

The Bamako Initiative

The Bamako Initiative, sponsored by UNICEF and WHO and adopted by African ministers of health in 1987, was based on the realization that, despite accepting in principle the core tenets of comprehensive primary health care, by the late 1980s many countries – especially in sub-Saharan Africa – were burdened by a lack of resources and practical implementation strategies. In particular, many health facilities lacked the resources and supplies to function effectively. As a result, health workers were sometimes merely prescribing drugs to be bought from private outlets, often unlicensed and unsupervised, while many patients had lost confidence in the inefficient and under-resourced public health facilities. All of these developments threatened to reverse the gains of the 1980s. The core challenges were to promote additional donor investment, stop and reverse the decline of government expenditure on social spending in general and health in particular, and attract the money spent in the private and informal sectors back into the public system.

The Bamako Initiative aimed to increase access to primary health care by raising the effectiveness, efficiency, financial viability and equity of health services. Bamako health centres implemented an integrated minimum-health-care package in order to meet basic community health needs, focusing on access to drugs and regular contact between health-care providers and communities. Based on the concept that communities should participate directly in the management and funding of essential drug supplies, village committees engaged in all aspects of health-facility management, with positive results for child health in West Africa in particular.

The purpose of community financing was to capture a fraction of the funds households were already spending in the informal sector and combine them with government and donor funding to revitalize health services and improve their quality. The most effective interventions were priced below private sector charges and cross-subsidized through higher markup and higher co-payments on lower priority interventions. Immunization and oral rehydration therapy were supplied free of charge. Local criteria for exempting the poor were established by the communities.

Although countries followed different paths in implementing the Bamako Initiative, in practice they had a common core objective: providing a basic package of integrated services through revitalized health centres that employ user fees and community co-management of funds. A

number of common support structures were organized around this core agenda, including the supply of essential drugs, training and supervision, and monitoring.

‘Going to scale’ was a critical step in the implementation process. The pace of expansion varied depending on the availability of internal and external resources, local capacity, the need to work at the speed of community needs and pressure from governments and donors. Most of the sub-Saharan countries that adopted the Bamako Initiative employed some form of phased scaling up, and several countries – most notably Benin, Mali and Rwanda – achieved significant results.

In essence, implementing the Bamako Initiative was a political process that involved changing the prevailing patterns of authority and power. Community participation in the management and control of resources at the health-facility level was the main mechanism for ensuring accountability of public health services to users. Health committees representing communities were able to hold monitoring sessions during which coverage targets, inputs and expenditures were set, reviewed, analysed and compared. It is estimated that the initiative improved the access, availability, affordability and use of health services in large parts of Africa, raised and sustained immunization coverage, and increased the use of services among children and women in the poorest fifth of the populace.

The Bamako Initiative was not without its limitations. The application of user fees to poor households and the principles of cost recovery drew strong criticism, and though many African countries adopted the approach, only in a handful were initiatives scaled up. Even in those countries where Bamako has been deemed a success, poor people viewed price as a barrier in the early 2000s, and a large share did not use essential health services despite exemptions and subsidies. The challenge that Benin, Guinea and Mali still face, along with other African nations that adopted the Bamako Initiative, is to protect the poorest and ensure that costs do not prevent access to essential primary health-care services for poor and marginalized communities.