Integrating Community Health Program

MALI COUNTRY SNAPSHOT

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LAST MILE HEALTH

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Acronyms

AMM	Association of Malian Municipalities	*Association des Municipalités du Mali*
ASACO	Community Health Association	*Association de Santé Communautaire*
ASC/CHW	Community Health Worker	*Agent de Santé Communautaire*
CNSEC	National Advocacy Coalition for Essential Services in the Community	*Coalition Nationale de plaidoyer en faveur des Soins Essentiels dans la Communauté*
CSCOM	Community Health Post	*Centre de Santé Communautaire*
FELASCOM	Local Federation of Community Health Associations	*Fédération Locale des Associations de Santé Communautaire*
FENASCOM	National Federation of Community Health Associations	*Fédération Nationale des Associations de Santé Communautaire*
GFF	Global Financing Facility for Women, Children and Adolescents	*Mécanisme de Financement mondial pour les femmes, les enfants et les adolescents*
HP+	Health Policy Plus	
iCCM	Integrated community case management	*Prise en charge intégrée des maladies enfantiles*
ICH	Integrating Community Health	
IHP+	International Health Partnership	
LMH	Last Mile Health	
MAP	Mali Action Plan	
MDG	Millennium Development Goal	*Objectifs du Millénaire pour le Développement*
MoH	Ministry of Health At different times, also called Ministry of Health and Public Hygiene, and Ministry of Health and Social Affairs, and Ministry of Health and Social Development	*Ministère chargé de la santé* *Autrement : Ministère de la Santé et de l'Hygiène Publique, Ministère de la Santé et des Affaires Sociaux, Ministère de la Santé de du Développement Social*
PASEC	Program to Support the Sustainability of Essential Services in the Community	*Project d'Appui aux Soins Essentials dans la Communauté*
PRODESS	Health and Social Development Program	*Programme de Développement Socio-Sanitaire*
RAMU	Universal Health Insurance Plan	*Régime d'Assurance Maladie Universelle*
SEC	Essential Services in the Community	*Soins Essentiels dans la Communauté*
SECPro	Strengthening the SEC Strategy Project	
UNICEF	United Nations International Children's Emergency Fund	*Fonds des Nations Unies pour l'Enfance*
USAID	United States Agency for International Development	*Agence des États-Unis pour le développement international*
WHO	World Health Organization	*Organisation Mondiale de la Santé*

Preface

Accelerating the Integration of Community Health Worker Programs through Institutional Reform

Approximately half of the world's population do not have access to essential health services. A growing emphasis on the roles of communities recognizes community engagement, including community health workers (CHWs), as a means of realizing the full potential of the primary healthcare (PHC) system.[1] High performing CHW programs at scale are an integral component of responsive, accessible, equitable, and high-quality PHC.

Recognizing the potential for community health to address gaps in coverage, improve financial protection, and support access to quality care, the Declaration of Astana in 2018 committed to strengthening the role of community health in PHC as a means to accelerate progress toward universal health coverage (UHC). Before the Declaration of Astana, the transition from the Millennium Development Goals to the Sustainable Development Goals (SDGs) also helped to reposition communities as resources for health systems strengthening and sources of resilience for individuals and families.

The United States Agency for International Development (USAID) initiated a collaboration with the United Nations Children's Fund (UNICEF) and the Bill & Melinda Gates Foundation in 2016 to advance country commitments toward communities as resources in PHC systems to accelerate progress towards the achievement of the SDGs. The Integrating Community Health (ICH) collaboration fueled a global movement with more than twenty countries to elevate national priorities and progress for institutionalizing community health in primary health care systems. USAID, in collaboration with UNICEF, invested in catalytic partnerships with governments, their trusted NGO partners, and communities across 7 countries (Bangladesh, the Democratic Republic of Congo (DRC), Haiti, Kenya, Liberia, Mali, and Uganda) to institutionalize reforms and learning, with a focus on CHWs. In alignment with these efforts, the Bill & Melinda Gates Foundation supported the development of new evidence and knowledge regarding performance measurement, advocacy and pathways to scale in the seven focal countries via the Frontline Health Project with Population Council and Last Mile Health as lead partners. Using Last Mile Health's Community Health Reform Cycle framework, the Country Snapshots highlight the ICH collaboration's catalytic partnerships to strengthen national CHW programs as an essential component of PHC and to place these programs within the context of institutional reforms and political commitment needed for national progress in health outcomes.

Re-envisioning health systems to achieve UHC requires leadership and political commitment from within countries. Countries must mobilize the whole society—both public and private sectors as well as communities—as essential resources in this effort. The community component of PHC must be designed to enable the health system to reach the most underserved, respond to pandemics, close the child survival gap, and accelerate the transformation of health systems. Without a major expansion of support for national CHW programs, the measurable acceleration urgently needed to reach the health-related targets of the SDGs by 2030 is unlikely. With a decade remaining to achieve the SDGs and faced with the challenge of the COVID-19 response, building global political momentum with countries and funders is critical to support urgent national priorities, evaluate progress, and develop and share new knowledge to inform bold political choices for a whole of society approach to health systems strengthening.

Community Health Institutionalization as a "Reform Cycle"

The Country Snapshots featured in this series highlight the seven ICH countries' reform efforts within a framework for institutional reform: the Community Health Systems Reform Cycle (often referred to here as the "reform cycle").[2] Countries experience community health systems reform as a process and pathway to institutionalizing community health. The likelihood that any particular reform is successfully institutionalized in an existing policy environment depends on political will and buy-in from key stakeholders, the technical design of the policy, the available capacity and resources to launch and govern the intervention, the ability to learn, and the willingness to adapt and improve the program over time.

The reform cycle framework has guided—and been refined through—a descriptive analysis of the ICH countries' reform journeys. Country Snapshots, reflecting the ICH investment on community health systems reform, demonstrate the practical linkages between available literature and specific country experiences. This framework provides health systems leaders with an approach to plan, assess, and strengthen the institutional reforms necessary to prioritize community health worker programs as part of national primary health care strategies to achieve universal health coverage.

The reform cycle traces several stages of institutional reform, which are summarized below. Reforms may encompass an entire community health worker program or target specific systems components, such as health information systems. While reforms may not always follow each stage in sequence and timing can vary depending on the complexity of the program or activity, deliberate and comprehensive planning can strengthen buy-in and overall effectiveness.

THE COMMUNITY HEALTH SYSTEMS **REFORM CYCLE**

PROBLEM PRIORITIZATION

Actors identify a meaningful and relevant problem. They diagnose pain points and unmet needs, and connect them to priority areas for reform, where possible. Actors acknowledge the need for reform within the community health system and commit to a joint vision for addressing gaps.

COALITION BUILDING

A group is formed around a compelling problem or vision. Members define the coalition's goals, roles, size, and composition. Diverse members fill critical roles in the reform effort (e.g., leaders, connectors, gatekeepers, donors, enablers, change champions, and liaisons to key players outside the coalition).

SOLUTION GATHERING

Potential solutions are gathered, drawing from existing local and international programs. Actors define criteria and metrics to assess solutions, and specific ideas for reform are piloted, where possible. Promising solutions are prioritized for integration into the health system.

DESIGN

Key decision makers, stakeholders, and planners map out different options for program design. Where possible, evidence about the options, expected cost, impact, and feasibility are identified. Through consultations, workshops, and other channels, stakeholders offer feedback on options, and decision makers select a design. This may include operational plans, training materials, job descriptions, management tools, data collection systems, and supply chain processes.

READINESS

Coalition members and champions prepare for launch by getting buy-in from actors instrumental to the launch, rollout, and maintenance of the program. Stakeholders also translate program design into costed operational plans that include clear strategies and tools for launch and rollout. Investment plans for sustainable financing and funding mechanisms are put in place. Stakeholders are prepared for their new roles and responsibilities, and potential areas of policy/protocol conflicts are addressed.

LAUNCH

New policies, processes, and organizational structures are implemented, and key actors execute their new roles. As these shifts progress, learning is gathered to demonstrate momentum and identify challenges to achieving scale. Particular attention is paid to issues around rollout, and timely design and implementation shifts are made as needed.

GOVERNANCE

Stakeholders establish a project governance framework, which includes key leadership and decision-making bodies, clear roles and responsibilities, and explicit decision rights. Processes for risk and issue management, stakeholder engagement, and cross-functional communication are established. Actors monitor program progress to advance clear decision-making and address critical issues or challenges.

MANAGEMENT & LEARNING

Key stakeholders regularly review program data to inform problem-solving at the national or subnational level. Stakeholders engage in continuous learning and improvement, identifying challenges and changes to program design and other systems bottlenecks.

Country Snapshots of Institutional Reform

PURPOSE AND GOALS OF COUNTRY SNAPSHOTS

- Describe the community health landscape within each country
- Present the country's vision for community health reform and situate progress to-date within the framework of the reform cycle
- Articulate the primary community health institutionalization challenges that the country is or was facing at the outset of the ICH investment
- Trace the policy and advocacy process taken by country stakeholders to move reform forward, using the ICH investment as a catalyst
- Identify lessons learned and opportunities for strengthening existing reforms arising out of the ICH investment

The Country Snapshots complement other resources generated within and beyond the ICH investment, such as the countries' Community Health Acceleration Roadmaps, ICH Country Case Studies, and Frontline Health Project Research Studies. The Country Snapshots place a unique emphasis on tracing the process of policy choice, advocacy, and implementation. Together, these complementary initiatives are catalyzing community health systems reform and advancing efforts towards a strong primary health care system and UHC.

APPROACH AND METHODS

The Country Snapshots highlight examples of a country's reform journey through the specific stages of institutionalization outlined in the framework. Country Snapshots both demonstrate the features of each stage within the country context and elevate salient examples of countries' learning and success. The Country Snapshots reflect a process of desk reviews and consultations with country stakeholders. Stakeholders include but are not limited to current and former ministry of health representatives, leaders from non-governmental and technical organizations, and members of multilateral and bilateral institutions. The Country Snapshots elevate both existing insights captured in policy and strategy documents that are often difficult for those not working within the country to access, as well as novel perspectives gained through methods such as workshops or in-depth interviews with key stakeholders. Where the Country Snapshots draw on existing materials, citations are noted. Insights and country stakeholder recommendations on the reform cycle's application serve not only to validate the framework, but also to highlight ways in which the framework can help trace powerful narratives of reform and accelerate community health systems policy and advocacy efforts.

These narratives reveal opportunities to accelerate the prioritization of community health worker programs and primary health care strategies with the goal of UHC. The Country Snapshots reflect valuable feedback from stakeholders on how the framework can help advance community health systems policy and advocacy.

Key Resources

- USAID Vision for Health Systems Strengthening 2030
- Astana Declaration
- CHW Resolution
- CHW Guidelines
- Exemplars—Community Health Workers
- Community Health Roadmap
- Institutionalizing Community Health Conference 2017
- Institutionalizing Community Health Conference 2021
- Community Health Community of Practice
- Global Health: Science and Practice Supplement 1: March 2021
- Journal of Global Health: Advancing Community Health Measurement, Policy and Practice

Mali's Community Health Policy & Advocacy Landscape

Health Access and Outcomes in Mali

Mali recently announced a series of ambitious plans to reform its healthcare system, including the adoption of a universal health insurance law in 2018 and the planned nationwide deployment of professional community health workers. The 2020 Mali Action Plan promises that "Mali will achieve the greatest improvements in key health indicators in Africa by 2030," thanks to an inspiring proposal to invest in upgrades across the health infrastructure and dramatically increase healthcare access by removing financial and geographic barriers to care.[3]

With some of the poorest health indicators in the world, Mali is in dire need of this type of radical investment to drive change. Mali has one of the five largest disease burdens in the world, driven by communicable, neonatal, maternal, and nutritional diseases, including a malaria incidence rate that is among the highest in the world.[3–5] Without dramatic investment in Mali's health system, outcomes are likely to worsen as climate change advances and further impoverishes a country deeply dependent on rain-irrigated agriculture and already facing a heavy burden of malnutrition. Nearly one in five children under five are malnourished in Mali, and one in ten are emaciated.[3] While Mali has seen some improvements in its health indicators in the last couple of decades, Table 1 demonstrates that many indicators are still unacceptably poor.

TABLE 1: Various Health Indicators for Mali

INDICATORS	2012-2013[6] (DHS)	2018[7]
Infant Mortality Rate (per 1,000 live births)	56	33
Under-Five Mortality Rate (per 1,000 live births)	95	101
Maternal Mortality Ratio (per 100,000 population)	368	325
Children Fully Vaccinated	39%	45%
Children with Diarrhea Treated with ORS	40%	43%
Unmet Need for Family Planning	26%	24%
Skilled Birth Attendance	58.6%	67.3%
ANC 4+	41%	43%

BARRIERS TO PRIMARY HEALTHCARE ACCESS

Mali's poor health outcomes reflect the geographic and financial barriers its population faces in accessing healthcare services. Of Mali's 19 million people, only 57% have access to facility-based health services, defined as living within 5 km of a health facility.[8] Most regions have fewer than five health workers per 10,000 people, as 45% of all health professionals are based in the capital city of Bamako.[3] Insecurity and sparse population density in the north and center of the country have made it extremely challenging for Mali to provide essential health services. These regions, in particular, experience disruptions to the medical supply chain, poor availability of qualified personnel, and diverted national resources to address humanitarian and security needs. Barriers to healthcare access result in stark disparities across the country, with full vaccination coverage ranging by region from 52% to less than 1%, and under-five mortality in rural areas almost twice that of urban areas (111 versus 61 per 1000 live births).[3]

Mali's financial barriers to healthcare can be traced, in part, to the Bamako Initiative. Signed by African health ministers from across the continent at a 1987 regional WHO meeting in Mali, the Bamako Initiative has shaped healthcare policy in the majority of African countries for the last thirty years. In line with principles set out in the Bamako Initiative, the government of Mali divested from the primary healthcare sector and shifted costs to users by imposing service fees.[3,9] These fees represent an often insurmountable barrier in a country where nearly half of the population lives below the poverty line and that ranks 184 out of 189 countries, according to the Human Development Index.[10,11] As a result, in 2017, 46% of people reported not going to a health center when they needed care because it was too expensive.[3] In 2015 alone, out-of-pocket health expenditures were solely responsible for a 2.3% increase in the national poverty headcount.[3]

Out-of-pocket expenses represent 35% of Mali's health expenditure, already exceptionally low at 30 USD per capita.[3] In 2018, the government of Mali spent only 0.2% of the national budget on primary healthcare,[3] leaving the healthcare system ill-prepared to address the needs of the population. For those who do manage to seek health services in a clinic facility, the conditions are deeply inadequate, especially in rural areas. Only 25% of the community health posts (CSCOM) have reliable access to water, and 93% of those without water serve rural populations. In rural areas, only 28% of facilities have all essential equipment, including a scale, thermometer, stethoscope, blood pressure cuff, and light source.[3] Overall, lack of central investment in the national health system has pushed high-quality primary healthcare out of reach of most people in Mali, especially those in rural areas and regions hit by insecurity.

A LOOK AHEAD: REFORMS TO IMPROVE HEALTH

Mali's health system reforms are intended to mobilize resources to substantially improve primary healthcare services and bolster the community health system to bring high-quality care to the doorsteps of its rural populations. Progress in rolling out an effective community health system has advanced in fits and starts, with communities across Mali playing a critical role in promoting the community health agenda. Mali is now in a catalytic moment of change: In 2019 then-President Ibrahim Boubacar Keïta announced the integration of a professionalized network of community health workers (known as *Agents de Santé Communautaire* or ASCs) into the formal health sector[12]—an accomplishment in advancing the institutionalization of community health that few other countries have achieved. The newly announced Mali Action Plan (MAP) lays out the country's vision for sweeping health reform, including a suite of free primary healthcare services for women, children, and the elderly as well as a national cadre of paid, professional ASCs.[3] Although it remains to be seen whether Mali will be able to fully operationalize this vision for its national community health system, the country's recent commitments display impressive political will. Delivering on the goals of the MAP would bring transformative change to a country that continues to struggle with inadequate health outcomes.

Mali's Community Health Reform Foundations

DECENTRALIZATION AND THE SPREAD OF THE ASACO

Community engagement and civil society leadership has played a uniquely central role in Mali's health system for decades.[13–15] Since the dawn of community health in Mali, reform and institutionalization of the community health system has been closely tied to the question of financing.

In a context of structural adjustment policies, the Bamako Initiative, and the decentralization of the health sector, the Malian state progressively disengaged from primary healthcare services in the 1980s and 1990s. Thus, the state transferred the management of primary healthcare to communities, which organized in Community Health Associations (*Associations de Santé Communautaire* or ASACOs), to address their health challenges. The communities helped to build community health posts (*Centres de Santé Communautaire* or CSCOMs), which operated on a cost-recovery basis under the ASACO's management.[9,16,17]

This model appealed to public officials looking to advance decentralization and reduce central budget expenditures. Initially developed through community self-organization, the ASACO model was standardized, adopted as national policy, and rapidly scaled up, often with weak community participation.[9,13,16] The CSCOMs were well-established as a pillar of multiple health policy documents and plans over the course of the 1990s and early 2000s.[16,18] CSCOMs thus formed the foundation of Mali's health system. Today, nurses, midwives, and medical assistants offer a basic package of curative, preventive, and health promotional services in the approximately 1,368 CSCOMs in operation.[i] However, community health stakeholders estimate that an additional 1,336 facilities are necessary to meet population needs, as many CSCOMs serve a far larger catchment area than intended and 43% of Malians live more than five kilometers from a health facility.[19]

COMMUNITY CO-MANAGEMENT SYSTEMS FOR HEALTH

From the beginning, the ASACO struggled to ensure the CSCOM's financial viability, from mobilizing the initial resources required to launch a new facility to recovering sufficient costs to maintain high-quality operations.[9,13] Faced with these ongoing challenges, in 1994 the ASACO and the Malian state signed the Convention of Mutual Assistance, under which the local commune governments would support the financing of the CSCOM. Communes committed to contribute (as they were able) to the cost of CSCOM infrastructure, providing the initial stock of essential generic medicines, and paying an annual subsidy for major equipment—as well as part of the salaries and activity budget of the CSCOM.[13] In practice, mobilizing these funds has continued to pose a significant challenge.[19] The Convention of Mutual Assistance, renewed in 2004, tethered the Malian government's provision of community health to local commune authorities, and the transfer of responsibilities for health services to the local level shapes Mali's primary healthcare landscape to this day.

Community health is, therefore, co-managed by the ASACO and the commune mayor. They are supported by a network of other local actors, including representatives from community partners, the government's technical and clinical offices, NGOs, CSCOM clinical staff, and mutual benefits associations.[4,20] Under this cooperative management system, all of these actors are convened in a committee, and responsibilities are shared in an array of overlapping roles, including: training, supervision, and performance management; recruitment and contracting of personnel; financial accountability and management; and payment of salaries. The functionality of this system varies widely, and tensions often emerge over the lack of funds.[13,16,19–21]

[i] The Minimum Service Package includes the diagnostic and treatment of common diseases, including parasitic infections, and referral of more complicated cases. Preventive and promotional services include vaccinations, ante- and post-natal consultations, hygiene promotion, health education, contraception promotion, simple deliveries, and basic tests (e.g., urine, blood, and fecal). The number of existing CSCOM was reported by FENASCOM as of the end of 2018.

The ASACOs are responsible for the administrative and financial management of community health, including ensuring the financing of salaries, medicine stock renewal, replacement of small equipment, and establishing pricing for services and medication. However, there is substantial variation in ASACO capacity, and in the effectiveness, transparency, and oversight of their management, particularly financial.[16,19,20]

As the Malian Ministry of Health (MoH) institutionalized the CSCOM in its Health and Social Development Program 1998-2002 (*Programme de Développement Socio-Sanitaire* or PRODESS)—extended and renewed to the current day—it also enshrined the uniquely important role of civil society in Mali's community health management at the national level. Mirroring the importance of the ASACO at the community level, the MoH invited the National Federation of Community Health Associations (FENASCOM) to co-chair the technical and monitoring committee meetings for PRODESS.[4]

It is critical to understand the importance of FENASCOM, the national coordinating body of Mali's ASACOs, in community health policymaking—and reform. FENASCOM serves the dual purposes of monitoring the management of the ASACOs and representing civil society in national policymaking, coordination, and monitoring of health services.[13,14] FENASCOM's strength comes from a number of factors. It is stable and apolitical, and has endured as a voice for civil society through multiple political regimes. In addition, it has a large base with high levels of contribution and participation, and is trusted for its respect of governance.[13] While FENASCOM ensures that its member ASACOs adhere to PRODESS policy, the government of Mali safeguards the role, identity, and importance of civil society. As a result, FENASCOM has been a leading voice driving community health reform.

EFFORTS TO FILL COMMUNITY HEALTH GAPS

Throughout the 2000s, the ASACO-run CSCOM served as the primary source of facility-based healthcare services, but utilization rates were poor due to a combination of financial and geographic barriers.[4,15,22] Variation in user fees from one CSCOM to another was designed to take the purchasing power of the local population into consideration—with pricing decided in general meetings—but some reports cast doubt on the affordability of services.[9,15,22–24] One study found that facility-based services were perceived as a last resort for sick patients, who preferred to seek out traditional healers and delayed care-seeking due to social norms as well as direct and indirect costs, including distance to care.[22]

Faced with continually poor health outcomes—in part due to the cost of care—Mali introduced various fee waiver programs in the 2000s. The country established free treatment for HIV/AIDS, tuberculosis, Cesarean sections, and malaria (for children under five and pregnant women) as well as free consultations for the elderly, women using modern contraceptive methods, and those with a certificate of indigence.[19,25] These laudable initiatives, however, have been accused of eroding the income base of the CSCOM, and adherence to these policies is often contingent on the CSCOM's financial security.[9,16,25]

In addition to the geographic and financial barriers to accessing healthcare, communities generally lacked preventive and health promotional services, as the ASACO tended to prioritize revenue-generating curative health activities to enhance the CSCOM's financial viability.[19] Out of these gaps grew a cadre of unpaid community health volunteers now known as *relais communautaires*. Dating back to the 1990s, NGOs and disease-specific programs deployed community volunteers under names such as *relais communautaires*, Village Pharmaceutical Agents, Guinea Worm Extractors, and Nutrition Promoters.[22,26,27] These volunteers provided a fragmented collection of services, primarily related to health education and mass health campaigns.

Despite these efforts, however, Mali was still not on track to meet the Millennium Development Goals (MDGs), particularly MDG 4. As a potential solution, UNICEF and other development partners advocated for a national policy for integrated community case management (iCCM) of malaria, diarrhea, and pneumonia.[22,28,29] This advocacy faced resistance as

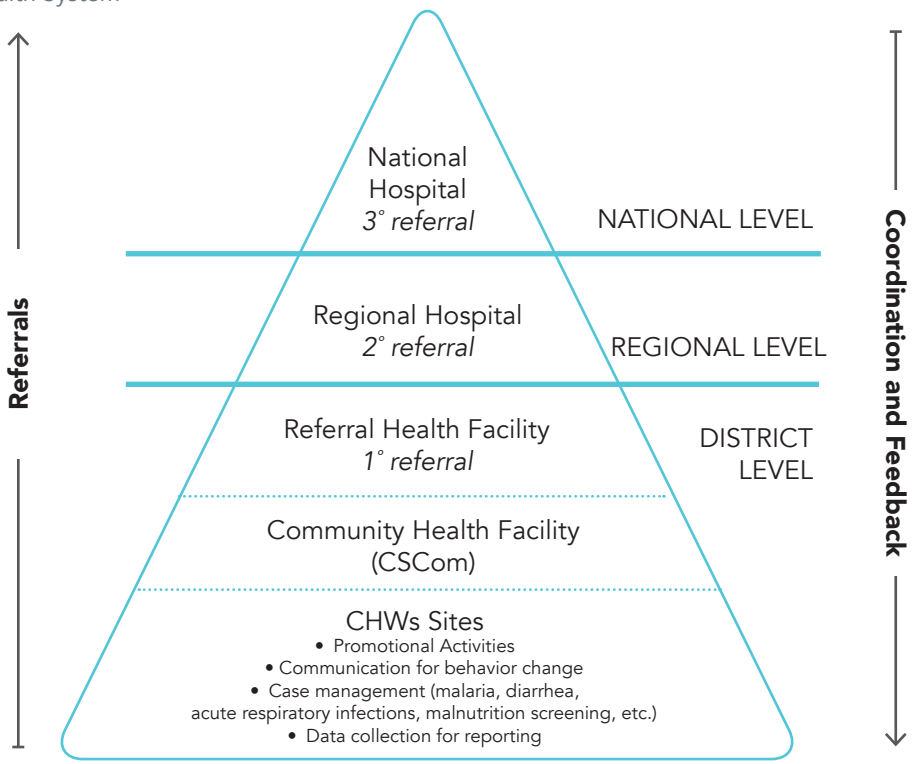
MoH stakeholders expressed deep concerns that the existing community health volunteer cadres were not sufficiently skilled to deliver curative iCCM services. In particular, policymakers were worried about potential antibiotic misuse and resistance due to community treatment of pneumonia.[28,29] In light of advocacy to establish an iCCM policy and motivation to achieve MDG 4, the MoH began to think about developing a new cadre of professionalized community health workers.

INTRODUCING COMMUNITY HEALTH WORKERS AND THE SEC STRATEGY

At a turning point for community health in Mali, in 2009 the country held a national forum on improving health access. High-level government officials heard about the success of community health worker programs in Mali and other African countries in increasing health coverage and effectively providing services.[4,22,29] The MoH recognized the need to harmonize community health in a context of proliferate NGO-run pilots and to upskill existing community health volunteers for a national iCCM policy. As a result, the MoH decided to develop a cohesive strategy for Essential Services in the Community (*Soins Essentiels dans la Communauté* or SEC). The goals of the SEC strategy were to strengthen the community health platform and establish a new cadre of health workers.[4] These new workers, the ASCs, would connect the community to the CSCOMs and extend essential services to the household level in partnership with *relais communautaires*, unpaid community health volunteers.

The MoH and its partners, including FENASCOM, designed the new cadre of paid, professionalized ASCs to be completely linked with the existing community health system. (See Figures 1 and 2). Under the SEC strategy, newly recruited ASCs offer promotional, preventive, diagnostic, and treatment services, while supervising the *relais communautaires* in continuing to provide promotional and preventive services. The ASCs are similarly linked to the CSCOM, which oversees the community health platform, through supervision and a referral and counter-referral system.[4] Importantly, ASCs operate as CSCOM personnel. As such, they work under the same community co-management structures. Under technical supervision by the Technical Director of the CSCOM, ASCs are recruited and managed by the

FIGURE 1: Mali's Health System



ASACO. In light of the challenges in financing the CSCOM, the ASACO initially expressed reservations about the financial implications of introducing a paid community health worker cadre.[28] From the beginning, the question of ASC salaries has been at the forefront of the national debate on community health.[22,30]

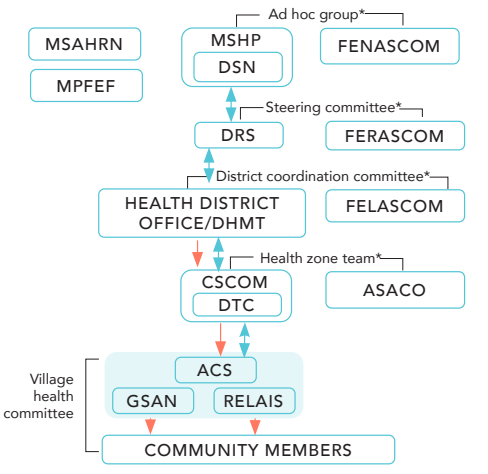
In 2011, the MoH launched an initial implementation phase to pilot the SEC strategy in five regions of Mali, each with its own set of implementing partners—following the development and validation of the strategy and its associated training materials, reporting tools, and job aids.[4,22] A midterm evaluation of the pilot phase in 2013-2014 showed promising results, despite continued challenges, and a revised SEC Strategic Plan was developed in 2014. One of the major difficulties highlighted in the midterm evaluation was the insufficiency and irregularity of ASC salaries, which contributed to inconsistent ASC availability in the community and, therefore, an under-utilization of ASC services.[4] As ever, community health financing was at the crux of the debate around health reform.

In the midst of these significant advances in strengthening community health, a socio-political crisis erupted in 2012, leading to a *coup d'état* as a rebellion broke out in the north of the country. The Malian government was forced to divert state resources to address the crisis—and partners withdrew from the country.[22,30] The question of sustainably financing the SEC strategy—and especially ASC salaries—took on new urgency and complexity. FENASCOM signed an agreement with the Association of Malian Municipalities (AMM), the umbrella organization of all of Mali's communes, to seek ways to integrate ASC salaries into commune budgets and initiate the Program to Support the Sustainability of the SEC (PASEC).[4] PASEC organized two round tables on resource mobilization for the SEC—one with donors under the chairmanship of the then-Prime Minister, and the other with the private sector.

Despite these efforts, the SEC strategy still has not been fully scaled up across the country, and ASC salaries continue to be paid through international donor projects, leaving ASCs without pay when these projects end.[19] The PASEC failed to pick up the momentum it needed, and the gaps identified in the SEC strategy midterm evaluation persisted as the MoH launched the SEC Strategic Plan in 2016. Although community health had a firm basis in policy, its institutionalization as a sustainable, standardized national program was incomplete.

FIGURE 2: Mali's Health System Management Structure

LEVEL	MANAGING ADMINISTRATIVE BODY	SERVICE DELIVERY POINT	KEY ACTORS AND THEIR RELATIONSHIPS
NATIONAL	MSHP (DNS), MSAHRN, MPFEF, FENASCOM, Ad hoc group	National Hospital	
REGIONAL	DRS, FERASCOM, Steering committee	Regional Hospital	
HEALTH DISTRICT	DHMT, FELASCOM, District coordination committee	CSRef	
HEALTH ZONE	ASACO, CSCOM staff, Health zone team	CSCOM	
COMMUNITY	Village health committee, ASC	ASC, *relais communautaire*	



* ALSO INCLUDES REPRESENTATIVES FROM NGOS, LOCAL GOVERNMENT ACTORS, LOCAL DIVISIONS OF THE MSAHRN AND THE MPFEF, CIVIL SOCIETY AND OTHER FINANCIAL AND TECHNICAL PARTNERS.

Supervision →
Flow of community-level data →

Institutionalization Challenges in Mali

Community health stakeholders in Mali have a clear vision of what constitutes the full institutionalization of community health, and it rests on the complete nationwide scale-up of the SEC Strategic Plan and the recognition of ASCs as formal members of the national health workforce, with guaranteed income covered by the Malian health system. In achieving these goals, Mali would sustainably embed a community health system that could increase access to essential health services into its long-term national infrastructure. As long as ASC salaries continue to be financed through donors and implementing partners, however, their future role is precarious, subject to the whims of the international community.[31]

The launch of the SEC strategy in 2011 represented a major undertaking in advancing community health in Mali. However, by 2016, progress had stalled at a stage of partial program rollout. Recent advocacy efforts have since contributed to significant advances towards the institutionalization of community health, including the creation of a coalition of civil society organizations to promote SEC. In order to understand the value of these efforts, it is first helpful to analyze the progress that Mali had made through the middle of the 2010s on the initial rollout of the SEC strategy. The reform cycle, detailed in the Preface, is a useful framework to evaluate this progress as well as the stumbling blocks the country encountered on its path towards community health institutionalization.

Overall, the creation, launch, and initial implementation of the SEC strategy was based on priority health problems and involved a multitude of partners in a lengthy policy design process. This strategy was initiated, and the pilot phase of implementation was evaluated. However, Mali's inability to mobilize sufficient resources to reach full coverage in the rollout of the SEC strategy revealed weaknesses in earlier stages of the reform cycle process.

PROBLEM PRIORITIZATION AND COALITION BUILDING

By the end of the 2000s, the MoH and its partners had identified inadequate access to services as a critical factor driving poor health outcomes and had prioritized primary care services to target maternal and child health indicators.[4,22,32,33] To address the geographic and financial barriers to care in the subsequent decade, Mali focused on introducing the ASCs[34] and creating a roadmap for achieving universal healthcare.[23]

Mali has a strong record of inclusive policy-making processes under the leadership of the MoH—bolstered over time with the introduction of a sector-wide approach for health (SWAp), the Harmonization for Health in Africa initiative, and the International Health Partnership (IHP+).

In 2007, Mali was the first francophone African country to join the IHP+, intending to improve aid effectiveness through strengthened cooperation among government and its partners. Shortly after Mali's pivotal 2009 forum on community health, the MoH and 13 donors signed the IHP+ Country Compact, committing to jointly support the Health and Social Development Plan (the extended PRODESS II, 2009-2011 and PRODESS III, 2014-2018). The process for developing both the IHP+ Country Compact and the PRODESS III has been lauded as participative and inclusive, generating stronger collaboration between government and partners than in countries without the same history of government-led coordination.[26,35] However, even in the context of these coordination efforts, Mali's health system continued to face fragmentation challenges including donor proliferation, a preference for targeted projects rather than general system support, and duplication of efforts. The 13 donors that signed the IHP+ Compact represent a relatively small portion of the 50 donors involved in the health sector.[26]

These dynamics of inclusive policy-making and lingering fragmentation are reflected in Mali's community health system as well. To design the SEC strategy, the MoH followed the same principles of participative policy development, assembling partners such as FENASCOM, international donors, and NGOs. Among these actors, a strong alliance between FENASCOM and AMM led to the PASEC initiative in 2013 to mobilize resources for ASC salaries.[4] Despite the collaborative nature of the SEC strategy development, however, later discrepancies in implementation practices would reveal a lack of cohesion among the different partners involved. Similarly, the PASEC initiative struggled to bring other partners into alignment and generate sufficient support.

SOLUTION GATHERING

Following years of NGO-run pilot programs to provide different health services through the relais communautaires and several fee waiver policies to try to address poor health outcomes, Mali's health indicators still revealed worrying gaps. For instance, the policy waiving fees on malaria care had only generated an estimated 30% increase in consultations as many found the cost of the consultation fee itself a barrier to accessing care.[24] Looking for potential solutions, Malian stakeholders thus considered existing evidence from a number of African countries, as well as in-country experiences.[4,22]

In August 2009, the government began work on the SEC strategy, including the launch of an initial pilot of curative interventions in a couple of districts to inform the approach.[22] The NGO Muso had been partnered with the MoH since 2008 to design and test a community health service delivery model, which involved active case searching by community health workers, healthcare financing to remove fees for those who could not afford them, and clinical capacity building. As part of their efforts to support the government in identifying scalable solutions, Muso established an Operational Research Pilot Committee that included local, regional, and national ministry representatives who met regularly to review the results of this intervention and related innovations to inform policy decisions.[36]

To address the concern that including treatment for pneumonia and acute respiratory infections in the SEC service package would lead to antibiotic resistance, the MoH and UNICEF commissioned a study of ASCs' ability to manage pneumonia at the community level. The study demonstrated that ASCs were able to correctly diagnose and treat pneumonia, regardless of their literacy level.[29] Furthermore, a local study demonstrated that communities were already purchasing antibiotics without an appropriate diagnosis.[28] Together, this research evidence persuaded policy makers to include pneumonia treatment at the community level in the SEC strategy.[28,29]

While these pilot experiences generated learnings that informed policy, some community health stakeholders now feel that it is time to address a different challenge: reaching full coverage of the SEC strategy. As Dr. Koné Brahima of the General Directorate of Health explained, "Today, we are no longer in the pilot phase, we are in the scale-up phase. We have enough experience."

POLICY AND PROGRAM DESIGN

The Malian government, with an array of partners, developed the SEC strategy and planned its implementation over the course of two years (2009-2011). The MoH and implementing partners aimed to ensure alignment and fully prepare operational tools, which contributed to the long planning phase.[22] By 2011, the MoH and its partners had finalized the national policies, implementation guide, training modules, and manuals, as well as registers, tools, and reporting forms for stock management, supervision, financial accounting, and monitoring. All of these tools were tested in pilot sites and validated by 2011.

Following the results of the 2013-2014 midterm evaluation, the government and partners further refined the implementation guide, supporting work tools, and strategic plan. The resulting documents present in comprehensive detail the roles and responsibilities of the ASCs and *relais communautaires*, recruitment processes, linkages with the rest of the health system, coordination bodies, and monitoring and evaluation procedures.[4] However, implementing partners have not always adhered to standardized procedures in practice, particularly concerning ASC salaries.[22] Though the strategy is well-developed on paper, its translation to reality has faltered.

PROGRAM READINESS

The most substantial gaps in Mali's institutionalization process have centered around the mobilization of resources to support the full rollout of the SEC strategy, particularly as it relates to the integration of ASC salaries into domestic budgets. In 2010, the Global Fund suspended finances over grant management concerns, and the military coup of 2012 led many donors and partners to withdraw funding from Mali. The MoH submitted a draft law to the National Assembly of Mali in 2013 to increase the health budget from its current 4.5% to 15% of the national budget, but the bill has not advanced. In order to initiate and maintain the SEC strategy, therefore, Mali has had to compile a multitude of funders and implementing partners to cover different regions in a fragmented patchwork of implementation.

The cost of the program in 2015 was calculated to be 13 million USD per year, of which 88% was provided by donors and implementing partners.[31] The costing analysis noted that the MoH did not have precise information about the number, location, terms of service, and payment modalities—nor a clear understanding of the real costs of service delivery, comprehensive of human resources, medicines, supplies, training, supervision, and management costs. There was a calculated funding gap of 2 million USD per year, which was expected to rise to over 5 million USD per year by 2020. The funding gap mainly affected supervision, management, in-service training, equipment, and salary payments for ASC.[31] Even this restricted budget envelope, however, does not account for the additional funding that would be required to recruit and deploy the additional 10,521 ASCs called for in the country's roadmap for community health—on top of the existing 3,000 ASCs.

A recent landscape assessment reported that at least 13 donors, 8 technical partners or NGOs, and five United Nations agencies were involved in program execution for the SEC strategy. This variety of partner ownership has made it difficult to ensure continuity over time, consistency across regions, and harmonization across partners. Different partners have continued to implement the program according to their own priorities, and the government—reliant on these partners to provide services—has little leverage to enforce standardized protocols. Nowhere has this issue been more apparent than in the provision of ASC salaries. Incentive amounts have varied by partner, and when project funding for a particular partner ends, ASC salary payment stalls such that most ASCs have unrecovered arrears of wages.

PROGRAM LAUNCH

The initial implementation phase of the SEC strategy, beginning in 2011, was designed as a pilot to assess its potential impact. An evaluation of the program in 2013 found that 17% of the malaria cases, 28% of the diarrhea cases, and 24% of pneumonia cases among children under five in the pilot regions were treated by an ASC.[4] The two-week training period was found to be sufficient, particularly given that many ASCs

reported receiving in-service refresher training and that community members reportedly perceived ASC services as being of high quality. Other strengths included the existence of coordination bodies, political will, support from communities and partners, a harmonized service package and associated tools, and the organization of national and regional review sessions.

However, there were some challenges with the initial implementation, including: delays in the deployment of some ASCs due to political insecurity, poor retention in a context of inconsistent salary payment, unreliable supervision, and medication stock-outs (particularly of antimalarials and rapid diagnostic tests for malaria). The evaluation found that only 63% of sampled ASCs had received a supervision and drug replenishment visit in the previous three months, and just over 50% had been directly observed during patient interactions.[22] The MoH prioritized a number of problems, including insufficiencies in the areas of coverage, coordination and engagement of government, financing, demand for and quality of services, supervision and human resource management, and monitoring and evaluation.[4]

Although Mali achieved 94% of its target for ASC recruitment by 2013, this success in the early rollout phase does not reflect community health service coverage in the country as a whole. Failures in program resource mobilization have resulted in only a partial program scale-up despite the many years that have elapsed since the initial policy conception. ASCs currently cover approximately 22% of the population living more than five kilometers from a CSCOM, so there remains a massive gap in access to services for the majority of people in need.[19] Entire regions in the north of the country—which already face insecurity, deprivations in facility-based health services, and threats from climate change—have not yet benefited from the life-saving services of ASCs.

PROGRAM GOVERNANCE

To launch the SEC strategy, the MoH convened the National SEC Ad Hoc group with FENASCOM as co-chair.[4] Implementing partners contribute to the coordination and management of the SEC strategy through this group, which has been an important platform for program governance. Similarly, coordination committees at regional and health district levels convene health officials, civil society representatives, and implementing partners to oversee program management.[37] These coordinating committees, however, have lapsed over time.[38] Within the MoH, the Community Health Unit is part of a sub-directorate of Health Facilities and Regulations. Therefore, it is not well-positioned hierarchically to take on a strong leadership role and coordinate partner alignment in the national community health policy or strategic plan.

Support for ongoing implementation has been dependent on donors and thus ad hoc, and partners have not always followed a standardized strategy, sometimes preferring to maintain their own procedures. A striking example of the weaknesses in this stage of the reform cycle is reflected in how persistently the SEC strategy's challenges have endured. In the midterm review of the SEC strategy in 2013-2014, numerous performance challenges were identified. These were noted in the SEC Strategic Plan document of late 2015 but insufficiently addressed in terms of programmatic adjustments within the Strategic Plan.[4] When community health stakeholders identified key problems still to be resolved after the Strategic Plan was developed, they were essentially the same as those that had been cited in the midterm review; the Malian government has not succeeded in solving recurring challenges. While mobilizing sufficient resources for community health may not be a panacea, funding shortfalls have undeniably blocked progress towards institutionalization and the standardized scale-up of the SEC strategy.

PROGRAM MANAGEMENT AND LEARNING

The midterm evaluation of the SEC strategy highlighted an array of challenges, which align closely with the problems prioritized in more recent efforts by stakeholders to improve community health. In addition to the lack of a sustainable plan for financing ASC salaries and incomplete coverage of implementation, the midterm evaluation noted difficulties involving: weak performance on certain key indicators, insufficient

utilization of services, poor linkages between the community health platform and the rest of the health system, community desire to increase the ASCs' package of services, and a need for full harmonization of community health indicators. Furthermore, the evaluation reported that not all essential mechanisms were fully functional, such as follow-up, supervision, coordination, community engagement, accountability, and reporting.[4] Fragmentation among donors and implementing partners made planning and coordination of resources difficult for the MoH to manage.[31]

In the initial phases of the program rollout, community health services data was aggregated with health facility data, which complicated analyses and learning processes focused on the community health system. However, partners and the government worked together to identify challenges, test innovative solutions, and adopt new approaches into policy. One strong example of this collaborative approach has been the work of Muso in strengthening the national ASC supervision system. Inconsistent supervision had been cited as a key challenge in the initial implementation of the SEC strategy, and in 2012 Muso identified frequent, high-quality, and supportive supervision as a critical motivating factor for ASCs to do quality work.[39] As a result, the organization developed a system of comprehensive, dedicated supervision for ASCs, studied the results, and found that ASCs under this supervision model significantly improved the quality, speed, and quantity of care they provided. After Muso's government partners presented the study results to the national community health steering committee in 2018, the new supervision model was accepted into the national plan.[40]

By 2016, Mali had progressed through the reform cycle to put the SEC strategy in place, but this process had stalled in partial rollout, largely due to challenges in resource mobilization. Community health reform was at a critical moment: There was sufficient evidence of the SEC strategy's effectiveness and value to the community, but the later stages of institutionalization—that would ensure that community health could deliver on its promises and become entrenched in Mali's health system—had not yet been accomplished.

Mali's ICH Investment as a Catalyst for Reform

The Objectives of the ICH Investment in Mali

As Mali launched the 2016-2020 SEC Strategic Plan without having fully resolved these key questions of institutionalization, community health stakeholders embarked on an advocacy effort to reform and refine the SEC strategy. This reform process effectively re-initiated Mali's community health reform cycle effort, aiming to strengthen each stage of the cycle, respond to the challenges identified in SEC implementation, and address the bottlenecks in the trajectory of institutionalization. The sustainability of ASC salaries and their integration into domestic budgets was the critical problem around which FENASCOM and other partners hoped to align all stakeholders.

The Integrating Community Health (ICH) investment, introduced in Mali in early 2016, became a key vehicle for this process. A partnership between USAID and UNICEF, the ICH investment provided catalytic funding to support Mali's MoH in attaining its community health objectives. The ICH investment intended to align support for solid community health systems that provide primary healthcare, contribute to broader health sector strategies, and promote universal healthcare coverage. In Mali, the Aga Khan Foundation worked with the MoH, FENASCOM, and AMM to develop priority objectives for the ICH investment.

The SECPro project had several interconnected workstreams at different levels of the health system that together aimed to improve the institutionalization and effectiveness of community health.[41] Most importantly for the reform process, SECPro emphasized national partner coordination and advocacy to mobilize domestic resources for community health and revise the SEC strategy. Given the paramount importance of securing sustainable financing for ASC salaries, a critical component of the SECPro learning agenda concerned identifying, documenting, and sharing best practices for increasing domestic health financing.

ICH IN MALI AT A GLANCE

PROJECT: Strengthening the SEC Strategy Project (SECPro)

IMPLEMENTING PARTNERS: Aga Khan Foundation, Human Network International/Viamo, *Direction Nationale de la Santé* (DNS), FENASCOM, AMM

DATES: March 11, 2016 – March 10, 2020 Amount: 1,835,230 USD (USAID), 556,230 USD (cost share), 1,302,566 USD (leverage)

OBJECTIVES:

- Develop effective and efficient linkages of community health approaches in systems, policies, and plans.
- Generate and use quality data and information for decision making to influence local and national systems and policies.
- Improve coordination and collaboration between governments, civil society, and/or the private sector to implement and influence local and national policies and plans

GEOGRAPHIC FOCUS:

- **National:** policy, advocacy, and coordination
- **Regional:** Mopti and Djenné districts

The project also intended to strengthen SEC coordinating committees at the national, regional, and local levels—with a focus on the Mopti region where the Aga Khan Foundation supports direct SEC strategy implementation through its AQCESS project. As part of its strategy to enhance SEC management, the project planned to collect data using the national DHIS2 system and build capacity to use this data for decision-making. Another strategy to enhance implementation quality lay in improving SEC education for ASCs, including a digital training platform (known as 3-2-1). The SECPro implementing partners ultimately intended to use data and lessons learned from across the different project arms to influence the national advocacy agenda and improve the health system.

Reform Strategies and Achievements during the ICH Period

With scale-up and institutionalization of community health in Mali stalled, community health stakeholders maintained a steady campaign to promote SEC. As seen in the reform cycle analysis discussed previously, the process of reform had faced significant challenges in the program readiness phase. It is unsurprising, therefore, that stakeholders from civil society, MoH, and NGO partners focused attention on advancing this aspect the reform. Together, a coalition of community health advocates sought solutions to the resource mobilization challenges of allocating increased financing to the SEC strategy and identifying sustainable payment mechanisms for ASC salaries. Underpinning this work were a strong advocacy coalition and revitalized community health coordinating bodies, all substantially supported and accelerated through SECPro.[ii]

These extensive advocacy efforts bore fruit: Mali has announced a series of sweeping reforms in the last two years. Since late 2018, the country has committed to implementing a universal healthcare scheme, a formal national scale-up of paid, professionalized ASCs providing free primary care services, and other major system improvements.[12] The reform cycle can again provide a useful framework to understand how these reforms came to be, the strategies that community health stakeholders employed, and the progress that Mali has made towards institutionalization of community health.

COALITION BUILDING FOR SUSTAINED ADVOCACY

A NEW NATIONAL ADVOCACY COALITION

One of SECPro's primary accomplishments was the creation of the National Advocacy Coalition for SEC (*Coalition Nationale de Plaidoyer en Faveur des Soins Essentiels dans la Communauté*), launched in July 2017.[41] The idea for this coalition was born of the alliance between FENASCOM and AMM—accompanied by UNICEF and USAID—and the difficulties these civil society organizations had faced in securing alignment with other partners through their PASEC initiative. FENASCOM and AMM hoped to enlarge their coalition in order to properly harmonize implementation. They therefore suggested that this coalition be a key aspect of the SECPro project, recognizing the need to devote resources and time to create and sustain an effective, well-coordinated coalition with buy-in from a diverse array of stakeholders.

The goals of the National Advocacy Coalition were to advocate for the proper payment, education, and support of ASCs—or in broader terms, for the institutionalization and effectiveness of the SEC strategy. It grew in membership year by year, from 12 member organizations at the end of the first year of SECPro to 26 by the end of 2019. During that time, the National Advocacy Coalition emerged as a leading voice driving national efforts for SEC sustainability. Its success derived from a combination of its savvy recruitment of members and champions, and its development of functioning organizational structures—namely, a Steering Committee and a Technical Committee, both of which have met regularly since they were established.[42]

ii Much of the information concerning the activities, goals, and accomplishments of the SECPro project and the National Advocacy Coalition for SEC was provided through personal communication or during an in-person workshop with key stakeholders from the Ministry of Health, FENASCOM, AMM, Aga Khan Foundation, USAID, and UNICEF (February 24-28, 2020 in Dakar, Senegal).

However, the continual turnover of government personnel represented a major stumbling block for advancing policy decisions.[43] Since 2016, for instance, several different people have filled the position of the head of the General Directorate of Health, more than one per year. With each transition, community health stakeholders had to re-initiate advocacy efforts to ensure that the new official was aligned with the long-term goals of institutionalizing community health—by which point, the position might have changed hands again. Without a stable advocacy body prepared to undertake this ongoing work, progress towards institutionalization would be destined to languish.

PROBLEM PRIORITIZATION FOR THE COALITION

One of the organizational structures contributing to the National Advocacy Coalition's success was the annual action plan, developed each year through a collaborative effort involving civil society, NGOs, and donors. The process of developing this action plan represents an annual exercise in problem prioritization. In 2017, the National Advocacy Coalition defined its priority advocacy points as:[38]

- Achieving the designation of ASCs as civil servants through the National Assembly
- Promoting the national adoption of the SEC strategy
- Advocating for an increase in budgets allocated to SEC by the state
- Integrating SEC in training curricula of medical schools
- Working with the Directorate of Human Resources to integrate ASCs into the communes' civil service
- Promoting the use of data and evidence in the implementation and revision of the SEC strategy
- Contributing to the functioning of the SEC Ad Hoc group

The goals of the National Advocacy Coalition had been attempted before, notably through PASEC, but without financing to support coalition building, these efforts had been largely unsuccessful. With SECPro funding available to finance activities, the National Advocacy Coalition has advanced the work of advocacy, coalition-building, and solution development. Overall, the National Advocacy Coalition's role has been to maintain pressure on stakeholders even in the face of personnel turnover, to follow issues through various bureaucratic channels to prevent them from stalling or getting lost in the shuffle of daily governance, and to strategically bring the activities and lessons learned of different partners together under one roof.

MOBILIZING CHAMPIONS

In addition to organizing field trips for the Minister of Health and other high-ranking government officials to build support for SEC, the National Advocacy Coalition also looked beyond the health sector to mobilize "golden-hearted champions." They identified and recruited important figures who were likely to support community health from among parliamentarians, artists, and religious figures—like Chérif Ousman Madani Haïdara, a major religious leader in Mali and now President of the Malian High Islamic Council. The National Advocacy Coalition particularly focused on women leaders and religious figures who promoted gender equality and the abolition of female genital mutilation—thus framing the SEC strategy as critical to addressing women's issues. It was similarly important that these champions be people that the President would listen to. Following letters of correspondence and in-person meetings with each of the identified champions, they all accepted. Together with these leaders, the National Advocacy Coalition ensured that the efforts to institutionalize community health were broadcast through local media channels to help raise awareness and concretize political will.

SOLUTION GATHERING

REVITALIZING THE COORDINATING BODIES

In order to ensure that policy decisions were properly debated, assessed, agreed upon, and validated under the aegis of the MoH, SECPro tackled the revitalization of the different SEC coordination committees—from the national SEC Ad Hoc group to the regional and community-level SEC committees. These committees existed on paper, but in reality, their functioning had lapsed as partners left or redirected their resources. The SEC Ad Hoc group did not meet regularly, and

meetings were virtually absent in the Mopti region (targeted by SECPro).[38] These committees were deemed essential to creating dialogue around SEC, ensuring that information passed from one level of the system to another and supporting the high-quality implementation of national directives. By re-initiating the regular meetings of these committees, SECPro was also laying the groundwork for improved program management and governance further down the reform cycle. Each level had to work in order for the system as a whole to work.

SHARED PARTNER LEARNING

Through SECPro, the MoH created a platform for sharing experiences and learnings among community health stakeholders. The annual stakeholder lessons learned workshop has included: sessions on the results of a SECPro evaluation of ASC training, a Save the Children experiment in ASC salary payments (developed in Kadiolo, Sikasso region, with FENASCOM and AMM), a family planning pilot by the NGO Muso, and experiences with different supervision models. In 2018, participants recommended that this workshop be held twice a year, a marker of its perceived value. The recommendations emerging from the workshop contrinuted to the revision of the SEC strategy that informed the new SEC Strategic Plan, set to be validated in 2021.

DESIGN AND READINESS

COSTING ANALYSIS

In 2016 and 2017, the USAID-funded Health Policy Plus (HP+) project conducted a rigorous costing analysis for community health in Mali.[31] Because of ongoing fragmentation, HP+ encountered substantial challenges to even understanding the costs of the SEC strategy. This included inaccurate information about the numbers, locations, terms of service, modes of payment, and employment prerequisites for ASCs; and a lack of a central database outlining how much ASCs are paid and by whom. In response, the project conducted a situation analysis and developed a mapping tool to project service costs, available funding, and anticipated financial gaps. Overall, they found the global cost of community health (SEC) to be about 13.7 million USD per year, with funding shortfalls of at least 2 million USD (an amount that is expected to increase over time).[31] They reported that the majority of ASCs were operating without a formal contract and with irregular monetary and insufficient non-monetary incentives. The central government represented less than 1% of ASC funding sources, and the National Advocacy Coalition was determined to increase this share of government contribution.

MOBILIZING DOMESTIC RESOURCES FOR ASC SALARIES

The heart of the National Advocacy Coalition's goals is to persuade the government to provide a specific budget line to municipalities for the payment of ASC salaries. To achieve this goal, the National Advocacy Coalition approached both the central government and communities, including commune governments and the ASACO. In the first year of the SECPro grant, community health stakeholders held meetings between the government, donors, and implementing partners to identify mechanisms for paying ASCs through commune budgets. They also drafted a service contract between ASCs and community-level local authorities describing this payment mechanism.

Kadiolo health district presented an appealing potential model. Save the Children had been working with local mayors and the ASACO since 2014 to shift ASC salaries to local budgets. This effort began with trainings for local authorities on budget analysis, roundtables on fund mobilization, and closer monitoring of health expenditures. The mayors agreed to a staged process to take on more of the financial burden over time. In 2015, the communities would pay 50% of the ASC salaries (evenly split between commune and ASACO budgets), with Save the Children paying the other 50%. In 2016, the communities would pay 75% of the salaries; and from 2017 onwards, they would pay 100%. The then-Minister of Health Dr. Samba Sow visited Kadiolo just after the commune mayors and ASACO committed to taking full responsibility for ASC salaries. This marked an

important advocacy win demonstrating not only the importance and challenges of the SEC strategy, but also the community's commitment to ASCs.

Ongoing advocacy with the National Assembly, the body responsible for approving Mali's national budget, led to another major success: the appointment of a point person for SEC in the Assembly. Following persistent relationship-building efforts and repeated meetings—financed by SECPro—the National Assembly's Health Commission identified a representative (known as the focal person) to review SEC-related dossiers that come to the National Assembly. The National Advocacy Coalition works with this focal person to identify advocacy opportunities to promote the SEC strategy. The focal person is positioned to sound an alarm if the Malian government were to review a national budget that did not earmark funding for ASC salaries. Fortunately, the Health Commission appointed a particularly effective advocate for SEC to this role—a marker of how important they think the SEC strategy is—though the role is not yet formalized as a recurring, long-term position.

SECURING LEGAL STATUS FOR ASCS

The question of integrating ASCs into the national health system and paying their salaries was gaining traction as SECPro got off the ground. In September-October 2016, PASEC (led by FENASCOM and AMM) assembled a multisectoral group of experts and held a 15-day workshop in Kangaba, Koulikoro region. The goal was to determine whether there was any aspect of Malian law that prohibited the ASCs from being civil servants. They found that the existing ASCs needed an "exceptional status" to be paid salaries through the government. It would require dedicated advocacy work to follow up on these findings and ensure that the appropriate juridical statute was written.

This effort soon got a boost. Community health stakeholders had repeatedly held sessions with Mali's National Assembly on the importance of the SEC strategy as a whole, and resource mobilization for ASC salaries specifically. In April 2018, the National Advocacy Coalition and the National Assembly's Health Commission organized testimonies to highlight the challenges of SEC sustainability if ASC salaries were not paid with domestic resources. The speakers included an ASC, a mother, a village chief, a representative of the women's committee of CSCOM users, an ASACO president, a FELASCOM president, and the technical director of the CSCOM. In response, the National Assembly recommended a bill to integrate ASCs as civil servants—a major advocacy win that was broadcast on national television and radio.

The National Advocacy Coalition has taken up the task of following this recommendation to ensure that it comes to fruition. They have met with the Directorate of Human Resources for the health sector about creating a national human resource database for ASCs, and with the MoH's Support Unit for Decentralization and Democratization (*Cellule d'Appui à la Décentralisation et de la Déconcentration* or CADD/MSAS) to draft a position on the legal status of the ASCs.

PROGRAM HARMONIZATION

As highlighted in the HP+ report on SEC financing, a major impediment to the sustainability of ASC salaries was fragmentation among different implementing partners. Community health stakeholders, in collaboration with the General Directorate of Health, developed a committee to harmonize first the ASC incentive amounts, and later other aspects of the ASC service package. Since the SEC Ad Hoc group had been capacitated to strengthen its coordinating functions through the SECPro project, it was an effective platform to make and validate these decisions. Together, the SEC Ad Hoc group and the National Advocacy Coalition pressured donors to harmonize their financing and approaches. Based on this harmonization process, stakeholders convened at a workshop in Sikasso. The goal was to revise the SEC work tools and agree on adjustments to be integrated into the 2018 SEC Strategic Plan review.

DEVELOPING UNIVERSAL HEALTHCARE POLICY

In parallel, a policy process on UHC began to advance. In September 2016, the WHO and Save the Children supported the Ministry of Solidarity to hold a workshop to draft a new UHC bill. The assembled team of experts—part of a National

Reflection Committee on UHC—studied the three existing health insurance regimes in the country: Mandatory Health Insurance (AMO), Medical Assistance Plan (RAMED), and mutual insurance societies (*mutuelles*). Together these programs created a fragmented system that only covered about 12% of the population—largely those working in the formal sector.[23,25] The National Advocacy Coalition for SEC was a member of this National Reflection Committee on UHC, and FENASCOM organized a parallel group of experts to ensure that civil society concerns and perspectives were taken into consideration in the new health insurance model.

This work on a national UHC policy would finally come to fruition nearly two years later, with a bill to establish the Universal Health Insurance Plan (*Régime d'Assurance Maladie Universelle* or RAMU).[44] RAMU was adopted by the Council of Ministers in June 2018 and by the National Assembly in December 2018. It was announced by then-President Keïta on December 31, 2018. The National Advocacy Coalition credits the SEC focal person at the National Assembly for helping guide them through the process of promoting RAMU's adoption. The policy is expected to benefit mainly people from rural areas and the informal sector, but Mali will need to mobilize an estimated 160 million USD to operationalize the scheme. RAMU's implementation is still pending.

HEALTH SYSTEM REFORM ANNOUNCEMENT

The adoption of RAMU was merely the beginning of a wave of sweeping health system reforms borne of the intensive advocacy efforts by SECPro partners and others. A 2018 workshop to review the SEC Strategic Plan revealed a lack of progress in health indicators, generating frustration and wide-ranging discussion of the difficulties facing the health system. The then-Minister of Health, Dr. Samba Sow, appointed in 2017, took real interest in advancing UHC and community health. He leveraged a growing sense that more drastic reform was needed to drive this agenda.

Soon after the adoption of RAMU, in February 2019, then-President Keïta announced an even broader reform of the health system.[12] This reform guarantees the free provision of a comprehensive package of primary health services for women, children, and the elderly. Critically, it also officially establishes ASCs as a formal part of the health sector, integrated into CSCOM and providing free essential services at the community level. This announcement offered the potential to unblock a major challenge to the institutionalization of community health. Unfortunately, because ASCs had not previously been mentioned in the country's national health system law, it was not clear that they were eligible to be paid from the national budget[31] and medical schools were not teaching the ASC curriculum. To help resolve these issues, a legal team in the regulatory unit is currently drafting the appropriate laws that will enable ASCs to be paid by the state, and the SECPro team—including the National Advocacy Coalition—expects that a national ASC training program will be developed and delivered in medical schools.

PROGRAM DESIGN FOR A REFORMED HEALTH SYSTEM

Following then-President Keïta's reform announcement, the MoH and other community health stakeholders have been working through the SEC Ad Hoc group to develop program guidelines and operational documents. The group convenes every two weeks to track progress among the several technical working groups that were formed to address this reform. Similarly, the SEC Ad Hoc group is incorporating adjustments to the SEC strategy, including those that emerged out of the harmonization process, adopting the NGO Muso's dedicated supervision model to improve implementation quality, and adding services for HIV and tuberculosis into the SEC package. SECPro partners took the lead to ensure the consensus of all stakeholders and implementing partners in planning for implementation, including organizing the meetings of the SEC Ad Hoc group.

GLOBAL FINANCING FACILITY INVESTMENT CASE

The Global Financing Facility (GFF) of the World Bank aims to help governments develop prioritized, costed national plans to catalyze high-impact investments for nutrition and reproductive, maternal, newborn, child, and adolescent health. In

March 2019, the government of Mali began working with GFF to begin the development of an investment case to mobilize funding for the next PRODESS and in support of the 2019 health sector reforms, including the national scale-up of ASC.[45] With GFF support, Mali has conducted a resource mapping for the investment case, which will focus on: delivery of quality health services across the continuum of care, support for the health system pillars, and governance. Over time, the GFF will support Mali to institutionalize the resource mapping process, ensure that donor resources are aligned with national strategic plans, and advocate for additional funding.

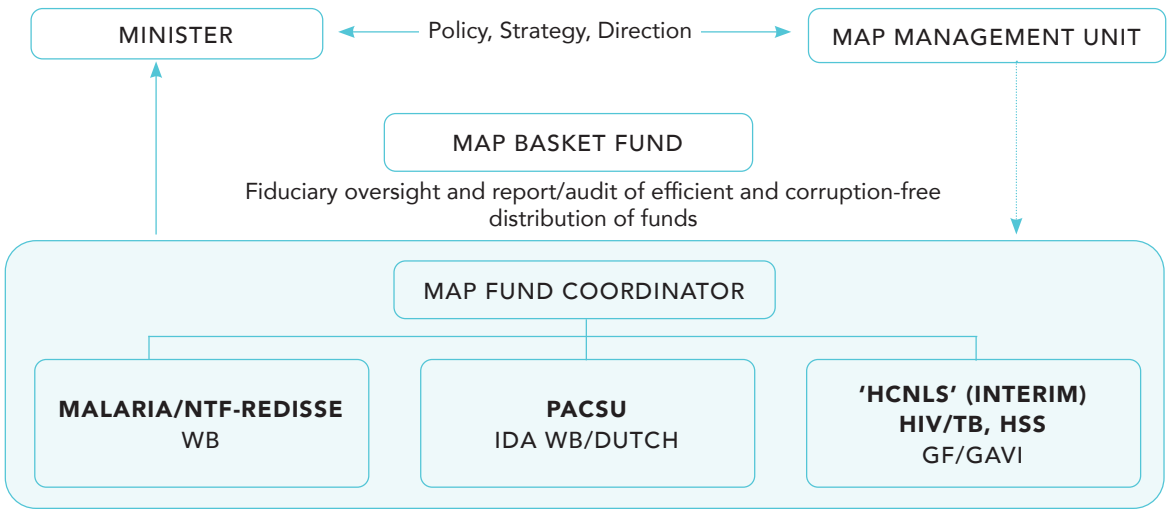
THE MALI ACTION PLAN

In the midst of this work to reform the health system, the then-President of Mali abruptly fired his top government officials in response to ongoing insecurity and strikes. The new government included a new Minister of Health, Michel Sidibé. Fortunately, because the reform announcement had come from the President himself, this turnover in the MoH did not spell the end of these advances. On the contrary, the new Minister worked to solidify and build on the reform work underway though a new policy document—the Mali Action Plan for 2020-2023 (MAP).[3] Initially, community health partners were concerned that the MAP would upend their careful, hard-won progress on community health reform. But the MoH was quick to reassure them that the MAP was situated in existing health policies and was emphatically not a distinct or parallel policy.

The MAP, released in January 2020, sets out an ambitious vision of sweeping reform, encompassing four pillars of the health system, the first of which is community health. This plan aims to create a "best-in-Africa" professionalized ASC cadre of mostly women, providing free preventive and curative services in partnership with the CSCOMs (which will also provide a package of free primary healthcare services). The plan calls for a new MAP Management Unit dedicated to the strategy—though it is unclear how this structure will relate to existing coordinating bodies like the Ad Hoc SEC group. (See Figure 3.) The MAP addresses issues of resource mobilization by proposing a Basket Fund to pool and allocate all donor resources. Furthermore, it notes the possibility of increasing government revenue through targeted taxes on specific sectors, improved tax collection, refinancing Mali's debt burden, and marketing government bonds to the Malian diaspora.

Many aspects of the reform the community health stakeholders envisioned at the beginning of SECPro to institutionalize community health are captured in the 2019 reform announcement and the MAP. What remains are the details of operationalizing the MAP's ambitious plans and ensuring that the different goals that have been pursued over the last few years are brought to fruition. If these ambitions are realized, Mali could achieve a community health workforce that is entrenched in national budgets, highly trained, supported with dedicated supervision and able to provide high-quality primary healthcare services.

FIGURE 3: MAP Basket Fund and Management Unit. Source: MAP



Opportunities and Next Steps

Community health is at a critical turning point in Mali, with exceptional opportunities for transformational progress. This opening is thanks to the strong political will demonstrated by the government of Mali and the significant efforts of a coalition of key stakeholders. The global COVID-19 pandemic shifted priorities across the world, however, and Mali weathered two coups d'état in less than a year in 2020 and 2021. These changes in the political context may slow the reform process, but the expected validation of a new five-year SEC Strategic Plan in mid-2021 gives reason for optimism that advocates for SEC can lead the country to progress despite these setbacks. To consolidate the gains of SECPro and accelerate the institutionalization of the SEC approach in Mali—including the formalization of the payment of ASC salaries—community health stakeholders have identified a number of next steps. Given the policy achievements represented in then-President Keïta's reform announcement and the MAP, much of the work to come will focus on the later stages of the reform cycle: finalizing the program design and readiness, and ensuring program launch, governance, and management and learning.

POLICY DESIGN

The MoH and other community health stakeholders have developed a Community Health Roadmap for Mali, in collaboration with USAID, UNICEF, the Rockefeller foundation, the Bill & Melinda Gates Foundation, and the World Bank. The Community Health Roadmap documents the progress accomplished and prioritizes next steps in the work to strengthen and institutionalize community health, with the goal of ensuring partner alignment to government priorities and helping donors understand where their resources could provide catalytic support.

Translating MAP goals into guidelines: First and foremost, it is essential that Mali maintain its political commitment to community health reform and operationalization, starting with the MAP. The MAP lays out ambitious goals and its implementation should be a primary focus for the MoH and its partners. However, before the MAP can be rolled out, it will be vital to determine how the programs and structures described in the MAP will translate to reality on the ground, and adopt the progress and lessons learned already underway. Mali will need to undertake a full process of program design and readiness to roll out the reforms promised in the MAP. This work has already started in response to the then-President's 2019 reform announcement and in refining the SEC strategy. But the necessary guidelines, work tools, coordinating bodies, and other supporting systems will need to be updated to align with the MAP or integrated into new materials generated to support MAP rollout.

Launching the new SEC Strategic Plan: When the SEC Strategic Plan expired in 2020, community health stakeholders were prepared to support the MoH in elaborating the new Strategic Plan. Incorporating the adjustments tested over the past several years was a high priority for ensuring the continuity of the SEC approach. After delays related to the COVID-19 pandemic and political turmoil, the new five-year SEC Strategic Plan is set to be validated in 2021. As Mali prepares to implement this Strategic Plan, it will be important to situate it in the MAP implementation and to maintain political will in an uncertain political climate.

Formalizing ASCs: The 2019 reform announcement declared that ASCs would be an official part of health policy in Mali, and a legal team is currently drafting the juridical status for ASCs. The National Advocacy Coalition intends to ensure that this legal status for ASCs is taken up both to have them paid through government budgets and to institutionalize their role in the Malian health system.

PROGRAM READINESS AND LAUNCH

Mobilizing domestic resources for ASC salaries: The full rollout of SEC will require increased mobilization of state and domestic financial resources for the community platform, especially salaries for ASCs. Community health stakeholders have made progress in building support and laying the groundwork to ensure that ASC salaries are a national priority, but these efforts are not yet complete. SEC advocates continue to debate the mechanism of financing ASC salaries in the short term. They also debate the urgency of getting Mali to a point of full donor independence as opposed to channeling donor resources through the government. In the short term, the National Advocacy Coalition is urging the central government to identify a specific budget line that communes can use to pay ASC salaries. The goal was for the MoH to increase the decentralized budget for communes in order to ensure the payment of ASCs by December 2020.[42] In the long term, the goal is to put ASC salaries fully on the state budget.

Mobilizing and scaling through the MAP: In order to implement the plans laid out in the MAP, the Malian MoH and its partners will need to undertake a financial analysis to budget MAP costs and identify financial gaps. The Basket Fund and MAP Management Unit are intended to consolidate all implementing partner and donor activities. This process will need to entail mapping the persons in charge, resources, and periodicity of each partner's activities. Furthermore, to avoid challenges encountered during the PASEC initiative, the MoH will need to ensure that donors and partners participate in the Basket Fund and that it can accommodate their funding policies. According to the Community Health Roadmap, Mali aims to hire 10,521 new ASCs and enough staff for the creation of 1,336 new CSCOM by 2022.[19] Reaching total coverage in MAP implementation will be a herculean task. This rollout is currently expected to occur in phases, starting with a targeted approach to reach communities and populations most in need and not reaching full coverage until at least 2024.

PROGRAM GOVERNANCE, MANAGEMENT AND LEARNING

Institutionalizing community health structures: Three critical structures driving advances in community health institutionalization have contingent status: the SEC Ad Hoc group, the SEC focal point in the National Assembly, and the National Advocacy Coalition.

1. **SEC Ad Hoc Group:** The name of the SEC Ad Hoc group implies its status as a temporary and unentrenched structure despite the fact that it is the primary coordinating body for the SEC strategy. SECPro partners faced obstacles when they advocated for the group to be institutionalized and renamed to reflect its role. With the President's reform and the MAP, it should be possible to solidify the SEC Ad Hoc group into a permanent steering committee for SEC.
2. **SEC focal point in the National Assembly:** Similarly, the SEC focal point role has not been formalized. In theory, the position should be

renewed at the end of the person's term of duty, but this continuity is not guaranteed.

3. **National Advocacy Coalition:** With the ICH funding coming to an end, the National Advocacy Coalition's action plan is no longer financed. SECPro and the National Advocacy Coalition have provided essential support to strengthening and restructuring the community health system in Mali. A clear transition and financing plan for the activities supported by SECPro is essential to build on this progress. Concrete next steps for the National Advocacy Coalition include: identifying activities at risk with the end of SECPro, developing mitigation strategies, updating the annual action plan, elaborating a longer-term strategic plan, and seeking funding to maintain activities. Fortunately, because the National Advocacy Coalition has already built the structures and process for defining priorities—and has a few years of experience to build on—the tasks of developing and costing their activities and strategic plan should be facilitated.

Harmonization and learning: The government of Mali receives significant support from external partners and donors, but this support has sometimes been verticalized and dispersed, weakening efforts to implement and institutionalize the SEC strategy effectively and efficiently. The Malian government will need to ensure the technical adherence of all donors and implementing partners to the newly harmonized SEC strategy. This harmonization must include indicators and data collection relating to SEC implementation in order to better demonstrate the added value of SEC and enhance evidence-based decision-making.

In Conclusion

The trajectory of community health reform in Mali has reached a critical tipping point of institutionalization. Enough progress has been made in mobilizing champions, political will, and community demand that the status of community health in Mali's health system is well established. Since 2016, the ICH investment has substantially supported the process of problem prioritization within the community health system, coalition building to advocate for the institutionalization of the SEC strategy, and solution gathering for the challenge of ASC salaries and other shortfalls in community health. The results have set Mali on track to implement an ambitious health system reform. As demand for high-quality community services rises among the Malian population—channeled through powerful civil society organization—it is no longer a question of whether Mali will deploy a community health workforce, but how and when will it do so in a way that ensures high-quality service delivery. The National Advocacy Coalition and other community health advocates can look with optimism to a future where reform efforts are focused on institutional refinement of an existing community health system.

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