felt that something was to be done urgently if the Child Survival Revolution had to be preserved from the unproductive open-ended process of the WHO approach and the hard-nose economic vision of the WB. The surprise launch of the Bamako Initiative during the September 1987 WHO Regional Meeting of the African Ministers of Health was his response to the critics of the Growth Monitoring, Oral Rehydration, Immunization, Family Planning, Female Education (or GOBIFF) approach and his attempt to focus the world attention to the African situation.

Fury, timidity and sobriety

The WHO was furious, the WB showed timid interest and the public health community was split along ideological lines on the issue of equity. The Executive Board of UNICEF reflected the different ideological positions of their respective health advisors with many developing countries in favor and the few with large donor support reflecting their donor position.

Grant's proposal was based on the awareness that many health facilities lacked the medicines and the cash in hand to function. As a result the health workers were merely prescribing drugs to be bought from private outlets, very often unlicensed and unsupervised. Many patients were not even bothering to turn up, when sick, to the inefficient public clinics. They were just buying drugs in pharmacies and markets or visiting private clinics, where they were available and affordable.

So in Grant's mind several questions were urgently in need of practical answers.

How could we increase and sustain the progresses in immunization? How could we ensure that diarrhoea, respiratory infections and, maybe, malaria, could get properly addressed in an efficient way? How could we guarantee that drugs were always available in public facilities to attract a large number of clients to the curative and preventive services required to drastically reduce child mortality?

From challenge to reform

The core of the challenge was to promote additional donor investment, stop and reverse the decline of Government expenditure and attract back into the public health system the money spent by people to purchase drugs in the private and informal sector. He was determined to convince the donors to rehabilitate and expand the network of basic health units providing an essential package of life saving services, in which the Governments will continue to pay salaries and some of the recurrent cost and the users, in exchange of contributing part of what they were before spending in the unregulated market, will not only receive good quality services but will also take a leading role in managing their health units.

The communities were not expected to contribute ***more*** resources out of their pocket, but on the contrary to receive better quality services, curative as well as preventive, from a ***fraction*** of what they were already spending in the informal system. The cost reduction was to be achieved by improvement of the infrastructure, supply of drugs and consumables, training of the staff (all financed by donors) and by introducing a mechanism of oversight, run by community representatives.

The expected advantages of this reform process were the availability of a limited, but lifesaving package of health services, both preventive and curative and a community of users responsible for running their basic health units, while primed for health action at community level. The issue of the poor who could not contribute to the new model and were anyway excluded from the old one was to be addressed by improving access, reducing cost and, in dialogue with the community, by establishing solidarity mechanisms under the local community control.

Unfortunately responses to the Bamako Initiative Reform by the majority of public health experts was to instinctively reject the idea as a sell out to the cost recovery proponents and the debate became so ideological that in many cases no serious dialogue was possible. UNICEF with its allies went ahead providing support to several countries willing to test the working hypothesis and by the time James Grant died in 1996 around 33 countries in Africa, Asia and Latin America had adopted the principles of the initiative with variable results.

In 1996, with the advent of a new leadership, UNICEF suddenly reduced its support and investment in the Health Sector, with consequences still to be evaluated for UNICEF's organisational credibility and more seriously for child health in poor countries. One of the serious consequences of the UNICEF's unexplained abandonment of the health agenda has been the decapitation of the Child Survival Movement. Only recently, in 2004, under the pressure of bilateral donors, alarmed by the growing evidence that during the last decade child mortality stopped declining and in Sub-Saharan Africa is actually rising, UNICEF, WHO and WB are discussing the creation of a "new" partnership for child survival.

Beyond the Bamako Initiative

Promising work around the revitalization of District Hospitals in the area of costing and financing via community health insurance, to support essential obstetric care was also abandoned. The UNICEF's supportive role in the Bamako Initiative from 1987 to 1996 has been very well documented in terms of monitoring of progress, operation research studies and an early evaluation was carried out in 1992 (McPake et al. 1992, McPake et al. 1993). One other casualty of the sudden withdrawal of UNICEF has been the diminished possibility of learning opportunities from this 10 year multimillion dollar effort in the area of health sector reform.

The World Development Report 2004 (World Bank 2003) takes up several concepts and experiences that were initiated or tested by the Bamako Initiative and are still of importance for today's effort to achieve the Millennium Development Goals (MDGs). From the early stages of the Initiative it became clear that, while underfinancing was a major obstacle, one of the main causes of poor quality, poor mix of curative and preventive services and low coverage was the imbalance of power between provider and clients.

New and continuing challenges and lessons

Over the years the health workers had responded to the loss of purchasing power of their salary, to the decaying of the public administration and to the lack of supplies, by developing coping mechanisms that resulted in the capture of the system by the workers. In reality the public system, neglected by the politicians was privatized by its employees, looking for ways and means to extract a living from individual clients, having given up any pretence of fulfilling a public function. What the initiative did was first identify this situation as really important and not modifiable by yet more training of the staff, second, try to change it by creating a system of checks and balances (accountability) based on the only group of people with a vested interest in public health: the local community.

Public accountability is now well recognized as a non-optional component in the production of public goods and can be achieved in several ways depending on the cultural and political context. It can be visualized as an arc, which can be very long in a strong democracy. In fledging or faltering democracies, with poor governance, the accountability arc works only if it is short: in the case of a health unit, it directly links the provider and the organized users. If the users are powerless, the system works for the provider's exclusive interest.

We also learned that this power is not free to have and it needs to be maintained. A centrally financed system via taxation provides a long and effective accountability in a very democratic society, but it is totally dysfunctional in situations where the people's voices do not reach the capitals of countries, where power usually resides. A substantive amount of control by the users of the resources needed for the functioning of the health unit is a prerequisite for accountability. If money is essential, information is equally important. In the Bamako Initiative, health committees representing communities were able to hold monitoring sessions in which coverage targets, inputs and expenditures were set, reviewed, analysed and compared. The health staff acted as technical resources, not as masters of the facilities.

UNICEF had invested substantial resources in training user representatives in financial and data management. This type of governance of basic health units cannot only provide a comfortable degree of accountability; but it also represents the most promising route to establish mechanisms to protect the right of the poor to access health services. While the establishment of the accountability mechanism was the central strategy to sustain the changes, *rapid improvement* of services was the trigger for people involvement and support. I have seen too many health sector reform processes bogged down for years in an attempt to reform the central MOH, prepare policies, build technical coordination mechanisms while burning substantial resources. Under such circumstances, the population, informed by politicians and media of the resources involved or at least pledged, do not see any changes in services and becomes very sceptical.

In the Bamako Initiative experience the bulk of resources was invested in the basic health units to improve availability, quality and affordability of services to gain a rapid support of the people in the early phase of the process. Policy work was done along a parallel track. To gain the popular support needed to win over the resistance of staff to changes of their power, it is important to start by producing rapid improvements at the service delivery end.

The challenge to provide quality services for the poor is compounded today by the AIDS pandemic. Health statistics in Africa are worse in 2004 than they were in 1987. On the positive side, Africans are today more aware that it is up to them to hold their leaders accountable. The experience gained in implementing the Bamako Initiative could provide them with few practical hints of how to assert their rights to essential social services. If the Bamako Initiative has only

helped in sharpening our collective understanding of how public accountability could work in the health system, it was worth every dollar invested.

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