A minimum package of effective services, including immunization of children, can rapidly improve the health status of the population, even in difficult economic conditions. Photo WHO/UNICEF/H. Davies

The Initiative launched in 1987 in the capital of Mali has proved to be an effective strategy for improving the quality of health care for most people, as well as their access to it.

- state participation to ensure that the whole population can have a minimum package of services, selected for their cost-effectiveness;
- rationalized and decentralized implementation of programmes at the level of the district health system.

The most striking result of applying these principles is the increased use made of preventive and curative services. In some countries, like Benin and Guinea, the numbers of fully immunized children had fallen to very low levels a few years ago. The countrywide extension of the Initiative enabled immunization coverage to grow steadily. As a result, the percentage of fully immunized children rose from 16% to 75% in Guinea and from 24% to 80% in Benin between 1985 and 1995. These results were obtained by the health centres and did not require the support of mobile immunization teams. The use of prenatal consultations also rose to a similar degree.

Preventive care

The steady growth in immunization coverage in countries or districts applying the principles of the Initiative has resulted in a big reduction in the diseases concerned. Rwanda, for example, during the
two years preceding its civil war, did not have a single case of indigenous measles. Moreover the resources generated and managed locally by village communities have made it possible to extend coverage with preventive care to remote areas.

The rates of curative consultations have also improved. In the central region of Togo, for instance, the consultation rate was very low and saw-sawed up and down depending on the arrival of drugs. The revitalization of the health centres involved training the staff, organizing an efficient supply of generic essential drugs, and introducing community control of the management. The frequency of consultations tripled or quadrupled in some health centres immediately after they were restructured, and has remained stable throughout the year.

In Mali, after reform of the health districts, there has been a big increase in the numbers of emergency cases transferred to the district hospitals, particularly pregnant women with obstetric complications. Here the activities include improving the running of community health centres, ensuring a better quality of emergency obstetric care at the district hospital and, above all, entrusting the community health associations with the responsibility of improving management and transport. Thanks to the contributions made by the health associations and the hospital towards the management and running costs of an ambulance, the patients pay only a modest sum for being taken to hospital and the ambulance is permanently available.

**Reaching the poorest of the poor**

In remote areas where everybody lives on the verge of poverty, it is not easy to provide health care for the poorest of the poor. But today it is clear that the preventive care offered free and in a decentralized manner is benefiting the entire population. This is also the case for the treatment of certain chronic diseases such as leprosy and tuberculosis, which is often subsidized by the state.

To improve access to curative care, systems of payment now include exemption, pre-payment, post-payment and health insurance. Hitherto none of these systems were used on a large scale in sub-Saharan Africa. In the central region of Togo, the method applied by the health committees is to compare the proportion of patients exempted from payment at their health centres with the equivalent proportion at the local missionary dispensary, where the nuns in charge are dedicated to treating all the population, including the very poorest. At their dispensary between 10% and 15% of patients do not have to pay. These rates are accepted as a reference point by all the other health centres, which try to keep their own rates at this level.

Another interesting experiment was undertaken at the Dioila Hospital in Mali, where patients with urgent problems are treated at once from a reserve stock of drugs and equipment established expressly for this purpose. They are then invited to settle their bills after treatment. Contrary to what might have been feared, the rate of recovery of the costs exceeds 95%.

Of course, the cost is not the only obstacle preventing the very poor from using health services. Ignorance, physical or mental handicap and cultural barriers also contribute significantly to excluding the poor from health care.

Thanks to the introduction of generic essential drugs, to the rationalization of services and particularly to greater community control of the running of basic health services, the Bamako Initiative has proved to be an effective strategy for improving the quality of health care and access to it for most people. If the poorest of the poor and communities in remote areas are to benefit fully from the health care that is their right, this will certainly require an additional effort of solidarity on the part of governments, as well as the introduction on a much larger scale of systems for sharing financial risks, such as health insurance. But in no case should this assistance prevent the decentralized services and the communities themselves from being imaginative and adopting solutions that affirm their resolve to help and serve the poorest members of their community.