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Mali : Basic health care and family planning

Ex post evaluation

OECD sector	12230 / Basic health infrastructure	
BMZ project ID	1990 66 325	
Project-executing agency	Ministère de la Santé	
Consultant	Department of Tropical Hygiene and Public Health, Heidelberg University	
Year of ex-post evaluation	2006	
	Project appraisal (planned)	Ex-post evaluation (actual)
Start of implementation	Q2 1992	Q1 1993
Period of implementation	8 years	7 years
Investment costs	EUR 6.1 million	EUR 5.3 million
Counterpart contribution	./.	./.
Financing, of which Financial Cooperation (FC) funds	EUR 6.1 million	EUR 5.3 million
Other institutions/donors involved	World Bank, etc	World Bank, etc<>
Performance (overall rating)	4	
• Significance / relevance (sub-rating)	4	
• Effectiveness (sub-rating)	4	
• Efficiency (sub-rating)	4	

Brief description, overall objective and programme objectives with indicators

The project objective is to increase the quality and quantity of health care provision, particularly in the field of preventive medicine, and to increase the provision of family planning measures (education and distribution of contraceptives). The overall objective is to contribute to improving the health of the population in Mali and to reducing the overall fertility rate while at the same time guaranteeing individual freedom of choice.

Indicators for the achievement of the project objectives:

- Share of the population covered by health care centres (population couverte): 60% (time frame: 2002-2005)
- Share of immunised children (under the age of 1): 40% (time frame: 2002-2005)
- Prenatal care for women: 60% (time frame: 2002-2005)

- Contraceptive prevalence rate: 10% as a national average (time frame: 2002-2005)

Programme design / major deviations from the original programme planning and their main causes

The FC project “Basic health care and family planning” was part of the “Projet Santé, Population et Hydraulique Rurale (PSPHR)” financed by the World Bank and other donors (e.g. USAID, EU and FAC). With the help of FC, the following measures were carried out in five regions, Kayes, Koulikoro, Mopti, Ségou and Bamako District:

(1) Constructing/rehabilitating/extending and equipping 159 health centres on the first reference level
(2) Providing the health care centres with an initial supply of essential drugs
(3) Supplying medicines to combat bilharzia
(4) Start-up financing for the Fonds d’Action Sociale pour l’Education Familiale (FASEF)
(5) Consulting services to support the project executing agency (accompanying measure)

There were no major deviations from the original project plan.

A key design element is the transmission of operational responsibility for the health care centres from the Ministry of Health to autonomous user groups established under private law. This decentralisation strategy is also bearing fruit in other sectors of the social infrastructure (e.g. water supply for rural areas and small towns). No deviations from this concept were detected.

Key results of the impact analysis and performance rating

The project objective for health care has only been partially achieved. The average user rate of the health care centres – measured in terms of the ratio between the population within a radius of 15 km and first curative consultations, first prenatal consultations and BCG (tuberculosis) DTCP (diphtheria, tetanus, whooping cough and polio) and VAR (measles) immunisation for children under the age of one – is only 37%. The target was a user rate of 60%.

In some regions the percentage of immunised children is above 100%, well above the target of 40%, as children from neighbouring regions were included in immunisation campaigns. The same applies to prenatal care (initial consultation), which, with a minor exception, is well above the required value of 60% in all regions. By contrast, the contraceptive prevalence rate of 10% was not achieved. According to data from the Enquête Démographique et la Santé (EDSM – III), it is well below that figure – at 8.4% for all methods and 5.8% for modern methods.

The reasons for the low utilisation rates relate to the supply of services, which the patients consider insufficient, and in the level of consultation and treatment fees. Other reasons have to do with the socio-cultural environment. Many patients often do not visit a health care institution until it is too late. There are a number of different reasons for the low contraceptive prevalence rate. One of the most important causes is the still widespread desire to have many children.

The overall objective was also only partially achieved. The general data on the health situation show only gradual improvements, despite some improvements in the risk groups of children and mothers. The overall fertility rate has also not changed. According to current statistics, it has been 6.8 for years.

The group targeted by the project comprises the entire population in the regions of Kayes, Koulikoro, Ségou, Mpoti and Bamako District. The economic and social situation in the target

group is still characterised by income poverty and a lack of access to establishments in the economic and social infrastructure. Because the economic structure is dominated by agriculture, the risk of the population groups that are currently not affected by poverty slipping below the poverty line can be assumed to be very high (e.g. in long periods of drought). The target group with access to the health centres comprises some 6 million inhabitants, which corresponds to 52% of the entire population of the country (11.4 million). These figures are well above the figure of 3 million inhabitants envisaged when the project was appraised (30% of the population in Mali in 1990 – around 10 million inhabitants).

The executing institutions that are ultimately relevant for the FC project are the private user groups as management positions. Ideally, the process of setting up a user group is initiated by representatives of the territorial administration (prefect, sub-prefect) partly in cooperation with social workers from the Ministry of Health. The inhabitants of a specific "aire sanitaire" with several villages and hamlets (between 10,000 and 14,000 inhabitants) are called to establish a user group and are asked to propose a chairman ("approche communautaire"). As a result of this process of consultation, the territorial administration appoints a chairman; at the same time the user group is registered officially as a private association. There is no further registartion of the members of a user group. Further steps to the official establishment, such as the appointment of a managing director, taking over the health centre, including the supply of medicines, accountability to state offices and members of the user group, operational documentation, etc have not been formalised. Rights and duties of the user groups have neither been documented properly nor established in writing in agreements with the relevant administration as is the case in the drinking water sector, for example. However, as there seems to be no evidence to date of conflicts over access restrictions for individual users or user groups, it can be assumed that the process of establishing a user group and, in particular, appointing a chairman meets the socio-cultural criteria of ethnic heterogeneity and legitimacy.

Owing to the fact that they are the first point of contact between the patients and the health system, the range services provided by the health centres is small. In addition to general consultation, the treatment of minor injuries, prenatal consultancy and birth support are provided to a limited extent. In addition, immunisation campaigns are carried out in the surrounding area. Other preventive measures such as education about the risks of HIV/AIDS infection and how to avoid and treat diarrhoea, anti-malaria preventive measures, education about the health care risks of genital mutilation, are only provided in exceptional cases. This is said to be due to a lack of information and insufficient financial resources.

At most health centres, the economic and financial situation cannot be assessed because of the user groups have not kept adequate records. It must be assumed that, for example, the collection rate for consultation and treatment fees is probably between 60% and 70% at the most. The income actually collected is therefore not sufficient to secure long-term operation. The reasons would appear to be tied up with the inability of the users to pay for the medical help that they require and with the fact that the staff grant generous admittance to free consultation and treatment because of social obligations to members of the same ethnic group, the same family, etc. The subsidies required because of the insufficient income are made, on the one hand, by financing the salary of the medical director from the budget of the Ministry of Health and, on the other, the town hall assumes the financing of a salary, e.g. of an assistant midwife, at certain locations. In addition, existing financial deficits are financed from the revolving fund set up for the supply of medicines and most of all by not maintaining buildings and furnishings.

This leads to decapitalisation of the aforementioned fund and to neglect of the existing infrastructure. The sustainability of the medium and long-term operation of the health centres cannot therefore be considered to have been secured.

A positive aspect of the project that should be emphasised comprises the child immunisation rates that have been reached and the number of women who have been given prenatal advice and have taken advantage of the assistance of a midwife at the birth. According to the calculations of the Enquête Démographique et de Santé (EDSM II and EDSM III), the probability of child mortality between the ages of one and five has been reduced significantly in all project regions. By contrast, there has been a very positive development in the probability for the other groups (children < 1 month, children 1 to 12 months, children < 12 months in the Ségou region alone).

In addition, the project gives the local people the option of participating actively via the user groups in planning the work of a health centre. By transferring responsibility for the initial health care supply to user groups, the project promotes the decentralisation and deconcentration of centralised government areas of intervention which is an explicit political objective.

Our overall assessment of the project's developmental effectiveness can be summarised as follows:

Sustainable efficiency

The estimated specific investment costs of the health stations are, at around EUR 180 per m^2, are still good. The costs per unity of contraceptives distributed or per bilharzia infection avoided can no longer be determined today as no monitoring was set up for the single measures completed in 2000. Overall we judge the production efficiency to be satisfactory.

Despite partial subsidising of the health centres using government funds, the sustainability is jeopardised because of the insufficient coverage of operating costs and the decapitalisation of the revolving fund for the supply of medicines in most of the health centres. At present there do not appear to be any measures to secure sustainable operation by promoting the professional skills of the user groups. Sustainable use is, in our view, no longer in keeping with operational input. We therefore assess the allocation efficiency as inadequate.

Because of the limited management skills of the user groups, only limited structural effects can be expected. No structural impacts were generated by the Fonds d'Action Sociale pour l'Education Familiale (FASEF), which has since been dissolved. There is no information about the use of the financed medicines to combat bilharzia. (Subrating: 4)

Sustainable effectiveness

The project objective was also only partially achieved. While the child immunisation rates and the degree of prenatal care were achieved and even partly exceeded, the use of the health centres for curative measures, prenatal care and immunisations is, at an average of 37%, well below the expected 60%. On the one hand, the demand for health services at the first reference level is to be evaluated as low; on the other, outdated facilities, a lack of material and inadequately trained staff make health service provision acceptable in isolated cases only. The objective that was envisaged by financing contraceptives, i.e. increasing the provision of family planning measures, was also not achieved. No objectives were defined for the distribution of medicines to combat bilharzia. The efficiency of the structures is likely

to decline further in the future. The project’s effectiveness is therefore rated as insufficient (sub-rating 4).

Sustainable significance / relevance

The project design is, as described, highly relevant. It is only partly significant at the medical level because essential health care improvements are limited to the child immunisation rate and care for pregnant women. For example, the statistics show, in part, a clear decline in child mortality in the project regions. However, this situation can only be maintained over the long term with the help of external donors; these are, for example, USAID and UNICEF, as the most important donors with recognisable activities in the area of immunisation campaigns. We assume that these organisations will provide further financing for immunisation campaigns in the future. The overall objective of reducing the general fertility rate while preserving individual freedom of choice was not acheived. The significance / relevance is rated as slightly insufficient (sub-rating 4).

The achievement of the target indicators for immunisation and pregnancy advice is not enough to offset the insufficient use and the substantial sustainability risks for operation and hence for the services of CSCOM. Substantial long-term effects cannot therefore be expected. As the project appears to have no more than a minor structural impact and the components “start-up financing for the FASEF” must be considered as having failed, **we assess the overall developmental effectiveness of the project as slightly insufficient degree (Rating 4).**

Conclusions and recommendations

Limited investment funds should not be distributed to a large number of different individual projects in several regions but, for reasons of efficiency, used for specific specialised areas and regions.

Deconcentrating the responsibility for the sustainable operation of investment in the social infrastructure of central government institutions to organisations (user groups) established under private law requires the government institutions to give their activities a new basic orientation, which essentially means creating/reinforcing adequate framework conditions for the private sector. This also means that the central government institutions should be involved consistently in the measures to support deconcentration.

In the case of similar political approaches, such as decentralisation, and similar sustainability risks in sectors in which private (autonomous) user groups assume the operational responsibility for decentralised infrastructure investment, cross-sectoral cooperation of the various players (e.g. health and drinking water supply) should be strengthened or promoted by suitable measures in order to implement synergy effects and cost savings by means of a common approach and coherent strategy.

An insufficient collection rate is also an operational risk for health care facilities. In order to limit this risk it is recommended that from the outset legally established and practicable mechanisms for collecting the fees be taken into account (such as the territorial administration, town hall or similar bodies assuming costs establishing cost assumption rules so that poor people can be subsidised).

Assessment criteria

Developmentally successful: Ratings 1 to 3	
Rating 1	Very high or high degree of developmental effectiveness
Rating 2	Satisfactory developmental efficacy
Rating 3	Overall sufficient degree of developmental efficacy
Developmental failures: Ratings 4 to 6	
Rating 4	Overall slightly insufficient degree of developmental efficacy
Rating 5	Clearly insufficient degree of developmental efficacy
Rating 6	The project is a total failure.

Criteria for the evaluation of project success

The evaluation of the “developmental efficacy” of a project and its classification during the ex-post evaluation into one of the various levels of success described in more detail below concentrate on the following fundamental questions:

- Have the **project objectives** been achieved to a sufficient degree **(project effectiveness)?**
- Does the project generate **sufficient significant developmental effects (project relevance and significance** measured by the achievement of the overall development-policy objective defined beforehand and its effects in political, institutional, socio-economic and socio-cultural as well as ecological terms)?
- **Are the funds/expenses that were and are being employed/incurred to reach the objectives appropriate** and how can the project’s microeconomic and macroeconomic impact be measured (aspect of **efficiency** of the project concept)?
- To the extent that undesired **(side) effects** occur, can these be tolerated?

We do not treat **sustainability**, a key aspect to consider when a project is evaluated, as a separate evaluation category, but rather as an element common to all four fundamental questions on project success. A project is sustainable if the project-executing agency and/or the target group are/is able to continue to use the project facilities that have been built for a period of time that is, overall, adequate in economic terms, or to carry on with the project activities independently and generate positive results after the financial, organisational and/or technical support has come to an end.