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Research Group supporting health policy on the implementation of the agenda for aid effectiveness (GRAP-PA Santé)

DOCUMENTING RESULTS OF EFFORTS TO IMPROVE HEALTH AID EFFECTIVENESS

MALI CASE STUDY

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Translated from French

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List of abbreviations used

ANC	Antenatal care
AFD	French Development Agency
AfDB	African Development Bank
BTC	Belgian Development Agency
CAD	Development Assistance Committee
CCAS	Common Country Assistance Strategy
CHPP	Country Health Policy Process
CNS	National Health Accounts
CPS	Planning and Statistics Unit
CROCEP	PRODESS Regional Orientation, Coordination and Evaluation Committees
CRS	Creditor Reporting System
DAF	Administrative and Financial Directorate
DGB	National Budget Directorate
DRS	Regional Health Directorate
EC	European Commission
ECOWAS	Economic Community of West African States
EDS.M	Demographic and Health Survey – Mali
EPI	Expanded Programme on Immunization
EU	European Union
FENASCOM	National Federation of Community Health Associations
FP	Family Planning
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GFATM	Global Fund to Fight Aids, Tuberculosis and Malaria
GHO	Global Health Observatory
HDR	Human Development Report
HMN	Health Metrics Network
HSS	Health System Strengthening
HR	Human Resources
IDB	Islamic Development Bank
IHP+	International Health Partnership and related initiatives
IMF	International Monetary Fund
JANS	Joint Assessment of National Strategies
LHIS	Local Health Information System
MBB	Marginal Budgeting for Bottlenecks
MDG	Millennium Development Goals
MoEF	Ministry of Economy and Finance
MoH	Ministry of Health
MoSDSE	Ministry of Social Development, Solidarity and the Elderly
MPA	Minimum package of activities
MTEF	Medium-Term Expenditure Framework
NGO	Non Governmental Organization(s)
NHIS	National Health Information System

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OECD	Organization for Economic Cooperation and Development
PAGAM-GFP	Governmental plan of action to improve and modernize management of public finances
PD	Paris Declaration
PDDSS	Ten-year Health and Social Development Plan
PDES	Economic and Social Development Programme
PFM	Public Finance Management
PNDRHS	Politique Nationale de Développement des Ressources Humaines pour la Santé
PPM	Popular Pharmacy of Mali
PPP	Purchasing Power Parity
PRGSF	Poverty Reduction and Growth Strategic Framework
PRODESS	Five-year Health and Social Development Program
PRSP	Poverty Reduction Strategy Paper
PSN-RSS	National Strategic Plan for Health System Strengthening
RGPH	General Population and Housing Census
RH	Reproductive Health
SHA	Secretariat for Harmonizing External Assistance
SIB	Special investment budget
SWAp	Sector-wide approach
TA	Technical Assistance/Assistant
THE	Total Health Expenditure
TT HATS	Task Team on Health as A Tracer Sector
UNDP	United Nations Development Programme
WAEMU	West African Economic and Monetary Union
WHO	World Health Organization

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Executive summary

Context and definition of issues

Mali is a very poor country but it has nevertheless managed to maintain an economic growth rate of 5% in real terms over the last ten years. It has good macroeconomic and political stability that enabled the Government to undertake a number of reforms that have a bearing on the health sector.

Mali is heavily dependent on official development assistance (ODA) that accounts for some 9% of GDP and 30% of public expenditure. The Government of Mali gives priority to budget support, which has greatly increased since the beginning of the 2000s and which now represents just over 40% of ODA.

Despite an improvement in the main indicators over the last decade, the health situation of Mali's population continues to be of concern, and demographic pressure presents a major challenge for the provision of social services. Health policy is operated through the Health and Social Development Programme (PRODESS).

The proportion of the State budget allocated to health has increased in recent years, currently standing at 8.4% of total State budget allocations. The State budget is the main source of PRODESS funding. External project funding rose steadily to 2007 and then saw a sharp drop in execution in 2008 and 2009.

About 50 donors are involved in the health sector, posing major challenges. Since the launch of PRODESS in 1999, it has been managed using a sector-wide approach, whereby all stakeholders – government, donors and civil society – support the same programme through an institutionalized process piloted by permanent government structures.

To what extent have aid effectiveness principles been put into practice in the health sector?

The fundamental mechanism for putting aid effectiveness principles into practice is the sector-wide approach that has governed PRODESS and which is based on the following components:

- PRODESS, its strategic companion documents and the MTEF that translate them into budgetary terms define coherent sectoral strategies and constitute the unique programming framework of the sector;
- PRODESS steering bodies constitute the sole sectoral coordination framework, directed by the Government of Mali and drawing heavily on the participation of civil society;
- PRODESS is by the.
- PRODESS implementation and results monitoring is carried out jointly by steering bodies.

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The sector-wide approach has achieved rapid progress and has been consolidated over time, especially following the signing in April 2009 of the IHP+ national Compact that formalizes the commitment of the GoM and 13 donors to jointly support the PRODESS in a common framework. In addition, other changes in the methods used to implement aid effectiveness principles have filtered down to the health sector from the central level, particularly where budget support is concerned. All in all, the aid effectiveness principles have been put into practice as follows:

- National stakeholder ownership of PRODESS has been strengthened significantly, constituting one of the "quick wins" of the sector-wide approach, placing the Government of Mali in command of the sectoral programme bodies, while allowing wide participation at the regional level of civil society and the donors. The PRODESS "bottom-up" planning process and the annual joint monitoring mission help to consolidate ownership at the operational level. Collaboration with the Ministry of Economy and Finance (MoEF) and other ministries has also been reinforced. The IHP+ Compact preparation and monitoring process has introduced a highly inclusive work dynamic, which is now institutionalized.
- Leadership of sectoral development management and stakeholder coordination has also been strengthened. The capacity of the standing PRODESS secretariat has been boosted to help it accomplish its mission. A virtuous circle has developed between the components of the Paris Declaration: alignment with the national programme has underlined the need to strengthen the capacities of the Planning and Statistics Unit (CPS) and concurrent support has reinforced its leadership and its capacity to direct the programme
- Regarding alignment on national strategies, all external funds dedicated to the health sector are inscribed in the PRODESS, except for certain marginal interventions (except for the recent building by China of a new hospital in Bamako). However, at the operational level, certain interventions by donors are not totally integrated into the normal activities of health-care structures.
- Regarding alignment with national procedures, the specific "PRODESS" procedures are largely inspired by national MoF procedures but leave more management freedom to MoH structures – that is why the latter prefer PRODESS procedures to SBS that is managed by MoF services. The four aid options favoured by the IHP+ Compact (general and sectoral budget support, PRODESS procedures and HACT) have led to progress in terms of alignment with national procedures for financial management. However, donors still proliferate and a large number of projects targeting specific health problems with their own procedures (in particular, the Global Fund) are still managed within the sector. Although there were initial problems with the management of sectoral budget support, partners have searched for solutions to improve its management and support public financial management more extensively; in this way, collaboration with the MoEF was strengthened significantly.
- General and sectoral budget support is submitted within a harmonized framework and further progress on harmonization can be seen in the common coordination and planning process, annual joint monitoring

missions and the agreement on a common PRODESS monitoring matrix. Donors increasingly organize activities jointly to support the MoH.

- The focus on monitoring and management based on results in the health sector as a whole began with the launch of the sector-wide approach in 1999 and has been progressively strengthened under the influence of the PRSP (2002), European Commission general budget support (2003), sectoral budget support (2006) and the IHP+ Compact (2009). Thirty-five indicators in the PRODESS M&E matrix were chosen to create a common monitoring framework, now monitored by all participants through the steering bodies. In recent years, the focus of policy dialogue has shifted to strategic priorities.
- Mutual accountability is mainly exercised by the PRODESS steering bodies, which bring together all the ministries involved, civil society and donors. The IHP+ Compact preparation process has strengthened the common work dynamic and the framework for sectoral dialogue now has a stronger focus on monitoring results and problem analysis. The IHP+ Compact defines the respective commitments of the government and donors, and the monitoring of its implementation has reinforced mutual accountability. Improvements are also noticeable with the increase in sector resources, including the budget and PRODESS audits.

Result no.1: Has aid effectiveness improved in practice?

- The resources allocated to PRODESS in the national budget have greatly increased since 2008: State budget allocations passed from 43.4 billion XOF (nearly entirely executed) in 2007 to 61.4 billion in 2008 (of which 50 executed), and have maintained that level up to now. That suggests that the sector indirectly benefits from general budget support. However, external financing, excluding sectoral budget support for the health sector, dropped dramatically in 2008 and especially in 2009 (executed external financing passed from 31.3 billion XOF in 2007 to 6.8 billion in 2009) the sense that donors providing SBS consequently reduced their project aid.
- *Ex ante* aid predictability (that is, regarding pledges) has improved, but disbursements are often made late in the year, delaying the execution of activities. On the other hand, *ex post* predictability (that is, regarding execution) of aid from projects, which can be estimated by comparing funding in operational plans and their execution, was very weak in 2008 and especially in 2009 (6.8 billion XOF executed out of 37.9 pledged). Those discrepancies may be due to several reasons: disbursements may be blocked or late, structures may not able to execute the funds that have been mobilized, or funding may arrive halfway through the year without previous allocation for use.
- Sectoral coordination entails certain transaction costs for the Government of Mali and donors, but these costs create added value in terms of confidence and improved coherence of interventions, and can therefore also be considered as an investment. The switch to sectoral budget support did not decrease transaction costs, on the contrary. Yet, the experience acquired by the MoH in steering the sector-wide approach and monitoring budget support has reduced certain costs over time, but Mali's authorities still bear

significant non added-value-creating transaction costs from large projects containing ad hoc procedures that are still managed in the sector, in particular those of the Global Fund.

- The sector-wide approach and the introduction of general and sectoral budget support have highlighted the need to strengthen capacity for strategic analysis, programming, financial management and sector monitoring and evaluation, and have attracted technical assistance (TA) with a greater focus on systemic needs (statistics, financial management, etc.). Since the development of the 2008 Strategic National Plan on this area, these HSS support efforts have been more coherent, although TA interventions are still provided bilaterally.

Result no. 2: Has the health system been strengthened?

While increasing attention is given to HSS, this process also requires behavioural changes at the operational level, and therefore takes time. Practical results are therefore expected in the medium-term, but various elements already appear to be on the right track:

- Several problems persist within the health sector, at the sectoral governance, analysis and planning level, but a number of improvements have been noted in recent years. Thus the health sector programming and planning process is very participative and has improved in the last few years. Donors and civil society have been involved in priority-setting and strategy formulation. The evaluation of the PDDSS and the preparation of the new plan are also very participative.
- In terms of funding, the health budget structure has become more decentralized, stimulated in part by dialogue between PRODESS monitoring bodies and sectoral budget support committees. Regarding financial management, while procedures specific to PRODESS give greater management freedom to MoH structures, sectoral budget support initially caused various problems. Nevertheless, its monitoring highlighted various financial management problems and thus gave the MoEF a greater role in sectoral discussions, in order to find solutions. Various problems have been resolved through this coordination initiated by sectoral budget support. Furthermore, sectoral budget support has encouraged the MoEF and donors to pay greater attention to the intrasectoral allocation of resources, with a view to using them more effectively.
- Coverage in terms of infrastructures significantly improved, particularly in initially disadvantaged regions.
- The issue of human resources continues to be a major concern for the sector. This was the subject of an intense discussion in the context of PRODESS monitoring, which benefited from the support of various donors. However, most of the strategies included in the strategic plan have not yet been put into practice and great inequalities remain in the distribution of health-care personnel between Bamako and the regions.
- The implementation of various strategies has improved the availability of and access to essential medicines. However, despite the existence of a public

supply system, various other systems coexist and their mode of distribution varies.
- The National Health Information System (NHIS) has benefited from various sources of assistance. The local system is now computerized up to the health district level and data collectors' capacities have been enhanced. Collaboration has also been begun with the private sector to include it in data collection exercises.

Result no. 3: Have health services improved?

This progress at the level of individual health system components has improved the population's access to health services and their use. Access to health care at 5km rose from 44% in 2002 to 57% in 2009. Most of the outcome and impact indicators have improved: health-care services are increasingly used (curative consultation rate rose from 0.21 in 2002 to 0.37 in 2009; ANC from 54% in 2002 to 90% in 2009; assisted deliveries from 40% in 2002 to 66% in 2009), and in an increasingly equitable way, throughout national territory and among poverty quintiles. Progress has been recorded at the impact level (MMR decreased from 577 for 100.000 births in 1996 to 464 in 2006; under-five mortality rate decreased from 237.5 in 1996 to 190.5 in 2006). The PDDSS evaluation concludes that PRODESS has globally contributed to a positive impact on MGD. The view of participants interviewed is that, in general, things are going in the right direction, even though uncertainties remain regarding governance and the efficiency of spending.

Recent evaluations conclude that the increase in coverage by community health centres and qualified health personnel have doubtlessly contributed to an improvement in outcomes, as well as the scaling-up of high-impact strategies and strategies that aim to improve access to health services for the poor, women and children. These strategies constitute new priorities under the extended PRODESS II, which is strong confirmation of the relevance of the national strategy in terms of outcomes, and pleads in favour of a strengthened alignment with this strategy. However, not everything is perfect and a certain number of structural constraints persist, for example affordability, operational management of community health centres and hospitals, and inefficient management of resources.

What factors were decisive in achieving these results? What constraints were encountered and how were they overcome?

A number of achievements, in terms of changes in behaviour and practice in the implementation of aid effectiveness principles *specific to the internal dynamic of the health sector*, are at the origin of the progress seen. The sector-wide approach launched in 1999 has led to significant progress, in particular:
- It has considerably reinforced stakeholder (including civil society) ownership over national policy, MoH leadership and coordination of donors.

Subsequently, there has been better coordination between the interventions of different actors, thus guaranteeing increased aid effectiveness.

- It has highlighted the need to strengthen the capacities of the MoH in terms of analysis, planning, implementation and monitoring/evaluation, thereby justifying various forms of systemic institutional support. In turn, strengthening these capacities has helped the MoH assume its leadership in the sector.
- The quality of sectoral dialogue in the context of PRODESS support, which is increasingly evidence-based, has improved markedly. This dialogue highlights various critical issues in the system (human resources, reduction of regional disparities, PFM…), which have been the subject of many discussions and, in particular, of reforms carried out by the MoH, often with the support of donors. Yet, the intensity of sectoral dialogue depends partially on the personal involvement of some donor representatives.
- Confidence among participants and the global vision of the sector have been reinforced. Many partners are now seeking to join to carry out common activities in support of the MoH. This positive dynamic will probably facilitate the common resolution of problems arising from the implementation of the programme.

Following on from the sector-wide approach, the intense preparation process for the IHP+ Compact and its supporting documents has been a catalyst for significantly strengthening the common work dynamic within the MoH and with the donors and civil society. This way of proceeding has now become entirely institutionalized. The follow-up of the Compact commitments during the PRODESS steering bodies has also empowered the latter.

The common bottom-up planning process has improved coordination between stakeholders, including the donors, community partners, civil society and local authorities. In recent years, this process has also seen improvements such as better targeting of priorities and a greater attention to the analysis of results.

The supply of increasingly coherent HSS assistance is gradually falling into place in support of the national HSS plan (rather than isolated HSS queries) and promises further progress in the future, as is the case with collaboration with the private sector, which has recently been initiated by the MoH.

Various other factors, linked to the implementation of aid effectiveness principles *at the national level, but having filtered through to the health sector,* have also contributed to progress. Especially, sectoral budget support has not led to expected added values in terms of alignment and reduction of transaction costs, but it has introduced the practices of monitoring a matrix of performance indicators linked to annual targets, improving the quality of information provided and analyses carried out by the MoH, expediting the agenda on devolution/decentralization and reinforcing collaboration between the MoH and the MoEF. This may be the reason for the increase in the proportion of the State budget devoted to the health sector in recent years.

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Conclusions

Important progress has been made on the implementation of aid effectiveness principles in the health sector in Mali. Various achievements have been noted as regards changes in behaviour and practice, both by the government and by a number of donors; these have, in all likelihood, helped to improve the system and the health sector results. However, out of the 50-like donors active in the sector, only 13 have signed the Compact and only 3 are doing SBS, which is probably insufficient to influence global alignment, and the drastic fall in external financing since 2008 is of great concern and threatens to have a negative effect on results. Furthermore, there is some evidence of a "two-speed implementation" of the principles of the Paris Declaration and IHP+. These have, until now, been implemented only in part, while certain forms of behaviour contrary to these principles persist among a large number of stakeholders: donors continue to proliferate; many donors are pressing ahead with ad hoc targeted projects and persist in using project management units and ad hoc procedures; likewise, they do not provide notification of their funding intentions (as they should), nor are disbursements made on time; they persist in organizing bilateral missions from their headquarters and ad hoc audits, and TA interventions are carried out on a bilateral basis. This inability to change behaviour means that expectations regarding the outcomes of aid effectiveness principles should be tempered with realism. At the bottom line, until now, few results have been achieved in terms of alignment with national procedures on financial management, aid predictability, more resources for health (quite the contrary), or mutual accountability.

Mali's health sector authorities currently face a number of significant challenges, specifically preparing a new health development plan, improving financial management procedures, persuading donors to align themselves with and put the principles of the IHP+ Compact into practice effectively. Only under these conditions will the full potential of the agenda to improve aid effectiveness be realized, achieving results in line with expectations.

1. Introduction

This case study is part of a joint initiative by WHO, the World Bank and IHP+ to document the results of efforts to implement health aid effectiveness principles in various countries. It aims to answer three questions:
1. To what extent have aid effectiveness principles been put into practice in the health sector?
2. Has this helped to improve results?
- Has aid effectiveness improved in practice?
- Has the health system been strengthened?
- Have health services improved?

3. What factors were decisive in achieving these results? What constraints were encountered and how were they overcome?

This type of analysis creates inevitable methodological challenges. Here we have tried to find the *plausible links* between the changes in government and donor methods and aid effectiveness, and identify how these changes have contributed to strengthening the health system and services. This analysis is based on a literature review, interviews and data from the national health information system and surveys.

This case study is mainly based on a documentary analysis, using various documents drawing on Malian experience of the health sector-wide approach, co-drafted by the health sector Planning and Statistics Unit (CPS) [Samaké 2009; Samaké et al. 2011; CHPP], and interviews carried out by the consultant in October 2010 as part of a budget support evaluation [Lawson et al. 2011], in January 2011 for the preparation of the final report on the Task Team on Health as a Tracer Sector (TT HATS) [Samaké et al. 2011], by telephone interviews in May 2011 and finally, in October 2011 for the finalization of this study. It is also based on data from the National Healthcare Information System (NHIS), surveys and various evaluations – especially the final evaluation of the Ten-Year Health and Social Development Plan (PDDSS).

2. Context and definition of issues

2.1 Socioeconomic and political country environment

Mali is a vast landlocked country with an area of 1.2 million km^2, located in the Sudano-Sahelian region of Western Africa. Its economy is poorly diversified and vulnerable to climactic conditions. It is part of Economic Community of West African States (ECOWAS) and West African Economic and Monetary Union (WAEMU). With a Human Development Index of 0.309 in 2010 (160th out of 169), **Mali remains one of the poorest countries in the world [**UNDP-HDR**].**

Nevertheless, it has succeeded in maintaining a stable macro-economic environment over the last ten years and annual real GDP growth of approximately 5% [Lawson et al. 2011]. According to IMF estimates, real GDP growth should stay at around 4.5% in 2010 [IMF, 2011]. That strong growth enabled to reduce poverty in recent years. Monetary poverty incidence decreased from 47.5% in 2006 to 43.7% in 2009, that is an 8% reduction in three years [DNSI quoted in MEF/SHA 2011].

After the revolution in March 1991, Mali began a process of democratization. The Constitution of the Third Republic, adopted in January 1992, established a multi-party system and other civil and social rights. A series of institutions were established and, since then, elections (presidential, legislative and municipal since 1999) have been held regularly. The second and final term of office of the current president, Amadou Roumani Touré, will continue until 2012. **Political stability** has enabled the government to implement a number of programmes to improve the socioeconomic and human rights situation; many of these programmes have had an impact on the health sector.

A process of **administrative decentralization** at the end of the 1990s, led to the creation of local authorities: 703 communes, 49 districts and 8 regions in addition to the District of Bamako. Various powers were transferred to them, particularly in the areas of health and education. Decentralization is a strong political option of the Government of Mali (GoM) but it is difficult to implement, notably because of some incoherence with sectoral policies as well as lack of capacities in many local authorities. Thus the transfer of the resources required to carry out these responsibilities is not yet complete. A state reform process is also under way, focusing on greater devolution of activities and resources from the sectoral ministries (central level) to their regional directorates. This is particularly important in face of the huge territory and the traditional bias towards the capital city (at the expense of regions) observed in public expenditure. These two reform processes interfere with the health policy. It should be noted that the decentralization of powers to local governments in the health sector is not yet entirely effective and in practice there are various grey areas regarding the sharing of responsibilities between local authorities, the Community Health Associations (ASACO) and the regional State services.

The first **Poverty Reduction Strategy Paper** (PRSP) was implemented over the period 2002-2006. The second, Poverty Reduction and Growth Strategy Paper (PRGSP), covers the period 2007-2011 and is based on three main strategic areas: (i) the development of infrastructure and the production sector; (ii) the implementation and consolidation of structural reforms; (iii) the reinforcement of the social sector. The PRGSP was used as a basis for the development of the 2008-2012 Economic and Social Development Programme (PDES) of the President of the Republic. In 2011, consultations are under way for the preparation of the third PRSP.

Since 2005, the Government of Mali has been implementing a Government Action Plan for Improvement and Modernization of Public Finance Management (PAGAM-GFP). This has led to a number of important achievements, but various

projects remain unfinished. According to the successive evaluations carried out on these areas, the quality of public finance management (PFM) has improved markedly over the last decade, especially in terms of budget credibility and budgeting based on development policies. However, serious problems remain regarding the effectiveness of the control and monitoring functions of the treasury and public accountants [ECORYS, 2010]. The second stage of PAGAM/GFP (2011-2014) is perfectly in line with the PRGSP and the Institutional Development Plan of the State of Mali. This is an ambitious action plan to modernize public finance management to encourage transition from project aid to budget support. Strengthening budget execution and public accounting systems is a priority of the new phase of action, as is the strengthening of budgetary decentralization, the decentralization of the procedure of public procurement and the reinforcement of regional line management, with a view to better supporting the decentralization effort. Results-based management and the implementation of sectoral medium-term expenditure frameworks (MTEF) are also part of this phase [ECORYS, 2010].

2.2 Global development assistance environment

Mali is heavily dependent on official development assistance (ODA). Firstly, it should be noted that the ODA figures do not tally and are not comprehensive. According to the statistics produced by the DAC/OECD on the basis of reports by donor countries, Mali received 0.8% of total ODA over the period 2000-2009, or 808 million USD (2008 current prices) per year over that period: 964 million in 2006, 1089 million in 2007, 964 million in 2008 and 1014 million in 2009 [DAC/OECD, CRS]. According to the data collected by the Government of Mali, on average, ODA represented nearly 9% of gross domestic product (GDP) over the period 1999-2008 and more than 30% of total public expenditure over the period 2003-2009.

Since the mid-1990s, the Government of Mali has been trying to improve aid effectiveness, in line with the work of the Development Assistance Committee of the Organization for Economic Cooperation and Development (DAC/OECD).[1] Mali is a signatory of the Paris Declaration and Accra Agenda for Action. In March 2007 it finalized a *National Action Plan on development assistance effectiveness - Paris Declaration 2007-2009* and in April 2008, a *Ten-year action plan to achieve the Millennium Development Goals (MDGs) 2006-2015.*

Following the development of the first PRSP in 2002 and the Rome Declaration on the harmonization of aid in 2003, **the option of switching to budget support was chosen at the end of March 2004,** during the Round Table Conference of Mali Donors in Geneva. The Government of Mali accordingly developed a harmonized framework for the provision of budget support,

[1] At the end of the 1990s, Mali also underwent a pilot study on aid options and is one of the three pilot countries in which the new DAC/OECD budget support impact evaluation methodology was tested in 2009-2010.

including a framework arrangement (signed in March 2006) and specific arrangements for general budget support and for sectoral budget support operations.[2] Budget support has increased significantly over the last ten years, from 12% of total ODA in 1999 to 42% in 2009. In 2009, Mali received general budget support and/or sectoral budget support from ten donors, four of which supported the health sector.[3] The total value of budget support disbursed over the period 2003-2009 was of approximately 635 billion CFA francs (CFAF), or 968 million euros [Lawson et al. 2011].

Table 1: External funding (percentage of GDP)

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Total external funding	**9.2%**	**10.4 %**	**9.1%**	**8.5%**	**8.6%**	**7.1%**	**8.1%**	**9.4%**	**9.8%**	**6.0%**	**9%**
Budget support	**1.1%**	**2.1%**	**1.2%**	**2.2%**	**3.5%**	**1.3%**	**2.2%**	**3.9%**	**3.4%**	**2.8%**	**3%**
General budget support donations	0.8%	1.7%	1.2%	0.7%	2.1%	1.3%	1.6%	1.4%	1.2%	0.6%	1%
Sectoral budget support donations	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.2%	1.4%	1.4%	1%
General budget support loans	0.3%	0.4%	0.0%	1.4%	1.4%	0.0%	0.7%	1.3%	0.8%	0.7%	1%
Projects	**8.2%**	**8.3%**	**7.9%**	**6.3%**	**5.0%**	**5.8%**	**5.9%**	**5.5%**	**6.4%**	**3.2%**	**6%**
Donations	3.8%	3.6%	3.3%	3.1%	2.5%	2.7%	2.4%	2.4%	2.6%	1.4%	3%
Loans	4.4%	4.7%	4.6%	3.2%	2.6%	3.1%	3.5%	3.1%	3.8%	1.8%	3%

Source: Lawson et al. (2011) based on data from the Ministry of Finance/Treasury

Progress has been achieved since 2002 with respect to **development assistance coordination**, following the PRSP monitoring and evaluation [MEF/SHA, 2011]. The main State structures in charge of donor coordination are the Secretariat for Aid Harmonization (SHA) and, indirectly, the PRSP Technical Coordination Group. Donors are organized in a donor group, whose deliberative body is the Group of Donors, which is headed by a Troika (comprising the lead partner, its predecessor and successor). The Group generally meets once a year to coordinate the annual report and programming, and holds additional monthly coordination meetings. A technical pool directs the work of the donor group's secretariat. In addition, a joint coordination and political dialogue framework exists between the Government of Mali and donors under the PRGSF monitoring procedure, which brings together the Mali-Development Partners Joint Commission, the annual review of the PRGSF and the joint budget review. These general coordination bodies are supplemented by various sectoral coordination bodies comprising a dozen thematic groups, three cross-cutting groups and a number of subsectoral working groups [see http://www.mali-apd.org]. It should be noted that the health sector coordination mechanism preceded the general donor mechanism, but was incorporated into the latter when it was established.

[2] Mali receives sector budget support for the sectors of health and social development, education, decentralization and State reform, and public finance management.

[3] The Netherlands and Sweden have provided sectoral budget support since 2006, Canada since 2007 and Spain since 2009, but Sweden abandoned sectoral budget support to switch to general budget support only in 2011.

As regards donor coordination, a Common Country Assistance Strategy (CCAS) 2008-2011 was developed by the donors involved in the country and the Government of Mali, with input from civil society. The CCAS has the following specific objectives;

a) Support the implementation of the PRGSF by aligning the assistance of donors with the priorities defined in the PRGSF, the PDES and the ten-year MDG plan;
b) Improve the general effectiveness and efficiency of aid to the Government of Mali through better programming and predictability of international aid, better alignment with national systems and procedures, better harmonization and coordination of aid (procedures, options and conditions) to reduce the transaction costs borne by the Government of Mali, better coordination and division of labour between donors, joint monitoring of development results with the Government of Mali and accountability for these results vis-à-vis respective public opinions.
c) Develop a more effective and cooperative framework for dialogue with the Government of Mali by improving existing coordination/collaboration frameworks and mechanisms;
d) Develop a coordinated approach to strengthen systems/procedures and national capacities;
e) Direct the institutional framework towards ensuring good governance of the CCAS based on information sharing, continuous dialogue, the participation of the various stakeholder families and transparency in decision-making [CCAS].

Despite important progress achieved in recent years in terms of aid effectiveness in Mali, the main weaknesses that persist and have been identified by the recent national evaluation of the Paris Declaration (Phase 2) deal with:

- Weaknesses in the aid coordination mechanism;
- Lack of clarity of roles of the structures in charge of aid management as well as difficulties in aid accountancy;
- Weaknesses in reporting for better accountability of ODA resource use towards citizens;
- Insufficient power delegation from donors' headquarters to their local offices;
- Little aid predictability;
- Unwillingness of some donors to align on national procedures;
- Unwillingness to reduce the number of parallel management units [MEF/SHA, 2011].

2.3 Main health and systemic challenges and political priorities in the health sector

2.3.1 Health Situation

Despite an improvement in the main outcome and impact indicators over the last decade, **the health situation of Mali's population continues to be of concern.** A third of under-fives suffer from chronic malnutrition and maternal mortality is still high (EDS.M 2006). Analyses show that Mali is not on track to meet the MDGs in 2015: it could achieve five out of the eight MDGs through political changes (eradicate extreme poverty and hunger; achieve universal primary education; promote gender equality and empower women; reduce child mortality; combat HIV/AIDS, malaria and other diseases), but is clearly off-track in terms of improving maternal health [UNPD/MDGMonitor]. In 2009, more than 40% of the population still lived more than 5km away from a health centre, skilled delivery attendance coverage, although on the rise in recent years, was on average only 66% (but only 29% in the regions of Gao and Kidal), and the average rate of use of health services was of 0.37 new consultations per inhabitant per year [NHIS Yearbooks]. In absolute terms, the principle causes of mortality, registered by health centres, are suspected cases of malaria, malnutrition, suspected cases of infectious diarrhoea, coughs under 15 days and acute lower respiratory illness, wounds and injuries [NHIS]. It should be noted that **demographic pressure is a major challenge for the provision of social services in Mali**. The General Population and Housing Census (RGPH) of 2009 shows that Mali had a resident population of 14.5 million in 2009, compared to 9.8 million in 1998, representing an average annual increase of 3.6% over the period 1998-2009 [INSTAT/BCR 2009]. The two tables below give an overview of the development of various health indicators in Mali in recent years. These aggregate figures conceal significant regional discrepancies, although these are generally decreasing (see subsection 4.3). It should be noted that the coverage rate and the rate of use of health services are based on the population prior to the last census, and largely underestimated. The real rates are therefore lower than those indicated here.[4]

Table 2: Trends in various health sector coverage and use indicators, 2002-2009 (routine data)

	2002	2003	2004	2005	2006	2007	2008	2009
% pop. living within 5 km of a functioning health facility	44	46	48	50	51	58	58	57
% rural pop. living within 15km of a health facility offering MPA + advanced strategies	68	69	72	75	76	79	80	88
Rate of use of medical consultations (new cases/population/year)	0.21	0.23	0.25	0.26	0.26	0.29	0.33	0.37
Rate of prenatal consultations (%)	54	59	75	75	75	78	84	90

[4] Figures calculated retrospectively on the basis of new population estimates are, however, not yet available.

Percentage of births attended by skilled personnel (%)	40	42	49	53	55	58	63	66
Rate of use of family planning services (%)	2.98	2.71	2.36	3.16	3.76	4.17	4.05	4.55
Immunization coverage DTCP3 (PENTA 3) < 1 year (%)	74	79	90	91	92	94	94	101
Measles immunization coverage < 1 year (%)	64	72	78	78	82	89	91	98
Cases of malaria treated at health facilities (millions)	0.72	0.81	0.85	0.96	1.02	1.29	1.33	1.29
Tuberculosis detection rate (%)	17.9	19.1	19.0	21.0	26	26	27	29

Sources: LHIS Yearbooks 2002 to 2007; NHIS and LHIS Yearbooks 2008 and 2009

Table 3: Principal health-care impact and coverage indicators, 1996-2006 (survey data)

	1996	**2001**	**2006**	**2010**
Maternal mortality rate / 100 000	577	582	464	
Neonatal mortality rate / 1000	60	57	46	
Infant mortality rate / 1000	122.5	113.4	95.8	
Under-five mortality rate / 1000	237.5	229.1	190.5	
Prenatal care rate	46.9	56.8	70.4	
Rate of births attended by skilled personnel	40.0%	40.6%	49.0%	56.0%
Total fertility rate	6.7	6.8	6.6	
Knowledge of Family Planning (FP) Methods	65%	76%	75%	
Contraceptive prevalence rate (modern FP methods)	4.5%	5.7%	6.9%	8.0%
Underweight ratio in under-fives	40.0%	33.2%	26.7%	18.9%
Immunization coverage rate 12-33 months (measles)	50.8%	48.7%	68.4%	73.0%
Immunization coverage rate 12-33 months (DTP3)	37.5%	39.6%	61.9%	72.1%
HIV prevalence	0.03%	1.70%	1.30%	

Sources: EDS.M III (1996), IV (2001) and V (2006)

2.3.2 National health policy

Health is a priority area for the Government of Mali, identified both in the PRGSP and in the PDES of the President of the Republic. The **Population and Health Sectoral Policy** (PSSP), which is the reference guideline for health sector strategies, was adopted in December 1990. It is based on a comprehensive approach, including the principles of primary health care and the Bamako Initiative, thus establishing cost-recovery and a system of health districts. It also develops the contractualization of health-care services with Community Health Associations (ASACOs), which are responsible for managing community health facilities, the first level in the health-care pyramid. [5]

The Malian **health system** has a pyramid structure, based on the health-care district system, comprising three levels:

[5] For an analysis of health sector reforms in Mali since the end of the 1980s, resulting in the current policy, see Maiga et al. (2003).

- The peripheral or operational level, essentially made up of community health facilities, referral health facilities and private establishments;[6]
- The regional or intermediary level, comprising health authorities (Regional Health Directorates) and public hospitals operating on a second referral basis;
- The central level, comprising, on the one hand, the health authorities (central directorates and affiliated services) and, on the other, tertiary-level public referral hospitals and other research establishments.

The sectoral policy is implemented through the 1998 Ten-Year Health and Social Development Plan (PDDSS), which is also divided into two 5-year plans, managed, since they were launched, through a sector-wide approach (SWAp), which has become consolidated over time (see below). The first **Health and Social Development Plan (PRODESS)** was implemented from 1999-2004. It was based on five themes, the first – extension of health-care coverage – eventually being accorded priority. PRODESS II, which was launched in 2005, had two components, the first relating to health and the second to social development. The PRODESS II health-care component is made up of seven sections: (1) geographical access to health district health-care services; (2) availability, quality and management of human resources; (3) availability of basic medicines, vaccines and medical consumables; (4) improvement of the quality of health-care services, increase in demand and better disease control; (5) affordability, demand and participation support; (6) reform of hospitals and other research establishments; (7) strengthening of institutional capacities and decentralization [PRODESS II]. It should be noted that it was PRODESS that sustained the national health strategy, subsequently recycled by PRSP I and II and PDES, thus guaranteeing perfect coherence between these policies.[7]

PRODESS II, which should have been completed in 2009, has been extended until 2011, to align itself with PRGSF objectives. The emphasis has been

[6] For some years the private sector has been expanding and participates actively in health-care coverage. However, the data generated by this sector is still not sufficiently taken into account in the national health information system, and official collaboration between the Ministry of Health the private sector is only just beginning. A diagnosis of private medicine in Mali shows that it is characterized by:

- Its unequal distribution in the country (the proportion of private doctors established in Bamako is estimated at 70%), which limits the market's capacity for absorption and leads certain medical service providers to offer lower quality care;
- Its poor coordination with the public sector, which inhibits its public-service role of training and immunization and does not produce synergies between private and public health-care facilities;
- Challenges by certain private operators of the validity of categorization of health-care establishments, which affects the contribution of the private sector to public health objectives;
- A lack of assistance for establishment and support in respect of funding and training needs [BCG/IFC 2001].

[7] However, the decentralization policy has not yet been implemented in total coherence with sectoral policy.

placed on various priorities that have assumed greater importance in recent years, in particular the reduction of maternal, neonatal and under-five mortality and morbidity. To speed up the attainment of these objectives, innovative strategies have been implemented in a number of areas (free caesareans, free management of malaria in under-fives and pregnant women, etc.). Some priorities have led to the development of specific policies, in particular the National Policy and the National Strategic Plan for the Development of Human Resources for Health, and the National Strategic Plan for Health System Strengthening. Aside from these routine activities, 2011 is devoted to the PDDS final evaluation and the development of the next health development plan.

2.3.3 Health Financing

According to the latest national health accounts (CNS) going back to 2006, total health expenditure in Mali is financed mainly by private funds (55% in 2004), with public funds accounting for 22% and external partners 14%.

Table 4: Health financing structure, 1999-2004

billion CFAF	**Public Funds**		**Local authorities**		**Private Funds**		**Rest of the World**		**Total**	
Year	Total	%	Total	%	Total	%	Total	%	Total	%
1999	14.6	13	2.9	3	83.0	76	8.8	8	109.4	100
2000	19.0	16	3.9	3	86.4	73	9.3	8	118.8	100
2001	23.5	17	8.0	6	84.6	60	25.2	18	141.4	100
2002	21.8	15	6.6	5	94.9	66	20.8	14	144.2	100
2003	29.4	20	13.2	9	89.2	60	18.0	12	149.8	100
2004	36.4	22	15.1	9	91.0	55	22.8	14	165.3	100

Source: CNS 2006

The WHO Statistical Information System (WHOSIS)/ *Global Health Observatory* (GHO), updated in April 2011, provides the following information about the principal health finance indicators in Mali over the last ten years.

Table 5: Selection of indicators relating to health financing in Mali

	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**
Total health expenditure (THE) as % of GDP	6.3	6.4	6.3	6.3	6.3	6.1	5.9	5.8	5.6	5.6
External resources allocated to health as % of THE	7.8	17.8	14.8	11.7	13.8	15.2	21.8	22.0	22.2	25.6
General government expenditure on health (GGHE) as % of THE	32.9	44.9	40.2	44.1	49.2	46.8	48.5	48.4	47.1	47.9
GGHE as % of General government expenditure	9.6	13.6	10.4	12.3	13.0	11.3	11.5	11.2	11.1	9.3

THE per inhabitant PPP (NCU in US $)	49	58	50	53	59	62	65	64	65	66
GGHE/ inhabitant PPP (NCU in US $)	16	26	20	24	29	29	31	31	30	32

Source: WHOSIS/GHO

With regard to public expenditure, in recent years the health sector has represented 7% of the general State budget and approximately 11% of recurring costs. The share of the State budget allocated to health has tended to increase in recent years, benefiting from budget support resources [Lawson et al. 2011]. Accordingly, the health sector received budget contributions of CFAF 96.8 billion in 2010 and CFAF 112 billion in 2011, representing 7.6% and 8.4% of total State contributions respectively [MEF/DGB].

Following the decision to change to budget support and the signing of the framework agreement in March 2006, a specific agreement between the Government of Mali and development partners on sectoral budget support to assist the health and social sector*s* was signed on 19 July 2006. The Netherlands and Sweden began pledging sectoral budget support to PRODESS in 2006, Canada in 2007 and Spain in 2009.[8] Yet, Sweden stopped its sector budget support in 2011 to concentrate solely on general budget support.

2.4 The main aid effectiveness challenges in the health sector that efforts to implement the Paris principles have attempted to address

A very large number of donors are involved in the health sector: no less than 50 are involved in PRODESS operational plans. They mostly use ad hoc procedures, which evidently pose significant challenges in terms of coordination, coherence and alignment with national policies and systems and of accountability. It is particularly difficult to estimate the total ODA allocated to this sector, as certain projects (especially those financed by NGOs) are not accounted for by the Government of Mali. Furthermore, data from various sources attempting to calculate aid shows areas of inconsistency. The Ministry of Economy and Finance (MoEF) (Budget and Treasury) monitors disbursements for budget support and projects that pass through the Special Investment Budget (SIB), but the Administrative and Financial Directorate (DAF) of the MoH collects additional information on projects through planning tools and PRODESS activity reports. These are more comprehensive than the MoEF reports but also more unpredictable as they depend on data collection tools and the cooperation of donors to communicate their information.

Currently, the main active donors in Mali's health sector are Canada, the Netherlands, UNICEF, the Global Alliance for Vaccines and Immunization (GAVI) and the Islamic Development Bank (IDB). In recent years there have been fewer

[8] A new specific arrangement was signed to support the implementation of the PRODESS II, extended over the period 2010-2011.

direct interventions by the European Commission and the World Bank in financing the sector, following their switch to general budget support in 2003 and 2007 respectively; there has been an increase in participation by Canada, GAVI and the Global Fund; and Spain and IDB have joined the sector's donors. The table and graph below gives an overview of the main active donors in the sector in 2011, with reference to their operational project funding pledges. One observes the important fragmentation of the financing in the health sector.

Table 6: Funding pledges for operational plans within the PRODESS health component, 2011

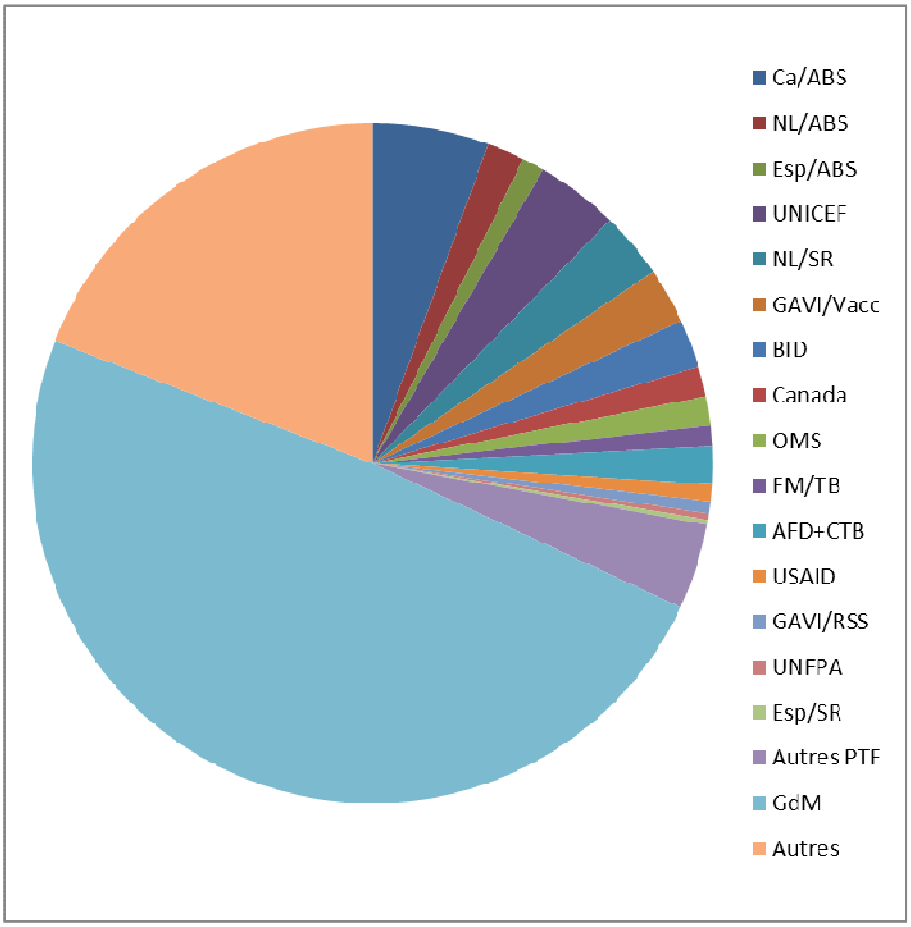
2011	Canada/ SBS	Neth./SBS	Spain/SBS	UNICEF	Neth./Repr.Health	GAVI /Vacc	IDB	Canada	WHO
Billion CFA francs	6,93	2,23	1,312	4,923	3,936	3,33	2,88	1,782	1,744
% of total	5,54%	1,78%	1,05%	3,94%	3,15%	2,66%	2,30%	1,42%	1,39 %

(Cont.)	GFATM /TB	AFD+CTB	USAID	GAVI/ HSS	UNFPA	Spain/ Repr.Health	Other donors	State budget	Other
Billion CFA francs	1,214	2,218	1	0,74	0,371	0,283	5,095	61,174	23,946
% of total	0,97%	0,89%	0,80%	0,59%	0,30%	0,23%	3,40%	48,90%	19,14 %

Source: Administrative and Financial Directorate/MoH, Operational Plans 2011

Graph 1 : Funding pledges for operational plans within the PRODESS health component, 2011

Translated from French



Since the launch of PRODESS in 1999, efforts have been made to improve the coherence of interventions and aid effectiveness. PRODESS has been directed using a sector-wide approach, which means that all the relevant stakeholders - government, donors and civil society - support the same programme through an institutionalized process directed by standing government institutions. The general sector cooperation mechanism is dependent on PRODESS steering, coordination and monitoring bodies, described in the box below.

Box 1. PRODESS steering and coordination bodies

PRODESS is managed by standing institutions of the Malian Government through a thoroughly institutionalized process. Its day-to-day management (planning and evaluation activities) is carried out by the Permanent PRODESS Secretariat, which is based at the Planning and Statistic Unit (CPS) currently shared between three Ministries (Health, Social Development and Women and Family Affairs). The Minister or the General Secretary of the Ministry of Health (MoH) and of the Ministry of Social Development, Solidarity and the Elderly (MoSDSE) jointly direct the PRODESS decision-making bodies. These include the following:

- At the national level, the annual or biennial Technical Committee, is mainly responsible for discussing the activity reports for the previous year and the operational plans for the following year; the results of its studies are submitted to the Monitoring Committee, for its decision; since 2007, this has

been held at the beginning of the year (around May) to permit the alignment of the PRODESS planning process with the State budget;

- The annual Monitoring Committee is mainly responsible for validating reviewed operational plans following the recommendations of the Technical Committee and new pledges by donors.
- The Steering Committee is a small body bringing together the leaders of both ministries and representatives of donors. It meets every two months or upon request to discuss, on behalf of the Monitoring Committee, urgent matters that cannot wait for the annual meeting;
- The PRODESS Regional Orientation and Assessment Committees (CROCEP) at the regional level, in addition to the Management Councils at the health district level, ensure the PRODESS monitoring and programming at the operational level;
- Every year since 2001, PRODESS has also undergone a joint monitoring mission organized by all the partners in two regions and at the central level.

PRODESS annual planning follows a "bottom-up" process, which is nevertheless determined by the advice and constraints set by the PRGSP, MTEF and sectoral priorities, which are reiterated in the guidelines issued by central management to all the structures at the beginning of the process. *At the regional level,* sectoral planning is carried out by the CROCEP. This is a participative process, whereby needs are communicated by Community Health Centres to the health districts, then the regions and the central level - all under the guidance of the latter. *At the central level,* planning is carried out during the National Assessment and Planning Days of the Central Structures. The operational plans for the following year, prepared over these days, are discussed at meetings of the Technical Committee. The PRODESS Permanent Secretariat and planners at the Regional Directorates update the operational plans taking into account the recommendations of the Technical Committee, the Appropriation Bill and all pledges submitted by donors. The operational plans are finally validated by the Monitoring Committee. This process keeps sector planning in line with the budgetary process at a national level.

Donors and civil society participate actively in these bodies. Specifically, civil society is represented by the National ASACO Federation (FENASCOM), PIVOT Group (which heads active national NGOs and certain international NGOs, active in the health sector) and certain larger NGOs. FENASCOM also co-presides the PRODESS technical and monitoring committees. In addition, there is a donor coordination body, which holds a monthly meeting under the direction of a lead partner, who changes every other year[9]; the MoH, the MoSDSE and representatives of civil society are invited to these meetings. Thematic work groups addressing various technical issues (reproductive health, decentralization, human resources, budget support, etc.) involving the MoH, the MoSDSE, civil society and donors, also meet regularly. This is an essential mechanism for enabling the various stakeholder bodies to address specific issues, and has led to the formulation of a number of strategy documents.

[9] The current donor lead partner for health is UNICEF.

Dialogue between stakeholders is therefore continually guaranteed through these different official and unofficial coordination bodies.
Source: Samaké, Salif, Elisabeth Paul, Bruno Dujardin, Ignace Ronse, « L'évolution et la dynamique de l'Approche Sectorielle Santé au Mali », Chapter 1, in Samaké (Ed.), 2009.

The results from the SWAp are developed in the following sections. The main determining events in the implementation of the health aid effectiveness agenda in Mali are summarized in the table below:

Table 7: Time frame for the main events relating to the implementation of health aid effectiveness principles

1998	- Development of PDDSS and PRODESS I[10]
1999	- Beginning of the implementation of PRODESS through a sector-wide approach and the development of its procedural manual
2004	- Development of PRODESS II
2005	- Beginning of the implementation of PRODESS II - National brainstorming workshop on sectoral budget support
2006	- Harmonization of the PRODESS planning cycle with the State budget cycle - Start of sectoral budget support (Netherlands and Sweden) - Start of the initiative « Harmonization for Health in Africa » (HHA) in Mali
2007	- Fourth Demographic and Health Survey in Mali (EDS.M-IV) - Commitment of Canada to PRODESS sectoral budget support and withdrawal of the World Bank from the health sector following its switch to general budget support (it granted PRODESS a special credit in 2007) - Workshop on the implementation of sectoral budget support to the health and social development sectors - Adhesion of Mali to IHP+, signature of the IHP+ Global compact
2008	- Significant increase in the contribution to the MoH in budgetary planning - Registration of sectoral budget support credits allocated to health districts in the 2008 Budget Law - Strengthening of dialogue with MoEF technical services for the mobilization of general and sectoral budget support → creation of a MoEF/MoH/MoSDSE coordination platform ; creation and operationalization of financial facilities for the National Health Directorate, Regional Health Directorates, and Administrative and Financial Directorate; appointment of regional accountants - Decision by the Government to extend PRODESS II to align it with PRGSF objectives - Greater efforts on health system strengthening (HSS) → preparation of the IHP+ Compact and the policy on human resources, submission of a HSS support pledge by GAVI
2009	- Spain commits to PRODESS sectoral budget support - Completion of the revised 2009-2011 MTEF - Signature of the IHP+ Compact (20 April) - The council of ministers approves the policy on human resources (December)
2010	- Incorporation of sectoral budget support committees in the PRODESS steering bodies

[10] On the basis of experience from reforms tested at the end of the 1980s and, in particular, the Health, Population and Rural Water Supply Project (PSPHR) supported by various donors in the 1990s. See Maiga et al. (2003).

Translated from French

	- Preparation of the CHPP portal and final PDDSS evaluation begins - Evaluation of budget support operations in Mali
2011	- Validation of the CHPP, *Joint Assessment of National Strategies* (JANS) and final PDDSS evaluation - New health development plan preparation

Source: *Author's compilation based on Samaké et al. (2009), Lawson et al. (2011)and interviews*

3. To what extent have aid effectiveness principles been put into practice in the health sector?

The main achievements as regards actual implementation of aid effectiveness principles in Mali's health sector are summarized below, indicating, where applicable, the changes in practice and behaviour of the Government of Mali and of donors. Furthermore, it should be noted that the **main instrument for the implementation of aid effectiveness principles is the sector-wide approach directing PRODESS since its launch in 1999, which has been strengthened by the IHP+ Compact establishing joint support for the extended PRODESS**. This SWAp is based on the following components [Samaké et al. 2009; Paul et al., 2009]:

- **PRODESS and its additional policy documents now make up the sole framework defining sectoral strategies.** Its objectives are clear and its guidance is followed by all stakeholders (except for some partners outside the OECD). Under the preparation of the IHP+ Compact, the MoH has steered the production of a number of documents aiming to strengthen PRODESS strategies, such as the National Strategic Plans on the development of human resources (HR) and health system strengthening (HSS), to provide a coherent framework for assistance and development in these areas. PRODESS undergoes an annual "bottom-up" planning process, which involves all the health districts and donors, including NGOs and local authorities.
- **PRODESS is translated into budgetary terms by the MTEF,** which includes all the sector's funding sources.
- **PRODESS steering bodies make up the sole sectoral framework, directed by the Government of Mali**. These bodies are highly participative and are jointly presided by the top authorities of the two ministries involved (MoH and the MoSDSE) and the civil society representative (FENASCOM). While the steering bodies (bi-monthly) constitute a fairly limited assembly, the technical and monitoring committees (annual), where a review of the previous year and planning for the next year are carried out, bring together several hundred participants, including representatives from all national directorates and autonomous public institutions, the regional level, civil society (NGOs and Pivot Group, medical orders, associations, etc.) and the donors. The composition of these bodies has been modified very recently to include the ministry responsible for family matters (under the Health Planning and Statistics Unit) and the private sector. In addition, PRODESS planning and daily monitoring and the coordination of donors, are entrusted to a standing Secretariat governed by a permanent body of the Government of Mali, the Health Sector Planning and Statistics Unit.
- **Monitoring of PRODESS implementation and results is carried out jointly by the steering bodies.** In the context of preparing for the IHP+ Compact, the extended PRODESS II matrix of tracking indicators was revised and 35 fundamental indicators were chosen to make up a

common framework with a greater focus on impacts, especially as regards the MDGs (see Annex 1). The Government of Mali also organizes an annual joint monitoring mission in two regions and at the central level.

The sector-wide approach has led to rapid achievements in terms of stakeholder ownership, coordination and the coherence of interventions, and has become consolidated over time. The SWAp has been strengthened by the adhesion of Mali, in November 2007, to the **International Health Partnership (IHP+),** effected in April 2009 by the signing of the Compact "Scaling up for better health in view of achieving the MDGs" formalising joint support to the extended PRODESS [Samaké 2009].[11] Extended PRODESS II and its policy documents, as well as the MTEF which puts these into budgetary terms, now comprise the **unique health-sector planning framework** governing the IHP+ Compact. However, out of approximately fifty donors active in the sector, only thirteen have signed the IHP+ Compact and only three provide sectoral budget support, which is not likely to create a marked trend in terms of alignment.

It should be noted that this dynamic is specific to the health sector, but that it increasingly involves greater collaboration with other ministries. Furthermore, other changes in the methods of implementing aid effectiveness principles have filtered through to the health sector from the central level, especially with regard to budget support. Below we analyse how the SWAp dynamic, strengthened by the IHP+ Compact, and other initiatives and practical changes, have permitted aid effectiveness principles to be put into practice.

3.1 Ownership and leadership

The national evaluation of the Paris Declaration notes that ownership is most advanced in education, health and macroeconomic management [MEF/SHA, 2011]. Indeed, since its launch in 1999, **national stakeholder ownership of PRODESS has been significantly strengthened. This can be considered as one of the "quick wins" of the sector-wide approach**, placing the Government of Mali in command of the sectoral programme steering, coordination and monitoring bodies, while ensuring extensive participation by civil society and donors at the regional level. A large majority of donors (including international NGOs and even certain donors outside OECD, but not global funds) follow this sector-wide approach and participate in the sectoral coordination mechanism, allowing national authorities to focus on coordination.

The PRODESS "bottom-up" planning process, with annual CROCEP meetings bringing together all the health districts and donors, including community partners (NGOs) and local authorities, contributes significantly to stakeholder ownership up to the operational level, as does the annual joint monitoring

[11] Mali has also benefited from the initiative "Harmonization for Health in Africa" since 2006 but this has largely converged with the IHP+ since 2007.

mission, which also brings together government representatives, donors and civil society.

The processes in recent years, in particular sectoral budget support and the preparation of the IHP+ Compact, have **strengthened collaboration between the MoH and the Ministry of Economy and Finance (MoEF),** both at the central level and at the regional level, which is also a sign of stronger national ownership. This could be the reason for the significant increase in the State budget resources allocated to the health sector over recent years, especially since 2008.[12] Preparation for the policy on human resources has strengthened collaboration between the MoH and the ministry responsible for the civil service, as with the rest of the government, having been approved by the Council of Ministers at the end of 2009.

The IHP+ Compact preparation and monitoring process has also strengthened collaboration with civil society and established a very inclusive work dynamic, based on a work programme and calling upon the technical assistance of the donors according to the capacities that they can contribute to the process. This work dynamic was applied to the development of the human resources policy, the MTEF and the Compact [Samaké et al. 2011]. It is now completely institutionalized, as seen in the current final PDDSS evaluation process and the preparation for the next plan, which is based in particular on a consensual diagnosis of the strengths and weaknesses, opportunities, and threats in the health system, carried out for the development of the "Country Health Policy Process" (CHPP) Portal, and which underwent a Joint assessment of National Strategies (JANS) at the end of May/beginning of June 2011, to ensure that the next plan will be consensual and unifying.

Given that PRODESS planning and daily monitoring, as well as the coordination of donors, is overseen by the standing Secretariat under the direction of the Health Planning and Statistic Unit, **leadership of the development of the sector and the coordination of stakeholders has also been strengthened** since the launch of PRODESS. The MoH is now in a better position to refuse projects that are not in line with national strategy.[13] The capacities of the standing PRODESS Secretariat have been boosted in recent years (more staff training, material resources, technical assistance, etc.) to help it accomplish its mission. Its competence has also been extended to a third sector (women and family affairs, in addition to health and social development). **A virtuous circle has developed between the different components of the Paris Declaration**

[12] Spending recorded as pertaining to the health sector by the General Budget Directorate (DGB) went from 41.79 billion CFAF in 2004 to 83.35 billion CFAF in 2009, representing an average year-on-year increase of 15% over that period, compared to an average annual increase of 9.4% in total expenditure over that same period. Regarding social sector expenditure, this went from 27.97 billion CFAF in 2004 to 42.39 billion CFAF in 2009, representing an average increase of 19% over the period [budget execution figures-DGB].

[13] For example, at one point the AfDB wanted to carry out a project supplemented by a ad hoc management unit in the Sikasso region, but the MoH convinced it to manage the funds through the Malian authorities, with the support of advisers.

as alignment with the national programme through the sector-wide approach has underlined the need to strengthen the capacities of the Planning and Statistics Unit (CPS) and concurrent support has reinforced its leadership and capacity to channel the programme towards achieving results. It is therefore undeniably the MoH that has steered the preparation of the IHP+ Compact and its supporting documents (human resources policy, health system strengthening plan, etc.), by drawing as much as possible on the participation of the other stakeholders – donors and civil society. The MoH also steers and coordinates other processes now under way in the sector (PDDSS evaluation, JANS, preparation of the next plan, etc.) [Samaké et al. 2011]. **It should, however, be noted that management of these processes remains limited to a "hard core"** of civil servants belonging to the Planning and Statistics Unit and various other directorates (mainly the Finance and Material Directorate and the National Health Directorate) in frequent interaction with donors, and that a significant group of civil servants and structures remain outside the system in place.

3.2 Harmonization and alignment with national systems

3.2.1 Alignment with national strategies

Firstly, it should be noted that the Government of Mali has extended PRODESS over the period 2009-2011 to align it with PRGSF objectives. It is supplemented by a series of annex documents providing a coherent framework. However, the sectoral strategy does not yet clearly specify how the decentralization policy should be implemented.

As regards donors, **officially, all external funds supporting the health sector are allocated to PRODESS**. **However, certain interventions** (in particular from partners outside OECD or NGOs) **remain outside the national programme**, but they are marginal (except for the recent building by China of a new hospital in Bamako). It should also be noted that, **at the operational level, certain interventions by donors are not totally integrated into the normal activities of health-care structures** [Devahive 2011]. The current process to develop the new plan, which is intended to be very inclusive, aims to produce a consensual and unifying instrument to boost alignment with future national strategies, and with their implementation.

The lack of coherence between sectoral and decentralization policies mentioned above is also reflected at the level of the assistance provided by donors. Although the specific agreement on sector budged support did require the MoH and the agency responsible for supporting local authorities to sign an agreement for the construction of community health centres, aside from that, most donor decentralization assistance does not explicitly aim to strengthen the local authorities' capacities with regard to the transferred competences.

3.2.2 Alignment with national financial management procedures

At the time of the switch to SWAp, the Government of Mali developed **specific "PRODESS" procedures** to encourage donors to pool their funds into the different programme accounts.[14] These procedures were largely inspired by the government's national procedures, although they are more flexible, giving MoH structures greater freedom to manage their funds, particularly through the appointment of PRODESS regional accountants as acting approving officers, the current use of advance accounts and the rapid replenishment of the programme's separate accounts, up to the Circle (local government) level. That's why MoH authorities keep on preferring that modality rather than SBS, the latter being managed by the MoEF structures and falling into the national Treasury However, many donors do not use national procedures (see below). Furthermore, to meet sectoral budget support needs, **the PRODESS programming cycle was harmonized with the MoEF budget cycle in 2006 -** improving "intra-government" alignment, but causing problems due to certain donors not being able to make their funding pledges early enough in the process.

Many of the donors use the PRODESS accounts and procedures (Belgium, France, Canada, etc.). **Some donors have switched to general budget support** (for example the European Commission and the World Bank, which have subsequently made a drastic cut in their direct support to the health sector) and since 2006, **some provide sectoral budget support** for the health sector. Currently, only three donors provide sectoral budget support[15], which represents 10-12% of sectoral financing. By definition, general budget support and sectoral budget support are aligned with national policy and systems.[16] In addition, under the Joint United Nations Programme, common procedures were adopted in 2009, based on a harmonized approach to cash transfers (HACT) to execution partners. Four agencies active in the health sector use this approach: WHO, UNICEF, UNFPA and WFP.

These four aid options, (general and sectoral budget support, PRODESS procedures and HACT) have led to progress on alignment, and are, in addition, favoured by the IHP+ Compact. **However, donors continue to proliferate and a large number of projects targeting certain health problems and which are managed with ad hoc procedures**, regarding which the MoH still has problems obtaining information (especially regarding execution), **still exist within the sector.**

This is particularly true of the **Global Fund**, whose management is based on an (admittedly) highly participative coordination mechanism, but which is also very draining for Mali's authorities and the partners who manage it on a volunteer basis. The Global Fund uses ad hoc procedures, which give its management unit great freedom, and are not subject to the Mali's standard financial State controls.

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[14] Account A (central level), accounts B at the Regional Health Directorate level and accounts C at the Referral Health Centre level.

[15] The Netherlands, Canada and Spain. Sweden left sector budget support in 2011 to switch to general budget support.

[16] However, up to 2011, sector budget support in Mali was traceable, in other words, considered as both resources and expenditure under the Budget Law, with specific codes.

This system slows down the resolution of problems since the Global Fund has no office in Mali and so problems often take months to be resolved. It also imposes significant transaction costs on Mali's authorities, especially due to the proliferation of audits and ad hoc monitoring observed in recent years. Moreover, this ad hoc management system does not appear to be at all effective in lowering fiduciary risk, as indicated by the misappropriation of significant Global Fund assets in 2009-2010 [Global Fund's OIG, 2011]. The irony is that it was the internal MoH control system that detected the misappropriation of funds, yet various donors reacted by freezing their disbursements to the MoH (particularly for budget support)! Subsequent audits have dispelled suspicions of generalized corruption at the sector level. Although some cases of misappropriation have been confirmed in an audit by the Auditor-General, these involve modest amounts and the Government of Mali has taken measures to prosecute the individuals responsible and guarantee reimbursement of the funds.

The radical variation in the reactions of partners to the problems noted in Mali's financial management is to be highlighted. The Global Fund acted unilaterally, sending auditors, whose reports (in English only!) were closed to criticism from national stakeholders – and thus preventing solutions being found for these problems. Its immediate reaction was to freeze all funding and activities – a policy which still continues and which has affected other donors, some of whom froze their disbursements (in particular on sectoral budget support) or withdrew from the sector following the first suspicions of misappropriation. On the other hand, the GAVI Alliance, which used national PRODESS procedures for its HSS component, has **sought to collaborate with the MoH to find solutions to these problems, displaying a positive and constructive attitude**. After the problems identified in the management of the Global Fund subventions, GAVI chose to continue financing its personnel on the HSS component, continue sharing real-time information with the government and other partners (it even published a statement calling for this measure on its web site) and move the publication of a PRODESS financial management evaluation forward to the end of 2010. This evaluation identified various gaps in the effective implementation of financial management, requiring adjustments to reduce fiduciary risks, but it concluded that the national financial management mechanism for the HSS component should be maintained and extended to the immunization component [GAVI Alliance 2010]. GAVI therefore chose to assist the MoH transparently in identifying the aspects to improve, with a view to resuming activities as soon as possible. This is to be singled out as an example of good partnership practice.

The management of sectoral budget support initially raised concerned within MoH because it constitutes a loss of managing freedom compared to PRODESS procedures and accounts. In its first years of operation, there were problems for mobilising resources (especially at regional level), but this did not prevent partners from seeking solutions to improve management and to support public financial management more extensively. In this way, collaboration with the MoEF was strengthened significantly and Canada added capacity-building assistance to its sectoral budget support, particularly directed at strengthening

internal audits. Furthermore, Canada recently wished to assign additional funds (63 million Canadian dollars, or approximately 30 billion CFAF over five years) to maternal and child health, but ultimately chose to channel these funds through sectoral budget support. In practical terms, the funding gap in maternal and child health identified by the extended PRODESS II MTEF was chosen as the basis on which to build an action plan for these activities. The funds will be released as soon as the MoH completes this action plan.

3.2.3 Other efforts in terms of alignment with national systems

Alignment with the national budget cycle requires donors to make their funding pledges in sufficient time to integrate them into the budget and/or the MTEF (*"ex ante"* or pledge aid predictability). To this end, the IHP+ Compact encourages donors to make their funding pledges (amount and dates) over various years. Seven Compact signatories have made funding pledges over a three-year period (2009-2011), in other words, until the end of the extended PRODESS II, while two others have made their pledges over two years (2009-2010), and in general, a growing number of donors now make annual pledges before the PRODESS planning bodies have convened [Samaké et al. 2011].

The MoH also encourages donors to use the indicators from the extended PRODESS II common framework, comprising thirty-five key indicators chosen from the extended PRODESS II exhaustive monitoring matrix (see Annex 1). The idea was that donors wishing apply conditionalities to their interventions (e.g. their budget support) would use a subset of these indicators. However this practice is not yet widespread and there are differences in the formulation of the indicators included in the new agreement for sectoral budget support to PRODESS II over the period 2010-2011, and those found in the common framework.

3.2.4 Harmonization of donor interventions

Since 2006, general budget support and sectoral budget support are provided via the framework agreement and the specific PRODESS sectoral budget support agreement, under a harmonized framework mainly based on:

- Common monitoring committees (even though disbursement decisions are made by each individual donor);
- The use of a common matrix of triggers / process benchmarks and indicators (even though some donors do not use all of them).

Donors who were exploring the possibility of switching to sectoral budget support have carried out joint risk analysis missions. The Netherlands represented Sweden (until 2010) and now represents Spain (since 2009) for PRODESS sectoral budget support, through delegated partnerships. In 2010, the sectoral budget support monitoring committees were integrated into the PRODESS technical and monitoring committees, thus avoiding duplication of dialogue bodies.

In addition to these financial details, further progress on harmonization can be seen in the **common coordination and planning process (up to the operational level),** the annual joint monitoring missions (including field missions) and the agreement with donors, in the context of developing the IHP+ compact, on a harmonized PRODESS monitoring framework (common matrix) (see Annex 1). As stated below (point 4.1.4), **donors increasingly organize joint activities to support the MoH.** This is particularly true of surveys (DHS, etc.) that are often co-financed by various donors, and of the current PDDSS evaluation and the preparation of the new plan which, steered by the Health Planning and Statistic Unit, benefits from co-funding from various partners for a series of activities (for example WHO financed the development of the CHPP, Canada financed the baseline study on the advancement of women, various donors financed external consultants and the organization of JANS, etc.)

It should also be noted that under the implementation of the EU Code of Conduct on the Complementarity and the Division of Labour, various donors are progressively withdrawing from the health sector (e.g. France, Belgium), unfortunately without compensating the sector, while others (for example Spain and previously Sweden for sectoral budget support) are involved through silent partnerships.

3.3 Results-based management

The national evaluation of the Paris Declaration (phase 2) notices that the health sector is among the most advanced ones regarding results-based management as well [MEF/SHA, 2011]. **The focus on monitoring health sector results as a whole began with the launch of the sector-wide approach in 1999.** Since then, results monitoring has been reinforced under the influence of the PRSP (2002), European Commission general budget support (2003), sectoral budget support (2006) and the IHP+ Compact (2009) [Samaké et al., 2011].

The **National Health Information System (NHIS)** provides routine data from operational structures. It is made up of the Local Health Information System (LHIS), the Hospital Information System and the Epidemiological Alert System. The Health Planning and Statistics Unit is in charge of consolidating the data provided by these structures, and producing the statistics yearbooks. This data is supplemented by the impact indicators from surveys such as the five-yearly Demographic and Health Surveys (DHS), the Multiple Indicator Cluster Survey (MICS), integrated household surveys, national health accounts, etc., most of which are co-financed by various donors.

The original PRODESS II was supplemented by a conceptual framework and a series of monitoring indicators. The health component defined 8 impact indicators (on chronic malnutrition, under-five and maternal mortality, fertility, HIV/AIDS) and 65 direct implementation and result indicators. Under the extension of PRODESS II over the period 2009-2011, this indicator matrix was revised, placing greater stress on impacts and new priority strategies (neonatal

and urgent obstetric care, reduction of regional disparities, encouraging health personnel to work in difficult areas, decentralization of resources, etc.). **Thirty-five indicators in this exhaustive matrix were chosen to create the common PRODESS monitoring framework,** now monitored by all participants through the technical and monitoring committees [extended PRODESS II] (see Annex 1).

In particular, SBS is accompanied by monitoring mechanisms relying on annual performance indicators, technical and financial reports, and an audit of the sector programme. Part of disbursements depends on reaching a number of sectoral objectives, which has reinforced results-based management. Yet, the evaluation of the Paris Declaration regrets that donors do little to reinforce national programmes' monitoring mechanisms and tools [MEF/SHA, 2011]. Nevertheless, the Government of Mali appears to have increased its focus on those indicators used to monitor budget support, while other indicators (e.g. on nutrition) appear not to have received much attention [Lawson et al. 2011].

Monitoring of the implementation of recommendations is carried out jointly (by central and regional ministries, donors, civil society) through the PRODESS steering bodies. In recent years, the quality of the reports submitted by the MoH has improved and discussions have shifted towards a greater analysis of evidence-based results. Since then, **the focus of policy dialogue has shifted to strategic priorities**, seeking to explain the results observed and seek solutions for the problems identified. Sectoral budget support seems to have contributed to strengthening the use of indicators in policy dialogue, the quality of the information submitted and the analyses carried out by the MoH [Lawson et al. 2011].

An in-depth analysis of the processes linked to the implementation of the aid effectiveness agenda began in 2007 with the support of the Belgian Technical Cooperation Agency (BTC) for the establishment of an expert technical committee to monitor the sector-wide approach and budget support in the health sector, which resulted in a book capitalizing that experience [Samaké 2009]. This process was strengthened by the IHP+ (2008-2009) and the creation of the CHPP (2010-2011), which provides a consensual diagnosis of strengths and weaknesses and priorities in terms of health system strengthening.

Finally, the development of the revised PRODESS MTEF used the Marginal Budgeting for Bottlenecks (MBB) software that intends to draw clear links between financing and reaching of objectives.

3.4 Mutual accountability

Mutual accountability is mainly exercised by the PRODESS steering bodies, which bring together all the ministries involved, civil society (which co-presides the technical and monitoring committees) and donors. The preparation process for the IHP+ Compact and its supporting documents (PRODESS extension, MTEF, human resource policy, etc.) has significantly strengthened the common work

dynamic and the general consensus is that **the framework for sectoral dialogue has improved** over time and is now more coordinated, transparent and has a stronger basis in results monitoring and problem analysis [Lawson et al. 2011]. The IHP+ Compact clearly defines the respective commitments of the government and donors and the preferred aid options. The monitoring of its implementation, with the annual review of stakeholder pledges and the independent evaluation carried out by IHP+ Results, has reinforced mutual accountability. In this way, IHP+ Results carried out a first case study in 2009, unfortunately too soon after the signing of the Compact to be able to record any significant results.[17] However the annual Scorecards highlight areas that are lagging and put a certain amount of pressure on partners, at an international level, to expedite the execution of their pledges. The 2010 Scorecard on Mali (based on the data for 2009) shows progress on mutual accountability, highlighting active joint monitoring and the commitment of civil society in sectoral coordination mechanism, concluding that "joint evaluations are a result of the progress made on the execution of pledges in the health sector, especially with regard to aid effectiveness" [IHP+Results 2010]. The current PDDSS evaluation process, which is supported by a number of partners and is totally inclusive (especially with the CHPP and JANS), also reinforces mutual accountability.

As for accountability vis-à-vis domestic stakeholders, sector resources passing through the budget have increased (particularly due to the increase in the State budget allocated to the sector that has been favoured by general budget support), and with them the control of Parliament and national auditing institutions (the Accounts Department of the Supreme Court, the Office of the Auditor General) over the use of resources. Under sectoral budget support, PRODESS is also subject to a yearly external audit by a private company. The donors participate in drafting the terms of reference of this audit and are free to submit comments on the consultants' provisional report.

[17] Moreover, the document was drafted in English, which meant that local stakeholders could not take ownership of it.

4. Has this helped to improve results?

4.1 Result no. 1: Has aid effectiveness improved in practice?

4.1.1 Trends in external financing allocated to the sector

The table below shows, for each source, the increase in PRODESS funding since 2005.[18]

Table 8: PRODESS budget forecast and execution by source of funding, 2005-2011

(Million CFAF)	**2005**		**2006**		**2007**		**2008**		**2009**		**2010**	**2011**
	expected	***executed***	***expected***	***executed***	***expected***	***executed***	***expected***	***executed***	***expected***	***executed***	***expected***	***executed***
State budget	38 343	38 754	41 784	38 379	43 433	43 371	61 427	50 155	62 048	53 981	61 427	61 174
Sectoral budget support			5158	5036	8827	8037	11 128	7503	9260	9260	11 128	10 472
Cost recovery	9802	4757	10 031	11 106	13 524	11 965	15 959	14 069	7141	7141	15 959	18 451
Communities	320	246	196	193	593	210	1535	355	1023	624	1535	1522
Local governements	493	114	488	386	1327	311	2123	364	2614	471	2123	3973
Donors (projects)	36 796	17 972	40 807	23 193	29 341	31 330	42 376	19 516	37 925	6827	42 376	26 218
Total	**85 754**	**61 844**	**98 464**	**78 293**	**97 043**	**95 225**	**134 548**	**91 962**	**120 466**	**78 303**	**134 548**	**121 777**

Source: DAF/MS, presentations to the PRODESS Monitoring Committees, 2006-2010.

As Table 8 indicates, **State budget allocations to the health sector have increased a lot between 2007 and 2008. On the contrary, external financing, excluding sectoral budget support, fell dramatically in 2008 and especially in 2009.** The strong increase in domestic funding suggests that the sector benefits indirectly from general budget support. The recent evaluation of budget support operations in Mali attempted to isolate the contribution of general budget support to the priority sectors on the hypothesis that, since 2002, the priority sectors had received an equal share of domestic income. In doing this, the authors calculated that general budget support would allow for an average yearly additional expenditure of 0.3% GDP in the health sector, in addition to funds accounted for by the increase in domestic income.[19] On the basis of this hypothesis, the authors estimated that annual average growth in the

[18] 1 EUR = 655 957 CFAF. It should be noted that the data on external funding (especially executed funding) are imprecise, sources vary and are not exhaustive. The figures presented here were collected by the Administrative and Financial Directorate of the MoH, using PRODESS planning tools and activity reports, which differ somewhat from the figures collected by the Ministry of Economy and Finance.

[19] The health expenditure portion of the State budget went from 5% in 2002 to 8% in 2009 and as a percentage of GDP, sector expenditure went from 1% in 2002 to 2% in 2009. However, the domestic income level has remained practically constant as a percentage of GDP.

various health budget sources between 2003 and 2009 was 10% for domestic income, 43% for general budget support, 27% for sectoral budget support (over the period 2006-2009 only), and 11% for projects. This gives them reason to suppose that sectoral budget support has completely substituted to project financing and a portion of general budget support (in the sense that donors turning to budget support consequently reduced their project aid). According to these estimates, including the general budget support contribution to sectoral expenditure, they conclude that the health sector expenditure portion managed through the budget (domestic income + general budget support + sectoral budget support) has increased from 62% in 2000-2002 to 76% in 2006-2009 [Lawson et al. 2011]. Of the remaining 24% (projects), most are included in the external special investment budget.[20]

4.1.2 Trends in aid predictability

As mentioned in point 3.2.3, ***ex ante* aid predictability (that is, regarding pledges) is improving**, given that seven of the Compact signatories have made pledges over three years and that a growing number of donors are now making their pledges before the planning bodies convene. In particular, *ex ante* predictability of budget support is relatively good considering that pledges are made over various years and that disbursements generally track annual predictions. However, the modest budget allocation to sectoral budget support, is not sufficient to create a general upward trend in aid predictability. However, as the table below shows, mid-year sectoral budget support disbursements have, up till now, always been late. This has delayed the execution of activities, as the General Budget Directorate would not, at first, open its sectoral budget support credits before the donors had made their tranche disbursements.

Table 9: Sectoral budget support forecasts and disbursements to PRODESS registered by the Treasury, per donor and per tranche, 2006-2009

	2006			**2007**			**2008**			**2009**		
(Million CFAF)	**Forecast**	**Disbursement**	***Date of disburs.***	**Forecast**	**Disbursement**	***Date of disburs.***	**Forecast**	**Disbursement**	***Date of disburs.***	**Forecast**	**Disbursement**	***Date of disburs.***
Netherlands 1st tranche	2558	2600	*25/10*	1560	1560	*Apr-07*	1560	1574	*15/04*	1560	1560	*Apr-09*
Netherlands 2nd tranche				1040	1040	*Oct-07*	1040	1050	*1/12*	1040	1040	*Apr-09*
Sweden 1st tranche	2558	2185	*29/12*	2500	1500	*Apr-07*	1279	1471	*25/05*	1308	1308	*2nd quarter.*
Sweden 2nd tranche							1279	833	*26/12*		874	*Dec-08*
Canada 1st tranche				1061	1100	*Apr-07*	2420	2017	*18/04*	2775	2775	*Apr-09*

[20] Variations between the data from the DGB and the MoH Administrative and Financial Directorate (DAF) are significant but on average an estimated 70% of projects are included in the special investment budget.

Canada 2nd tranche							2420	3063	*6/11*	2836	2906	*Nov-09*
Spain 1st tranche										656	656	*1st quarter.*
Spain 2nd tranche										656		
Total	**5116**	**4785**		**6161**	**5200**		**9997**	**10 007**		**10 831**	**11 119**	

Source: MoEF/National Directorate of the Treasury and Government Accounts/Treasury Accounting Agency

In general, as Table 8 shows, ***ex post* (execution) project aid predictability**, which can be estimated by comparing funding pledges for operational plans and their execution, rose between 2004 and 2007, but fell sharply in 2008 and especially in 2009. There is still considerable inconsistency between forecast external financing and actual execution, either because disbursements are blocked or arrive late, because structures are not able to execute the funds that have been mobilized, or because funding arrives halfway through the year without previous allocation for use [Lawson et al. 2011].[21]

4.1.3 Trends in transaction costs

In terms of trends in transaction costs, it should be noted that sectoral coordination entails certain costs for the Government of Mali and donors, but these costs **create added value in terms of confidence and improved coherence of interventions**. They can therefore be considered as investments rather than sunk costs.[22]

The shift to sectoral budget support has firstly raised transaction costs both for the government and (to a lesser extent) for donors, because it necessitated setting up a new system and initially, the sectoral budget support monitoring committees were separated from normal PRODESS steering bodies. In the initial years, the MoH had difficulties supplying timely information required for the payment of tranches (indicators and methods of calculating them), which resulted in a proliferation of meetings. Furthermore, sectoral budget support has not actually improved alignment as it only involves a handful of donors, and still only represents 10% of PRODESS financing and less than a third of external contributions; and in view of the fact that the donors providing sectoral budget support (except for Spain) were already using the PRODESS accounts and procedures (more flexible and reinforcing the responsibility of social and health authorities at the regional level), so that these accounts and procedures are used

[21] Poor project aid predictability in 2009 can be explained, in part, by the huge administrative constraints that the Global Fund loads on to the MoH, since it is not represented in Mali, and sometimes takes months to reply to simple requests. The MoH, being absorbed by the Global Fund, which seems to have become a priority, does not appear to have the time to manage its other partnerships, thus discouraging other donors [Lawson et al. 2011].

[22] See Elisabeth Paul and Frieda Vandeninden, "Foreign Aid Transaction costs: What are they and how are they minimised?", *Development Policy Review,* to be published in 2011.

less frequently. However, various adjustments have since helped to lower transaction costs in sectoral budget support, especially delegate partnerships and, as of 2010, a single sectoral budget support tranche payment by the Netherlands and the integration of sectoral budget support monitoring committees into the PRODESS and IHP+ Compact monitoring bodies.

The experience acquired by the MoH in steering the sectoral approach and monitoring budget support has **reduced certain transaction costs over time**, especially by improving the quality and timeliness of information, with a view to basing dialogue on concrete data. In short, it should be noted that **Mali's authorities still bear significant non added-value-creating transaction costs from aid fragmentation and large projects with ad hoc procedures, which continue to be managed within the sector**. This is particularly the case of the Global Fund, whose management places an enormous burden on Mali's authorities and on the donors who carry this out on a voluntary basis, and which requires numerous audits and ad hoc inspections [Lawson et al., 2011]. For instance, although annual PRODESS audits are carried out at the national level (under the external supervision of the Accounts Department of the Supreme Court and the Office of the Auditor-General, and by a private company in the case of sectoral budget support), five additional ad hoc audits were carried out in 2010, placing considerable pressure on the Finance and Material Directorate of the MoH. This was also identified as one of the main causes of the difficulties in the implementation of planned activities as the Finance and Material Directorate was incapable of meeting all the demands of donors and had to neglect its day-to-day management of domestic resources [Lawson et al. 2011, Samaké et al. 2011].

4.1.4 Changes in terms of partnership

Various changes can be observed in terms of **partnership behaviour among donors**. As one of our informants indicated, "people always try to work together". Donors and civil society participate in joint annual monitoring missions on the ground. Surveys (EDS.M, MICS, health map, etc.) are generally co-financed by various donors. Some donors are now organizing joint activities, such as the integrated UNICEF/WHO/GAVI immunization campaigns, Luxembourg/UNFPA/WHO joint reproductive health assistance and the WFP/UNDP/FAO/UNICEF/WHO food programme. Various donors have also co-financed activities linked to the PDDSS evaluation (consultants, workshops, development of the CHPP and organization of the JANS, etc.).

4.1.5 Capacity-building assistance

The sector-wide approach and the introduction of general and sectoral budget support have highlighted the need to strengthen capacity for strategic analysis, programming, financial management and sector monitoring and evaluation, and have attracted **technical assistance (TA) with a greater focus on systemic needs**. This capacity-building assistance is crucial in encouraging donors to use

national systems. Assistance has sometimes taken several years to bed down, but some positive examples should be highlighted, such as assistance in strengthening the statistics apparatus (European Commission), capitalization of the experience of sector-wide approach and budget support (Belgium), public finance management assistance (Canada), human resources assistance (France), etc. Since the request submitted to GAVI on the HSS component and the development of the 2008 Strategic National Plan on this area, HSS assistance efforts have been more coherent. Nevertheless, although the IHP+ Compact establishes an institutional framework on the supply of TA and the creation of a TA Coordination Commission, TA interventions are still provided bilaterally, in a non-harmonized environment. For instance, the MoH receives support from some 150 Cuban and Chinese medical doctors, and a series of other technical assistants, but these interventions are provided on a bilateral basis by the donors, who sometimes impose their own priorities.

Taken together, these aid effectiveness results are likely to improve the effectiveness and efficiency of expenditure in the health sector and create virtuous circles strengthening capacities, ownership, leadership, orientation towards medium-term results, and improving health results.

4.2 Result no. 2: Has the health system been strengthened?

While increasing attention is given to HSS and structural changes, this process also requires behavioural changes at the operational level, and therefore takes time. Practical results are therefore expected in the medium-term, but various elements already appear to be on the right track. This is a brief overview of the main changes observed since the beginning of the implementation of PRODESS in terms of the six components of the health system identified by WHO (WHO 2007), and which have been influenced by external aid, at least in part.

4.2.1 Changes in governance, analysis and health planning

A number of governance problems persist within the health sector. The PDDSS evaluation particularly highlights problems in micro-planning (which does not take the characteristics of each district sufficiently into consideration), the management of resources (inventories, maintenance, etc.) and the infrequent nature of integrated supervisions [MoH 2011]. Problems can also be seen in the collaboration between different structures and MoH directorates because, while some stakeholders are very committed to reforms, others persist in inappropriate behaviour.

Nevertheless, a number of improvements have been noted in recent years, partly due to the more and more inclusive way of cooperating with partners. Thus, boosted by alignment with national systems and strategies through the sector-wide approach and sectoral budget support, and with a shift in focus towards results, the **health sector programming process**, though not yet perfect, **is**

very participative and has improved in the last few years. Donors and civil society have been involved in priority-setting and strategy formulation for the extension of PRODESS II (maternal health, control of cancer, malnutrition, neglected tropical diseases) and the development of specific policy documents (national child survival strategy, human resources policy, strategic HSS plan, maintenance strategy, etc.). Some donors (in particular UNICEF) have supported revision of the MTEF integrating these new strategies and attempting to link financing and results. **The evaluation of the PDDSS and the preparation of the new plan are particularly participative**, especially due to the use of the CHPP and JANS tools, which suggests that the new plan will be of a better quality.

As a result of regular complaints on this subject during the sectoral budget support committees, the MoH is working to remedy shortcomings in planning tools (poor readability and coherence between the MTEF, the operational plan and the Budget Law). In order to remedy the weaknesses seen in the work carried out in the CROCEP (in particular, in terms of analysis) and in the quality of operational plans, **the annual planning process has been revised and significantly improved** over the last five years with the introduction of **results-based management.** While the operational structures initially encountered various difficulties planning what they were going to do with sectoral budget support (not being used to receiving non-earmarked funds), it appears that they have progressively learnt to use sectoral budget support resources as supplements to earmarked funds [Lawson et al. 2011]. Collaboration with the MoEF in all these processes has also improved.

4.2.2 Changes in financing (assignment of resources and financial management)

As shown in Table 8, the State budget is the main source of PRODESS funding. In the period 2006-2009, **sectoral budget support accounted for approximately 10% of sectoral expenditure** and external projects for approximately 23% - not taking into account the indirect contribution of general budget support to the financing of the sector [Lawson et al. 2011]. However, **external project funding increased steadily up to 2007, but dropped dramatically in terms of execution since 2008 and especially in 2009.** That year, executed external funding was six times lower than expected funding. The cause of this drop apparently lies in the funding management problems experienced by the Global Fund in 2009 and 2010[23] (slow resolution of problems due to the lack of representation in Mali, multiplication of ad hoc audits, disbursement delays and freezing of funds following the discovery of their misappropriation) which overwhelmed the MoH financial administration, rendering it incapable of carrying out some of its daily management tasks and managing its relations with other partners. In the end, these problems affected other donors who froze their disbursements for several months (Lawson et al. 2011). Total cost recovery also decreased in 2009, probably following the introduction of a number of free services (caesarean, malaria treatment for groups at risk, etc.) [MoH 2011].

[23] On this topic see Global Fund's OIG (2011).

It is hard to carry out a thorough analysis of **trends in the allocation of health expenditure** due to the lack of detailed data, given the nature and purpose of such expenditure. As Table 10 below shows, the data relating to PRODESS execution per component since 2005 shows that PRODESS component 7 (institutional capacity-building and decentralization) garners the majority of resources (including external financing); an increase in spending on human resources development, essential for progress in the sector, appears to have begun in 2009.

Table 10: PRODESS execution by component, 2005-2009

(Billion CFAF)	**2005**	**2006**	**2007**	**2008**	**2009**
Component 1 Geographical access (infrastructures)	11 996 664	9 471 974	14 030 896	6 326 438	10 801 709
Component 2 Human resources	3 876 544	4 415 891	5 247 464	3 822 453	7 381 389
Component 3 Medicines and consumables	6 833 150	11 131 507	12 040 399	12 085 080	9 764 678
Component 4 Quality of services, increase in demand, disease control	3 350 611	5 567 551	9 981 784	6 043 623	6 272 377
Component 5 Affordability	631 630	2 090 372	2 183 908	1 963 549	2 246 364
Component 6 Hospital and research institutes reform	8 069 273	12 322 575	16 449 146	17 934 679	10 011 207
Component 7 Institutional Capacities and decentralization	24 001 397	33 382 577	35 290 905	43 786 262	31 825 353
TOTAL	**58 759 269**	**78 382 447**	**95 224 502**	**91 962 084**	**78 303 077**

Sources: MoH Administrative and financial directorate report to the Monitoring Committees 2006 to 2010

In general, the health budget structure has become more decentralized, not only with regard to beneficiary structures (respect of intra-sectoral assignments by MTEF, or 60% of PRODESS budget executed in the regions) but also to the spending structures, with an increase in payments allocated directly to the decentralized level in the Budget Law, which is crucial in a large country like Mali where usually, a majority of public expenditure is concentrated in the capital city. This trend has undoubtedly been influenced, in part, by the dialogue between PRODESS monitoring bodies and the sectoral budget support committees [Lawson et al. 2011].

Another outcome of the alignment with national systems can be seen in public finance management. **While the specific PRODESS procedures give MoH structures greater management freedom, sectoral budget support initially encompassed various management problems,** in particular for the mobilization of resources at the regional level. This was caused in particular by the delayed supply of funds, which hampered the execution of activities, to such an extent that many sector activities (inspection missions, immunization activities, etc.) have to be prefinanced rather than paid after the service, as is usually the case with State procedures. The burden and lengthiness of public procurement have also been questioned. **Nevertheless, sectoral budget support monitoring highlighted various financial management problems** (for example Treasury liquidity problems, poor adaptation of State procedures to certain sector characteristics) and thus **encouraged dialogue with the donors**

and gave the MoEF a greater role in sectoral discussions – and inversely, allowed MoH participation in internal MoEF meetings – in order to find solutions to these problems. Following regular calls on the MoEF by the health authorities over the first two years of the implementation of sectoral budget support, a **ministerial coordination platform** (at the national and regional levels) was established and the MoEF strengthened its regional assistance. Various problems have thus been resolved through this coordination, in particular initiated by sectoral budget support, by building on management capacities at the decentralized level, creating advance accounts and a special account for MoH directorates, appointing of regional accountants, faster mobilization of credits, and (since 2008) recording sectoral budget support credits for health districts in the Budget Law to expedite the decentralization of resources. Furthermore, sectoral budget support has encouraged the MoEF and the donors to pay greater attention to the intra-sectoral allocation of resources, with a view to using them more effectively [Lawson et al. 2011].

4.2.3 Changes in infrastructure

PRODESS component 1 on the extension of health coverage has received much attention since it was launched, which improved coverage in terms of infrastructures, particularly in initially disadvantaged regions [NHIS]. The table below shows the development in the number of operational community health centres in each region. The most significant increases since 2003 have been seen in Kayes, Koulikoro, Tombouctou, Gao and Kidal, which were initially the worst-served regions. The increase in health coverage was probably not influenced by aid effectiveness principles directly, but possibly by efforts to reduce regional disparities, as regularly mentioned in policy dialogue within PRODESS bodies.

Table 11: Number of Community Health Centres by region, 2002-2009

	2002	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	***Increase 02-09 (%)***
Kayes	89	94	110	115	130	141	156	167	***87.64%***
Koulikoro	82	85	88	103	107	116	120	156	***90.24%***
Sikasso	136	141	142	152	152	153	156	188	*38.24%*
Ségou	106	123	127	134	134	145	163	165	*55.66%*
Mopti	83	94	102	109	109	112	118	134	*61.45%*
Timbuktu	25	31	35	41	51	51	53	67	***168.00%***
Gao	31	37	39	40	43	49	48	55	***77.42%***
Kidal	5	5	6	7	7	7	7	9	***80.00%***
Bamako	48	50	50	52	52	52	52	52	*8.33%*
Total	**605**	**660**	**699**	**753**	**785**	**826**	**873**	**993**	*64.13%*

Source: LHIS Yearbooks 2002 to 2007; NHIS Yearbooks 2008 and 2009

4.2.4 Changes in terms of human resources

The issue of human resources continues to be of major concern for the sector's development. This was the subject of intense dialogue in the context of PRODESS monitoring, which benefited from the support of various donors. The development of the National Policy and the National Strategic Plan for the Development of Human Resources for Health (including training, recruitment, motivation and career plans) and its validation by the Council of Ministers, and the creation of a Human Resources Directorate in 2010, are all positive and bode well for better management of human resources. The motivation plan, in particular, plans to provide significant subsidies to encourage medical staff to work in hardship areas. However, most of the strategies in the national strategic plan have not yet been implemented and there are still great inequalities in the distribution of health-care personnel between Bamako and the regions. Thus, in 2009, the ratio of health-care personnel to inhabitants was 1 doctor per 1603 inhabitants in Bamako compared to 1/22 045 in the Koulikoro region, 1 midwife per 1886 inhabitants in Bamako compared to 1/58 965 in the Sikasso region, and 1 nurse or medical assistant per 435 inhabitants in Bamako compared to 1/6008 in the Mopti region [NHIS Yearbook 2009].

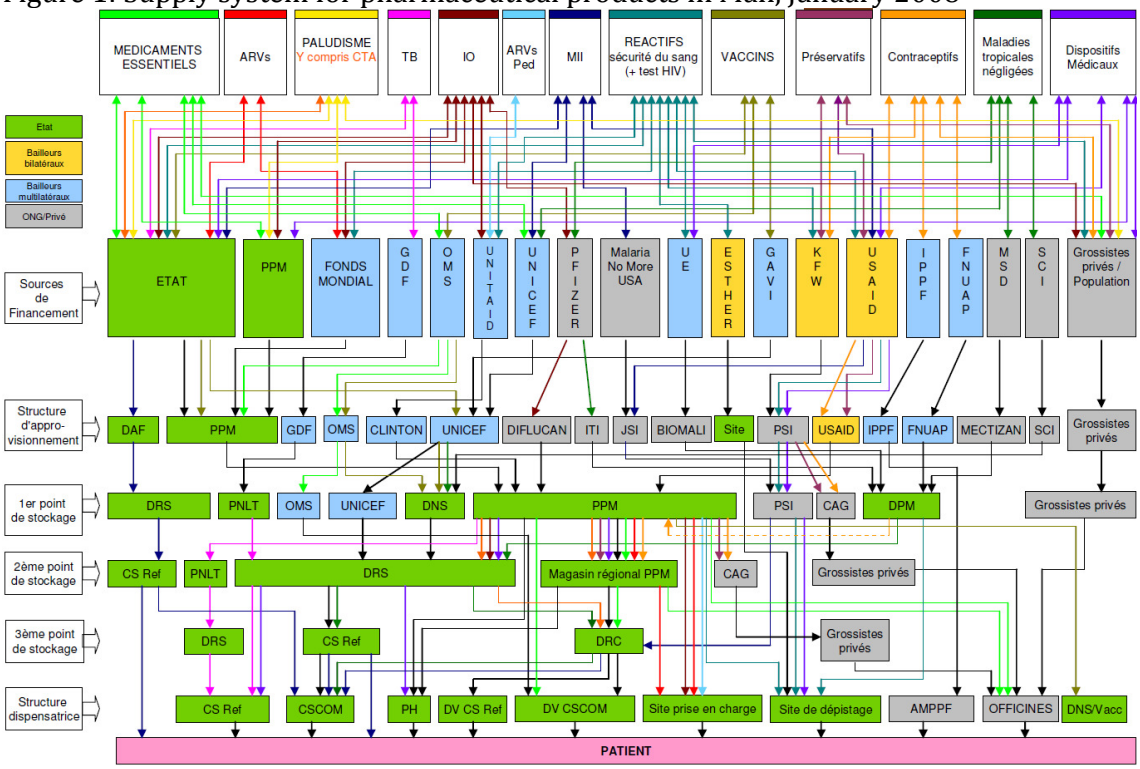
4.2.5 Changes regarding medicines, vaccines and consumables

Regarding the supply of medicines, vaccines and medical consumables, the Popular Pharmacy of Mali (PPM) is primarily responsible for supplying essential medicines throughout Mali. It therefore operates as a central procurement and distribution body at the regional level. Sale deposits are available in all public and community health facilities. PRODESS aims to achieve "zero interruption" of deliveries in 80% of operational public health establishments. To this end, an Essential Medicine Supply Master Plan has been developed, recommending monthly regional supplies and a three-month reserve supply. Implementation of various strategies has improved the availability of and access to essential medicines, for example reducing their sale price in public facilities, subsidizing a number of inputs (particularly insecticide-treated mosquito nets), supporting the manufacture of essential medicines and improving the supply and distribution service. A survey carried out by the MoH and WHO therefore concluded that 80% of essential medicines were available in the public sector. Another survey carried out with the support of USAID at the end of 2007 in Sikasso, Segou and Bamako showed that 85% of essential medicines were available in the public sector [MoH/CPS, 2008].

However, despite the existence of a public supply system, various other supply structures coexist, including some that sometimes import products without marketing authorization in Mali. The mode of distribution also varies sometimes according to the supply structures. The central procurement body does not supply EPI vaccines [MoH/Pharmacy and Medicine Directorate and WHO, 2008]. The figure below gives an overview of the complexity of the pharmaceutical supply system in Mali, which is far from displaying a high level of alignment.

Translated from French

Figure 1: Supply system for pharmaceutical products in Mali, January 2008



Source: MoH/ Pharmacy and Medicine Directorate with the support of WHO, mapping and in-depth evaluation of the supply and distribution system for medicines and other health products in Mali, August 2008

(Translation of boxes from left to right:
First row: Essential medicines; ARVs; Malaria including ACTs; TB; Opportunistic Infections; Paediatric ARVs; Insecticide-treated mosquito nets; Reagents blood safety (+HIV test); Vaccines; Contraceptives; Neglected tropical diseases; Medical facilities.
Second row: (vertically) State; Donors; Multilateral donors, Private NGO;
Third row: Sources of financing; State; PPM; Global Fund; GDF (Global Drug Facility); WHO; UNITAID; UNICEF; PFIZER; Malaria No More USA; EU; ESTHER; GAVI; KFW (German Development Bank); USAID; IPPF (International Planned Parenthood Federation); UNFPA; MSD (Merck Sharp and Dohme); SCI; Private wholesalers/Population.
Fourth row: Supply structure: DAF; PPM; GDF; WHO; CLINTON; UNICEF; DIFLUCAN; ITI (International Trachomatis Initiative); JSI (John Snow Inc.); BIOMALI; Site; PSI (Population Services International); USAID; IPPF; UNFPA; MECTIZAN; SCI; Private wholesalers.
Fifth row: 1st storage point; DRS (Regional Health Directorate); PNLT (National Tuberculosis control programme); WHO; UNICEF; DNS (National Health Directorate); PPM; PSI; CAG (Central Store for Generic Medicines); DPM (Pharmacy and Medicine Directorate); Private wholesalers.
Sixth row: 2nd storage point; Referral Health Centres; PNLT; DRS; Regional PPM shop; CAG; Private wholesalers.
Seventh row: 3rd storage point; DRS; Referral health centres; (Cercle Distribution Deposit) DRC; Private wholesalers.
Eight row: Distribution structure; Referral health centres; Community health centres;

Hospital pharmacy; Referral Health Centre Sales Deposit; Community Health Centre Sales Deposit; Management site; Detection site; AMPPF (Malian Association for the Protection and Promotion of the Family); Offices; National Health Directorate Vaccines.
Ninth row: Patient

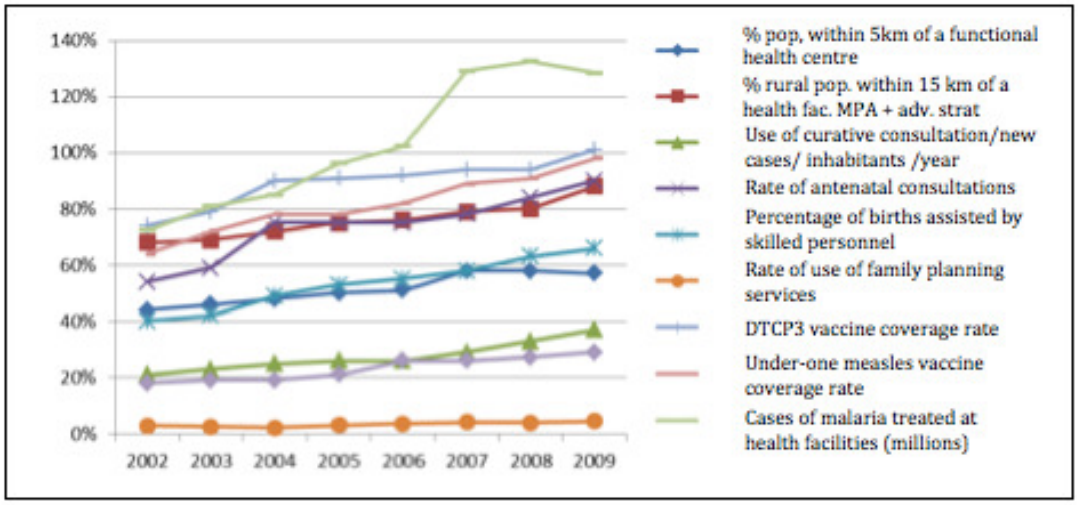
4.2.6 Changes in the health information system

Particular attention has been given to the National Health Information System (NHIS) in view of focusing on results and budget support monitoring. It has benefited from various sources of assistance, particularly the European Commission's general budget support (which has provided assistance to the Planning and Statistics Units since 2003 and reinforced this assistance in 2008) and the Health Metrics Network, which carried out a diagnosis of the NHIS in 2008. It identified various weaknesses in the collection of basic information and the duplication of some data, but measures have been taken to address these problems. The local health information system (LHIS) is now computerized up to the health district level using tailored and harmonized business software. Data collectors have undergone introductory training and received additional material. They are under great pressure to speed up the transmission of statistics and provide greater statistical detail. Collaboration has also begun with the private sector to enlist it in data collection [Samaké et al. 2011]. All these efforts **boost the capacity of the health information system to monitor and quantify results and promote dialogue with a view to reshaping sectoral policy**.

4.3 Result no. 3: Have health services improved?

This progress at the level of individual health system components has improved the population's access to and use of health services. Even though there is no evidence of a causal link between efforts to implement aid effectiveness principles and impacts on health, and acknowledging that the changes observed since the implementation of PRODESS have benefited from the reforms initiated at the end of the 1980s (see Maiga et al. 2003), it is obvious that **health sector results have improved markedly since the beginning of the implementation of PRODESS**. As shown in Tables 2 and 3, in section 2.3.1, most of the outcome and impact indicators have improved: health-care services are increasingly used, and in an increasingly equitable way, throughout national territory and among poverty quintiles. The graph below illustrates the progress in terms of access to and use of health services.

Graph 2: The main health sector outcome indicators in Mali, 2002-2009



Sources: LHIS Yearbooks 2002 to 2007; NHIS Yearbooks 2008 and 2009

These aggregate figures conceal regional disparities, though these are, in general, decreasing. Several graphs are presented in annex and show the trends in some access and use of services per region.

Progress has also been registered at the impact level (see Table 3). The PDDSS evaluation concludes that PRODESS has globally contributed to a positive impact on MDG indicators: the maternal and under-five mortality rates greatly decreased between 1996 and 2006, although this is not enough to meet the MDG for maternal mortality. In addition, **the use of services and impacts are also distributed more equitably in favour of poor populations.** The comparison of results at the poverty quintile level show an improvement in the indicators for the poorest as well as between the poorest and the richest: for example, the decrease in infant mortality is more noticeable amongst the poorest, and differences in immunization and antenatal consultation rates have been significantly reduced, though much less so for births attended by skilled personnel [MoH 2011]. The table below shows the trend in relation to each MDG for the poorest and richest quintiles.

Table 12: Disparities between poverty quintiles in terms of MDGs[24]

	20% the poorest			**20% the richest**		
Indicators	**1996**	**2001**	**2006**	**1996**	**2001**	**2006**
MDG 1						
Underweight rate in under-fives			30.8%			17.0%
Immunization coverage rate 12-23m (DTC3)	17.4%	28.1%	65.1%	67.3%	70.7%	77.4%
Immunization coverage rate 12-23m (measles)		58.1%	67.5%		77.6%	78.1%
MDG 4						

[24] Note that obviously, it is easier to improve results for the most disadvantaged quintile.

Infant mortality rate / 1000	185.1	141.8	124.0	93.6	94.9	80.0
Under-five mortality rate / 1000	322.4	244.6	233.0	163.9	164.8	124.0
MDG 5						
Prenatal care rate	25.5%	38.3%	60.7%	82.5%	89.0%	92.6%
Rate or births attended by skilled personnel	15.7%	20.8%	35.2%	79.5%	84.6%	86.3%
Contraceptive prevalence rate (married women)			2.8%			16.4%

Sources: EDS.M III (1996), IV (2001) and V (2006), referred to MoH (2011)

Overall, the outcomes achieved have permitted most PRODESS II objectives to be met, but the extended PRODESS II objectives, which were highly ambitious, are unlikely to be met, especially in view of the available funding [MoH 2011]. The view of participants interviewed is that, in general, things are moving in the right direction, even though uncertainties remain regarding governance and the efficiency of spending.

The final PDDSS evaluation [MoH 2011] and the budget support evaluation [Lawson et al. 2011] indicate that the determining factor explaining these results is the extension of health coverage in terms of community health centres offering a minimum package of activities, which mainly results from an increase in qualified health personnel (more than 97% of community health centres had at least one qualified nurse in 2009). This means that **the first two PRODESS components, supported by the partners, are totally relevant in achieving health results.**

Another determining factor in the improvement of results is **the scaling-up, by the MoH with the support of partners, of high-impact strategies** (immunization, distribution of insecticide-treated mosquito nets and artemisinin-based combination therapies) and those aiming to **improve access to health services for the poor** (certain free health services, organization of referral and evacuation at the health district level, encouraging alternative financing initiatives), **women** (reproductive health standards and procedures, free caesareans, emergency obstetric care, free distribution of insecticide-treated mosquito nets) **and children** (expanded programme on immunization (EPI), integrated management of childhood illness, prevention of mother-to-child transmission of HIV) [Lawson et al. 2011]. **These strategies constitute new priorities under the extended PRODESS II and many of them have been developed jointly with the support of donors**. Thus, for example, the national child survival strategy resulted from a UNICEF project in various pilot regions, and has since been scaled-up. The EPI is also the result of collaboration between the MoH, WHO, UNICEF, GAVI and other partners.

Other factors behind the progress observed in health results and impacts are better availability of and access to medicines and health products, the National Malaria Control Programme which has led to the introduction of new medicines, more resources allocated to the regions with greater attention to reducing regional inequalities, better harmonization of donors yielding more effective

resource management (e.g. integrated campaigns), and the development of the private healthcare sector [Lawson et al. 2011]. Except for this last point (which is nevertheless beginning to be integrated into national strategy), these are the priorities of the extended PRODESS II. **This is strong confirmation of the relevance of the national strategy in terms of results, and supports a strengthened alignment with this strategy.**

However, not everything is perfect and **a certain number of structural constraints persist**, (e.g. geographical access in the country's northern regions)[25], of **affordability, operational management** of community health centres and hospitals, and **inefficient management of resources** [MoH 2011].

[25] Despite the significant progress registered, more than 40% of Mali's population still lives more than five kilometres from a community health centre; the greatest disparity, concealed behind the average attendance rates, is found in the populations living less than or more than 5 kilometres away from a community health centre [MoH 2011].

5. What factors were decisive in achieving these results? What constraints were encountered and how were they overcome?

A number of achievements, in terms of changes in behaviour and practice in the implementation of aid effectiveness principles *specific to the internal dynamic of the health sector*, are behind the progress registered. Among these, the most important are the following: Firstly, the **sector-wide approach** launched in 1999, and which consists in alignment with the national programme, supporting its results-based management and the development of national capacities, has led to significant progress and has removed certain obstacles. In particular:

- It has considerably **reinforced the ownership** of stakeholders (including civil society) over national policy, **MoH leadership** in steering the sector and **coordination** between the government and donors. Subsequently, there has been a marked decrease in duplication of work and better coordination between the interventions of different participants, thus guaranteeing greater aid effectiveness.
- The sector-wide approach has highlighted the need to strengthen the capacities of the MoH (particularly of the standing PRODESS Secretariat) in terms of analysis, planning, implementation and monitoring/evaluation, thereby justifying various forms of **systemic institutional support** (support for the health information system, capitalization of the sectoral budget support experience, human resources management, etc.). In turn, strengthening these capacities has helped the MoH assume its leadership role in this sector. The highly proactive personality of the Health Planning and Statistics Unit Director, and his involvement in various global forums (IHP+ and positive synergies, TT HATS, etc.) have undoubtedly consolidated collaboration with the international community in view to strengthening efforts to improve aid effectiveness. However, it should be noted that this leadership is limited to a hard core of staff pertaining to the Planning and Statistics Unit and a few central directorates, but that it does not extend to all structures.
- The **quality of sectoral dialogue** in the context of PRODESS support, which is increasingly evidence-based due to the use of sectoral budget support monitoring indicators and the common matrix, has improved markedly in recent years. This dialogue highlights **various critical issues in the system, which have been the subject of many discussions and, in particular, of reforms** carried out by the MoH, often with the support of donors. These include reforms on human resources for health (in particular with a view to deploying healthcare personnel in the regions); the decentralization of financial resources; strengthening equality and reducing regional disparities; issues linked to demographic pressure and strengthening family planning (which continues to be a largely neglected health policy area); the promotion of contractualization between the State and the communes, NGO/associations and the private sector (which is slowly beginning); the reduction of maternal, neonatal and under-five mortality [Lawson et al.

2011]. Yet, the intensity of sectoral dialogue depends partially on the personal involvement of some donor representatives.

- The sector-wide approach has also **reinforced confidence among participants and the global vision of the sector**. For this reason, many partners are now seeking to pool their resources to carry out joint activities in support of the MoH. The rotation of the lead donor also highlights various priorities. Thus, for example, greater attention was given to the food issue under WFP leadership in 2007-2008, favouring its integration into health policy, while the subject of public finance management and sectoral budget support were given greater attention during the most recent mandate held by the Netherlands (2008-2010).
- This positive dynamic **may facilitate the joint resolution of problems arising during the implementation of the programme**, as is the case of the management of sectoral budget support at the regional level and GAVI alliance financial audits.

Following on from the sector-wide approach, the **intense preparation process for the IHP+ Compact and its supporting documents** has been a significant catalyst for **strengthening the common work dynamic** within the MoH, with donors and civil society. This way of working has now become entirely institutionalized, as seen in the PDDSS final evaluation process currently under way [Samaké et al. 2011]. The follow-up of the Compact commitments during the PRODESS steering bodies has also empowered the latter, and their composition has been enlarged to better include other ministries linked to health as well as the private sector.

The **common bottom-up planning process** has improved **coordination** between stakeholders, including donors, community partners, civil society and local authorities. In recent years, this process has also seen improvements such as **better targeting of priorities** and a greater attention to results analysis.

Lastly, **the supply of increasingly coherent HSS assistance** is gradually falling into place in support of the national HSS plan (rather than isolated HSS queries) and promises further progress in the future, as is the case with collaboration with the private sector, which has recently been initiated by the MoH.

Various other factors, linked to the implementation of aid effectiveness principles *at the national level, but having filtered through to the health sector,* have also contributed to progress. Thus, **sectoral budget support** has not yielded the expected added value in terms of alignment and reduction of transaction costs, but it introduced the practices of monitoring a **matrix of performance indicators** linked to annual targets, **improving the quality of information** provided and analyses carried out by the MoH, expediting the agenda on **devolution/decentralization** (which is necessary to improve results in such a vast and originally centralized country like Mali) and **reinforcing collaboration between the MoH and the MoEF**, especially with a view to solving public finance management problems which have appeared in the management of sectoral budget support [Lawson et al. 2011]. This may be the reason for the rise in the proportion of the State budget assigned to the health

sector in recent years (see sub-section 4.2.2), and is certainly behind the extension of national PRODESS ownership. Furthermore, the recent budget support evaluation in Mali notes that **conditionalities appear to have different effects depending on consistency with real government priorities** [Lawson et al. 2011]:

- Conditionalities linked to real government priorities (for example immunization) may boost the increase of resources assigned to these priorities, hence these conditionalities can have a leverage effect;
- However, conditionalities that attempt to promote a reform that, in the view of donors, the government is taking a long time to implement (e.g. family planning), take longer to produce results; if they do, they act only through dialogue and definitely do not have an automatic effect;
- "Operational" rather than result conditionalities (e.g. percentage of the budget decentralized) appear to have a fairly automatic leverage effect.

Concern for poverty reduction, as seen in the development, implementation and monitoring of the PRSP 2002-2006 and the PRGSF 2007-2011, have strengthened the focus of the health programme in this area. Lastly, **the process of State reform**, in particular the decentralization and the devolution agendas, also receives a significant amount of support from donors and has influenced the health sector.

6. Conclusions

In conclusion, **important progress has been made on the implementation of aid effectiveness principles in the health sector in Mali, mainly as a result of the sector's internal dynamic, while others have filtered through from the national level. Various achievements have been noted as regards changes in behaviour and practice, both by the government and by a number of donors; these have, in all likelihood, helped to improve the system and the health sector results.** However, **the drastic fall in external financing since 2008 is of great concern** and threatens to have a negative effect on the quantity and quality of services [MoH 2011]. This is all the more worrying since the execution of internal financing has also been delayed this year due to the change in government in 2011. Furthermore, **there is some evidence of a "two-speed implementation" of the principles of the Paris Declaration and IHP+, which have, until now, been implemented only in part, while certain forms of behaviour contrary to these principles persist among a large number of participants**. The following problems have also been observed:

- **Donors continue to proliferate**: out of fifty active donors in the health sector, registered under the PRODESS operational plan, only thirteen have signed the IHP+ Compact.
- Aside from Spain's transfer to sectoral budget support in 2009 and the increase in Canadian funding, **there is no upward trend in sectoral budget support in the sector.**

- Many donors (such as Canada, USAID, the Netherlands, Spain, IDB and soon the World Bank) **continue specific targeted projects,** especially on reproductive health rather than on HSS in general. Even though the reproductive health activities are in line with PRODESS strategies, this raises the question of whether more generalized HSS intervention would not have a greater impact on health objectives. Furthermore, a large proportion of external financing is geographically targeted, without taking regional balance into consideration.
- Even though some donors follow the national public procurement procedures, many of them continue demanding to have their say at each stage of the process (preparation of the requests for proposals, evaluation, award of contracts). Important donors, especially the Global Fund and USAID, continue to use **project management units and ad hoc procedures** for the majority of their funding. This is supposed to give them more control on the use of resources, but this is not at all the case for the Global Fund, which suffered heavy misappropriation of funds in 2009-2010 – detected by the internal monitoring system of the Government of Mali.
- Many donors do not respect their commitments to make their **funding pledges and disbursements on time**, even when Mali meets all the conditionalities. Only external financing managed by the MoH is confirmed at the planning and budget session, while information on NGOs and other donors that manage their funds themselves is not available.
- Although they are all invited to participate in the joint missions and reviews, almost all the active donors in the sector **continue to organize bilateral missions** and various workshops from their headquarters, imposing their own agenda on the government.
- Although annual PRODESS audits are carried out at the national level (under the external supervision of the Accounts Department of the Supreme Court and the Office of the Auditor-General, and by a private company in the case of sectoral budget support), five additional **ad hoc audits** were carried out in 2010, placing considerable pressure on the Finance and Material Directorate of the MoH. This was also identified as one of the main causes of the difficulties in the implementation of planned activities as the Finance and Material Directorate was incapable of meeting all the demands of donors and had to neglect its day-to-day management of domestic resources [Lawson et al. 2011 and Samaké et al. 2011].
- The MoH receives support from some 150 Cuban and Chinese medical doctors, and a series of other **technical assistants**, but these interventions are provided on a **bilateral basis** by the donors, who sometimes impose their own priorities, far from the IHP+ Compact recommendation to create a common TA pool.

This lack of change in behaviour means that **expectations regarding the outcomes of the implementation of aid effectiveness principles must be tempered with realism**. In general, until now, **few results have been achieved in terms of alignment with national procedures on financial management, aid predictability** (even though some donors make their funding pledges in advance and over various years, total external aid disbursements registered are still far off predictions), **or even of more resources for health.** On the contrary,

executed exterior financing fell drastically in 2009, while the Government of Mali has respected its commitment to increase the health proportion of the general State budget. **Mutual accountability is also struggling to establish itself effectively,** as seen in the Government of Mali's failure to make donors respect their commitments in terms of increasing funding and aid predictability.

Mali's health sector authorities currently face **a number of significant challenges**, specifically on **expediting the final evaluation of the PDDSS and preparing the new plan** to address the concerns raised by the evaluation. This process uses the CHPP (to reach a consensual diagnosis of the strengths and weaknesses of the health system) and JANS instruments (which should help improve the quality of the new plan and boost donor confidence in this plan), which should contribute to making the new plan into a unifying instrument for future assistance. Another challenge is that of **improving financial management procedures**, particularly in view of aiding the mobilization of resources at the operational level and the transparency of public procurement, to persuade a greater number of donors to use these procedures. The recent evaluation of budget support operations was extremely positive and has reassured the donors that had adopted this option. It will perhaps also encourage the use of this aid instrument – especially as the recent PEFA evaluation[26] indicated significant progress in terms of public finance management and the PAGAM-GFP priorities are completely relevant in addressing remaining problems [ECORYS 2010]. Furthermore the perspective of the upcoming public expenditure tracking survey should also help strengthen confidence in national procedures. The third major challenge is **persuading donors to respect their commitments and encouraging others, in particular the Global Fund, to align themselves with and put the principles of the IHP+ Compact into practice effectively by increasing their funding and aligning themselves with national strategies and systems**, as well as by supporting HSS in its entirety rather than specific health problems, by minimizing parallel reviews and audits, in addition to joint reviews and audits, and increasing the predictability – and the timely disbursement – of their funding [Samaké et al., 2011]. Only under these conditions will the full potential of the agenda to improve aid effectiveness be realized, achieving results in line with expectations.

[26] The *Public Expenditure and Financial Accountability* (PEFA) methodology was developed by a consortium of agencies. It allows providing an objective diagnosis of the performance of PFM, public procurement and financial accountability systems so as to facilitate the identification of reforms and priorities in terms of capacity building in partner countries. See http://www.pefa.org.

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- PNUD, Human development report: http://hdr.undp.org/en/statistics/
- MaliCHPP Portal: https://www.healthintelligenceportal.org/index.php/Portal:Mali

7.4 Persons interviewed

7.4.1 October 2010 (evaluation of budgetary assistance)

- Abebech Assefa, Health and Education Adviser, Embassy of Canada
- Chaka Bagayoko, Finance Service Director, MoH Administrative and Finance Directorate
- Amadou Bengaly, Adviser, Embassy of Canada
- Youssouf Berthé, Human Resources Director, Health sector
- Pierre Beziz, Statistician, European Union Delegation
- Sidi Yeya Cissé, Health Planning and Statistics Unit
- Olga de Azaola, Embassy of Spain
- Sadio Diarra, Health specialist, Embassy of the Netherlands
- Florence Duvieusart, Adviser, Embassy of Belgium
- Michel Francoys, Programme director, BTC
- Claude Goulet, Deputy Cooperation Director, Embassy of Canada
- Oumar Maiga, Head of Division, MoH Administrative and Finance Directorate
- Luc Risch, Adviser, Embassy of Belgium
- Salif Samaké, Health Planning and Statistics Unit Director
- Tiécoura Sidibé, UNICEF
- Jeanine Simbizi, Resident representative, BTC
- Christine Sow, UNICEF
- Mahamane Touré, MoH Administrative and Finance Directorate
- Namory Traoré, Adviser, Embassy of the Netherlands
- Jacob Waslander, Head of cooperation, Embassy of the Netherlands
- Organization of a focus group with active donors in the health sector

7.4.2 January 2011 (preparation of a note for the TT HATS report)

- Chaka Bagayoko, Head of Finance Service, MoH Administrative and Finance Directorate
- Issa Berthé, Health Planning and Statistics Unit
- Salif Samaké, Health Planning and Statistics Unit Director
- Souleymane Traoré, Deputy Director, MoH Administrative and Finance Directorate

7.4.3 Telephone interviews, May 2011

- Salif Samaké, Health Planning and Statistics Unit Director (24 May)
- Amadou Bengaly, advisor, Embassy of Canada (24 May)

Translated from French

7.4.4 October 2011 (finalization of the study and restitution of the results of the case study-

- Salif Samaké, Health Planning and Statistics Unit Director
- Issa Berthé, Health Planning and Statistics Unit
- Presentation of the results of the case study to the donor meeting, October 20

Translated from French

Annex 1: Common framework of extended PRODESS II measures

	Indicators	2005	2006	2007	2008	2009	2010	2011
		Executed			Planned			
1	Percentage of the population living less than 5km from an operational community health centre	50	51	58		60	62	64
2	DTCP3 vaccine coverage rate of under 1-year old children	91	92	94		≥ 90	≥ 90	≥ 90
2.1	Max. regional difference of DTCP3/PENTA3 immunization coverage and the national average							
3	Rate of births attended by skilled personnel	53	55	59		60	63	65
3.1	Maximum regional difference of births attended by skilled personnel and the national average							
4	Rate of antenatal consultation coverage per expectant mother			35		40	43	46
4.1	Maximum regional difference of effective ANC compared with the national average							
5	Percentage of under 1-year old children vaccinated against measles	78	82	89		≥ 90	≥ 90	≥ 90
5.1	Maximum regional difference in the percentage of 1-year olds vaccinated against measles compared to the national average							
6	Rate of curative consultation use	0.26	0.26	0.29		0.33	0.34	0.34
7	Incidence of malaria in health facilities	963	1023	1292				
8	Prevalence of pulmonary tuberculosis							
9	Tuberculosis detection rate	21%	26%	26%				45
10	% of BEmONC community health centres			28%		32	33	34
11	% of referral health centres offering de CEmONC			2%		6	8	9
12	Hospital mortality rate	10	10.6	12.4				
13	Percentage of patients admitted on referral/evacuation	22	22.6	22.2				
14	Bed occupancy rate (surgery/medicine)	44/62	47/55	45/60				
15	Ratio of healthcare personnel/inhabitants							
	Doctors/inhabitants		1/10370	1/10389				
	Midwives/inhabitants		1/23928	1/23615				
	Nurses/ Medical assistants/ inhabitants		1/4190	1/3365				
15.1	Maximum regional difference in the ratio of healthcare personnel/inhabitants with the national average							
16	Coverage of basic personnel needs per category in community health centres		94.14	96		98	100	100
17	Availability of health-basket medicines			95%		95%	>=95%	>=95%
18	Caesarean operation rate		1.89%	2.06%		3%	4%	5%
19	Percentage of seropositive newborns born of seropositive mothers on ARV							
20	Percentage of seropositive pregnant women put on ARV					100%	100%	100%
21	Average number of medicines prescribed per prescription					3	3	3
22	Number of Couple-Years of protection			68 487				
22.1	Percentage of couple-year protection (%)			2.37				

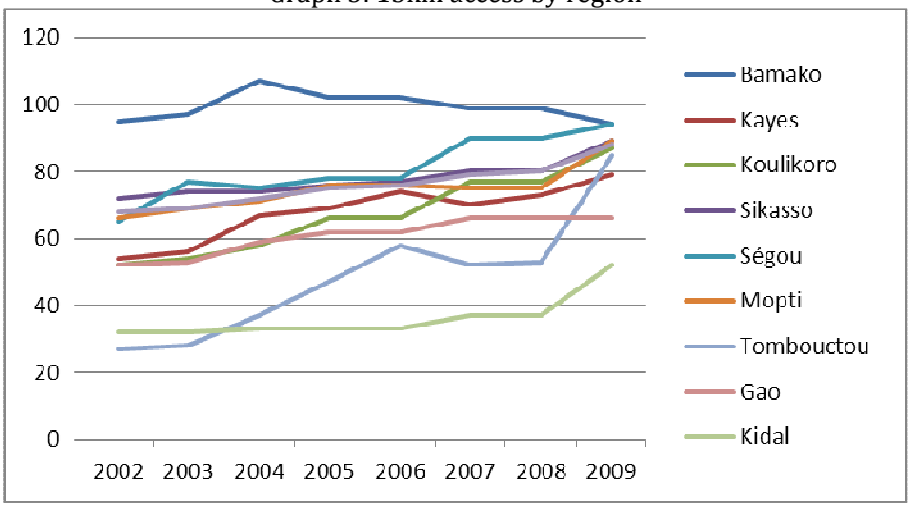
Translated from French

	Indicators	2005	2006	2007	2008	2009	2010	2011
		Executed			Planned			
23	Percentage of referral health centres having carried out at least two integrated supervisions in each community health centre							
24	Rate of execution of ordinary State budget assigned to the procurement of medicines, vaccines and contraceptives					>=95%	>=95%	>=95 %
25	Average cost of prescription in health facilities per level							
	Referral health centres		1058 F	1282 F		<=2000F	<=2000F	<=2000F
	Community health centres		946 F	1107 F		<=1500	<=1500	<=1500
26	Budget execution rate					>=95 %	>=95%	>=95 %
27	Percentage of financial resources used in accordance with the MTEF							
28	% recurrent resources transferred to decentralized services in execution of budget N-1							
29	Maternal mortality rate / 100000		464					344
30	Under-five mortality rate / 1000		191					150
31	Infant mortality rate / 1000		96					56
32	Neonatal mortality rate / 1000		46					30
33	Underweight rate in under-fives		32%					27%
34	HIV/AIDS prevalence rate (%)		1.3					1
35	% of children with diarrhoea receiving ORS		44.7					50

Source: MoH/Compact (2009)

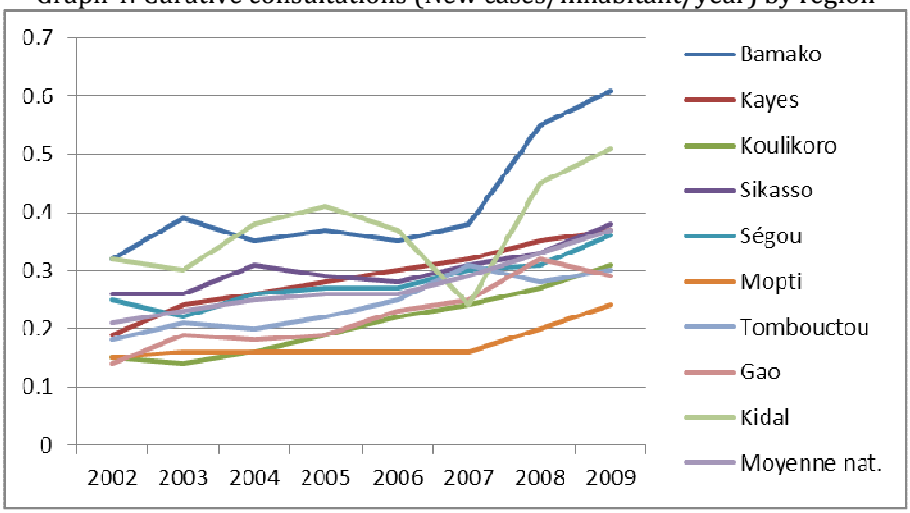
Annex 2: Trends in some access and health service use indicators per region

Graph 3: 15km access by region



Sources: LHIS Yearbooks 2002 to 2007; NHIS Yearbooks 2008 and 2009

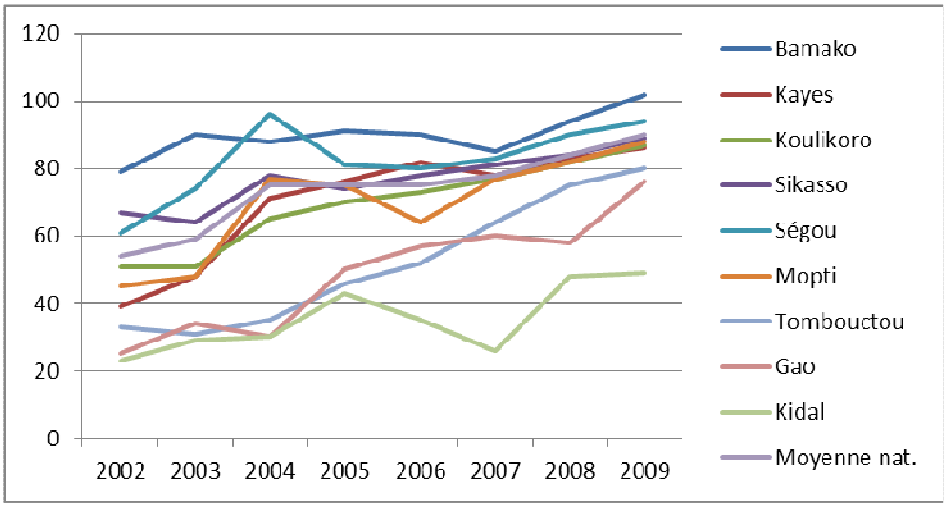
Graph 4: Curative consultations (New cases/inhabitant/year) by region



Sources: LHIS Yearbooks 2002 to 2007; NHIS Yearbooks 2008 and 2009

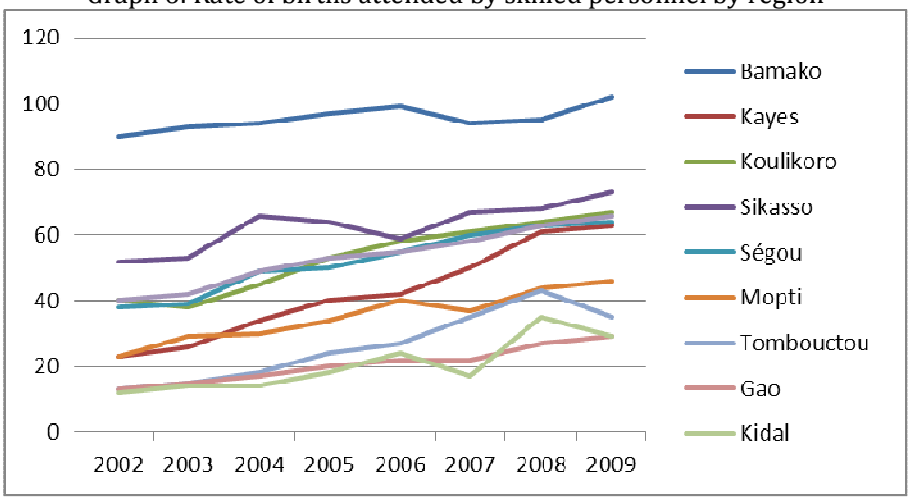
Graph 5: Prenatal consultation use (%) by region

Translated from French



Sources: LHIS Yearbooks 2002 to 2007; NHIS Yearbooks 2008 and 2009

Graph 6: Rate of births attended by skilled personnel by region



Sources: LHIS Yearbooks 2002 to 2007; NHIS Yearbooks 2008 and 2009