National community health insurance at village level: the case from Guinea Bissau

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The experience in Guinea Bissau of a voluntary levy scheme at village level, called ‘Abota’, makes one point very clear. Collective health insurance schemes at village level may be feasible and manageable in rural parts of Africa if the village population is allowed to decide on the amount of money and method of collection \textit{and} if the government supports the scheme by guaranteeing sufficient drugs, low prices, effective control measures and a village health worker who is officially part of the national referral system.

Without these conditions, cost-recovery schemes should perhaps be postponed until a continuous and integrated care system can be guaranteed. It should be recognized that the absence of an informal drug market in Guinea Bissau and the relative isolation and small-scaleness of its population have been two important enabling factors for the success of the collective health insurance scheme. Suggestions to introduce similar cost-recovery schemes in other settings therefore need to be analysed with caution. The best that UNICEF and WHO can do at the moment, related to the Bamako Initiative, is to abandon the ‘easy and rapid solutions approach’ to development and negotiate with national governments for a more equitable and participative approach to improve the health of those that both UN agencies want to serve. Fee-for-service schemes appear the easiest solution to cost recovery, but they are not necessarily the best in the long-term.

Introduction

According to Carrin’s\textsuperscript{1} review of some 20 community financing schemes in sub-Saharan Africa, prepayment schemes for health financing are the exception rather than the rule: only one local prepayment scheme in Senegal (village of Gott, Thiès region) is described, and two schemes that involve a combination of prepayment and additional charges at the time of illness. This gives the impression that, although prepayment schemes have the advantage of risk-sharing between the sick and the healthy, they have to be compulsory in order to guarantee a large enough enrolment. Such an impression is confirmed in a recent review of community financing by the Primary Health Care Operations Research Group (PRICOR).\textsuperscript{2}

It is unfortunate, however, that the experience with a prepayment scheme in Guinea Bissau has passed unnoticed in these documents. It has not been mentioned in a World Health Organization (WHO) discussion paper\textsuperscript{3} on alternatives to direct user charges for drug financing or in a more recent paper\textsuperscript{4} that reviews experiences in pharmaceutical cost recovery. It had been mentioned earlier, however, in a document on cost-recovery for recurrent costs in Guinea Bissau, submitted to the World Bank in 1987,\textsuperscript{5} where this village insurance scheme is described as ‘the only level of the health system that self-finances a significant portion of its recurrent costs’.

Guinea Bissau is a small country on the west coast of Africa, situated between Senegal and Guinea. It has a unique geography and political history – a 12-year war against Portuguese colonialism, resulting in solidarity and social cohesiveness – that has been documented elsewhere.\textsuperscript{6,7} This paper will concentrate on the way the collective payment scheme has developed at village level over the last 10 years to cover the
whole country. It will first discuss how the scheme was set up and how it is embedded in the national health system. Next, some of its strengths and weaknesses will be discussed, referring when appropriate to the current debate on the 'Bamako Initiative', whose main aim is to raise funds for primary health care (PHC) at community level in sub-Saharan Africa through charging for drug treatment. Funds thus collected are meant to go into a revolving drug fund to be managed by the community or its representatives and be used to replenish drugs as well as pay for administrative and possibly salary costs for developing primarily maternal and child health activities. Emphasis will be placed on the important role of the community in deciding the amount of money available and the handling of funds. At the same time the role of the basic health services (BHS) in facilitating this process will be highlighted.

It is unclear at present whether the collective payment scheme will survive. The severe economic constraints in the health sector, related to the structural readjustment programme have substantially deteriorated morale and motivation of health workers. The important devaluations of the local currency (Pesos) from 40 PG to the US dollar in 1982, to 990 PG to the US dollar in May 1988, has increased the cost of health care to an extent that the very survival of the collective scheme at present depends on the political will of the government. Substantial increases in treatment fees have been proposed by the World Bank and have recently been accepted by the council of ministers. They are not yet operational in the country and will not be discussed in this paper.

Paying for basic health services

In contrast with most sub-Saharan countries, paying for out-patient consultations in Guinea Bissau has been practised officially since 1976. The ministry of health (MOH) considered 'free medical care' an unrealistic option for the country and proposed a differential treatment fee at the various levels of the health care pyramid.

Up to 1985, when the exchange rate of the Pesos oscillated between 33 and 41 PG to the US dollar, the fee for one out-patient consultation, including the necessary drugs, was:

- 15 PG (US$ 0.37) at the health centre level (nurse)
- 25 PG (US$ 0.62) at the district hospital level (medical doctor)
- 50 PG (US$ 1.25) at provincial level (specialists)
- 100 PG (US$ 2.50) at the national hospital.

These fees are charged for out-patient services. At the same time they give access to in-patient care when this is considered necessary. There is no additional fee when a patient is referred. A 15 PG health centre entrance fee entitles the patient who may be referred up to the district, regional or even national level to all care associated with a stay of any length in the regional or national hospital, including drugs. Fees are uniform throughout the country and cover all treatment costs, although there are separate fees for laboratory tests. Drugs are dispensed without additional charge.

The system exempts certain population groups from payment: children aged 0-15 years, pregnant women, government staff (including health personnel) and their families, and the veterans of the liberation war. Together these groups represent more than 60% of the population. Finally, preventive services such as vaccinations, tuberculosis and leprosy treatment, and malaria prophylaxis schemes, are free-of-charge for everybody.

Village level collective financing: the 'Abota' scheme

General considerations

Community (that is, village) financing for drugs started in 1980 as part of the general village health scheme described elsewhere. In this scheme, drugs are given free-of-charge to the village for an initial period of six months. Thereafter the village, consisting of between 200 and 500 people, is collectively responsible for raising money to buy its drugs at district or regional level. The collective nature of this scheme is based on two general considerations. Firstly, fee-for-
service systems at village level in the long-term seem a counterproductive proposition, as control of income from the village health worker (VHW), derived from the sale of drugs, is almost impossible to achieve. Neither the village health committee - being illiterate - nor the supervising nurse can easily master this control, due to the detailed and complex monthly calculations that are necessary. Therefore, if community control is to be seriously considered, a more simple administrative scheme should be envisaged, tailored to the administrative capacity at community level.

Secondly, the monetary economy in rural Guinea Bissau is only slightly developed and virtually non-existent for about six months of the year in the rainy season. The subsistence economy does not utilize cash. It is only after the harvest that money circulates in the villages. This money is then used to pay taxes, buy the necessary clothes, radios and bicycles (if available), and organize the big social events that will assure the labour-support necessary for the harsh work on the dikes at the beginning of the next rainy season. After that, very little money is available and the economy reverts to an exchange nature.

Foster refers to this point when she questions: 'How can the burden to pay for drugs at the time of illness be shifted to periods when people are better able to pay?' In a situation such as that of Guinea Bissau, direct payment schemes are clearly inappropriate, as people will not be able to pay for their drugs during six months of the year. Risk-sharing appears feasible not only by including both sick and healthy people in the scheme, but also by collecting money at the appropriate time when it is available.

When discussing with the villagers at the beginning of 1980 the administrative control of the scheme and the seasonal availability of money, alternatives to direct payment schemes were considered. The project manager asked the villagers how they organized social events (such as funerals and parties). Their answer was simple and perhaps applicable to other parts of Africa: 'We decide together how much everybody should put into a collective fund'. Such a communal fund was locally called 'Abota', translated here as a 'voluntary levy'.

The project staff decided to use this existing 'traditional' collective payment procedure to propose a village insurance scheme. In fact, the Abota scheme bears similarities with existing 'Rotating Savings and Credit Associations' (ROSCA's) and traditional 'tontine' schemes in west Africa.10,11

**Village level implementation of the health insurance scheme**

While implementing the collective payment scheme at village level, four major issues had to be worked out.

*The amount of money every person should contribute to the ‘Abota’*

Here, clarity on the issue of 'who takes responsibility for the village health situation' emerged as important for the discussion. At first, the villagers asked the project staff how much they should contribute to the collective fund. The project staff suggested that 75 PG (US$ 2.00) per adult (male and female) would yield sufficient money to supply the village with drugs for one year. In the following months, however, the staff observed with growing concern that few people actually contributed to the new scheme. Clearly, something had gone wrong.

Luckily, one of the staff overheard a conversation between two villagers: 'The doctor says that each should contribute 75 Pesos'. Although this had never been the intention, it had clearly been understood this way. In other villages, therefore, the project staff did not specify the amount of money people should collect. Instead, the villagers were told 'to pay whatever they felt to be sufficient'. This worked in the sense that, in a relatively short time, more than 80% of the population in these villages participated in the Abota, although each person only paid about 10 PG (US$ 0.25). But this seemed to prove that people were willing to pay for their drugs in advance. It was too little to guarantee drugs for the period of one year, but at least the large majority participated, so the project staff accepted this contribution. (At that time, a chicken was worth 300 PG (US$ 7.50). Thus 75 PG for an annual contribution to a health insurance scheme at village and higher levels was not considered excessively high by the project staff.)
The total amount of money thus collected in each village was used to buy the drugs at the regional centre. The supply lasted about three months. Clearly the money had been insufficient, and the villagers could now see this for themselves. As the responsibility for the decision on the amount of payment had been in their hands, the project staff declined any loans or an advance of drugs during the months that followed the depletion of stock. Thus villagers had to wait until the next harvest, when they again discussed how much everybody should contribute to the Abota. This time they more than doubled the amount to 25 PG per person.

Over a period of three to four years, lessons were learned in the majority of the villages that:

- an amount of at least 50-75 PG is necessary to guarantee a sufficient quantity of drugs to last the village until the next harvest. The villagers decide how much they want to spend for the availability of these drugs in their village
- responsibility for collecting the money lies with the village. Often it is a member of the village committee or the VHW that goes from door to door to collect the money
- a receipt is given to everyone who contributes to the Abota. It is valid for one year. Only those with a receipt receive free treatment at the village health unit (VHU). Generally, the villagers decide that only adults (both male and female) should pay. Children receive care with the receipt of their mother
- the total amount of money collected at village level is easily cross-checked with the total number of adults in the village, to find out how many people have paid. The money is kept with the chairman of the village committee (or someone he appoints) until everyone has contributed. Then it is handed over to the VHW and/or a committee member who buys the drugs
- when back from the drug-purchase journey, the chairman of the village committee shows the receipt from the health services, together with the drugs received, to all those who are interested. This happened more often in the beginning of the scheme
- should villagers collect insufficient money, no loans are granted by the higher-level health services to buy drugs.

The risk that reluctance to participate by the majority of the population would jeopardize its very existence

If only half (or less) of the population were to be interested in participating in the scheme, the amount of money collected would not be sufficient to have drugs available for everybody for most of the year. On the whole, at least 75% of the adult population of a village would have to contribute to ensure sufficient drugs for everyone (including the children) for a sufficient period of time.

During the village discussions, a number of people (mostly male adults) indicated they were not particularly interested in participating, as they rarely became ill. The answer given by the nurse supervisors was that anyone could fall ill at any time and that this was not for man but for God to decide. Furthermore, even if someone were not to become ill, his children could certainly do so at any moment. Parents needed to realize that the Abota scheme secured their children's situation too.

Yet still some people did not participate. If these people later became ill, they were not treated by the VHW unless they paid an additional sum to the Abota, to be decided by the village at its general meeting. Thus the danger of people benefiting from the scheme without participating financially was in most cases avoided by this village-imposed fine.

The relationship between the village health scheme and the national health structure

The question was raised by a villager while discussing the payment structure:

'If I participate in the Abota in my village, by paying the collectively decided sum, and the VHW is not able to treat me here and thus has to refer me to the next health centre or even district hospital, do I have to pay there again?'

This was a much more difficult question than the one on the amount of money that everyone should contribute, as it required a definition of the relationship between the VHW at community level and the next referral level of the basic health services (BHS). The question could not be answered locally and was therefore raised at ministry of health (MOH) level. It took more
than three years to obtain a decision on this issue.

Some MOH staff argued that such a policy would be too costly for the government, because of the loss of income from the referrals of the VHW. Others pointed out that, with this issue, the MOH had a unique chance to integrate the VHWs into its total health care delivery system, without paying them any money, but simply by officially endorsing their referrals. Eventually it was the Minister herself who, in 1983, decided to exempt from payment for consultation within the BHS those who presented themselves with a referral note from their VHW, and who could thus prove participation in the Abota scheme in their village.

**Pricing of drugs**

As no private drug market was operational in the country at the time, and the 12 state-owned pharmacies (FARMEDI) were situated only in the major towns, the MOH accepted drug prices that aimed at the recovery of expenses on drugs (replenishment of stocks) and the cost of transport. Thus the price the villages had to pay were UNIPAC prices plus an additional 30% for transport and losses.

These prices were accepted nationwide and in fact meant a subsidy for the functioning of the rural network of VHUs staffed by the VHWs. Individuals were not allowed to buy their drugs at these regional distribution centres. These centres were operated by the regional supervisors for the PHC programme. Because of the isolated economic position of Guinea Bissau (due to the non-convertability of Pesos to hard currency, hardly any external products were for sale in the country) a black market for drugs was virtually non-existent at the time.

**Experiences with the Abota scheme**

From the moment the MOH sanctioned the referral of the VHW to the BHS in 1983, the Abota became part of the national health care policy in the country and the importance of the work of the VHW (including his/her referral) was endorsed.

In 1988 the council of ministers endorsed this collective payment scheme as part of a more extensive World Bank proposal to improve cost-recovery of the health services. However, due to severe limitations for public expenditure (including health) within the structural readjustment programme, the village health scheme has recently come under strong pressure. Petty corruption is increasing and few health staff are still inclined to suffer the hardship of working in rural areas given the rapidly diminishing salary this entails.

Data from an evaluation of VHW activities in 1988\(^1\) show an interesting increase in the number of participating villages in the national community health scheme: from 14 villages in 3 provinces in 1979 to 457 villages in 8 provinces in 1988, covering about 200 000 people (about one-fifth of the total population). Time was insufficient to assess with precision the performance of these villages in the Abota scheme. All villages buy their drugs, if available, at district or regional level. The drug administration is done by the nurse supervisor at the corresponding level. He or she in turn uses the money to purchase the drugs at the central medical store in the capital, Bissau, where special stocks are set aside for the village scheme. Funds in Bissau are managed by the PHC directorate, and the administrative/financial director of the MOH.

At present, the only funds retained directly by the MOH are those collected at village level, as the fees collected from out-patient care at the BHS are handed over to the ministry of finance. However, no formal procedures have been set up to convert the local money, received by the MOH, into foreign currency through the national bank, to enable the stock to be replenished. Plans were drawn up, but never materialized, to ask the United Nations Children’s Fund (UNICEF) to change this money through its ‘reimbursable purchase scheme’. In the meantime drugs were replenished for several years by various donors.

Recent data on the cost per consultation and the amount of money collected in all these villages are not available. Detailed information for one province has been provided elsewhere.\(^1\)\(^2\) These data show an average of 3.5 consultations per person per year with a per capita annual expenditure on drugs of around US$ 0.30, a very small
amount indeed. Serious undertreatment (too few drugs for one course of treatment) seems the most likely explanation.

According to a report to the World Bank, informal estimates of the actual proportion of drug costs recovered by the fee system at village level range from one-third to full recovery. Unfortunately, no official data are available on this important issue. The same report does point out, however, that the scheme represents 'a rudimentary model of an insurance system for PHC. The annual abota is in fact an insurance premium and as such a prepayment scheme that could serve as a precedent for a health insurance programme, should such a policy be considered in the future by the MOH, as part of its cost recovery policy. The system may prove, through further study, to present a viable model for a health insurance scheme extending beyond the village level'.

Discussion

From the foregoing description of this collective insurance scheme at village level some strengths and weaknesses emerge.

At national level

The most obvious difficulty over the years at national level has been the incapacity of the government to solve the issue of convertibility of the incoming money from the sales of drugs into foreign currency to replenish the stock at national level. Clearly, different interests and priorities between the national bank of Guinea Bissau, the ministry of finance and the MOH are major impediments to a solution. It is unclear at the moment whether this may be resolved later. Money collected at national level from the sale of drugs is used by the MOH to pay for other items, thus filling one gap but creating another. In this way no guarantee is given to sustain the collective scheme in the future.

Clearly, proposing revolving drug funds, as is currently done by WHO and UNICEF in the Bamako Initiative, will have to take these monitoring and control aspects into account. Even in a small country such as Guinea Bissau, with less than 1 million inhabitants and a sizeable UNICEF staff, monitoring of this cost-recovery system appears difficult. Attempting it elsewhere in less favourable circumstances would merit very serious thought, as the risk of failure to introduce a revolving drug fund is all too prominent. Furthermore, the Guinea Bissau experience shows that the problem of convertibility of local funds into internationally accepted currency should be tackled before embarking on cost-recovery.

At intermediate level

The risk of misuse of collective drug funds is considerable at the intermediate level. During the recent evaluation, it was twice found that supervisory nurses, having received the money from the population to buy drugs in the capital, Bissau, had used the money for themselves. Carrin describes similar practices. These are likely to jeopardize the whole system because villagers may not collect the Abota another time as they have no control over what the supervisors are doing with their money – and consequently lose confidence in them.

In fact the issue is not so much one of misuse of village money, but rather of the incapacity of the government structures to take appropriate action. This points to an important feature of any cost-recovery scheme. Are the structures that should guarantee control procedures working effectively? To what extent are those who handle the money of the population effectively controlled? To what extent can those that break the law be punished?

Financial hardship reigns everywhere within the public service where the structural readjustment programme is underway, and civil servants have often not been paid their salaries for more than six months. In such a situation, taking money from a village that one is supposed to be supervising is unlikely to be seen as a serious contravention of the law. Indeed, experience shows that someone is not likely to be punished even in a clear case of abuse.

Again, it seems an almost unacceptable risk in such a situation to embark upon large-scale cost-recovery schemes such as the Bamako Initiative, which are likely to lead to misuse of funds, if there are no corrective mechanisms available. An alternative worth exploring further would be the creation of drug-warehouses at district-level,
allowing community representatives themselves to replenish their stock.

At village level
The scheme seems to work at village level. Collective control, although sometimes time-consuming, is sufficiently strong to guarantee that more than 75% of adults participate in the scheme. During the five years of experience in the area, only once did a VHW take the money that he was supposed to collect and use it for personal use. It took the villagers more than a year (while being without drugs) to get him to pay back the money, but they finally managed. As it was their responsibility, internal village pressure did what outsiders would not have achieved.

Rather than creating differences between those who have access to drugs and money and those who have not, the scheme tends to reinforce solidarity and collective decision-making at village level. Both the amount and the use of the collected money is decided upon by the villagers. As such, the scheme appears to be an alternative to PHC projects elsewhere in rural Africa that introduce small-scale private practice by allowing VHWs to make a profit from the sale of drugs. In fact, due to lack of time and vision, the PHC approach often seems to reinforce private practice at the expense of collective payment schemes.

Although the Bamako Initiative does not take an official position on this matter, it may give opportunity to the promotion of ‘small-scale entrepreneurism’ in rural Africa, unless precautions are taken by local community or governmental structures. These measures should stimulate and support collective payment schemes with clear forms of control and continuity, thus preventing capitalistic tendencies, foreseeable in the ‘fee-for-service schemes’. While promoting cost-recovery, UNICEF and WHO assume that sustainability will follow. But if control is not assured by authentic community structures, this assumption might appear wishful thinking in the future.

Conclusion
A collective payment scheme to finance annually the purchase of drugs at village level in Guinea Bissau has been discussed. The scheme is based on a traditional system of voluntary levies called ‘Abota’. It is sufficiently simple to permit village management and control of the funds raised; it also resolves the problem that little money circulates in the village during half of the year.

From the implementation point of view, the major advantages of this collective scheme prove to be:

- the relative simplicity of its administrative system. Once a year only, a collectively decided amount of money is gathered by the villagers themselves, thus avoiding the problem of drugs running out in the rainy season
- the clear handing over of responsibility to the villagers in deciding on the amount of money they want to pay for their drugs and the method for collecting it. This experience has shown that small funds can effectively be handled and controlled at village level
- the system can only work, however, if the health services have drugs available at low cost whenever the villagers come to buy. This is very important to instil confidence in what the government claims to offer. To make the system work, a relatively well-functioning drug procurement and distribution system at national level is necessary, together with flexible donor support for purchase of essential drugs, and the ability to convert local currency recovered into foreign exchange
- a crucial factor for success appears to be the formal decision of the MOH to exempt those who have paid their Abota in the village, and who have been referred by a trained VHW, from paying fees at higher-level health institutions - thus reinforcing the role of the VHW and integrating his/her work in the official health-care pyramid of the MOH. In this way the MOH has considerably extended its rural network at very little cost.

These four factors cannot be considered in isolation. At the time they were part of an active equity-orientated policy of the MOH in Guinea Bissau. Therefore, if Carrin concludes that ‘voluntary prepayment schemes risk too many refusals, that might make them unworkable and too costly’, he omits the socio-political climate that in fact defines the conditions under which prepayment schemes may work.
Community health insurance

Donor agencies should look at these general enabling factors which create the conditions that make collective payment schemes possible. This seems even more important now that the Bamako Initiative seems to advocate fee-for-service schemes. The absence of a widespread private drug market in Guinea Bissau, and the small-scaleness of its rural villages, have been two positive conditions that are unlikely to be found in many other countries.

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Comment: the Bamako Initiative and the WHO Regional Office for Africa
As we know, African countries are today experiencing terrible economic difficulties resulting mainly from the economic recession from which no one has been spared.

The prices of raw materials, the main sources of national revenue, have plummeted, and are unstable. The meagre resources that African countries still possess are completely absorbed by debt servicing.

No economic indicator today gives a glimmer of hope for the near future.

In this situation, governments no longer have the necessary resources to cover the health costs of
the population. Moreover, already inadequate, national health budgets have in most cases been considerably reduced, notwithstanding government determination to promote the health of the people.

We must therefore find appropriate ways out of this situation in which resources have been dramatically reduced and the health situation has deteriorated drastically. This is imperative, especially now that health has been recognized as the cornerstone of all socio-economic development.

Only people in good health are able to engage in productive work and to contribute to development. Thus, we find ourselves in a vicious circle.

This is why the WHO Regional Office for Africa, realizing that 'the health of the individual is, first and foremost, a matter for the individual', is laying emphasis today on community mobilization.

We must mobilize, organize and prepare the people to take charge of their own principal health problems. To avoid dental problems, for example, people must understand the importance of brushing their teeth. No one else can do that for them. Primary health care is above all an individual matter, which is why communities must be taught to look after themselves.

The Bamako Initiative was devised with this in mind. It is a strategy for community self-financing of primary health care, aimed especially at women and children.

The goal of the Initiative is to help communities look after themselves. They must be weaned off the hand-out mentality of passive beneficiaries who wait for those above them to solve even their simplest problems. They must be taught to be active and fully responsible for themselves, since they have the innate ability and willpower.

The Bamako Initiative was not devised as a panacea, a magic potion. It must be introduced judiciously, and must be based on in-depth analysis that takes account of the particular circumstances of each location.

The ‘Abota Plan’ that has been initiated in Guinea Bissau accords fully with community participation in primary health care activities. It therefore merits our support. The progressive approach adopted by the authorities is appropriate.

Those in charge of the programme have had the wisdom to stop midway and review the progress they have made. This is as it should be because such a review enables the organizers to observe trends as they develop, to draw conclusions and to adjust their aims, if necessary.

Many lessons have indeed been learned, and they should be given consideration in order to improve their yield.

I therefore appeal to all people responsible for primary health care across the continent to learn from the ‘Abota Plan’.

What we wish to emphasize here is the methodological approach adopted by the plan. Although based on the conditions in each locality, projects of this kind cannot be conducted in isolation. One should be open to others, open to opinions, remarks, comments and suggestions. Both sides will benefit from such exchanges, which enrich everyone’s experience.

This, indeed, is exactly what the officials of the ‘Abota Plan’ intend to do.

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