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MALI APPLIED POLITICAL ECONOMY ANALYSIS

Building Local Health Systems in a Fragile State

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Building Local Health Systems in a Fragile State

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ACRONYMS

ANICT	Agence Nationale d'Investissement des Collectivités Territoriales
AQIM	Al Qaeda in the Maghgreb
ASACO	Association de Santé Communautaire
BVG	Bureau Du Vérificateur Général
CADD	Cellule d'appui à la Décentralisation et à la Déconcentration
CANAM	Caisse Nationale d'Assurance Maladie
CBHI	Community-Based Health Insurance
CDC	Center for Disease Control
CHVs	Community Health Volunteers
CHW	Community Health Worker
CPS	Cellule de Planification et de Statistique
CSCOM	Centres de Santé Communautaire
CSO	Civil Society Organization
CSREF	Centres de Santé de Référence
DDG	Deputy Director General
DRG	Democracy, Human Rights, and Governance
FENASCOM	Fédération Nationale des Association de Santé Communautaire
FGDS	Focus Group Discussions
GoM	Government of Mali
HSS	Health Systems Strengthening
IBK	President Ibrahim Boubacar Keïta
IDP	Internally Displaced People
IP	Implementing Partners
KIIs	Key Informant Interviews
LEAP III	The Learning, Evaluation, and Analysis Project
MNLA	Movement for the Liberation of Azawad
MoH	Ministry of Health
OOP	Out of Pocket
PEA	Political Economy Analysis
PPM	Pharmacie Populaire du Mali
PPN	Politique Pharmaceutique Nationale
RAMED	Régime d'Assistance Médicale

RAMU	Régime d'Assurance Maladie Universelle
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Fund
USAID	United States Agency for International Development
UTM	Union Technique de la Mutualité
WHO	World Health Organization

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[1] Source: United Nations Source: Office for Coordination of Humanitarian Affairs, 2017.

EXECUTIVE SUMMARY

Despite decades of investment from development partners, as well as modest but steady improvements in some important health indicators, like child mortality, Mali's public health care system continues to exhibit significant gaps in service delivery and low budget allocations to health. In 2019, the United States Agency for International Development (USAID) / Mali Health Team launched a new health strategy that focuses on addressing these gaps, by improving community oversight of local health services and increasing citizen's participation in the management, performance, and accountability of health systems at the local level.

The new strategy requires a deeper understanding of the structures and patterns of governance within the health sector and of the factors influencing accountability and change within the system. In particular, the Health Team sought to assess how well decentralized budget transfers from the central government to the regions are being managed and utilized at the local level, and to what extent decentralization within the health system has contributed to the Government of Mali (GoM)'s stated policy of equal access to basic health services. Toward that end, USAID / Mali contracted USAID's Learning, Evaluation, and Analysis Project (LEAP III) to conduct an Applied Political Economy Analysis (PEA) of local health systems, focusing on the business plans and financial management of community health centers (*Centres de Santé Communautaire,* CSCOMs) and their management associations (*Association de Santé Communautaire*, ASACOs). Furthermore, the analysis sought to identify the challenges and opportunities for strengthening accountability and quality of service in local health centers, which are facing increasing demands under a new health reform initiative committing the government to provide free health services for all pregnant women and children under five.

While the initial scope of the research focused only on a narrow question around health care financing at the local level, it became clear to the team through initial consultations that many of the political economy challenges were systemic to the health sector at all levels. Accordingly, to build a deeper understanding of local health systems, specifically of gaps in financial management and oversight in relation to service delivery, as well as implications for health care coverage under the new health reform law, the assessment was broadened to properly capture these issues along the following three pathways of inquiry:

1. What is the financial relationship between decentralized health financing and health structures at the community, municipal, and district levels;
2. What are the risks, opportunities, and perceptions of health reform and identification of bottlenecks and pathways for implementation of reform with regard to improved coverage; and
3. What are the barriers to inclusion of marginalized populations in accessing health care?

In consultation with Mission and Washington DC staff, the Applied PEA team designed a research instrument (see Annexes V and VI for the English and French versions) that uses the above pathways of inquiry to gain insight into local level governance of health resources and how management of those resources impacts local health service provision. The team sought perceptions of the highly publicized new health reform law and explored the political economy context for implementation of health sector reform. The research team also analyzed barriers to inclusive health access with the understanding that

health care service provision is seen as a critical pathway to strengthening state legitimacy and to greater stability for a fragile state like Mali.

KEY FINDINGS

1. DYSFUNCTIONAL DECENTRALIZATION COMPROMISES HEALTH FINANCING AND SERVICE DELIVERY.

The findings from this research reveal the impact of Mali's dysfunctional decentralization on the health sector, unveiling systemic corruption, endemic impunity due to low levels of accountability, and an absence of transparency both in the government agencies responsible for financial transfers and within health care centers. The team found that corruption is present at every level of health-related service provision, impacting both service quality and acting as a barrier to care.

Efficient and reliable transfers of resources are critical to the success of health reform, however, responsibilities have been transferred to regional authorities without the corresponding resources needed to carry out these obligations. While the central government has sought to avoid blame for the slow pace of reform, insisting that local governments are at fault for failing to mobilize additional resources, the vast majority of the existing tax base is in Bamako, leaving local authorities with very little ability to locally fund CSCOMs. Budgetary allocations at the national level are simply insufficient to implement the promised health sector reforms, despite the post peace accord proposal to increase the regional share of public resources from three to 30 percent. In addition, decentralization has reduced accountability, keeping officials separately occupied with their tasks rather than providing oversight to ensure that state resources are effectively and efficiently allocated, and transferred to CSCOMs for service delivery.

Addressing these problems with a top down approach is unlikely to yield improvement and may contribute to further high-level budget misappropriation. Under decentralization, local Circle Councils are responsible for transfers of allocations to reference hospitals, and regional councils are responsible for transfers to district hospitals. Trumpeted as a bottom-up planning process from the community level to the municipality and the district, with requests submitted from the district level to the Ministry of Health (MoH), the national budget process yields allocations of what officials estimated to be about fifty percent of the requests. In practice, budget allocation decisions are primarily based on the previous year's allocation and are influenced heavily by the personal relationships of regional governors or other officials with Bamako. The decision is theoretically made based on the population and tax base of an area, but in practice, there is very little transparency about that process. No clear formula for regional health budget allocations appears to exist.

While salaries for health workers are paid directly by the MoH, there is a tier of doctors and health technicians who are tasked with managing the human resources, medical supplies, and logistics, as well as the actual health care operations at the regional and local levels. Inadequate oversight and accountability negatively impact the availability and quality of health services and create opportunities for rent-seeking through a lack of transparency in the management of financial and other resources. Respondents explained how doctors frequently funnel patients to private clinics; health care workers engineer stock-outs of supplies to sell pharmaceuticals on the side patients are overcharged and wait too long for triage and diagnosis in CSCOMs; differential treatment is accorded to those with higher

status in society; and patients are charged for services that are supposed to be free. All of these issues undermine the credibility of public CSCOMs and endanger the overall health system.

At the local level, mayors are key figures due to the role these elected officials play in managing transfers of subsidies to local CSCOMs. Allocations for CSCOMs are transferred to the mayor in a lump sum, using a fixed rate subsidy based on the number of CSCOMs in a municipality. This has provided mayors with incentives to encourage the formation of CSCOMs. In practice though, it has also led to half-built or unbuilt CSCOMs, paid for through investment funds from donor sources but receiving subsidies for services. CSCOMs are managed by local elites who divert funds for personal and political gain. Mayors have incentives to collude with ASACOs who use health resources to influence electoral politics, in order to maintain political power.

2. THE FEASIBILITY OF HEALTH REFORM IN THE CONTEXT OF STATE FRAGILITY IS QUESTIONABLE.

The health reform law passed in 2018 was introduced in the context of state fragility and a public health system that exhibits very low capacity for decentralized service delivery. The promise announced in February 2019, that by 2020 *"health services will be free for all pregnant women and children under five, contraceptives will be free, and the country will add thousands of health workers to its community health system"* is an unfunded political mandate and not part of the 2018 law. Nevertheless, it caught the imagination of the public and may have garnered some votes. This public promise of reform has raised expectations among Malians who find health care costs out of reach. The World Health Organization (WHO) estimates that out of pocket (OOP) costs represent almost half (46 percent) of household income in Mali. According to government respondents in this study, the new health reform law is designed to change that equation and reduce the personal burden of health care cost. In reality, the new law does not include free health care, a popular misconception among respondents, but it does include provisions aimed to significantly expand public health insurance. The law is designed to gradually replace existing health schemes and extend Universal Health Coverage (UHC) to all Malians. This study finds no evidence that the GoM has the resource capacity or political will to deliver on this promise.

3. RENT-SEEKING AT CSCOMS AND LACK OF AWARENESS OF PATIENTS' RIGHTS ARE A BARRIER TO HEALTH CARE FOR VULNERABLE MALIANS.

Findings from this assessment indicate that in addition to the deep structural problems with the governance of health finances, rent-seeking behaviors at CSCOMs present a significant barrier to achieving improved health care. Questions of inclusion and exclusion related to gender, ethnicity, geography, and education present challenges to broadening access to quality health care in Mali. Local governance of health resources is of critical concern because corruption at CSCOMs leads to exploitation of vulnerable Malians accessing health care when they are subjected to higher charges, longer wait times, and/or less effective treatments because they do not know their rights. Respondents perceive that poorer, illiterate patients pay more than others for health care services. The team found that broadly, services within Mali's public health system are subject to unofficial arbitrary pricing, parallel pharmaceutical supply chains, and referrals to private clinics where public health care providers moonlight. Our findings also suggest that inadequate supplies, equipment, and qualified professionals leave the majority of Malians dissatisfied with public health care. Moreover, this potential for exploitation and the anxiety over unknown costs of care drive most Malians toward traditional healers as a first recourse for most health care needs. This in turn places a greater burden on the local health

care system because patients arrive sicker and often in need of urgent and most costly care than would have been the case had they visited the CSCOMs at the onset of symptoms.

Although a patients' bill of rights does exist and does theoretically protect patients from the abuses of power of the health care workers, most citizens do not know their rights. Among focus group discussants, the issue of their rights came up repeatedly. What information respondents did possess tended to reflect what they had heard on the radio when President Ibrahim Boubacar Keïta (IBK) promoted health care reforms. The team identifies this gap in knowledge of rights to be an area for greater attention by donors.

What began as an assessment of the efficiency of financial transfers for health care delivery became an assessment of the ways the health care system fails to support inclusive access to the vital primary health care services needed to lower maternal, child, and neonatal mortality. Furthermore, the system has been manipulated by local elites to divert health sector funds for personal and political gain. Research findings indicate that promoting accountable governance in the health sector means tackling the problems of clientelism and corruption that are exacerbated by Mali's decentralized health system at the local level.

Table 1. Summary of Key Findings by Applied PEA Pillar

Themes	Summary of Key Findings
Foundational Factors	• State centric, top-down style of government thwarts decentralization efforts; • Food insecurity due to political and geographic isolation negatively impacts health outcomes; • Within households, food distribution is determined by embedded social and gender hierarchies and cultural beliefs, which can have significant effects on nutrition status; • Illiteracy, particularly female illiteracy, is a major factor in accessing family planning or seeking care at a CSCOM; • Youth groups did not hesitate to express their complete lack of faith in the public health system.
Rules of the Game	• Resources are not being transferred from the national to the regional government; • Health budget allocation is determined by patronage relationships; • ASACOs and mayors collide on rent seeking opportunities; • Parallel pharmaceutical supply chains (both formal and informal) enrich local political elites; • There is systemic corruption and endemic impunity; • Predatory behaviors of health care workers force patients to seek lower cost but potentially harmful alternatives.
The Here and Now	• Decentralization has exacerbated rent-seeking and poor service delivery in health; • Unfulfilled promised around health reform could be the spark for widespread discontent.
Dynamics	• Trust in health systems is waning in parallel with the trust in the State;

	• ASACOs are powerful potential spoilers of health reform.

RECOMMENDATIONS

The team identified numerous findings of which a smaller number map directly to actionable recommendations. These recommendations are also informed by the 2019 Democracy, Human Rights, and Governance (DRG) Assessment that outlines a strategic approach of "*Act, Assess, and Adapt*". To act, the team recommends identification of three to five target communities and municipalities for pilot interventions. These will build on existing successes (for example the work of USAID's Implementing Partners (IPs): Save the Children or the FHI360 Linkages Project). Next, use the data from these pilots to assess the feasibility of scaling the strategy to more communities within the same municipality (and possibly including one or two in higher risk zones such as Mopti); and, finally, adapt program interventions based on learning in the pilot phase.

To mitigate risk for USAID and its implementing partners, this assessment recommends making a higher number of modestly funded responses with the specific aim of demonstrating to local communities an immediate and tangible improvement in health care, while building local governance capacity at the municipal level over health resources. To help ensure the survival of CSCOMs, USAID should consider strategic but limited investments through regional governments, and specifically through municipalities that focus on building citizen engagement and understanding of rights and responsibilities. Furthermore, USAID should support local democratic processes that enable communities to counter entrenched local power relationships and redesign the process of getting their health care needs meet through CSCOMs. USAID could support community-driven demands, for example, for piloting sterile C-section kits and specialized training to midwives/nurses. The fundamental principal of these pilot interventions must be that they are evidence-based and that they closely align with the priorities of the community, not those of the ASACO, mayor, or donors.

1. INTRODUCTION

1.1 ASSESSMENT PURPOSE AND AUDIENCE

The United States Agency for International Development (USAID) / Mali chose to undertake a Political Economy Analysis (PEA) to better understand how health funding and management decisions are made within the Government of Mali (GoM) health service delivery structure. In particular, USAID / Mali is interested in better understanding the structures of authority and patterns of governance within the health sector, and how relationships within the sector affect USAID programming. To achieve these objectives, this analysis will examine which factors influence accountability and change within the GoM health care system, as well as which entities or individuals hold power when it comes to making decision-making and effecting change.

Integra, LLC led a scoping exercise with the USAID / Mali health team in September 2019 that zeroed in on USAID's concerns about the linkage between service delivery gaps and the mismanagement of finances within Mali's health system at the local level. While the initial scope of the research focused only on a narrow question around health care financing at the local level, it became clear to the team through the course of the work that many of the political economy challenges were systemic to the health sector at all levels. Accordingly, the assessment was broadened to properly capture these issues along three pathways of inquiry.

The team identified three pathways of inquiry:

1. What is the financial relationship between decentralized health financing and health structures at the community, municipal, and district levels (i.e. public financing for health)?
2. What are the risks, opportunities, and perceptions of health reform and identification of bottlenecks and pathways for implementation of reform with regard to improved coverage (i.e. political economy of health reform)?
3. What are the political economy barriers to inclusion of marginalized populations in accessing health care?

In consultation with the Mission and Washington DC staff, the PEA team designed a research instrument that could be used by the field team to explore the above pathways of inquiry through interviews and focus groups. The team sought public perceptions of the highly publicized new health reform law and explored the political economy context for implementation of health sector reform and decentralization. The research team also analyzed barriers to inclusive health access with the understanding that health care service provision is seen as a critical pathway to strengthening state legitimacy and to greater stability.

Findings from this PEA will inform the co-creation process of two new large bilateral agreements: *Health Systems Strengthening* (HSS), and *Integrated Community Health and Nutrition*. The analysis identifies potential champions and spoilers of reform strategies, maps key stakeholders within the health sector, highlights areas that need further exploration, and proposes pathways forward for ongoing contextual learning and adaptation. The research team employed USAID's Applied PEA methodology set out in USAID's Applied PEA Guide, in order to link programmatic objectives under USAID / Mali's health sector activities to a broader Democracy, Human Rights, and Governance (DRG) sectoral framework.

The DRG framework recognizes the important role that equitable access to quality health services plays in the continued development of all countries, as well as the fundamental role that governments should play in providing their citizens with access to these services. Health service provision in this PEA context is understood as a foundational factor of state legitimacy in the eyes of the citizenry.

1.2 APPLIED PEA FRAMEWORK

USAID's Applied PEA Framework and Field Guide defines a structure based on four analytical pillars: Foundational Factors, Rules of the Game, The Here and Now, and a cross-cutting theme: Dynamics.

Table 2: Overview of Applied PEA Pillars

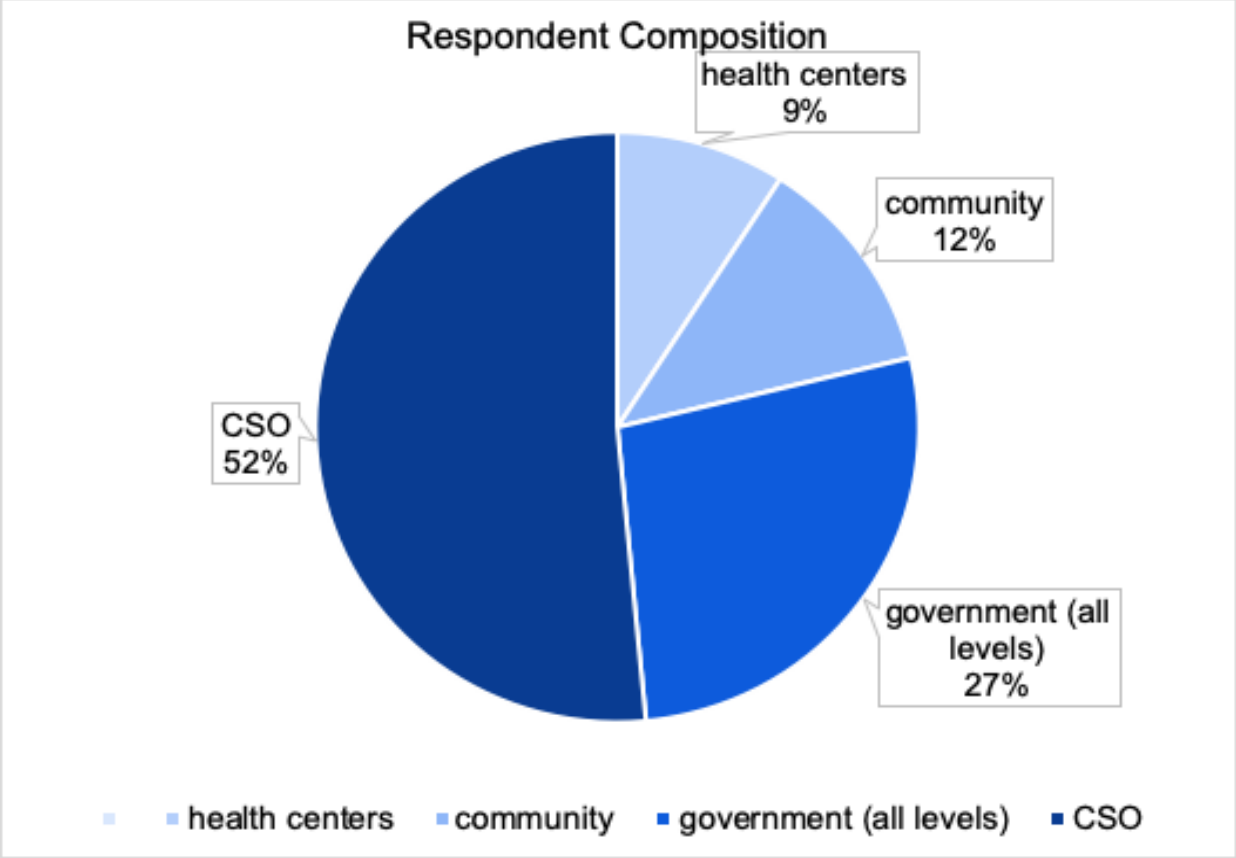
Key Analytical Pillars	Explanation of Pillars
Foundational Factors	These are deeply embedded, longer-term national, subnational and international features that shape the character and legitimacy of the state, the political system and socio-economic structures. These tend to be fixed or slow to change, such as geography, longstanding conflicts, class and power structures, and demographics.
Rules of the Game	These are the formal and informal institutions (rules and norms) that shape the quality of governance and influence actors' behavior, their incentives, relationships, power dynamics and capacity for collective action. This encompasses both the formal constitutional and legal frameworks, as well as informal norms, social and cultural traditions that guide behavior in practice and the extent to which state, civil society and private sector institutions work according to known rules (in predictable ways).
The Here and Now	These refer to how current events and circumstances influence the objectives and behavior of key actors or stakeholders, and how they respond to opportunities for or impediments to change. This could include leadership changes, scandals, or natural disasters, as well as political crises.
Dynamics	These references the dynamics and interactions between foundational factors, rules of the game and here and now. How do they affect each other, and how do they influence/shape prospects for change? For instance, what features are in flux and may drive an opening or closing of space for change? What international or domestic drivers of change are acting on the state, society and markets already? What levels of complexity and uncertainty are there in any potential changes that are identified? What are the incentives and disincentives for change; who are the potential champions and spoilers; and what kinds of alliances and coalitions can be encouraged to overcome resistance to change and promote reform.

The research team, following USAID's Applied PEA field guide recommendations, used a multi-step process that started with scoping the PEA questions of inquiry through a pre-fieldwork literature review and consultation with USAID, pre-fieldwork research design, and in-country field-based research. Fieldwork was conducted October 14 - 25, 2019 by two teams with a total of 45 interviews and focus groups.

1.3 Respondent Composition

Out of the total of 45 interviews, 34 were one-on-one Key Informant Interviews (KIIs) and 11 were Focus Group Discussions (FGDs) and/or small group discussions conducted in Bamako, Segou, Koutiala, and Koulikoro. In total, there was a total of 142 participants, which included the following broad categories[2] of Government (national, regional and local government officials), Health Centers (managers, health care providers including midwives, doctors, nurses, technicians and volunteers), Communities (IDPs, patients, women, youth), as well as Civil Society Organizations (implementing partners (IPs); and Non-governmental organizations, handicapped associations, youth and women's associations, development partners; private sector). Significant effort was made to include women and youth from both rural and urban/peri-urban Mali and to include the views of both those who had insurance and those who did not. Out of the 142 participants, 39 percent were women; FGDs were segmented to encourage people in marginalized groups, such as youth and women, to speak freely.

Figure 1: Respondent Sample Distribution



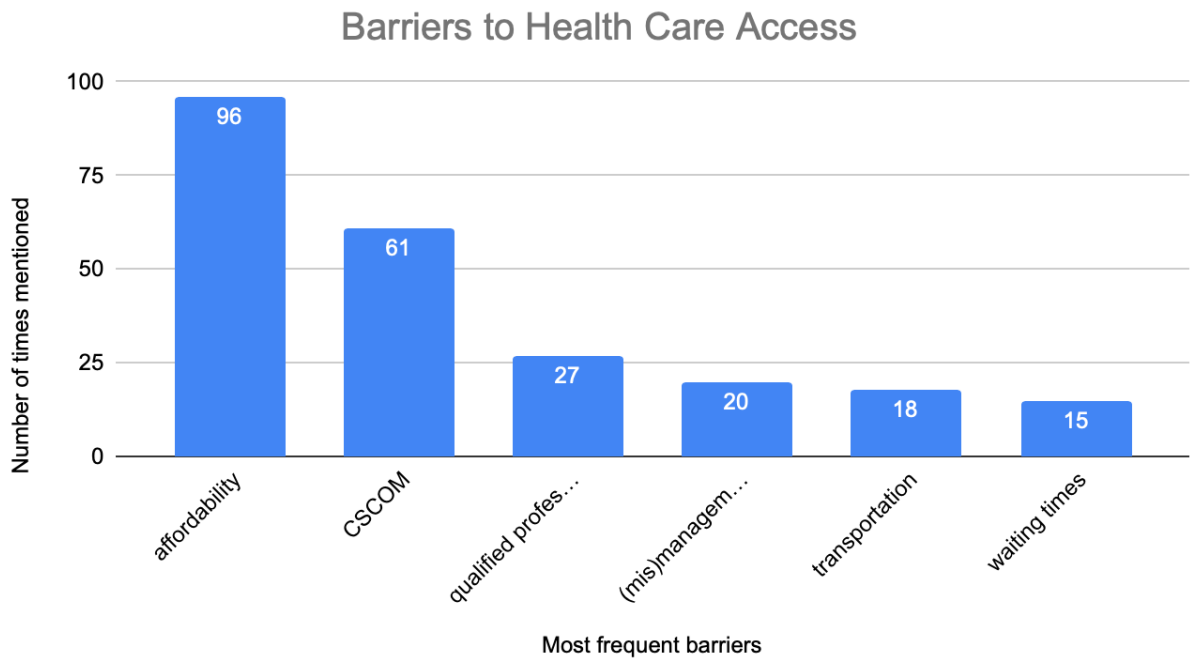
[2] A methodological note: the pie chart provides only broad categories, one of the benefits of google analytics, but may not be useful for further scrutiny of the categories, as some respondents like CSCOMs, their associations, and their federations, defined themselves as 'CSOs.' The pie chart shows that KIIs included a wide range of stakeholder beyond government and health centers, and a diversity of views of women and youth, urban and rural are reflected in the analysis.

1.4 DATA ANALYSIS

Four main cross-cutting questions related to Universal Health Coverage (UHC) awareness, barriers to health care access, health care champions and health care spoilers were constructed, in order to compare a larger sample size, and to identify broader trends across different stakeholder groups. Qualitative and quantitative methods were used to collect and analyze the data, as appropriate. Cross-cutting quantitative yes/no questions were also used to create frequencies. There was also a cross-reference between the mention of *Association de Santé Communautaire* (ASACO) presidents and mayors and clientelism, rent seeking and quid pro-quo.

Results indicate that 69 percent of our sample was aware of UHC, which is especially important considering the sample size has a large CSO and community population (Figure 1). When asked who benefits the most and the least from the health care reforms, most often the population as a whole were named as the primary beneficiaries (46 times), followed by the GoM (33 times). Within the population, the poor, children and women were perceived to benefit the most from the health care reforms - in that order. Despite the clear awareness of UHC, the sample population was also well aware of the barriers to health care access (see Figure 2).

Figure 2: Barriers to Health Care Access



Affordability, cost of service for patients and the quality of care at *Centres de Santé Communautaire* (CSCOMs) were noted as the primary barriers to accessing health care and a perceived barrier to implementation of UHC. Respondents' concerns about the lack of affordability revolved around the state's inability to provide basic health services, due to lack of qualified staff and equipment. Respondents overwhelmingly admitted a preference for traditional healers or self-medication from widely available "*street*" medicines imported through informal channels from Nigeria and India.

One of the major components of sectoral health policy in Mali is the promotion of CSCOMs. These centers are meant to broaden health service access and to bring care within the reach of even remote communities. Respondents, however, noted that the CSCOMs themselves are the second biggest barrier to accessing health care.

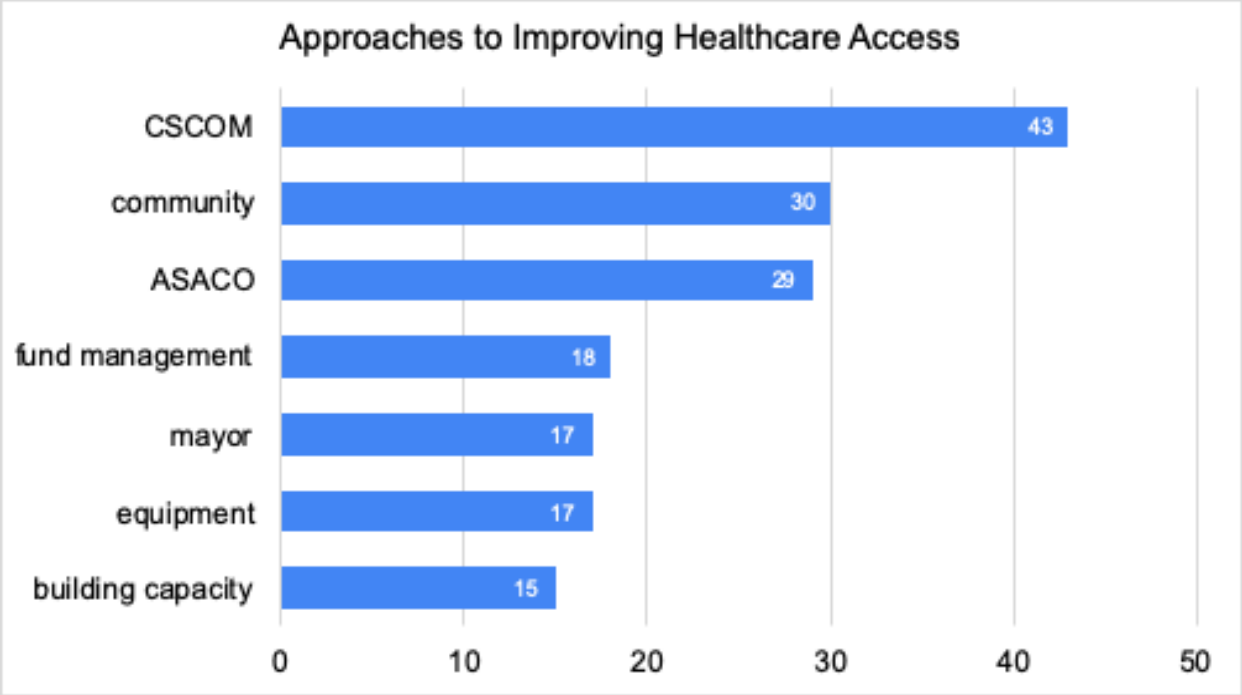
The CSCOM system, while theoretically sound, is hindered by a number of practical operational problems, in combination with more insidious challenges, which are discussed in detail in the body of the analysis.

Mismanagement was also noted as a significant barrier to health care access, with the relationship between ASACOs and mayors being frequently cited. In over a third of the cases where ASACOs were mentioned, they were discussed in the context of collusion, corruption and political capture. Similarly, over 40 percent of the times where mayors were mentioned, it was in connection to corruption. The following quote represents some of the concerns regarding the relationship between ASACOs, CSCOMs and Mayors.

> *"CSCOMs receive a subsidy from the state budget because health is decentralized. The mayor is in charge of mobilizing the funds. There is a problem with "perception" - there are some problems we discussed earlier about the ASACOs and mayors - even when the budget is fully received by the mayor, it doesn't mean that the CSCOM will receive the funds. It can depend on the mood of the people involved and it can depend on the personalities of the ASACO and relationships with the health district staff and the district medical officer in particular."*
>
> – KII Respondent

Most of the proposed solutions from the respondents centered around improving the relationship between CSCOMs, ASACOs, mayors, and communities (see Figure 3 below). The ASACOs and Mayors overseeing the financial management of the CSCOM are not always seen as representative of the community, thus it is no surprise that improving the community's ability to hold CSCOMs accountable or providing grievance mechanisms to report mismanagement, are often named as potential solutions. GoM respondents tended to frame rent-seeking behavior somewhat dismissively as '*mismanagement.*' The remedy suggested tended to be technical capacity building for financial management as a solution to fund mismanagement. Their argument is that with the reduction of mismanagement, more funds can go towards better quality equipment and services. However, the team found little evidence to support this claim given the scale of corruption.

Figure 3: Approaches to Improving Health Care Access



1.5 RESEARCH LIMITATIONS

This assessment focused on a narrow band around Segou, parts of Sikasso and Koulikouro, and Bamako. Generally, when referring to the northern part of the country the regions that fall under the category targeted by this report would include Timbuktu, Gao, Kidal, and northern Mopti; however, this assessment did not encompass any of the north or Mopti due to security and time constraints. References to literature on Mopti and the north are included in the assessment and documented in the literature review. This study includes four sites: Bamako, Segou, Koutiala and Koulikoro.

The research team was unable to include a greater sample from more diverse geographical regions within the two-week timeframe allotted for fieldwork. Travel in Mali, in general, and to the northern regions in particular, presents logistical and security considerations that required more on-the ground support and significant advance planning. With many interviews, the team encountered limitations due to a reluctance from informants to speak openly about sensitive topics. In general, social norms and power hierarchies in Mali discourage respondents from divulging information that might harm reputations or result in a personal reprisal. The team found this tendency to be especially apparent among GoM respondents who were reluctant to provide candid, unvarnished responses, and stuck to highly scripted responses. Moreover, government respondents at all levels were heavily concentrated in particular age and gender brackets, and therefore not representative of the population. To broaden our understanding of the health system in Mali, and to counter these potential biases, the research team made a concerted effort to meet with women and youth in rural and urban settings, and to meet with CSOs that tended to have a broader cross-section of age and gender using FGDs, to ensure capture of a wider variety of perspectives.

2. Political Economy Context of Mali

In 2019, Mali scored 94.5 percent[3] on the Fragile State Index and is among those countries with the greatest deterioration in stability over the last decade. Mali now finds itself clustered with Syria and Afghanistan. Any analysis of health care service provision by the GoM must be considered within this complex and deteriorating governance context.

Mali has a young and rapidly growing population, with nearly half of its 19 million people under 16 years of age, as well as the highest adolescent age-specific fertility rate in the world, with 17 births per 1000 women aged 10-14 and 15 percent of those aged 15-19 already having given birth.[4] Mali's per capita GDP is estimated at $750 in 2019, but this belies an excessively unequal distribution of income. Over half the population of Mali lives under the poverty line.[5] Mali is still one of the poorest countries in the world and this has significant impacts on health and Mali's ability to finance health care. Life expectancy remains at 58 years of age due overwhelmingly to high maternal and infant mortality rates, with 35 infant deaths per 1000 in 2019.[6] Mortality rates of children under five were recorded at 106 per 1000 in 2019, a strong indicator of poor access to health care that correlates with high levels of malnutrition.[7] Some 30 percent of under five children are stunted, but lowest wealth quintiles record rates of 40 percent.

A separatist rebellion by the Tuareg National Movement for the Liberation of Azawad (MNLA), assisted by jihadist affiliates of Al Qaeda in the Maghgreb (AQIM), led to the seizure of nearly two-thirds of the country in 2011. The subsequent occupation by armed Tuareg and jihadist groups led to nearly half a million people fleeing northern Mali and sparked a military coup in March of 2012. Following international condemnation and the imposition of sanctions, as well as further loss of territory in the north to militants, a civilian government was formed and the interim president, Dioncounda Traoré, requested military assistance from France to address instability in the north. With the encouragement of the African Union and the United Nations, as well as the direct assistance of the French, the government succeeded in toppling the Tuareg-jihadist alliance, but not without significant upheaval. Food insecurity worsened as violence by separatists continued in the North; the United Nations reported in 2013 that some 1.2 million vulnerable people had no access to basic services. By 2012, the French had sent Islamist fighters into hiding in remote desert strongholds, while the GoM planned for a new election. The grievances put forward by the separatist groups, however, over years of neglect, institutionalized corruption, and localized conflicts over access to land and water resources in a changing climate, fueled continued instability throughout northern and central Mali. Elections in 2013 brought a new President, Ibrahim Boubacar Keïta (IBK), who secured ongoing international military assistance to keep jihadists out of northern cities and to broker a peace accord.

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[3] United States Institute of Peace (USIP). "Fragile States Index 2019: Mali Profile." Washington, DC: USIP, 2019.

[4] The World Bank: Project Appraisal Document, Accelerating Progress Towards Universal Health Coverage (P165534), February 2019. Literacy Rates. Accessed 11/07/2019

[5] The World Bank: Country Diagnostic Mali 2009, GINI 49.9. Accessed 10/30/2019.https://data.worldbank.org/indicator/SI.POV.DDAY

[6] https://data.unicef.org/country/mli/ Accessed 11/07/2019.

[7] Mali Population. (2019-08-27). Retrieved 2019-11-07, from http://worldpopulationreview.com/countries/mali/

While peace in the north remains elusive, IBK has committed the GoM to broad political reforms as part of a 2015 peace accord. This agreement promised greater regional autonomy and territorial decentralization, in order to defuse ongoing threats to stability and security in the north where the Malian state continues to struggle to reassert democratic rule.[8] The key secular Tuareg group, the MNLA, continues to occupy the northern town of Kidal. Newer jihadist groups loosely affiliated with AQIM also continue their efforts to form an emirate through a dual strategy of violence (deadly attacks in Mali between November 2018 and March 2019 increased by 300 percent[9]), and '*soft power*', including adjudication of local disputes (restoring order to lawless areas) and providing basic health care services in areas that lack adequate community health care.[10] This situation presents an enormous challenge for the GoM, and the future for Mali as a unified country rests in part on its ability to regain state legitimacy in these contested areas.

Increased decentralization and regional autonomy are central platforms in IBKs strategy to strengthen the legitimacy of the state through accelerated development in rural regions. The failure of decentralization efforts to bring greater autonomy to the North is a continuing source of discord and instability in 2019. These conditions have also impacted the government's ability to provide health services. In 2015, the United Nations reported that 90 percent of CSCOMs in the north of the country were closed. While it is unclear how many have since re-opened, it is clear that health services have been severely debilitated. It's not just the volatile areas of the North that have been affected though. Poorly implemented decentralization has had impacts on health services throughout the country and is potentially as big a threat to stability as discord in the North, since it impacts a far larger swath of the population.

For most of sub-Saharan Africa, the percentage of the national budget allocated to the health sector has never come close to the 2001 Abuja Declaration[11] target level of 15 percent. In Mali, this percentage has dropped from around eight percent to 4.6 percent since the coup, although it is important to note that this does not actually reflect a drop in level of health spending but instead reflects a 25 percent increase in defense spending during that same period, driven by insecurity and instability in central and northern Mali.

The 2019, USAID DRG Assessment noted that since decentralization first began in 1992, decentralization efforts have failed to genuinely bring the government closer to the people and have instead created greater opportunities for rent-seeking and other corrupt behavior at multiple levels of government. Conclusions from that report indicate that strengthening local governance and increasing accountability and transparency through inclusive, participatory citizen engagement are key to stability and legitimacy of the government, and this conclusion was kept in mind during the formulation of recommendations in this assessment. Indeed, because Mali's central state is weak and ineffective,

[8] Ten-Year Education and Justice Reforms (Décennal de l'Éducation and Décennal de la Justice)

[9] Lebovich, Andrew: Mapping Armed Groups in Mali and the Sahel: European Council on Foreign Relations. May 2019. Accessed November 9, 2019: https://www.ecfr.eu/mena/sahel_mapping

[10] Sensitive reports that stolen humanitarian aid (bed nets, malaria medicine, etc.) is being distributed by jihadi groups are confirmed by multiple sources. These goods, some with USAID labeling of neighboring countries, are also found being marketed on the street in Mali, indicating some complicity within Mali for cross-border trade in medical supplies exists beyond jihadi groups.

[11] In April 2001, heads of African Union countries met and pledged to set a target allocating at least 15 percent of their annual budget to improve the health sector. As of 2010, only 3 countries were on track and the situation has not changed significantly since then. https://www.who.int/healthsystems/publications/Abuja10.pdf Accessed Nov 11, 2019.

decentralization, despite being a centerpiece for peace and reconciliation, has exacerbated the tensions over resources within the context of ongoing conflict in the North. For that reason, the DRG Assessment recommended against investing efforts to bolster decentralization and rather to focus programming on concrete, visible investments in strengthening local governance and local accountability. Recommendations in this study flow from the understanding that improvement of local government service provision is a pathway to the incremental restoration of state legitimacy. Therefore, the focus is on investment in modest but visible improvements are seen at the community health level. USAID's new health strategy is in a position to support precisely this kind of intervention.

3. PATHWAYS OF INQUIRY

This section explores three pathways of inquiry developed in partnership with the USAID / Mali Health Team:

1. What is the financial relationship between decentralized health financing and health structures at the community, municipal, and district levels (i.e. public financing for health)?
2. What are the risks, opportunities, and perceptions of health reform and identification of bottlenecks and pathways for implementation of reform with regard to improved coverage (i.e. political economy of health reform)?
3. What are the political economy barriers to inclusion of marginalized populations in accessing health care?

3.1 POLITICAL ECONOMY OF FINANCING MALI'S PUBLIC HEALTH SYSTEM

Mali's public health sector services have been decentralized since 2009 through regional health structures (district hospitals, *Centres de Santé de Référence* (CSREFs), and CSCOMs) but the financial relationships are complex. Since 2014, regional and local governments are responsible for budgeting basic supplies, medical equipment, and investments in building infrastructure needed for regional health structures, through the Ministry of Health (MoH)'s decentralization support unit (*Cellule d'Appui à la Decentralization et à la Deconcentration*[12], CADD). Some 19 ministries have these support units to strengthen the effectiveness of transfers to health, education, and social services at regional levels. The unit sees their role as one of following the decentralization rules and regulations rather than problem-solving to ensure that that adequate resources are being received and services are effectively strengthened. The compartmentalization of the tasks involved in decentralization is one of the obstacles to transparency in the decentralization processes that creates space for mismanagement and corruption, by impeding effective monitoring and accountability. Funding allocations are subject to political manipulation.

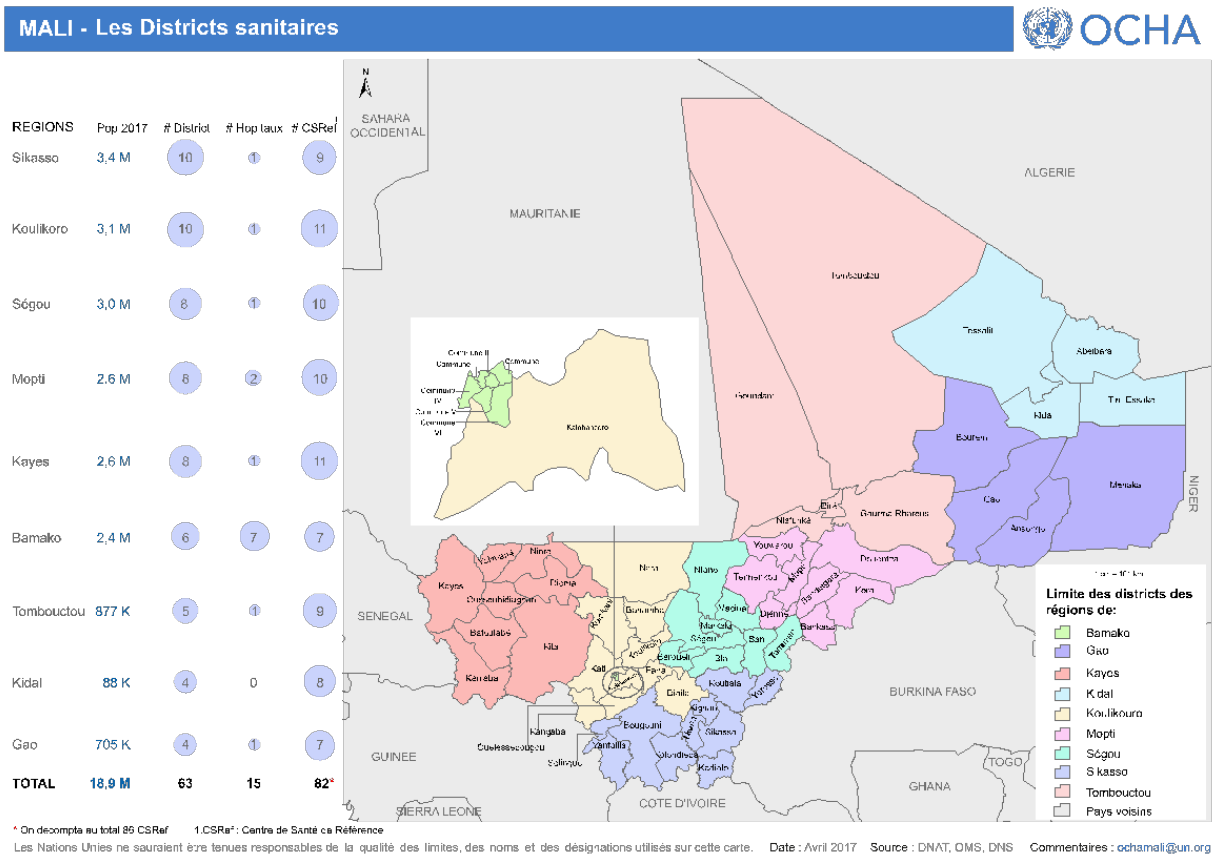
The financial flows to the regional CSCOMs are routed through the regional government administration system. Decentralized funds are transferred to the regional budget office at the level of the collectivity for the region (*Collectivités Territoriales).* The district hospitals receive budget allocations from the counsel of appointed representatives of the regional counsel (*conseil regional*). The CSREFs receive budget allocations through the appointed representatives of the Circle Council (*Conseil de Cercle*). CSCOMs are part of the public health care system but managed entirely by elected ASACOs and are supposed to be operating in a "*non-profit*" capacity, self-sustaining from cost recovery of fees for service. The CSCOMs, nonetheless, receive state subsidies through the municipality, specifically from the mayor, who is an elected official.

The MoH pays health staff salaries directly for district hospitals and referral centers, which also includes subsidies for community health associations as noted above. Pharmaceuticals are supplied to the public

[12] The Unit CADD is the "support unit for decentralization and deconcentration" of government resources within the MOH.

health structures through a well-monitored state-owned pharmaceutical supply chain, and all health structures have separate accounts for pharmacies. Parallel pharmaceutical supply chains are also established through approved private suppliers and can be a source of procurement kickbacks for ASACOs. In both the state and private pharmaceutical supply chains, opportunity for mismanagement of pharmaceuticals is present. Care providers can also use diverted pharmaceutical supplies as another opportunity to extract irregular payment from clients at the point of service. Free services are officially provided through public health centers and CSCOMs for malaria, tuberculosis, HIV/AIDS. Also included are Caesarian-sections (since 2011), due to the high incidence of pregnancy complications associated with FGM, which has a 94.1 percent prevalence rate in Mali.[13] These free services (*gratuités)* are subsidized by the MoH directly to CSCOMs, and mostly donor financed. In practice, these transfers are not always received, and the services are not always free.

Figure 4. Mali Health Districts[14]



Mali's territorial administration includes: 703 municipalities (*communes*) composed of numerous communities in villages (rural) or districts (urban), 49 circles (*cercles*), eight regions[15] and the district of

[13] The World Bank: Project Appraisal Document, Accelerating Progress Towards Universal Health Coverage (P165534), February 2019. Accessed 11/07/2019

[14] Source: United Nations Source: Office for Coordination of Humanitarian Affairs, 2017.

[15] Eleven (11) new regions created by the Act of 2012 have not yet been established: Taoudenit, Menaka, Nioro, Kita, Dioila, Nara, Bougouni, Koutiala, San, and Douentza Bandiagara

Bamako with its six municipalities (all Territorial Communities). The municipal councilors, including the mayor are elected by direct popular elections through a system of proportional representation; regional and circle councils are elected by electoral colleges from lower-level authorities (the municipal councils elect the circle councils who in turn elect the regional councils). Each municipal council sends councilors to constitute the circle council and each of them will also send councilors to constitute regional council. There is currently legislation pending to harmonize the electoral code with the Peace and Reconciliation Accord. The health district map above shows the health structure distribution across administrative districts (Figure 4).

3.1.1 Public Health Care Structure

The CSCOMs are managed by ASACOs that have become widely reviled, both among government respondents and civil society, for subverting the funds of the CSCOMs for personal and political gain. Some respondents intimated that the entire health reform law is designed to neutralize the ASACOs. The government modeled the ASACOs on the assumption that communities would need help managing the health care provision at these community-based health centers, not imagining that the ASACOs would exploit community members for personal and political gain. The ASACO presidents are typically linked to local political elite and traditional leaders. Research for this study suggests that CSCOM's are frequently perceived to be part of the problem and not the solution to strengthening health care service in Mali. Among respondents interviewed, the poor quality of services and relatively high cost of CSCOMs are the second most frequently cited barrier to health access.

> *"The issue is that there is corruption. The ASACOs game the system. Local elites control the ASACOs. The government has lost control of the ASACOs and they want to get the control back."*
>
> -KII respondent

The new health reform in Mali is part of a long-term national strategy and a regional movement toward universal health coverage and free health care throughout Western sub-Saharan Africa being promoted by the World Bank, UNICEF, bilateral donors, and philanthropical foundations. In the 1980s, Mali and its neighbors struggled under staggering debt. Structural Adjustment Programs (SAPs) from the World Bank and IMF dismantled social benefits like free health care under austerity measures to address the debt. Donors pushed African leaders to commit to the "*Bamako Initiative*" in 1987 based at least partly on the idea that user fees for health services would be best for health care and the national budget. Health outcomes deteriorated in the decades that followed. In recent years, the consensus has shifted away from the Bamako Initiative toward UHC. There is ample statistical evidence, and many randomized control trials that document the benefits to health outcomes of lowering the cost of accessing health care.

Abolishing user fees is a popular idea in Mali, because being able to afford health care is a major problem for Malians. Respondents agreed unanimously that the biggest problem in accessing health care is one of cost. Access is only a matter of being able to afford the cost of transport and treatment, according to respondents. Malians want free or subsidized health care, even if only for mothers and children under five. Those few respondents interviewed who were part of a mutual health insurance scheme did report

that they were satisfied that they were able to get access to health care. Though they admitted there were still some problems with quality, these respondents were not afraid to go to a health care center. Some donors like *Medicins Sans Frontiere* (MSF) are in fact directly supporting CSCOMs in Koutiala and elsewhere in Mali through mayors, to deliberately enable health care costs to be lowered to encourage use of the CSCOMs for preventive health care. Lowering the costs of health care in Mali is fundamental to improving health outcomes. Currently, CSCOMs are viewed with suspicion among many respondents because the costs are unclear due to all the issues mentioned of corruption, differential treatment, diversion of medicines, and patients from public health centers to private clinics. Volunteers in many communities are tasked with encouraging people to visit health centers for routine health care, but the suspicion, based largely on cost and belief in traditional healers, remains strong. The behavior of ASACOs in manipulating CSCOM funds for electoral politics and personal gain fuels this suspicion so that even legitimate costs might be considered illegitimate. Respondents argued for improving communication and transparency at the CSCOM level to improve the view of CSCOMs and ultimately health outcomes.

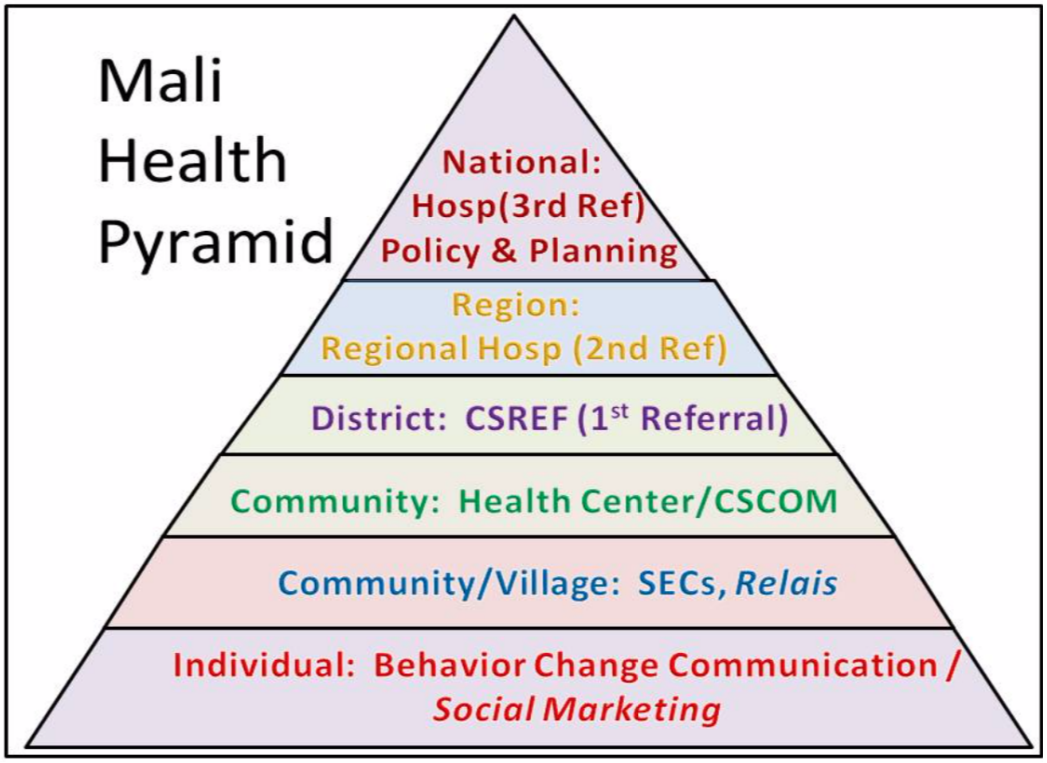


Figure 5: Mali Health Pyramid

The health care structure, often characterized as a pyramid approach with services available at each level of the triangle, is theoretically an example of decentralized service provision. In reality, however, the health pyramid has complicated the landscape and obscured accountability at each level. Resource limitations and management gaps are common themes at all of the levels but the pinnacle of the pyramid is the National Hospitals (of which only seven exist in the country). MoH statistics from 2013 indicate that CSCOMs are located within 15 km of 87 percent of communities in Mali, however, recent World Bank mapping of CSCOMs reported in 2018 that only 30 percent of people are within 15 km of a CSCOM.

The pyramid is meant to distribute care at various levels through a tiered system. According to the World Bank "*In Mali, primary care is provided by the 1,294 CSCOMs which are private non-profit entities contracted by the communes to provide basic health care. The basic benefit package (Paquet Minimum d'Activités, PMA) is also provided by semipublic facilities, by rural maternities, and by private for-profit facilities. A second layer of care is covered by 63 first referral facilities (Centres de Santé de Référence, CSREF or district hospitals). The second level of care is provided by the 7 regional hospitals (Établissements Publics Hospitaliers, EPH). At the third level, specialized care is provided by 5 EPHs at the national level."*[16]

Mali has struggled to enlist adequate numbers of qualified health care providers and CSCOMs to support its own policy of equal access to health and improve health outcomes. High rates of illiteracy, insecurity, and poverty contribute to small numbers of Malians able to become qualified health care providers. Large numbers of unqualified health care providers are getting certified through unregulated schools. Moreover, the few qualified providers of health care tend to be unwilling to be posted to more remote areas. The numbers of CSCOMs have increased since decentralizing that responsibility to local governments often with donor support through the National Local Government Investment Agency, *Agence Nationale d'Investissement des Collectivités Territoriales (*ANICT). ANICT operates outside the public financial management system, to enhance monitoring and transparency of donor support for specific investments. This parallel structure has been effective in enabling more transparent flows, but donors suggest that it has not served to strengthen public financial management more broadly. Ultimately, the investments in projects still do not always yield tangible benefits. Government respondents complained about the difficulty in tracking and monitoring these investments.

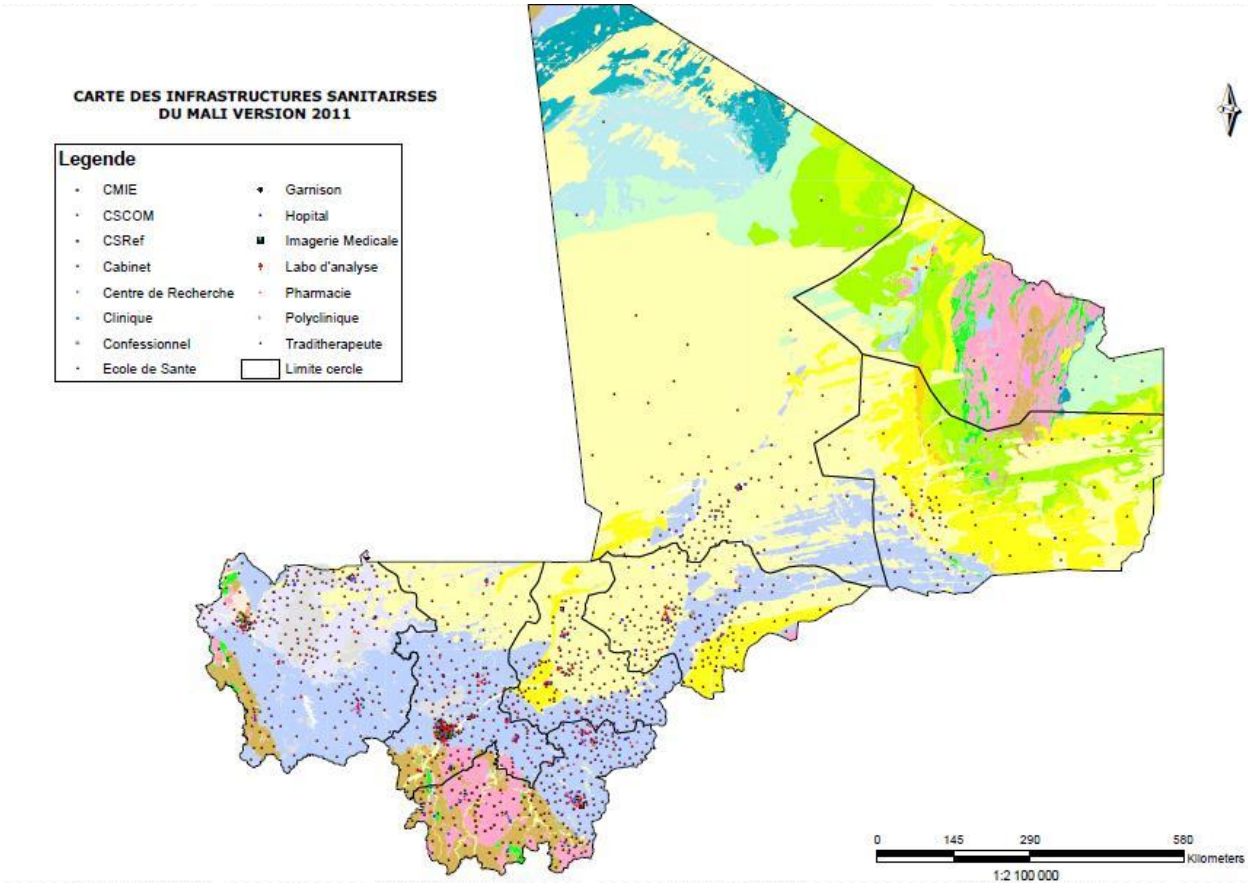
The problem reported by discussants is that many of these centers have not been community-demand driven. Respondents complained that local government took advantage of resources offered based on the need for increased geographical coverage of CSCOMs catchment areas to reach all communities within 15 km, known as the *'15 km rule*.' In 2018, development partners and the GoM redefined ways to achieve increased geographical access to care and reduced the original 15 km distance to 5 km as the new target goal the CSCOMs catchment area (i.e., citizens should be living within a radius of 5 km to 15 km of a CSCOM). However, the 15 km rule may have unwittingly promoted a proliferation of CSCOMs without adequate due diligence. Some respondents mentioned that this rule enabled more CSCOMs to be formed but expressed their skepticism of the quality of these new CSCOMs. Moreover, though more CSCOMs were constructed under this push, several sources indicated that many CSCOMs were either only partially constructed or not built at all as a result of rent-seeking around the procurement of construction. Donors are monitoring this issue and perhaps for that reason, the Netherlands and other donors who backed the creation of new CSCOMs pulled funding from the MoH in 2019. Rather than acknowledging the problems, ministry respondents complained that they need new donors to support investments in health center construction, appealing to USAID specifically.

Regardless of the corruption, the more pressing issue was that demand from the community was not always behind the creation of the CSCOMs primarily, respondents indicated, because they are afraid of the cost of care and prefer traditional healers with which they are more familiar. Moreover, the resources needed for the centers and for community outreach to "*drum up business*" from a very poor and unconvinced client base, have been remarkably absent. As a result, the CSCOMs are not serving

[16] The World Bank: Project Appraisal Document, Accelerating Progress Towards Universal Health Coverage (P165534), February 2019

their purpose. Local elites tasked with managing the ASACOs have been benefitting from CSCOMs, supporting local political campaigns of mayors and other issues of interest of traditional leaders and elites. Respondents indicated that communities follow the traditional leaders lead on determining whom to vote into office. While health service delivery should be something that people could hold the mayor accountable for, respondents expressed a powerlessness to change anything. Respondents emphasized the way that the 5 km rule has been subverted to funnel money into electoral politics. Furthermore, trust in CSCOMs from respondents was low. From the government officials in Bamako, it was clear that everyone knows this is happening, and the concern is not just one of wasting money but rather, as one of the original economists involved in creating the model for community care delivery in Mali said, that *"the ASACOs are destroying the health care system!"* The map below shows the concentration of CSCOMs in the south of Mali.

Figure 6: Map of geographic distribution of CSCOMs in Mali (2011)



3.1.2 Decentralized Administrative and Institutional Framework of financial flows for public health

The decentralized public health expenditure flows follow the institutional framework of Mali's decentralized administration as described above. Focusing on the municipal level (commune), an elected mayor is responsible for overseeing multiple communities.

Respondents indicated that clientelism determines who gets appointed for positions, how funds are allocated, and the levels of resources that are allocated from the MoH to the regional governments. For

example, there is no well-known objective formula reported by respondents to determine budget allocations. The government officials at the center say that the Bureau of Rural Statistics within the MoH use a combination of population levels and economic activity (or tax base) to determine the budget allocation levels. Some of the regional level officials offered the same response, but none were able to explain a formula or process for precisely how the levels are set or who exactly determines this formula, though the final budget figures seem to be generated within the MoH's Planning and Statistics Unit (*Cellule de Planification et des Statistique CPS)*. Heads of the *Collectivités Territoriales* (CTs), CT *presidents*, appointed positions, are the regional government officers that position themselves with Bamako-based government officials to ensure that regional allocations are made. They use family connections and personal relationships to get funds allocated to the region. It is the power of these individuals and the regional level relationships with that individual that matter.

"*Budget decisions are political. There are some regions that are good about negotiating their budget allocation before the budget is made. It depends on the regions - some are much more influential-it depends on the negotiating power of the president of the collectivité, family connections, and personal relationships."*

-KII respondent

The main finding was that these allocations are determined in Bamako by personal relationships between regional budget directors and ministry officials and appointments to key positions likewise. There appear to be a multitude of fiefdoms within the MoH. The Ministry of Economy and Finance has particular power for budget allocations, but the unit within the MoH with the most power of the purse appears to be the CPS. There is not one clientelistic structure, but the individual networks are tightly protected to preserve economic interests on the one hand and to receive budget allocations to enable operations on the other. Incentives are not driven by a commitment to improve service delivery. Many regional appointed government officials are doing their time in regional appointments, leaving their families in Bamako with the expectation that they will return to a better post in Bamako. They have no incentives to improve performance or to complain that allocations are insufficient. Some of the functionaries at the regional level are even highly qualified (at least one Harvard graduate), but the system and the culture does not favor efforts to improve efficiency (reduce corruption). The result is an incentive system, particularly at the CSCOM level, that is not aligned with the goals of improving access and quality of health care provision.

"All the decisions are taken in Bamako, in the Ministry. It is top-down. It comes from top even though all the plans from the bottom are there. They at the top decide what amount goes to each level and then Cellule de Planification et de Statistique (CPS) transfers funds. You give guidelines based on the plans. The ministry should be financing the building and maintenance of health care centers. It should not be up to communities to have to do it. Funds allocated are not based on needs. It is political. The amount you get for your region is dependent on your personal relationship with the ministry."

-KII respondent

There is little to no independent oversight of health care providers at any level from the financial administration or service delivery outcome point of view. No watchdog groups exists, and media have not analyzed local health care provision in any meaningful way. Oversight committees exist largely in name only, are rarely convened or lack meaningful coordination. When they have been convened, respondents indicated that collusion among health care providers and accountants with the oversight committees is commonplace. Prefects are supposed to be leading oversight committees. One prefect interviewed could not even recall the name of the committee or if it had ever been convened. Prefects

are typically conflict averse; they are appointed and tend not to be from the place where they are posted.

Third party independent auditing does not exist. There are committees from the national government that undertake supervision at the regional level, but no external auditors. There is the *Bureau Du Vérificateur Général* (BVG) trying to monitor ex-post facto. Some respondents indicated that the government officers at the central level do not understand how the budget works at the local level or the complexities of managing the resources through the region.

Where the MoH sees the need for more funding overall and targeted capacity building of key personnel (e.g., chief medical officers), health sector partners call for greater financial governance of health structures. The rigidity of public spending procedures, lack of transparency, and absence of credible accountability mechanisms contribute to the significant geographic and socio-economic inequities in access to essential health services. Mapping the relationships between the two regional and municipal government and health structures helps pinpoint the problems.

3.1.3 ASACO

ASACOs play a key role in electoral politics at the local level**.** They have close ties to traditional leaders, political party leaders, and mayors. As a result, electoral politics do play a role in the decreasing confidence of patients in CSCOMs. The centers are seen as political gifts that keep on giving by the local elites running the ASACOs. Political party's back management association presidents, who in turn back political parties and mayors. Remarkably the meagre funds generated from community health associations are used for vote buying. Respondents told us that it does not take much, bars of soap will do. Respondents even said it is well known that ASACO presidents also funnel funds from mismanagement through procurements for personal gain to perpetuate their elected positions. They work through the commune council, the local body with oversight of state budget transfers, and within the CSCOM, for example establishing parallel pharmaceutical supply chains. ASACO Presidents tend to be local elites, and federations of ASACOs at the local, regional and national levels have tremendous political power.

ASACOs operate with direct conflict of interest between their role as managers of CSCOM funds, meant for maintenance and improvement of CSCOMs, and their own interests. Salaries and in some cases, 'bonuses', are drawn directly from what is intended to be a community fund.

> *"At the level of each ASACO there is a monitoring committee that is supposed to report to the community. The Chief might be the leader of the oversight Committee and he may think that he is entitled to the ASACO funds - so this is Africa and this might happen - that is why the State should provide oversight of these committee."*
>
> -KII respondent

The nearly complete absence of transparent budget allocation for health at every level of the pyramid is another corrosive aspect of Mali's incomplete decentralization. While CSCOMs, CSREFs, and district and national hospitals participate in a budget process, budgets are submitted to the MoH and decisions about the transfer of funds to the regional and commune-level are held closely by the MoH and the Ministry of Economy and Finance. Government officials and health care managers alike bemoan the unilateral decision-making that characterizes fund transfers from the central government.

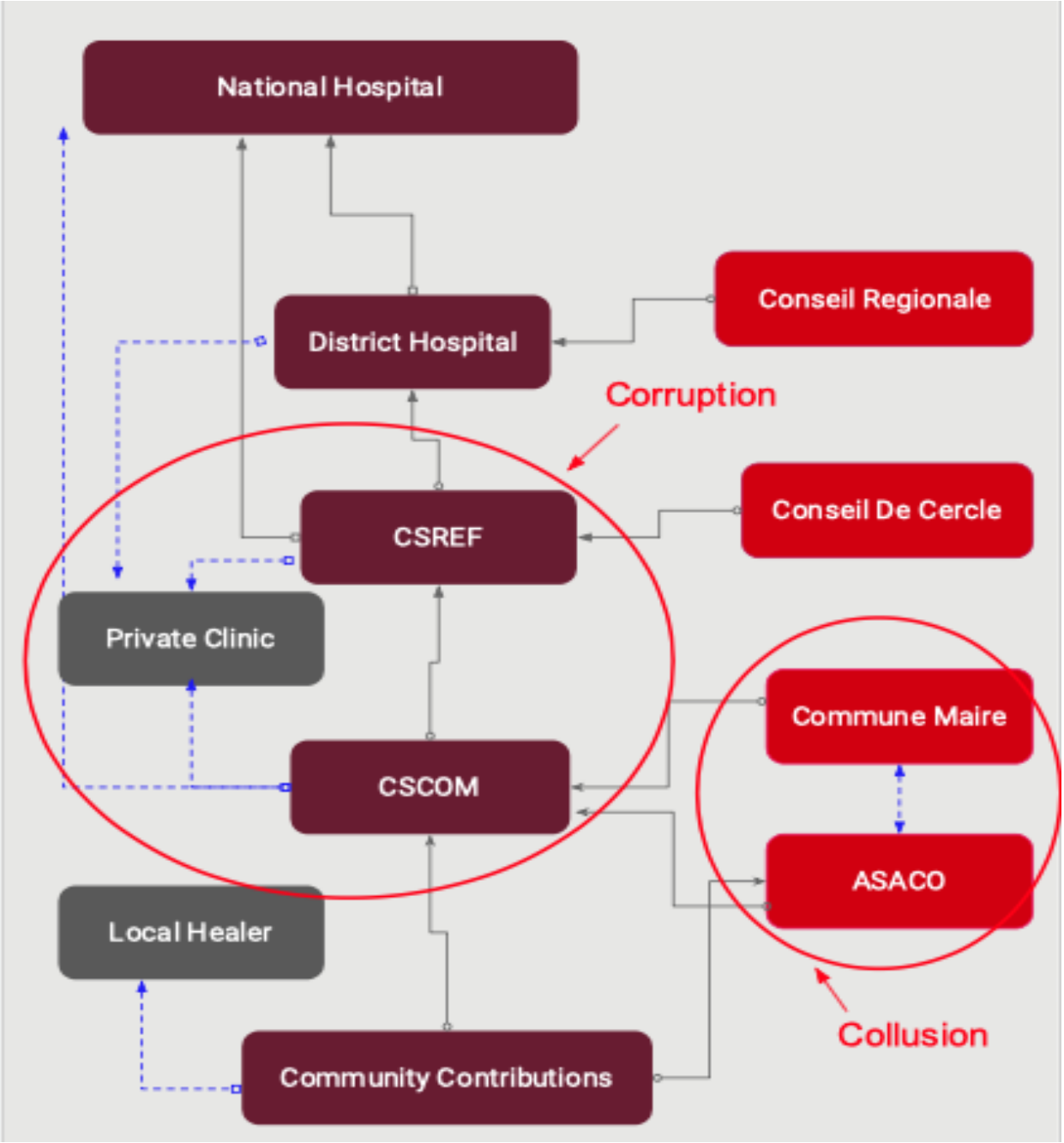
This budgeting process presents the veneer of decentralization - a system that appears to devolve decision-making to the local level but instead creates opportunities for graft and collusion between key actors, such as the mayor and ASACO president. Ultimately, this top-down flow of funds reduces MoH and GoM accountability and relegates the intended beneficiaries of health care in local communities, to a passive role. The perception of some senior-level officials is reflected in the following comment;

> "*Money recovered at the level of the structures stay there and the problems are mainly related to the management of this money. The problems of the management of the money of the state is hard to address. They [local government] use the justification that they do not have enough to do what they were budgeting for. We have trained them on how to use and manage the funds. We need to train the mayors (every 5 years) and we have to train the people - lots of capacity training but it is not enough. The problems come from city mayors and CSCOMs and their ASACO). The little money they have is not managed well. The problem is governance of the roles and responsibilities of the management of these funds."*
>
> -KII respondent

3.1.4 DECENTRALIZED HEALTH FINANCING FLOWS TO HEALTH STRUCTURES

Figure 7 below depicts the official financial relationships between public health structures funded by the MoH including the National, District, and CSREFs, and the CSCOMs managed by ASACOs with decentralized government entities. Official transfers are depicted with solid lines and include: Regional Counsel (Conseil Regional) allocates to the District Hospital; and Circle Council (Conseil Cercle) allocates to the CSREFs. Mayor at the municipal level (Maire and Commune) allocates a subsidy to the CSCOMs. Dotted lines represent the informal financial flows that are taking place. Areas of possible collusion and corruption are circled. A closer study of the interests and incentives could provide more insight into additional entry points for behavioral change on top of what is provided in this analysis.

Figure 7: Official and Unofficial financial relationships between health structures funded by the MoH



3.1.5 PHARMACEUTICAL SUPPLY CHAINS

The formal supply chain is reportedly well-monitored, but that has not prevented the establishment of parallel systems in which there is no oversight or quality assurance. The 1998 (*Politique Pharmaceutique Nationale*, PPN) provides a legal framework for the organization of the whole pharmaceutical sector, including defining the whole distribution chain. The PPN sets the establishment of a public contract

between the GoM and the principal public drug provider (*Pharmacie Populaire du Mali*, PPM). Essential drugs are available through PPM and private providers. Despite the existence of a legal framework, bottlenecks exist due to governance issues, weak logistical planning capacity, and suboptimal drug inventory management. Sources indicated that PPM has a debt of FCFA five billion, ($8 million). One of USAID / Mali's IPs works exclusively on pharmaceutical supply chain issues and notes that bottlenecks translate into delays and shortages in the supply chain, providing incentives for parallel supply chains from private providers, which can offer procurement kickbacks. The ASACOs have the most freedom to establish these parallel supply chains due to their semi-private status. They have little interest in maintaining government supply chains that are better monitored and from which they cannot take a kickback. Perverse incentives work against making the improvements needed in inventory management, planning and governance. Respondents reported that drug stock-out are frequent and are principally specific to some drugs.

In one account, when offered free malaria medicines at the height of the malaria season by a development partner, ASACOs refused, preferring to sell privately procured medicines at the CSCOMs than give them away free. Stock-outs are reported more frequently than what procurement specialists consider normal. This practice is believed to be widespread from the district level hospitals down. Stockouts at all levels of the health system are considered suspicious and also potentially related to the personal gain of health care workers and those responsible for managing supplies (ASACOs, Chief medical officers, accountants).

Respondents working in conflict zones framed the issues of donor support to health systems in the context of the trade in illicit drugs and insecurity stating that the continued occupation of the North is perpetuated by profitable illicit trade in seized humanitarian aid, including medicines and bed-nets from development partners. The inexplicable appearance of bed-nets from USAID / Guinea in a Malian MoH warehouse and markets points to complicity in the cross-border trade of drugs and medical supplies. The availability of illicit or fake medicines is also a threat to public health perpetuated by poor delivery of services by CSCOMs and related to corruption and complicity.

3.2 Political Economy of Health Reform in MALI

> *"When we talk about people on whom we rely we don't talk about politicians. Politicians are just interested in their own interests once that is done they are gone."*
>
> -FGD Respondent, Segou

President IBK has publicized the new health reform (*Régime d'Assurance Maladie Universelle,* RAMU) as a promise of UHC to demonstrate the state's efforts to deliver social services and rebuild trust in the state. Most agree, however, that this promise had more to do with IBKs bid for reelection, rather than a well-planned health care reform. Political observers and ordinary citizens alike commented that UHC represented IBKs populist attempt to garner waning support in the run up to the last election. The President hired an international insurance and health consulting firm[17] to review, assess, and recommend a plan of action for health reform. He has done this with the expectation that development partners will step up and support these efforts but it is unclear if partners were consulted on the specific aims of the UHC. Health experts, development partners, and ordinary citizens all express skepticism about the

[17] Pacific Prime International, accessed December 13, 2019: https://www.pacificprime.com/country/africa/mali-health-insurance/

ability of the GoM to deliver on this promise. The health reform law does not guarantee "*free*" health care but obligatory health coverage for all through a new packaging of existing schemes. Save the Children estimates that the GoM will need to mobilize $160 million dollars from its domestic resources, in order to cover approximately 80 percent of the promised basic health package of the population. Even if the GoM is successful in raising this amount by its target date of 2023, the national insurance rate of coverage would only increase from 12 percent to 31 percent of the population, leaving a substantial portion uncovered.[18] The universal health insurance program, RAMU, is premised on getting all Malians to buy into the plan.

Respondents outside of government expressed a great deal of skepticism about the ability of the state to provide the health coverage that IBK is promising. They expressed fears that Mali's political and economic fragility create urgency for stabilizing reforms like Universal Health Coverage, but that the country could fall apart before health care could demonstrably be improved. The absence of transparency at every level of the decentralized health budget allocation process is frustrating for development partners, but the failure to deliver basic health care and the exploitation by CSCOMs centers are eroding trust in Mali's public health system as an institution. Mali is in a fundamentally precarious position, with a population that is increasingly impatient with the continued status quo of a number of fundamental challenges that include health, education, and security concerns. Respondents lamented that they did not know how to use Malian democracy to improve the situation. Respondents also expressed how little difference there was between the political parties in Mali, noting that opposition leaders can be named in the ruling party cabinet without any problem overnight, wherever it serves them. Respondents said that there is no true political opposition despite the multiple political parties that exist only in name. It is all about personal interests. They feared that the health reform was not going to change anything.

To better explain the problems facing the health systems in Mali in the context of the security crisis during, which the reforms have been elaborated, respondents noted that the inability of the state to provide basic services like health or education is not caused just by the conflict. This failure erodes trust and puts distance between the State and the people and this in turn reduces government accountability.

> *"People do not trust the government, so they do not vote! The ruling party and opposition seem exactly the same. With impunity and lack of accountability, then people go to the street and protest because there is no legal way to protest. Then security threats are claimed to shut down civil liberties and where do we go? CSOs parade as civil society, but they represent the president. Who can we trust? It is all uncertain. We have been under a state of emergency for two years. It is all an excuse to shut down public debate and freedom of expression. The state is working on what is good for them not what is good for the Mali Population. The idea of Universal Health Coverage is not serving the Malian population. It is a pipe dream crafted by the president for international funds*".
>
> – KII Respondent

3.2.1 ACCESS TO INSURANCE

A key component of expanding health care accessibility is inclusion of some form of public insurance. The GoM envisaged inclusion of community-based health insurance (CBHI) schemes, known as *mutuelles*

[18] Save The Children Government of Mali adopts bill on Universal Health Insurance. Blog post by by Saleck Ould dah, Advocacy & Campaign Advisor, Save the Children Mali. Published Tuesday 7 August 2018. Accessed November, 2019:https://campaigns.savethechildren.net/blogs/saleckdah/government-mali-adopts-bill-universal-health-insurance

de santé, as a privately funded option to improve health care coverage. Yet, in Mali, only around 12 percent of the population has any form of health insurance.[19] Private sector insurance options are only open to formal sector workers, and highly concentrated in Bamako. As few as 40 firms pay 80 percent of all formal private sector salaries.[20] Research for this assessment did not uncover evidence of the GoM genuine commitment to bringing insurance within reach of ordinary Malians.

Currently, the vast majority of Malians have no health insurance. Those who have insurance are in one of three categories: 1) formal sector workers (public and private sector), including about six percent of Malians who are already part of a compulsory contributory system known as *Assurance Maladie Obligatoire* (AMO), which is deducted from payroll by employers; 2) Malians who are members of one of the many CBHI scheme (largely rural-based), which is partly state subsidized and partly based on voluntary contributions (five percent of Malians); or 3) only about one percent of Malians who are currently enrolled in the completely subsidized *Régime d'Assistance Médicale* (RAMED) for those classified as poor or disabled. Finally, in addition to these prepayment schemes, the government supports free care schemes (*gratuités*) by subsidizing specific services (e.g. caesarian-section, malaria treatment, HIV-AIDS testing and treatment) through public health care centers. This study presents contrary findings, however, in that respondents overwhelmingly challenged the view that any health care service is '*free*'.

The health reform law, RAMU, will provide an umbrella for continued coverage to those under existing schemes. For the remaining 88 percent of Mali, mostly rural informal[21] workers that have no insurance, the government expects them to join mutuals. While this assessment did not cover mutual insurance options in detail, it appears that mutuals can significantly reduce barriers to seeking services at local public clinics, but the funds collected have not been sufficient to cover costs without pooling of schemes.

Currently about 30 of Mali's 193 schemes are pooled through the Union of Mutuals (*Union Technique de la Mutualité,* UTM), and until recently, pooling of these schemes at regional and national levels has kept them affordable with a contribution from the state. The members of mutuals pay 50 percent of the cost of annual membership and the Ministry of Solidarity in the Fight against Poverty (*Ministere Solidarité et de Lutte contre la Pauvreté*) pays the other 50 percent, making it possible for members to pay for subsidized care at the level of the health centers, from the CSCOM through the CSREF to the district and national hospitals.

With the introduction of RAMU, however, the payments of subsidies have stopped in some regions creating a crisis for mutuals concentrated in Sikasso. The Chief of the division for mutuals at the Direction of Social Protection and Economic Solidarity (*Direction nationale de la Protection sociale et de l'Economie solidaire)* expressed concern for why these have not been paid, because to his mind, RAMU will need to extend community based health insurance, as it is the only affordable insurance mechanism that exists in Mali for informal sector workers that do not have insurance.[22] The state's willingness and ability to pay the subsidies is unclear. In a CBHI pilot, development partners saw the state agreeing to

[19] The World Bank: Project Appraisal Document, Accelerating Progress Towards Universal Health Coverage (P165534), February 2019

[20] The World Bank: Country Diagnostic Mali, 2019. https://data.worldbank.org/indicator/se.adt.litr.zs

[21] Informal sector is defined as the part of the economy that is neither taxed nor monitored by any form of government.

[22] Sissoko, A. "Région de Sikasso : les mutuelles de santé au bord de l'implosion par la faute de l'Etat" 27 June 2019 https://www.maliweb.net/echos-de-nos-regions/region-de-sikasso-les-mutuelles-de-sante-au-bord-de-limplosion-par-la-faute-de-letat-2825833.html Accessed 8 November 2019

finance only 19 percent of the total membership subsidies and that meant there were not enough funds to allow it succeed.[23] Achievement of RAMU's overall goal of having 45 percent of the total population covered by these three systems by 2023 under the current conditions of the health care system seems unlikely. In theory, lowering the barriers to health care access for these vulnerable populations would improve Mali's poor health indicators, including those around malnutrition, family planning, and maternal and neonatal health.[24] In practice, while cost is a major barrier to accessing health care, Mali's health system has deep structural problems rooted in the state's ineffectual decentralized system of governance and approach to health financing.

Furthermore, youth often provided a more pragmatic view. Youth focus groups did not hesitate to express their complete lack of faith in the public health system and frustration with the president in particular. Youth respondents expressed disgruntlement with the predatory and corrupt practices of CSCOMs that prey on patients seeking care. Very few youth respondents in this study possessed health insurance, and those without it were likely to consider private health care centers over public and tried to get themselves to better resourced district hospitals over poorly resourced CSCOMs. They rejected the notion that the state had any intention of implementing meaningful health reform. Many complained that they hear about international donors pouring money into Mali, but they have seen no evidence of improvements to health care. They do see rent-seeking by government officials at every level of the health system. These youth noted that in their lifetime, they have seen corrupt practices top to bottom even while the international community continued to praise Mali as a model of African democracy.

> *"Things are changing with social media - people express their concerns and they demonstrate! Youth is really active on social media for change. CSOs are also very active. The state does not like this. We need activism to change this!"*
>
> – KII Respondent

The MoH respondents argue that there is no other way to improve Mali's health care system and that RAMU has to work. The biggest opponents of health reform are the National, Regional and Local unions of ASACOs, FENASCOM, FERASCOM, FELASCOM respectively. These powerful actors are threatened by the installation of health coverage that will reduce the incomes of the CSCOMs. In analyzing the prospects for reform, the team noted that the champions and spoilers of reform fell into these two sharply contrasting categories.

3.3 POLITICAL ECONOMY OF EXCLUSION AND BARRIERS TO INCLUSION IN HEALTH ACCESS

Poverty is a major driver of poor health outcomes, particularly where free or reduced cost health care is not accessible. Mali has made significant efforts to expand access to care through its network of CSCOMs and community volunteers at the base of the public health pyramid. The access and quality of

[23] Ouattara O, NDiaye P. Potentiel des mutuelles de santé la mise en œuvre de la Couverture Maladie Universelle au Mali et au Sénégal. Coordination MASMUT zone UEMOA, 2017. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6195139/#R41 Accessed 11 November 2019.

[24] Intrahealth. "New Report: Mali Offers a Model Approach to Fistula Care in West Africa". 2019. Access on July 17, 2019. https://www.intrahealth.org/news/new-report-mali-offers-model-approach-fistula-care-west-africa

care available to citizens through the public health care system is determined by geography, socio-economic status, and proximity to the power of the State. Civil servants, elites in Bamako, and those with the means to pay for health services at private clinics are the beneficiaries of better care. In contrast, the vast majority of Mali's population live outside of Bamako, are employed in the informal sector, and have limited access to affordable insurance coverage, resulting in inadequate health services, if they can afford them at all. Vulnerable populations in particular, including women, children, those displaced by conflict, and the poorest, are at the greatest risk for exploitation at the point of service in health facilities at all levels of the health care pyramid. Exploitation is facilitated by widespread illiteracy; World Bank figures for 2018 report 35 percent literacy for the over-15 population overall (26 percent for women).

Barriers to inclusion in accessing health care in Mali take many forms. Respondents reported that CSCOMs often provide different treatment options to those with the resources to pay for them, while offering mostly palliative care to poorer patients. As one Internally Displaced People (IDP) reported; *"In Mopti, I was rich so in the hospital they would rush to me! - Regardless of the security situation, the rich are treated better!"* Now that IDP is penniless and fears of his wife getting pregnant because he cannot afford health care. The predominant driving factor affecting decisions to access health care reported by respondents was the choices available to them given their place in the hierarchy of gender, culture, and economic pow**er**. Gender, poverty, and illiteracy were the most commonly cited determinants of where one falls in the hierarchy. Mothers-in-law and husbands play a central role in directing household health care spending, which can be a barrier to women's access to reproductive health care and family planning. It also has significant implications for the health of children, although the direction of impacts can be more complex.[25] Many respondents recounted that CSCOMs victimized patients at their most vulnerable moments - when in need of urgent care, during labor or following birth, when they were forced to make costly decisions under duress.

3.3.1 GEOGRAPHICAL BARRIERS

Under the health orientation law, the catchment area is the geographical unit containing a minimum population of five thousand (5,000) inhabitants, which are included under the CSCOMs sphere of responsibility. Given the distribution of population in Mali, this distinction has very clear implications for those living in the sparsely populated northern region of the country.

The planning process, including the development of policies and tools to drive the program, entailed positive collaboration between the MoH and its development partners but may not have reflected realities on the ground. For example, the team learned that people in the sites included in the study sample, are more unhappy with the poor or inadequate services offered at high cost by local CSCOMs than by distance to a CSCOM. The most frequent complaint among respondents is that the CSCOMs lack well trained personnel and quality equipment. Specifically, frustration with poorly trained midwives or nurses and either the total absence of vital equipment, or utilization of used items, were common refrains among urban and peri-urban respondents. However, the team recognizes the real and urgent need to extend CSCOM care in the North where distance in excess of 15 km is common and where women in particular, confront grave risks during pregnancy and childbirth. Women consulted outside of Bamako did cite inadequate transportation as a barrier to accessing pre and post-natal care and

[25] USAID, "Qualitative Study of Agriculture and Nutrition in Mali through a Gender Lens." 2015

expressed deep concern about the risk of bleeding to death on the way to a birth center (*maternité*). In all of the FGDs, the suggestion of adding an ambulance emerged as an important need and remedy to the risk of, as one blunt comment describes it, *"...bleeding to death on the back of a donkey cart."*

4. KEY FINDINGS

This section presents key findings by each of the four PEA Pillars. A summary of key findings is presented in Table 3, and a detailed description is presented below.

Table 3. Summary of Key Findings by Applied PEA Pillar

Themes	Summary of Key Findings
Foundational Factors	• State centric, top-down style of government thwarts decentralization efforts; • Food insecurity due to political and geographic isolation negatively impacts health outcomes; • Within households, food distribution is determined by embedded social and gender hierarchies and cultural beliefs, which can have significant effects on nutrition status; • Illiteracy, particularly female illiteracy, is a major factor in accessing family planning or seeking care at a CSCOM; • Youth groups did not hesitate to express their complete lack of faith in the public health system.
Rules of the Game	• Resources are not being transferred from the national to the regional government; • Health budget allocation is determined by patronage relationships; • ASOCOs and mayors collide on rent seeking opportunities; • Parallel pharmaceutical supply chains (both formal and informal) enrich local political elites; • There is systemic corruption and endemic impunity; • Predatory behaviors of health care workers force patients to seek lower cost but potentially harmful alternatives.
The Here and Now	• Decentralization has exacerbated rent-seeking and poor service delivery in health; • Unfulfilled promised around health reform could be the spark for widespread discontent.
Dynamics	• Trust in health systems is waning in parallel with the trust in the State; • ASACOs are powerful potential spoilers of health reform.

4.1 FOUNDATIONAL FACTORS

STATE CENTRIC-TOP DOWN STYLE OF GOVERNMENT THWARTS DECENTRALIZATION EFFORTS.

Political interests and power relationships in Mali's national government perpetuate the highly centralized top-down government decision-making of the state. The French administrative system of governance upon, which Mali's administration is based complicates efforts at implementing meaningful institutional reform and accountability. Real devolution of administrative power to the regional and local government in Mali has not evolved over time. Efforts to deconcentrate the power through the

budgeting process for service delivery of health have been unsuccessful in Mali by most measures. The still fairly centrist model does not grant real power or decision-making authority to the local government, but instead delegates responsibilities without the requisite resources. The impact of this absence of resources and authority at the local level for health care creates perverse incentives that privilege personal enrichment over quality health care delivery. Decentralization remains a theoretical aim rather than a concrete reality.

FOOD INSECURITY DUE TO POLITICAL AND GEOGRAPHIC ISOLATION NEGATIVELY IMPACT HEALTH OUTCOMES.

Significant structural food deficits in Mali have been shaped by the changing climate, struggles over access to land and water, and competing livelihood strategies layered with political and geographic isolation. As a result, Malians are dependent on markets to meet their staple food needs, increasing vulnerability to price and supply shocks, and often forcing poorer households to choose between purchasing food or health care. CSCOMs across Bamako, Segou, Koutiala, and Koulikoro reported that health outcomes tend to be poorer during periods of high food prices and during the '*lean*' season, when households are growing less and are therefore more dependent on food purchases to meet their needs.

WITHIN HOUSEHOLDS, FOOD DISTRIBUTION IS DETERMINED BY EMBEDDED SOCIAL AND GENDER HIERARCHIES AND CULTURAL BELIEFS, WHICH CAN HAVE SIGNIFICANT EFFECTS ON NUTRITION STATUS.

As with health care spending, mothers-in-law and husbands play an important role in food distribution within the household, which can undermine the nutrition status of pregnant women and children within a household. Female respondents reported that mothers-in-law and husbands make most decisions around health care and food allocation, particularly for adolescent mothers, which represent as many as 44 percent of uneducated mothers.[26] As a result, these women tend to seek out traditional healers instead of CSCOMs for both cultural and economic reasons. Embedded hierarchies also bias treatment in CSCOMs forcing some patients to endure longer wait times, less effective medical options, and to pay higher prices for care.

ILLITERACY, PARTICULARLY FEMALE ILLITERACY, IS A MAJOR FACTOR IN ACCESSING FAMILY PLANNING OR SEEKING CARE AT A CSCOM.

Respondents also cited female illiteracy as another major barrier to accessing family planning or seeking care at a CSCOM because the costs appear arbitrary. More urban respondents said they sought CSCOMs or private clinics to access family planning or for delivery. Fear of costs of accessing a public CSCOM are a major barrier. Many respondents found the fact that information, when available at a CSCOM, was only available in written form - generally printed on a receipt or a sign - that many patients cannot read.

[26] In Mali births from mothers aged 10-14 years represent around 7.4 percent in Bamako, but up to 20 percent in rural areas. The 44 percent figure is of number of women who have given birth before 18, reported by women currently aged 20-24, versus those with education, where some 28 percent reported births before 18 (UNICEF and World Bank).

YOUTH FOCUS GROUPS DID NOT HESITATE TO EXPRESS THEIR COMPLETE LACK OF FAITH IN THE PUBLIC HEALTH SYSTEM.

Youth respondents expressed disgruntlement with the predatory and corrupt practices of CSCOMs that prey on patients seeking care. Very few youth respondents in this study possess health insurance, and those without it were likely to consider private health care centers over public and tried to get themselves to better resourced district health centers over poorly resourced CSCOMs. They rejected the notion that the state had any intention of implementing meaningful health reform. Many also complained that they hear about international donors pouring money into Mali, but they have seen no evidence of improvements to health care. They do see rent-seeking by government officials at every level of the health system. These youth noted that in their lifetime, they have seen corrupt practices top to bottom even while the international community continued to praise Mali as a model of African democracy. The IDP respondents interviewed for this assessment sought to avoid contact with CSCOMs, and actively avoided pregnancies. The increasingly narrowed view of ethnic tensions may also shape the context for health care access for this extremely vulnerable and growing population.

> *"Things are changing with social media - people express their concerns and they demonstrate! Youth is really active on social media for change. CSOs are also very active. The state does not like this. We need activism to change this!"*
>
> – KII interview

4.2 RULES OF THE GAME

RESOURCES ARE NOT BEING TRANSFERRED FROM THE NATIONAL TO THE REGIONAL GOVERNMENT.

Local government respondents reported that roughly half the amounts requested were approved in the national budget for health and transferred to the regional governments. Tracking the budget requests and allocations would help clarify the problem. Allocations and actual disbursements are reported publicly in lump sum. The budget preparation process is completed by the Ministry of Economics and Finance, but prior even to landing there, the health budget allocations are determined through an opaque budget allocation process that is based more on personal connections than on any formula calculated on population, tax base or other data, according to respondents. No government respondents could explain exactly how the budget allocations to the regions were determined. Part of the problem for regional officials is that decentralization regulations require "*own*" resource mobilization from a tax base that is essentially non-existent outside Bamako.

HEALTH BUDGET ALLOCATION IS DETERMINED BY PATRONAGE RELATIONSHIPS.

Within the health sector, the "*bottom-up*" budget planning process fails to effectively meet the resourcing needs of regional health care centers. Patronage relationships reportedly determine budget allocations. Some respondents mentioned over 90 percent of the health budget remains in Bamako, while just nine percent is allocated to the regions. While no officials corroborated such a stark picture, respondents indicated that there were clear problems associated with the lack of transparency around the so-called "*participatory*" and "*bottom-up*" budget process. Budget requests are based on a process that begins with CSCOMs needs at the commune level and feeds into regional budget requests and then to the MoH. In reality though, the amounts ultimately transferred to the regions often vary significantly

from requests. Typically, all the CSCOMs in a commune are allocated a small subsidy based on the previous year's budget, according to respondents. Additional amounts are granted for expenditures referred to as *"investments"* that are difficult to monitor or verify.

Respondents indicated that clientelism determines who gets appointed for positions, how funds are allocated, and the levels of resources that are allocated from the MoH to the regional governments. For example, there is no well-known formula reported by respondents to determine budget allocations. Government officials at the center say that the Bureau of Rural Statistics within the MoH uses a combination of population levels and economic activity (or tax base) to determine the budget allocation levels. Some of the regional level officials offered the same response, but no one was able to explain a formula or process as to how the levels are determined, though the final budget figures seem to be generated within the MoH's Planning and Statistics Unit (*Cellule de Planification et des Statistique)*.

ASACOS & MAYORS COLLUDE ON RENT-SEEKING OPPORTUNITIES.

Decentralizing health financing across Mali has not fostered improved local service delivery, but instead has provided opportunities to consolidate rent-seeking opportunities and political power into the hands of the local elite. This finding is particularly common at the municipal level where CSCOMs are officially private entities. Mayors responsible for allocating subsidies to CSCOMs are vulnerable to pressure to collude with the associations managing these entities, typically run by local elites "*elected*" to the positions to funnel CSCOM revenues to electoral politics, traditional leaders, as well as their own personal gain, much to the detriment of the quality of service at these centers.

PARALLEL PHARMACEUTICAL SUPPLY CHAINS (FORMAL AND INFORMAL) ENRICH LOCAL POLITICAL ELITES.

Weak oversight of commodity procurement, particularly at the district level, allows for parallel systems to develop alongside the state processes for pharmaceutical supplies, through which commodities are diverted into private distribution channels for financial gain. Respondents noted that the district should be supervising the private pharmaceutical supply chains for district hospitals, CSREFs and the ASACOs. Key informants explained that ASACOs have interest in the 10-15 percent they can skim from private sale of those medicines, running counter to the mandate that ASACOs provide medicines at lower cost to their communities.

THERE IS SYSTEMIC CORRUPTION AND ENDEMIC IMPUNITY.

The experience of corruption at CSCOMs among respondents from this research was almost universal. Respondents, even health care workers, emphasized that funds are misused and mismanaged, but even when they suspect their superiors of corruption, they have little recourse. There are no independent monitors and internal monitoring results only in complicity according to respondents.

Impunity is endemic at all levels of government and what one respondent described as the new culture of Mali. Government respondents pointed out recent steps forward on anti-corruption including the requirement for government officials to declare their personal assets. The new anti-corruption body, OCLEI *(Office Central de Lutte Contre L'enrichissement Illicité)*, however, has no power to monitor and process information on asset declarations despite the requirement. As a result, abuse of office is rarely sanctioned and there are few examples of prosecutions of prominent individuals.

Respondents referred to a reluctance to create conflict by questioning authorities in their communities because it could disturb social and family ties and even professional networks. They also express a fear of reprisal for speaking out. Maintaining a harmonious social network is an important part of the Malian culture, respondents told researchers, and even when there is an anonymous tip line for corruption or impropriety, individuals may be reluctant to use it. Even the auditor general, the BVG, tasked with auditing financial records often uses softer, less incriminating language when discussing mismanagement of funds. Moreover, layers of complexity reduce opportunities for accountability in the face of corruption and slow the monitoring of funds.

PREDATORY BEHAVIORS OF HEALTH CARE WORKERS FORCE PATIENTS TO SEEK LOWER COST BUT POTENTIALLY HARMFUL ALTERNATIVES.

Predatory behaviors of health care workers force patients to pay higher out of pocket (OOP) costs for care, pharmaceuticals, and medical supplies, or eschew the public health care system and seek lower cost but potentially harmful alternatives from traditional healers or street vendors. This "*embezzlement*" by health care workers is felt as particularly egregious when patients are asked to pay for services and medicines that they know are supposed to be free, and which they need desperately like c-sections. Respondents from focus groups complained bitterly about their exploitation by health care workers at CSCOMs.

4.3 HERE AND NOW

DECENTRALIZATION HAS EXACERBATED CORRUPTION AND POOR SERVICE DELIVERY IN HEALTH.

The state-centric model does not grant real power or decision-making authority to the local government, but delegates responsibilities without resources which has implications for new initiatives that promise free and subsidized health care. The state's promises of reform for health, education and justice sectors, and peace are all premised on greater regional autonomy. Real devolution of administrative power to the regional and local government in Mali has not evolved over time. Efforts to deconcentrate the power through the budgeting process for service delivery of health have been unsuccessful in Mali and have exacerbated rent-seeking and other forms of corruption as well as poor service delivery.

UNFULFILLED PROMISES AROUND HEALTH REFORM COULD BE THE SPARK FOR WIDESPREAD DISCONTENT.

If the population in Mali perceives the president's promises to be unfulfilled, patience with the democratic process may dissolve. IBK's 2013 unfulfilled presidential anti-corruption platform may have set a precedent that combined with new disappointments might be Mali's undoing. Internal conflict, armed jihadist fighters within the border waiting to exploit a moment of state weakness, and growing loss of trust in the state could create a volatile reaction. Popular Muslim clerics are gaining followings that do not embrace a Mali with open democratic rights and equitable access to health care. The GoM needs to demonstrate change.

Analysts told the research team that Mali is a tinderbox - any spark could set it off. Health reform failure could be the spark that ignites the anger. The president raised hopes about free health care, through politicized populist messaging about UHC. The subsequent failure to realize reforms of that scale and

the disappointment and desperation over the cost and availability of quality health care could be seen as emblematic of state failure.

4.4 DYNAMICS

TRUST IN HEALTH SYSTEM IS WANING IN PARALLEL WITH TRUST IN THE STATE.

Changing perceptions and behaviors around insurance means changing perceptions around trust in community and state. One of the biggest quandaries with implementing the health reform law is that it is premised on Malians buying into RAMU to receive coverage. Corruption, poor governance of health resources, and poor transparency around the pricing of health services has created a health finance crisis, which is also a crisis of trust in Mali. So-called free services are not free due to local level corruption and coverage is out of reach for the vast majority of Malians. If people do not trust in local health care systems, they will not buy into it, particularly for poor Malians who are struggling to meet household needs. Even under RAMU, the GoM will struggle to extend coverage to even 30 percent of the population.

ASACOS ARE POWERFUL POTENTIAL SPOILERS OF HEALTH REFORM.

Efforts to restructure the health care system will meet with resistance from ASACOs and their powerful national unions who perceive themselves as "*private sector*" or "*civil society*" rather than government and often have local elites aligned in their favor. ASACOs are sometimes seen as a scapegoat for government officials to blame for any failure of local health care systems and some respondents indicated a belief that the health reform had been engineered to destroy ASACOs because they are too powerful, and they threaten the health system.

Development partners and government respondents acknowledge that the cost of health care is a major barrier to access. The GoM failing to deliver adequate health care has increasingly grave repercussions for Mali, but the field research indicates that this problem cannot be resolved simply with more resources allocated to the MoH. The rigidity of public spending procedures, lack of transparency, and absence of credible accountability mechanisms contribute to the low quality of service provision and increase existing geographic and socio-economic disparities. Consequently, there is a need to increase efficiency and prioritization in donor support to improve health outcomes at the local level through stronger, more effective local governance of health resources.

4. CHAMPIONS AND SPOILERS

This section identifies potential champions of reform, those who might act as spoilers to health reform, and a third group that were identified by the researchers as potentially being either, depending on the context (see Table 4). For example, the Chief Medical Officer can play either a constructive leadership role in the community or they can act as a deterrent to equitable, quality health care by participating in corrupt practices and mismanagement. A more comprehensive social network analysis could provide useful insight into the level of influence of individual actors within the overall health care system. This mapping helps identify pathways for change for actors who can demand accountability of the MoH and CMO at the local and regional levels. The champions are coalition builders, the actors USAID wants to work with. In contrast, the spoilers will continue to influence the MoH and CMOs pulling them into their rent-seeking schemes to maintain their political interests. These are actors USAID will need to work with carefully at the local level or find effective work arounds to avoid supporting '*bad actors.*'

Table 4: Summary of champions and spoilers

Champions	Champions or Spoilers	Spoilers
Women	MoH staff	FENASCOM
Youth	Chief Medical Officers	Mayors
IPs		ASACO Leadership

Chief Medical officers play a critical but often ambiguous role.

Not all CSCOMs have CMOs but instead may have only a Chief Technical Director. It is assumed that the CMO should play the roles of administrator, medical doctor, and human resources manager all in one. These expectations can put the CMO in a vulnerable position in which they are under pressure to collude with management associations or local leaders. This seemed particularly true when the doctor was responsible for multiple CSCOMs and had no particular ties to anyone. In contrast, one respondent indicated that when he arrived, they had no patients because no one in the community knew the CSCOM existed and that it was something that they could access for their health care at a minimum cost.

One chief medical officer at a model CSCOM struggled to understand why women did not come to the CSCOM to give birth. He took action to find answers. He gained their trust by going into the local community and with small group discussions, he learned that women did not go to the CSCOM because the cost was too high. After deeper engagement with the community through home visits and small discussions, he learned the deeper reason that women do not come to CSCOM to give birth is because they lacked decision making power. Even if they got permission from a husband or mother-in-law, there was no privacy for birthing women, no separation from sick patients, and chatting and gossiping people, youths and children in close proximity at the CSCOMs all deterred women from utilizing the CSCOM for giving birth. The doctor listened and once he created a private space for birthing, women started

coming. Few health care centers make the effort to understand the local barriers to access and how to communicate with communities and reduce these barriers. It is about cost, but it is not only about cost.

> *"Women would not go to the CSCOM to give birth. I met with the community in the evening, joining the grins and I asked about the absence of women in the CSCOM. It took some time but I learned that women would like to give birth in privacy, not in the midst of a group of chatting people, youth and children - who will gossip. Once we moved these groups out of the CSCOM, women came to give birth. We just had to listen and understand."*
>
> -KII respondent

The chart of champions and spoilers identifies key actors and entry points for USAID programming that can strengthen governance of the health sector. By working through communities, focusing on youth and women, USAID and its partners can identify specific actors at the local level that are motivated and well-positioned to push for increased accountability from the ASACOs and Mayors. With implementation partners and CSOs, these communities can become powerful voices for change. They are already at the bottom of the health pyramid. With its new strategy, USAID / Mali can lead the way toward strengthened support of local health systems to build greater local accountability through stronger local governance of CSCOMs. The team recognizes this to be an entry-point for USAID's programming with a focus on improving the health sector's financial governance by targeting implementation efforts on improving the quality of service delivery at the point of service. The team was told repeatedly that patients often felt unwelcome in health centers and vulnerable. Small steps can be implemented to encourage better care and treatment of patients. An illuminated patient number system displaying the order of patient care could discourage bribes to '*jump the line*.' Payment of the tickets by mobile phone that document the electronic payment to the health center and can improve transparency and time of payment. Mobile phone ownership is high in Mali, even in rural areas. Electronic payments of health care payments in concert with improved information about patients' rights and obligations could reduce opportunities for corruption and exploitation of patients. Community score cards that include health care rankings could be displayed in care centers, outside of the mayor's office, and announced on local radio to encourage greater accountability by local government.

Research for this assessment indicates that getting more Malians to buy into health insurance schemes will be challenging under any circumstances, but particularly at this point in time when trust in the state's public health care system has declined. One problem with health reform is that it is a political promise that may or may not be fulfilled. The President made promises about free care for pregnant women and children under five, and these announcements have raised expectations. In the context of state fragility, the team believes that government complacency regarding fulfilment of the promise of UHC in combination with a pervasive lack of accountability at all levels of the health-care system, increases risk for expressions of popular dissent (e.g., anti-government protests akin to those of April 2019 when 30,000 people (CSOs, women, and religious leaders) took to the streets following the massacre of around 160 Fulani villagers by a militia allegedly affiliated with the Dogon ethnic group).[27] This is a noteworthy development because a similar protest took place just ahead of the 2012 military coup d'etat.

[27] Ross, A. "Mali struggles to disarm ethnic militia suspected of massacre." Reuters, April 5, 2019.

6. RECOMMENDATIONS

This section identifies recommendations based on the analysis of the key findings in Section 4 and contributions of USAID team members offered during both the in and out briefs. The recommendations are clustered according to each of the four PEA pillars.

The team identified numerous findings of which a smaller number map directly to recommendations as found in the table 5. Clusters of recommendations follow each finding grouped below to more closely align findings to specific, actionable recommendations. These recommendations are informed by the 2019 DRG Assessment that outlines a strategic approach of "*Act, Assess, and Adapt*". To act, the team recommends identification of three to five target communities for pilot interventions. These will build on existing successes (for example the work of Save the Children or the FHI 360 Linkages Project), use the data from these pilots to assess scaling the strategy to more communities (including 1-2 in higher risk zones such as Mopti), and finally adapt program interventions based on learning in the pilot phase.

To mitigate risk to USAID and its implementation partners, this assessment recommends making a higher number of modestly funded responses with the specific aim of demonstrating to local communities an immediate and tangible improvement in health care. If CSCOMs are not to languish, making a limited investment, where modest investment is likely to yield results, is strategic. For example, piloting sterile c-section kits and specialized training to midwives/nurses and where possible, doctors. The fundamental driver of these pilot interventions must be that they be evidence-based and that they closely align with the priorities of the community, not those of the ASACO, mayor, or donors. In all cases, the list of spoilers and champions identified above should be used as a starting point to identify specific opportunities and potential partners.

6.1 RECOMMENDATIONS ACROSS PEA PILLARS

Recommendations are summarized using USAID's PEA framework in the table below.

Table 5: Recommendations emerged from field research data

Theme	Recommendations
Foundational Factors ***(Recommendations Cluster 1)***	1. Pursue rapid visible, tangible changes, which strengthen local governance, improve services, and reduce exploitation of vulnerable patients. Prioritize cross-sectoral programming and planning within USAID / Mali on food security, gender, youth, education, and local governance to address malnutrition.
	2. Pilot plans for expanding free and low-cost care for adolescents as a priority. Given the huge youth population, and the highest adolescent birth rate in the world, with 17 of every 1000 girls aged 10-14 year old experiencing a pregnancy, prioritizing and piloting plans for free and low cost adolescent health care that consider cultural norms around household-level health care decision-making, is likely to have a high return on investment.

	3. Extend education and health communication through community channels. Mali's health statistics are poor but experience in the region shows that attention to the political economies, as well as the intra-household dynamics around health care can help identify appropriate ways to support existing community momentum toward positive change. Increase engagement with youth on public health through communications programs and social media efforts that can energize participation in public debates on health reform.
Rules of the Game ***(Recommendations Cluster II)***	1. Reduce focus on support for implementation of RAMU/UHC at the national level.
	2. Public reporting on the formula used to determine budget allocations in the health sector should be a requirement of USAID support.
	3. Reduce social exclusion at CSCOMs. Part of improving public trust in institutions involves strengthened social inclusion. Mobilizing targeted support for IDPs, including victims of sexual violence and conflict can help build community and individual resilience and trust in the state.
	4. Reduce public discontent with CSCOMs, increase community engagement in designing health care delivery systems that align with community needs.
	5. Establish checks and balances at the local level for health care transfers and expenditures to strengthen transparency and accountability and create a culture where impunity is not tolerated, and public reporting modalities are not burdensome and can be easily reviewed by third party auditors.
Here and Now ***(Recommendations Cluster III)***	1. Support messaging that while Mali is preparing to make affordable care a reality for all Malians, USAID is focusing on demonstrable, local improvements in health care access and delivery of affordable health care for all through greater accountability and transparency at the local levels of health care delivery and governance.
	2. Conduct a formal social network analysis of CMOs to determine what makes CMOs successful may help to identify the incentives driving good practices and factors producing poor outcomes at CSREFs and CSCOMs.
	3. Continue to invest in IPs and CSOs to strengthen oversight of the pharmaceutical supply chain, monitor alternative supply chains and illicit drugs, and strengthen health reporting.
Dynamics ***(Recommendations Cluster IV)***	1. Verify and certify CSCOM minimum standards of care and publicly report on centers that have performed well and why so that this information is accessible on the radio or even WhatsApp group reviews. This should help build public trust and a model of customer service that empowers the patient.

	2. Work closely with the Mayors and CSCOMs management associations on increasing transparency, use of digital transfers, and scrutiny of public financial management at the local level. Create quarterly reporting modalities that are not burdensome and that can be easily reviewed by third party auditors.
	3. Do not invest in UHC at the national level. Do invest in local governance of health resources.

6.2 Recommendations for Upcoming USAID / Mali Activities

In addition to recommendations based on the PEA framework and pillars, this section provides additional recommendations that are directly mapped to inform the co-creation process of the new USAID / Mali agreements*: HSS, and Integrated Community Health and Nutrition.*

Key recommendations for HSS

1. Establish an anti-corruption agenda to explicitly identify strategies to: 1) mobilize and motivate health workers to fight corruption; 2) improve monitoring and evaluation and regulatory compliance; 3) strengthen transparency and accountability in health systems and; 4) launch awareness campaigns that can educate patients and health workers. To be effective, anti-corruption strategies must be comprehensive in nature and integrate coordinated reforms across the sector so that vertical approaches such as leadership initiatives, the setting up of regulatory bodies and auditors and improved incentives are complemented by horizontal strategies that engage frontline health workers and patients. This should be undertaken at regional and sub-regional levels to effect local change.
2. Increase commitments to public reporting, third party monitoring, and digitization of financial transfers.
3. Work with CMOs and DMOs to strengthen requirements for planning and reporting on transfers, revenues, and budget gaps, and support the public dissemination of information.
4. Engage youth: poor voter turnout for the 2018 election was particularly notable among youth, who made up less than seven percent of voters. With a median age of 16 years, about half of Mali's 19 million people are positioned to determine Mali's future but chose not to vote in the most recent election and/or are voting with their feet by leaving Mali. There is also a growing following for popular Islamic clerics, sometimes perceived as more trustworthy than politicians in Mali, who offer an alternative political platform behind which to rally. They can be a major influence on public opinion. Engage youth in urban and rural communities with innovative approaches like social media and radio drama to strengthen knowledge of health rights to reduce exploitation of patients and improve understanding of local government allocations to CSCOMs that they can track.

KEY RECOMMENDATIONS FOR INTEGRATED COMMUNITY HEALTH AND NUTRITION

1. Prioritize co-location and cross-sectoral coordination with World Food Program, Food for Peace, and other partners working to address malnutrition and food insecurity, while recognizing the importance of resilient livelihood strategies and conflict resolution for vulnerable populations, with particular attention to regional variations in nutrition status that relate to climate impacts and other drivers of changing vulnerability. Build on these to target integrated community health programming.
2. Use democratic processes to put communities in the drivers' seat and take back management and leadership of CSCOMs through elections of new management association leaders and involvement of community in designing health care centers that meet their needs, with improved standards of care, and monitoring for results, with easy methods for patient feedback to health providers;
3. Work with CMOs and DMOs to strengthen commitments to building nutrition education and community outreach into their health care delivery objectives and include public dissemination of information through innovative approaches like radio dramas and social media.
4. Build trust and reduce public discontent through pilot programs that can improve access of women and marginalized groups to improved nutrition as part of a primary health care program. This in turn will offer a stepwise approach to affordable health care by decreasing the exploitation of vulnerable patients and broadening support for health coverage.

7. CONCLUSION

The fragility of the state and the extreme skepticism with which the president is regarded by many Malians forms the background against which this assessment was performed. The research and analysis highlight the degree of failure by the GoM to implement promised health reforms or improve health delivery could spark widespread discontent and even greater disillusionment with the Malian state, which has experienced increased fragility since the 2012 coup. Mali's health system is at a major crossroads. Health care providers express skepticism that the government can enact these reforms in the medium to long-term given the level of problems it currently faces in financing and providing even basic care. The health reform is premised on higher levels of development financing, but development partners question the state's capacity for and political will to execute health reform that will be inclusive, equitable, affordable, and meaningful.

Where the MoH sees the need for more resources, health sector partners see the need for better financial governance. Development partners and government respondents acknowledge that the cost of health care is a major barrier to access and that the GoM failing to deliver adequate health care has increasingly grave repercussions for Mali, however, the field research indicates that problems cannot be resolved with additional resources to the MoH. The rigidity of public spending procedures, lack of transparency in budgeting, and absence of credible accountability mechanisms all contribute to the low quality of service provision and low rates of access, as well as the significant geographic and socio-economic disparities in access. There is also a need to reduce donor redundancy and increase efficiency and coordinated prioritization in donor support to improve health outcomes at the local level. Local government accountability needs to be generated through improved local knowledge of rights around health care centers and an acknowledgement that any movement toward subsidized health care must begin with a strong health communication program to protect the most vulnerable populations and improve knowledge of rights to better health outcomes.

USAID can offer comparative advantage in other programmatic areas, such as health communication strategy, youth engagement, and coupling nutrition, as well as health as part of a comprehensive preventative health care strategy. Government, CSO, and citizens acknowledge the need to invest in change in the way health care is provided and financed. That change must be rooted in strengthening local government accountability around health budgets and transfers through greater transparency. Stronger action to address high levels of malnutrition through CSCOMs and youth-oriented health communication campaigns could foster change in perceptions of the role of community health providers and sense of local community ownership. These actions combined with investments in improving capacity for democratic governance of local health care centers may help reduce barriers to preventative health care, making health care more accessible and affordable for the most vulnerable communities.

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ANNEX II: KEY LAWS, DECREES AND REGULATORY POLICIES

1. The Constitution of Mali, February 1992.
2. Law on operation of Community-Based Health Insurance Schemes:

   Loi n°96-022 du 21 février 1996 régissant la mutualité en République du Mali

3. Hospital Law: Loi No. 02-050 du 22 juillet 2002 Portant loi hospitalière
4. Decree that transfers health responsibility from the State to the CTs, Circles, and Communes: Décret no. 02-314/p-RM du 4 juin 2002 fixant les détails des compétences transférés de l'État aux collectivités territoriales des niveaux Commun et Cercle en matière de santé.
5. Charter of Patient's Rights: Arrete N°08-2716 /MS-SG DU 6 OCT 2008. Portant Charte Du Malade. Dans Les Établissements Hospitaliers.
6. Decree No. 05–299/P- RM of June 28, 2005 Setting the conditions of creation and the basic principles of operation of the Community Health Centers (CSCOM) and decree No. 2013–711/P-RM of September 2, 2013 amending decree No. 05-299
7. Laws and decrees on decentralization through the Ministry of Territorial Administration: Les lois et décrets de la décentralisation. Ministere de l'Administration Territoriale et des Collectivités Territoriales, Direction des Collectivités Territoriales. 6éme édition 2009.
8. Regulations for operation of CBHI in ECOWAS states:

   Règlement n°07/2009/CM/UEMOA du 26 Juin 2009 portant réglementation de la mutualité sociale au sein de l'espace UEMOA sous le n° 2/S/99.00004/MLI.

9. Laws, decrees, for the deconcentration of regional and subregional services from the Ministry of Economy and Finance, Auditing of the budget allocation chain:

   Lois, décrets régissant les services régionaux et subrégionaux du Ministere de l'Économie et des Finances, Audit de la chaîne de la dépense, FMI, mars 2014.

10. Guide for the mobilization of execution of budgetary resources transferred to the CT's for health delivery in the Law https://www.ecfr.eu/mena/sahel_mapping on Finance of the Unit for Deconcentration and Decentralization (CADD) of the MOH: Guide de Mobilisation et d'Exécution des Ressources Budgétaires transférées aux collectivités territoriales en matière de santé dans la Loi de Finances, Cellule d'appui à la Décentralisation et à la Déconcentration (Unit CADD) mars 2015.
11. The Law on Universal Health Coverage: Loi No. 2018 074 du 31 Dec 2018: Portant Institution du régime d'assurance maladie universelle (RAMU).

ANNEX III: KIIs

Location	Interviewee Category	Title(s)	Name	Organization
Bamako	National/district/regional government	Deputy Director General (DDG)	Ahmadou Haidabar, Diakaridia Dembre	Ministry of Finance
Bamako	National/district/regional government	Director of Deconcentration and Decentralization (CADD-MoH)	Bobacour Traore	MoH
Bamako	National/district/regional government	Chief of party	Sedou Traore	Palladium
Bamako	National/district/regional government	DDG	Dr. Allassane Balabo Dicko	Caisse Nationale d'Assurance Maladie (CANAM)
Bamako	CSCOMs	Deputy Director	Amadou Traore	ANOM
Bamako	CSO	Project Director	Jean Bedel	Chemonics USAID Pharmaceutical Procurement Supply Chain Project
Bamako	CSO	Technical Assistant, embedded at the MoH, CADD	Hatou Dembele	USAID Sub-National Governance Project SNGP
Bamako	CSO	Administrative Secretary	Brahima Guiré, Bourema Togola, Sidi, Bekaye, Sekou Dembélé, Haba Diarra	FENESCOM
Segou	Local government	Mayor/Monsieur Aboucar Sow	Tidiani Cisse	First Deputy Mayor (Segou)
Segou	National/district/regional government	Director of Regional Budget	Karim Fomba	Regional Government of Segou
Segou	CSCOM/CFEREF	Director of Segou Regional	Abdulalouye Somego	Regional government

Segou	CSCOM	Deputy Chief Medical Officer	Dr. Topou	CSREF Segou
Segou	CSO	Director General CSO Platforme	Modibo Oomou Coulibaly	CSO
Segou	National/district/regional government	Président du Conseil de Cercle	Jean Mari Keita	Segou District Government
Segou	Local government/Commune	Treasure Payer	Ousmane Kouyate	Regional treasurer. and accountant
Segou	National/district/regional government	Director, Medicine an Pediologist	Dr. Drissa Touré	Direction Regionale de la Sante
Segou	National/district/regional government	Prefect	Monsieur Dramane Diakite	Regional government - Segou
Koutiala	Local government/Commune	Prefect	Prefect Koutiala	Government of Koutiala
Segou	CSCOM	President ASACO	Monsieur Mady Sissoko	ASACO
Koutiala	CSCOM/CFEREF	Technical Medical Director	Abdullaye Guindo	CSCOM Medina Coura and President of FELASCOM KOUTIALA
Koutiala	CSO	Project Coordinator	Dorborson Suwulubalah	Medicins Sans Frontier
Segou	National/district/regional government	Special Counselor	Monsieur Mamadou Bassirou Ballo	Special Counselor of Solidarity (MoH)
Koutiala	Local government/Commune	Maire	Oumar Dembele	Commune
Bamako	CSO/IPs	VP (he also works on security and the crisis situation)	Monsieur Aboloulaye Sall	Bureau de Commission des CSO - The GoM

Bamako	National/district/regional government	Director (Direceur)	Monsieur Aly Diop, Monsieur Kamissko, Dr. Sall Coulibaly	Ministry of Public Health and Hygiene CPS (Bureau of Planning and Statistics of MoH)
Gulu Gulu	CSCOM/CFEREF	General practitioner	Dr. Bourama Diarra	Gulu Health Center
Bamako	CSO/IPs	Chief of party	Monsieur Protais Ndabamenye	Save the Children - Mali
Bamako	CSO/IPs	Director and Interim Director	Boubacar Boucom and Dr. Modani Tall	FHI 360
Bamako	CSO/IPs	Director and Senior Resident Advisor, and Technical Advisor	Dr. Badie HIMA, Anis Samaali, Aly MAIGA	National Democracti Institute (NDI)
Bamako	CSO/IPs	COP in charge of Advocacy, DCOP, Data Analyst	Drissa Doumbia, Mahanadou Diakite, Sitan CIsse, Abrramane Bagayoyo	Linkages
Bamako	National/district/regional government	Deputy	Abdoulaye Guindo	National Direction de la Sante
Bamako	CSO/IPs	Resident Program Director	Monsieur Rudolph Grannier	International Republican Institute

ANNEX IV: FGDS

Location	Name of group(s) /organization	Titles	Names
Segou	Mixed youth group from CSOs	CSO	Ramata Kone, Fatouma Fayinke, Canta Z Ba, Lalla Cisse, Kadidja Traore, Adama Kone, Moussa Ibraham Traore, Ousmane Konare, Mohammed Sanogo, Seydou Traore
Segou	Network of Women's Entrepreneurs	Entrepreneur	Sidibe Coulibaly, Animaita Doukoure, Hawa Diarra, Kadiatou Traore, Aissata Ba, Anzou Tienou, Semite Coulibay, Mariam Deme, Dolo Sou, Fatouma Chiloguem
Koutiala	AMASSA	Community members	Many
Koutiala	CSCOM Madina Coura	Chief Technical Officer, Obstetric Nurse, President CFU, Obstetric Nurse, ASACO, Sage-Femme (midwife)	Allaye Guindo, Kadidja Coulibaly, Fatumata Sogotogo, Assetou Berthe, Maimouna Traore, Adiaretou Coulibaly
Koutiala	mixed group of community members of Koutiala	Community leaders and members	Ouroun, Aissata A. Kone, Mairie Koumantou, Daoda Traore,s/secteur Koumantou, Justice Diabate, Secteur Koutiala, Odile Dembele, SLPFEF, Youcouba Dembele, Miniankala CAFO, Moussa Coulibaly, ASACO M'Pessoba, Bakary Sanogo, Jamajigi, Kadiatou Dembele, Radio Yeredon,
Koutiala	Women's group in Koutiala	ASACO President, Promoting Women and Families, Chief of the Agriculture Program, Mayor of health	Minata Kone, Aissata A Kone, Odile Dembele, Justice Diabate
Koutiala	CAFO, APIFED, Femme Rapportes Santes Du nord, Association Niddu Bonhu, Organization Action pour la promotion des enfants,	Members	Djeneba Daau, Dumon Diakite, Rokiatau Dembele, Maimouma Traore, Mariam Djire, Azaharatan Raiga, Fatoumata Sanogo, Fatumata Traore, Mariam Makalau, Ilarte Sangare, Anita Tounkara, Djeneba Dembele

Segou	Mixed group	Traders	Mariam, Astan, Keita, Fanta, Sacko
Segou	IDPs/Refugee - not formal association	Refugees from Timbuktu (Mopti)	O. Famanto, Mamady Suleymana, Boubacar, Kadadator, Asane
Bamako	NDI organized but multiple CSO	General Secretary, Researcher, CSO REFAMP, CSO, Director and resident Advisor NDI	Mbacichate Coulibaly, Modibo Yacouba Diarra, Alwata Ichata Sahi, Salia Kariba Traore, Mahamadu Diarra, Madame Habribatou Traore

ANNEX V: RESEARCH INSTRUMENT (ENGLISH)

NOTE: These questions to open every KII/FGD

Cross-cutting questions	1. Have you heard about any changes to the health care system to improve access to basic health care to everyone in Mali? yes/no
	2A. Who do you think is MOST interested in improving access to free health care? (Champions) 2B. Who would BENEFIT THE LEAST from these changes? (Spoilers)
	3. What do you think are the **TWO** biggest obstacles to improving health care access in Mali? • affordability/cost • location of health care centers or transportation costs • services offered • lack of qualified professionals • my mother-in-law or husband object to using these services • other
	4. What do you think are the most important changes that should be made to improve service delivery and quality of care?

Theme	Interviewees	Questions
Health Care Budget and Financing	**National, district, and regional level government**	CROSS-CUTTING Have you heard about any changes to the health care system to improve access to basic health care to everyone in Mali? yes/no Who do you think is interested in improving access to free health care? Who would oppose these changes?

		What do you think are the **TWO** biggest obstacles to improving health care access in Mali? ● affordability/cost ● location of health care centers or transportation costs ● services offered ● lack of qualified professionals ● my mother-in-law or husband object to using these services ● other What do you think are the most important changes that should be made to improve service delivery and quality of care? --- ● **1A.** How does the MoH plan for health budget funding levels to support adequate staffing, equipment, and supplies to the CSCOMs, district and regional hospitals? ● **1B.** How long do CSCOMs have to allocate their funds? ● **2A.** How does decentralized health budgeting or allocation spending reach regional, district and local CSCOM revenues? ● **2B.** Which level is most challenging to manage? ▪ Regional ▪ District ▪ Local ● **3.** Is the core problem clientelism, inefficiency, or poor planning? ▪ clientelism, ▪ Inefficiency, ▪ poor planning, ▪ other ● 4A. Who is making decisions about funding or budgeting allocation decisions at different levels? ● 4B. How are the budget levels set? ● 5A. Does the full amount of funding budgeted by the state reach regional health centers? Yes/No ● 5B. Does the full amount of funding budgeted by the state reach district health centers? Yes/No ● 5C. Does the full amount of funding budgeted by the state reach local health centers? Yes/No ● 5D. If no, why does the funding fail to reach these levels? ● 5E. Is one level more challenging to reach than the others? ▪ Regional ▪ District ▪ Local

		● 6A. How is mismanagement of resources handled? ● 6B. How is capacity to manage resources monitored? ● 6C. How do you hold decision-makers accountable? ● 7A. Can greater transparency help us monitor budget and finance flows? Yes/No ● 7B. If yes, who should be responsible? ▪ Min of Health ▪ Local health care providers ▪ CSO ▪ Community (through local counsel) ▪ Other ● 8A. In your opinion, is impunity a problem for the GoM? Yes/No ● 8B. If so, how would you describe GoM impunity? ▪ Large problem ▪ Somewhat a problem ▪ A small problem ● 8C. Why? ● 9A. In what specific ways can enforcement of laws and regulations be measured, monitored, and improved? ● 9B. Who should be responsible for measuring, monitoring, and improving the enforcement of laws and regulations? ▪ Local (District) Gov ▪ Regional Gov ▪ MoH (National) ▪ CSO ▪ Health care providers ▪ Security services ▪ Everyone ▪ Other 10A. Are there specific laws, decrees, or regulations that interfere with providing UHC to citizens? Yes/No 10B. Name the law, decree or regulation
Health Care Administration and Management	**Health Centers**	CROSS-CUTTING Have you heard about any changes to the health care system to improve access to basic health care to everyone in Mali?

		Yes/No Who do you think is interested in improving access to free health care? Who would oppose these changes? What do you think are the **TWO** biggest obstacles to improving health care access in Mali? ● affordability/cost ● location of health care centers or transportation costs ● services offered ● lack of qualified professionals ● my mother-in-law or husband object to using these services ● other What do you think are the most important changes that should be made to improve service delivery and quality of care? --- 1A. When a patient arrives in the clinic tell me how you...: ● Diagnose ● Treat ● Refer for other care/services 2. How many patients do you see DAILY? ● 0-10 a day ● 10-20 a day ● 20-40 a day ● over 40+ a day 3A. On average, how much money do you earn DAILY? 3B. Do these fees cover your costs? 3C. Who is responsible for reporting these figures? 3D. Is this money being managed well? Yes/No 4A. How do you fund treatment? 4B. What mix of funds does the government receive? ● MoH

		● Patient fees ● Donors ● Private sector ● Universities/Research institutions ● Other 4C. Can you estimate what percentage of funds comes from each source? 4D. Which positions would typically manage these funds? 4E. Which positions would typically account for funds or audit funds? 5A. How do you report diagnoses and treatment, with associated cost of care? 5B. Who manages the income from treatment of patients? 5C. How does the management of these funds affect your ability to budget for health care needs and treat patients? 5D. How do you use this data? 5E. Do you know if anyone else uses the data, and for what? 6. When it comes to payment for services, would you say that the patient's ability to pay for services determine their care/treatment: ● A-lot ● Somewhat ● Not at all 7A. What are the challenges you face in budgeting and obtaining medical equipment and supplies needed to cover your health care provision? 7B. How do you deal with these challenges? 7C. How do challenges in acquiring medical equipment and supplies affect care? 8A. How do you plan and procure drugs? 8B. How do stock outs (running out of medicine) affect care? 8C. What do you do if you don't have drugs for treatment due to stockouts? 8D. How do you report stockouts? 9A. Are health professionals promoted for quality of care? Yes/No

		9B. How are care providers motivated to improve the quality of service they provide to patients? 10a. Do you have the staff to address typical needs? yes/no 10b. How many positions do you have? ● 10-20 ● 20-40 ● 40-60 ● 60+ 10c. How do you fill empty positions? 10d. Do you have difficulty filling the positions? 10e. How do you pay for these new positions? 11. Based on what factors is your health center is evaluated? ● Supplies ● Caregivers ● Equipment ● Wait times ● Patient satisfaction ● Other
Health reform	**Community and community health workers (CHWs)**	CROSS-CUTTING Have you heard about any changes to the health care system to improve access to basic health care to everyone in Mali? Yes/No Who do you think is interested in improving access to free health care? Who would oppose these changes? What do you think are the **TWO** biggest obstacles to improving health care access in Mali? ● affordability/cost ● location of health care centers or transportation costs ● services offered ● lack of qualified professionals ● my mother-in-law or husband object to using these services ● other

		What do you think are the most important changes that should be made to improve service delivery and quality of care? ---------- 1A. Do you think that there are opportunities in the current context to improve the financing of health care in Mali? Yes/No 1B. For example... 1. Is "mutualism" important to supplement community health insurance? 2. yes/no 3. Why or why not? 2. How could more access to private insurance improve health care? 3. What is the best option to pay for health coverage? ● Free ● Private / Government ● Private/other supplemental coverage (donors) ● Other
Socio-cultural and Religious Barriers to Access	**Health professionals, health centers, CSCOMs, communities, etc.**	CROSS-CUTTING Have you heard about any changes to the health care system to improve access to basic health care to everyone in Mali? Yes/No Who do you think is interested in improving access to free health care? Who would oppose these changes? What do you think are the **TWO** biggest obstacles to improving health care access in Mali? ● affordability/cost ● location of health care centers or transportation costs ● services offered ● lack of qualified professionals ● my mother-in-law or husband object to using these services ● other What do you think are the most important changes that should be made to improve service delivery and quality of care?

		--- 1. Will extending UHC to everyone in Mail change the perception of health care access? yes/no Why or why not? ● 2a. In what way could changes in health funding help health care access? ● 2b. Why or why not? 2A. Are there any people, groups or communities excluded from health care services? yes/no 3b. Which groups are excluded and why? 3c. Are there any people, groups or communities who find it **more difficult** to access health care than others or face **more barriers**? ● yes/no 3d. Which groups and what added barriers do they face? 4a. Are there any conditions or health care services that are considered more sensitive? yes/no 4b. Can you tell me about those? 4c. Have you observed any changes in treating these sensitive conditions since health care has become more widely available?
Access and Financing (focus groups)	**FGD communities & health workers/volunteers**	CROSS-CUTTING Have you heard about any changes to the health care system to improve access to basic health care to everyone in Mali? ○ yes/no Who do you think is interested in improving access to free health care? Who would oppose these changes? What do you think are the **TWO** biggest obstacles to improving health care access in Mali? ● affordability/cost ● location of health care centers or transportation costs ● services offered

		• lack of qualified professionals • my mother-in-law or husband object to using these services • other What do you think are the most important changes that should be made to improve service delivery and quality of care? ---------- • 1a. Where do you go first when you become ill? • I do not seek help until it is an emergency • Local healer • Family member • CHW • Local clinic • City clinic • Other • 1b. Why? • 2a. What do you do when someone in your family has big medical costs from an accident or illness? • 2b. How do you get the money to pay for that? • Family member • Church • Friend • Savings group • Personal savings • Community insurance 2c. If you can't pay for the doctor, how do you deal with that? • 3a. Did you pay for the establishment of your CSCOM? • yes/no • 3b. If yes, was it worth the investment you made? • yes/no/maybe • 4a. Do you understand your rights when it comes to accessing health care services? • yes/no • 4b. Who helped/helps you understand your rights around access to health care and services provided? • 5a. Do you participate in a health savings or CBHI program to cover your family's health care costs? • yes/no • 5b. If yes, describe using the health savings or CBHI:

		○ Very helpful (without it I could not access health care for my family) ○ Somewhat helpful ○ Not very helpful

ANNEX VI: RESEARCH INSTRUMENT (FRENCH)

Questions transversales	1. Avez-vous entendu parler de changements dans le système de santé pour améliorer l'accessibilité aux soins de base pour tous au Mali? • oui / non
	2a. Selon vous, qui est intéressé à améliorer l'accessibilité aux soins de santé gratuits? (Champions) 2b. Seriez-vous opposé à ces changements? (Saboteurs)
	3. Selon vous quels sont les **DEUX** principaux obstacles à l'amélioration de l'accessibilité aux soins de santé au Mali? • abordabilité / coût • emplacement des centres de santé ou coût du transport • offre de services • manque de professionnels qualifiés • ma belle-mère ou mon mari est contre l'utilisation de ces services • autre
	4. Selon vous quels sont les changements les plus importants qui devraient être apportés pour améliorer la prestation des services et la qualité des soins?

Thème	Personne Interviewée	Des Questions
Financement des soins de santé et questions liées à la budgétisation	**Paliers gouvernementaux nationaux, régionaux et**	QUESTIONS TRANSVERSALES Avez-vous entendu parler de changements dans le système de santé pour améliorer l'accessibilité aux soins de base pour tous au Mali?

	municipaux	• oui / non Selon vous, qui est intéressé à améliorer l'accessibilité aux soins de santé gratuits? Seriez-vous opposé à ces changements? Selon vous quels sont les DEUX principaux obstacles à l'amélioration de l'accessibilité aux soins de santé au Mali? • abordabilité / coût • emplacement des centres de santé ou coût du transport • offre de services • manque de professionnels qualifiés • ma belle-mère ou mon mari est contre l'utilisation de ces services • autre Selon vous quels sont les changements les plus importants qui devraient être apportés pour améliorer la prestation des services et la qualité des soins?
		1a. Comment le ministère de la Santé planifie-t-il le budget de la santé pour financer adéquatement l'embauche de personnel, l'équipement et les fournitures destinés aux CSCOMs, hôpitaux de district et hôpitaux régionaux? 1b. Durant combien de temps les centres de santé doivent-ils attribuer leurs fonds? 2a. En quoi la décentralisation de la budgétisation et des dépenses en santé affecte-t-elle les revenus des centres de santé de district, des centres de santé locaux et régionaux? 2b. Quel palier représente le plus gros défi de gestion? • Régional • De district • Local 3. Est-ce que le problème fondamental est le clientélisme, le manque d'efficacité ou la mauvaise planification? • clientélisme, • manque d'efficacité, • mauvaise planification • autre 4a. Qui prend les décisions liées à l'attribution du financement ou de la budgétisation selon les différents paliers?

		4b. Comment les niveaux budgétaires sont-ils établis?
		5a. Est-ce la totalité des montants alloués par l'État parviennent aux centres de santé régionaux? ○ oui / non 5b. Est-ce la totalité des montants alloués par l'État parviennent aux centres de santé de district? ○ oui / non 5c. Est-ce la totalité des montants alloués par l'État parviennent aux centres de santé locaux? ○ oui / non 5d. Si ce n'est pas le cas, pourquoi le financement ne parvient-il pas? 5e. Est-ce qu'il est plus compliqué de faire parvenir le financement à un palier plutôt qu'à un autre? ○ Régional ○ De district ○ Local 6a. Comment la mauvaise gestion des ressources est-elle prise en charge? 6b. Comment surveille-t-on la capacité de gestion des ressources? 6c. En quoi les décideurs sont-ils responsables? 7a. Est-ce qu'une meilleure transparence peut nous aider à mieux suivre les fonds? ● oui / non 7b. Si oui, qui devrait être responsable? ○ Le ministère de la Santé ○ Les prestataires de soins locaux ○ Organisation de la société civile ○ Les communautés (grâce aux conseils locaux) ○ Autre
		8a. Selon vous est-ce que l'impunité est un problème pour le GoM? ● oui / non 8b. Si oui, comment décririez-vous l'impunité du GoM?

		○ Un problème important ○ Un problème de moyenne importance ○ Un problème peu important 8c. Pourquoi? 9a. De quelles manières précisément, l'application des lois et des règlements peut-elle être évaluée, surveillée et améliorée? 9b. Qui devrait être responsable de l'évaluation, de la surveillance et de l'amélioration des lois et des règlements? ○ Les institutions locales (de district) ○ Les institutions régionales ○ Le ministère de la Santé (national) ○ Organisation de la société civile ○ Les prestataires de soins ○ Les forces de l'ordre ○ Tout le monde ○ Autre 10a. Existe-t-il des lois, des décrets ou des règlements en particulier qui nuisent à la prestation de la couverture maladie universelle aux citoyens? ● oui / non 10b. Nommez la loi, le décret ou le règlement
Financement des soins et des traitements en fonction des budgets et des ressources aux centres de santé	**Centres de santé**	QUESTIONS TRANSVERSALES Avez-vous entendu parler de changements dans le système de santé pour améliorer l'accessibilité aux soins de base pour tous au Mali? ○ oui / non Selon vous, qui est intéressé à améliorer l'accessibilité aux soins de santé gratuits? Seriez-vous opposé à ces changements? Selon vous quels sont les **DEUX** principaux obstacles à l'amélioration de l'accessibilité aux soins de santé au Mali? ○ abordabilité / coût

		○ emplacement des centres de santé ou coût du transport ○ offre de services ○ manque de professionnels qualifiés ○ ma belle-mère ou mon mari est contre l'utilisation de ces services ○ autre Selon vous quels sont les changements les plus importants qui devraient être apportés pour améliorer la prestation des services et la qualité des soins?
		1a. Lorsqu'un client se présente à la clinique, dites-moi comment vous...: Posez un diagnostic 1b. ...Traitez 1c. …. Référez pour d'autres soins ou services 2. Combien de patients voyez-vous QUOTIDIENNEMENT? ● 0 à 10 par jour ● 10 à 20 par jour ● 20 à 40 par jour ● plus de 40 par jour 3a. En moyenne combien d'argent gagnez-vous QUOTIDIENNEMENT? 3b. Est-ce que ces revenus couvrent vos dépenses? 3c. Qui est responsable de déclarer ces chiffres? 3d. Est-ce que ces sommes sont bien gérées? ● oui / non 4a. Comment financez-vous les traitements? 4b. D'où proviennent les fonds? ● Du ministère de la Santé ● Des frais déboursés par les patients ● Des donateurs ● Du secteur privé

		• Des universités et autres établissement s de recherche • Autre 4c. Êtes-vous en mesure d'évaluer le pourcentage des fonds provenant de chacune de ces sources? 4d. Qui gère ces fonds habituellement? 4e. Qui se charge de la vérification ou de l'audit de ces fonds?
		5a. Comment déclarez-vous les diagnostics et les traitements ainsi que les frais liés aux soins? 5b. Qui gère les revenus provenant du traitement des patients? 5c. En quoi la gestion de ces fonds affecte-t-elle votre capacité à budgéter en fonction des besoins en soins et à traiter vos patients? 5d. Comment utilisez-vous ces données? 5e. Savez-vous si quelqu'un d'autre utilise ces données et dans quel objectif? 6. Lorsqu'il est question de payer pour des services, selon vous est-ce que la capacité de payer du patient détermine la prestation de soins ou le traitement qu'il recevra : • Beaucoup • Un peu • Pas du tout 7a. Quels sont les défis auxquels vous devez faire face lorsque vous budgétez et faîtes l'acquisition de l'équipement et du matériel nécessaire aux soins que vous dispensez? 7b. Comment gérez-vous ces défis? 7c. En quoi les défis liés à l'acquisition de matériel et d'équipement médical nuisent-ils à la prestation de soins? 8a. Comment planifiez-vous vos besoins en médicaments et comment en faites-vous l'acquisition? 8b. En quoi les ruptures de stock (lorsqu'il vous manque de médicaments) nuisent-elles aux soins? 8c. Que faites-vous lorsque les médicaments nécessaires sont en rupture de stock? 8d. Comment déclarez-vous les ruptures de stock?
		9a. Est-ce que les professionnels de la santé peuvent obtenir une promotion pour la bonne qualité des soins qu'ils prodiguent?

		oui / non 9b. Comment encourage-t-on les prestataires de soins à améliorer la qualité des soins qu'ils dispensent? 10a. Disposez-vous du personnel nécessaire pour répondre aux besoins habituels? oui / non 10b. Combien de postes avez-vous? Intervalles 10c. Comment comblez-vous les postes vacants? 10d. Est-il difficile de combler ces postes? 10e. Comment financez-vous ces nouveaux postes? 11. Sur quels facteurs votre centre de santé est-il évalué? ● les fournitures ● les prestataires de soins ● l'équipement ● le temps d'attente ● la satisfaction des patients autre

ANNEX VII: INFORMED CONSENT IN FRENCH

KII/FGD LETTRE DE CONSENTEMENT PRÉALABLE ET RENSEIGNÉE

Introduction: Merci d'avoir pris le temps de nous rencontrer aujourd'hui. Je m'appelle _____ et nous sommes une équipe de chercheurs indépendants recrutés par l'USAID| Mali pour mener une évaluation qui contribuera à la mission de planification future du secteur de la santé. Les sujets incluront votre compréhension des Centres de Sante Communautaire, le paiement des soins de santé et un éventail de sujets liés au financement de la santé. Vous avez été sélectionné pour participer à cette recherche en raison de vos connaissances et/ou de votre expérience du secteur de la santé au Mali. L'interview d'aujourd'hui devrait durer environ une heure.

Risques et avantages: Nous minimisons les risques potentiels pouvant découler de votre participation à cet entretien. Nous poserons des questions sur des sujets pouvant être considérés comme sensibles, tels que les élections récentes, l'opposition politique et la corruption; Cependant, nous essayons d'atténuer les risques de discuter de ces sujets en veillant à ce que les entretiens restent confidentiels.

Confidentialité: Vos réponses à cet entretien seront gardées confidentielles par l'équipe d'évaluation dans la mesure du possible en vertu du droit américain et de la politique de l'USAID. Nous prendrons des notes, mais l'interview ne sera ni enregistrée ni filmée. Seule l'équipe d'évaluation aura accès aux notes prises. Votre nom ou position n'apparaîtra dans aucun rapport.

Veuillez noter que, bien que les chercheurs prennent toutes les précautions nécessaires pour préserver la confidentialité de cet entretien, la nature des entretiens de groupe ne nous permet pas de garantir la confidentialité. Nous aimerions rappeler aux participants de respecter la vie privée des participants et de ne pas répéter ce qui est dit dans l'entretien de groupe aux autres.

Participation volontaire: Votre participation est volontaire. Si vous ne souhaitez pas participer ou répondre à des questions spécifiques, vous n'êtes pas obligé de le faire. Si vous choisissez de participer, sachez que vous pourrez changer d'avis à tout moment de notre discussion. Votre décision de ne pas participer n'aura aucune conséquence.

Rapport: Les informations que vous et d'autre personnes vont fournir seront utilisées pour rédiger le rapport. Ce rapport sera partagé avec l'USAID et d'autres parties prenantes pour commentaires et une version réduite sera éventuellement réalisée

Liste des participants aux entretiens: Nous fournissons à l'USAID une liste des personnes qui ont participé aux entretiens pour leurs dossiers internes; Si vous ne souhaitez pas figurer sur cette liste, veuillez nous en informer et nous ne fournirons pas votre nom.

1) Avez-vous des questions? ☐Oui ☐ Non

2) Souhaitez-vous participer à cette interview? ☐Oui ☐ Non

Si vous avez des questions supplémentaires, vous pouvez contacter la directrice des opérations d'Intégra, Kimberly Hamilton, à khamilton@integrallc.com, ou le chercheur local d'Intégra, Amadou KOÏTA, aux numéros suivants + 223 77 48 72 77 et 68 64 46 46.