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Annex to “Framtid Afrika”

Health Support in Africa – Country Reports

Sida

SWEDISH INTERNATIONAL DEVELOPMENT
COOPERATION AGENCY

Department for Democracy
and Social Development
Health Division

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Preface

This is a compilation of brief country reports regarding health support to a number of countries in Africa. The countries in the report are countries where Sida has health support programmes at present (Angola, Kenya, Uganda, Zambia), countries where support is uncertain due to political difficulties (Ethiopia, Eritrea, Zimbabwe) and countries where Sweden has substantial collaboration in other areas but not in health but where it may be worth exploring the possibilities of health support (Mozambique, Tanzania, Burkina Faso, Mali, Malawi and Rwanda).

The reports are presented in alphabetical order. The report on Tanzania is more extensive than the other reports, this is due to the fact that the Regional Health Adviser was able to visit Tanzania and thus gather more information relevant to this study.

Contents

1. ANGOLA

1.1. A short summary of the situation

The internal war has hampered Angola's development for the last 25-years. The short peace of 1991 and 1992 was broken after the election during late 1992. Another period of relative peace following the Lusaka accord of late 1994 was gradually abandoned during 1998. The breakdown of social and financial networks has severely effected the whole population. Urbanization and large internal refugees movements have further contributed to the unstable situation. After a period of strong centrally based economy, limited market economy reforms have slowly been introduced during the 1990s. However, more than two decades of war has destroyed the economy. Additionally, it is worth highlighting that ethnic and social background influences the economic and social situation of a family. A small urban elite in Luanda has the political and military power in the country.

1.2. The health situation

Only 30% of Angola's population have access to health services. The Adult literacy rate is 56% for male and 29% for female. The national health system is week and the health situation of the majority of the population is detrimental. UNICEF estimates that every forth health clinic is destroyed or has been abandoned due to the war. Angola has one of the world's largest proportions of amputated people as per cent of the total population. The population is about 12 million, with a slight overrepresentation of women.

Infant mortality rate	170 per 1000 live births
Under 5 mortality rate	292 per 1000 live births
Maternal Mortality Rate	1.500 per 100 000 live births

The health service is organised in three levels. The "Gabinete do Ministério (??)" (the minister's department staff) supported by specialised departments including the department of planning, has the central role in the design of health policies. Under the Minister of Health there are seven national departments, each with a normative and/or executive function in its specific field. The organisation of the health system is characterised by a strongly centralised decision-making process and a complicated structure, which reduces the efficiency of resource allocation, monitoring and co-ordination of health programmes. There is a delay in elaborating a National Health Policy, although the Ministry of Health with technical assistance from World Bank, WHO and EU sources has elaborated several drafts.

1.3. Donors in the health sector

The main support from international donors to Angola is of humanitarian character, allocated through the UN-appeal. Nevertheless, a limited number of donors still work bilaterally in the health sector and attempt, to the extent possible, to maintain a development perspective. These include:

- the EU, whose post-emergency programme based within the Ministry is important for the health sector.
- Sweden, who has supported the health programme in Angola since the 1970s and who, for many years, was the main donor. Although several other donors increased their involvement in the health sector during the 1990s, Sweden still remains among the largest ones, and Sida decided to continue its support the health sector with 46 MSEK for 2 years as of 1 July 2000. The support will focus on strategic

areas of Maternal and Child Health, within the framework of humanitarian assistance. Due to the recent political developments and the large influx of displaced persons into the country's capital, most of the Swedish support to the health sector will be focused on the Luanda Province. A small part will also be channelled via UNICEF to the Expanded Programme of Immunization.

- A number of other countries are involved in health activities, both bilaterally, through NGOs and through the UN system. The bulk of this assistance, however, is humanitarian.

Among the UN organisations, the following ones work within the health sector:

- UNICEF continues to be the largest UN agency within the health sector, and a large part of the health related projects within the UN-appeal is channelled through UNICEF. As mentioned above, the Swedish funds for the Expanded Programme of Immunization is channelled through UNICEF.
- UNFPA mainly focus on capacity building at both central and provincial level and are supporting youth clinics in Luanda with a focus on sexual and reproductive health.
- WHO works more on a central policy level as well as supporting the Expanded Programme of Immunization, among other things with capacity building in the area of epidemiology.

Finally, a number of international and national NGOs work with humanitarian assistance within the health sector.

1.4. Conclusion

If the present situation prevails, continued focus on humanitarian assistance is foreseen. If and when the political situation stabilises, a long-term co-operation may be prepared, possibly in parallel to the phasing out of humanitarian assistance. Additionally, Sweden is promoting a stronger Angolan ownership and responsibility for the sector, a prerequisite for a successive phasing out of the Swedish support to the health sector in the long run.

2. ERITREA

2.1. Introduction

Eritrea was liberated after 30 years of war and to-day Eritrea is a one of the poorest countries in the world recovering from the protracted war of liberation. The war has severely affected the country and almost every family has lost members. BNP per capita is estimated at 200 USD/day. More than 80% of the population of 3.5 million are farmers or working with agriculture in other ways. The literacy rate is only 20% among men and 10% among women.

Since May 1998 a conflict between Eritrea and Ethiopia has dominated the internal and external situation.

Eritrea's strategic plan emphasises broad national goals of equity, service accessibility, affordability, local participation , intersectorial collaboration, and decentralisation of decision-making authority. The government is in the process of devolving authority and responsibility for program implementation to the six zones.

2.2. The health situation

It is difficult to obtain statistics such as maternal mortality rate and child mortality rate from Eritrea. The explanation is probably the long war situation. However, some figures could be given

Infant mortality rate per 1000 live births	62
Under five mortality rate, per 1000 live births	95
Maternal mortality rate	1.000

At independence in 1993, the health sector was a shambles, and a very active rebuilding program got underway, with support from international donors. The Government's spending on its health budget has grown from about 11 billion birr in 1992 to nearly 110 billion birr in 1997. Still, however, it represents USD 4.4/per capita, suggesting the need for much greater increases in coming years. As in other sectors, the country has a serious shortage of skilled personnel due to the 30-year long stuggle. The main health problems faced by Eritreans are amenable to primary health care intervention, e g maternal health problems, childhood direrhea, ARI, tuberculosis and malaria.

The ultimate development objectives of interventions are to improve the health status of the people, thereby enhancing the quality of their lives and their ability to particpate in the country's socio-economic development.

2.3. Donors in health sector

Sida does not provide heath sector support, but is providing education sector support of 25 MSEK for three years. Sida supports through UNICEF a project on female genital mutilation. The reports from this project have not ben supplied, mostly due to the war situation.

The World Bank and Eritrea are co-operating to strengthen the health care service in 2 zones. It also includes capacity building and amounts to 18.3 million USD, which is about 86% of the total cost of the project. Taking account of the epidemiological need

to address the increasing problem of road traffic accidents and the emerging concern in issues of HIV/AIDS, the project includes the development of a national blood bank.

Other actors are the WHO and the Italian Co-operation on public health and rehabilitation of infrastructure. USAID supports a project on child survival and UNICEF a programme on Micronutrient deficiency.

2.4. Conclusions

Sida and Eritrea do not co-operate in the health sector today.

It is uncertain whether Sweden/Sida will make an assessment of a programme of health co-operation with Eritrea. Any such assessment must await the conclusion of the present conflict with Ethiopia. Considering the health status of the population and the on-going World Bank/UNAIDS programs, it might be a comparatively good investment.

3. ETHIOPIA

3.1. A short summary of the situation

An analysis of development in Ethiopia from the beginning of the 1990s when the present government came to power is politically dominated by reforms that will decentralise policy-making and governance to the regions. Many of the reforms are still in their early stage of implementation. A Civil Service Reform is under implementation. It aims at addressing budgeting and performance systems and civil service rules. It defines responsibilities between the federal and regional levels. Since May 1998 the political situation has been dominated by the ongoing conflict with Eritrea.

3.2. Poverty

Since the beginning of 1990s central elements for the reform of the economy into market-based economy have been introduced. The macro economic indicators showed a decline in real GDP of 3.2% in 1991/92. Economic growth recovered, however, to an average of 6.6% during the period 1992/93–1994/95. However, due to the conflict with Eritrea the economy has showed increasing signs of weakness on account of the increasing level of defence expenditure, which was 4.9 per cent of GDP in 1997/98 and is estimated at 8.1 per cent in 1999/00.

The deterioration in the economy is affecting ordinary people in the country.

3.3. The health situation

The health status of the more than 60 million Ethiopians is poor, even in comparison with other low income countries, including those in Sub-Sahara Africa. Some 40% of all children under five years suffer from malnutrition and the mortality rate of children under five years is as high as 20%. Maternal mortality is amongst the highest in the region. Only 10% of all births are attended by trained health personnel, compared to approximately 60% in Tanzania. HIV/AIDS is an important cause of morbidity and mortality, especially in major cities. Official estimates state that about 9% of the population is infected, but a more realistic figure is twice as high in the largest cities. It is estimated that there are about 700,000 orphans due to HIV/AIDS.

Less than half of the population have access to basic health services (with regional variations of between 11–86%). Where health services exist the quality is poor, mainly due to a lack of trained health personnel and a lack of equipment and drugs.

3.4. Analysis of the health sector

In 1996 Ethiopia took a stand and launched sector programmes for roads, education and health in its struggle to improve the living conditions of the majority of the population. A Health Sector Development Programme (HSDP) for the period 1997–2002 was presented.

Ethiopia defined priorities and needs of the health sector in the national health policy which was approved in September 1993. The policy envisages principles for the democratisation and decentralisation of the health service system. A National Drug policy was approved in November 1993. Recently a Policy on HIV/AIDS has been approved after long considerations.

The main objective of the HSDP is to develop a health system that provides comprehensive and integrated primary care services, primarily based at community health level facilities.

Health status objectives

	1997	2002	2017
infant mortality per 1000 live births	110–128	90–95	50
maternal mortality per 100.000	500–700	450–500	300
Health service objectives are			
expand primary health care coverage	45%	55–60%	90%
contraceptives prev. rate	8%	15–20%	40%
immunisation cov. DPT3	67%	70–80%	90%

The HSDP has been estimated at 5,400 MSEK for the first five-year period. It is planned that the donors' contributions will be approximately 42% and the national share approximately 58%. It is intended that 90% of the funds will be allocated to the regions. The HSDP is scheduled to increase per capita government health spending from 1.60 US 1996/97 to 2.30 US in the fifth year of the programme. There are basically three ways of channelling funds to the HSDP

1. Disbursements directly to the Ministry of Finance for the health budget
2. Disbursements directly to the Ministry of Health to pay for predetermined projects run by the MOH
3. Direct payments to projects, including procurement and services.

3.5. Donors in the health sector

Sida has supported the health sector since 1950. The areas given prominence were the training of middle and lower levels of health cadres, with a focus on midwives, and the establishment of an agenda for reproductive health including human resource development.

Sida prepared unearmarked support (channel 1 above) at 120 MSEK for three years. Norad also stated their intention of providing unearmarked support. However, the two countries did not reach a decision due to the unstable political situation. USAID has earmarked support to the Southern province and the Ministry of Health, The Netherlands contribute to the pharmaceutical sector. Minor donors such as Italy and Irish Aid are giving earmarked direct support. The UN-family (WHO, UNICEF, UNDP and UNFPA) continue their support through channel 2 or 3.

3.6. Conclusions

A possible Swedish contribution to the HSDP will have to await the successful solution of the present conflict with Eritrea. After that a revised preparation phase has to be established as the situation will not be the same as it was when Sida took its positive standpoint in the beginning of 1999. The outcome of Annual Review Meetings and Joint Review Missions since early 1999 necessitates a deep analysis of monitoring and implementing capabilities. While awaiting the outcome of revised preparations, consideration might be given to supporting well-defined areas/projects.

4. KENYA

4.1. A short summary on the situation

Political

An analysis of development in Kenya from the mid 1990s shows a promising change, although backlashes and miscalculations have occurred. The Government of Kenya (GOK) has decided on reforms that in a long perspective will lead to a democratic development. President Moi was elected for a socond president period after the one-party system was abolished 1991. The former leader of the opposition party, Richard Leakey, has been appointed head of the Public Service and has created confidence in Public Service.

A Civil Service Reform is being introduced in all ministries. That means a restructuring of roles and responsibilities in all line ministries.

Poverty

Macro-economic growth has stagnated since the middle of the 1970s and the negative trend has continued. Average GDP growth decreased from about 7% during the 1970s to 2.2% for the period 1990–1997. Half of the population survives on less than 1 USD/day/person. It is not possible for 25% of the population to get sufficient food even if they spend all their earnings on food. Lifeexpectancy is 55 years, but estimates show that it will decrease as a result of HIV/AIDS. 23% of the population is illiterate and 47% lack access to safe drinking water.

According to the World Bank Development Report (1979) Kenya is one of the world's most unequal countries as to income distribution and access to resources for production. The richest 20% earn more than 62% of all incomes, while the poorest 20% only have access to 3%. Only 20% of the total area of Kenya is agricultural and 80% of the population of Kenya live within this area. The total population of Kenya is 28.4 million people.

Gender

Women in Kenya have less control over cultural, financial and political resources than men, which is manifested in all aspects of society, from political to household level. Traditional norms confirm the subordinate position of women, but also within the law system there are components that discriminates aginst women. Female Genital Mutilation is practised in some ethnical groups. According to DHS 1998, 40% of Kenyan women are genitally mutilated.

4.2. The health situation

Indicators	1960	1991	1995	1998
Infant mortality (per 1000 l .borne)	119	52	61	74
Child mortality (per 1000 l.borne)	202	75	60	112
Maternal mortality (per 100.000 l.bonre)	150–300	365–498		

Source DHS 1998

The HIV/AIDS prevalance is 11,6%.

4.3. Analysis of the health sector

The distribution of the health resources is unbalanced. Of the total budget, 80% is directed to the urban areas, while 80% of the population lives in the rural areas. The health expenditure per capita is USD 28 (1990–97, PPP) and USD 8 (1990–97, in nominal terms).

In 1994 the Kenya Health Policy Framework was decided and launched. Due to weak political leadership the ambition of the policy was not converted into practical action. As a result and as a way to strengthen the reform process three main analysies of the health sector have been performed: National Health Account Study (financed by USAID and in collaboration with Harvard Public School of Health), Budget Analysis (financed by Dfid and the World Bank), Health Situation Analysis (financed by Sida and EU in collaboration with Amref)

In 1999 the National Health Sector Strategic Plan (NHSSP) was adopted. In order to develop the NHSSP a Health Sector Reform Secretariat has been established. NHSSP includes three main areas for change:

- Decentralisation. The responsibilities for the planning and the implementation of services have been transferred from the central level to the district level. The responsibility for the follow up and monitoring has been passed from the central level to the province level. All districts shall develop District Health Plans. These plans shall be approved by the province.
- health service should be concentrated to meet prioritised areas as
- Reproductive health
- Integrated Childhood Illnesses
- Expanded programme on Immunisation
- Environment health
- HIV/AIDS, STD and TBC
- Malaria
- Revised Budget system. The allocation system has been given to the districts.

With the District Health Plans as a base, the districts request their budget through the province to the Ministry of Health. The Ministry of Health uses the requested budgets from the districts as basies for discussions with the Ministry of Finance when deciding on the allocation of resources.

NHSSP means a thorough change of the organisation and the structure of the Ministry of Health. For the first time in Kenya financial allocations have a direct link to the districts, through the District Health Plans.

4.4. Donors in the health sector

Several of the main donors are developing at the same time as Sweden programmes with the NGSSP as a base. The donor community shares to a large extent the same analysis as to the preconditions to further develop a health sector co-operation in Kenya. Working groups and Committees has been established, for example: Economic Governance Group (EGG) which was established 1997. Further, a Donors Democratic Group for Health with participants from EU, Danida, Dfid, GTZ, USAID and Sida is discussing the co-ordination. After the adoption of the NHSSP, co-ordination has been intensified. This co-ordination process could be seen as a step towards sector programme support.

World Bank started in October 1999 a preparation phase and the formulation of a more extensive programme of support is being developed.

EU is planning a three-year support of 80 milj Euro to all districts in 2 provinces (Central and Eastern).

After a non-supportive period Danida has started to plan a programme to support districts in Coast Province.

Discussions are underway to re-establish support through Finida to the Western Province.

Only Sida is planning to give its support through the system of the Ministry of Health. In order to avoid duplication and in order to facilitte the implementation and the learning process, it has been decided that the support to a district shall only be chanelled through one donor. EU and Danida have chosen to support the whole province.

The district for Sida-support is located in three provinces: Western, Rift Valley and Nyanza.

4.5. Role of Sweden

The planned Sida support will most likely start in the middle of 2000 and total 75 MSEK for three years. Sida supports the reforms and the National Health Sector Strategic Plan and its implementation in 8 districts in 3 provinces. Four components are included:

- health system
- reproductive health and IMCI (Integrated Management of Child Infections)
- Malaria prevention and environmental health
- Co-operation with Moi-Linköping

4.6. Conclusion

Swedish support will continue in the foreseeable future. It is estimated that the support will be roughly around the same size as the present support, i e around 25 MSEK per year.

5. MOZAMBIQUE

5.1. Political situation

Mozambique gained independence in 1975 but was almost immediately plunged into civil war. The conflict ended in 1992 and in 1994 Mozambique held its first multi-party election which established FRELIMO (Front for the Liberation of Mozambique) as the ruling party.

5.2. Economy and poverty

Mozambique is a very poor country with a GNP per capita of 210 USD.[1] The civil war severly affected the country, it disrupted the economy and distroyed much of the vital faciliteis in the country, including the transport system. In addition, natural disasters such as the floodings in the beginning of 2000 has caused a setback to some of the rebuilding and development.

In 1987, Mozambique embarked on a comprehensive economic reform programme which has had some positive effects, the inflation rate is down and the country has been able to attract foreign investments.

Measured by a number of indicators, Mozambique is a underdeveloped country in several aspects. On the Human Development Index, Mozambique is country number 169 out of 174.[2]

5.3. The health situation

The health status of the Mozambiquan population is poor. The maternal mortality rate is 1100 per 100 000 live births and the infant mortality rate is 135 per 1000 live births.[3] According to the Human Development Report 1999, Mozambique has so not been as affected by the AIDS-pandemic as its neighbours, 33.5 deaths per 100 000 people were recorded in 1997, compared to the 111.1 which is the regional average.

Access to health services seem to have increased based on a few indicators such as child immunisation and access to safe water and sanitation. In 1980, only 32% of the children under 12 months were immunized against measles but in 1997, this figure had increased to 70%.[4]

5.4. Analysis of the health sector

5.5. Donors in the health sector

5.6. Conclusions

[1] World Bank 2000

[2] Human Development Report 1999

[3] World Bank 2000

[4] 1999 World Development Indicators, World Bank

6. TANZANIA

6.1. General situation in Tanzania.

Tanzania has enjoyed a stable political situation since independence in 1961. This situation has however not resulted in an economic development and growth as could be expected. The GDP per capita is 210 USD compared with 480 USD that is the average for Sub-Saharan Africa. Tanzania has developed an overburdened civil service and an inefficient agriculture and industrial sector. The social services are no exemption from this pattern and health as well as education are non-performing sectors.

Looking forward Tanzania has embarked on a radical reform program concerning all sectors of the country. It has already gained result by increasing economic growth rate resulting from the macroeconomic and political reform programs. Tanzania has now also reached its decision points under the enhanced HIPC initiative, which will assist Tanzania to advance its poverty reduction program and stimulate further economic growth. A massive reform program is underway. In collaboration with the major development partners Tanzania is developing its Poverty Reduction Strategy and a Tanzania Assistance Strategy to coordinate the external actors in the economy.

The fact that the economic growth in recent years and Tanzania's rich natural resources so far have had no impact on the living condition for the majority of the people is now addressed by a number of reform initiatives. To improve the overall performance and governance of the public sector a local government reform program has been initiated that will decentralize the service delivery closer to the people. A public service reform is addressing the government administration and the working conditions, the numbers and remuneration of civil servants. There is also a financial sector reform program to improve the financial and accounting systems. In the social service delivery sector, health is one of the priority areas and a conclusive health reform agenda has been developed as part of the general reform programs.

To succeed with the reform programs Tanzania is depending on donor assistance both financially and mentally. There is a determined process to develop a partnership relation between Tanzania and the donors and in supporting GoT to have and keep the lead in the reform process.

6.2. Population and Health situation

The Tanzanian population is estimated to be[5] 32.1 million with an annual growth rate of 2.8%. Given the high population growth rate Tanzania has a broad base population structure with around half of the population below 15 years of age and a very high dependency ratio. The fertility rate is 5.6 and life expectancy at birth 47 years for males and 51 for females. Infant mortality per 1000 births is 98[6]. Illiteracy among population >15 years is 28%.

In spite of the political and social stability Tanzania's social indicators have remained among the poorest in the world.

The main causes of illnesses and death in Tanzania among vulnerable groups are preventable infectious diseases. Malaria, Diarrhea, HIV/Aids, water-born and water-washed diseases and prenatal/maternal diseases are the major causes of death and life

[5] World Bank estimates for 1998

[6] The Health Sector Program of Work June 1999

lost. HIV/Aids has become an increasing problem and Tanzania now ranks six among Sub-Saharan countries in HIV prevalence. Within the next few years Aids is expected to become the major cause of death amongst children and adults.

[7] The number of adult HIV infected in Tanzania 1997 was estimated to be 1,5 million productive adults. It can not be viewed as just a health problem but as a development problem. It is now the major cause of adult mortality in many part of Tanzania.

6.3. Tanzania health sector

Although diseases among children under five and pregnant women account for a large share of total life share lost they account for a smaller share than in other countries in the region. That is a reflection on that Tanzania has devoted considerable resources providing basic health services through the public sector. Per capita health care expenditures per intervention adjusted for purchasing power parity are shown in the table below.

[8] Purchasing power per capita, health care expenditures

Country	Community	Preventive	Curative	Total
Eritrea	0.17	0.85	7.27	8.28
Ethiopia	0.33	1.01	4.97	6.31.
Kenya	1.41	4.44	15.13	20.98
Tanzania	2.63	7.92	14.02	24.58
Uganda	5.70	5.89	21.72	33.31

Tanzania has a relatively high level of spending and a large proposition is allocated to preventive services.

The government health care expenditures except donor contribution shows that the governments health sector budget is skewed towards curative services.

Share of total government expenditures

Country	Community	Preventive	Curative	Total
Eritrea	1.3	8.3	90.4	100
Ethiopia	8.5	13.0	78.5	100
Kenya	7.9	15.5	76.6	100
Tanzania	6.7	15.4	77.9	100
Uganda	10.0	24.5	62.1	100

Tanzania has used a high total spending to decrease avoidable diseases but donors have provided a large proportion. Tanzania is therefore highly dependent on donor funding for the health spending impact on preventable diseases.

The government system is the most important source of care for the poor while mission and private facilities are more common for the upper end of the income distribution. Voluntary agencies run nearly one half of the hospitals and a smaller but not insignificant number of lower level facilities.

[7] NACP HIV/AIDS/STD Surveillance report 1998

[8] World Bank Tanzania social sector review

[9] Health facilities by ownership 1992

Facility	Government %	Voluntary %	Private for Profit %	Total
Hospitals	49	48	2	174
Beds	52	47	< 1	24,130
Health centers	97	3	< 1	276
Dispensaries	80	19	< 1	3,014

At present there are four regional hospitals including the national teaching hospital at Muhimbili College of Health Sciences, Bugando, Mbeya and KCMC-Moshi. Mirembe hospital in Dodoma is a specialized mental hospital and Kibongo hospital is for TB patients.

District hospitals run by government or religious organizations should have a catchment area of 200,000 people and have 60 to 120 beds.

Rural health centers serves a population of 50,000 people and have inpatient services for up to 12 people.

Dispensary serves between 6,000 and 10,000 people and contains a MCH unit and a delivery unit with at least 2 beds.

The government health network was established with extensive donor support without taking into account the financial resources needed for operation and maintenance. The physical structures suffer from lack maintenance and basic essential medical equipment, drugs and supplies are often not available.

6.4. Organization of the health care system

The service delivery structure is linked to the governance and administrative structure of the country. The country is divided into 60 regions and 114 districts. At the central level the MoH is responsible for policy formulation and guidelines to facilitate the implementation of the national health policy. The MoH also runs the four main referral hospitals and the health sector training schools.

At the regional level there is a regional Health management team headed by a regional medical officer responsible for the health services in the region. The main task is to coordinate and supervise the district health services.

At the district level there is a district management team headed by a district medical officer responsible for the services in dispensaries, health centers and district hospitals.

In the local government reform program, health services will be devolved to the local governments. District health boards consisting of councilors from the local government will govern the operation of the health services. The reform program will start in 37 districts scattered all over the country. An allocation of 0.5 USD per capita will be provided to this district for preparation of comprehensive council health plans and implement the National Packages of Essential Health Interventions.

There are a number of vertical programs that are run from the center for specific diseases as tuberculosis malaria, Aids as well as immunization services. Most of them are heav-

[9] World Bank Tanzania social sector review

ily donor funded and have vertical organizational structure starting from a central unit in the MoH down to implementing officers in the health units. The major vertical programs are[10]: Expanded Program on Immunization, Village Health Worker Program, ADIS Prevention, TBA training, Tuberculosis and Leprosy Control, Iodine Deficiency Prevention.

6.5. Health sector finance

There is little information on the total amount spent on health services in Tanzania. It is estimated that in 1995 government and donors spent per capita 2,317 Tsh/year, households 2,496 Tsh/year employers and religious missions 207Tsh/year which means a total amount of per capita 5,020 Tsh or 8.73 USD/year.

A recent analysis shows that the government budget is insufficient to fund the existing health network both now and in the foreseeable future. MoH has calculated that the government budget can only finance[11] 29% of the existing government health system. The estimated resource envelop and flow of funds for the year 1999/00 shows that of the 197.2 million USD the GoT budget caters for 93.6 million, user fees for 3.6 million and donors for 100 million USD.

Donor support constitutes 50.7% of the total resource envelope. The main part, 72%, is allocated to vertical programs, district support and health sector reform in general.

GoT has decided on priority areas for the resource allocations of the recurrent expenditures. The areas include health, education, water, energy, roads, agriculture and law and order. Expenditure data shows that the health sector share of the expenditures in the priority areas have increased from 8.9% 1996/97 to 10.4% in 1999/00. Comparable figures for the education sector is 21.1% in 1996/97 and 25.9% in 1999/00.

Health share of the development expenditure budget in priority areas is 10.9% in 1999/00 compared with 10,3% for the education sector.

As there is an insufficient capacity of the government budget to finance the health sector other sources have been explored. As a result there are a number of initiatives for alternative financing mechanisms as: Cost Sharing, Community Health Fund, Drug Capitalization Program and National health insurance.

Cost sharing has been introduced in all facilities except health center and dispensaries but there is a plan to introduce them even for these services.

The Community Health Fund is a prepayment scheme that was tested in 1996 in one district and will now be extended six other districts. The fund involves the communities directly and is managed by a District Health Board.

A drug revolving fund has been introduced through the Hospital Capitalization Program in some hospitals.

A national Health Insurance scheme is in its pre-implementation stage and a bill is ready to be presented to the parliament.

Private practice and pharmaceutical stores are expanding but are concentrated to the urban areas.

[10] World Bank Tanzania social sector review

[11] Health Sector Reform Program of Work June 1999

6.6. Capacity of the health sector

Several problems have been highlighted in the numerous external and internal reviews of the health system in Tanzania. One of the most commonly cited is the poor performance of poorly trained, and unmotivated personnel. The government has produces a large number of health personnel to staff the rapidly expanding health sector. To date thereare more than 30 cadres of health personnel that have been trained, each with its own duties. They constitutes a diverse group of health workers trained in one or several of the 110 allied training programs There is an large imbalance and maldistribution of the workforce in favour of urban areas and large referal hospitals. There is a lack of accurate basic data on HRM for management and future planning of the health work force.

6.7. Management capacity

The management capacity of the MoH is generally considered to be very low. Many officers in the ministry have a background in clinical medicin with little interest and knowledge of public health and community medicin. The central MoH has a very thin layer of capable officers for management and implementation of reforms. There is very little capacity to establish competent managers and administrators in the 110 district administrations.

6.8. Infrastructure

The delivery of health services throughout Tanzania are hampered by sever underfunding and lack of management capacity. Medical equipment in the public facilities is below acceptable standard and poorly maintained. Buildings are not maintained and many require major renovations.

The government system for supply of drugs to rural health units has inefficiencies resulting in drug shortages and leakage. In 1991 the government adopted a "Masterplan for the Pharmaceutical sector 1992–2000." The plan has only partly been implemented and needs to be updated in line with the National Drug Policy.

6.9. Donors in the health sector

Donors are estimated to support around 50% of the health resource envelope. There are around 20 donors active in the health sector mainly focusing on community and preventive care and the reform process. The largest donor in the sector is Danida with its Health Sector Support Program. The program provides support to the health sector reform as the introduction of district health boards and the regional health administration. Other major donors are Difid that supports vertical programs as Adult and Mortality Project. The Health and Nutrition District Support project and the National Control Program. IDA is active in Policy and planning, Human resource development and procurement. They are also supporting the development of the Community Health fund. USAID is active in Aids prevention and family planning.

The number of donor activities and the difficulties involved in coordinating donor programs has called for a closer cooperation between the MoH and donors. For the past three years the MoH and donors have attempted to work with the MoH to support a sector wide approach for the health sector. Donors have been actively involved in the development of the reform plans and regular meetings between donors and MoH are now taking place

[12] A pooled fund for allocation of donor support channeled through the government system has been developed and so far six donors have made commitment to the fund. These

[12] Side agreement between GoT and pooled fund partners March 2000

are DFID, Ireland aid, Netherlands, Norway, SDC and the WB. They have so far committed around 20 million USD. Other donors are in the process to join the pool. The pool is separated in one part for the center and one for districts. Special guidelines and audit arrangements have been developed for administration and management. The pooling partners and the Permanent Secretaries for the MoH and Ministry of Local Government jointly runs the fund.

The development of the pool fund is an important step towards a SWAP arrangement in Tanzania but there is still a long way to before the MoH is able to be firmly in the leadership and have all donors under a coordinated policy and planning umbrella.

6.10. Health sector reform

Tanzania has a long tradition in planning for the health sector. The first strategic plan was developed in 1967 three years after independence. The emphasis on this plan was the expansion of health facilities in the rural areas. The government was the sole provider of health services and with the extensive donor support the infrastructure program was to large extent achieved. The financial problem during t 1980s made the achieved health network unsustainable resulting in a non-performing health service and a run-down infrastructure.

To address these problems MoH appraised the health sectror performance with the intention to improve the quality of the health services. This resulted in 1994 in the report "Proposal for Health Sector Reform" The reform vision as stated in the report is;

> "*to improve the health and well being of all Tanzanians, with focus on those at most risk and to encourage the health system to be more responsive to the needs of the people*".

The proposal was turned into the Strategic Health Plan for 1995–1998. A joint mission with donors in 1995 resulted in an "Action Plan for 1996–1999". In the beginning of 1997 the scope of the reform plans were broadened to a sector wide improvement program SWAP.

The current "Health Sector Program of Work 1999–2002" is based on the previous plans and is now designed to implement Tanzanias health policy within the scope of the sector wide approach. To achieve objectives of the vision the plan of work has identified eight strategies for a comprehensive approach to address the problems in the sector.

Strategy 1: concerns itself with the provision of an efficient district health services.

Strategy 2: provides back up of secondary and tertiary level hospital services to support primary health care.

Strategy 3: redefines the role of the central Ministry of Health.

Strategy 4: addresses the human resource development.

Strategy 5: ensures the required central support systems.

Strategy 6: ensures the a sustainable health care financing.

Strategy 7: addresses the appropriate public/private mix.

Strategy 8: restructure the relationship between MoH and donors.

For the first year a "Health Sector Plan of Action" has been developed that spells out the activities that will be carried out during the first year of the plan. The activities have been further prioritized to be funded from the GoT budget and by the central and district pooled funds.

One of the main activities for the first year is focusing on the implementation of the decentralized operation of primary health services in the 37 pilot districts. MoH has developed National Districts Health Planning Guidelines to assist the districts in developing comprehensive district health plans. The plans will specifically spell out how the "National Health Package of Essential Health Interventions in Tanzania" will be implemented.

In general the activities for the first year are about getting baseline information and to make more detailed plans for the different interventions. Most activities are costed in order to secure donor funding. The limited implementation capacity at the MoH has made further prioritization necessary and the MoH has together with the pooled fund partners agreed on what the most priority areas are in the first year.

6.11. Analysis of the reform program

The starting point for the reform program is the non-performing health system with deficiencies in most areas. There is however very little baseline information in the reform documents on how the system works or does not work in different respects to base and prioritize the different reform activities on. Tanzania feature as number 156 of 191 in the WHO report 2000 that ranks health systems in all member states. As a lot of the problems that Tanzania is facing in the health sector relate to deficiencies in the health system this is important information. It means that Tanzania can learn a lot on how to improve its systems by making comparisons with other countries in the region and elsewhere.

To assess how the reform program will contribute to achieve the vision of the health policy will only be possible if the baseline data that now is missing can be collected and analyzed. There are therefore at present very limited output objectives and indicators at hand to measure to what extent the policy reform vision will be achieved.

The reform program is so far focused on planning for the reform and the general conditions for providing health services in terms of funding, infrastructure and resources. A lot of effort has been spent on costing the planned activities in order to secure funding from donors as this is critical for the reform process. On the other hand there is no attempt to calculate what could be an affordable health system for Tanzania in the coming 5 to 10 years.

The World Bank has together with the GoT estimated that the Government is able to finance only 29% of the total financial requirement for the health sector. Even if the governments allocation increases and other sources are explored it will still be a financial gap. These financial constrains should not only be dealt with in order to secure more funds but also in terms of restructuring and possibly downscaling and redirect some of the services. To achieve the policy vision and build a sustainable health sector the Government has to shift funds from curative to preventive services.

The MoH has committed itself to a very comprehensive reform program. The health sector reform is however part of the GoT:s reform program where reforms as the civil service reform, local government reform, financial management reform etc all have an impact on the success of the health sector program. Some of the fundamentals for the success of any sector program as the functioning of local government, renumeration of health workers etc are parts of these other reforms.

As the implementation capacity in the government in general is very limited and these reforms are planned to be implemented in 37 districts during the first year there will most probably be a need to revise the implementation schedule to what can realistically be achieved.

6.12. Scope for Sida support

The country strategy for Sida in Tanzania is focused on pro-poor growth, human resource development and democracy human rights. There is at present no planned direct support to the health sector in Tanzania from the country frame but there could be a possibility to support the sector through a likeminded agency as Norad. Sida supports however through the regional health program part of local costs for the development of National Health Accounts.

HIV/Aids should be seen as a development problem that affects the whole society and all development programs. It will therefor not be dealt with specifically in the context of the health reforms. The impact of HIV/Aids is of such a dimension that it needs its own sector wide program approach. A special report on HIV/Aids in Tanzania and recommendation on areas for support was prepared in December 1999[13].

There have been and still are many donors active in the health sector in Tanzania and many donors have tried to move the health system towards national sustainability. The Tanzania experience is however that many donors have their own priorities that influence their area of assistance. The movement towards a sector wide approach in the framework of agreed policies, workplans and procedures is therefore critical for building the national capacity in the health sector.

Sida's assistance to Tanzania is focused on three mutual reinforcing areas: poverty alleviation through economic growth, human resource development and democracy/human rights[14].

Health is a sector that impacts on all this areas directly or indirectly and can also be seen as a basic human right. Poor people is dependent on the public health services while the more better off can use the private sector that is now fast expanding. The development of the health sector especially the public services, are therefore of critical importance for the improvement of the living conditions for the poor.

The sector wide approach on the development of the health sector makes it possible to assist the Government to develop both the private and public sector in a way that is not discriminating the poor.

Improvements in the health sector are critical for achieving the overall objective to improve the living conditions for the people in Tanzania. Sida is committed to assist by monetary support and partnership in a number of sectors except health. Sidas focus on the poor and their living conditions should not exclude attention on how the reform program in health progress and what improvements are achieved.

Sida could contribute to the sector by co-fund projects run by a likeminded donor in an area of special interest like reproductive health and child health. These alternatives are not further explored here as it makes a more thorough detailed investigation in the running donor programs needed.

[13] HIV/Aids in Tanzania- Investing for future generations December 1999

[14] Country strategy for Tanzania 2000-2003 draft 1

Another option is to contribute to the central and/or district the pooled funds directly or through another donor. That should give Sida the opportunity to influence the development of the health sector as well as in building national capacity and sustainability in the public sector. This could be seen as a compliment to the support given to other reform programs as local government reform, civil service reform etc that have indirect effects on service delivery for the poor.

Given the very limited capacity of the information systems and the need to monitor and evaluate progress in the reform programs, special research activities are needed. If Sida is going to sponsor research programs there should be an opportunity to include health service delivery and health indicators in these programs.

The participation in the health sector by some kind of funding has to be prioritized against other commitments in country program. If there are no funds available Sida could explore to get information on the health sector reform from other donors in exchange for information from other sectors where Sida is active.

In line with Sida's general approach to assist Tanzania in building national capacity and partnership focusing on pro-poor growth, the health sector should not be totally excluded from the support agenda.

7. UGANDA

7.1. Political situation.

Uganda has a unique political system with the Nation Resistance Movement as the only political organization that is allowed to function in the country. Political parties are allowed to exist but are prohibited to conduct the normal political party activities. Uganda has just held a referendum on multiparty politics where the majority voted for a continuation of the existing system. The major political parties boycotted the elections and the participation by the electorate was low. Uganda is involved in the conflict in the DRC and is fighting rebel movements in the north and southwest of the country.

7.2. Poverty

Poverty affects a large portion of the population, and an estimated 46% of the Ugandans live in absolute poverty. For the last three years, the Government has been implementing a major Poverty Eradication Action Plan (PEAP) which prioritizes public investment in key sectors with the objective of eradicating poverty and improving quality of life. The PEAP is implemented through the Medium Term Expenditure Framework. Under the PEAP, the government strategy in the health sector is to shift health care resources in favor of rural areas where the majority of the poor live and to emphasize primary health care and bring services closer to the people.

The main pillars of the PEAP are:

- Creation of a framework for economic growth and transformation
- Ensuring good governance and security
- Directly increasing the ability of the poor to raise their incomes
- Directly improving the quality of life of the poor

7.3. Health situation

Despite robust economic development in the last decade, Uganda attained modest gains in its health status, which remains poor and compares unfavorably with the neighboring countries. According to the Demographic and Health Surveys (DHS) of 1991 and 1995, the Infant Mortality Rate and under 5 Mortality Rate fell from 122 to 97 per 1000 and 203 to 147 per 1000 respectively, while the Maternal Mortality Rate has remained high at 506 per 100,000 live births. The Average Life Expectancy has also dropped from 52 (1995)[15] to 42 years (1997)[16] largely as a result of the HIV/AIDS epidemic, whose prevalence, though now reported to be falling, remains unacceptably high at 9.5%. There are also significant variations between regions with the North and the Northeast lagging behind the rest of the other regions.

The leading causes of morbidity and mortality are attributed to preventable, largely communicable diseases, with women and children bearing a disproportionate amount of the burden of ill health. According to the burden of disease study (1995), over 75% of the life years lost due to premature death are attributable to ten diseases including prenatal and maternal related conditions (20.4%), malaria (15.4%), Acute Lower Respiratory Tract Infections (10.5%), HIV/AIDS (9.1%) and diarrhea diseases (8.4%). Together, these account for over 60% of the total burden of disease.

[15] Uganda 1995 DHS quoted in Draft Health Sector Strategic Plan, October 1999, MoH

[16] World Development Indicators 1999, World Bank

7.4. Health sector

Since 1986, the Uganda Government has concentrated on re-establishing the health systems destroyed during the preceding two decades of political unrest. The policies adopted were summarized in "The White Paper" on Health Policy (1993) and the Three-Year Plan 1993/4 to 1995/6 (rolled over to 1996/97). They included: restoring functional capacity and improving efficiency of existing health facilities; expanding health infrastructure in under-served areas; reallocation of resources towards prevention and promotion programs; mobilization of additional resources through both central government and alternative financing mechanisms such as cost sharing and other schemes; increasing the role of NGOs, the private sector and communities in service provision; and effective implementation of decentralization within the health sector.

Ugandans seek their health care from a variety of sources including traditional healers and midwives, a growing number of private pharmacies, private practitioners (mostly based in urban areas), Non-Governmental Organizations (NGOs) and government owned facilities. The latter account for two thirds of all of health units in the country. Modern health care is provided through a network of over 1,500 facilities which include Aid Posts, dispensaries/sub-dispensaries, health centers, maternity units, and hospitals. Table 1. shows the distribution of health units and health personnel in 1996.

Table 1: Uganda – Number of Health Units and Staff (1997) Population 19.5 (1996)

Health Units	Number
Hospitals	98
Health Centers	223
Dispensaries/maternity units	124
Maternity units	367
Dispensaries	603
Sub-dispensaries	57
Aid posts	33
TOTAL	1505
Population/Health unit	12,957
Hospital Bed/1000	0.9 (1990-'97)**
Staffing	
Doctors	964
Nurses	4,059
Midwives	2,624
Medical Assistants	664
Nursing Assistants	(new cadre)
Staffing Ratios	
Overall population/staff	8,311
Population/doctor	20,228
Population/nurse	4,804
Population/midwife	7,431
Population/medical assistant	29,367
Nursing Aids	2,346
Population/health staff	

Sources: Health Care in Uganda: Selected Issues (1999), P. Hutchinson *Draft HSSP, October 1999; ** World Development Indicators 1999, World Bank

7.5. National Health Policy

The National Health Policy (NHP)[17] was prepared within the framework of the PEAP and provides the strategic direction for health services. The policy is implemented through the 5 year Health Sector Strategic Plan and its overall objective is to reduce morbidity, mortality and fertility. The central strategy to achieve these goals and the primary focus of the health care system, is provision of the Uganda National Minimum Health Care Package (UNMHCP). The Package consists of cost-effective interventions that address conditions contributing the most to the disease burden in the country. It will be delivered through a decentralized system with districts taking primary responsibility for implementation. The policy stresses the need to improve quality and equity in access to services (geographically and for all social groups, especially the poor) and to develop partnerships with donors, private-for-profit and private-not-for-profit health providers and non-governmental organizations under a sector wide approach.

7.6. Health Sector Strategic Plan (HSSP)

The HSSP has five major strategies:

- implementing the Uganda Minimum Health Care Package;
- strengthening the health care delivery system;
- strengthening and making operational the legal and regulatory framework
- strengthening and making operational integrated support systems (human resources, quality assurance, information management system, procurement and drugs, equipment, supplies and logistics, health care financing).
- operationalizing policy, planning and information management systems and implementing research and development activities.

The HSSP details the objectives and activities of the major technical health programs comprising the Minimum Health Care Package, and support services, and their outputs. The HSSP is a working document and will be revised and updated periodically as it is implemented, to take account of new developments in the sector.

A number of quality improvement measures have already been instituted by the MOH and include: establishment of a quality assurance unit, enhancement of staff skills through in-service and other types of training, support supervision, improving local accountability by decentralizing management, capacity building in management (technical, financial and administration) including procurement and logistics. The perspective of clients/service users will be a critical factor in this process, and it is envisaged that communities will participate actively, through the Health Unit Management Committees and Village Health Committees in ensuring that the quality of services delivered improves over time.

The Overall HSSP has been costed at USD 954 million. Donors and the Government of Uganda will contribute 91% of the funds necessary to implement the HSSP. Donors and the Government are expected to contribute 90% of the funds. NGOs, Local Government and community contributions will account for the balance.[18] Over the past ten years, there has been a gradual increase in government allocation to primary health care (PHC), and GOU is providing funding to church-based NGOs using the Primary Health Care Conditional Grant (PHCCG).

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[17] Uganda National Health Policy, September 1999

[18] The figures provided are subject to change based on determination of donor commitments and the revenue capacity of Government.

The NHP made provision for adopting alternative financing sources. A health care financing strategy covering user fees, insurance and community insurance schemes is being developed. The GOU is concerned that cost sharing does not prevent the poor from accessing health services and therefore there are provisions for exemption of the poor with communities assisting in identifying those eligible.

7.7. Donor support

Five development partners are planning to provide budget support to the health sector from the start of HSSP. The provisional level of the budget support is outlined in Table 2. The actual disbursement of this support will be dependent on annual review of progress of the sector. Other donors to the sector will continue to provide a combination of project and budget support. However the important factor is that the support will finance elements of the HSSP.

Table 2: Provisional Health Sector Budget Support US$ 104.98 million

Development Partner	2000 / 2001	2001 / 2002	2002 / 2003
Belgium	4.00	4.00	5.00
DFID	8.00	16.00	24.00
Ireland Aid	1.00	1.20	1.80
Sida	2.90	2.90	2.90
World Bank	3.08	11.72	16.48
Total	18.98	35.82	50.18

Department for International Development (DFID). Over the MTEF period DFID plan to provide a slightly increasing level of support to the health sector in real terms. Budget support for GOU's implementation of HSSP will increasingly take the place of project investments, as the latter reach their scheduled completion points. DFID has no plans to develop new project investments with GOU. There may, however, be complementary support to the NGO sector (within the parameters of the SWAP) DFID will also contribute to the Partnership Fund to finance development of the SWAP. DFID's decentralized capacity at the country level offers the potential to contribute expertise across a range of disciplines on an on-going basis. Their close involvement with the MoF Uganda Participatory Poverty Assessment Program (UPPAP) and the work of the MoFPED Poverty Monitoring Unit can be drawn upon to improve performance of the health sector.

Ireland Aid. Ireland Aid is planning to increase its level of funding to the health sector in Uganda to four times its 1999 level over the MTEF period. It is intended that all Ireland Aid support to the health sector during this time be situated in the framework of the HSSP. The key focus will be on budget support for the HSSP implementation, with continued support for the development of human resources for health and district health systems. Ireland Aid will also provide continued funding to the Partnership Fund in support of the SWAp process. Ireland Aid is a responsive and flexible agency with considerable experience with the decentralization process in Uganda. In addition, its participation in the donor coordination group on budget support; its experience and involvement in other key social sectors and its support to the development of human resources for health will contribute to health sector development.

The World Bank. The World Bank's budget support for HSSP implementation will be provided under the Public Expenditure Reform Credit (PERC). The PERC will be introduced in phases and is expected over time to replace the Bank's current project and adjustment lending in Uganda. The first PERC (FY 2000/01–2002/03) will support the government's priority investment program in the education, water and sanitation, and health sectors. The PERC will also assist the government strengthen public sector management and accountability with a focus on procurement, financial management, auditing and, monitoring and evaluation. The World Bank has been involved in conducting analytic work in the health sector directly and through projects. In addition, the Bank also coordinates the overall macro-economic dialogue with the country. The proposed support to the health sector is an integral part of the preparation of the Country Development Framework (CDF) Pilot, which seeks to promote a more holistic approach to development. The overall Bank program is governed by the Comprehensive Assistance Strategy (CAS) for Uganda. The PEAP provides the framework for the Bank's CAS as well as the Poverty Reduction Strategy Paper (PRSP) for Uganda under the Highly Indebted Countries Initiative (HIPC). The Bank also has other macro-level assessments through which it engages the Government in improving public sector investment and performance, namely the Public Expenditure reviews and Country Portfolio Performance Reviews (CPPRs).

7.8. Sida support to the health sector

Sida is planning a moderate increase in the total level of support to the health sector in Uganda. As Sida support to the World Bank District Health Services Project and STI Project come to an end, funds will be reallocated in favor of budget support to health. Sida has no plans to develop new projects but will maintain funding to some NGOs as well as to some multilateral organizations whilst ensuring that the funded activities are within the HSSP framework. Sida will also contribute to the Partnership Fund. Sida has particular expertise to offer in supporting the decentralization process both at district and central level, mainly through financial and management capacity building at district level and in the area of support supervision at central level.

8. ZAMBIA

8.1. Political situation

Zambia is situated in a very turbulent region with conflicts in neighbouring countries such as Angola to the west and DRC to the north. Although at peace itself, the regional instability naturally affects the country in several ways (securitywise, refugees etc).

Internally, the political scene in Zambia is influenced by the upcoming presidential and parliamentary elections which are to be held in 2001. The main issue currently being discussed is if President Chiluba has the intention to run for a third term in office contrary to the provisions in the Zambian constitution.

8.2. Economy and poverty

Zambia is a poor country with a per capita GNP of 330 USD[19]. The Living Conditions Monitoring Survey 1998 showed that 73% of the population lived below the poverty line.

On the Human Development Index, Zambia is country number 151 out of 174.[20]

Since 1992, the Zambian government has initiated a number of market oriented economic reforms aimed at reducing state participation in and control of economic activity. One of the main issues have been the selling of the Zambia Consolidated Copper Mines (ZCCM). A new IMF Programme was started in January 1999 but the implementation has not been without problems.

8.3. The health situation

The health status of the Zambian population is poor. The maternal mortality rate is 650 per 100 000 live births and the infant mortality rate is 113 per 1000 live births. HIV/AIDS has hit the country hard and the number of AIDS-cases is 530 per 100 000 people which is alarming compared to the regional average of 111.1.[21]

8.4. Analysis of the health sector

The Zambian health sector has been subject to reforms since the MMD government came into power in 1992. The reforms have encompassed a decentralisation of the sector, shifting the emphasis of the sector from the central level and hospitals to the districts and primary health care.

However, the reforms have not been implemented without problems, such as the health sector reforms not being synchronised with the overall civil service reforms and the omission of the central hospitals in the initial phases of the reform process. These and other, to a certain extent political factors such as the shifting of ministers – a new minister was appointed in November 1999 – have derailed the health reforms.

The sector is still battling with inadequate funding (about 10 USD per capita per year including donor support) in relation to the structure of the sector.

A joint review of the sector was conducted between the donors and the Ministry of Health/Central Board of Health during the first months of 2000. The results from this

[19] World Bank internet information 28 March 2000

[20] Human Development Report 1999

[21] Human Development Report 1999 (alla data)

review have fed into the National Health Strategic Plan (2000–2003) which outlines the implementation of the reforms in three year rolling cycles.

8.5. Donors in the health sector

Donors in the health sector work sector wide with the National Health Strategic Plan as the basic document. At the district level, there is a basket funding mechanism where some of the main donors contribute with budgetary support to the districts. Some of the donors are not yet in a position to contribute to the basket fund but their support is (should be) still within the frame of the National Health Strategic Plan.

The main partners in the health sector are: Sida, Danida, DfID, EU, World Bank, US-AID, Irish Aid and the UN organisation such as Unicef and WHO.

Sida has substantial support to the health sector of about 45 million SEK per year 1999 –2001, of which 60% is contribution to the district basket and 40% is support for institutional capacity buildning and collaboration.

8.6. Conclusions

The sector programme implementation has faced some serious problems during the period 1997–2000. Due to Cabinet reshuffles, three different people have held the post as Health Minister during this period and this has of course affected the health reforms and the relations between the Government and the donor community. Doubts about the commitment to the reforms along with allegations of misuse/mismanagement of funds have further had negative impact on the donor-government relations. However, with the latest substantial review of the sector and the last change of minister, the reforms seem to be back on track and the relations have improved.

The involvement and support to the health reforms and the sector programme is seen as a long term commitment[22]. It is therefore foreseen that Swedish support to the health sector in Zambia will continue over the coming years. There is a possibility of increasing the support from the present 45 MSEK per year to at least the former amounts of 50 MSEK per year or, perhaps, even more.

[22] Bedömningspromemoria hälsostöd 1999–2001

9. ZIMBABWE

9.1. Political situation

The political situation in Zimbabwe is at present somewhat unstable. Elections have been held in June 2000 and although the ruling party ZANU-PF won, the election also resulted in a stronger opposition.

Since the beginning of this year, the land reforms have become a critical issue involvning outbreaks of violence and violations of human rights.

Swedish relations with Zimbabwe have been affected by the political situation and the status when writing this report is that existing commitments will be honoured but no new agreements on support will be made.

9.2. Poverty

The Zimbabwean economy has been experiencing difficulties since the mid 1980-ies. A growing budgetary deficit lead to the introduction of a structural adjustment programme and economic reforms in 1991. However, the reforms were not fully implemented.

GDP growth for 1998 was 1.6 percent and about 1.2 percent for 1999. Zimbabwe has been experiencing an economic and social crisis induced by dropping prices for its key export products, uncertainty about domestic policies, high inflation and jittery markets. The Zimbabwe dollar has depreciated over 90 percent since November 1997 and the inflation rate stood at 64% in July 1999. The Zimbabwe Government has developed an Action Plan to bring the economy out of crisis over a three year period. The plan provides for reduction of domestic public debt, fiscal deficit and parastatal losses, civil service, financial sector, land, tariff and social safety net reforms, strengthened social services and privatization among others.

9.3. The health situation

The health status of the 12 million Zimbabweans is still rated as "Medium Human Development" in the HDI 1999 (Zimbabwe ended up on 130th place of 171 in total). However, the health situation is deteriorating, maternal mortality is on the increase (570/100 000 live births) and life expectancy is decreasing (from 50.3 years in 1970 to 44.1 in 1999) due to the AIDS-pandemic. According to the HDI, there were 564.4 aids cases per 100 000 people in 1999 which is alarming compared to the regional average of 111.1.[23]

However, there are still several indicators showing a more positive picture than in comparison to the neighbouring countries like Zambia or Mozambique. For example, about 77% of the population have access to safe water (53% in Zambia and 24% in Mozambique) and 73% of all children under 12 months have been immunized against measles (69% in Zambia and 70% in Mozambique).[24]

9.4. Analysis of the health sector

The health sector in Zimbabwe is facing an increased demand from the population due to the deteriorating health situation at the same time as resources have declined dramatically.

[23] Human Development Report 1999 (alla data)

[24] World Development Indicators (World Bank) 2000

In order use the limited resources more efficiently, the Ministry of Health has developed a ten year National Health Strategic Plan (1997–2007) and a three year implemenation plan "2000–2003 and beyond – Programme Implementation Plan".

According to the Implementation Plan, the health system will direct its efforts towards the major illnesses contributing to the country's burden of disease: HIV/AIDS, TB, diarrhoea, childhood Illnesses, perinatal conditions and mortality, malaria, malnutrition, injuries, hypertension, reproductive health, pregnancy related conditions and mortality and mental health.

The Ministry of Health has identified six areas of reform for an effective implementation of the Plan:

- Implementation of Strategic Management and Health Reform
- Effective management of financial resources
- Human resources
- Health information and research
- Maintenance and improvement of infrastructure and medical equitment

It has been estimated that about 23 USD per capita would be necessary in order for the system to be able to provide adequate health care to the Zimbabwean population. However, the resources available are much smaller, roughly 12,5 USD per capita for 2000. It will therefore be necessary to focus on the first issue of reforms and restructuring of the sector in order make ends meet.

As one way of increasing the financial support for the health sector, the Health Services Fund has been established. This is a mechanism by which the health facilities themselves get to keep the locally collected resources (user fees) and use them for the improvement of services. The Fund started in 1997 and has since been gaining interest from international partners. At present, several partners are putting their funds into the HSF, mainly at the district level and the HSF is becoming an embryo to a basket funding mechanism in the health sector.

The Ministry of Health has expressed a wish to move towards a Sector Wide Approach in the health sector and the MOH does see the HSF and the coordination around it as steps in this direction. However, Zimbabwe is still only at the first stages in the process towards a SWAp.

9.5. Donors in the health sector

The main donors in the health sector are: Danida, Norad, EU, the World Bank and DfID (not so large).

Sida had a health programme in Zimbabwe which was phased out during 1999 and the first quarter of 2000. Since there is still a great need for support to the sector, the Embassy and the Health Division at Sida Stockholm have both recommended a continued support, preferrably through the HSF. However, due to the political and diplomatic situation, the possibilities of such support is still unclear.

9.6. Conclusions

Swedish support to projects in the health sector was phased out during 1999 and the first quarter of 2000.

From a technical view, it is clear that there is an increasing need for support to the sector, given the overall financial crisis of the country. It is also clear that the Health Services Fund is a possible channel for such support.

Sweden will during 2000 contribute 10 million SEK to the Health Services Fund. However, these are funds which were reallocated from budget support to the Government and should be seen as a one-off support to the HSF.

Despite the fact that there is both a need and a way, the political situation makes it unlikely that Sweden will be able to enter into an agreement with the Government on renewed support to the health sector. The conclusion is therefore that a Swedish health sector support to Zimbabwe is unlikely for the next two years.

10. BURKINA FASO

10.1. Situationen i landet

Burkina Faso är ett av världens fattigaste länder enligt UNDP:s Index för mänsklig utveckling. Utbildningsnivån är låg, bara cirka 20% av den vuxna befolkningen kan läsa eller skriva. Den förväntade meddellivslängden är 44 år. Många barn dör före 5 års ålder. Landet tillhör Sahel området vilket gör att människorna ständigt har att kämpa mot öknens utbredning och tillhörande problem som brist på ved, mat och vatten. Ekonomin är starkt beroende av bomull som svarar för mer än 50 procent av exporten. Andra viktiga exportprodukter är boskap, guld, frukt och grönsaker. Inkomsten per person var 1998 ca 240 US dollar, vilket var ungefär hälften av genomsnittet för länderna söder om Sahara och innebär att landet är ett av de fattigaste i världen.

10.1.1 Fattigdomsbekämpning

Enligt en hushållsundersökning från mitten av 1990-talet levde ca 45 procent av befolkningen under fattigdomsgränsen och 28 procent under gränsen för extrem fattigdom. Skillnaderna är dock mycket stora mellan städer och landsbygd och mellan olika regioner. Exempelvis levde bara 8 procent av befolkningen i de två största städerna under fattigdomsgränsen (och bara 3 procent extremt fattiga) medan andelen fattiga i de norra regionerna var 50–60 procent (och andelen extremt fattiga 35–40 procent).

Olika sociala indikatorer bekräftar bilden av stor fattigdom både absolut sett och jämfört med andra länder. Enligt UNDPs Human Development Index (HDI) rangordnades Burkina Faso 1997 som nummer 171 av 174 länder. Denna rangordning återspeglar landets dåliga hälsosituation och den bristande tillgången till hälso- och sjukvårdstjänster, men framför allt en extrem situation vad gäller analfabetism och utbildningsdeltagande.

Vid en jämförelse med andra afrikanska länder ter sig situationen inom utbildningsområdet i Burkina Faso ännu sämre än inom hälsoområdet. 1997 var 79 procent av befolkningen (femton år och äldre) icke läskunniga, vilket kan jämföras med 44 procent för länderna söder om Sahara (exklusive Sydafrika). Återigen finns stora skillnader mellan städer och landsbygd och mellan olika regioner. Könsskillnaderna är också påtagliga med hela 89 procent icke läskunniga bland kvinnorna att jämföra med 70 procent bland männen. Den höga befolkningstillväxten gör att nästan hälften av befolkningen är under 15 år. Utbildningsdeltagandet bland dessa barn och ungdomar är extremt lågt. I mitten av 1990-talet låg deltagandet i primärutbildning (*primary school gross enrollment ratio*) på 40 procent (30 procent för kvinnor) vilket kan jämföras med 72 procent för länderna söder om Sahara (exklusive Sydafrika).

10.1.2 Politik

90-talet i Burkina Faso har inneburit en successiv framväxt av flerpartisystem, fri press och självständiga rättighetsorganisationer. Den formella demokratin är på ytan välskött. Burkina Faso har genomfört två parlamentsval, två presidentval och ett lokalval. Förvaltning och styrande parti har dock en tendens att sammanfalla. Arvet från enpartistaten finns fortfarande kvar och den politiska agendan är styrd av yttre faktorer som krav på demokratisk utveckling, respekt för mänskliga rättigheter, marknadsekonomi och strukturanpassningsprogram. Det är svårt att se de ideologiska skillnaderna mellan regeringsmajoriteten och den politiska oppositionen Oppositionen har identitetsproblem och svårt att hävda sig. Däremot finns det många nationella frivilligorganisationer som tagit på sig uppgiften att föra ut demokratin i den traditionella afrikanska miljön.

Under det senaste året har landet genomlevt en politisk kris som i sin förlängning kan leda till en verklig demokratisering av landet, eftersom det civila samhället har blivit en kraft att räkna med.

Kvinnorna utgör mer än 52 procent av befolkningen i Burkina Faso. Trots att landet har antagit en mängd nationella och internationella lagar och konventioner, som till exempel den nya familjelagstiftningen som formellt ger kvinnan lika rättigheter som männen, är både kvinnor och flickor i mycket hög utsträckning offer för diskriminering och förutfattade meningar.

I Burkina Faso finns en uppsättning juridiska texter som skyddar kvinnans ställning men den informella kulturella och sociala rangordningen forsätter att vara ett stort hinder för kvinnorna när det gäller att hävda de rättigheter som uttrycks i de olika lagtexterna. Denna rangordning innebär att kvinnans rätt att uttrycka sig offentligt och delta aktivt i samhällets styrelse i praktiken är mycket begränsad.

10.1.3 Ekonomi

Burkina Faso tillhör sedan självständigheten 1960 CFA-zonen samt den västafrikanska monetära unionen. Den senare omvandlades 1994 till en ekonomisk och monetär union (West African Economic and Monetary Union, WAEMU). Landet har erhållit omfattande internationellt bistånd av olika slag (motsvarande 21% av BNP 1998) och har sedan början av 1990-talet genomfört strukturanpassning och ekonomiska reformer i samarbete med IMF och Världsbanken. Landet har under 1990-talet erhållit skuldlättnader både genom Parisklubben och HIPC initiativet.

Den realekonomiska utvecklingen sedan devalveringen av CFA-francen 1994 har varit god med en genomsnittlig årlig BNP-tillväxt 1995–1999 på 5,2 procent. Detta utgör en klar förbättring jämfört med perioden 1990–1994, då den genomsnittliga årliga tillväxten var enbart 2,3 procent.

Förbättringen återspeglar positiva effekter av den stora devalveringen (50 procent nominellt) och av det pågående reformprogrammet. Samtliga sektorer i ekonomin har under andra hälften av 1990-talet uppvisat goda årliga tillväxttakter även om jordbruket framstår som den centrala tillväxtmotorn i ekonomin. Prognoserna (från IMF och regeringen i Burkina Faso) anger fortsatt goda tillväxttakter 2000–2001.

Reformprogrammet under 1990-talet varit omfattande och förhållandevis framgångsrikt. De makroekonomiska obalanserna har gradvis reducerats, ekonomin öppnats upp mot omvärlden och ekonomiska incitament och institutioner förbättrats. Genomförandet av reformerna har fortskridit enligt upplagda planer. Detta gäller framför allt åtgärderna för att skapa makroekonomisk balans och mikroekonomiska och institutionella förutsättningar för fortsatt god tillväxt. Reformerna har också gett resultat i form av relativt höga tillväxttakter.

10.1.4 Biståndet

Burkina Faso är ett starkt biståndsberoende land men trots det är inte biståndet till landet omfattande. Bistånd per capita ligger på 40 USD men spelar ändå en mycket viktig roll för landets utvecklingsansträngningar. Frankrike är den största bilaterala givaren. Övriga större givare är Holland, Tyskland och Danmark. Givet landets fattigdom spelar de multilaterala aktörerna en stor roll och bland dessa ökar EU sitt bistånd. Huvuddelen av biståndet är gåvobistånd och det genomsnittliga gåvoelementet är 75%. Biståndets inriktning tar hänsyn till att landet är fattigt med sociala indikatorer som är bland de lägsta i världen.

10.2. Hälsosituationen

10.2.1 Sjukdomspanorama

Burkina Faso karakteriseras av hög sjuklighet och dödlighet i smittsamma sjukdomar främst malaria, luftvägsinfektioner och diarré. Undernäring och blodbrist bidrar till den höga dödligheten. 43% av alla konsultationer bedöms som malaria och 19% av de inneliggande patienterna[1].

Tabell 1. Hälsoindikatorer i regionen[2]

Indikatorer 1998	Burkina Faso	Mali	Guinea Bissau	Senegal
Dödlighet under 5 år/1000	165	237	205	121
Spädbarnsdödlighet/1000	109	144	130	70
Beräknad livslängd	45	54	45	53
Mödradödlighet/100000 levande födda	566*	577**	910	—

*Project de document politique sanitaire nationale, (WHO uppskattar dödligheten till 910)
**Partenariat Mali; Banque Mondiale 1997–1998

Hälsoindikatorerna har stagnerat de senaste fem åren trots stora satsningar på sjukvården av givare och hälsoministeriet. Till den höga mödradödligheten bidrar ett icke fungerande referenssystem samt att kostnaden för ett kejsarsnitt är hög, ca 30 000 CFA (390 SEK).

Burkina Faso har efter Elfenbenskusten och Togo den högsta prevalensen av hiv/aids i Västafrika. Prevalensen för hiv/aids är 7,17% (1998) vilket motsvarar 370 000 smittade. Antalet smittade har fördubblats på fyra år. Mindre än 10% upptäcks av hälsosystemet. Mer än 50% av beläggningen på sjukhus är aidsrelaterat. Den främsta smittospridningen sker heterosexuellt men många smittas också via mor-barn och via blodtransfusioner. I åldersgruppen 13–24 år är fem till åtta gånger fler smittade kvinnor än män. Epidemin karakteriseras som generell[3].

Regeringen har helt nyligen prioriterat hiv/aids politiskt som en utvecklingsfråga. Det finns en aids komission, som fortfarande finns inom hälsoministeriet men ska flyttas till undervisningsministeriet eller till premiärministerns kabinett. Kommissionen tycks ha vissa ledningsproblem[4].

Burkina Faso är ett av FN-systemets pilotländer där man ska integrera aktörer utanför FN i UNAIDS tematiska grupp. Det första mötet med givarna kommer att ske i juli. UNDP hoppas på att givarna ska komma överens om att samordna sina aktiviteter för att passa operationsplanen, som nyligen tagits fram av bl a UNDP. Det nationella policydokumentet är ännu inte riktigt färdigt och regeringen tycks inte ha den ledande rollen i kampen mot aids[5].

Vaccinationstäckningen är låg och sedan 1995 har en minskning av vaccinationstäckningen skett. Förklaringen till detta kan vara att vaccinationsaktiviteterna ofta avbryts pga att andra oplanerade punktinsatser måste prioriteras samt att kampanjer för att främja medvetenheten om nyttan av vaccinationer har avtagit. Trots att regeringen fördubblade

[1] Plan triennal 2001–2003 (Provisoire); Ministère de la Santé, Draft Juin 2000

[2] The state of the world's children, 2000; Unicef

[3] Epidemie du VIH/Sida. Diagnostics et résponses opérationelles; PNUD,IPC, Coop Francais. 2000

[4] Muntlig kommunikation, C Lemaire, UNDP

[5] Muntlig kommunikation, C Lemaire, UNDP

budgeten för vaccinationsprogrammet mellan 1996 och 1998 hade drygt två tredjedelar av hälsocentralerna störningar i sitt program pga brist på vacciner, bränsle till kylskåp, transporter etc.

Tabell 2. Vaccinationstäckning hos barn yngre än ett år[6]

Vaccinationstäckning %	1993	1995	1998
BCG	72	74	52
DPT 3	47	47	31
Mässling	42	56	38
Gula febern	42	56	33

Poliofall finns fortfarande liksom mässlingsepidemier. Anmälda fall av nyföddhetstetanus har varit mellan 14 och 20 fall per år de senaste sju åren. Det råder stora regionala skillnader.

Tre graviditetskontroller är normen och sedan 1995 når ca 45% av de gravida kvinnorna upp till målet. 27% av förlossningarna assisteras av utbildad personal eller tränade traditionella barnmorskor. Ca 6% använder preventivmedel.

10.2.2 Faktorer som påverkar hälsosituationen

Den allmänna fattigdomen och dålig tillgång till vatten och sanitet är bakomliggande orsaker som påverkar hälsotillståndet. Fattigdomen orsakar näringsbrist, samt är en begränsning när det gäller att söka vård som kostar pengar.

Endast 26% är läskunniga (29% av männen och 10% av kvinnorna) vilket begränsar möjligheterna att nå ut med hälsobudskap samt bidrar till den låga utbildningsnivån och bristen på hälsopersonal.

Nyttjandegraden av hälsosystemet är mycket lågt med 0,21 nybesök per år (enligt WHO bör nybesöksfrekvensen ligga mellan 0,5–1 per år). Orsaken till den låga besöksfrekvensen är sannolikt att vården är för dyr samt att befolkningen inte har tillit till vården pga dess dåliga kvalitet. 1986 var besöksfrekvensen högre (0,32 nybesök per år).

10.3. Hälsosektorn i Burkina Faso

10.3.1 Organisation och struktur

Det offentliga vårdsystemet tillhandahåller den största delen av hälsovården i Burkina Faso.

Systemet består administrativt av tre nivåer; distriktsnivå, regionnivå och central nivå. Även om det finns ett stort mått av autonomi samordnar t ex regionerna distrikten och ministeriet regionerna. En decentraliseringsprocess har pågått i sektorn sedan 1996.[7] Parallellt med denna process pågår en decentralisering av hela den offentliga förvaltningen. Denna decentralisering stämmer organisatoriskt inte riktigt stämmer överens med den decentralisering som genomförts inom hälsosektorn. Det är därför oklart vilka förändringar i hälsosystemets organisation som kommer att bli nödvändiga framöver för att passa in i det övriga förvaltningssystemet.[8]

[6] Revue des depenses publiques secteur de la santé; Ministère de l'Economie et des Finances, Janvier 2000

[7] Muntlig kommunikation, M Somé, secretaire générale, Ministère de la Santé

[8] Muntlig information från M. Coulidiati, Secrétaire Permanent och M. Outtara, Socio economiste – Planifiacateur, Commision National de la Décentralisation

Vårdsystemet är organiserat enligt följande[9]:

Den lägsta nivån är Centre de Santé et de Promotion Sociale (CSPS), det är en hälsocentral som tillhandahåller basal primärvård och det finns 784 CSPS i landet. Denna nivå tillhör administrativt distriktet men styrs av en kommitté (comité de géstion – COGES).

Nästa nivå, som också är ett distriktsansvar, är Centre Médicale avec Antenne Chirugicale (CMA). Det är den första nivån för remitterade patienter från CSPS. På denna nivå finns möjligheter till kirurgiska ingrepp och centret har normalt 40–60 sjukhusbäddar. Det finns totalt 30 CMAs i Burkina Faso.

Dessa två nivåer styrs av distriktsadministrationen och etableras i enlighet med fastställda nationella kriterier. Som framgår nedan är det få av distrikten som uppfyller kraven för en operationell distriktsvård i dagsläget (endast 4 av 53 distrikt).

Den tredje vårdnivån är regionsjukhusen, Centre Hospitalier Régional (CHR). Det finns 9 sådana regionsjukhus och de har en kapacitet om ca 140 bäddar. Regionsjukhuset styrs av ett "administrationsråd" – conseil d'administration som finns i varje hälsoregion (région sanitaire). Regionen har en halvautonom ställning, de finansieras med centrala medel men har relativt stora möjligheter att själva styra över verksamheten.

Den högsta nivån i systemet består av två nationella sjukhus – Centre Hospitalier National (CHN). Denna nivå har till uppgift att ta hand om svåra fall som inte kunnat få tillräcklig vård vid någon av de andra nivåerna i systemet. Sjukhusen har även utbildningsfunktioner för läkare och specialistpersonal.

Förutom den offentliga sektorn, finns en till främst de stora städerna begränsad privat sektor som växer relativt okontrollerat.

10.3.2 Finansiering

Under perioden 1992–1999 gick i snitt ca 8,8% av de offentliga utgifterna till hälsosektorn och steg under perioden från dryga 7% under 1992–95 till dryga 10% under perioden 1995–99.[10] Av de offentliga medlen går ca 70% till löner för personalen i sektorn.

Hälsosektorn finansieras även med biståndsmedel, via projekt eller via investeringar eller budgetstöd. Av det totala biståndet till Burkina Faso går 9,5% till hälsosektorn (15,1 miljarder FCFA[11] 1999).[12]

Enligt den "Revue de dépenses publiques" (Public Expenditure Review) som genomfördes i januari 2000 går det inte att med de data som finns tillgängliga göra en tydlig uppdelning av hur mycket av de totala resurserna som gått till respektive nivå i systemet. En viss fingervisning kan dock följande tabell ge som visar hur delar av de offentliga medlen fördelades på olika vårdnivåer 1999:[13]

[9] Revue des dépenses publiques, secteur de la santé, Ministère de l'Economie et des Finances, jan 2000

[10] Revue des dépenses publiques, secteur de la santé, Ministère de l'Economie et des Finances, jan 2000

[11] 100 CFA = 1 Fransk franc = ungefär 1,35 SKR

[12] Revue des dépenses publiques, secteur de la santé, Ministère de l'Economie et des Finances, jan 2000

[13] Revue des dépenses publiques, secteur de la santé, Ministère de l'Economie et des Finances, jan 2000

Nivå	Miljarder FCFA
Centre hospitaliers nationaux	3,9
Centres hospitaliers regionaux	2,8
Districts sanitaires	1,7

Som framgår av tabellen (även om den är ofullständig) går stora delar av resurserna till den centrala nivån. Detta beror delvis på en snedfördelning i systemet men även på Bamakoinitiativet som medför att det lokala samhället och patienterna bidrar stort till finansieringen av lägre vårdnivåer och på att givare ger stöd direkt till denna nivå.

De offentliga medlen går från finansministeriet till hälsoministeriet centralt och vidare till regioner och distrikt. Givarmedel och medel via olika organisationer som går direkt till distrikt eller regioner via olika s k vertikala program bokförs sällan centralt och syns därmed inte i statsbudgeten.

Enskilda organisationer och befolkningen bidrar också med medel till hälsosektorn. Befolkningen bidrar förutom med arbetskraft för att bygga hälsocentraler på bynivå, även med patientavgifter och via betalning för läkemedel. Hushållen i Burkina Faso lade i snitt 37 821 FCFA per år på hälsa under 1996, vilket motsvarade ca 10% av hushållets totala utgifter.

I samband med att Bamakoinitiativet infördes i Burkina Faso avskaffades den fria vården och patientavgifter för olika ingrepp eller tjänster introducerades. Avgifterna sätts av respektive lokalkommitté (GOGES – se ovan) och varierar därmed över landet. Avgifter för konsultationer representerar ca 6% av vad hushållen spenderar på hälsovård totalt, den stora utgiften är läkemedel, som representerar 88% av de totala hälsokostnaderna.

Kommentar
Det är svårt att få en klar bild av exakt hur den offentliga hälsovården i Burkina Faso finansieras. Det kan bero på bristande data men även till viss del på att systemet är under förändring. Bamakoinitiativet är introducerat men distrikten och vårdenheterna där förefaller få del av offentliga medel i större utsträckning än i t ex Mali där initiativet är genomfört fullt ut (dvs staten hjälper endast till i en etableringsfas av ett hälsocenter, därefter får det lokala samhället finansiera driften med egna medel).

Flera givare och organisationer ger medel direkt till distrikt eller regioner vilket försvårar en analys av storleken på och fördelningen av resurser i sektorn.

Vad gäller fördelningen av medel förefaller stora delar av de egna resurserna stanna på högre vårdnivåer i systemet, inte minst pga att det är här som majoriteten av den utbildade personalen finns.

Det förefaller även finnas en snedfördelning mellan medel för utveckling (till stora delar givarfinanserat) och de medel som avsätts för löpande kostnader. Betydande summor, ca 70 miljarder FCFA mellan 1996–1999, har investerats i utveckling av sektorn såsom nya byggnader och hälsoenheter. Däremot har inte medlen för underhåll och löpande kostnader ökat i samma omfattning eller kunnat svara upp mot det behov som uppstått – dvs det finns ett behov av att balansera utvecklingsplanerna med tillgänglia medel för löpande kostnader.

10.3.3 Kapacitet i hälsosektorn

10.3.3.1 Administrativ kapacitet

Den administrativa organisationen av hälsosystemet finns på tre nivåer. Den centrala nivån (inkluderar hälsoministeriet centralt), regionsdirektionerna och den lägsta nivån som består av hälsodistrikten. På alla nivåer saknas kompetens i administration och organisation samt tydliga normer om vilka befogenheter varje nivå ska besitta.

De regionala sjukhusen håller på att bli autonoma och vi hade tillfälle att besöka regionsjukhuset i Kaya, där sjukhusdirektören såg tydliga fördelar med denna ansats. Det enda som saknades, enligt sjukhusdirektören, var specialister (gynekolog, barnläkare och tandläkare) och specialiserade sjuksköterskor.

Kriterierna för att en hälsocentral (CSPS) ska vara fungerande är att det ska finnas:

- en lokal med förlossningssal,
- tre personal (en sköterska, en förlossningsassistent och ett biträde),
- en basläkemedelsdepå och
- en organisationskommitté.

Av de 784 hälsocentralerna (CSPS) under 1999 hade 624 fungerande lokaler, 441 personal behovet tillgodosett och 594 basläkemedelsdepåer enligt kriterierna.

Följande kriterier gäller för att ett hälsodistrikt ska betraktas som operationellt:

- Två läkare med utbildning i kirurgi
- Åtminstone ett anestesibiträde och en operationsassistent
- Fungerande operationssal
- En distriktskommitté med en läkare som har kompetens i administration och folkhälsa
- En depå för basläkemedel med en apotekskunnig personal
- Åtminstone 75% fungerande hälsocentraler (CSPS) i distriktet

Enligt dessa kriterier fungerade endast 4 av 53 hälsodistrikt 1998. Brist på utbildad personal är det största problemet.

10.3.3.2 Hälsopersonal

Den befintliga hälsopersonalen täcker inte behoven som finns, mer än hälften av hälsopersonalen finns dessutom i de två största städerna, som sammanlagt har 16% av befolkningen. Endast 60% av vårdcentralerna har minimibehovet av personal uppfyllt. På vårdcentralerna med operationsmöjligheter (CMA) finns däremot för mycket personal men inte med de kvalifikationer som behövs. Totalt finns 6500 anställda inom hälsoministeriet. Burkina Faso når inte upp till WHOs personalbehovsnormer[14].

Tabell 3. Hälsopersonal per invånare[15]

Personalkategori	WHOs normer	Burkina Faso 1998
Läkare	1/10 000	1/23 308
Barnmorska	1/5000	1/25 090
Sjuksköterska	1/5000	1/9 069

[14] Project de document Politique Sanitaire Nationale (PSN); Ministère de la Santé, Mai 2000

[15] Direction des Etudes et de la Planification, Ministère de la Santé

Ett annat problem är personalomsättningen. Personalen stannar endast en kort period i distrikten pga dåliga arbetsförhållanden och få möjligheter till karriär. I de större städerna finns fler valmöjligheter. En sköterska tjänar i genomsnitt 111887 FCFA per månad (1450 SEK).

10.3.3.3 Utbildningsnivån inom hälsosektorn
I huvudstaden finns en medicinsk fakultet, som utbildar läkare, apotekare och laboratorietekniker. Varje år utexamineras 30 läkare och 15 apotekare vilket är för få för att täcka behoven. Enligt WHOs normer skulle det behövas 1160 läkare. Dessutom har ministeriet svårt att anställa dem pga för låg hälsobudget. Kvalificerad hälsopersonal blir ofta anställda inom undervisningsministeriet (universitetet) eller arbetar privat. Läkarna kan vidareutbilda sig i allmän kirurgi (6 månaders utbildning) men i övrigt sker all specialisering utomlands. Hälsoministeriet är bekymrade över personal situationen och har planer på att införa ytterligare specialisering för läkare i landet (gynekologi, pediatrik, kirurgi) men dessa planer har ännu inte konkretiserats.

Barnmorskor och sjuksköterskor utbildas på den nationella hälsoskolan. Varje år utexamineras 30 barnmorskor, 100 barnmorskebiträden och 300 sköterskor. Enligt WHOs normer behövs 2300 sköterskor och mer än 11 000 förlossningskunnig personal.I hälsoministeriet diskuteras strategier för att motivera sjukvårdspersonal att söka tjänster i distrikten och i den kommande treårsplanen definieras personalsituationen som ett av de viktigaste områdena att lösa.

10.3.3.4 Infrastruktur
Målsättningen är att hela folket ska ha tillgång till den offentliga hälso- och sjukvården. Avståndet till närmaste vårdcentral är igenomsnitt 8,5 km (1997), men distributionen är mycket ojämnt fördelad. Målet är att ingen ska ha längre än 5 km till vårdcentralen 2005.

Varje hälsocentral (CSPS) har i genomsnitt ett upptagningsområde på 13 731 invånare. (WHOs norm är 1 hälsocentral/10 000 invånare).

Trots anammandet av ”Bamakoinitiativet” 1992 med införande av hälsodistrikt så fungerar endast ett fåtal av hälsodistrikten med ett fastställt minimum av aktiviteter. En anledning till förseningen av implementeringen på distriktsnivå är att regionsnivån likaså är svag och att detta inte stärkt distriktens autonomi.

10.3.3.5 Läkemedel
Efter självständigheten fram till 1986 dominerades läkemedelssektorn av den privata marknaden. Sedan regeringen i början av 1990-talet antog läkemedelsreformen och strategin med basläkemedel och ”Bamako initiativet” har basläkemedelstillförseln blivit avsevärt bättre i distrikten. En nationell inköpscentral (CAMEG) har inrättats, som köper in generiska läkemedel billigt. Dessa läkemedel säljs till distrikten utan profit, och på apotek i anslutning till hälsocentralerna säljs de med viss profit och måste också tillhandahållas på privata apotek. Det finns 105 privata apotek varav 88 finns i Ougadougou och i den näst största staden, Bobo-Dioulasso.

Den inhemska läkemedelsproduktionen representerar bara 2% av läkemedelsförsörjningen. De traditionella läkemedlen är ännu inte klassificerade och exploaterade för att kunna minska importkostnaderna för läkemedel.

Fortfarande finns brister inom läkemedelsområdet. Det saknas en utvecklingsplan för produktion och distribution av läkemedel, det finns inte möjlighet att göra kvalitetskontroll på läkemedel, reglementen och lagar är ibland inte tillämpbara, förskrivningen av

läkemedel är inte rationell, automedicinering och olaglig försäljning av läkemedel är vanligt förekommande.

Kommentarer
Gruppen hade tillfälle att besöka Barsalogho i Kaya regionen, ett av de trettio referensjukhusen på lägsta nivå (CMA). Sjukhuset, som är rent och förhållandevis nybyggt, verkar ha hög medicinsk och administrativ kapacitet. Distriktet får stöd från Plan International och Save the Children – Holland och en belgisk enskild organisation. Gruppen besökte också regionsjukhuset i Kaya, som inte fick får stöd från internationella organisationer. Sjukhuset verkar fungera på samma nivå som ovannämnda CMA, trots att det är ett regionsjukhus. Det gjorde ett välorganiserat och propert intryck och som tidigare nämnts (3.3.1 Administrativ kapacitet) var det största problemet brist på specialiserad sjukvårdspersonal. Sannolikt var dessa sjukvårdsinrättningar av betydligt högre kvalité än genomsnittet. I Ougadougou hörde vi många skräckhistorier om hur det går till på det nationella sjukhuset, som vi tyvärr inte hade möjlighet att besöka.

10.4. Hälsosektor reformen

Den första politiska hälsoprogramförklaringen täckte perioden 1980–1990 och byggde på primärhälsovårdsstrategin från Alma Ata konferensen 1978. Implementeringen av denna strategi stärktes efter att landet började införa ”Bamakoinitiativet” 1992. På grund av landets ekonomiska svårigheter som har drabbat hälsosektorn svårt har man inte lyckats införa strategierna fullt ut.

I maj i år har hälsoministeriet tagit fram en ny hälsopolitik[16] och en preliminär treårs plan 2001–2003[17]. Strategin bygger fortfarande på Alma Ata deklarationen men den största skillnaden jämfört med tidigare planer är att man nu tar med alla nivåer i hälsosystemet och inkluderar all ohälsa. T ex inför hälsoministeriet ett program för att bekämpa cancer. Hälsobefrämjande insatser placeras emellertid utanför hälsoministeriet.

Hälsopolitikens mål är att bidra till ett förbättrat hälsostatus hos befolkningen med hjälp av alla aktörer inom området liksom med invånarna själva och intersektoriell samverkan.

Målsättningen är att:

- Reducera dödligheten
- Öka täckningen av hälsoservice
- Förbättra kvalitén på sjukvården
- Förbättra finansieringssystemet
- Förstärka den institutionella kapaciteten inom hälsoministeriet.

Strategin för att uppnå målen är att:

- Satsa på de vanligaste sjukdomarna och särskilt mödrar och barn
- Förbättra infrastruktur och utrustning, garantera fungerande distrikt och referens sjukvård, förstärka inflytandet från invånarna och inkludera den privata sektorn i planeringen
- Förbättra tillgängligheten ekonomiskt för patienter, förbättra tillgång på läkemedel, garantera en bra vård genom normer och utbildning av personal

[16] Project de document de poiltique sanitaire nationale (PSN); Ministère de la Santé 15 Mai 2000

[17] Plan triennal 2001–2003 (provisoire); Ministère de la Santé, Juin 2000

[18] Project de document de poiltique sanitaire nationale (PSN); Ministère de la Santé 15 Mai 2000

- Förbättra finansieringen av hälsosystemet genom solidariskt betalningssystem och genom utbildning i management och administration.
- Omorganisera hälsoministeriet och att förstärka organisationskapaciteten och policyutvecklingen. Utveckla mekanismer för koordinering av givarinsatserna. Förstärka det intersektoriella samarbetet och harmonisera decentraliseringsprocessen mellan hälsosystemet och det administrativa systemet.

De största hindren för att verkställa den nationella hälsoplanen är väsentligen av ekonomisk och sociokulturell karaktär. Dessa hinder hänger starkt ihop med fattigdomen och den låga utbildningsnivån, varför lösningen av hälsoproblemen måste ses som en multisektoriell uppgift[18].

Kommentarer
Det hälsopolitiska dokumentet och treårs planen har arbetats fram tillsammans med många olika aktörer inom och utom hälsosektorn. Givarna tycks inte ha haft en framträdande roll i denna process, men dokumenten borde kunna fungera som en bas för hur givarna ska distribuera sitt stöd. Briserna i hälsosystemet är väl identifierade och analyserade i dokumenten men av alla problem framgår det inte vad som först bör prioriteras. Det framgår klart att svagheterna också är beroende av många faktorer utanför hälsosektorn. Den administrativa decentraliseringsprocessen befinner sig fortfarande i ett initialskede som fördröjer en reell reform av hälsosystemet. Kapaciteten är begränsad i att genomföra dessa reformer.

I det nationella hälsopolitiska dokumentet betonas bristen på management kapacitet på alla nivåer inklusive centrala nivåer. Ett annat stort problem är givarna, som hittills agerat utan styrning från hälsoministeriet.

Den treåriga hälsoplanen är mycket ambitiös och täcker hela hälsosektorn, och den innehåller strategier och aktiviteter inom alla områden och alla nivåer. Det är svårt att tänka sig att alla brister ska kunna åtgärdas inom tre år och det framgår inte klart vad som ska prioriteras med de begränsade resurser som finns.

Inom hälsoministeriet finns ett fåtal erfarna och välmotiverade personer att driva processen framåt men sannolikt finns inte denna kapacitet inom ministeriet i stort.

10.5. Karakteristik av hälsosektorn i Burkina Faso

Positiva aspekter
- I samhället finns en stor öppenhet och starkt folkligt deltagande i den demokratiseringsprocess som pågår
- Hälsoministeriet har en stark ambition att samordna givarna mot ett sektor stöd
- Det finns många givare och andra aktörer i hälsosektorn
- Decentraliseringsprocessen inom hälsoministeriet är på gång och det finns en nyligen framtagen hälsoplan och hälsopolicy.
- Läkemedel finns tillgängliga i distrikten

Negativa aspekter
- Befolkningen är mycket fattig och har dålig hälsa
- Läskunnigheten är låg
- Decentraliseringsprocessen är i otakt med den administrativa decentraliseringsprocessen
- Det är en låg utnyttjandegrad av hälsosystemet

- Det råder stor brist på hälsopersonal
- Hälsoplanen är inte realistisk och det är låg kapacitet inom hälsoministeriet
- Hälsofinansieringssystemet är inte transparent
- Givarstödet är okordinerat och ”balkaniserat”
- Det tycks vara en begränsad kapacitet att utnyttja hälsobudgeten

10.6. Givare, givarsamordning och biståndsformer

De stora givarna och aktörerna i hälsosektorn är[19]:

Mulitlaterala: Världsbanken, EU, Unicef, UNFPA, UNDP (hiv/aids) och WHO (tekniskt stöd).

Bilaterala: Nederländerna, Tyskland/GTZ, Frankrike, Belgien och Italien (stöd till malariaprogram).

Hälsoministeriet håller kvartalsvisa givarmöten med lokala partners och står även värd för ett större möte en gång per år. Givarna samordnar sig också informellt med varandra och direkt med de distrikt och regioner i vilka de verkar.

Givarna arbetar fortfarande i program och med projekt, ofta fokuserat på ett geografiskt område. Hälsoministeriet (ministern och statssekreteraren) uttryckte missnöje med denna uppdelning av landet och önskar röra sig mot ett sektorprogram och i förlängningen mot budgetstöd. Därför har ministeriet utvecklat en treårsplan för sektorn 2001–2003 som nämnts ovan, som skulle presenteras för givarna strax efter det att gruppen lämnat landet (mitten av juni 2000).

Kommentar
Givarna föreföll ha en god relativt samordning mellan sig men förtroendet för ministeriet och det administrativa systemen i landet var bristfälligt. Samordningen mellan hälsoministeriet och givarna föreföll lämna en del övrigt att önska. T ex verkade ministeriet ha utvecklat ett förslag till plan för sektorn ganska isolerat (möjligen i konsultation med Världsbanken) som övriga givare inte kände till ännu. Dessutom hade givarna/organisationerna inom FN-systemet med UNDP i spetsen utvecklat en plan för att bekämpa hiv/aids i landet, utan t ex statssekreterarens kännedom.

Tankarna på ett sektorprogram har väckts och förhoppningsvis leder den process som därmed är nödvändig till en bättre samordning och till förbättrade relationer mellan givarna och hälsoministeriet. Intrycket, givet erfarenheter från andra länder, är att man står på första rutan i den lång process som leder fram till ett sektorprogram.

10.7. Svenskt stöd till hälsosektorn – analys

Hälsoministeriet i Burkina Faso (representerat av hälsoministern och statssekreteraren) var mycket positivt inställt till Sverige som en möjlig ny partner i hälsosektorn. Ministeriet hade t o m redan innan besöket sänt in ett projektförslag som man – i ljuset av det tänkta sektorprogrammet – gärna ville omformulera något för att bättre möta de identifierade behoven.

Även om gruppen hade svårt att få träffa bilaterala givare och urvalet därför är begränsat, föreföll det inte alls finnas den tveksamhet till en ny partner som gruppen mötte under besöket i Mali.

[19] Muntlig information från M Somé, secretaire générale, Ministère de la Santé

Det finns redan vissa band mellan Sverige och Burkina Faso och mellan den svenska hälsosektorn och hälsosektorn i landet. T ex pågår ett utbyte mellan Borås lasarett och sjukhuset i Bobo Dioulasso som samordnas av föreningen Burkinas Vänner.

Det råder ingen tvekan om att det finns otillfredsställda behov i hälsosektorn. Hälsoindikatorerna är dåliga och sektorn är i en internationell jämförelse underfinansierad (ca 7 USD per capita i förhållande till de ca 12 USD per capita som Världsbanken satt upp som undre gräns för att kunna tillhandahålla ett minimipaket av vård till befolkningen).

Absorbtionskapaciteten förefaller vara en riskfaktor, i Burkina Faso liksom i Mali. I Public Expenditure Review tas detta upp som en viktig faktor att arbeta vidare med, dvs att öka effektiviteten i systemen för att medlen skall nå ut så snabbt som möjligt.

Trots denna risk rekommenderar gruppen att Sverige/Sida avsätter resurser för att ge stöd till hälsosektorn i Burkina Faso. Det finns stora behov i sektorn, Sverige ses som en välkommen ny partner och det finns redan vissa etablerade kontakter mellan den svenska och den burkinska hälsosektorn. Gruppen ser också att Sverige, som har god erfarenhet av sektorprogramprocesser i olika länder och sektorer, skulle kunna spela en viktig roll i den sektorprogramsprocess som just nu är på väg att börja.

Den administrativa och den tekniska kapaciteten är dock helt avgörande. En förutsättning för att delta i sektorprogrammet och inte minst i förberedelsefasen är att en handläggare finns på plats. Det behöver vara en person som kan tala franska och som kan delta aktivt i processen, dvs helst någon som har ett grundläggande tekniskt kunnande om sektorn, även om en heltid kanske inte är nödvändig (kan delas med andra sektorer).

Om detta inte är en framkomlig väg är gruppen mer tveksam. Det finns ett projektförslag från hälsoministeriet som går ut på att sända några få läkare till Sverige för utbildning i primärvård. Detta anser inte gruppen vara ett kostnadseffektivt sätt att använda biståndsmedlen på. Gruppen diskuterade frågan med biståndsministern och med statssekreteraren och de var överens om att förslaget bör omformuleras i ljuset av det sektorprogram man tänker genomföra.

Om ett större stöd till hälsosektorn via ett sektorprogram inte är aktuellt skulle en möjlighet kunna vara att ge ett mer begränsat stöd till läkar/medicinutbildningen, i enlighet med ministeriets önskan. Om så är fallet rekommenderar gruppen att Sida kontaktar hälsoministeriet för en fortsatt diskussion och en omarbetning av det förslag som inkommit till ett stöd/möjligt institutionellt samarbete med medicinfakulteten i Ougagadougou/ev samarbete med någon svensk fakultet.

11. MALI

11.1. Situationen i landet

Mali är ett av världens fattigaste länder. Enligt UNDPs Human Development Index (HDI) rangordnades Mali 1997 som nummer 166 av 174 länder. BNP per capita uppgick 1998 till 250 USD, 70% av befolkningen lever under det s.k. fattigdomsstrecket. Landet är kustlöst och tillhör Sahel området, vilket gör att människorna ständigt har att kämpa mot öknens utbredning och tillhörande problem som brist på ved, mat och vatten. Färre än 30% av befolkningen kan skriva eller läsa. Ekonomin är starkt beroende av den primära sektorn som svarar för hälften av BNP. Export från den primära sektorn och export av bearbetade bomullsprodukter svarar för mer än 90 procent av exporten.

11.1.1 Fattigdom

Ingen fattigdomsstudie har gjorts de senaste fem åren i Mali och tidigare studier är bristfälliga. Kunskapen om de fattiga i Mali är därför begränsad. Hushållsundersökningen för år 1993 fann att fattigdomen var mycket utbredd och att 55 procent av befolkningen befann sig under den relativa fattigdomsgränsen.[1] Skillnaderna var stora mellan städer och landsbygd, med 64 procent av landsbygdsbefolkningen under den relativa fattigdomsgränsen jämfört med enbart 8 procent av stadsbefolkningen. Stora regionala skillnader förelåg också mellan de norra och de södra delarna av landet.

Olika sociala indikatorer bekräftar bilden av stor fattigdom både jämfört med andra länder och absolut sett. Enligt UNDPs Human Development Index (HDI) rangordnades Mali 1997 som nummer 166 av 174 länder. Denna rangordning återspeglar bl.a. landets dåliga hälsosituation, med omfattande undernäring, hög barnadödlighet och utbredd analfabetism (i synnerhet bland kvinnor).

1997 var bara 35 procent av befolkningen (femton år och äldre) läskunniga, vilket kan jämföras med 56 procent för länderna söder om Sahara (exklusive Sydafrika). En viss förbättring har dock ägt rum sedan mitten på 1980-talet, då enbart 19 procent var läskunniga. Men stora skillnader kvarstår mellan urbana (främst huvudstaden Bamako) och rurala områden och mellan regionerna. Könsskillnaderna är också påtagliga: 1997 var bara 28 procent av kvinnorna jämfört med 43 procent av männen läskunniga. Den höga befolkningstillväxten (ca 2,8 procent) gör att nästan hälften av befolkningen är under 15 år.

Viljan att söka minska fattigdomen i Mali har ökat de senaste åren, till viss del som en följd av påtryckningar från givarsamhället. Men införandet av ett flerpartisystem i början av 1990-talet, bättre politisk representation för minoriteten från norra Mali samt utvecklingen av ett starkare civilt samhälle har också bidragit till denna ökade vilja.

11.1.2 Politik

Under 1980-talet var Mali en militärdiktatur men under 1990-talet har landet med varierande resultat inlett demokratiseringsprocesser. Mali har till skillnad från Burkina Faso sluppit politiska konvulsioner under de senaste åren och har en politisk ledning som har en starkare demokratisk framtoning. Övergången från enpartivälde till ett pluralistiskt system Mali i början på 1990-talet innebar att nya män och kvinnor kom till makten som inte var präglade av den gamla tiden, men landet har ännu inte tillägnat sig demokratins kultur. De ideologiska skillnaderna är inte särskilt stora i Mali mellan regeringspartierna och oppositionen; det är snarare en fråga om makt och marginalisering.

[1] Den relativa fattigdomsgränsen definieras som två tredjedelar av de genomsnittliga utgifterna per invånare.

I Mali utgör kvinnorna utgör mer än 52 procent av befolkningen. Trots att landet har antagit en mängd nationella och internationella lagar och konventioner, som till exempel den nya familjelagstiftningen som formellt ger kvinnan lika rättigheter som mannen, är både kvinnor och flickor i mycket hög utsträckning offer för diskriminering.

Det finns en mängd enskilda organisationer som är verksamma och aktiva i Mali inom det civila samhället. Dessa organisationer arbetar inom områden som jordbruksutveckling, miljö, hälsa, småindustri, och mänskliga rättigheter. De kvinno-organisationer som har bildats under de senaste åren har speciellt inriktat sin verksamhet på att öka kvinnornas deltagande i beslutsfattande positioner såsom i parlamentet, kommunala styrelser, fackföreningar etc.

11.1.3 Ekonomi

Den realekonomiska utvecklingen sedan 1994 har varit god med en genomsnittlig årlig BNP-tillväxt 1994–1998 på 4,5 procent. Detta utgör ett bättre resultat än genomsnittet för afrikanska länder söder om Sahara (exklusive Sydafrika), vilket låg på 3,8 procent för motsvarande tidsperiod.

Mali har erhållit omfattande internationellt bistånd av olika slag (i genomsnitt för 1995–1998 motsvarande ca 18% av BNP) och har alltsedan 1980-talet genomfört ekonomiska reformer i samarbete med IMF och Världsbanken. 1992 hölls de första demokratiska valen sedan självständigheten. Landet har under 1990-talet erhållit skuldlättnader både genom Parisklubben och HIPC initiativet.

1984 blev Mali medlem av den västafrikanska monetära unionen, vilken 1994 omvandlades till en västafrikansk ekonomisk och monetär unionen (WAEMU). Förbättringen av den ekonomiska situationen i Mali återspeglar positiva effekter av den stora devalveringen (50 procent nominellt) av CFA-francen i januari 1994. Liknande positiva effekter återfinns i de andra CFA-länderna, speciellt i de länder där jordbrukssektorn är dominerande. En annan faktor som har bidragit till de goda tillväxtresultaten under senare år är de relativt gynnsamma väderförhållandena. En tredje bidragande faktor är de positiva effekterna av de ekonomiska reformer som genomförts i samarbete med IMF och Världsbanken.

De stora budgetunderskotten fram till slutet på 1980-talet ledde till en snabb ökning av Malis statsskuld. Under 1990-talet har sedan statsskulden (som andel av BNP) stabiliserats dels genom att tillväxten ökat och dels genom ökat bistånd. I slutet av 1990-talet låg utlandsskulden som andel av BNP på ca 110 procent. Ca 60 procent av utlandsskulden utgörs av multilaterala lån och knappt 40 procent av bilaterala lån. Skuldens nuvärde relaterat till exporten låg 1997 på 247 procent och skuldtjänstkvoten på 11 procent. Mali erhöll under 1990-talet bilaterala skuldlättnader genom Parisklubben.

Nyligen utvidgade Bretton Woods institutionerna HIPC initiativet så att ytterligare skuldlättnader skulle kunna erhållas och fler länder skulle kunna bli berättigade. I februari 2000 beslöts att Mali i princip var berättigat till ytterligare skuldlättnader inom ramen för det nya HIPC initiativet (benämnt HIPC2). Beslutspunkten *(decision point)* för HIPC2 kommer för Malis del att samordnas med beslutet om slutpunkt för HIPC1, dvs beräknas (om uppställda villkor uppfylls) kunna äga rum i juli 2000.

11.1.4 Biståndet

Flera givare har bilateralt samarbete med Mali, bland de större bilaterala givarna kan nämnas Frankrike, Tyskland och Holland och Belgien. Bland de multilaterla är EU aktiva tillsammans med de flesta större FN organisationer som UNICEF, UNDP, WFP och UNHCR.

Biståndet synes främst vara inriktat på sociala sektorer (främst utbildning och hälsa), infrastruktur och naturresurser. Nästintill alla givare betonade vikten av resurserna främst satsats på flickor som är den mest åsidosatta gruppen i Mali framförallt vad gäller skolgång. Det stora hindret för utveckling torde inte vara regeringens visioner och ambitioner utan snarare den brist på humankapital som råder inom de flesta områden i landet.

11.2. Hälsosituationen

11.2.1 Sjukdomspanorama

Hälsosektorn karakteriseras av sjukdomar man ser i de fattigaste delarna av Afrika. Malaria är den främsta orsaken till sjuklighet och 31% av sjukligheten klassas som malaria. Efter malaria är luftvägsinfektioner (15%) den vanligaste orsaken till att man söker sjukvård. Andra vanligt förekommande och prioriterade sjukdomstillstånd är undernäring, epidemier (hjärnhinneinflammation, kolera), endemier såsom spetälska, tuberkulos, onchocerciasis och guineworm (inälvsmaskar). Aids och mödradödlighet har på senare tid kommit i fokus.

Tabell 1. Hälsoindikatorer i regionen[2]

Indikatorer 1998	Mali	Burkina Faso	Guinea Bissau	Senegal
Dödlighet under 5 år/1000	237	165	205	121
Spädbarnsdödlighet/1000	144	109	130	70
Beräknad livslängd	54	45	45	53
Mödradödlighet/100000 levande födda	577*	566**	910	

*Partenariat Mali; Banque Mondiale 1997–1998
**Project de document politique sanitaire nationale, Burkina Faso (WHO uppskattar dödligheten till 910)

29% av förlossningarna sker med hjälp av utbildad personal eller traditionella barnmorskor som fått träning[3]. Mödradödligheten är extremt hög vilket sannolikt beror på dålig infrastruktur och höga kostnader för både transporter och kejsarsnitt. 7% av fertila kvinnor använder preventivmedel.

Frekvensen av hiv/aids är låg (4%[4]). Möjligen kan den traditionella muslimska kulturen vara en positiv faktor, som begränsar spridningen. Smittan kommer främst från återvändande migrationsarbetare i grannländerna.

Vaccinationstäckningen är förhållandevis låg. Drygt hälften av barn yngre än ett år är vaccinerade mot mässling och DPT (difteri, kikhosta och stelkramp). Vaccinationstäckningen har inte förbättrats nämnvärt sedan 1990[5]. 43% av kvinnorna har fått adekvat vaccination mot stelkramp.[6]

11.2.2 Faktorer som påverkar hälsosituationen

Mali är ett av världens fattigaste länder vilket bidrar till befolkningens dåliga hälsostatus. Endast 36% av befolkningen har tillgång till rent vatten. Det är stora avstånd och dålig

[2] The state of the world's children, 2000; Unicef

[3] Identification des interventions dans le secteur de la santé financement de la Commisson européenne sur fonds du 8 FED; République du Mali, 1999

[4] Plan decennal de developpement sanitaire et social (PDDSS); Ministère de Santé, 1998

[5] Afristat; Requeil de statistique, Mali

[6] 2000 World Development Indicators; The World Bank

infrastruktur. Läskunnigheten är låg (54% av männen och 69% av kvinnorna över 15 år är illiterata) och Mali har högst antal elever per lärare (80) i världen[7].

Förtroendet för västerländsk sjukvård är låg och det registreras endast 0,16 nybesök per person och år. Målsättningen är att inom 10 år nå upp till ett nybesök per år och person. Sjukvården är dessutom kostsam och kvaliteten på vården tvivelaktig, vilket inte bidrar nämnvärt till att sänka sjuklighet och dödlighet. Befolkningens hälsokunskaper tycks vara mycket bristfälliga och hälsoundervisning bedrivs för det mesta endast sporadiskt på klinikerna. Akut undernäring hos barn under tre år är hög, 23%. Bidragande faktorer är, förutom fattigdom, traditionella föreställningar om mat och hälsa, uppfödningsmönster där det yngsta barnet har lägsta prioritet[8].

11.3. Hälsosektorn i Mali

11.3.1 Organisation och struktur
Sedan 1990 satsar Mali på att bygga ut primärvården och på lokalt deltagande i enlighet med Bamakoinitiativet (se kap 4 om reformer nedan).

Det offentliga hälsosystemet är det dominerande i landet och det är organiserat på följande sätt:

Den lägsta nivån i systemet heter Centre de santé communautaires (CSCOM) eller Centre de santé d'arrondissement revitalisés (CSAR). Dessa är hälsocentraler som tillhandahåller ett baspaket av vård "paquet minimum d'activités" (PMA). Det finns ca 450 operationella hälsocentraler i dagsläget (juni 2000).[9] CSCOM finansieras av patientavgifter och genom försäljning av läkemedel samt vissa bidrag från lokala samhället via skatter. Även personalen anställs och betalas lokalt. Hälsoministeriet bidrar med 75% av av investeringskostnader för byggnader och för större utrustning. Vissa CSCOM får även stöd direkt från givare eller enskilda organisationer (för t.ex. utbildning).

Nästa nivå är distriktsnivån där det finns s.k. Centre de santé de cercle (CSC). Till dessa distriktshälsocenter sänds patienter som inte kan tas om hand på CSCOM-nivå (t.ex. för kejsarsnitt). Det finns 55 CSC som förutom de kliniska funktionerna även har en stödjande och uppföljnings/monitoring funktion gentemot lägre nivåer i systemet. Denna nivå finanserias främst med offentliga medel (stat/givare) även om vissa patientavgifter är aktuella.

Följande nivå är regionsjukhusen och det finns sex regionsjukhus i landet. På denna nivå finns förutom sjukhusadministrationen ett regionteam som är ansvarigt för hela regionens sjukvård (planering, budget, uppföljning etc).[10] Det finns därutöver även tre nationella sjukhus med specialistkompetens på tertiärnivå[11] som lyder direkt under hälsoministeriet.

På central nivå finns även några specialiserade enheter såsom blodtransfusionscenter, ett nationellt institut för forskning och folkhälsa samt förstås hälsoministeriet. Hälsoministeriet har en policyformulerande och samordnande roll i systemet. För en överblick av systemet, se organogram i bilaga 1.

11.3.1.1 Offentligt – privat
Privat hälsovård var förbjuden i Mali fram till 1985 och alla läkare som utexaminerades i Mali garanterades arbete inom den offentliga vården. Privata vårdgivare är numera til-

[7] 2000 World Development Indicators; The World Bank

[8] Moore, 1998

[9] 409 i början av 1999, 450 siffra från intervju med Nederländerna

[10] PRODESS 1998–2002

[11] PRODESS 1998–2002

låtna men den privata sektorn är fortfarande begränsad i sin omfattning och återfinns till största delen i Bamako.

Det finns en rad enskilda organisationer som arbetar inom hälsoområdet. Sedan 1992 finns en sammanslutning, en paraplyorganisation, med namnet Groupe Pivot de Santé (GPS). Denna sammanslutning har som mål att stärka organisationernas kompetens på hälsoområdet (för att komma till rätta med den tidigare situationen som delvis präglades av mer vilja än kunnande) samt att förstärka samarbetet mellan de enskilda organisationerna och hälsoministeriet. De flesta organisationerna är från Mali men har internationella samarbetspartner. GPS har Save the Children som samarbetspartner och får finansiering för sin verksamhet av USAID.

Samarbetet med hälsoministeriet har ökat sedan GPS bildades och GPS deltog aktivt i utarbetandet av den strategiska planen (PRODESS). I dagsläget tillhandahåller många organisationer vård och olika hälsotjänster på lokal nivå ute i landet. Det finns enligt GPS oftast en kontakt med det offentliga hälsosystemet men några formella kontraktsförhållanden (dvs organisationerna ”köps in” för att tillhandahålla viss vård) existerar sällan eller aldrig.

11.3.2 Finansiering

Staten är inte den enda och inte heller den största finansiären i hälsosystemet. Hushållen bidrar med drygt hälften av de totala resurserna i sektorn. Enligt siffror från 1997 ser fördelningen ut enligt följande[12]:

Finansieringskälla	Miljarder CFA	Procent (av totala)
Staten	10,0	17,5%
Andra (NGOs)	3,3	5,8%
Bistånd	14,2	25%
Hushållen	29,2	51,5%
SUMMA	**56,7**	**100%**

Som framgår av ovan står hushållen för mer än hälften av resurserna i sektorn. Fördelningen av medel inom systemet har hittills haft en snedvridning mot högre nivåer. Staten har t.ex. satsat mesta delen av de inhemska medlen på sekundär och tertiär nivå. I och med ett ökat givarstöd har primärvården fått ökade resurser men under 1997 satsades inga interna medel på primärvård. Detta ändras i och med den nya strategin för utveckling av sektorn (Programme de développement sanitaire et social, PRODESS 1998–2002 – dvs den strategiska planen för sektorn, se vidare avsnitt om reformer).

Hushållen betalar avgifter på alla nivåer i systemet. Den lägsta nivån i systemet, är i enlighet med Bamakoinitiativet helt finansierad med lokala resurser (patientavgifter och lokala skatter). Staten (eller biståndsgivare) bidrar med start/utvecklingskostnaderna (byggnader och annan infrastruktur). På högre nivåer i systemet betalar patienterna en mindre avgift för vården även om de blivit remitterade från lägre nivåer (det finns dock vård som är undantagen från patientavgifter).

[12] ”The World and the Health Sector in Mali” an OED Country Report, World Bank 18 Augusti 1998

Hushållens utgifter fördelar sig enligt följande:[13]

Kostnadsslag	Miljarder CFA	Procent
Avgifter i den offentliga sektorn	0,9	3,1%
Privat vård eller informella sektorn	1,5	5,1%
Illegala privata avgifter	1,0	3,4%
Traditionell medicin	1,0	3,4%
Modern medicin (läkemedel)	24,8	84,9%
SUMMA	29,2	100%

Som framgår av tabellen ovan lägger hushållen den största delen av sina hälsoutgifter på läkemedel, nästan 85%. I och med Bamakoinitiativet som gjort läkemedel tillgängliga på lokal nivå ute i landet har utgifterna skiftat från dyra märkesläkemedel till generika.

Kommentarer
Bamakoinitiativet med lokal finansiering av den lägsta nivån i systemet innebär att hushållen måste bidra med resurser för denna nivå. Huruvida detta skapar hinder för tillgänglighet till vården är omtvistat. Enligt de personer vi mötte beror den låga utnyttjandegraden av systemet mest på socio-kulturella faktorer och inte på att människor inte kan betala för sig. På de hälsocentraler vi besökte berättade man att det fanns en möjlighet att slippa betala om man inte kan, men att ingen hittills utnyttjat denna möjlighet. Det stod emellertid klart att det berodde mycket på att ingen vill bli utpekad som fattig i det lokala samhället. På sjukhuset vi besökte (regionsjukhus) var det betydligt mer vanligt att patienter inte kunde betala för sig.

11.3.3 Kapacitet i hälsosektorn

11.3.3.1 Administrativ kapacitet
Hälsoministeriet har nyligen (februari 2000) fått en ny, stark hälsominister, som tidigare arbetat just med decentraliseringsprocessen. Hälsoministeriet har omorganiserats och det verkar finnas en stor beslutsamhet att genomföra hälsostrategin och planen verkar väl förankrad på lägre nivåer. Generellt är kunskapsnivån låg vad gäller organisations- och ledarskapsfrågor och sannolikt blir det svårigheter att verkställa planen.

Fram till 1990 var Mali centralstyrt och baserat på vertikala hälsoprogram. Det finns således ingen tradition av att planera och administrera på lägre nivåer i systemet. Sedan början av 1990-talet har emellertid decentraliseringsprocessen framskridit. Kvaliteten och kapaciteten varierar mycket mellan olika distrikt och decentraliseringen är ännu inte implementerad fullt ut. Fortfarande anställs personalen av hälsoministeriet centralt och distrikten har inte full kontroll över sin budget.

Hälsocentralerna på bynivå (CSCOM och CSAR) drivs av hälsokommittéer. De anställer sin egen personal. Hälsoministeriet bidrar med 75% av kostnader för lokaler och större utrustning. Ministeriepersonal har också ansvar för en kontinuerlig tillsyn av verksamheten. Konceptet bygger på Bamakoinitiativet, som går ut på att byhälsovården ska generera inkomster från patientavgifter och genom försäljning av basläkemedel. Sjukvården planeras och drivs av befolkningen själv och med ett kontrakt med hälsoministeriet. Mali är det land som kommit längst i att verkställa konceptet i praktiken[14].

[13] se föregående fotnot

[14] Report on the review of the implementation of the Bamako initiative in Africa; WHO, Government of Mali, Unicef, 1999

11.3.3.2 Hälsopersonal

I Mali finns[15]

- 5129 hälsopersonal varav 2998 är anställda i huvudstaden, Bamako. 48% av samtlig personal är anställda av centrala hälsoministeriet eller inom någon specialitet.
- 1150 är anställda av hälsokommittéerna på de perifera enheterna (CSCOM och CSAR).
- 363 hälsoarbetare finns i den privata sjukvården, främst i Bamako, varav 57 läkare.
- 492 diplomerade sjuksköterskor
- 367 barnmorskor varav 43% finns i Bamako. Behovet av sköterskor och paramedicisk personal de närmaste fem åren är 2274.
- 404 läkare varav 256 är specialister främst verksamma i Bamako. Totalt finns ca 90 läkare utanför Bamako. Mali har ytterligare behov av 211 läkare under de närmaste fem åren.

Av den personal som kommer att behövas (2888) räknar man med att 1668 ska anställas av hälsokommittéerna på bynivå och 959 av staten.

Genom införandet av Bamakoinitiativet och därmed utvecklingen av distriktssjukvården har tillgången på sjukvårdspersonal ökat i periferin. På varje hälsocentral ska det finnas en sköterska, en förlossningskunnig personal och en personal ansvarig för klinikens apotek. Det är emellertid ett stort problem att få sjukvårdpersonal att stanna på de perifera enheterna eftersom det inte ger någon möjlighet till karriär. Trenden är att de söker sig till en statlig sjukvårdsanställning eller till privata sjukvårdsenheter i städerna när tillfäller erbjuds. Ett annat problem är att få barnmorskor till platser utanför de största städerna eftersom barnmorskorna inte kan flytta utan sina män, som dessutom ofta har fler än en hustru att ta hänsyn till.

I den 10 åriga hälsoplanen finns planeras en ny direktion för hälsopersonal (Direction des Ressources Humaines).

11.3.3.3 Utbildning

Den utbildning som kan erbjudas hälsopersonal räcker inte till och är inte anpassad till de krav som ställs när den nya hälsostrategin ska implementeras. Endast 16% av landets behov kan täckas med de nuvarande utbildningsanstalterna för sjuksköterskor, barnmorskor och laboratorietekniker. I tioårsplanen skissas på ett samarbete med privata utbildningsinstanser för att bättre tillgodose utbildningsbehoven. Vidareutbildningskurserna som ges är inte tillräckligt strukturerade för att fylla de luckor som finns hos personalen. Det finns få karriär möjligheter för personalen vilket bidrar till dess låga motivation.

Läkare och apotekarutbildningen sker på Ecole National de Médecine et de Pharmacie. Utbildning av hälsoarbetare för de perifera enheterna sker på Ecole de Formation pour le Développement Communautaire. Utbildningsinnehållet behöver revideras för att bättre anpassas till behoven. Specialisering av hälsopersonal sker utomlands.

En av de högsta prioriteterna i tioårsplanen är att höja kvaliteten på hälsopersonalen, att revidera utbildningarna och att skapa incitament för att personalen ska ta anställning utanför de större städerna.

[15] Programme Developpement Sanitaire et Social (PRODESS); Min de Santé, 1998-2002

11.3.3.4 Infrastruktur

347 hälsocentraler (CSCOM) fungerar (februari 1998) vilket täcker 40% av befolkningen (som har kortare än 15 km till närmaste hälsocentral)[16]. Inom fem år ska tillgängligheten ökat till 65%. Hälsocentralerna erbjuder ett definierat minimun av aktiviteter och detta görs trots ofta dåliga lokaliteter. 56 hälsocentraler är byggda men inte utrustade. Remittering är ofta svårt då transportkostnader är höga. I flera distrikt har man utvecklat ett solidariskt finansieringssystem, där kostnaderna delas mellan patienten, samhället och referenssjukhuset.

Många hälsocentraler och sjukhus är nedgångna och i stort behov av reparationer. Utrustning saknas ofta, särskilt på referensnivå, vilket gör det meningslöst i vissa distrikt att remittera patienter från distrikt till regionsjukhus. Underhåll av medicinsk apparatur är eftersatt liksom hantering av sjukhusavfall.

Målsättningen i tioårsplanen är att öka tillgängligheten till basal hälso- och sjukvård. 234 hälsocentraler ska skapas med ett upptagningsområde på mindre än 15000 invånare och ytterligare 66 hälsocentraler för en befolkning på mer än 15000 invånare. Underhåll och utrustning ska förbättras, personalens kompetens ska höjas och folkhälsoupplysning ska prioriteras. I tioårs planen ingår också en satsning på högre nivåer i hälsopyramiden, som blivit eftersatt de senaste åren genom den stora satsningen på att utveckla sjukvården i periferin.

Den lilla privata sjukvården, som sedan 1985 växer i det närmaste okontrollerat trots förordningar ska prioriteras och integreras i det nationella hälsosystemet.

11.3.3.5 Läkemedel

På 1980-talet skedde all läkemedelsimport av ett parastatligt företag (Pharmacie Populaire du Mali, PPM), som hade monopol på importen. Läkemedlen som importerades var dyra och inte tillgängliga för flertalet av befolkningen. Det förekom också illegal import, som bidrog till en ”svart marknad” för läkemedel helt utan kontroll av kvalité, förskrivning och prissättning.

Vid införandet av Bamakoinitiativet, som till stor del bygger på tillgång av generiska, billiga basläkemedel tog en läkemedelsreform fart i början av 1990-talet. PPM omstrukturerades och kom att prioritera endast generiska basläkemedel All läkemedelsimport sker sedan dess med anbudsförfarande och PPM deltar i kampanjer för rationell förskrivning och användning av läkemedel. Ett lokalt icke vinstgivande företag har dessutom bildats, G.I.E. Santé pour Tous, som importerar och distribuerar basläkemedel. Detta har skapat en konkurrens, som håller priserna nere. Läkemedelspriserna är nu endast en tjugondel mot var de var innan reformen lanserades. Privata importörer har legaliserats och dessa importerar och försäljer övriga läkemedel. Generiska läkemedel säljs också i privata apotek..Det finns 237 privata apotek varav 162 i Bamako.

Ca 60% av patienterna har tillgång till basläkemedel. Detta är högt i jämförelse med andra länder i Afrika. Basläkemedlen täcker 80% av de vanligaste sjukdomarna. Basläkemedelsreformen får anses vara mycket framgångsrik i Mali trots fortsatta problem med svart marknad, försäljning utan recept och dålig förståelse för korrekt läkemedelsanvändning[17].

Målsättningen för den kommande tioårsplanen är att ytterligare fördjupa och implementera den nationella läkemedelspolicyn. Mali har med stöd från WHO påbörjat att klassificera de inhemska traditionella medicinalväxterna.

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[16] Lévolution du système de santé au Mali depus línitiative de Bamako: Ambassade Royale des Pays-Bas, 1999

[17] The World and the health sector in Mali:An OED country sector report no 18112, World bank, 1998

Kommentar
Vid besök på ett regionsjukhus (Sikasso) framkom att vården som bedrivs här sällan håller den sekundärnivå som är avsedd. Det saknas material, utrustning och framförallt utbildad personal. Lokalerna är oerhört nedslitna och det gör ett skräpigt och förfallet intryck. Personalen verkar uppgiven och menar att staten måste investera mer i sjukvården om det ska bli någon förbättring. De flesta sängarna är tomma, och de inneliggande patienterna ser ordentligt sjuka ut (främst barn med svår malaria och undernäring). Förlossningssalen liksom operationssalen ser primitiva ut och det är svårt att tro att detta är ett av de sex regionsjukhusen. De flesta patienter kommer från staden (75%) och få patienter är remitterade från lägre instanser.

Vid besök på de lägsta sjukvårdsnivåerna (CSCOM) i Bamako (Assaconia) och Kemeni och Niankoro i Ségou regionen får gruppen en bra inblick i hur Bamakoinitiativets intentioner har förverkligats. I enkla lokaler bedrivs basal sjukvård helt under lokalsamhällets ledning. Ett generellt problem verkar vara att tillströmningen av patienter är för lågt samt att rekrytera bra personal som kan ta sig an patienterna på ett respektfullt sätt. På referenssjukhuset i Ségou (Koutiala) har man brist på utrustning och likaledes för få patienter.

11.4. Hälsosektor reformen

Under kolonialtiden var hälsovården etablerad i städerna och var endast kurativ. På landsbygden fanns mobila team. Efter självständigheten 1960 förbjöds privatsjukvården men sjukvården fotsatte att vara begränsad till städerna. Sjukvården hade dålig kvalité och var underutnyttjad. All hälsopersonal garanterades anställning och sjukvården var gratis. Efter Alma Ata konferensen 1978, som bl.a. betonade preventiv sjukvård och hälsa för alla, började internationella organisationer etablera sig i Mali med olika projekt på landsbygden. Stödet var ad hoc och hälsoministeriet hade inte resurser att koordinera insatserna. Å andra sidan behövde inte ministeriet satsa sina resurser på landsbygden eftersom givarna tycktes täcka det behovet[18].

Den första genomgripande hälsosektorreformen i Mali (Politique Sectorielle de Santé et de Population: PSSP) påbörjades 1990 och byggde på Bamakoinitiativet med en finansiell delaktighet av invånarna. Målet var att hela befolkningen skulle få tillgång till ett definierat minimum paket (PMA) av aktiviteter i hälso- och sjukvården. Implementeringen mellan 1993 och 1997 i fyra regioner skedde bl a genom projektet ”Folkhälsa och vattenförsörjning på landsbygden” (Projet Santé Population et Hydraulique Rurale; PSPHR), som stöddes finansiellt av världsbanken, EU, USAID och KfW.

1997 utvecklade hälsoministeriet en ny tioårs plan (Plan Décennal de Développement Socio Sanitaire: PDDSS) som täcker perioden 1998–2007. Denna tioårs plan har presenterats för givarna, som uppmanats att stödja hälsosektorn genom planen både tekniskt och finansiellt. Budgeten är 192 miljarder FCFA (2,48 miljarder SEK) där staten beräknas stå för 28%, hushållen för 21% och givarna för 49%.

Planen innehåller följande målsättningar och strategi:

- Minska sjukligheten och dödligheten i de vanligaste sjukdomarna
- Öka tillgängligheten av ett vårdutbud med god kvalitet både geografiskt och finansiellt med hjälp av befolkningen
- Bekämpa de marginaliserade befolkningsgrupperna och inkludera dem i vårdutbudet
- Ökad social mobilisering för hälsa
- Befrämja alternativa finansieringsmekanismer
- Utveckla personalens kapacitet

Till skillnad från tidigare plan (PSPHR) så ska denna plan integreras i de befintliga strukturerna på hälsoministeriet. Kommittéer på central och regional nivå ska tillsättas för att följa implementeringen och utvärdera planen. Mekanismer för hur planen ska finansieras och resurser för att iscensätta strategin finns ännu inte fastslagna.

Programmet för de första fem åren (1998–2002) har utvecklats i Programme de Développement Sanitaire et Social (PRODESS). Samtidigt har en läkemedelsreform antagits (1998) som definierar landets läkemedelspolitik.

Målsättningen för PRODESS är att minska:

- mödradödligheten med 30%
- dödligheten relaterat till kvinnlig omskärelse
- barnadödligheten i malnutrition och sjukdomar som kan undvikas med vaccinering med 30%
- dödligheten hos barn i malaria, luftvägssjukdomar och diarré med 50%.

Vidare ska PRODESS bl a minska sjukligheten i hepatit B, undernäring, A-vitamin, folsyre, jod och järnbrist samt i tuberkulos och andra stora folksjukdomar. Man ämnar utrota polio och nyföddhets stelkramp, samt minska HIV/AIDS från 3 till 2%. Målsättningen är att öka nybesök till 0,5 besök per individ och år.

Kommentarer
Sedan 1993 har hälsosystemet successivt decentraliserats och utvidgats. Hälsoministeriet har mer tagit på sig rollen som normgivande i stället för att vara operationellt. Regionerna koordinerar och stödjer distrikten tekniskt. Man har infört ett referenssystem och infört normer för vilken service som ska finnas på olika nivåer i hälsosystemet och integrerat den privata, icke vinstgivande, hälsovården i systemet. Trots stora ansträngningar är hälsoindikatorerna fortfarande dåliga. En bidragande orsak kan vara att den första hälsoplanen inte beaktade den dåliga kvalitén på den tertiära nivån och utbildningskvalitén på hälsopersonal. Man hade heller ingen strategi för att lösa problemen med att få hälsopersonal att stanna kvar i systemet, att öka utnyttjandegraden av hälsosystemet och att utveckla ett system så att mest utsatta befolkningsgrupperna skulle få tillgång till sjukvård. Regeringen satsade inte heller tillräckligt på primärhälsovården.

Den nya hälsostrategin är väl genomtänkt och ovanstående svagheter från den förra planen är prioriterade. En av förutsättningarna för att strategin ska kunna verkställas är att givarna kan koordinera sina insatser i överensstämmelse med planen och att resurserna kan absorberas och användas optimalt.

11.5. Sammanfattning av typiska karakteristika för hälsosektorn i Mali

- Landet är stort och glest befolkat
- Befolkningen är mycket fattig och utbildningsnivån är låg
- Kvinnans ställning är underordnad mannen
- Hälsoindikatorerna tyder på dålig hälsa trots relativt väl utbyggda hälsostrukturer
- Hälsoministeriet har utarbetat en väl förankrad hälsopolicy och tio årsplan
- Mali har kommit långt i decentraliseringsprocessen
- Givarsamordning och hälsosektorstöd har hög prioritet.
- Det finns många aktörer inom hälsosektorn inklusive lokala och internationella enskilda organisationer.
- För nästan all hälso- och sjukvård tas en kostnad av patienterna.

- Det är en låg utnyttjande grad av hälsosystemet
- Det råder brist på utbildad personal, särskilt utanför de stora städerna.
- Läkemedel finns tillgängliga i distrikten.

11.6. Givare, givarsamordning och biståndsformer

Det finns ett antal både multi- och bilaterala givare i hälsosektorn. De flesta har tills nu haft en tendens att fokusera sitt stöd på antingen geografiska områden (distrikt/regioner) och/eller olika vertikala program (vaccinationer, mödravård etc.). Eftersom ett sektorprogram är i sin inledningsfas kommer detta troligtvis att förändras inom de kommande åren.

11.6.1 Givare

De stora bilaterala givarna är: *USA* (bl.a. barnhälsa, nutrition, vaccinationer, stöd till NGOs), *Nederländerna* (stöd till utvalda distrikt samt läkemedel), *Tyskland/GTZ* (stöd till en region – Mopti), *Belgien* (stöd till utvalda distrikt samt malaria), *Schweiz* (stöd till utvalda regioner samt regionsjukhuset i Sikasso) och *Frankrike* (stöd till CSCOM, sjukhusreformer, utbildning och hiv/aidsbekämpning).

De stora multilaterala aktörerna är: *Världsbanken* (institutionell kapacitet, systemutveckling, stöd till partnerskap med civila samhället), *UNDP* (tekniskt stöd hiv/aids program, stöd till primärvård, handikappstöd), *Unicef* (stöd till primärvård, sanitet/hygien, barnhälsa, nutrition etc.), *UNFPA* (stöd till primärvård, familjeplanering, NGOs), *EU* (läkemedelssektorn, planerar stöd till PRODESS) och *WHO* (tekniskt stöd inom de områden som hälsoministeriet definierar). *ADB* kommer också att delta i finansieringen av PRODESS men det är inte klart i vilken omfattning.

11.6.2 Givarsamordning

Hälsoministeriet samordnar officiellt givargruppen. Årliga möten hålls i Comité d'Organisation et d'Evaluation du PRODESS (COCEP). Detta är en mer politisk församling där främst ambassadörer och cheferna för respektive organisations landkontor är representerade. I denna kommitté deltar även andra ministerier. En liknande samordning sker på regionnivå i de sk CROCEP (Comité Régional d'Orientation, de Coordination et d'Evaluation) där givarna på regionnivå deltar.

Under COCEP finns en teknisk kommitté som träffas två gånger per år, samordnat av hälsoministeriet. Dessutom träffas givarna oftast varje månad i mer informella möten, dessa möten är formellt sammankallade av hälsoministeriet men WHO står ofta som värd och har sekretariatsfunktioner.

11.6.3 Biståndsformer

I Mali inleds/pågår ett sektorprogram inom hälsosektorn. Det finns en strategisk plan (PRODESS) som anger riktningen för utvecklingsarbetet under perioden och som är kostnadsberäknad. Samtliga större givare i hälsosektorn deltar i programmet men stödet är fortfarande till stora delar öronmärkt – till geografiska områden eller till vertikala program.

Möjligheterna till budgetstöd diskuteras för närvarande och hälsoministeriets förhoppning är att givarna skall börja få förtroende för systemen och så småningom röra sig mot budgetstöd. För att underlätta för givarna avser ministeriet att inrätta konton på olika nivåer så att de givare som t.ex. endast vill ge stöd till primärvård får möjlighet att göra det (konton på distrikts, region och nationell nivå). De givare som sagt sig vara villiga att ge budgetstöd är Världsbanken (stöd till hela sektorn dvs nationell nivå), Nederländerna (stöd till nationell och regional nivå) och Belgien (stöd till regional nivå).

Kommentar
Givarsamordningen ger intryck av att fungera relativt väl och det förefaller som om samordningen ökat och kontakterna fördjupats under senare år i samband med att PRODESS utarbetats och i samband med utvecklingen mot ett sektorprogram.

Givarnas förtroende för hälsoministeriet har ökat i och med att en ny hälsominister tillträdde i våras. Hon arbetade tidigare för Världsbanken i Mali som hälsohandläggare och har goda tekniska kunskaper om sektorn. Däremot är förtroendet mer tveksamt inför de administrativa och finansiella systemen inom den offentliga förvaltningen.

11.7. Svenskt stöd till hälsosektorn – rekommendationer och slutsatser

Vid en första anblick förefaller Mali vara mycket intressant för ett svenskt hälsosektorprogramstöd; hälsosituationen är dålig, det finns stora behov i hälsosektorn, det finns en strategisk plan, en tillfredsställande givarsamordning och de finansiella systemen är under granskning och kommer att förstärkas.

Men efter en närmare granskning blir dock slutsatsen den motsatta.

Den strategiska planen för sektorn (PRODESS) har utvecklats gemensamt av givarna, olika partner i sektorn och ministeriet under ett antal år. Arbetet har inte varit okomplicerat. Nu har äntligen enighet nåtts kring dokumentet och processen kan påbörja nästa fas. Vid gruppens besök fanns en känsla av oro inför en eventuell ny partner och vad detta skulle kunna innebära – skulle Sverige vilja riva upp diskussionerna igen?

Det fanns också en viss tveksamhet till var Sverige skulle kunna passa in, vilken roll vi skulle kunna spela. Varken hälsoministeriet eller de andra givarna kunde definiera ett klart behov, även om hälsoministeriet vid flera tillfällen uttryckte en positiv inställning till svenskt stöd i mer allmänna ordalag.

En anledning till denna ”ljumma” inställning till en ny partner kan vara att den nuvarande strategiska planen redan har full finansiering. Även om det finns stora och otillfredsställda hälsobehov i landet och behov av medel i sektorn är absobtionskapaciteten mycket låg. Världsbanken redogjorde t.ex. för allvarliga problem med att få ut de medel som faktiskt redan idag står till sektorns förfogande. I ett dylikt läge förefaller risken stor att svenska medel som ges till sektorprogrammet, direkt eller via någon annan givare, samlas centralt på ett konto och inte kommer befolkningen till del.

Gruppen gör därför bedömningen att det vore olämpligt att i dagsläget gå in med stöd till sektorprogrammet i hälsosektorn i Mali. Gruppen vill dock inte utesluta möjligheterna till stöd för hälsosektorprogrammet i framtiden. Det är mycket möjligt att det kommer att finnas behov om några år, när de finansiella systemen setts över och när sektorprogrammet kommit igång fullt ut. Rekommendationen blir därför att – inom något/några års tid – ompröva ett ev. beslut om att inte delta i sektorprogrammet just nu (t.ex. inför utarbetandet av nästa strategiska plan när den nuvarande löper ut år 2002).

I bedömningen har även hänsyn tagits till att Sverige inte har några direkta komparativa fördelar annat än att vi är helt nya och neutrala. Det finns få eller inga kontakter mellan den maliska och den svenska hälsosektorn.

Vidare har den svenska administrativa kapaciteten att hantera ett hälsostöd vägts in. I dagsläget är det aktuellt att anställa en person under en period av sex månader med placering på UNDP-kontoret i Bamako.

Det kan naturligtvis tänkas att det finns andra program och projekt som kan vara aktuella för svenskt hälsostöd, även om inga konkreta förslag inkommit ännu. En svensk närvaro i landet kan förstås förändra denna situation. Dylika förslag bör då behandlas efter hand.

12. MALAWI

The Silent Crisis – Supporting Malawi's Health Sector?

12.1. General situation in Malawi

Malawi is the sixth poorest country in the world and has a child mortality rate ranking among the highest globally. Life expectancy is the third lowest in the world, and HIV/AIDS prevalence is as high as 35% among urban adults of reproductive age. Despite its extreme poverty and poor economic and social prospects, Malawi's challenges seem little recognized in the global media. Recently emerging from an oppressive one-party regime, the new government has inherited formidable difficulties. Malawi represents a 'silent crisis' on a turbulent continent.

12.1.1 Population

Malawi is a landlocked and densely populated country covering an area of about 118 500 square km. The country shares borders with Tanzania, Mozambique and Zambia. The total population is about 10 million, with an annual growth rate of 3.2% per annum. Growth is mainly due to the high fertility rate of 6,7.[1] This in turn is a result of several factors such as early marriage, early age of first pregnancy, and closely spaced births[2].

About 85% of the population live in rural areas. Almost half of Malawi's population is under 15 years of age and child labour is prevalent. It is estimated that over 1 million children today are orphans due to AIDS.[3]

12.1.2 Political situation

Following British colonial rule, Malawi was a one party state under President Kamuzo Banda from 1964 to 1994. During the Banda regime, political and civil rights were abused and the country fared poorly in assuring basic human rights. The multiparty system was introduced in 1994 and Bakili Muluzi was elected as president. In 1999 the second multiparty democratic general elections were held with President Muluzi and the United Democratic Party (UDF) retaining power. Government policies are openly debated in Parliament, but as a whole the society is still learning about the democratic process. A new Constitution was adopted in 1994. Written media are little interfered with by the government although the broadcast media are still government controlled.

The country is divided into three regions, north, central and southern, which are politically and culturally distinctive. The regions are comprised of 26 districts and these are divided into Traditional Authorities, each covering a group of villages. Decentralisation is a key issue for the government, and the process is underway, with the recent abolition of the regions and devolution of authority to the districts.

Malawi has long been stable and is not suffering from internal conflicts. The crime rate is low, although it has increased since 1994. The legal system in the country is affected by a great shortage of resources and fails to respond to the needs of the poor majority. Corruption is a recognised problem in the country and the government has established an Anti-Corruption Bureau.

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[1] The State of the World's Children 1999, MSIS 1996

[2] Malawi National health Plan 1999–2004

[3] Human Development Report 1999 In Malawi National Health Plan 1999–2004

12.1.3 Socio-economic development and poverty

Malawi has an agricultural economy which employs over 80% of the population in subsistence or commercial farming. Main cash crops are tobacco, tea, coffee and sugar. Agriculture accounts for over 90% of export earnings, mainly derived from tobacco. The sector is highly vulnerable due to dependency on good weather conditions and drought risk.[4]

Malawi is one of the world's poorest countries with a GDP of US$ 210 per capita. The country also has one of the most unequal distributions of wealth. There are about 4 million absolute poor in Malawi, living under the poverty line of US$ 40 per adult per annum. The rural population and especially rural women are the most disadvantaged. Poverty is primarily due to lack of education, the high population density, unequal access to productive resources, and control by a small elite of the management of the economy. Another factor in the worsening situation is the high prevalence of HIV/AIDS[5] and decimation of the productive working population.

Few foreign private investments are taking place, mainly due to the poor financial infrastructure. The government is working on a privatisation programme in an attempt to improve the management of state-owned enterprises and to free up public service capacity for priority services. The government is also promoting liberalisation of the financial market in an attempt to make it easier for individuals and companies to borrow money and invest.[6]

12.1.4 Education, gender and equity

Human resource capacity is very weak due to poor education, shortage of teachers, migration and the impact of AIDS. The migration of educated people is a serious threat to development, and is most often due to poor terms of employment, especially in the public sector.

The literacy rate is low in comparison to other countries in the region. Female literacy is only about 32% and for men 52%[7]. Women occupy a very inferior social status in Malawi, reinforced by traditional culture and lack of education. Over 30% of all girls age 15–19 have borne a child. Women are mainly self-employed within traditional female occupations. Women produce about 80% of the food consumed in Malawi, but have little role in the economic output of the agricultural sector. There are few women in senior positions in politics, government and in the civil service. However, since 1994 there has been growth in the number of women activists and lobby organisations such as the Women Lawyers Association and the Association of Progressive Women.

12.2. The health situation

12.2.1 The disease panorama

Malawi has among the poorest health indicators in the world. The infant mortality rate is 135 per 1,000 live births. The under five-mortality rate is high as well, at 215 per 1,000 live births.[8] Most deaths are due to malnutrition, anaemia, acute respiratory infections (ARI) and diarrhoeal diseases. Morbidity and mortality due to malaria is high both among adults and children and the number of fatalities is rising due to increased resist-

[4] Malawi National Health Plan 1999–2004

[5] GoM-UNICEF Mid-Term Review Draft Report

[6] DFID, Malawi Country Strategy Paper 1998

[7] Malawi Population and housing Census Analytical Report (Zomba) In Malawi National Health Plan 1999–2004

[8] The State of the World's Children 1999

ance to anti-malarial drugs. Malaria is the main killer among children under five. The economic impact of the disease is substantial in terms of costs to health care, production and workdays lost.

It is estimated that 50 percent of all children are suffering from chronic malnutrition. Malnutrition is usually due to household food insufficiency, poor feeding and weaning practices and infections. Lack of safe water supply, poor sanitation and hygiene are the main reasons for diarrhoea. Less than 50% of the population have access to safe water for drinking (urban 95% rural 40%).[9]

Table 1: Health Indicators

Indicators for 1997	Malawi	Tanzania	Zambia
Under-5 mortality rate	215	143	202
Infant mortality rate (per 1000 live births)	135	92	112
Life expectancy at birth (years)	41	51	43
Maternal mortality rate	620*	530*	650*

*The period 1980–97

The maternal mortality rate is about 620 per 100,000 live births. Most deaths are related to high fertility, high-risk pregnancies, poor access to health facilities, and low quality and utilisation of essential obstetric services.. About 30% of the women attending antenatal services in the main urban centres (Lilongwe and Blantyre) during 1997 were infected with HIV.

HIV/AIDS is today the major cause of deaths among persons of reproductive age. It is estimated that more than 40% of adult and 30% of paediatric hospital inpatients are HIV positive. An estimated 267 persons became infected with HIV daily in 1998. Most women with AIDS are in the age group under 30.[10] Five out of six HIV infected youth are female. There is a massive increase in tuberculosis incidence due to AIDS, creating yet more pressure on the health care system. Other AIDS-related opportunistic diseases also absorb significant health resources.

Community awareness concerning HIV has been very low. A lack of political openness, poor communications systems, and traditional beliefs have been barriers, although now public information is widespread. A multisectoral Roundable Conference on HIV/AIDS was held in March 2000, and welcomed a new openness to the issues surrounding HIV/AIDS.

12.3. The health sector in Malawi

12.3.1 Malawi health care delivery system.

Health care in Malawi is mainly provided by three agencies. The Ministry of Health and Population (MoHP) provides about 60%, the Christian Health Association of Malawi (CHAM) provides 37% and the Ministry of Local Government (MLG) provides 1%. Other providers such as private practitioners, commercial companies, army and police account for 2% of the services. The private sector is at present small but is expanding rapidly.

[9] ibid.

[10] GoM-UNICEF Mid-Term Review Draft Report

The Ministry of Health and Population is under the leadership of a newly appointed and dynamic Minister of Health, Aleke Banda. There are two principal secretaries, one for health and population, and one for finance and administration. The PS for health and population has authority over the six Ministry departments, Regional Health Offices and central hospitals, as well as the AIDS Secretariat, Central Medical Stores (CMS) and training institutions. District Health Officers are under the authority of RHOs. This structure is now in transition, with the dissolution of regional health offices and a move towards greater autonomy of training colleges and CMS (see Annex 3 Figures 1 and 2: Current and proposed MOHP organisational structure).

Table 2: Distribution of health facilities in Malawi (number of facilities)[11]

Description	MOHP	Church Providers	Other	Total
Central hospitals	3	0	0	3
District hospitals	22	0	0	22
Mental hospital	1	1	0	2
Rural hospital	16	17	1	34
Other hospitals	1	22	0	23
Health centres	199	87	48	334
Maternity units	1	4	12	17
Dispensaries	45	13	10	68

Table 3: Health service providers by facilities[12]

Provider	Facilities	Beds
MoHP	339 (40%)	8,156 (55%)
Mission	164 (19%)	5,648 (38%)
Local Government	65 (8%)	493 (3%)
Private/NGO	282 (33)%	596 (4%)
Total	850	14,893

Until recently public sector health services were organised around the three regions, but these regional offices have now been abolished. There are 26 districts and four cities that administer health services. The responsibilities of the District Assemblies will be expanded in line with the decentralisation policy to include: personnel recruitment and management, water supply and hygiene, management of hospitals and other health facilities, communicable disease control, vector control and public health inspection.

Other government agencies providing health services are the Ministry of Local Government, the Police and the Army. In the NGO sector there are a number of mission and other organisations such as ADRA, Banja la M'tsogolo, and Marie Stopes, that run hospitals and primary care facilities. It is estimated that around 40% of the inpatient services are run by the church health sector. The Christian Health Association of Malawi is the co-ordinating body for the main church health organisations. There is no reliable information on the private for-profit sector but it is generally accepted that it is growing in a rapid and unregulated fashion in the urban centres.

[11] GoM A vision for the health sector in Malawi (MoHP 1999)

[12] Source MG basic health statistics 1994

12.3.2 Health sector finance

Government health services in Malawi are provided free of charge. There is a very small health insurance industry in Malawi. A few employers contribute to the Medical Aid Society of Malawi (MASM) for health schemes for senior officers.

Care is provided at three levels: primary, secondary and tertiary. District hospitals and CHAM hospitals, some of which have specialist functions, provide secondary level services. A breakdown of the recurrent expenditures by level of care is shown below.

Recurrent expenditure 1996/97

Administration	36%
Tertiary care	20%
Primary/secondary	42%
Training institutions	3%

The overall financing of the health sector expenditures from government and donors shows the following:

Government sources (MK) 1996–97

Recurrent	444,114	77%
Development	93,636	16%
Transfer to CHAM	36,508	6%
Subtotal	574,258	100%
Total Government		**49%**
Donor sources	**604,448**	**51%**
Total expenditures	**1,178,706**	**100%**

Donors currently finance more than half of the spending in the health sector and at least 80% of the expenditure represents recurrent costs.

As shown in the table below, Malawi does not differ greatly from other countries in the region concerning proportion of donor financing. The figures should, however, be treated with caution as there are differences in systems and reliability of basic data.

Table 4: Health sector financing: Malawi, Uganda, Tanzania

Financing	Malawi[13]	Uganda[14]	Tanzania[15]
Gov. Spending %	49	39	51
Donor spend. %	51	61	49
Per.Capita USD	8.1 (4.0 Gov)	12 (3.95Gov)	Xx (3.46Gov)
Share of Gov bud	9%	10%	12.3%
Share of GDP %	3.3%		

A global summary of the sources of financing health services shows that more than a quarter of the national health expenditure is privately financed as can be seen in the following table.

[13] Malawi National Health Plan

[14] Uganda Health Sector Strategic Plan

[15] Tanzania Plan of Work 2000–2003

Source of financing[16]

Government	36.0%
Donors	38.6%
Employers	7.1%
Households	18.2%

Employer and household contributions are generally out-of-pocket as there are few health insurance schemes. In regional and district hospitals the MOH has introduced limited private services where patients pay for faster and better service. The hospitals have the right to retain the revenues but the fee level is so low that it does not cover the extra costs. There are plans to make selected services in the hospitals autonomous and thereby make it possible to increase revenues from paying patients.

12.3.4 Capacity of the Health Sector

12.3.4.1 Personnel

Malawi is facing a crisis in the area of health sector human resources. Rapid attrition of the workforce, particularly in the professional cadres, is occurring due to unfavourable conditions of service and better opportunities in the private and NGO sectors. HIV/AIDS-related deaths of health workers are another causative factor. Deteriorating secondary education and low attendance, particularly of females, has resulted in insufficient numbers of qualified candidates eligible for nursing or medical training. Nursing and medical colleges are operating far below full capacity due to lack of tutors, deteriorated facilities and inadequate infrastructure. Some training colleges have closed down.

Malawi has approximately one physician per 50,000 population, well below the WHO standard for developing countries of 1/12,000. Of 900 authorised posts for registered nurses, only 438 are filled.[18] Hospitals report operating with 'skeleton staffing' and many district hospitals are without a doctor. Some rural health facilities have been closed due to lack of staff. Thus, the capacity in Malawi to deliver promotive, preventive and curative health services is extremely weak.

Table 5: Staff levels for selected categories

Staff Category	Established posts filled
Clinical officer	50%
Medical assistant	37%
Pharmacy assistant	42%
X-ray technician	20%
Laboratory technician	21%

The MoHP has prepared an analysis of human resources development in the health sector and a financing proposal, presented to donor representatives in May 2000. The programme encompasses upgrading training institutions, training of health cadres, policy and planning, reform of the salary structure, information systems development and creation of a health services commission.

Donors have been requested to pledge commitments to the 5-year project, budgeted at US$146m. In response, donors expressed the need for a more strategic approach and

[16] DIFID Development of a health care financing strategy

[18] Project Financing Proposal for Human Resources Development in the Health Sector, MoHP, March 2000.

clearer MoHP priorities concerning HR development. While the plan may require some refinement, it does represent the MoHP's own most urgent requirements. The project will not produce immediate results as it relies on revitalising training institutions and producing new professionals who require 3–4 years of training. In the short term the government may need to contract out to immediately enhance services and expertise. In a recent meeting with the donors, the Minister of Health called upon the assembled representatives to urge their agencies to support long term positions, particularly for doctors.

12.3.4.2 Management capacity

The development of the National Health Plan and several corresponding planning documents (National Health Facilities Development Plan, Human Resources Plan, AIDS Strategic Framework) are an indication of the emerging planning and management capacity in the MoHP. Operationalizing the plans remains, however, a great challenge.

The management capacity of the MoHP is directly impacted by the manpower shortage. At the headquarters level, the MoHP is understaffed particularly at the middle management level. In the Department of Health Planning Services, only one fully qualified Malawian Health Planner is present, and the Department is strengthened by expatriate advisers. Only about 50% of districts have a District Health Officer. Management capacity is being continuously built up, through donor-sponsored training and technical assistance, but not retained, due to what the Minister of Health characterised as a 'haemorrhage' in human resources.

While in the throes of a human resources crisis and faltering health indicators, the MoHP is undergoing a restructuring process, which puts a severe strain on limited management resources. The abolition of the Regional Health Offices and delegation of authority to District Assemblies requires the development of regulatory instruments, working procedures and capacity development of district officials and District Health Management Teams (DHMT). This government-wide restructuring entails election of local governments, however many of the fundamental systems are not in place, nor are there yet budgets established for the local governments. This presents an opportunity for donors to assist in capacity building and the creation of sustainable management systems.

Short-term crisis management is the rule at present, where management staff is minimal, budgets are inadequate, and needed routines and policies either absent or not in use.

12.3.4.3 Human resources development/training

The Malawi College of Health Sciences has three medical and nursing schools (Lilongwe, Zomba and Blantyre). Additionally the University of Malawi trains nurses, and there are nine nursing schools attached to mission hospitals. Due to personnel and resource constraints these institutions are operating at a low level of capacity. Many courses have been suspended and student intakes are down. Teaching materials, facilities, libraries, hostels and other infrastructure are in a poor state, particularly in the government institutions.

A national training policy for health professions is in place, however, there has never been a national training plan. The Health Sector Human Resources Plan 1999–2004 outlines the basis for a training plan with the following objectives: rational utilisation of financial resources, equity, appropriate management succession, and appropriate techniques and procedures in line with service requirements.

Health sector human resources development is dependent upon the lower levels of the educational system. Due to the deficiencies in secondary education, the country finds it difficult to recruit the target 25 candidates per year to medical school training, despite modest entry requirements. This illustrates the important link between the education and health sectors and the opportunity for cross sectoral approaches for donor support.

12.3.4.4 Infrastructure

In a survey of senior managers in the MoHP, physical infrastructure was identified as one of the most urgent problems, and a task force is established to deal with the issue. A National Health Facilities Development Plan has been prepared based on a thorough mapping and analysis of the current distribution of facilities and population. Access to health facilities is relatively satisfactory, with 80% of the population residing within 10km distance from a health facility. In order to achieve a ratio of one health centre per 5,000 population, the construction of 75 health centres is needed. However, there appears to be no assurance that the existing and new facilities will be equipped (e.g. personnel, drugs, equipment) to provide adequate services.

Despite the relatively satisfactory distribution of health facilities, the absence of personnel and drugs at the lower levels results in excessive patient load at district and central level, where patients with minor complaints dominate the outpatient services. There is discussion of charging a fee for patients by-passing the health centre level. A general observation concerning health seeking behaviour and patient load is that poverty and illiteracy contribute greatly to the irrational use and wastage of health resources.

The condition of many government health facilities is poor, and there is broad need for renovation and refurbishing. Electricity and water are lacking in many rural health centres, and at the district level telephone facilities are often absent or non functioning. Medical equipment is scanty, often outdated or in a state of disrepair.

Physical assets management is a very weak area. Support is being provided by EU and GTZ in developing a maintenance policy for facilities and equipment, and provision of spare parts. Several donors have taken on the construction, renovation and upgrading of specific facilities. The MoHP vehicle fleet is relatively well maintained, but wholly insufficient. Logistics, patient transport, supervision and management all suffer due to the lack of adequate transport.

12.3.4.5 Drug supply

Central Medical Stores in Lilongwe is responsible for procurement and distribution of drugs and medical supplies nationwide. Two regional medical stores support the northern (Mzuzu) and southern (Blantyre) regions. Pharmaceuticals and related supplies account for 15–20% of the MoHP budget. In 1999 only half of the MoHP budget requested for drugs was approved. Chronic undersupply and stockouts of essential drugs and supplies such as gloves and syringes, inadequate transport and insufficient systems to supply drugs to regional, district, and health centre level, are primary problems. Poor forecasting, leakage, expiration and weak logistics management contribute to a high degree of wastage and maldistribution.

Donor assistance in training, management information systems, and logistics management has been provided over the past decade, as well as substantial support to drug procurement. In June 2000 the programme providing a World Bank credit of US$55m for drugs and AIDS support will come to an end. Recommitments in drug procurement from donors beyond the year 2000 (except KFW) have not materialized. DfID has provisionally allocated £15m for reform of CMS and its potential restructuring as a semi-autonomous body, as well as support to STI drug procurement and the essential drugs programme.

12.4. Health sector reform

12.4.1 Malawi Fourth National Health Plan

As shown by the extremely poor health indicators, the economic and social sectors are not performing well. Poverty, illiteracy and poor economic development are important contributing factors. There are a number of deficiencies in the existing health infrastructure that have been identified and problems that are difficult to address. There is inequity in access to health facilities, and where facilities exist, there are shortages of trained personnel, unavailability of essential drugs, medical supplies and equipment. To address the situation the MoHP has embarked on a comprehensive reform program covering the governing and administrative structures as well as the health care delivery system.

In the context of the civil service reform program, health service delivery will be decentralized to the 26 districts. The Government's policy on National Decentralization, outlined in Act.No. 42, devolves the responsibility for administration and health service delivery to the District Assemblies and their administrative structures. This reform is under implementation and elections to the Assemblies are planned to take place in the near future.

The reform in the health sector is based on Malawi's *Fourth National Health Plan 1999–2004*. The plan is based on 26 district draft plans, developed with involvement of district health staff, communities and private health partners. The plan specifies five medium-term objectives that will support improvements in health status over the next five-year period. The objectives are:

1. To increase access to health care facilities and basic health care services
2. To provide better quality of care in all health facilities
3. To improve efficiency and equity in resource allocation
4. To strengthen collaboration and partnership between the health sector, communities, other sectors i.e. (Local Government and Tourism) and private providers (allopathic and others).
5. To increase overall resources in the health sector equitably and distribute them efficiently.

The strategies to achieve these objectives are:

- Strengthen primary health care by introducing the Essential Health Care Package
- Address the inadequate and inefficient allocation of resources through a sector wide approach (SWAP)
- Decentralise health care management
- Increase financial resources by introduction of cost recovery/user fees.
- Strengthen mechanism for policy formulation and regulation
- Strengthen the management information system
- Strengthen human resources

Under these strategies, on which the health service reform is based, the MoHP will address five critical health sector priority areas and within these the top priorities that emerged from the district health plans.

Reproductive health

Reduction of incidence of HIV and other sexually transmitted infections and improvement of the quality of life of those infected by AIDS. Safe Motherhood will be addressed through reduction of maternal and infant mortality and morbidity by means of improved services, training and information.

Child Health
Use of the IMCI initiative and promotion of breastfeeding during the first six months of life

Health promotion, disease prevention and rehabilitation
Prevent mortality and radically reduce morbidity from malaria
Eliminate TB as a major health hazard in Malawi
Eliminate schistosomiasis/bilharzia
Develop prevention messages to resolve the unmet needs in oral health.
Introduce a school health program

Diagnostic and treatment services
Launch a comprehensive effort to ensure consistent quality of curative health services.
Improve referral systems

Environmental health
Ensure safe water and sanitation for all
Develop systems to monitor and counteract environmental pollution

12.4.2 Strengths and weaknesses in the reform programme
The Malawi reform programme should be seen from the background of the overall crisis that the country faces, not only in the health sector. Civil service reform and decentralization are intended to enable the government to manage and implement the plans that have been developed for the different sectors. Both reforms are, however, at a preliminary stage. Capacity generally is very limited to manage reform programs in the social service sector.

In the National Health Plan deficiencies in the current management structure have been identified in almost every part of the system. The Ministry is planning to conduct a number of studies and correct the weaknesses based on the recommendations from these studies. The problems are, however, of such a magnitude that they can only be solved in a medium- to long term-perspective. Hence the MOHP's implementation capacity for the five-year health plan period will be extremely weak.

The National Health Plan is, however, an impressive document which encompasses the whole health sector, with special emphasis on primary health care. Supplementary planning documents add to the information base, including the Health Facilities Development Plan, Human Resource Development (HRD) Plan and National Health Financing Strategy.

The plan has very ambitious service delivery goals which are most likely not possible to achieve during the five-year period. There seems, however to be a strong commitment to the health reform within the leadership in the MOHP. It must be acknowledged as an achievement to have succeeded to process the plan. It is a document that can well serve as a basis for discussion in the MOHP, other ministries, among donors and stakeholders on how to make optimal use of scarce resources by prioritizing among the needed activities and interventions.

No such prioritizing has so far taken place. To translate the priority areas in the plan into subsequent resource allocations will be critical in the process of securing donor contributions. The first area that the MOHP has addressed for support is the supply and training of medical staff. From the Ministry's presentation of the HRD plan it is not clear how the request is linked to priority areas and the burden of disease that the NHP is addressing as its first priority.

The plan has to be part of the Medium Term Expenditure Framework (MTEF) process whereby government allocates funds based on the plan and the priorities. With the financial constraints the government is facing, the level of implementation will be very much dependent on the amount of donor support provided. The introduction of autonomous hospitals, user fees/cost sharing and insurance schemes will not change this situation in the forseeable future.

12.5. Donors in the Health Sector

Donors provide a steadily increasing share of health expenditure. In 1997–1998, donors financed 52% of expenditure in the sector. While the current portfolio of donor assisted projects is fragmented and programming is donor-driven, pooling of resources or a sector wide approach are seen as important goals to work toward among donors. Since the change in government in 1994 international NGOs have entered the sector, and indigenous NGOs proliferated. These play an increasing role in health sector support. An overview of some of the key donor-funded programmes follows.

12.5.1. Key donors and programmes

DFID (Department for International Development, UK) finances eight health projects of varying duration with a budget over the coming four years estimated at £50–60 million. Programming is focused on health systems development and reform, as well as reproductive health. DFID channels funds directly to the MoHP via the Reserve Bank of Malawi. The following health reform areas are supported: development of the national health plan, studies concerning user charges and health insurance, health care financing strategy, public/private mix studies, reallocation of administrative functions from regions to districts, and reform of the Central Medical Stores (at planning stage presently).

A strong proponent of sector wide approaches, DFID provides 'basket funding' in support of the MoHP's TB programme (£5.5m), together with NORAD and KNCV (Dutch TB Association), and to the National Sexual and Reproductive Health Programme (£35m). Three long-term advisers are deployed (one to the TB programme and two to safe motherhood). Institutional collaboration and technical assistance to DFID programmes is provided by the Liverpool School of Tropical Medicine and Hygiene.

Health is one of the three priorities of the **European Union** country programme for Malawi. EU is the largest donor in monetary terms, with an estimated annual contribution of about ECU 25m, 75% of which is direct support to the recurrent non-salary budget of the MoHP. The main areas of support are: the decentralisation and reform process (ECU 32m over 6 years); physical assets management (ECU 6.5m together with GTZ), infrastructure – rebuilding of two hospitals; and safe motherhood. Within the HIV/AIDS sector, EU finances a safe blood programme (ECU 7.8m), a programme targeting high risk vocational groups, workplace prevention and community-based support via NGOs. Three long term advisers provide technical support (two in health reform, one in physical assets management) and one more will be recruited to assist in HIV/AIDS programmes.

The **World Bank** has supported a $55m credit to finance drugs and AIDS programming, and this programme concludes in the year 2000. A project supporting population and family health in three districts has also been financed ($5.5m). Learning oriented loans (LEOLs) are also financed. Despite the large public and donor investment, the performance of the sector has been poor, and the Bank will not identify another project until the government has prioritised its National Health Strategy.

USAID is in the completion phase of two bilateral projects: 1) Community Health Partnerships (CHAPS), focused on support to NGOs and District Health Management Teams (DHMT) in child survival; and 2) Support to AIDS and Family Health (STAFH), focusing on reproductive health. USAID assistance has also been provided to the health reform process in technical assistance to national health accounts and hospital autonomy. The latter refers to the proposal to contract out selected services of the four central hospitals. A national programme on social marketing of condoms has also been supported. USAID is developing its next five-year plan 2001–2005, with an anticipated budget of US$ 50–55 million. USAID funding is channelled through project accounts held outside of the government financial system and via NGOs and other non-public sector structures.

UNFPA is in the third year of a 5-year plan, relevant health components of which are:

- Support to the Reproductive Health Department of MoHP (safe motherhood, family planning, logistics, community-based services, STI management, HIV voluntary counselling and testing – VCT)
- Support to the Ministry of Education to integrate sexual and reproductive health (S/RH) into the school curriculum (Sida has committed 9 MSEK to this programme)
- Standardization and upgrading of training in HIV/AIDS and S/RH for all front line community workers

Due to UNFPA budget constraints, training and other project components have been reduced, and additional support from other donors would be welcome.

UNDP has very limited funds for health related inputs, but has a key role in donor coordination and overall coordination of UN agecies. Their key interest is in health policy and in assuring that a realistic health action plan is put in place. Together with Unicef and UNFPA, UNDP supports a programme for people living with AIDS, financed with Turner Foundation funds (US$3m). UNDP intends to arrange a roundtable conference on the health sector strategy.

Norway established an embassy in Malawi only two years ago, and **NORAD** is gradually building up its aid programmes, including in the health sector. The following assistance is currently provided:

- assistance to the National TB Programme, in collaboration with the National Institute for Health in Norway.
- support of NKR10m per year for implementation of the National HIV/AIDS Strategic Plan
- support to the Malawi College of Medicine (12–13m/year) in collaboration with a Norwegian university
- assistance to the Christian Health Association of Malawi (CHAM) to support nursing training
- balance of payment support (non-tied)
- developing routines for the NGO fund within the National AIDS Secretariat

NORAD was clearly positive to establishing potential collaboration with Sida. Other subjects of interest raised included development of regulatory and management systems for the decentralisation process, development of a Health Sector Reform Unit, and strengthening the Auditor General's office.

Many other donors are active in the Malawi health sector including: **GTZ, African Development Bank, Netherlands, JAICA, Taiwan,** and NGOs such as **CARE,**

ADRA, Save the Children, PLAN International, Worldvision, MSF, etc. A matrix of donor contributions in relation to the objectives and activities of the National Health Plan has been developed.[19] This can be a useful instrument for donor coordiination if expanded to reflect coverage and the amount of the inputs.

12.5.2 Donor coordination

Donor coordination in the health sector is well established, and is generally donor-driven. A Donor Coordination Group for Health and Population meets monthly, co-chaired by USAID and UNDP. Information exchange is the main focus of meetings, however there is an aim to move toward joint planning and strategy development. The presence and contribution of the MoHP to these meetings is weak. NGOs, while gaining a stronger role in the sector, are not well represented.

The recently appointed Minister of Health, Aleke Banda, has proposed quarterly donor coordination meetings at the Ministry of Health, the first of which was convened in May 2000 to discuss the draft financing plan for Human Resources (the consultant team attended the meeting). Within the Health Planning Department of the MoHP there is an Aid Administration Office, concerned primarily with EU financing, but with the intention to broaden its function to oversee financial coordination of other donor inputs. No updated summary of donor programmes and financial contributions was available from the MoHP. A Consultative Group (CG) meeting is scheduled for 15–19 May 2000 in Blantyre.

A number of coordination sub-groups deal with special interests. A sub-group on Sector Wide Approaches (SWAPs) has been formed, consisting of DFID, UNFPA, NORAD and WHO. There is also a donor theme group on gender, headed under the Ministry of Gender, Youth and Community Services.

A technical working group for HIV/AIDS has been in place since 1996, and operates as a donor coordination body under the co-chairmanship of UNAIDS and the National AIDS Secretariat. Originally including only UN agencies, the working group now comprises donors, MoH, NGOs, and persons with AIDS, and is seeking to include private sector representation. A key aim is to determine how to support the National Strategic Framework for HIV/AIDS in a coordinated partnership.

12.6. Sida support to the health sector

12.6.1 Need of support to the health sector.

Malawi is a country in crisis and faces enormous problems in all development areas. Economic growth is very low and there are limited prospects for improvement. The population is heavily affected by HIV/AIDS, particularly with the decimation of skilled workers and professional cadres. The result is a critical shortage of trained people, which has a devastating effect on the country's development capacity. The health sector is greatly impacted by the economic and manpower problems, as reflected in staff shortages, poorly maintained health facilities, and shortage of drugs and medical equipment.

There can be no doubt that the health sector is in dire need of the substantial support it obtains from the donor community. So far the support has mainly been provided as project support with relatively little coordination from government. The Fourth National Health Plan addresses this situation, with the aim of having projects and activities integrated into the comprehensive plan and eventually developing a sector-wide approach (SWAP) process for the sector. The very limited management capacity at MoHP and districts is, however, a serious obstacle for achieving this end.

[19] MoHP, Donor Activities Mapped Against the National Health Plan, Preliminary Draft, Sept. 1999.

It is clear that the health sector in Malawi will need considerable long term donor support for the foreseeable future. The challenge for the donor community is to assure an acceptable level of sustainability and build capacity at the service delivery level as well as in health systems and management. Donor assistance may encompass both development aid as well as humanitarian and emergency assistance.

The Fourth National Health Plan is an encouraging document which demonstrates that the MoHP has made a thorough analysis of the health sector and documented the problems to be addressed. The leadership in the MoHP is very committed to the development of the sector. There is a relative political stability, and problems with corruption are not worse than in other donor-supported countries in the region. In conclusion, based on these findings, there are no indications that should prevent Sida from providing support to the health sector.

12.6.2 Potential areas for Sida support

There are several areas of need where Sida could consider expanding support and which are consistent with Sida's own areas of strategic interest: health reform, sexual and reproductive health, and human resources development.

Health Reform/Decentralisation

One of Sida's focal areas is Health Systems Development/Reforms. Involvement in this area is timely, given the early stage of the decentralisation process. Sida's long experience gained in supporting the decentralisation in neighbouring Zambia could be beneficial.

The Ministry of Health has identified health systems deficiencies which could be addressed by various forms of technical support:

- development of management capacity at the intermediate level
- development of system-wide accounting / financial systems
- training in planning, epidemiology and financial management at district level
- development of the regulatory framework and operational procedures for district health management
- developing the regulatory framework for the rapidly expanding private health sector
- management of the pharmaceutical sector and restructuring of Central Medical Stores

Sexual and Reproductive Health and Rights (SRHR)

SRHR is another focal area of Sida, which has a strong relevance for the situation in Malawi. Of particular importance is HIV/AIDS/STD control and prevention. Sida is already supporting AIDS programming in Malawi at a level of 20 MSEK in 2000–2001 via the following projects:

- Girls Literacy and Sexual Health Empowerment (AGLIT – via Liverpool School of Tropical Medicine))
- Youth Community-Based Distribution Agents (Banja la M'tsogolo – via UNFPA)
- Secretariat Logistics (via UNFPA to National AIDS Secretariat)
- Program to educate 20,000 primary school teachers in sex education, including baseline survey (via UNFPA to Ministry of Education)

Given the magnitude of the epidemic, and relatively small outreach of many of the programmes, there remains vast scope for expanding resources in combatting HIV/AIDS. The following additional opportunities were identified in discussions with donors:

- Co-funding to Unicef, UNDP and UNFPA programmes that support people living with AIDS
- Co-funding to the UNDP project to enhance and standardise HIV/AIDS training for all frontline community workers.
- The Lighthouse Project - Clinic-based care for people living with AIDS

Support to Human Resources Development

The MoHP has identified human resource development as its most critical area of need. In addition to its long term development objectives, the Human Resources Development Plan of the MoHP must be complemented by measures that address the current crisis situation. There is ample scope for a coordinated donor input in this area. Moreover, the government needs to focus in a holistic way on the problems in the education sector and on the limited training capacity for health workers. There is an opportunity for providing complementary support to the education (e.g. secondary education) and health sectors. Secondment of full-time training experts and rehabilitation of medical and nursing training institutions are some of the options for assistance which the MoHP seeks.

13. RWANDA

Time to support sustainable health sector development in Rwanda

13.1. General situation in Rwanda

13.1.1 Population

Rwanda has the highest population density in Africa. The total population is estimated to be 8.1 million and there are 329 persons per square kilometer. The population growth rate is now about 3.6% a year, which is among the highest in the world. Urban population is around 6% of the total population of which 60% lives in Kigali. A comparison with some other countries in the region is shown below.[1]

Table 1. Population data in the region

Population data	Rwanda	Uganda	Malawi	Tanzania
Density/sq. km	329	105	112	36
Growth rate % (1980–1998)	2,5	2.7	3.0	3.0
Urban/Total %	6	14	22	31
Birth rate /1000	46	47	47	41

The population pyramid shows a large base reflecting the high fertility rate and a narrow summit of the persons >60 years. The dependency rate is very high with about 50% of the population <14 years. The war in 1994 is clearly reflected in the population growth trends where the numbers were reduced by 2.3 million caused by the genocide and people leaving the country[2]. In 1997 the population were back to the pre-war figures.

13.1.2 Political situation

The present government of Rwanda was set up in 1994 after the Rwanda Patriotic Army had taken control of Kigali and ended the genocide that killed 800 000 to 1 million people. It has a Transitional National Assembly consisting of appointed representatives from each of the eight political parties.

The political situation has however to be regarded as highly unstable. About 120 000 genocide suspects in overcrowded prisons are waiting for trial, which puts a lot of pressure on the justice system. In the Democratic Republic of Congo (DRC) former Rwanda army forces and the Interahamwe make cross-border attacks into Rwanda. The Rwanda army, RPD, has moved far into the DRC, not only to secure its borders but also to support one of the rebel forces whose aim is to overthrow the Kabila government. In a recent development, Rwanda has clashed with its former ally Uganda in fighting that took place in Kisangani.

At the same time the Rwanda government has made impressive progress in rebuilding the social, political and economic fabric of Rwanda. In March 1999 grassroots elections were held on Cellule and Secteur level and later this year elections will be held at Commune and Prefecture level.

[1] 2000 World Bank: World Development Indicators

[2] Rwanda Development Indicators 1998

To address the historic division among ethnic groups, the government has set up a Unity and Reconciliation Commission and a Human Rights Commission. A number of government institutions have been set up to ensure good governance at the National Tender Board, Office of the Auditor General and the Rwanda Revenue Authority.

Rwanda's current transitional constitution is respected, as giving good legal protection for its citizens. A Legal and Constitutional Commission has been established, which is consulting the population, in the work of drafting a new permanent constitution.

13.1.3 Socio-economic development and poverty

Rwanda is one of the poorest countries in the world with a per capita GDP under 220 USD. In the UNDP Human development index Rwanda ranks 164 out of 174 countries. The events of 1994 caused a radical increase in poverty in Rwanda and it is estimated that 70% of the people were living under the poverty line in 1997 compared with 53% in 1993. The GDP fell by 50% in 1994 and has still not recovered.

Agriculture is the most important sector in the economy and constitutes about 43% of the GDP with 91% of the population involved. Coffee and tea are the major export crops and earned about 49 million USD in 1998. Agricultural production is in general based on small family farming, producing 80% for own consumption and only 20% for the market. Manufacturing value added is low at about 13% of GDP. Most of the manufacturing is small (less than 1 million USD) and mostly producing for the domestic consumption.

The macroeconomic performance has however improved and the GDP real growth came to 9.6% in 1998, while the inflation rate was down to 4.1%. In spite of this progress the domestic savings and investment components remain very weak. Private investment was estimated to only 3% and domestic savings to be negative. (−2% of the 1998 GDP.

Rwanda has a public debt, which is equivalent to 72% of the GDP. Following negotiation with the World Bank, Rwanda has been included in the HIPIC initiative, which provides for a reduction of the debt by 67% and generous rescheduling terms.

Donor aid has a big impact on the economy. In 1997 aid constituted 65.3% of imports of goods of services and as much as 17.6% of the GDP. Much of the economic growth has been favoured and driven by this donor support.

13.1.4 Education gender and equity

Rwanda has a high gross primary school enrolment rate of 89%. The quality of the education is however low with only 46% of the teachers qualified. There is a lack of teaching material and high drop-out rates. The enrolment in secondary school is very low at only 7% in 1998. The literacy rate for >15 years is 52% compared with 56% in Malawi, 62% in Uganda and 69% in Tanzania.

Women constitute the majority (54%) of Rwanda's population of which 42% are widows. They are the major labour force, particularly in agriculture. Women are facing substantial constraints in participating in the economy and in the society. Discriminatory laws and practices in education, employment, inheritance and finance marginalise them.

The majority of women in Rwanda remain poor and vulnerable.

13.2. The health situation

13.2.1 The disease panorama

As in most low-income countries mortality and morbidity data are characterised by a predominance of infectious diseases and nutritional disorders. Lately HIV/AIDS has been added to the pattern.

The mortality and life expectancy figures are markedly worse than the Sub-Saharan average. Estimates of the "burden of disease" suggest that underlying malnutrition and malaria are the major causes of death.[3] Recent data for mortality reported in the government hospitals of Rwanda show that malaria, respiratory tract infections and diarrhoea account for over 80% of all deaths in children under five.[4] The 1995 nutritional survey found a very high level of chronic malnutrition (41,9% of children under six years old). HIV/AIDS shows an alarming increase with an incidence rate of 12,8% in the population. The Minister of Health points out three priority disorders to tackle: Malaria, HIV/AIDS and malnutrition.

Table 2. Basic health indicators in the region[5]

Indicators for 1998	Rwanda	Uganda	Malawi	Tanzania
Under five mortality rate/1000	170	134	213	142
Infant mortality rate/1000	105	84	134	91
Life expectancy at birth	41	40	39	48
Maternal mortality ratio/100000 live births	810*	510	620	530

*Rwanda development indicators 1999

13.2.2 Health service coverage

64% of the district health services are delivering the established minimum package of health services.

The immunisation coverage is a bit lower than in other neighbouring countries, which is remarkable since the health infrastructure is well covered. Since 1996 there has been a decline in immunisation coverage. On the other hand diseases related to immunisations are not common. Neonatal tetanus is very rare as well as polio. There are some outbreaks of measles especially among refugee populations.

Concerning deliveries undertaken by qualified personnel the coverage is estimated to be 10%. Of those deliveries (38 786) 25% took place in the home. Modern family planning methods are used by 2,9%[6].

The health information system is weak and statistics are not very accurate.

[3] Ministry of finance and economic planning: Rwanda Development Indicators 1999

[4] Health programme review-Rwanda J Borg KIT, Netherlands. Dec 1999

[5] The state of the world's children, 2000; Unicef

[6] Rapport Annuel 1998; Ministere de la Santé

Table 3. Child immunisation under one year of age[7]

Immunisation %	1996	1998	1999
BCG	93	79	83
DPT 3	98	77	61
Measles	76	66	61

13.2.3 Factors influencing the health situation

Poverty and the low level of sanitation and hygiene are the underlying causes of the country's poor health. Only 44% of the population have access to safe water and less than 5% of the rural population have sanitary latrines. The principal constraint to the improvement of the quality of health services is the lack of qualified health workers and the low sensitisation of the population in health issues. Only 40% of the population know that malaria is transmitted through mosquitoes. A priority for the government is to improve the quality of health service delivery, addressing the major health problems in the country. There is a low utilisation of health facilities with 0,27 new visits per inhabitant/year (WHO standard is between 0,5–1,0 new visits per year). The low frequentation might be due to the poor quality of the services, financial constraints, and low confidence in western medicine.

13.3. The health sector in Rwanda

13.3.1. Rwanda health care delivery system

The government, the not-profit sector and the private for-profit sector including traditional practitioners provide health services in Rwanda.

The government health system is organised in three levels: health care centres, district hospitals and referral hospitals. There are 330 first level health units, 33 district hospitals of which 28 are functioning in 1997[8], and 4 national referral hospitals. The referral hospitals are the Central Kigali Hospital, Butare University Hospital, King Faycal Hospital (privatised) and the Ndera Psychiatric Hospital.

The public health administration is organised in 11 health regions with 39 health districts. A district management health team manages the health district. A network of voluntary "animators" has been introduced to assist with community sensitisation and health promotion and advocacy.

The district health system is based on three strategies: decentralisation, integration of services and community participation. District health committees are put in place to collectively make decisions on financial as well as management issues. In principle the activities of planning, training, supervision, and management are now decentralised. The capacity to carry out these functions is however lacking.

The MoH has its own internal on-going decentralisation process, which has progressed at a more rapid rate than the national government's decentralisation process. Health administration is therefore not at present integrated in the government structure of prefectures and communes.

The not-for-profit sector is primarily made up of approved church- related and other non-governmental organisations. The approved organisations operate around 41% of

[7] Ministry of finance and economic planning: Rwanda Development Indicators 1999

[8] 1998 Public Expenditure Review Health Sector.

all the hospitals and 42% of all health centres. The government seconds staff to the facilities and pay 80% of approved personnel employed by the promoter. The promoter pays 100% of staff they employ without approval.

The private-for-profit sector has grown exponentially since 1990. After a decline in 1994, the number of facilities has increased from 39 in 1994 to 224 facilities in 1998. They are curative oriented and only cater to the middle class in the urban areas that are able to pay. There are no regulations or legislation in place to control this sector.

The majority of the Rwandan people use traditional practitioners including traditional birth attendants. This sector is at present not organised and there is no legislation in place that make such organisation possible.

13.3.2 Health sector finance

Public recurrent expenditures in Rwanda are extremely low compared with other countries in the region as shown below.

Table 4. Public recurrent expenditures

Country	Recurrent Exp. as % of GDP
Rwanda	0.3
Malawi	2.3
Uganda	1.9

As can be understood from the table, financing of the health sector in Rwanda is heavily dependent on donors. Figures for 1998 reveal that overall donors provided 88% of the total expenditures for health care and 100% of the investments. Government allocation to health has declined over the last decade from 7% to 3.23% of the total recurrent budget. The government expenditures per capita/year excluding donor contributions are only 0.85 USD and with donors included 1.82 USD.

There is limited data available on private contributions to health finance. Estimates show that 500 million RwF is generated by cost recovery on the district level and 300 million RwF on hospital level. If the tertiary level hospitals were added the total amount would be around 1 billion RwF. This corresponds to a cost recovery rate of 15–20%.

It is also estimated that the sale of pharmaceuticals provide an additional 400 million RwF a year for health centres, districts and referral hospitals.

There are two private health insurance schemes that have just started. There are also initiatives to establish community insurance mechanism, so called "mutuels", to cater for health service charges.

The projections for health service finance show a sharp decline after the year 2000. This is a reflection of the total dependence on donor support. After the genocide, donor money for humanitarian support and rebuilding of infrastructure poured into the country. Most of the infrastructure is now in place and there is an uncertainty to what extent the withdrawal of emergency and humanitarian support will be replaced by development and budget support to the same amount.

13.3.3 Capacity of the health sector

13.3.3.1 Management capacity

The development of the National Health Plan and the ongoing decentralisation plan are an indication of the emerging planning and management capacity in the MoH. However, the capacities for implementing the plans and management on the lower ministerial level and in the regions and districts are very limited.

The central strategy for increasing the number of services being delivered by district facilities, as well as their quality, lies in the implementation of district health management arrangements. This strategy was initiated in the middle of 1996. Within one and a half years, significant progress had been made in putting management arrangements in place.

By the end of 1997, of the 39 districts:

- 38,5% had elected district health committees
- 85% had elected health centre health committees and
- 82% had elected hospital management committees[9]

The latest information from 1999 shows that the main challenge is to make sure that the competence is there to use the committees as a tool for better health services and to maintain the structures in place.

13.3.3.2 Personnel

Though there are many employees in the health sector, there are insufficient nurses and doctors trained on an appropriate level. Many district hospitals lack, i.e. skilled personnel for handling complicated deliveries. The number of health agents are 20/100 000[10], in line with the WHO recommendation, but their quality is insufficient.

There are totally 250 national physicians and 1,5 physicians/100 000 (the WHO standard for developing countries is 1/12 000). There are 50 expatriate doctors, especially from the DRC, who fill in empty positions. There is 1 nurse/8000 (WHO standard 1/5000).

The World Bank has initiated a civil service reform, which will decrease the staff by 9000. All health staff employment is administered through the central level but there are plans to decentralise this process during next year.

The salaries are low and NGOs are topping up salaries in the districts where they are working. Since NGOs are working in more than half of the districts the topping up has created a problematic situation for the MoH. The MoH would like that the NGOs channelled the money aimed at topping up to the MoH, which could divide the money among all health staff.

13.3.3.3 Training human resources

The Ministry of Health has identified the principal constraint to improvement of the quality of health services to be the lack of qualified human resources. There is a significant shortage of trained health workers. So far, there is no overall analysis or plan to tackle the problem. There are plans to create a Human Resource Development Agency under the President's Office.

[9] 1998 Public Expenditure Review Health Sector; Min of Health, Rep of Rwanda, March 1999

[10] 1999 Rwanda Development Indicators; Ministry of Finance and Economic Planning, Rep of Rwanda

The Ministry of Health has recently revitalised the Kigali Health Institute (KHI) which trains qualified specialised nurses including midwives. The Ministry of Education has about twenty schools with integrated nurse courses as part of the secondary education. The quality of these nurses is poor and there are ongoing discussions regarding how to tackle the quality of training. Two missions also have training for nurses. Since there is a need for health personnel, many private evening courses have mushroomed and the government has intentions to control and close down some of them.

There is one medical school located in Butare, the second largest city with 353 medical students of which 20% are women. Before 1999 the school was exclusively hospital and curative oriented. Now the school has opened up towards the community and the last year of training is spent in district health.

The department of public health has recently been created for specialisation of health personnel and there are advanced plans to co-operate with the community in operational research and other projects. The school receives technical support from, among others, Johns Hopkins University.

13.3.3.4 Infrastructure

An enormous effort went into the rehabilitation of the infrastructure after the war and genocide. From 1996 to 1998, the health centres increased from 247 to 332. From a bird's eye perspective one would assume that the availability of government health services would be practically universal. 87% of the population has less than two hours walk to the nearest health facility, however there is an uneven distribution. There are 20 378 inhabitants per health centre[11].

Most of the health centres are well equipped with basic equipment and in some districts they have radio communication with the district hospital. Generally speaking, the districts where NGOs are assisting the government health facilities, the infrastructure, equipment and communication (telephone or radio) is in place.

The referral system is still a problem because of the costs for transport (both private transport and ambulances) which probably contributes to the high maternal mortality rate.

13.3.3.5 Drug supply[12]

The MoH has adopted an essential drugs policy. This means that the entire population shall have access to cheap, essential, and generic drugs through pharmacies in the health facilities. The MoH has created a semi-autonomous central body CAMERWA (Centrale d'Achat des Médicaments Essentiels du Rwanda) that is importing essential (generic) drugs, basic medical equipment and materials for the government structures (presently 68% of drugs imported) which are stored in the districts. District hospitals and district health authorities pay a reduced price for the drugs on a cash-and-carry basis.

The facilities use a revolving fund to buy from CAMERWA, which are financed from the charges for drugs from the patients. Drugs are available in the districts, while in addition to this distribution system, there are private pharmacies as well with both generic drugs and regular imported drugs. The NGOs also import drugs (24%) which are distributed directly to their projects. Totally, the private sector provides 31,6% of drugs.

[11] 1999 Rwanda Development Indicators; Ministry of Finance and Economic Planning, Republic of Rwanda

[12] Rapport Annual 1998; Ministere de la Santé, Republique Rwandaise, Avril 1999

The MoH inspects the private pharmacies, and of the 108 private pharmacies in Kigali, 70% lacked a pharmacist. Most of the private pharmacies are located in Kigali. The MoH has closed several pharmacies since they do not reach the norms required.

The constraints in the pharmaceutical sector are:

- Absence of legislation and pharmaceutical regulations
- Absence of a central registration of drugs
- Fraudulent importation of drugs
- Lack of experienced and qualified staff in the sector

13.4. Health sector reform

13.4.1 Policy and plans

The national health policy existing before the war in 1989 indicated a commitment to the primary health care approach. A plan to establish a district health system was prepared but did not reach the implementation stage.[13]

The present government policy on health was outlined in a National Health Policy in 1994. This policy was adapted by the cabinet meeting of ministers in March 1996. The overall objectives in the policy were formulated as follows:

> *"The overall objective is to promote the population's health by providing continued, integrated and comprehensive health through a health system equipped with decentralised, permanent and multipurpose services with the participation of the community. To organise this system it is necessary to define a minimum package of activities for the first level and a supplementary package for the referral level"*

The strategies to achieve the objectives are based on the elements of primary health care, community participation, decentralisation of health services, development of human resources, development of the pharmaceutical sector, health research, intersectoral collaboration and strengthening of the health information system.

For the period of 1999–2001 a set of objectives have been formulated:

- Rationalise the geographic access to care of the population.
- Assure the financial accessibility of 100 per cent of the population to first and second level health.
- Reinforce the active participation of the population in the management and financing of the health services.
- Improve the quality of service delivery for the major health problems of the country.
- Improve the organisation and management of services at all the levels of the health system.
- Reinforce the co-ordination and rationalisation of external aid.

For all these objectives a number of activities have been identified.

The government is realising that there are severs budget constraints in carrying out this strategy and has therefore made three important priorities for achieving the objectives:

- Improving access to services which make the most difference on the health of the population.

[13] Health Programme Review-Rwanda J Borg KIT, Netherlands. Dec 1999

- Improving the quality of services being provided
- Improving efficiency with which these services are delivered.

The Rwanda government is realising that it is not in a position to finance a comprehensive health service for the population and will therefore continue to provide subventions to approved organisations. It also intends to regulate the quality of care not only in the public but also in the private sector.

The key issue for health planning in Rwanda is the availability of financial resources. As the current projection of external assistance shows a sharp decline, it is unlikely that the health services can be maintained at the present level without additional external support.

The specific objectives related to primary health care have been indicating three scenarios focusing on primary care facilities as service delivery units. One of the scenarios based on the essential packages of health services as defined by the World Bank, costing 12 USD per capita, was not further developed as considered to be unrealistic for Rwanda. The other scenarios show an increase in per capita expenditure by 2.8 respective 3.89 USD over a period of 6 to 10 years. Both scenarios foresee an expansion of the rural health infrastructure with the construction of two new district hospitals and 22 new health centres. In both scenarios the shortfall in financing of the district services is about 55%, which needs to be externally financed. No government contributions have been assumed for the investment costs and this gap equalled RwF 2,520 millions in 1999.

13.4.2 Strength and weaknesses in the reform program

Rwanda is emerging from an emergency situation where so far the emphasis has been on the rebuilding as well as restructuring of the infrastructure. The implementation of the national health plan has therefore just started. The focus has been on the decentralisation of service delivery and health service packages. In many cases there is little or no information on how the health services actually are performing. The fact that there is a very low utilisation rate in the primary care units should be of concern for the reform program. As the program as such contains all the usual elements of a health plan based on primary care services, there is a need for more analysis of how the current health situation in general impacts on the strategy for implementation. The emphasis is now on the financial constraints with little concern on how the human resources and administration should be developed. The reform program has therefore to be complemented with a strategic plan for how these areas could be improved to reach the performance objectives.

13.5. Donors in the health sector

Most important donors in Rwanda follow political developments critically. The majority see reconciliation, democratisation, good governance and justice as priorities for future assistance. Support to social services development and especially to the health sector is low on the agenda. Organisations focusing on humanitarian assistance are pulling out or swift to provide development assistance. 8% of external sources went to the health sector in 1995–98.

13.5.1. The main donors

It is difficult to get an overall picture of the actors in the health field. WHO has been asked to put together information on the donors for the Ministry of Health.

- The main bilateral donors are Belgium, Germany, France and Luxembourg.
- The main donors to international NGOs are USA, Sweden and Holland.

- The main NGOs are Norwegian People's Aid, Save the Children, Health Net International and Concern.

The UN family and the World Bank are considering long term commitments to Rwanda shifting away from humanitarian aid to development aid.

- The World Bank will start their pre-appraisal studies next year to be able to formulate a health program by the end of 2000 beginning of 2001.
- The UN family currently carries out a Common Country Assessment, government and NGO:s, which could lead to a Common Assistance Framework for the country with one program co-ordinator.
- UNICEF is in the process of finalising their 5-year country strategy plan 2001–2006.

The ministry is striving toward co-ordination of the donors, aiming to develop support based on a sector-wide approach, instead of the present geographically and project-oriented support. Actors that seem to be positive to this approach are USA (USAID), Great Britain (Dfid), Netherlands, WHO and World Bank. Other donors are more hesitant, i.e. Belgium and the European Union. In general, the English-speaking donors are more positive regarding support to the government's effort to decentralise and improve the health system than the francophone countries that retain a traditional project support with technical assistance.

13.5. 2 Donor co-ordination

The emergency situation has attracted many donors and NGOs supporting the country. Most support has been project-oriented with limited control from the government. Rwanda is now addressing this situation by setting up two institutions for donor and project co-ordination. There is a Development Committee that will approve projects submitted by a Central Project and External Finance Bureau (CPEXE). CEPEX is tasked to provide guidelines and policy for the line ministries identification and preparation of projects. They will also screen project proposals for submission to the development committee before presentation in parliament or any other decision making body.

On the donor side there is no formalised co-ordination of projects and meetings are mostly for information and general communication. WHO is, however, about to take the role of a co-ordinating body.

A sub-group dealing with HIV/AIDS has been created by UNAIDS, and is presently chaired by Unicef. The group, consisting of donors, the World Bank and the national AIDS program, aims to co-ordinate activities to fit into the national HIV/STD/AIDS strategic plan framework.

13.6. Summary of general characteristics regarding the health sector in Rwanda

- There is a very rapid decentralisation phase and a well organised society.
- Corruption is not evident.
- The top level in the MoH is very dedicated towards the improvement of the health system.
- There is a good infrastructure and access to drugs in the periphery.
- Pilot trials underway in districts with cost sharing schemes.
- A will to co-ordinate and guide the donors towards sector-wide support.
- Not donor-crowded in the health sector.

- NGOs reformulating their humanitarian projects to development support by strengthening the district health structures where the situation is stable.
- Low capacity in the MoH in the districts to implement policies and plans.
- Very low quality of health personnel and service delivery.
- No plan for development of human resources in the health sector.
- Very poor people with poor health status.
- Uncoordinated donor support.

13.7. Scope for Swedish support

13.7.1 Ongoing support

The support to health issues has so far been channelled as humanitarian support through SEKA. Apart from support to the UN system, funds are channelled to NGOs working in the districts. The remaining NGOs are now transforming their support from emergency into development support, except in the northwest where there is still an emergency situation. For a detailed list see appendix D "Ongoing areas of co-operation".

13.7.2 Future support

External financing will be needed for recurrent expenditures for some years to come. However, these needs must be provided in ways, that conform with government policy and priorities and which come within an overall strategic framework for the sector agreed between government and donors. There is a need for development support as well as humanitarian support.

There is certainly scope for Swedish support to the health sector. Rwanda is in a transition period where most donors are phasing out their humanitarian support. There seems to be lesser interest from donors in the health sector than in the areas of good governance, legal, and reconciliation issues. The Swedish assistance that so far has been channelled through the UN and other agencies has had a clear health profile with 51% of the humanitarian assistance provided for local capacity building related to health.

The government of Rwanda has a policy and a reform program that have all the components that a donor could ask for but needs substantial financial and technical donor support. The implementation strategy should consider the population's current health seeking behaviour regarding the low attendance rate at health centres and use of traditional practitioners.

It will be an invaluable new experience for Sida to continue the humanitarian support now being transformed into development support. Since the NGOs are integrated into the public health system and now concentrating on strengthening of the district health system, this will be in line with the government's priorities to decentralise and implement the health policy.

The creation of the *fund for capacity building* will be a first and important step toward direct support to the Ministry of Health. The Ministry of Health has rightly identified human resource development as the most critical area to be addressed. Projects under preparation might be funded through this fund i.e. the project "Improved nursing and midwifery education in Rwanda" (Health Net International). See appendix E "Areas of co-operation under preparation".

Sida should participate in the ongoing discussions concerning sector wide support with the MoH and donors, and provide technical assistance if the MoH expresses the need for it in the ongoing development of the health reform.

If possible, Sida should take an active part in the ongoing country assessments by the UN and the World Bank and the development of a UN Development Assistance Framework for Rwanda.

14. HDI

Below is a table that summarises a few indicators such as Human Development Index (the ranking of the country where 1 is highest and 174 is the lowest), real GDP per capita in purchasing power parity dollars, maternal mortality rate per 100 000 live births, infant mortality rate by per 100 live births and life expectancy – number of years – at birth.

All data is picked from the Human Development Report 1999 in order to be comparable. However, it should be noted that data can still be unreliable and in case other figures are shown in the summary text for each country, the source of the data is probably different. Despite the uncertainties, an overview like this may give some information as to the differences between the countries.

Country	HDI	GDP/capita	MMR	IMR	Lifeexp
Angola	160	1430 ppp$	1500	170	46.5
Eritrea	167	820 ppp$	1400	73	50.8
Ethiopia	172	510 ppp$	1400	111	43.3
Kenya	136	1190 ppp$	650	57	52.0
Mozambique	169	740 ppp$	1500	130	45.2
Tanzania	156	580 ppp$	770	92	47.9
Uganda	158	1160 ppp$	1200	86	39.6
Zambia	151	960 ppp$	940	112	40.1
Zimbabwe	130	2350 ppp$	570	53	44.1

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