CONSTRANTS TO SCALING-UP HEALTH RELATED INTERVENTIONS: THE CASE OF CHAD, CENTRAL AFRICA

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Abstract: This analysis of constraints to scaling-up health-related interventions in Chad shows that emphasis has to be put on systemic approaches which address absorptive capacity, on removal of structural constraints, and on efficient and equitable production of health services. In the production of services the development of infrastructure must not exceed the development of human resources. If the millennium development goals are to be achieved, major investments in basic and in-service training and in management skills are crucially needed. In addition, the study shows the importance of promoting health services which actively seek to fulfil community demands and those of disadvantaged groups. Copyright © 2003 John Wiley & Sons, Ltd.

1 INTRODUCTION

Chad, in Central Africa, is one of the poorest countries in the world. Its economy is not diversified and is based on cotton and cattle. Chad is landlocked, and suffers from repeated droughts and the heritage of colonisation. The UNDP human poverty index lists Chad in the 166th position out of 173 (UNDP, 2002). With few reliable data available, the socio-economic and demographic state of the country is difficult to outline. The Gross National Product per head was estimated to be US$200 in 2000 (World Bank, 2002). The economy is one of the most fragile on the African continent, with the balance of payments chronically in deficit, little tax revenue, and a high degree of dependence on foreign aid. The population is poor, their state of hygiene and nutrition is precarious, life expectancy is short, infant and maternal mortality rates are high, and access to education and social services is restricted.

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Public expenditure for health care is funded by the government and by foreign aid, which together provide approximately US$30 million a year, for an estimated population of 7.5 million. In 1999, public sector health care funding amounted to only US$4.2 per head, of which US$3.7 was funded by foreign aid (MSP, 2000) (Table 1). That amount does not include the resources made available through user fees paid by patients. These revenues from cost recovery schemes were estimated to total approximately US$15 million, of which half was used for the purchase of essential drugs (MSP, 2002).

A principal recommendation of the Commission on Macroeconomics and Health was that investment in the health sector should be greatly increased in order to achieve the millennium development goals (MDGs) (Commission on Macroeconomics and Health, 2001). The report also acknowledged that there is increasing evidence for the connection between health and the economy (Frenk and Knaul, 2002) and that a number of challenges have to be overcome in order for the additional resources to be invested effectively and efficiently (Mills, 2002). In this context, this paper reviews constraints to scaling-up health related interventions at country level. Scaling-up is understood as the increase in the level of coverage of a target population from existing levels (Kumaranayake and Watts, 2001). More precisely, the extent and the intensity of constraints, and their relevance to efforts to improve health outcomes of the poor and strengthen the peripheral delivery system, are assessed. Difficulties in reducing constraints and more specifically the level at which they operate are identified. The paper also documents the experience of selected projects in Chad which have attempted to relax constraints, in terms of their effectiveness, the scale on which they are applied, and the necessary conditions for a project to be successful.

The study is organized within the conceptual framework suggested by Hanson et al. (2003). The following sections discuss constraints at five levels: the community level, the health service delivery level, the health policy level, the cross-sectoral level and the level of governance. Experiences of relevant projects are discussed in boxes in the light of emerging opportunities for scaling-up health related interventions.

### 2 CONSTRAINTS AT COMMUNITY AND HOUSEHOLD LEVEL

In Chad, the health information system records the activities of the health services and allows the main health problems to be identified (MSP, 2002). It provides statistics that

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<tr>
<th></th>
<th>US$</th>
<th>%</th>
<th>per person per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Health</td>
<td>3 461 987</td>
<td>11</td>
<td>0.5</td>
</tr>
<tr>
<td>External resources (aid)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Budgetary aid</td>
<td>5 773 254</td>
<td>19</td>
<td>0.8</td>
</tr>
<tr>
<td>Loans</td>
<td>7 196 513</td>
<td>24</td>
<td>1.0</td>
</tr>
<tr>
<td>Gifts</td>
<td>14 147 940</td>
<td>46</td>
<td>1.9</td>
</tr>
<tr>
<td>Total</td>
<td>30 579 694</td>
<td>100</td>
<td>4.2</td>
</tr>
</tbody>
</table>

*Does not include private expenditures and financial resources generated through user fees. 
express the level of activity of the public and the private non-profit sectors. No statistics exist for the private for-profit sector; however, this sector plays only a marginal role outside the capital, N’Djaména. Self-treatment, mainly by purchasing drugs at the level of street sellers, markets and pharmacies as well as the use of ‘traditional’ and religious therapists such as marabouts is very common, especially in rural areas. However, Table 2 shows that in 2000, in a total population of 7.5 million, only 2 million new cases and 3.4 million curative contacts were recorded in the country’s health facilities. A ‘new case’ is defined as a person who suffers from an episode of illness.

The number of curative consultations was 0.27 per head per year. This means that on average only about one person in four visits a health care provider once a year. There is no reference data for ‘typical’ curative consultation rates. However, on the basis of figures from other countries, a number between 1 and 2 new cases per head per year is a realistic expectation.

According to the annual statistical report of the Ministry of Public Health, it is estimated that 27 per cent of children are completely vaccinated by the age of one year (MSP, 2002). Other data point towards a lower rate of around 10 per cent (BCR, 1998). The level of contact for antenatal consultations is also low, with only about 34 per cent of women having at least one antenatal visit. The number of child deliveries assisted by health service providers, either at home or at the primary health care or hospital level, reached 52,500 in 1999, which corresponds to approximately 14 per cent of all expected births.
Within Chad, however, the variations in the use of health services are considerable. For example, higher coverage of assisted deliveries is observed in the South of the country, in the prefectures of Logone and Tandjile as well as in N’Djaména. Certain groups, especially in the rural areas, have very little access to health services. In the Sahel zone and in the pastoral nomadic communities, few children or even none at all are vaccinated; likewise few or even no pregnancies are assisted (Hampshire, 2002).

Generally speaking, all the available data highlight a low frequency of use of curative and preventive services and statistics drawn from the health information system show that the utilization levels of curative and preventive services are frequently low. In many places, health workers and services are under-utilized. These low utilization rates are linked to both demand- and supply-side issues.

With regards to the household and family level, a structural reason on the supply side for the observed low utilization rates is that geographic access is limited for most people, in particular for those who live in the Sahelien zone. For instance, in the prefecture of Biltine the average distance to a first contact health service is 28 km, corresponding to more than one day travel by donkey. It is obviously difficult to encourage pregnant women and children to cover such distances for preventive care. Another barrier to the utilization of available services is poor communication between health providers and communities. Exchanges are usually characterized by mutual distrust. For example the nomadic communities suspect the State of wanting to manipulate them to achieve its own goals, and in turn the public services accuse the nomads of not wanting to collaborate with the modern state. This situation has lead to social and economic exclusion, to the marginalisation of certain communities and to these people not being integrated by the public sector into the provision of basic services such as education and health. As a result, it is hardly surprising to see that in Chad, where the adult literacy rate of 15 per cent is one of the lowest in the world, the schooling rate amongst the nomadic populations is around 0 per cent.

The organizational concepts of health planners and providers are rarely in tune with the cultural concepts of families, households and the population. The health services do not take sufficient account of the patient’s environment which would allow for more appropriate solutions to problems of cultural and structural origin. As a consequence, it is important to promote health services that stem from the same social and cultural logic, the thinking that dictates patient behaviour, and from the cognitive systems that people use.

On the demand side, constraints limit the adoption of health interventions and drive individual choice. Before deciding to visit a health service provider, an individual will weigh the benefits and the inconvenience and efforts required to access the service. Advantages are measured in terms of medical drugs seen as a symbol of cure, and costs in terms of spending money, time and energy. Cultural and social factors prevent people from using health services. One factor is knowledge: a cross-sectional survey on Knowledge, Attitude and Practices (KAP) conducted in 1996 showed how little knowledge the population has of efficient interventions (Wyss et al., 1996) (Table 3). There are also gender factors that must be considered as it is well known that in Chad, as elsewhere, the gender division of roles is largely unfavourable to women (Hampshire, 2002). The traditional division of roles by gender places a particularly heavy burden on Muslim women, and for instance, in rural zones of the prefecture of Biltine only 2.1 per cent of girls have been to school.
Box 1. Strengthening of peripheral health services in the region of Biltine
In Biltine, a Sahelian region in the West of the country on the border with Sudan, a project implemented by the Swiss Red Cross has focused on the strengthening of peripheral health services. Between 1996 and 2000, a number of strategies have been implemented with the aim of increasing the utilisation of primary health care services. Institutional capacities were fostered, outreach activities were strengthened, community development was supported, and contracting with local NGOs was promoted. The activities in the prefecture of Biltine were being implemented in a difficult context characterised by a very low economic standard of the population, geographic remoteness with a poor communication network (e.g. very rocky and dangerous roads, no electricity and telephone), unfavourable working conditions for health staff, and limited willingness of people to pay for services.

Health service utilization indicators over the five-year project period did not improve. Despite a scaling up of health-related interventions through the construction of new infrastructure and the promotion of outreach activities, the number of curative consultations, the rate of antenatal consultations and the percentage of assisted deliveries remained the same or even decreased. Efforts to strengthen peripheral health services did not have the expected results. Better use of the health services can only happen if health service development is accompanied by economic development and small nuclei of economic progress are created, including better working conditions for health staff. Flexible and new strategies are required, which focus on increasing the demand of communities for peripheral health services and on new forms of collaboration and communication between providers and potential users.

Box 2. Project for improving access to health services for nomadic people
The nomadic groups in Chad have virtually no access to health services and since 1998 a programme of the Swiss Tropical Institute has been identifying interventions which can improve health prevention and care among nomadic people in the Lake Chad region where pastoral nomads are concentrated. The project is based on the concept of ‘one medicine’ with the objective of reinforcing the interactions between the nomadic communities and both the human and veterinary health services (Zinsstag and Weiss, 2001). Its approach relies on both research and field interventions. A Research—Action—Capacity Building approach actively involves the nomadic populations in the process of planning and implementation.

The first results show that working in networks of multi-sectoral dialogue can bring together the veterinary and the public health services. Thanks to meetings and regular exchanges, collaborations are being established which involve both sectors and also local groups (health committees, etc.). The veterinary services are important to communities dependent on their animals and are already well known among nomadic groups. The interactions identify priority interventions based on the users’ demands and also encourage local service providers (health auxiliaries, traditional midwives) and the existing health facilities to take responsibility for the health care of the nomadic populations. Cross-disciplinary teams (public and veterinary health) have been able to significantly increase the vaccination coverage rates of children and women, and to supply essential drugs to nomadic groups for the treatment of a restricted number of diseases.
3 CONSTRAINTS AT HEALTH SERVICE DELIVERY LEVEL

Throughout Chad, the shortages of infrastructure and equipment are enormous. The deficiencies are particularly pronounced at regional and district levels. For instance, out of 49 districts in the country, only 29 (59 per cent) have a hospital carrying out the core activities defined by national policies. Faced with such massive shortages, most donors, notably the World Bank, have placed the building of new infrastructure amongst the top priorities.

The national pharmaceutical policy, in accordance with the Alma-Ata declaration, is aiming at building a system which gives priority to primary health care, particularly by guaranteeing an adequate supply of quality drugs which are safe, effective and affordable (essential drugs). A Centralized Pharmaceutical Procurement Office (‘Centrale Pharmaceutique d’Achat’) with the role of ensuring essential drugs supply as well as supporting the Division of Pharmacy of the Ministry of Public Health in fostering rational drug use and quality assurance, was established in the late 1990s. Thanks to these efforts, the supply of drugs in the public sector (through the Centralized Pharmaceutical Procurement Office and through the Regional Supply Pharmacies) is reasonably regular. Medical supplies and non-generic drugs for pharmacies and the private sector are imported through a private company which is able to assure a regular supply.

Regarding human resources, the shortage of qualified people constitutes the most important ‘bottleneck’ limiting the return on investment in the health sector. For a population of 7.5 million and for 640 primary health care services and 30 hospitals, Chad has 279 Grade I nurses and 361 Grade II nurses (Table 4). Approximately two-thirds of health workers have no qualification, and a great number of primary health care services are managed by non-qualified staff. Consequently, there is an urgent need for more qualified staff (Table 5). Further, the distribution of government employed health staff in the country is very uneven, with a concentration in N’Djaména and at the central level of

<table>
<thead>
<tr>
<th>Knowledge, attitude, behaviour (KAB) of mothers</th>
<th>Eastern Chad (prefectures of Batha, Biltine, Guêra and Ouaddaï)</th>
<th>Southern Chad (prefectures of East Logone, Middle-Chari and Salamat)</th>
</tr>
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<tbody>
<tr>
<td>Have heard of Oral Rehydration Therapy (ORT)</td>
<td>27%</td>
<td>66%</td>
</tr>
<tr>
<td>Know how to prepare ORT (ingredients and quantities)</td>
<td>25%</td>
<td>16%</td>
</tr>
<tr>
<td>Use a (bed)net</td>
<td>46%</td>
<td>19%</td>
</tr>
<tr>
<td>Use health services as a first choice</td>
<td>29%</td>
<td>16%</td>
</tr>
<tr>
<td>Don’t make use of health services due to geographical distance</td>
<td>41%</td>
<td>11%</td>
</tr>
<tr>
<td>Don’t make use of health services because of costs</td>
<td>12%</td>
<td>48%</td>
</tr>
<tr>
<td>Know the pill as a contraceptive means</td>
<td>6%</td>
<td>18%</td>
</tr>
<tr>
<td>Did not visit a medical practitioner during last pregnancy</td>
<td>88%</td>
<td>50%</td>
</tr>
<tr>
<td>Do not visit the ANC because of geographic distance</td>
<td>64%</td>
<td>24%</td>
</tr>
<tr>
<td>Do not visit the ANC because of financial costs</td>
<td>8%</td>
<td>47%</td>
</tr>
<tr>
<td>Delivered their baby at public or private provider</td>
<td>3%</td>
<td>22%</td>
</tr>
<tr>
<td>Fed their baby on other foods in addition to mother’s milk before the age of 6 months</td>
<td>52%</td>
<td>87%</td>
</tr>
</tbody>
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Source: Wyss et al., 1996
the Ministry of Health. Efforts to achieve a redistribution of health workers have all failed, mainly because of weak implementation of policies and the unattractive working conditions in rural areas. Staff shortages result in a situation where many positions are held by workers who do not have the appropriate skills and training for the job and cannot function efficiently and effectively.

A relatively high number of trained health workers can be considered as lacking in key competencies and unsuited to their jobs, and performance is often inadequate, translating into low quality of care. These problems stem from inadequate training, recruitment and supervision mechanisms. Graduating students almost always find work in the government sector; there is an imbalance between the type of training given and job descriptions, which means that young graduates are not well prepared to perform the tasks required of them; follow up on individual staff records is insufficient and performance is not effectively monitored; there are no clear career structures in place; assessment practices are unsatisfactory; quality standards are poorly defined; and little attention is paid to transparent monitoring mechanisms. Staff generally seem to have little commitment to their assignments. The effects of this are manifold: required working hours are not respected; health workers engage in parallel private practice; there are no outreach

<table>
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<tr>
<th>Table 4. Health staff by qualification in the public sector</th>
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<tbody>
<tr>
<td>Title</td>
</tr>
<tr>
<td>Unskilled workers</td>
</tr>
<tr>
<td>Technical health officer</td>
</tr>
<tr>
<td>Nurses, grade I</td>
</tr>
<tr>
<td>Nurses, grade II</td>
</tr>
<tr>
<td>Medical doctor</td>
</tr>
<tr>
<td>Assistant technical engineer</td>
</tr>
<tr>
<td>Contracted workers</td>
</tr>
<tr>
<td>Qualified midwife</td>
</tr>
<tr>
<td>Nurses, grade III</td>
</tr>
<tr>
<td>Secretary</td>
</tr>
<tr>
<td>Technicians</td>
</tr>
<tr>
<td>Medical officer with specialisation in gyneco-obstetrics</td>
</tr>
<tr>
<td>Technical officer</td>
</tr>
<tr>
<td>Office staff</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Total</td>
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<table>
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<tr>
<th>Table 5. Comparing theoretical and current staff numbers at district level</th>
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<tbody>
<tr>
<td>Theoretical need</td>
</tr>
<tr>
<td>------------------</td>
</tr>
<tr>
<td>Medical doctors</td>
</tr>
<tr>
<td>Nurses, grade I</td>
</tr>
<tr>
<td>Midwives</td>
</tr>
<tr>
<td>Nurses, grade II</td>
</tr>
<tr>
<td>Administrators</td>
</tr>
<tr>
<td>Planners</td>
</tr>
</tbody>
</table>


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activities; and interpersonal communication and dialogue with clients is deficient (Parent and Coppieters, 2001; Zachariah et al., 2001).

The number of posts available in the civil service is limited in the context of structural adjustment policies, and the yearly increase in posts is fixed at 90 health workers for the whole sector. Further, emigration and brain drain of health workers is driven by poor working conditions. As in other African countries (Bundred and Levitt, 2002; Pang et al., 2002) the medical and paramedical diaspora is large and is estimated to be in the hundreds of health workers.

In Chad there is also inadequate assessment of experience (‘capitalization’), poor communication of information on best practices, and a high level of fragmentation and segmentation of projects and activities (‘balkanization’). The coordination and communication of best practices amongst donors is also inadequate.

Box 3. Project for establishing initial training at decentralized level

Until recently, the commitment of donors to training has been limited, but faced with such a massive shortage of human resources most donors now see training as a high priority. Since 1998 the ‘Decentralized Initial Training Project’ has established 3 peripheral paramedical schools for basic training. These centres are intended to train male and female nurses, who will be assigned to the region in which they were trained. The 8th European Development Fund (EDF) project of the European Union and the World Bank are financing the establishment of these training nuclei. 135 future nurses are currently studying for their degree and by 2004, 540 nurses will have been trained in these centres.

Raising funds for decentralised basic training is problematic. Despite the commitment of several donors (World Bank, European Union, French Cooperation) there is no consolidated budget for the project. Also due to considerable delays in the start of the 8th EDF project, the annual financial commitments are not being met.

What also hinders the functioning of the medical training schools is the debate over the policy on student allocations and grants. The Government’s policy promotes grants for students admitted to the schools, but in most cases donors are unwilling to fund these grants as they have identified other priorities for investment. The most obvious solution would be to separate the functioning of the school from grant allocation mechanisms, but the government and donors currently cannot agree on this issue. Furthermore, the project stumbles on the problem of the training quality and validity, and places for internships are difficult to identify as there are few district managers willing and able to supervise students.

4 CONSTRAINTS AT HEALTH SECTOR POLICY AND STRATEGIC MANAGEMENT LEVEL

The process of health sector reform started in Chad in 1988. It resulted in the establishment of a pyramidal system based on three levels: the central level, comprising Ministry of Health and national institutions; the intermediate level, comprising 14 regional administrations with a regional hospital; and the peripheral level encompassing 49 districts. District services are in two tiers: in the first tier are the health centres, each of which covers
a zone of responsibility (646 in total), and in the second the district administration and a
district hospital.

Today the country has a well-defined health sector policy and clear strategic
orientations. These prioritize the development of districts and the implementation of a
‘complementary package of activities’ at district hospital level and of a ‘minimum
package of health services’ at health centre level. They also promote the integration
of vertical programmes and the promotion of the private sector. There is a clear focus on
the package of essential services (vaccination, reproductive health, etc.). However,
institutional and human resource capacities for carrying forward the health policies are
limited and often rely on international consultants. One explanation is a lack of skills
for designing and translating strategic visions into concrete policies and implementation
plans.

Chad’s health sector is faced with considerable problems. The biggest problems are the
very limited geographic, financial and cultural access, and poor quality of services; the
shortage of human resources at all levels, both in quantity and quality; low motivation of
health workers and huge gaps in both initial and continuing professional training; weak
institutional capacities for the management of the health system and insufficient support
structures at the central, regional and local levels; and poor implementation of the existing
policies. Promising, effective and efficacious long-term strategies remain to be identified
and many health districts are not yet operational. Community participation, in particular
issues beyond the financial participation of local communities, is still inadequate.
Partnership and collaboration of the public sector with the for-profit and non-profit private
sector, including the NGOs as well with other development sectors and donors, is weak.
The respective roles and functions are not well defined.

The financial administration of the Government budget is cumbersome and it does not
sufficiently involve health administrators and planners at regional and district level. Although
most projects have established yearly planning mechanisms, these practices have not been
adopted by the Ministry of Health. Moreover, the Ministry of Health has no policy for
management procedures. However, it is increasingly important that Ministry of Health
departments in charge of planning and administration should start to manage finances
effectively, define budgetary standards for capital and recurrent investments, measure results
against budgeted plans, analyse costs, expenditures and available resources, fix plans
encompassing inputs from the private sector, the public sector and other donors, and establish
controls and progress indicators. Performance monitoring systems and quality management
remain rare, and do not yet guide the decisions of administrators and managers.

The largest projects in the health sector, which are funded by the World Bank and
through the European Development Fund (EDF), have adhered to a project approach,
although the appropriateness of this approach must be questioned in a context of strategic
and sector-wide planning. The project approach is characterized by an independent
planning phase, a phase of negotiation between the government and the involved
donor, a phase for settling the contract with the executing agency, and finally the
implementation phase. This procedure inevitably results in the period of actual activity
being short, and is usually detrimental to the executing agency and the beneficiaries. For
instance the 7th EDF project started in 1992 for a five-year period. The feasibility study for
the continuation of the project was carried out in 1998. Until late 2000, the routine
activities continued with leftover funds. The tendering for the next phase was done only in
late 2000, and the actual implementation started at the beginning of 2002, four years later
than initially scheduled.
5 PUBLIC POLICIES CUTTING ACROSS SECTORS

Poverty alleviation and the development of the social sectors (education and health) are among the priorities of the Chadian government. The Government has also initiated the participatory preparation of a Poverty Reduction Strategy Paper (PRSP) which is likely to underpin this commitment. Cross-cutting public sector reforms are being discussed: the reform of the public service and pay, public procurement, financial management, monitoring and evaluation and measures to increase transparency and participation, and to fight corruption. In the meantime, the management of public services is neither transparent nor effective. Administration suffers from political centralization, great mobility of staff at all levels, poor distribution of managers, a remuneration system based on diplomas and not on tangible performance, and from poor circulation of information. Bureaucratic procedures are particularly cumbersome in the area of public spending. Usually it takes four to five months for the approval of a public tender and corruption is endemic in the allocation process.

The performance of the Chadian public administration is mediocre. Personal interests often overrule public service ideals. In the health sector as in others, lengths of service and competency criteria are not respected in appointments to positions of responsibility. Consequently, the most competent people do not always fill these positions. The efficiency of the government further suffers from the great mobility of its members; for example a new minister and deputy minister of health are frequently appointed several times a year. A number of career planning principles for physicians and health workers have been

Box 4. The strengthening of health service delivery at a regional level

The support programme funded by the 7th European Development Fund aimed at improving the coverage and quality of health services in eight regions. Activities were tailored towards regional administrations through the strengthening of regular planning, administration and supervision mechanisms. The project’s experiences highlight the fact that the major impediment to service improvement was the poor development of human resources (de Lamalle, 2000). The few young physicians and public health doctors appointed at district level were more often that not inadequately trained, in particular for obstetric and surgical emergencies and for management of peripheral services. As a result, the activities of the project had little impact on the provision and quality of curative services and on the strengthening of regional administrations.

In terms of requirements for scaling up the interventions, the 7th EDF project demonstrates that the activities should focus in particular on the production of health services and on performance. In order to achieve this, the development of infrastructure must follow the development of human resources and use flexible approaches. An improvement in health service coverage should first and foremost be pragmatic and be based on a consolidation of experience. Any new physical infrastructure should preferably be subject to the availability of human resources, and minimum recurrent financial means. Geographical access to health services should improve in parallel with quality improvements of these services. These objectives should be achieved through investments in training and management, continuing education through supervision as well as the establishment of quality standards for these services.
established, but they are seldom respected because of the shortage of medical staff and because of a lack of formalisation of career structures.

6 GOVERNANCE AND OVERALL POLICY FRAMEWORK

For a population which is 85 per cent illiterate and where few intellectuals exist, the State is still an abstraction, with no tangible reality for most citizens. Thus, the country is faced with important challenges, among them how to promote social and economic growth while maintaining political stability.

Over the last decade there have been some achievements towards better governance and democratising of the country. Chad opened to a multi-party system in 1990. The birth of political freedom was accompanied by a new dynamic within civil society, allowing the establishment of more than 400 associations and community-based organizations, many of them having health-related activities. Organisations for the protection of human rights were created and trade unions were established. Freedom of the press was followed by the emergence of independent newspapers.

With a multitude of political parties, of citizens associations, of trade unions, and of newspapers, one would be inclined to say that a democratic culture has emerged. However, day-to-day life is far from the claimed ideal. For the people, democracy has not yet brought the expected benefits. The safety of persons and the protection of goods are not guaranteed. Indeed, the traditional, political, administrative and military authorities, in urban as well as rural areas, are guilty of many abuses. There are still rebellions which are the result of people not respecting democratic ideals. The absence of peace has economic implications and is discouraging investment in industry and services.

The government promotes three strategic axes in its development policy: the promotion of the private sector, the strengthening of human and organisational capacities, and the fight against poverty. The country remains heavily dependent on outside assistance, but major donors such as the World Bank (IBRD), the European Union (EU) and France co-ordinate relatively well with each other and are expected to continue their partnership to help Chad achieve its primary goals of poverty alleviation and economic growth. Health accounts for roughly 9 per cent of total government expenditure. However, governance in Chad is still characterized by a waste of public resources, mainly due to the burden of military expenditure and to the imbalance between the allocation principles and practices of corruption; a predominance of the State, which is organized on strongly centralized basis and leaves only a negligible role for the private sector and civil society; and an absence of opportunities that would allow the population to participate actively in the development process.

7 CONCLUSIONS

This paper has examined constraints to scaling-up health-related interventions in Chad in the context of the report of the Commission on Macroeconomics and Health (Commission on Macroeconomics and Health, 2001). First, it is important to understand the country context. Chad is a country still recovering from a period of emergency and armed conflict. However, progress is now being made towards the reconstruction of national structures and the reconstitution of civil society, and though it is still classified by the World Bank
among the poorest countries in the world economically, Chad does benefit these days from relative political stability.

Utilization rates of preventive and curative services are very low, especially among the most disadvantaged groups such as nomadic people and women. Community participation remains weak, leading to a situation where the approaches of planners and providers do not correspond to the cultural concepts of the population. At the level of health service provision, Chad is severely short of qualified people, and many health structures do not function even at a minimal level due to the lack of qualified personnel. The human resource deficiencies also lead to weak technical guidance, programme management and supervision. There is a concentration of health facilities and human resources in urban areas. In other words, there are serious distributional problems which lead to important health sector inequalities such as those shown for other countries (Feachem, 2000; Gwatkin, 2000; Wagstaff, 2002). At the health policy level there is ineffective implementation of the existing national policies, related to weak institutional capacities, an unproductive administration, and lack of coordination in the health sector, as well as insufficient management skills at national and local level.

The analysis of multi-sectoral policies shows that the health sector fails to develop effective partnerships with other development sectors, or with the private and associated sectors. Considering that many health interventions require cross-sectoral links to increase effectiveness, these interactions clearly need to be strengthened. However, there is no strong political will to work along these lines even though the process of decentralization is modestly promoted. On the level of the governance of the country, Chad is exposed to the typical problems of low-income countries such as an unstable political situation, a weak government, a weak capacity to implement regulations and laws, and corruption.

This case study shows that when scaling-up health interventions in such highly constrained countries as Chad, activities have to put special emphasis on systemic approaches which address the absorptive capacity of the health system, on the removal of structural constraints, the production of services and measures of performance. The example of efforts to strengthen peripheral services in Biltine (Box 1) shows that health sector development depends also on economic development and that without such development the millennium development goals (MDGs) will be difficult to achieve. Further, flexible and new strategies are required, which focus on increasing community demand for peripheral health services and on new forms of collaboration and communication between providers and potential users.

In the production of services the development of infrastructure must not outpace the development of human resources. Human resources are a crucial input of the health system production function (Borgdorff et al., 2002) and it is unclear whether the MDGs can be met given the current and future availability of appropriately trained and distributed health staff. Significant investments into training capacities are required. Given the lead-time required to produce new health workers, such investments must occur in the early phases of scaling up. Better quality of care must evolve in parallel with improvements in physical access. Investments in basic and in-service training and management skills as well as systems of supervision and assessment based on participatory elaboration of quality standards may contribute to the achievement of these objectives. Contracting work to the private sector may be an instrument for rationalizing and extending services which offers an opportunity to overcome the scarcity of human resources in the public sector (Carrin et al., 1998) and eventually problems related to the retention of staff in the public sector.
However, this requires the regulation of the private sector, which is itself demanding of public sector capacity.

In addition, the study shows the importance of promoting health services which actively seek to fulfill community demands. A possible approach is the promotion of platforms of exchange and communication among the various actors involved and across different sectors. This approach should place special emphasis on disadvantaged groups.

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