FACTS Reports

Field Actions Science Reports

Special Issue 8 (2012)
Access to Healthcare, Healthcare Funding and Performance

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Electronic reference
Bruno Boidin, Emeline Laidet and Rémy Manier, « Community health and its failures in the Kayes region of Mali », *Field Actions Science Reports* [Online], Special Issue 8 | 2012, Online since 06 November 2012, Connection on 08 November 2012. URL : http://factsreports.revues.org/1724

Publisher: Institut Veolia Environnement
http://factsreports.revues.org
http://www.revues.org

Document available online on: http://factsreports.revues.org/1724
This document is a facsimile of the print edition.

http://factsreports.revues.org/1724
Published 10 September 2012

FACTS Reports

Community Health and its Failures in the Kayes Region of Mali

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Abstract. This article looks at advances and failures of community health in Mali. The work is based upon a study undertaken on the ground with community health bodies and their users in the Kayes region. The results show that despite the services provided by community health, this can only be a real tool for health under certain conditions, mainly involving the role of public bodies in regulating health centres and rebalancing their unequal resources.

Keywords. Community health, decentralisation, financing, Mali.

1 Introduction

Since the late 1980s, Mali has chosen to develop a community health system in which the population uses decentralised health structures, as recommended by the Bamako Initiative. The country has seen a considerable increase in the number of community health centres, CSCOMs for short, from just 10 in 1993 to 993 in 2009. A CSCOM is a non-profit health centre, at the base of the Malian healthcare pyramid. CSCOMs are managed by users organised into community health associations, ASACOs for short (Balique *et al*, 2001). CSCOM staff are recruited for each skill level (healthcare assistant, matron, nurse, senior health technician, doctor, etc.) according to various statuses. The staff will either be civil servants (in the case of staff provided to ASACOs by the district), or else be provided by the Heavily Indebted Poor Countries (HIPC) funds, or by the ASACO itself. In the first case, the staff have the status of civil servants and so fit into a pre-established wage structure, while in the second and third cases they are contractual staff.

Since the Decree of 4th June 2002, a certain number of skills that were provided by the state have had to be provided by the districts. However, the development of community health centres does not, in principle, signify a reduced role for the state. Firstly, the state must provide financial support. Then the state sets regulations for the setting-up and running of CSCOMs. An ASACO is recognised if it signs an agreement with the state. This then exempts it from paying any taxes, and allows it to obtain grants and receive training.

This article looks at advances and failures of community health work, and is based upon a study undertaken on the ground with community health bodies and their users in the Kayes region. The issue of the limits of community health in a weakened state was raised by Fassin and Fassin (1989) and Balique (2001). We reconsider the issue and show that, despite the services provided by community health, the results show that this can only be a real tool for health under certain conditions, mainly involving the role of public bodies in regulating health centres and rebalancing their unequal resources.

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2 Methodology of the study

This study was undertaken in cooperation with the Association for the Coordination of Useful Initiatives in Developing Countries, with the aim of assessing difficulties in the operation of community health centres in the Kayes region, and how these might be resolved. In addition to examining the relevant literature and documentation, the study of CSCOMs in the Kayes region is also based upon a qualitative assessment undertaken between 11th may and 19th August 2010 at 16 health centres. This study involved 120 people from the following four profiles: CSCOM care staff (48 people interviewed); ASACO members (35 people interviewed); district representatives (18 people interviewed); patients (19 people interviewed).

The study comprised two parts. The first part concerned the collection from each centre of numerical data on patients and the health services available (number of inhabitants, number of villages in the health area, type of care provided, geographical accessibility, cost of services, number of staff per category, monthly salary, water and electricity access, etc.). A second part, based on semi-structured interviews with 120 people, aimed to tackle the following five areas with each category of person:

- general presentation of the health centre (history, characteristics of its health area, etc.);
- geographical and financial accessibility, and possible obstacles;

- operation of the health centre: staff, patient care, activities undertaken and organisation of the referral system. The end-goal was to understand the operation of the health centre and to identify the difficulties encountered and the methods implemented to get around them;
- internal organisation, management and relations with the districts;
- relations with the other players (care providers, associations, cooperatives, health insurance schemes).

The study method has a number of methodological limits, particularly because the study does not include all of the people who might be able to shed some light on operation of the health centres and any difficulties encountered, despite the variety and number of people questioned. Also, the study was focused on the Kayes region and so its results cannot be extrapolated to other regions of Mali. Nevertheless, several characteristics of this study allow us to draw wider conclusions. First of all, we have sought to cover the different major categories of staff working either in the administration of CSCOMs, or in relation with them. Finally, we complete our study with an examination of prior documentation.

3 Results: CSCOM deficiencies[1]

The study allowed us to pinpoint three groups of deficiencies: those affecting finance and management; those relating to the taking over of the running and management of ASACOs by the beneficiaries; more general deficiencies relating to the decentralising of administrative and health services in Mali. The following results relate to the first kind of difficulty (financing and management) and the third kind (decentralisation).

3.1 Financing and management difficulties

Three difficulties were identified as causes of the deficiencies in financial and management resources. They all related to management in the wider sense of the word: management and motivation of human resources, raising and securing of funding, or even budgeting capabilities.

3.1.1 Management and motivation of human resources and volunteer agents

The status and remuneration of staff in the health centres

The lack of a work contract (with its associated payments into a pension fund) is one of the difficulties encountered by the care staff. There is a particularly high number of staff without contracts in the Diéma Circle. The staff concerned is that of the ASACO and the district. According to the Regional Social Development Department, in 2009, the ASACOs of the Kayes region employed 747 people, yet only 260 of them were registered with the National Social Security Institute (responsible for pensions and health coverage), that is to say a little under 35%. In spite of complaints from staff, the situation has remained blocked for several reasons: the monthly salary is too low to be declared to the National Social Security Institute, and the employer does not wish to raise salaries; according to the staff questioned, the voluntary lack of a contract on the part of the municipality or of the ASACO allows them to retain a certain control over the staff; the district or the ASACO does not want to or cannot pay contributions to the National Social Security Institute; the employers, most of whom are members of the community and farmers, have an informal approach to life.

There are major differences in salary between the CSCOMs, as well as in relation to the collective agreement, which is not always respected. The average monthly salary of managers in the CSCOMs studied is 41,000 CFA francs, which is 19,000 CFA francs less than the amount specified in the agreement. The lowest salary is 15,000 CFA francs, while the highest is 69,000 CFA francs. There are major remuneration disparities between the heads of the medical centres. The amount paid is not always commensurate with the diploma level: a nurse may be paid more than a doctor. The salary depends on the status of staff on one hand (notable differences can be seen between civil servants and contract staff, including prospects for raises), and a direct negotiation between the employee and the ASACO on the other hand. In addition, this wage may be complemented by bonuses, also negotiated between the employee and the ASACO on a case by case basis according to criteria relating to the proper operation of the centre or even the reputation of the head of the medical centre.

Salary arrears are a second major problem. Payment difficulties are linked either to the ASACO or to the district. The responsibilities of the people concerned are not clearly established, making any recourse uncertain:

- the district encounters great difficulties in collecting taxes;
- the ASACOs generally link the payment of salaries to a centre's results.
- diversion of funds on the part of the ASACO or the district have been reported in certain centres, without this necessarily being the fault of the current staff.

The lack of qualified agents for each task encourages the staff to exceed their primary skill: an injection turns a healthcare assistant into a nurse, while a prescription elevates a nurse to doctor status. This adaptation to constraints appears necessary, since it allows the staff to guarantee health services that are essential to the population. Yet it is characterised by *"the partial abandonment of the agent's main role"*, as Konate et *al*. (2003) have already noted.

The difficult mobilisation of community relay agents

The voluntary community relays have become key players in African community health policy, particularly under the aegis of UNICEF. Generally appointed by village notables, the relays must actively participate in the so-called Behaviour Change Communication (BCC) strategy.

[1] For reasons of editorial standards, the interview questions and results are not presented in detail here.

In the region studied, the community health agents were responsible for a major proportion of health policy in a context where structural adjustment plans and the economic slump have reduced the importance of the state in social policy. Yet the success of such programmes varies according to country and to period. In Benin (Boidin, Savina, 1996), the decentralisation of the health system under structural adjustment ran up against the difficulty of mobilising human resources in rural areas. The economic constraints of health staff seem to be incompatible with the idea of volunteer activities, whether they be paid in kind or through social recognition. More recently, in Senegal, the fight against malaria has seen major advances in the home-treatment of malaria patients (PECADOM), supported in part by the commitment of the local communities, and particularly the role of home-care providers (DSDOM) – volunteer agents chosen by the village and who were paid during their training. Our study reveals that, in Mali, the importance of community health agents is now limited, compromised even, following an initial period of mobilisation. The people carrying out the role of relays have encountered difficulties in devoting the necessary time to this activity, in light of the required economic compromises. In all of the health areas studied, the health staff felt that the health relays were not really undertaking their tasks properly. Quite apart from the difficulty of mobilising people lacking remuneration, the non-renewal of volunteer agents seriously threatened the longevity of the system. Finally, the relays ran into difficulties related to illiteracy, which made it impossible to refer sick people to the health centre or to record and register births.

3.1.2 Raising and securing of funding

The difficulty in collecting social security payments

In accordance with the pyramidal structure in place, patients requiring more advanced treatment than that available at the CSCOM must be referred to another health centre that is equipped to care for them. The Malian state initially concentrated on obstetrical emergencies. Each administrative area, or 'circle' has a social security scheme set up to cover referral costs: fuel, drivers, ambulances, maintenance, repairs, etc. Each scheme is funded by the ASACOs, the 'circle' councils and the districts; a share of these costs must be paid each year. In the CSCOMs included in the study, three out of eight ASACOs were not paying their shares, nor were three-quarters of the districts. The result is that the patients of three out of five CSCOMs do not receive free referral trips to the referral centre, but must put up at least half the costs. For some centres, the cost may be as high as 50,000 CFA francs, given the distance between the CSCOM and referral centre.

The ASACOs have set up various methods to enable them to pay their shares:

- implementation of a collection system in the villages of a particular health area. Every year, the community association is informed of the total amount of the share to be paid. It then divides up this amount between the villages in that health area. Each village chief decides which method to use: a set amount per family, or a tax on each person. Once the sum has been collected, the village chiefs pay their dues to the ASACO, which has generally advanced some of the costs, thanks to the consultation fund.
- implementation of a system of payment upon consultation; each patient of the CSCOM pays for their consultation plus a supplement;
- withdrawal of the sum from the consultation fund, without any subscription or special tax.

Of these three methods, only the second is recognised as being effective is terms of contribution collection, but it is only applied in a single CSCOM, at Gory Gopéla. The supplement, which appears on each prescription, is not opposed by the population of the health area and allows the ASACO to build a fund for referrals. The first system (annual fee) is a failure. Collection is effective for the first few years, but then drops off. Interviewees mentioned a considerable reticence on the part of households, owing to a lack of knowledge of how the collected sums were used. The third system, involving withdrawals from the consultation fund, is a simple method, but of limited effectiveness according to the managers of the centres questioned, given the low level of use of some CSCOMs.

The explanations sketched out here must be put into perspective with the studies that look at the reasons why health insurance schemes tend not to be used in poor countries. Defourny and Failon (2011) provide several explanations that are common to several geographical study areas. The precariousness of some people's lives prevents them from making plans for the future and seeing the point of contribution or insurance schemes; a focus on the here and now makes patients reluctant to pay twice – once for a contributory subscription, and again for the consultation itself, even at a lower rate; fluctuations of income, not to mention its generally low level, require considerable flexibility in the collection and periodicity of such payments; awareness campaigns are insufficiently developed and suited to rural populations. These different explanations faithfully reflect the conditions in which social security schemes operate in the region we studied. They certainly help to explain the difficulties encountered by the ASACOs.

The districts no longer properly guarantee payments into the social security schemes. Elected representatives and civil servants unanimously state that the district does not have sufficient funds. The municipalities of the Diéma Circle are the ones who make the most contribution to the social security scheme. However, their collection rate was only 17% for 2009. The tax is difficult to collect and what income there is does not cover all of the costs.

The more general difficulty of financing

Legal texts entrust the management of a CSCOM to its ASACO. The association's income is exclusively composed of funds collected by the health centre, thanks to the pricing of consultations and the sale of medicines. However,

technical or material support is provided to certain CSCOMs. The state and its partners (international organisations) provide:

- the first stock of medicines, a motorcycle and a refrigerator when the CSCOM is set up;
- some inputs (vaccines), mosquito nets (distributed by the centre to pregnant women and vaccinated children free of charge), nutritional products (flour and oil received from the World Food Programme) and possibly some furniture (chairs, beds, etc.).

In spite of their lack of resources, some districts participate by financing (in certain centres) the wages of some of the staff and even water and electricity bills. They provide technical support to the ASACO in putting together funding applications.

But the CSCOMs mainly depend on their own resources, despite this targeted aid. Some centres also benefit from the contributions of migrants, which can create inequalities between centres, as we will see.

3.1.3 Ad hoc management style

According to the law, the CSCOMs must respect the separation between the medicines fund, composed of revenue from the sale of medicines, and the consultation fund, whose revenue comes from the payment of consultations. Five ASACOs recognise that they are unable to guarantee the operation of the centre using the revenue from consultations, so they dip into the medicine fund. The problem is how to restock products, for this is only possible if the withdrawals made do not exceed the amount made from sales. Otherwise, the value of the stock depreciates and the ASACO must call upon outside assistance to restock the products.

It is difficult to judge if the other centres make a separation between the two funds. The treasurer often keeps the money at their home, and so the sums paid into the bank accounts do not always correspond with the true amounts saved.

In addition, there is almost no management monitoring. No budgets are drafted for the coming year, and the statement for the past year often shows nothing but the value of the stock of medicines and the money held in the bank. All of the management is left up to the manager, who keeps a daily track of the centre's income (and sometimes expenditure). The weekly and monthly statements are drafted by the head of the medical centre and the treasurer. According to the texts, the administrative secretary should usually retain the accounting archives, while the treasurer is responsible for current accounting documents. This is not actually what happens, and there are few ASACO members who have the monitoring documents.

3.2 Decentralisation and institutional deficiencies

3.2.1 Limits of decentralisation

The first district elections took place in 1999, following the implementation of decentralisation in the 1990s. 500 new districts were planned, according to the village inclusion criteria; in fact, 700 were created. This difference is partly explained by the unclear nature of certain criteria. Not all of the districts visited had the 20,000 inhabitants required by the village inclusion criteria. Low population numbers and income levels (owing to farming work) means that it is difficult in rural areas to collect the tax, a district's main revenue, and to cover the many costs. The wages of the district staff come directly from the proper collection of taxes. Yet tax collection is difficult and costly and the municipal teams blame the state's disengagement. In 1999, during the first mandate, the state gave 2 million CFA francs per quarter. Today, this has dropped to 100,000 CFA francs per quarter. The districts find themselves dealing with a skills transfer, without training and without additional financial support.

In the course of our study, we interviewed 18 representatives of the eleven different districts in the Yélimané, Kayes and Diéma Circles. In nearly all of the districts, the role of the municipality in the area of health is not known. In nine districts where we were able to get information, only three were contributing to the referral fund. With ASACOs having been set up, the districts did not always make health one of their priorities. Some elected representatives clearly indicated a preference for financing visible initiatives such as the building of a school, rather than employing a new matron or paying their share of the referral fund.

In light of the difficulties and the accumulated delay in relation to the legal texts, the district team of the town of Kayes set up a health commission in late 2009. This has 11 members, all of them elected volunteers. Its major task was initially to make contact with the different health stakeholders (care staff of the CSCOMs and the hospital, the ASACO and decentralised state services), to study the texts and to specify its role. However, this commission was not supported by the decentralised state services. According to the chairman of the commission, this situation may be explained by the fact that the technical services would fear that the district might take over all health issues.

The ASACOs operate relatively autonomously compared with the districts and the state services.

3.2.2 One consequence: disparity of human and technical resources

Seven of the sixteen centres visited are run by a doctor, eight by a nurse and one by a healthcare assistant. We noted that there is no apparent link between the number of villages in the health area and the role or status of the head of the centre. Some CSCOMs covering a large number of villages are therefore run by a nurse, while others covering a smaller number are run by a doctor. Half of the CSCOMs are in charge of a health area covering more than five villages. In addition, the size of the population covered by the health area does not seem to be a criterion that would explain the status of the head of the centre, even though we should mention that the three centres covering the largest population (Dioumara, Kayes N'Di, Khasso) are run by doctors (but some are run by nurses covering a larger population than

other centres run by doctors). Finally, if we look at the number of inhabitants per health agent, we note a very large disparity between the centres.

Access to water and electricity is also disparate. Ten out of sixteen CSCOMs have access to electricity. In urban areas, the centres are connected to the electricity network, while rural infrastructures get their energy from solar panels. Eight out of the thirteen rural CSCOMs studied have no access to water within the health centre itself.

3.2.3 The role of migrants: assistance which has ambiguous effects

Fund transfers by migrants constitute a non-negligible resource for the health centres, partly compensating for the deficiencies in public and community funding. The Kayes region is special in this respect, given the large number of migrants behind the transfer of funds. But beyond the beneficial financial effects, the role of migrants can lead to some imbalances between health centres and a particular interpretation of the "community". In a rural area, more than half of the CSCOMs have benefited from support on the part of migrants in the shape of construction or rehabilitation of premises housing the centre, or of various kinds of funding. These are often migrants who are called upon to provide the share of investment that should be provided by the community. In some cases, they do not participate directly, but enable the obtaining of funding from NGOs or local government in the North.

More than half the heads of medical centres questioned, who were not from Kayes, told us of the potentially negative effects that this sending of money could have, in their view. The migrants left their villages a number of years ago, but feel that they know the health priorities. When a major decision needs to be taken at a CSCOM, such as hiring another matron, some heads of medical centres are forced to go through not only the ASACO, but also the migrants. As a result, the populace is not involved in the ASACOs, since they know they can count on the migrants, who respond to requests for money.

4 Discussion: the missing links between the institutional players

As has been underlined by several economic and political authors, the decentralisation promoted by funders and development aid players, does not seem to be a panacea in a context of weak centralised or non-democratic states and poor economies. Cartier-Bresson (2010) repeats the arguments of Platteau (2004) and other works (International Social Science Journal, 1998) which show that decentralisation is only operational in rich, democratic and pacified societies. Mali is indeed democratic, but it illustrates the difficulties of implementing decentralisation in such a context. This is a good example of the inherent risks of experimenting with decentralisation of the health system in a context where neither the place of the state nor administrative decentralisation is strong enough or established. All in all, we highlighted three sources of community health deficiencies, based on the area studied.

The first source of deficiency is the diversity of health areas, be that in terms of external funding (which reveals the major role played by migrants), or the involvement of staff and local populace. Inequalities may therefore come from the local level.

The second source of deficiency, still at the local level, is the ambiguous relationship between the district and the ASACO: is the district becoming the governing body of the community association, or not? Since 2002, legal texts have established that some of the role exercised by the state in the past is now granted to the districts. Central power retains the tasks of supervising and developing national directions in terms of health. But in actual fact, this transfer has not occurred. Elected officials and district technicians alike do not appear to be applying the texts on the ground, even when they are familiar with them.

This ambiguity is partly linked to the time gap between the decentralisation of the state's competences to the ASACOs and the decentralisation towards the districts: the first precedes the second. In a study dating from 2002, dealing with the "issue of the community management of health structures at the operational level (CSCOM, CSREF) in the context of decentralisation", the Regional Health Department mentioned the difficult collaboration between ASACOs and the local authorities. The report highlighted the fact that the stakeholders were not very familiar with the texts, hence the confusion of roles and individual responsibilities.

Finally, the third deficiency comes from the relationships between local stakeholders (the health area, symbolised by the district, the ASACO and the population) and global players (states, NGOs, international organisations). The former are ripe for considerable actions on the part of the global players. But interventions by the latter are responses to different plans and motivations, and are not homogenous. International organisations do not act in all health areas in an equal manner (as can be seen in the case of flour distribution by the PAM), just like NGOs or the state. The diversity of interventions risks reinforcing certain inequalities of access between the health areas. The Malian state is not playing its role of arbitration and territorial rebalancing as regards these issues. The public authorities are thus a weak link in the decentralisation of health. The deficiencies of the Malian state, mentioned previously by other authors (Fassin and Fassin, 1989, Balique, 2001, Balique et *al*, 2001), have not been absorbed and so contribute to limiting the improvement of the health system.

All in all, the decoupling of the promotion of community health from the administrative decentralisation of public stakeholders has led to problems of coordination and definition of responsibilities. The conditions for the improvement of the community health system would seem to lie in the strengthening of territorial authorities and adherence to the programmes of the Ministry of Health and the Ministries in charge of relations with the territorial authorities.

Acknowledgements

We would like to extend our sincerest thanks to Mr Jean-Luc Desmarets, President of ACAUPED, as well as to Mr Karim Diakité, Malian doctor specialised in public health and ACAUPED coordinator in Mali, who has followed the planning of the study and has been a great help to us in organising the study and making contact with the people to whom we spoke.

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