REPUBLIC OF MALI

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GOVERNMENT OF THE REPUBLIC OF MALI

Proposal for support for Mali's Health System Reinforcement (HSR)

Submitted to the:

Global Alliance for Vaccines and Immunisation (GAVI)

(final version)

February 2008

PERMANENT SECRETARIAT of the HEALTH AND SOCIAL DEVELOPMENT PROGRAMME
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An electronic version of this document is available on the website of GAVI Alliance (www.gavialliance.org) and is provided on CD. It is highly recommended that proposals be submitted by electronic mail, including scanned documents bearing the necessary signatures. Please send your completed proposal to:

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Please ensure that the proposal reaches the GAVI secretariat by the deadline indicated. Proposals received after that date will not be considered in this examination round. GAVI will not be held responsible for delays in delivery or failures to deliver by courier companies.

All documents and appendices must be submitted in English or French. All the required information must be included in this proposal form. GAVI's secretariat will not accept any separate document as forming part of the proposal. The GAVI secretariat will not be able to return the documents and appendices submitted to the counties. Subject to instructions to the contrary, the documents may be made known to GAVI's partners, its collaborators and the public.

Contents

Abbreviations and acronyms

AB	:	budgetary support (BS)
ABS	:	sectoral budgetary support (SBS)
ACDI	:	Canadian International Development Agency
AMM	:	Association of Municipalities of Mali
ARV	:	Antiretroviral
ATR	:	Retrained traditional midwife
BCEAO	:	Central Bank of West African States
BCG	:	Bacille Calmette-Guérin vaccination
AT	:	Technical Assistance (TA)
ASACO	:	Community Health Association
CADD	:	Decentralisation and deconcentration support unit
CCC	:	Communication for behaviour-modification
CDMT	:	Framework for medium-term expenditure
CPM	:	head of medical station
CPN	:	prenatal consultation
CPS	:	Planning and Statistics Office (PSO)
CROCEP	:	Regional Committee for guidance, coordination and evaluation of health and social programmes
CTB	:	Belgian Technical Cooperation
CSCOM	:	Community Health Centre
CSCRP	:	Strategic Framework for Growth and Poverty Reduction
CSLP	:	Strategic Framework for Poverty Reduction
CSREF	:	reference health centre
CT	:	territorial collectivity
DAF	:	Administrative and financial department
DBC	:	Distribution on community basis
DHS	:	Demographic and Health Survey
DIU	:	Intra-uterine device
DMT	:	Traditional medicine division
DNS	:	National Department of Health
DNRH	:	National Department of Human Resources
DPM	:	Department of Pharmacy and Medicine
DRB	:	Regional Budget Department
DRC	:	Cercle's distribution depot
DRS	:	Regional Department of Health
DTC	:	Diphtheria – tetanus – whooping cough

INRSP	:	National Public Health Research Institute
MATCL	:	Ministry of Territorial Administration and Local Collectivities
ME	:	essential medicine
MEF	:	Ministry of Economics and Commerce
MEIC	:	Ministry of Economics, Industry and Commerce
MF	:	Ministry of Finance
MII	:	Mosquito net impregnated with insecticide
MS	:	Ministry of Health (MH)
MTA	:	Improved traditional medicine
ND	:	Not available
OMD	:	Millennium Development Goals
OMS	:	World Health Organisation (WHO)
ONG	:	Non-Governmental Organisation (NGO)
PDDSS	:	Ten-year health and social development plan
PDSC	:	Cercle's health and social development plan
PDSSC	:	Cercles' health and social development plan
PEV	:	Expanded Vaccination Programme (EVP)
PF	:	Family Planning (FP)
PIB	:	Gross Domestic Product
PIC	:	Integrated Communication Plan (PIC)
PMA	:	Minimum activities package
PNLT	:	National Programme for the fight against TB
PNRS	:	National Health Research Policy
PO	:	Operational Plan
PPAC	:	Complete multi-annual plan
PPM	:	Popular Pharmacy of Mali
PPTE	:	Heavily Indebted Poor Countries (HIPC)
PRODESS	:	Health and Social Development Programme
PTF	:	Technical and Financial Partnership
PV VIH	:	persons living with HIV
Qc	:	Quebec
RAC	:	Communication Administrative Network
RAS	:	Nothing to report
RGPH	:	General Census of Population and the Habitat
RF	:	Financial resources
RH	:	Human Resources
RSS	:	Health reinforcement
SIDA	:	Acquired immune-deficiency syndrome (AIDS)
SIH	:	Hospital Information System
SIMR	:	Integrated surveillance of disease and recurrences
SLIS	:	Local health information system
SNIS	:	National health information system
SOU	:	emergency obstetric care
SOUC	:	full emergency obstetric care
SRJA	:	reproductive health of young adults
VIH	:	human immunodeficiency virus
UMPP	:	Mali Pharmaceutical Products Plant
UNICEF	:	United Nations Children's Fund
USA	:	United States of America
USAID	:	United States Agency for International Development

For the attention of any party submitting a proposal

- *Please ensure that all the abbreviations and acronyms used in the proposal and supporting documents are included in the list presented below.*

Summary

For the attention of any party submitting a proposal

• Please provide a summary of the proposal setting out the goal and objectives of the proposal for support from *GAVI for HRS, the principal strategies which will be followed and the activities which be undertaken, the results expected, the duration of support and the total amount of funds requested as well as the basic data and the objectives to be reached in respect of the priority indicators chosen.*

• Please indicate the person(s) who will be responsible for the *entire activities and preparation for the proposal for support from GAVI for HSR and specify the role of the CCSS (or its equivalent), as well as the persons who participated in drafting the proposal.*

Mali's proposal with a view to obtaining support from GAVI Alliance in order to reinforce its health system is an integral part of the implementation of the Health and Social Development Programme (PRODESS II), the second, five-year section of the country's Ten-year Health and Social Development Plan (PDSS). It covers three years, in line with: a) the duration of PRODESS II (2005-2009), whose extension until 2011 was approved by the Steering Committee on behalf of the Supervisory Committee at its meeting on 13 February 2008; b) the duration of CSCRP (2007-2011); c) and that of the PPAC. (2007-2011). The finalisation of the said document for extending the PRODESS is underway, in compliance with the strategic axes of the CSCRP.

The aim of this proposal for support is to obtain a health system that is efficient, accessible and equitable for all. The objectives target five of the seven PRODESS priority areas: i) the development of human resources ii) reinforcing the quality of health services, iii) reinforcing institutional capacities and decentralisation, iv) reinforcing the monitoring/ evaluation system, v) operational health research.

The main activities proposed for reinforcing Mali's health system are as follows:

- Reinforcing the system for motivating staff to work in disadvantaged areas by allocating financial bonuses as incentives to technicians.
- Reinforcing the HR information sub-system on all members.
- Forming framework teams for the districts in terms of management, leadership and in accordance with the requirements for implementing the programme.
- Providing integrated, quarterly supervision for staff at the CSCOMs including monitoring rational prescriptions and the costs of prescriptions.
- Carrying out quarterly checks on community networks
- Checking rational prescriptions and prescription costs in the course of internal medical audits.
- Increasing the medicalisation of first-contact health services.
- Devising and disseminating tools to assist rational prescription and taking control of malnutrition
- Introducing an accreditation system for districts that perform well in particular by applying a patient-centred approach.
- Recruiting a Technical Assistant for each region in Poverty Zone 1 to take charge of the districts with the poorest performance.
- Monitoring the application and evaluating the implementation of mutual assistance agreements/ contracts between the municipalities and the ASACOs.
- Developing the Public-Private partnership at the level of the districts by drawing up performance contracts for the entire minimum activities package (MAP) and information exchange (at the level of the reference health centres (CSREF).
- Reinforcing the process for drawing up an OP at district level (5 days: participation by one person from the DRS, 1 from FELASCOM, 1 from TC, 1 from the NGOs and the Prefect).
- Reinforcing FELASCOM's skills in order to support the ASACOs.
- Reinforcing the Ministry's capacity to intervene at central level in order to support the health system.
- Revising the NHIS with a view to integrating data from all the areas and players, including hospital data and data from the private sector and certain poverty-related indicators concerning nutrition.
- Reinforcing the monitoring/ control system at the level of each health area.
- Improving the quality of integrated supervision (guide, set-up and regular monitoring of CSCOM/CSREF supervision).
    - Assessing the effect of motivation on technical staff in disadvantaged areas.
    - Assessing the effect of accreditation on districts that are performing well in particular by taking a patient-centred approach.

- Assessing the effect of mutual aid agreements between the communities and the ASACO regarding the performance of the CSCOM.
- Assessing the effect of performance contracts through the Private-Public partnership.
- Assessing the effect of intervention from the DRS on the improvement of district health services in general and in particular the chapter on integrated supervision.
- Evaluating the frameworks for local meetings with a view to reinforcing them

The proposal covers all the CSCOM and health districts throughout the 8 regions of Mali and the district of Bamako, the country's capital, particularly the poor, very poor and disadvantaged areas.
The results expected will help to improve vaccine cover, enhance the quality of the supply of health-care services and increase take-up of the services in all the areas concerned.

This proposal with a view to obtaining support from GAVI for reinforcing the healthcare system covers the fourth quarter of 2008 (the year of the proposal) and the years 2009, 2010 and 2011.

The total amount requested from GAVI comes to approximately for million seven hundred and sixty-four thousand US Dollars (USD 4 764 000).

The process of formulating this request has been coordinated by the Planning and Statistics Office of the Ministry for Health under the guidance of the steering committee on behalf of the supervisory committee of PRODESS.

The responsibilities of the steering committee on behalf of the supervisory committee of PRODESS are: i) the approval and adoption of the proposal document; ii) approval of work plans for allocating the GAVI funds; iii) approval of annual action plans for activities financed by GAVI; iv) the supervision and monitoring of these support funds from GAVI for reinforcing the healthcare system. The supervisory committee of PRODESS is the highest instance for the coordination of the health sector in Mali. In the course of drawing up this proposal, it gave a mandate to the steering committee within which all the instances are represented. In turn, the steering committee has delegate the drawing up of this proposal to a technical commission.

The entities involved in the process of drawing up a proposal are chiefly: i) the CPS/MS, ii) DNS/MS, iii) DAF/MS, iv) the National Immunisation Centre, v) MF, vi) MEIC, vii) GPSP, viii) FENASCOM, ix) the profit-making private sector (Mali Doctors' Association, Association of Midwives of Mali, Association of Pharmacists of Mali), x) WHO xi) UNICEF.

As regards NGOs, they have not only been involved in the process of drawing up the proposal (through the GPSP, which is the umbrella group for NGOs in Mali with the Pivot Social Development Group), but will also be actively involved in the phase of providing support.

As regards FENASCOM, it has also participated actively at all the stages of the process for drawing up the proposal. Through its local entities, such as FELASCOM and the ASACOs, it takes part in managing the entire system at national level.

Part 1: Process of drawing up the proposal

F.A.O. any party submitting a proposal

- In this section please describe the process followed by your country in drawing up the proposal for support from *GAVI for HSR.*
- Please begin by presenting your committee for the coordination of the health sector or its equivalen*t (table 1.1)*

1.1 The Health sector's steering and supervisory committees

- Designation: Steering Committee (StC), on behalf of the supervisory committee (SC) of PRODESS.

- The StC-SC has been carrying out all of its tasks since February 2001 (Decree No 01 – 115/PM-RM of 27 February 2001 setting up bodies for guiding, coordinating and evaluating the health and social development programme in Mali.

- Structure (e.g. sub-committee, independent body): Technical Commission.
- Frequency of meetings[1]: steering committee/supervisory committee: one a month (GAVI) or once every 2 months

  Technical Commission: once a week
- Role and functions (Decree No. 01 – 115/PM-RM of 27 February 2001):

  - PRODESS supervisory committee (SC). The supervisory committee is PRODESS' supervisory body and is subject to the authority of the ministries in charge of health and social development. On this basis it is charged with: i) defining the directions to be taken in the implementation and evaluation of PRODESS; ii) promoting dialogue between the government and its partners in the implementation of PRODESS; iii) evaluating the state of progress of PRODESS and suggesting solutions to the problems encountered in the course of implementation; iv) approving the PRODESS activity reports and annual operational programmes; vi) approving the healthcare plans of the 'Cercles' [districts]; vii) reporting to the Interministerial Committee for the Promotion of Health and Social Action. It meets once every six months upon being convened by its chairpersons and whenever necessary.

  - PRODESS Technical Commission (TC). The technical commission is PRODESS' technical coordination body and is subject to the authority of the General Secretaries of the ministries in charge of health and social development. On this basis, it is charged with: i) preparing the sessions of the SC; ii) ensuring at a technical level the coherence of the healthcare and social development plans of the Cercles (PDSSC)); iii) examining the state of progress of the operational programme and giving instructions for the preparation of operational programmes; iv) examining the extent of implementation of the budgets allocated to each level in compliance with the directions put forwards by the SC and making proposals on budget allocation; v) examining all questions concerning the specific programmes and studying the conditions for integrating them ; vi) reporting to the SC on all questions. It meets once ever quarter upon being convened by its chairpersons and whenever necessary. It I the technical body for coordinating the sectoral programme.
  - PRODESS steering committee (StC). It is also presided over by the General Secretaries of the ministries in charge of health and social development. It unites the central technical services of the two departments and those of the PTF as well as representatives of civil society. Meetings are held every two months and whenever needed in order to monitor the implementation of the programme so that bottlenecks, restrictions and obstacles are regularly overcome.

[1] The reports from CCSS concerning support fro HSR including minutes of the meeting in the course of which the proposal was adopted must be attached to this proposal as a supporting document. The minutes must be signed by the president of the CCSS. The minutes of the meeting on the adoption of this proposal on the support from GAVI for HSR must be signed by all members of the CCSS.

F.A.O. any party submitting a proposal

- Please describe the entire process followed by your country in drawing up a proposal for support *from GAVI for HSR (table 1.2).*

1.2 Summary of process for drawing up a proposal

F.A.O. any party submitting a proposal

Who coordinated and supervised the process of drawing up the proposal?
The Director of the Planning and Statistics Office (CPS) of the Ministry for Health

Who was in charge of drafting the proposal?
This is the focal point, delegated for this purpose by the Ministry for Health, which has extensive international experience and which is a body within the CPS.
Was technical assistance provided? Yes

Please give a brief summary of the chronological process of activities, meetings and examination rounds which preceded the submission of the proposal:

- The process of drawing up the proposal began on 23 October 2007 with a report on the said process to the two ministers (Healthcare and social development) by the Director of PCPS/Health at the meeting of the PRODESS II supervisory committee. The idea was approved and authorisation was given to initiate the process.

- On 30 November 2007: setting up of the Technical Commission (technical group) for drawing up the proposal. The Technical Commission elected from its members a core of five members in charge of gathering the relevant information, formulating all the drafts for each of the nine (9) stages of the proposal and submitting them once a week to the Technical Commission for approval in the course of meetings organised for that purpose by the Health Ministry's planning office (PRODESS permanent secretariat).

- On 5 December 2007, the first meeting was held by the steering committee on behalf of the PRODESS supervisory committee. The object of the meeting was to exchange information on the process of preparing the Request, approving the proposal of the members of the technical commission for drawing it up.

- On 6 December 2007, the core of five (5) members (hard core) began the documentary research and formulation of the 1st draft in relation to the two first sections of the proposal.

- On 14 December 2007, the process for formulating the request to GAVI for HSR was presented to the PTFs in the health sector at their monthly meeting.

- On 17 December 2007, the second meeting of the Technical Commission was held. Its aim was to exchange information concerning the process and to approve the drafts proposed by the hard core of the Technical Commission.

- On 26 December 2007, the third meeting of the Technical Commission was held. Its aim was to approve the drafts formulated for the first three parts of the proposal.

- On 3 January 2008, the fourth meeting of the Technical Commission was held. Its aim was to approve the drafts formulated for the fourth part of the proposal.

- 10 January 2008. The Technical Commission held its fifth meeting in the course of which the fourth, sixth and seventh parts of the proposal document were approved.

- On 15, 16, 17 and 18 January 2008, workshops for finalising the technical plan were organised at Selingué (Mali). These workshops united all members of the Technical Commission. The general objective pf the workshops was to finalise, Mali's proposal document for support from GAVI to HSR at a technical level. This was the document presented to the steering committee on 13 February 2008 at a meeting organised for that purpose. The specific objectives of the workshops were to: i) select the activities for which GAV financing can be allocated in terms of the overall package; ii) ensure consistency between objectives, obstacles, activities and indicators; iii) ensure consistency between GAVI and other support from the other partners.

The results expected were that at the end of the workshops: i) Mali's proposal document for support from GAVI for HSR would be finalised in the required format; ii) that the two-page proposal (1,500 words) for support for the health system from IHP funding is available.

- From 21 January to 7 February 2008, the members of the Technical Commission's hard core worked on consolidating the technical document by integrating into it all of the workshop's recommendations and those of the director of the CPS and drafting it before the meeting for approval by the steering committee on behalf of the PRODESS supervisory committee.

- On 13 February 2008, a meeting of the PRODESS steering committee was held. That meeting approved the proposal document.

- From 13 to 14 February 2008, the comments/ suggestions of the PRODESS members of the steering committee were integrated into the proposal document.

- From 15 to 22 February, the proposal document was examined by the peers.

- From 25 to 26 February 2008, the peers' comments/ suggestions were integrated into the proposal document.

- Who was involved in examining the proposal and what procedures were followed?
  Dr Jean Pierre Noterman, Health Officer of the Belgian Embassy in Mali
  Dr Mamadou Adama Kané, Chief health inspector of Mali's Ministry for Health
  Dr Mountaga Bouaré, former doctor and Assistant National Director for Health in Mali

- Who approved and adopted the proposal before it was submitted to GAVI's secretariat?

The PRODESS steering committee/ supervisory committee. After approval by the steering committee, the proposal document was submitted to the Ministers for Health and Finance to be signed.

F.A.O. any party submitting a proposal

• On the following page please describe the roles and responsibilities of the key partners *associated with drawing up the proposal for support from GAVI to HRS (table 1.3).*

Note: Please ensure that all the key-partners figure in the description: the ministry for health, the ministry for finance, the vaccination programme, bilateral and multilateral partners, the coordination committees concerned, the NGOs and civil society and finally the collaborators from the private sector. If there has been *no involvement of civil society or the private sector in drawing up the proposal for support from GAVI for HSR please explain the reasons below (1.4).*

1.3 Role and responsibilities of key partners (members of CP and others)

Title / post	Organisation	Member of CP yes/no	Roles and responsibilities of this partner in providing support from GAVI for HSR
Mr. Oumar Ibrahima TOURE Mali's Minister for Health	Ministry for Health	Yes	• Consultation and technical support; • Participation in grassroots supervision/ monitoring teams; • Quarterly supervision of activities and budget • Concluding contracts with international consultants
Mr. Abou Bakar TRAORE Minister for Finance	Mali's Ministry for Finance	Yes	• Consultation and technical support; • Participation in grassroots supervision/ monitoring teams; • Quarterly supervision of activities and budget
Ms. Bah Fatoumata Nene SY Minister for the Economy, Industry and Commerce	Ministry for the Economy, Industry and Commerce	Yes	• Consultation and technical support; • Participation in grassroots supervision/ monitoring teams; • Quarterly supervision of activities and budget
Dr. Fatoumata Binta DIALLO Resident representative of WHO in Mali	WHO	Yes	• Consultation and technical support; • Participation in grassroots supervision/ monitoring teams; • Quarterly supervision of activities and budget • Concluding contracts with international consultants
Mr. Marcel RUDASINGWA Resident representative of UNICEF in Mali	UNICEF	Yes	• Consultation and technical support; • Participation in grassroots supervision/ monitoring teams; • Quarterly supervision of activities and budget
Mr. Alassane Diawara Resident representative of the World Bank in Mali	World Bank	Yes	• Consultation and technical support; • Concluding contracts with international consultants • Quarterly supervision of activities and budget
Mr. Yves PETILLON Representative of Canadian Cooperation in Mali	ACDI	Yes	• Consultation and technical support; • Participation in grassroots supervision/ monitoring teams; • Quarterly supervision of activities and budget
Dr. Mamadou DIALLO, Resident representative of FNUAP in Mali	FNUAP	Yes	• Consultation and technical support; • Participation in grassroots supervision/ monitoring teams; • Quarterly supervision of activities and budget
Mr. Paul Van IMPE Representative of Belgian Cooperation in Mali	CTB	Yes	• Consultation and technical support; • Participation in grassroots supervision/ monitoring teams; • Quarterly supervision of activities and budget
Mr. Souleymane DOLO Director of GPSP	GPSP	Yes	• Consultation and technical support; • Participation in grassroots supervision/ monitoring teams; • Quarterly supervision of activities and budget
M. Fadiala KEITA	FENASCOM	Yes	• Consultation and technical support;

President of FENASCOM			• Participation in grassroots supervision/ monitoring teams; • Quarterly supervision of activities and budget

F.A.O. any party submitting a proposal

• If the CCSS should wish to make further comments or should it have recommendations concerning the *proposal for support from GAVI for HSR for GAVI's secretariat and the independent examining board, please let it do so below:*

• If there has been no involvement of civil society or the private sector please give reasons and indicate *whether these parties were invited to play a role in the provision of services or the plea in the course of implementing support from GAVI for HSR.*

1.4 Other comments on the process of drawing up the proposal for support from GAVI for HRS:
nothing to report

Section II: General information about Mali

F.A.O. any party submitting a proposal

- *Please provide the most recent demographic and socio-economic information at your disposal concerning your country. Please indicate the sources of the dates and data provided (table 2.1).*

2.1 The most recent socio-demographic and economic information about Mali (2)

Information	Value	Information	Value
Population	11,988 631 inhabitants* (source: RGPH, 1998)	GNP per inhabitant	440 USD (source: World Bank 2007)***
Number of annual births	493,83 * (source : DNSI/Mali 1998)	Mortality level among children below the age of 5	191/1000 EDS IV (2006)
Surviving infants**	479,647 (source: GAVI 2006 situation report)	Infant mortality level	96/1000 live births (EDS IV, 2006)
Percentage of GDP allocated to healthcare	6.8% (2005) PPAC tool 2005	Percentage of government spending on health care	10.18% (2005) PPAC tool 2005

[2] If the proposition identified the actions to be taken at an infra-national level, infra-national data must be provided wherever available. These data must be provided in addition to the national data.

* Information updated by RGPH in 1998 – forecast for 2006, with an average annual growth rate of 2.8%); Perspectives 2005-2010.
**Surviving infants = infants still alive at the age of 12 months

*** The objective of reducing poverty by a quarter over the period 2001-2006 and aimed at bringing this level down to 47.5% in 2006 has not been achieved. The analysis reveals a significant gap between the countryside (73%) and urban areas (20.1%). Poverty has declined in urban areas with the incidence of urban poverty dropping from 26.2% in 2001 to 20.12% in 2006, i.e. a reduction of 6 points. Thus, the low level of poverty reduction in the course of the CSLP is explained by poor control of demographic growth, the insufficient growth rate of Mali's economy, the unequal distribution of wealth from the growth that has occurred and poor access to basic services (CSLP 2nd generation 2007-2011). As for GNP expressed in F CFA per inhabitant, which was 250 USD en 2002, there has been no progress. While the GNP rose to 440 USD in 2006, this was due to the devaluation of the Dollar in relation to the F CFA, which is a strong and stable currency.

F.A.O. any party submitting a proposal

- Please provide a summary of the health sector plan for your country (or its equivalent) which sets out the *plan's main objectives, the strengths and weaknesses identified in the course of analyses of the health sector as well as the priority areas for future improvement (table 2.2).*

2.2 Summary of Mali's health sector plan, setting out its main objectives, the chief strengths and weaknesses that have been identified and the priority areas for future improvement.

2.2.1 Political and institutional bases, strategic plans and directions

In 1990 Mali adopted a sectoral health and population policy based on the primary health strategy, African health development strategy and the Bamako initiative. Its principal objectives are centred on improving the health of the population, extending health cover and seeking greater viability and performance from the health system. A ten-year health and social development plan (PDDSS) serves as a framework for implementing the sectoral policy. The PDDSS is implemented in two five-year stages the second of which (PRODESS II) is currently underway. Decree No. 01/115/PM-RM of 27 February 2001 defines the tasks of the various bodies in charge of providing directions for, coordinating and evaluating the PRODESS.

In order to achieve the objectives of the sectoral health policy, the following strategies have been set out: i) differentiating roles and tasks at the various levels in the health system. This entails shifting the concept of a healthcare pyramid from a hierarchical and administrative basis towards a more functional one; ii) guaranteeing the availability and accessibility of essential medicines, rationalising distribution and prescriptions through a reform of the pharmaceutical sector; iii) participation of the Community in managing the system and mobilising funding for the healthcare system including recovering costs and optimising use; iv) promoting a dynamic private and community sector that complements the public system.

In order to extend healthcare cover, the sectoral policy opted for Community health centres (CSCOM). The main strategy it adopted was to shift the concept of the health pyramid from a hierarchical basis towards greater functionality. Thus, the role of planning, programming, budgeting and implementation has been assigned to the 'Cercles' [districts], that of technical support to the regions and strategic support and development of standards to central government. Each component or structure in this arrangement is in communication with the others and the whole works as an efficient system. This extension is occurring in a spirit of determination to improve the geographical cover and financial accessibility of health services whose quality is guaranteed. As envisaged, the extension applies to the entire zone health system: i) the first level is comprised by the CSCOM, private healthcare centres and traditional medical establishments; ii) the second level is made up of the Cercle's reference healthcare centres; iii) the third level includes the zone's department of health as well as the regional public hospitals.

In 2002, the government of Mali undertook to draw up a strategic framework for the fight against poverty (CSLP) to serve as a reference framework for policies and strategies in the area of the fight against poverty. It seemed necessary to integrate different policies and sectoral strategies into a coherent macro-economic framework. This document is the chief instrument of negotiation with all technical and financial partners (PTF). That is the spirit in which the Department of Health revised the PRODESS with a view to bringing it into line with this poverty reduction framework by means of an analysis of the health situation and the links between health and poverty. This analysis allows us to make a certain number of observations and to deduce strategic approaches for a contribution by the health sector to the document of the Strategic Framework for the Fight against Poverty (CSLP), whose second generation, referred to as the Strategic Framework for Growth and Poverty Reduction (CSCRP 2007-2011) was approved by the Government of Mali in November 2006.

In 2003, Mali's Department of Health drew up the Strategic Framework for Medium-term Expenditure (CDMT) for the health sector. This CDMT is the reference document for implementing the policies and activities described in the CSLP. Thus, the objectives of the CSLP are to achieve the Millennium Development Objectives (MDO) in the long-term (2015). The CDMT is part of the public management reform (Institutional Development Programme) currently underway in Mali which is aimed at improving health and reducing poverty.

The extent of poverty depends on the environment in which a person lives (urban or rural), the sector in which they work (primary, secondary or tertiary), their age and sex. In order to assess the link

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1) Mali Ministry of Health (1998): Health and Social Development Programme (PRODESS I)

2.2.2 Priority areas (chapters) defined in the health component of PRODESS II (2nd five-year phase of the PDDSS)

The logic behind intervention as well as the strategic results of the health component of PRODESS II are closely associated with the objectives and strategies of CSLP/CSCRP: the reduction of neonatal, infant and infanto-juvenile mortality by responding to problems of acute respiratory infections (IRA), diarrhoea, malaria, malnutrition, transmissible diseases such as HIV and tuberculosis; the reduction of maternal morbidity and mortality by responding to maternal. Prenatal and obstetric healthcare needs and fighting against nutritional deficiencies as well as transmittable diseases.
This is established firstly in a logical framework set out for each chapter. The methodology used is that of RBM (results-based management). The output has been defined on the basis of the special effect of each chapter. Each output must be realised through a certain number of interventions (activities and investments). For each special effect and output one or more indicators have been defined.
The health component of the PRODESS is structured around seven (7) priority areas, which are:
i) geographical accessibility to healthcare services of the health districts: access to primary and first-contact healthcare must be improved, particularly in areas of poverty. This concerns access by the population to quality healthcare services by means of specific, targeted strategies which make services available and accessible in public, community and private structures with an emphasis on zones that are poor, deprived and/or with difficult access. The three levels of the pyramid have been considered by integrating the private sector within a partnership for the sustainable development of healthcare.
The approach to implementation will be systematic and will be undertaken at the three levels of the health pyramid and also at these three levels with the private health services in the context of a partnership for sustainable development of healthcare. The objective is to obtain a synergy for action for the public health services vertically in relation to the health pyramid and horizontally in collaboration with the non-public healthcare structures in the context of a complementary healthcare system, capable of ensuring an ongoing supply of health services to users by means of the reference system.

The strategies implemented in order to improve geographical access to health services have been developed around four major axes and in partnership with the private sector service providers (NGOs, associations and private).

- The extension of cover: increasing the number of health centres providing a package of services through a fixed strategy, including those zones that are considered “non-viable". State subsidies will be received for opening up centres in the "non-viable zones".
- The strategy put forward for people living more than 5 km away from a fixed healthcare centre providing an advanced package of services aimed at reducing neonatal, infant, infanto-juvenile and maternal mortality, fertility and malnutrition.
- The community, mobile, multi-purpose strategy for populations who cannot benefit from the advanced strategy.
- Reinforcing the organisation of the reference/ evacuation system in order to reach all the Cercles in the zone.

ii) the access to and quality and human resources management. The emphasis is on access to sufficiently competent, qualified and motivated human resources. This is one of the chief guarantees of the quality and continuity of the services offered to the population. In this context, different strategies were developed, in particular: i) recruiting contract staff (particularly multi-purpose nurses and doctors) by the municipalities using the HIPC subsidies for the health sector as well as recruitment by decentralised communities of additional staff, in particular nurses and obstetric nurses of whom there is a large deficit at present; ii) strengthening production capacities in human resources (recruitment and supervision of training schools); iii) continuous training at technical and management levels; iv) setting up a system to motivate healthcare staff, both civil servants and contract workers, to work in rural areas, in particular those further away from urban centres and most disadvantaged: developing a strategy of financial and other incentives for workers in the disadvantaged areas; v) setting up a system of performance-related bonuses for staff within performance contracts; vi) providing obligatory housing for nurses and doctors in disadvantaged rural areas; the availability of matrons in all community healthcare centres; vii) the training and retraining of traditional midwives, matrons, healthcare assistants and healthcare training managers;
The training of healthcare specialists and drawing up of a specialisation programme for doctors and specialised healthcare technicians in order to satisfy the needs of hospitals, specialised establishments and research institutes.

iii) the availability of essential medicines, vaccines and medical consumables. This is a question of making the full range of essential medicines available to the entire population of Mali as quality products at affordable prices. This includes vaccines and consumables in the health establishments used by the people. In order to achieve this, the strategies set out below were developed, in particular: reinforcing the capacities of production structures for medicines and the supervision of the pharmaceutical sector; guaranteeing the quality of medicines and medical equipment; improving logistics for the supply and distribution of essential medicines, vaccines and medical consumables; reinforcing the DMT/INRSP in diversifying research in perfecting MTAs and large-scale production of vegetal primary materials; re-launching the activities of the UMPP by shifting production towards the basic essential medicines; staff training; IEC; subsidies for essential consumables for public health such as impregnated mosquito nets; condoms for vulnerable groups (prostitutes, lorry-drivers, soldiers, etc.) oral rehydration salts, iodine, anti-tubercular and paediatric medicine; the security of blood transfusions at all levels.

iv) Improving the quality of health services, increasing demand and fighting against illness.
The aim is to produce at the level of the health districts the conditions and aptitudes needed to ensure effective and efficient health production for the population, in particular the most disadvantaged. In the course of the five-year plan, the capacity of healthcare staff and technical platforms will be reinforced in order to facilitate the application of the standards and procedures developed and disseminated in order to improve the handling of cases. The emphasis on the poor members of the population must allow i) reduction of neo-natal, infantile, and infanto-juvenile mortality by responding to problems of acute respiratory infection (IRA), diarrhoea, malaria, malnutrition, transmittable diseases such as HIB and tuberculosis; and ii) the reduction of maternal morbidity and mortality by responding to needs in maternal, prenatal and obstetric healthcare and fighting against nutritional deficiencies as well as transmittable diseases.

The struggle against illness will require common intervention such as: the application of the laws and technical procedures and guidelines; devising and disseminating certain training modules for staff; the integrated application of supervisory tools and Standards and Procedures for quality healthcare; reinforcing the handling of cases referred or disposed of; reinforcing planning and integrated programming in compliance with the revised guide; the adequate use of a health information system that works well for each level involving the different sectors and civil society; promoting research activities into illnesses; research activities into the appropriate management mechanisms among other things for health programmes; the application and monitoring/ evaluation of integrated epidemological surveillance of disease and recurrences (SIMR).

v) Financial accessibility, support for demand and participation. This will be accomplished by i) promoting a local-planning and monitoring system and consolidating it at the level of the Cercles; ii) subsidising essential consumables for public health such as impregnated mosquito nets, condoms for vulnerable groups, SROs, anti-tubercular and paediatric medicines; iii) reinforcing social mobility in order to increase take-up for the health care services; iv) facilities allocated to the poorest groups as regards paying for consultations, medicines, condoms and preventative care in health establishments; v) promoting the participation of women, young people and the poorest groups; vi) reinforcing the management capacity of the ASACOs and municipalities; vii) revising the pricing system in the establishments; viii) supporting efficient traditional forms for promoting solidarity; ix) developing an interface between the health establishments and the population; x) developing micro insurance for Emergency Obstetric Care (EOC) and ill children.

vi) Reform of the hospitals and other research establishments. In this context, patients referred to hospitals shall be treated in compliance with the standards and this includes poor people. Specialised establishments including research institutions contribute to improving the population's state of health, in particular that of the poor, by implementing their action plan. At the level of the hospitals, reform emphasises: the availability of health services and improvement of their quality; the development of a reference and counter-reference system: organisation of initial and continuous training; participation in the resolution of public healthcare problems; reinforcing the institutional framework and improving the hospitals; management framework. At the level of the other research establishments, the emphasis is on improving the quality of research, the participation of specialised establishments in training, quality supervision of products and the management framework of specialised establishments; the strengthening of the specialised establishments' institutional framework.

vii) Reinforcing institutional capacities and decentralisation. The strategies for improving access for poor people to quality healthcare also requires the participation of all the actors. The involvement of decision-makers, the development of the partnership (public and private at local, national and international levels) and inter-sectoral cooperation, honouring undertakings entered into at local and international levels, in particular the application of the rights of women and children.
In this way, the local communities to which the Heath Department has transferred a portion of its technical and financial powers (2) must now be capable of efficiently managing their healthcare problems in the municipalities, Cercles and regions and their healthcare services must accomplish their tasks and role in the implementation of PRODESS II.

2.2.3 Planning/ management of the implementation and funding of PRODESS II. PRODESS II is being implemented according to a sectoral approach which aims at avoiding the problems which a project-based approach would have encountered. In the health sector in Mali, the community of PTFs has taken up this sectoral approach. It aims at providing a support framework for development and the implementation of an equitable, coherent and satisfactory policy. In other words, the PTFs rather than financing activities on a project by project basis, will co-finance the activities of a programme in order to ensure the health policy's coherence.

These coordinated efforts are being deployed on the basis of objectives set by the State and in the context of a coherent sectoral programme based on the priorities commonly agreed upon, with common objectives (PRODESS), common planning, management structures/ bodies, joint monitoring missions, external audits and surveys.

Mali's Department of Health has decided to allocate the new budgetary margin to seven priority areas (or chapters) (described in section 2.2.2), in its Medium-term Spending Framework (CDMT). Five of these chapters are aimed at removing bottlenecks in relation to health creation at the levels of the household, community and healthcare system.

On the basis of healthcare production strategies and the health policy which have been selected in the logical framework of the health CDMT, the budgetary margin at the disposal of the Department of Health was specified in relation to a series of hypotheses and scenarios as regards the future development of financing of the sector. There would be a regular increase in the budget, taking all sources together, from 52.7 billion FCFA in 2002 to 68.2 billion in 2003, to reach 133.2 FCFA in 2009.

The CDMT lays down the principles and characteristics that are required from the framework: a clear and precise identification of sources, destinations and targeting of funding up to the results expected. What is innovative in this area is abandoning the structuring of the framework of expenditure on the basis of the unit cost of a PMA to benefit planning designed to overcome the obstacles. In perspective, the CDMT (2008-2009) for the health sector, which had already been devised and the second stage of PRODESS (2005-2009), which is underway, will allow the allocation and further take-up of financial resources in order to achieve the objectives of the CSLP and MDGs in the health sector. In fact the CDMT approach and the drawing up of PRODESS II are aimed at correcting the main weaknesses and bottlenecks observed in this sector and improving its performance.

2.2.4 Health system forces (3), (4), (5)

The government of Mali set up an innovative health system several years ago based on real participation and empowerment of the communities in managing their CSCOM.

This system's strengths are being felt at all levels, in particular those of healthcare policy, management of human resources, the active participation of different actors, infrastructures, planning/ management of activities and access to healthcare. The system's weaknesses are largely addressed in part 3 of the proposal.

At the level of healthcare policy:

- The healthcare policy has been clearly defined by Mali's Department of Health. It is coherent, its relevance has been recognised and the PTFs are sticking to it.
- There is a real convergence between healthcare policy and the policy of social development, both of which have been integrated into a single sectoral policy, that of social and health development.
- A decentralisation process is underway, even if at present in the area of health decentralisation applies to powers but not yet to financial and human resources.

- The health system is fairly reactive: interesting initiatives and experiments have been carried out; health mutual benefit insurance systems, country doctors, new management and funding system for a health Cercle (experiment in Sélingué, Mali), etc. However, these experiments have not been capitalised on much.
- The policy on prescribing medicines in the form of a DCI is increasingly accepted by prescribers, chiefly at the level of the Cercles, even if there is still over-frequent recourse to the specialisations (mainly in the private sector and in the reference hospitals).

In terms of human resources:

- The faculty of medicine trains a significant number of doctors, while the health science institutes train a large number of nurses. In the first analysis, the absolute number of healthcare service providers available throughout the country appears sufficient. It is their geographical distribution, their skills and their motivation that are causing problems.

As regards the participation of the different actors :

- Relations between MS and the PTFs are very good and open. The MS has implemented an efficient system for joint procedures for monitoring and exchange by means of integrated joint supervision, joint monitoring teams, the technical commission, supervisory committee and PTF meetings.
- The main categories of actors are united within the representative associations, PTF, health-related NGOs, traditional healers, population, (FENASCOM which has attained the status of a public utility institution).
- The participation of the communities is well-structured at the level of the health regions and Cercles (ASACOs and FENASCOM).

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(2) Decree 02- 314
(3) ESP-ULB (2007): Strengths and weaknesses of Mali's health system
(4) Ministry of Health SNV Mali (2005): Evaluation report - Programme for strengthening the capacities of PRODESS actors
(5) ETC Crystal – HERA – *Alter* (2002): External evaluation report – PRODESS I

As regards the infrastructures:

- The planning for the infrastructures is almost complete, except for the CSCOMs (785 CSCOMs of the 1,070 scheduled, chiefly in the north of the country where 50% of the CSCOMs have yet to be built), 59 district hospitals and 11 2nd and 3rd reference hospitals of respectively 1070, 59 et 11 scheduled (however, in the north of the country, 50% of the CSCOMs scheduled have yet to be built).
- A radio communication system (RAC) between CSCOMs and reference health centres is operational in almost all of the health Cercles (even if maintaining the equipment is a problem in some cases).

As regards the planning and management of activities:

- Highly developed planning (OP, CROCEP) has been carried out following an effective bottom-to-top approach with real participation from service providers, managers, PTFs, social partners and the communities,
- Vertical programmes are well-structured, strategies are well-defined and some of them work very well (e.g.: le PNLT).
- The concept of "results-based management" supports planning efforts.
- Generic medicine and certain improved traditional medicines are generally available at the level of the CSCOMs and reference health centres.
- The healthcare information system is highly developed and makes it possible at the level of the health centres to ensure highly effective monitoring of the programme results (use, health cover, etc.) and management according to the procedures described. The system is also fairly well mastered by the service providers. It would be useful to integrate qualitative aspects (healthcare process and quality). The quality and reliability of hospital data must be improved,
- The transparency and efficiency of management of the sector's finances is being greatly improved.

In terms of access to healthcare :

- Healthcare cover (76% of the population living less than 15 km from a health structure) has been greatly improved.
- Specific strategies (mobile, multi-tasking teams, advanced strategies) have been put in place for zones with difficult access or a mobile population.
- The government has made a special effort to reduce the prices of generic medicines in order to make them accessible to the entire population.
- Referral for obstetric emergencies has been organised and caesarean sections are free for patients (the operation and medical costs but not the transport).
- Emergency surgery is available in most healthcare districts: a surgical unit equipped with a general practitioner with surgical skills, oxygen and laboratory equipment for carrying out blood transfusions.
- The health of mother and child have been improved: free distribution throughout the national territory of impregnated mosquito nets during CPN, free treatment of malaria for pregnant women and children under 5 years.
- Recent decentralisation in the regions and certain districts of HIV screening and the provision of ARV free of charge.

Part Three: Situation analysis/Evaluation of needs

F.A.O. any party submitting a proposal

Support from Gavi for HSR: Support from GAVI for HSR may not address all the obstacles present in a health system that have repercussions on vaccination services and other health services for mothers and children. Support from GAVI for the RSS must supplement rather than substitute existing (or scheduled) activities and initiatives or doubling up on them in order to reinforce the health system. Support from GAVI for HSR must fill in existing "gaps" in the current endeavours to improve the health system.

- Please provide information on the most recent evalu*ations of the health sector which have identified the constraints and obstacles in the health system. (table 3.1).*

Note: The evaluations may include a recent balance sheet for the health system (undertaken in the course of the last 3 years), a report or recent study of the sectoral constraints, a situation analysis (like the one undertaken for the PPAC), or any summary of these documents. Please attach the reports of these evaluations to the proposal (with summaries if available). Please number them and list them in Appendix 1.

Note: If there has not been any recent in-depth evaluation of the health system (in the course of the last three years) it is absolutely necessary that an examination be carried out that identifies and analysis the chief bottlenecks in the healthcare systems before placing your request for support from GAVI for HSR. This examination must identify the chief strengths and weaknesses of the healthcare system and the points where the capacities of the system need to be strengthened in order to improve vaccination cover and maintain it at the level achieved.

3.1 Recent evaluations of the healthcare system [3]

Basis of evaluation	Institutions involved	Areas/ topics covered	Dates
Strengths and weaknesses of Mali's health system	ESP-ULB Mali's Ministry of Health (30 actors of whom 5 communicated their opinion/ comments)	Strengths of Mali's healthcare system Weaknesses of Mali's healthcare system	October 2007
National Accounts for Mali's Department of Health 1999-2004	Mali's Ministry of Health; World Bank; Coopération Française; WHO; USAID	i) National accounts for health, instrument of choice for studying the financing of the health system; ii) trends in expenditure for health and structure of financing for health; iii) Chief features of the health system according to the national accounts for health 1999-2004: iv) Justifications used in the CSLP healthcare component and the CDMT ; v) Some aspects of the strategy chosen in the CDMT ; vi) Institutionalisation of national health accounts .	July 2006
CSLP 2nd Generation: 2007-2011 Strategic Framework for growth and poverty reduction	Government of Mali United Nations System	i) Evaluation of the strategic framework for growth and poverty reduction (CSLP I) ; ii) Long-term strategic vision; iii)global objectives and macro-economic framework; iv) strategic orientations; priority areas for intervention; v) implementation, monitoring and evaluation ; vi) Presentation of document CSLP II	November 2006
Demographic health survey (EDSM-IV (preliminary report)	♦ Mali's Ministry of Health ♦ Ministry of Planning and Development of the Interior ♦ Measure DHS, Macro international, Inc., Alverton, Maryland, USA	Socio-economic, demographic and health indicators throughout the entire population and sub-population groups for women from 15 to 45, children under 5 and men from 15 to 59	April 2006
External review of EVP	♦ Mali's Ministry of Health; ♦ ICST-EVP WHO AO ♦ UNICEF ♦ USAID	I) vaccination cover (children from 12-23 months; children 0-11 months) ii) Logistical aspect of the EVP; iii) the chapter on Communication; iv) The institutional and financial chapter	August 2006
Report on vaccination in Mali: Analysis of iniquities in vaccination cover	♦ Mali's Ministry of Health ♦ University of Montreal, Qc, Canada	i) Rate of vaccine cover; ii) Inequalities in vaccine cover depending on the region in Mali and the family's socio-economic level; ii) Development of vaccine cover in terms of the Demographic and Health Survey (EDS) and the Malian regions; iii) Factors that favour the iniquities from losses and their development in the Kayes region	September 2005
Mali Health profile, 2005	WHO, Mali	i) Analysis if the health care system and its relations with the components of the system (political, economic, education) as well as their trends; ii) data from indicators	2005
Follow-up report on the implementation of the Millennium Development Objectives (MDO)	Government of Mali United Nations System	i) National development context ; ii) implementation of MDOs ; iii) challenges to meet for a real global partnership for development	November 2004

Social/health development programme (PRODESS II): phase 2 of the PDDSS 2005-2009 “health component”	Mali's Ministry of Health	i) Geographical accessibility to the districts' healthcare services; ii) availability, quality and management of human resources; iii) availability of essential medicines, vaccines and medical consumables; iv) improving the quality of health services, increasing demand and struggling against disease in the health district; v) Financial accessibility, support for demand and participation; vi) Reform of hospitals and other research establishments; vii) reinforcing institutional capacities and decentralisation	December 2004
Strategic Plan for Reproductive Health(RH) in Mali, 2004-2008	Mali's Ministry of Health	i) General analysis and horizontal factors (physical context; demographic context; political and administrative context; socio-economic context); ii) Health context (state of national health , equipment, situation as regards RH, Opportunities; iii) Aims and objectives; iii) Strategic axes; iv) Development of strategies by specific objective; v) institutional framework; vi) evaluation follow-up	January 2004
Final report of the external evaluation of PRODESS	WHO, Mali ETC Crystal – HERA – *Alter*	i) General analysis and horizontal factors (relevance of objectives, conception and implementation, management procedures, financial aspects, fight against poverty reduction, internal partnership, external partnership); ii) Analysis of chapters 1, 2 3, 4 of PRODESS I)	November 2002
Health and poverty in Mali : Analysis of the indicators	Government of Mali WHO; World Bank	i) Relationship between health and poverty: conceptual framework ii) Health and poverty: Analysis of health indicators (behaviour of households; Performance of public and private healthcare services).	September 2001

[3] In the course of the last three years

F.A.O. any party submitting a proposal

- Please provide information about the main obstacles in the health system to the improvement of vaccine cover which have been identified by the recent evaluations listed above. (table 3.2).

  Please provide information on the obstacles which are in the process of being overcome in a satisfactory manner using the existing resources. (table 3.3).

- Please provide information about the obstacles which are not in the process of being overcome in a satisfactory manner and which require support from GAVI for the HSR. (table 3.4).

3.2 Chief obstacles to improving vaccine cover identified by recent evaluations (3),(4),(5),(6), (7),(8)

The obstacles identified below are organised and classed according to seven (7) priority areas (chapters) in the health and Social Development Programme (PRODESS) of Mali's Department of Health.

As well as the obstacles listed below for each of the seven chapters of PRODESS, we can identify two others which influence the implementation of activities and which thereby constitute one of the priorities of the Mali Government's policy:

- The ineffectiveness of the decentralisation of responsibilities to the communities
- Slowness in the transfer of some of the powers of the State and the resources in the context of the new decentralisation policy.

i) geographic accessibility to health services for the health districts

- The combination of constraints of geographical access to the health services and their low take-up;
- The increase in health cover has not been followed by an increase of the same proportion in take-up of the services, in particular curative consultations (e.g. to allow catching up of non-vaccinated women and children)
- The imprecision of demographic data (number of population and health area) and the inclusion of the population who do not belong to the area in calculating the rates of preventative cover and curative use falsify the SIS indicators.
- The quality of the process for determining priorities in the contents of the minimum activities package is not based on any study or on the choice of which intervention would entail the best cost-effectiveness relation taking account of the limited financial resources;
- The approach for reinforcing the quality of healthcare is largely insufficient or inexistent at the first and second levels, excepting the reinforcement of the reference system;
- The absence of a clear approach for reinforcing the quality of services apart from that for reinforcing the reference system;
- Reinforcing the CSCOMs, in particular their renovation does not appear to constitute a priority although on the ground it can be observed that healthcare training is outmoded and under-equipped and does not offer staff a motivating work environment, which leads to a reduction in the quality of healthcare services;
- As regards the hospitals insufficient coordination of actions can be noted. This is probably related to the inadequacy due to an excessively high level of registrations for this task;
- The increase in healthcare cover has not been followed by a significant increase in the take-up of services.

ii) The availability, quality and management of human resources

- The absence of permanent structures for developing and managing human resources;
- The delay in drawing up and adopting a policy for developing human resources;
- Insufficient knowledge of available posts, staff numbers, qualifications and skills available due to the inadequacy of staff files
- The poor distribution of tasks among the various actors;
- The management of human resources is suffering from inadequacies in the formulation of the guidelines given to each operating unit and for team work
- Lack of qualified HR at various levels (especially CSCOM);
- The instability of qualified staff;
- Too many CSCOMs (over 30%) that do not have sufficiently skilled human resources or which lack equipment; the teams in place are highly unstable, which adversely affects the quality of the interface with the community;
- Healthcare staff are unmotivated due, among other reasons, to the very inadequate salaries in rural areas and/or enclaves (the bonuses for moving away, 5,000 FCFA, are completely inadequate), the lack of recompense and also an almost entirely non-existent HR management; there are no career plans; service providers are isolated; team work is very underdeveloped
- There is an overwhelming number of trainees in the healthcare establishments and a lack of quality control in the professional training;
- The majority of pupils in public and private training schools for technical staff are insufficiently trained;
- The inadequacy of resources for supervising training (MCS- PRODESS, 2005) ;

iii) the availability of essential medicines, vaccines and medical consumables.

- Inadequate application of the legislative and regulator texts;
- Inadequate application of the management procedures for the Main Scheme for supplying essential medicines (supply, stocks management, financial management, prescriptions of medicines by level);
- Inadequacy in monitoring activities relating to management and the prescription of medicines and the failure to apply recommendations from inspection and supervisory forces;
- The poor availability of MTAs included in the national list of essential medicines;
- The failure to respect the displayed price of essential medicines by certain CSCOMs;
- The low availability of the full range of contraceptive products in the health regions and districts;
- Inadequate allocation of material resources (equipment, infrastructure);
- Inadequate allocation and training of human resources;
- Inadequate supply to public and community structures;
- Frequent variation in the course of the year of prices of medicines at the level of the PPMs;
- The delay in payment by the Public Treasury in honouring its undertakings to the State-PPM contract plan;
- Inadequate ambulatory logistics at the level of the PPMs in order to ensure fresh supplies for the health regions and districts correctly;

- The low storage capacity of the PPM warehouses, particularly at regional level (warehouses for storage and distribution are in poor condition);
- Persistent inadequacy in the evaluation of needs for medicines (including ARVs) by staff in the health districts;
- The low level of the threshold set by the public markets (50 millions FCFA) leading to losses and profits and breakdowns in the supply of medicines;
- Inadequate cold chain shipping in certain CSCOMs, particularly the region of Kayes and Ségou;
- The lack of a system for supplying reagents organised at national and regional levels;
- The poor capacity for management of the ASACOs and some SD managers;
- Insufficient monitoring of activities associated with the management and prescription of medicines and the failure to follow recommendations from the inspection and supervisory bodies;
- Poor use of the results of research to improve services.

iv) Improving the quality of health services, increasing demand and fighting against disease

- The standards and strategies concerning healthcare quality, the rationality of prescriptions and prevention of infections are not always respected;
- The operation of the first-contact health services does not meet the criteria of a patient-centred approach: the delays for patients are lengthy (before consultation, between the lab and the treatment), the quality of reception is poor and correct and relevant information is rarely transmitted to patients, the management and improvement of the interface between the patient-communities and service providers is not perceived as a priority;
- Several CSCOMs have poor control of the population for which they are responsible and fail to include information on patients' geographical origin (inside or outside of the area) in their system;
- In the CSCOMs, curative and preventive healthcare measures are often separated and provided by different staff members, which does not encourage the integration and global nature of healthcare;
- Inadequate supervision of certain CSCOMs;
- Inadequate management of reagents for the HIV test (only one EPH regularly transmits re-stocking support);
- Vertical programmes are not sufficiently integrated. All too often, the daily functioning of health services is disturbed by the intervention of specific programmes such as intensive and repeated training and direct supervision, which short-circuit the social/health teams of the Cercles

v) Financial accessibility, support for demand and participation

- The delay in mobilising resources for implementing activities approved in the national Op is due to treasury problems and problems relating to the geographical location of certain Cercles (delay in receipt of credit by the delegations);
- The lack of synchronicity between the disbursement of funds and the time-frame for the implementation of sectoral activities;
- The difficulties in involving the representatives of the MEF's de-concentrated services in the budgetary planning for the PRODESS in certain regions (insufficient staff numbers in the DRB);
- Insufficient integration of the OPs in the municipalities' budget programme;
- The official non-transmission of the approved OPs for the de-concentrated services of the MEF (DRB, financial control, treasury);
- A high percentage of the population does not yet have access to health services (CSCOM, CSREF), particularly if account is taken of indirect costs (travel, etc.) in light of the country's poverty;
- The status of indigent is poorly defined and the funds for treating indigents operate poorly or are insufficient;
- Voluntary help is not motivating for the members of the ASACO office and management sometimes leaves something to be desired;
- Poor cover in terms of health insurance, particularly in the regions of Tombouctou and Kidal;
- Low funding and poor planning for activities promoting health insurance;
- Apart from the management aspects, the ASACOs and FELASCOM are not sufficiently included in their role of supporting the development of the health areas: an inter-sectoral approach, hygiene in the environment, etc. and are too backward-looking;
- Financial accessibility is critical: at the first level indirect costs are very high, in the reference structures, the prescription of patent medicines and long lists of medicines often make lack of access to treatment very onerous;
- Certain ASACOs fail to participate in their share of the reference organisation;
- The research applied to reinforce the health system and the improvement of the quality of healthcare serviced is not sufficiently supported by the universities and research institutions. The lack of capitalisation of the experiments carried out is glaring.
- The loss for the social-health actors of their role as the party truly in control of the SBS funds;
- The constraints of a ceilings for the departments of advances and justification;
- The delay in nominating managers at DRS level;
- The difficulties in monitoring certain indicators used in the specific arrangement in place;
- The low capacity of certain actors in the context of management of the SBS funds;

vi) the reform of the hospitals and other research establishments

- Inadequate criteria used in evaluating public hospitals and initiation of the system for State – public hospital contracting;
- The lack of a body to approve the Hospital Information System (HIS) statistical directories;
- The absence of approval of the integrated national director in particular SLIS and SIH by a body or workshop;
- The absence of a health research information system;
- The absence of hospital information software at regional level;
- Inadequate analysis and interpretation of data at all levels in the regions;
- The delay in the transmission of the data collected in particular for supplying the SLIS;
- Inadequate maintenance of electronic data in the regions;
- The delay in approving the national Health Research Strategy (PNRS).

vii) The reinforcement of institutional capacities and decentralisation

- Difficulties relating to monitoring and evaluation of the healthcare system;
- The delay in adopting the draft implementing acts for Decree 02-314;
- The delay in adopting the draft decrees available to the MS (revised decrees 02-314 and 01-115);
- The poor dissemination of laws and decrees relating to the transfer of powers and resources in the area of healthcare to the key players;
- The poor functioning of the steering committees at national level, in particular the inter-ministerial commission. The problems are institutional pen-pushing, the effective participation of statutory members and rigorous review of the decisions taken;
- The delay in restructuring the DNS and DPM and their dismantling at regional level;
- The delay in the conclusion/ regularisation of the mutual assistance agreements between the Municipalities and the ASACOs;
- The non-involvement of representatives of the CTs and MATCLs in the revision of the PRODESS II manual for procedures and management;
- The delay in compiling a list of material resources to be transferred to the CTs;
- The insufficient involvement of the TCs (in particular AMM and ACCR) in the conception and drafting of the large files by the two departments in charge of the PRODESS;
- The legal non-validity of the decision of certain regional authorities, in particular the Governor of the Region of Segou as regards the transfer of the CSCOMs to the TCs;
- The delay in the transfer of PRODESS's financial resources, in particular from the partners of the TCs;

- The failure to take the needs of the health and social services adequately into account in the PDSECs of the collectivities and cercles (in particular investments and salaries);
- Insifficient monitoring and control of management of the ASACOs;
- Slow progress in the process of deconcentrating the health services;
- Difficulties in planning, in identifying needs and in the complementarity of local resources (RF, RH);
- Slow progress in the handover of property and the problems of the issue of title to the propertyy in infrastructures and equipment and logistics transferred to the levels of the muncipalities and Cercles;
- The budgetary evaluation of financial resources needed for the exercise of the powers transferred in the area of health has not yet been completed at the level of the DAF;
- The inventory of human resources and definition of a special status for the healthcare professionals of the territorial collectivities have not yet been completed;
- The provision of officials (medical, paramedical and other staff) has not yet become effective;
- The various tools for implementing the transfer are still being designed by the unit;
- The poor level of education/ information of the collectivities and their collaborators regarding the procedures for planning and mobilising the PRODESS resources;
- The poor level of education/ information of the ASACO and healthcare staff regarding decentralisation;
- Low involvement of the private sector in vaccination activities;

3.3 Obstacles which are in the process of being overcome in a satisfactory manner using existing resources (see above, classed according to the 7 priority chapters/ areas of PRODESS)

The text boxes below contain the main actions undertaken in the course of PRODESS II in order to overcome the obstacles identified in section 3.2 in a satisfactory manner with existing resources.

Activities undertaken in order to overcome these obstacles

- Planning by using the database, needs for healthcare staff in the medium term and new staff to be trained and recruited by category.
- Redefining the criteria for allocating and transferring staff; designing a plan for the redeployment of staff and then proceeding to redeployment.
- Setting up a structure for the management of human resources development with regional removal of members.
- Applying Decree 02-314 PRM of 4 June 2002 in the area of the management of the HUPC funds (same decree also for deciding on the use of these funds for motivating staff and improving staff working conditions).
- Reviewing the organisational framework for producing an inventory of TA needs, recruitment of TAs, coordination and monitoring of TAs.
- Drawing up a multi-annual plan for the entire TA, both long and short term, by level and area, accompanied by a timeframe.
- Updating the demographic data on the basis of the national census which will be held in 2008 or on the basis of municipal censuses. Then adapt the HIS in order to calculate the various indicators.
- Organise the CSCOMs and as an advanced strategy the activities for monitoring the growth of children from 0 to 5 years and early screening for cases of malnutrition.
- Setting up and equipping nutritional recovery units
- Making available to health district managers a reference work on traditional Malian pharmacy and a database on medicinal plants among Mali's flora.
- Organising an emergency service for medicine, surgery etc. at the level of the CSREFs and the private clinics.
- Training 40% of district health managers in research action methodology.
- Listing the cases of obstetric fistulas for reference and referring them to hospitals that are qualified to treat them.
- Setting up an alternative health-funding mechanism for treating obstetric fistulas.
- Train ing(practical training) healthcare staff to carry out rapid diagnoses for cases of complications connected with excisions.
- Setting up an alternative health-funding mechanism for treating obstetric fistulas.
- Training (practical training) emergency obstetric care staff (SOU) to treat obstetric complications in establishments set up for this purpose.
- Equipping/ endowing the establishments offering SOU with equipment, financial medical resources and qualified HR
- Setting up 86 establishments offering SOU and 33 establishments offering SOUCs
- Training/ retraining staff from health establishments in correct and early diagnostics of obstetric complications
- Carrying out caesaerean sections for pregnant women needing them in establishments offering SOU.
- Setting up community networks connecting ATRs and traditional practitioners in good time to the competent establishment in complicated cases.
- Organising a system for referring or dealing with all emergencies that are fundamentally obstetric of paediatric throughout the health districts (organise reference for 37 new CSREFs and reinforce the 29 existing ones).
- Training staff from the health establishments in SRJA .
- Create a multi-functional centre for listening to and advising young people in each region.
- Holding CCC (communication for behaviour-modification) meetings targeting households in order to increase attendance of the maternity hospitals for prenatal consultations and assisted births.
- Holding CCC meetings to increase demand for FP.
- Training/ retraining at least 50% of staff in long-term methods (IUD, Norplant).
- Recruiting and training community networks for implementing DBC activities in the health areas.

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- Recruiting and training community networks for implementing DBC activities in the health areas.
- Training and retraining 60% of ATRs (retrained traditional midwives) in early detection of pregnancies at risk with a view to referring/ dealing with cases.
- Treating pregnant women who are HIV positive free-of-charge with subsidised ARV.
- Treating persons living with HIV free-of-charge with subsidised ARV.
- Screening voluntary applicants for tests for HIV at the screening centres.
- Training health-service providers to integrate concepts of gender and listening to patients in order to treat RH problems among men.
- Organising support upon request or spontaneously in the area of the fight against practices that harm the health of women and little girls.
- Appointing/ training staff to monitor the quality of drinking water.
- Constructing new, adequate incinerators in the CSREFs and private clinics and surgeries.
- Organising the transport of biomedical waste to incinerators located in the CSREFs and CSCOMs.
- Trainin staff in the hygiene, order and maintenance of premises and in collecting and incinerating biomedical waste in the CSREFs, CSCOMs and private clinics.
- Monitoring para-public, private and religious establishments on a quarterly basis.
- Organising periodic consultation meetings with a view to encouraging all users, locally elected persons and representatives of civil society to take part fully in implementing the healthcare programmes.
- Endowing health establishments on a permanent basis with medicines and reagents for diabetes, AHT, sickle-cell anaemia, epilepsy, etc.
- Supplying centres for listing to people and giving advice regarding contraceptive products
- Giving essential paediatric medicines by way of subsidies to children below the age of 5
- Giving subsidised condoms to persons at high-risk.
- Offering subsidised ARV to persons living with HIV.
- Providing stocks of medicines, equipment and financial resources in advance to the DRSs and CSREFs.
- Training 50% of healthcare staff to cooperate effectively with the key players in traditional medicine in order to deal with priority health problems.
- Listing traditional practitioners who are competent and recognised by the communities according to their area of activity.
- Training traditional practitioners at a local level to cooperate with conventional healthcare structures through meetings/ consultations for treating and referring ill persons.
- Organising periodically consultation meetings at a regional level in the context of promoting traditional medicine by involving prescribers, traditional practitioners, the territorial collectivities, the associations and the PTFs concerned.
- Providing systematic annual medical checkups for pupils of the primary schools and children who do not attend school.
- Organising monitoring of healthcare provided in the infirmaries of secondary schools.
- Organising monitoring of staff and the operation of infirmaries in prisons.
- Organising periodic consultation meetings with a view to encouraging users, locally elected persons, and the representatives of civil society to take part fully in the implementation of the health programmes.
- Devising health programmes in consultation with other departments and actors in the health programmes, involving different sectors.
- Training healthcare teams in dealing with gender issues.
- Training members of ASACOs in dealing with gender.
- Holding CCC meetings for promoting breast-feeding exclusively over the first six months following birth for newborn infants.
- Carrying out surveys on the use of MIIs by infants of 0 to 5 years and pregnant women;
- Organising three-monthly distribution weeks and weekly distribution of VIT A for children from 0 to 5 years and fully programme the integration of this activity in the PMA.
- Introducing VIT A in HUICOMA oil in the factories.
- Holding CCC meetings for households to encourage greater use of iodised salt.
- Holding CCC meetings for households for greater use of improved latrines;
- Monitoring households in order to promote essential family practices.
- Treating people affected by onchocersose, lymphatic filiarisis, etc. in coordination with the communities.

- Treating people affected by onchocersose, lymphatic filiarisis, etc. in coordination with the communities.
- Devising and apply an Integrated Communication Plan (PIC) in favour of the priority health programmes.
- Holding CCC meetings targeting at least 60% of households on the use of condoms (persons aged 15 to 49 years).
- Drawing up a list of medical biology analyses that can be undertaken according to service and skill levels and acquire the necessary reagents for analyses.
- Developing support for the planning, organisation and control of the acquisitions of medicines, vaccines and consumables by level
- Constructing or renovating PPM warehouses and regional depots as well as depots of the Cercles and CSCOMs (according to their needs) to adapt them to the conditions of "good practices" in stocking products.
- Ensuring the adequate supply of reagents for laboratories in the health districts' reference health centres.
- Recruiting biology technicians for analyses of medical biology in the reference health centres.
- Retraining managers of regional depots, CSREFs and CSCOMs in the area of planning, organisation and monitoring of the supplies of essential medicines and consumables.
- Reinforcing the management of the distribution depots for the Cercles: adopting the texts for the creation and operation of the DRCs including the affiliation of the CSCOMs, determining the criteria and modes of recruitment for managers, include in mutual assistance agreements how cases of faulty management of the depots (lack of transparency, embezzlement, misappropriation of goods) should be managed).
- Introducing a mechanism for encouraging private pharmacists to set up in the health districts where there are none. For example: negotiate advantages such as tax relief where they set up in difficult areas.
- Regulating and ensuring management of allocations in order to ensure centralisation and redistribution to the benefit of users of public health establishments.
- Ensuring monitoring of the authorisation to market, authorisations to operate import businesses, wholesale sales and sales to pharmacies.
- Putting in place a quality control policy for medicines produced in Mali and imported medicines.
- Determining the range of medical-biology analyses that is feasible for each level.
- Planning and organising (procedures) for confiscating and destroying expired medicines;
- Training/ retraining staff in the CSCOMs in rational prescribing.
- Encouraging the medical managers of the CSREFs and public hospitals to draw up therapeutic protocols that privilege the prescription of essential medicines in a generic form and to organise medical audits.
- Soliciting and involving the State's technical services in drawing up and implementing the territorial collectivities' plans.
- Implementing guidelines on the application of decree 02-314 (including the definition of the legal status of community heT0 0 0 r3ie.04 0 0 16 6246.nf-214(s)1(c)1uteses.

- Supporting organisations for women and young people and the poorest groups in their development projects at institutional level.
- Making associations aware of the use of tools for educating elected persons, women and members of ASACO about PRODESS and decentralisation.
- Promoting the set up of community networks for promoting health on the basis of cover plans.
- Devising and implementing integrated communication plans for behaviour modification.
- Promoting community approaches.
- Developing social mobilisation actions in the regions.
- Involving specific groups in the management committees for the health centres (PVVIH, young people, handicapped persons, etc.).
- Establishing the link between the ASACOs, the targeted territorial collectivities and the community networks for preventative and promotional activities at the level of households and villages.
- Promoting the use of medical assistance funds, mutual benefit insurance, obligatory health insurance, funds for referring/ dealing with cases and forms of traditional cooperation.
- Promoting the use of medical assistance funds, mutual benefit insurance, obligatory health insurance, funds for referring/ dealing with cases and forms of traditional cooperation.
- Harmonising the texts (framework law on health, Decree 02-314, 01-115 and the mutual assistance agreement).
- Ensuring the application of Law 98-036 governing the fight against epidemics and obligatory vaccination against certain diseases.
- Ensuring the application of guidelines for quality medical treatment for HIV/ AIDS and synergistic activities.
- Drawing up a national policy for the medical and nutritional treatment of PVVIH.
- Accelerating the promulgation of texts applying Law 02-044 in relation to RH (particular case of mothers infected with HIV) and Law 98-036 on the fight against epidemics.
- Revising the supervision guide by integrating the diseases to be eradicated.

3.4 Obstacles which are not in the process of being overcome in a satisfactory manner and which require support from GAVI for HSR

The text-boxes below contain the main obstacles identified in section 3.2 above which are not in the process of being treated in a satisfactory manner and which require support from GAVI for HRS

- Inadequacy of HR qualified at various levels (especially CSCOM).
- The instability of qualified staff.
- Healthcare staff are unmotivated, among other reasons, because the salaries are very inadequate particularly in rural and/or inaccessible areas (the bonus for moving of 5,000 FCFA is completely inadequate), the lack of recompense and also an almost non-existent management of human resources: there is no career plan. Service providers are isolated: working in teams is very underdeveloped.
- Too many CSCOMs (over 30%) do not have sufficiently skilled human resources or lack equipment. The teams in place are highly unstable, which has an adverse effect on the quality of the interface with the community.
- Most pupils at public and private schools for training technical staff are inadequately trained
- Insufficient resources for supervising traineeships.
- An overwhelming number of trainees in health establishments
- The non-involvement of the MH in signing diplomas for the private schools.
- The operation of the first-contact health services does not meet the criteria of a patient-centred approach: the delays for patients are lengthy (before consultation, between the lab and treatment), the quality of reception is not good and correct, relevant information is rarely transmitted to patients, the management and improvement of the interface between patients-communities and service-providers is not perceived as a priority.
- The operational files used and the repor.52 518.599 Tm[f63.6 632 632 63lysreg iiteite fotmee ne nnt alitl coatioue

- The 2nd and 3rd level reference hospitals are autonomous in their management but do not meet the needs of the system (looking for benefits takes priority over improving the reference function) and are poorly integrated into the health policies. However, the non-state system (private and religious) is also used by the poorest people and is not sufficiently taken into account by the public sector.
- The low dissemination of laws and decrees relating to the transfer of powers and resources in the area of health to the key players.
- The non-involvement of the CTS and the MATCL in revising the PRODESS II manual for procedures and management.
- The delay in producing an inventory of material resources to be transferred to the CTs.
- The insufficient involvement of the CTs (in particular AMM and ACCR) in the conception and drawing up of the large files of the two departments in charge of PRODESS.
- The poor integration of the needs of health and social services in the PDSECs of the common collectivities and Cercles (in particular investments and salaries).
- Inadequate monitoring and control of the management of the ASACOs.
- Difficulties in planning, identifying needs and the complementarity of local resources (RF, RH).
- The poor level of training/ information of the collectivities and their collaborators regarding the procedures for planning and mobilising the PRODESS resources.
- The poor level of training/ information of the ASACOs and healthcare staff regarding decentralisation.
- Low involvement of the private sector in vaccination activities.
- Insufficient operational health research in order to capitalise on innovative experiments in the health system.
- Inadequate monitoring/ evaluation of health activities, particularly at the peripheral level (CSCOM.CSREF).
- Inadequate monitoring of activities relating to the management and prescription of medicines and the failure to follow recommendations from inspection and supervision teams;

Part 4: Goals and objectives of support from GAVI for RSS

F.A.O. any party submitting a proposal

- *Please describe below the goals of support from GAVI for HSR (Table 4.1)*
- *Please describe (and number) the objectives of support from GAVI for HSR (table 4.2). Please ensure that the objectives chosen are strategic, measurable, feasible, realistic and limited in duration.*

4.1 Goal of support from GAVI for HSR

Helping to improve the people's health and social conditions in order to allow them to participate more effectively in the country's economic and social development. This contribution aims at providing a better response to the Malian people's health needs, in particular those of children and mothers, including continuous immunisation.
This goal which is that of support from GAVI is the main goal of the Ten-Year Health and Social Development Plan and of its two five-year phases including PRODESS II, which was approved by the PTFs involved in the country's health development and the PRODESS steering committee. In order to achieve this goal, support from GAVI for HSR is requested to contribute by taking charge of some of the PRODESS activities.

4.2 Objectiives of support from GAVI for HSR

The objectives of support from GAVI for reinforcing Mali's health system refer to the priority strategies of the country's Department of Health.
The proposal targets the CSCOMs and the CSRefs, particularly those in zones of poverty, extreme poverty and difficult geographical accessibility, in implementing the activities. The selection criteria for the district CSCOM and CSREF are:

i) a rate of vaccine cover that is lower than 75 % (taking all antigens together/ in combination)
ii) the proportion of the target population/ population served: over 75,000 inhabitants in general in the health districts affected.

iii) The difficulties associated with the geographical accessibility of services (certain districts that have a population of less than 75,000 have been included in the proposal because of their geographical isolation and their accessibility problem).

iv) The poor performance of district health services (take-up of services, qualifications of the district framework team, availability of resources, etc.)

Objective 1 aims at improving the availability of qualified human resources in the health services and emphasises the peripheral services. The chief activities defined for this objective are:

- Reinforcing the system for motivating staff to work in disadvantaged areas by subsidising financial bonuses as incentives to technicians.
- Reinforcing the HR information subsystem on all members.

Objective 2 aims at improving the quality of health services. The activities associated with this objective are:

- Forming framework teams for the districts in terms of management, leadership and in accordance with the requirements for implementing the programme.
- Providing integrated, quarterly supervision for staff at the CSCOMs including monitoring rational prescriptions and the costs of prescriptions
- Carrying out quarterly checks on community networks
- Checking rational prescriptions and prescription costs in the course of internal medical audits.
- Increasing the medicalisation of first-contact health services.
- Devising and disseminating tools to assist rational prescription and taking control of malnutrition
- Introducing an accreditation system for districts that perform well in particular by applying a patient-centred approach.
- Recruiting a Technical Assistant for each region in Poverty Zone 1 to take charge of the districts with the poorest performance.

Objective 3 aims at reinforcing institutional capacities and decentralisation. The main activities associated with achieving this objective are:

- Developing the Public-Private partnership at the level of the districts by drawing up performance contracts for the entire minimum activities package (MAP) and information exchange (at the level of the reference health centres (CSREF).
- Reinforcing the process for drawing up an OP at district level (5 days: participation by one person from the DRS, 1 from FELASCOM, 1 from TC, 1 from the NGOs and the Prefect).
- Reinforcing FELASCOM's skills in order to support the ASACOs.
- Reinforcing the Ministry's capacity to intervene at central level in order to support the health system.
- Revising the NHIS with a view to integrating data from all the areas and players, including hospital data and data from the private sector and certain poverty-related indicators concerning nutrition

Objective 4 aims at reinforcing the system for monitoring and evaluation, emphasising the peripheral services in particular. The main activities defined for that objective are:

- Reinforcing the monitoring/ control system at the level of each health area.
- Improving the quality of integrated supervision (guide, set-up and regular monitoring of CSCOM/CSREF. supervision).

Objective 5 aims at reinforcing operational research. Reinforcing operational research will make it possible to capitalise on innovative experiments In the health system. The activities associated with achieving this objective are:

- Assessing the effect of motivation on technical staff in disadvantaged areas.
- .
- Assessing the effect of accreditation on districts that are performing well in particular by taking a patient-centred approach.
- Assessing the effect of mutual aid agreements between the communities and the ASACO regarding the performance of the CSCOM.
- Assessing the effect of performance contracts through the Private-Public partnership.
- Assessing the effect of intervention from the DRS on the improvement of district health services in general and in particular the integrated supervision section.
- Evaluating the local consultation framework with a view to reinforcing them

Part 5: GAVI support activities for HSR and time-frame for implementation

F.A.O. any party submitting a proposal

For each objective identified in table 4.2, please describe in detail the main activities which will be undertaken in order to achieve the objective mentioned and the time-frame for each of these activities for the duration of support from GAVI for HSR (table 5.2 on the following page)

Note: GAVI recommends that support from GAVI for HSR should only address a limited number of objectives and activities with a high degree of priority. It must be possible for activities to be implemented, monitored and evaluated over the entire duration of support from GAVI for HSR.

*Note: Pleas*e add (or delete) lines so that table 5.2 contains the exact number of objectives corresponding to your *proposal with a view to support from GAVI for HSR and the exact number of activities for each of your essential objectives.*

Note: Please add (or delete) years so that table 5.2 corresponds to the duration of your proposal for *support from GAVI for HSR, the exact number of objectives corresponding to your proposal with a view to support from GAVI for HSR and the exact number of activiites for for each of your essential objectives.*

F.A.O. any party submitting a proposal

- *Please indicate how you intend to maintain the results obtained from support from GAVI for HRS* (5.1) at a technical or financial level once the resources from GAVI's supprt for HSR are no longer *available*

5.1 Continuous support from GAVI

As an integral part of PRODESS, this proposal will be monitored and evaluated by the management bodies of the sectoral health programme which involves all the players (State, PTFs, NGOs, Territorial Collectivities, Associations).
In order to encourage participation by the PTFs and the government in GAVI's support activities in the HSR and to maintain their interest, they will be regularly informed about the results of these activities through joint meetings and regular correspondence (by email or post). We believe that this strategy will encourage the PTFs and the government to remain financially and technically involved after GAVI, particularly if they see that good results are achieved and that the activities are well managed and the time-frames adhered to.

Support from the participation/involvement of the decentralised territorial collectivities, NGOs and associations in carrying out the activities is an important strategy for continuing support from GAVI. These organisations will be a potential source of funding and technical support once financing from GAVI for HSR is no longer available.

Budgetary support whether global or sectoral guarantees the participation of the State and certain important partners in the implementation of the sectoral programme. With the present support from GAVI, efficient HSR strategies will have been implemented and will therefore be financed by this BS

As the cost recovery system is associated with take-up of the services, and thus with the quality of services, improving the health system aims at improving quality and will lead to an increase in the amount recovered. The operational research proposed should document that.

	Prefect).														
Activity 3.3	Reinforcing FELASCOM's skills in order to support the ASACOs.														
Activity 3.4	Reinforcing the Ministry's capacity to intervene at central level in order to support the health system.	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Objective 4	Reinforcing and institutionalising a system for monitoring and evaluation														
Activity 4.1	Reinforcing the monitoring/ control system at the level of each health area.	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Activity 4.2	Improving the quality of integrated supervision (guide, set-up and regular monitoring of CSCOM/CSREF supervision).		x	x	x	x	x	x	x	x	x	x	x	x	x
Objective 5	Reinforcing operational research														
Activity 5.1	Assessing the effect of motivation on technical staff in disadvantaged areas.	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Activity 5.2	Assessing the effect of accreditation on districts that are performing well in particular by taking a patient-centred approach.	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Activity 5.3	Assessing the effect of mutual aid agreements between the communities and the ASACO regarding the performance of the CSCOM.														
Activity 5.4	Assessing the effect of performance contracts through the Private-Public partnership.	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Activity 5.5	Assessing the effect of intervention from the DRS on the improvement of district health services in general and in particular the integrated supervision section.	x	x				x	x				x	x		
Activity 5.6	Evaluating the local consultation frameworks with a view to reinforcing them	x	x	x	x	x	x	x	x	x	x	x	x	x	x

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** The tables relating to the main activities, their time-frame for implementation and the bodies responsible for implementation are set out in Appendix 1*

*** Abbreviation for the quarterly period*

Mali has resolutely committed itself to a decentralisation process. It is concerned to reinforce the country's health system and this will has been expressed in the health and social sector by the transfer to the "common" collectivity of the responsibility for health administration. Today the country has several assets including, among others: the authorities' awareness of the need to harmonise practices, to reinforce the capacities of local frameworks through their participation in a number of workshops, the determination to help the players by providing a guide on contracting and very recently the determination to draw up a national policy on contracting.

This is a question not only of strengthening the MH's capacity for intervention through its central and regional instances but also those of the TCs to which the Ministry of Health has transferred part of its technical and financial powers (cf. Decree 02-314), to manage health problems at a peripheral level effectively. This will considerably help the health services concerned to accomplish efficiently their tasks and role redefined in the implementation of PRODESS. Thus, for example, the Mayor is the head of the health administration in his district. That is the framework within which the objectives for support from GAVI for HSR will be achieved.

All of Mali's health and social policy documents emphasise the need to involve private players in implementing the various projects, programmes and plans relating to them. This involvement cannot be achieved informally and in isolated cases. The parties, in particular the State, civil society, the territorial collectivities and the profit-making private sector need to enter into contractual

relations. The multiplicity of the actors and the objects to which contractual relations could relate calls for a contracting policy as a regulatory framework for contracts in this area. The contracting policy is the pretext for recalling the obligations of public service owed by private persons who are associated with the State.

The non-profit-making health centres other than the CSCOM contribute de facto to the public service mission. The Ministers in charge of Health and Social Development ensure that relations with this category of service providers evolves towards a form of contracting whose spirit is that of association with the public service mission.

Among the innovative strategies for achieving this objective, we may mention among others the improvement of the capacities for steering and providing directions for the system: I) controlling the health system, ii) improving the structure of the health information system, the major surveys (in particular the World Health Survey) and the planning process; iii) improving the efficiency of the collaboration between the Ministry of Health and its partners; iv) coordinating and evaluating PRODESS by involving other actors; v) monitoring and profiting from the work of liasing between the different partners and other departments (youth, education, promotion of women, children and the family, social development, the environment, etc.); vi) coordinating and monitoring the implementation of the CSLP's health-population chapter through a coordination and inspection unit in coordination with the CSLP's national coordination unit; vii) improving collaboration with civil society through contracting with NGOs; viii) promoting the accountability of health establishments, both to the authorities and to the people; ix) studying the possibility of promoting consumer protection in relation to healthcare through community organisations such as the ASACOs or consumer protection organisations; x) set up a mediation/ arbitration structure for resolving conflictual situations between the ASACOs, the people, health workers and the health authorities.

Part 6: Monitoring, evaluation and operational research

F.AO. any party submitting a proposal

- *All proposals must include these three indicators of incidence/ main results of support from GAVI for HSR*

i) National cover by the DTC3 (%)
ii) The number/% of districts achieving a rate of cover by DTC3 (4) that is greater than or equal to 80%
iii) The mortality rate for children under the age of five years (per 1,000)

- *Please also provide a maximum of three indicators of incidence/ results that could be used to evaluate the effects of support from GAVI for HSR on the improvement of the vaccination services and other health services for mothers and children.*

Note: We would strongly encourage you to choose indicators associated with some of the objectives of the proposal and not necessarily with activities

- *For all the indicators, please give the source of the data, the value and the date serving as a reference basis for the indicator and a target level and a date. Some of the indicators may have more than one data source (table 6.1).*

Note: The indicators chosen must be drawn from those used for monitoring the national health sector plan (or its equivalent) and in principle will already have been measured (i.e. it will not cost any extra to measure them). They need not necessarily come under the heading of support from GAVI for HSR. Examples of extra indicators of incidence and results are given in the tables below. If activities are implemented particularly at an infra-national level, it is also recommended that they be monitored at an infra-national level as far as possible.

Example of indicators of incidence

- Maternal mortality rates

Example of indicators of results

- National cover for measles vaccine
- Proportion of districts whose cover is greater than or equal to 80%
- Cover for Hib
- Cover for HepB, cover for BCG
- Drop-out rate for DTC1-DTC3
- Proportions of births assisted by qualified health workers
- Take up of prenatal care
- Levels of vitamin A supplementation

(4) If the number of districts is provided, then the total number of districts in the country must also be given.

Intervention	Possible indicators
Vaccination	National cover by vaccination against measles; proportion of districts with cover greater than or equal to 80% ; cover by BCG; cover by le Polio 3; cover by Hib; cover by HepB vaccination
Maternity protection	Take-up of prenatal care; qualified assistance of births; at least two doses of Tetanic Toxoide; rates of caesarean sections; postnatal care
Family planning	Use of contraceptives by women
Appropriate care for ill children	Rehydration orally and continued nourishment of children suffering from diarrhoea; demand for healthcare for pneumonia; antibiotic treatment for pneumonia
Nutrition	Rate of breastfeeding (starting from first day, exclusive between 0 and 3 months; dietary diversification between 6 and 9 months; rate of vitamin A supplementation for children from 6 to 59 months (over the last 6 months) and mothers up to 8 weeks after giving birth.
Water/hygiene	Access to a source of drinking water; satisfactory sanitary installations
Tuberculosis	Cover by DOTS, treatment directly observed, short period (rates of success of treatment, screening rates)
Malaria	Children suffering from fever receive anti-malaria treatment

Examples of activity indicator

Indicator	Numerator	Denominator	Data source
Systematic supervision	Number of heath centres which were visited at least six times in the course of the last year, where during the visits a quantified check list was used	Total number of centres without	Inventory of health establishments
Health workers' knowledge	Average grade obtained by health workers in the public health centres or those managed by NGOs in an oral examination of knowledge including examples of concrete cases		Inventory of health establishments
Index of availability of medicines	Average number of ten types of essential medicines in stock at the health centres included in the sample		SIGS & Inventory of health establishments

6.1 Indicators of incidence and results

Indicator	Data source	Reference base value (5)	Source (6)	Date of reference base	Objective	Long stop date
1a. National cover by le DTC3 (%)	SLIS; annual SI report	68%	EDSM IV	2006	90%	2011
1b. National cover by DTC3 (%)	SLIS; annual SI report	63% (valid doses according to cards and histories) 65 % (valid doses confirmed by cards only 80% (antigens according to cards and histories)	External revue of EVP	2006	90%	2011
2. Number/% of districts achieving cover by DTC3 greater than or equal to 80%	SLIS; annual SI report	69%	SLIS, Evaluation of districts (WHO)	206	80%	2011
3. Mortality rate of children under five years (per 1,000)	EDSM-IV	191‰	EDSM IV	2006	2/3 (MDG 2015 Objective)	2011
4. Infant mortality rates (per 1,000)	EDSM IV	96 ‰	EDSM IV	2006		2011

(5) If databases are not available, please indicate whether you intend to gather this data and when this will be completed.
(6) This information is important for facilitating access to data and checking conformity.

		Indicator	Numerator	Denominator	Data source	Value of reference base (5)	Source	Date of reference base	Objective	Longstop date
Activite2.3	Carrying out integrated, three-monthly supervision of CSCOM staff including monitoring rational prescriptions and prescription costs.	Percentage of integrated supervisions of CSCOM carried out each year by the Districts' framework teams	Number of integrated supervisions of the CSCOMs carried out each year by the districts' framework teams ; Number of integrated supervisions of the networks carried out each year by the CPMs	Number of integrated supervisions of networks scheduled per year by the CSCOM; Number of integrated supervisions scheduled by the networks each year	SLIS survey	PM	DRS	2007	100%	2011
Activity 2.4	Checking rational prescriptions and prescription costs in the course of internal medical audits.	Average number of medicines per prescription; average prescription cost	Number of prescriptions with one or more medicines in a sample considered; the total cost of prescription selected in a sample	Total number of sample of prescriptions; total number of prescriptions selected	Supervision reports SLIS survey					2011
Activity 2.5	Devising and disseminating tools for assisting rational prescription; specific supervision	Percentage of tools devised and disseminated	Number of tools devised and disseminated	Scheduled number of tools	Activity reports	0		2008	100%	2011
Activity 2.6	Subsidising a system for encouraging and honouring performance by the departments and workers	Percentage of technical staff who may qualify for performance-related incentives at the levels of the CSCOMs, CSREFs and regional public hospitals	Number of technical healthcare staff contracted	Number of health workers planned for the contract	Activity reports	0		ND	100%	2011
Activity 2.7	Introducing an accreditation system for districts that perform well in particular by applying a patient-centred approach.	Percentage of accredited districts	Number of accredited districts	Scheduled number of districts	Activity reports	0		2008	80%	2011
Activity 2.8	Devising and adopting a TA (pooling) policy. GAVI will provide support in the form of a recruitment fund	Percentage of TAs recruited	Number of TAs recruited	Scheduled number of TAs	Recruitment contracts	0		2008	100 %	2011
Activity 2.9	Increasing the medicalisation of first-contact health services.	Percentage of CSCOMs run by a doctor	Number of CSCOMs run by a doctor	Total number of CSCOMs	DNS activity reports	12 %	DNS activity report	2007	50 %	2011

		Indicator	Numerator	Denominator	Data source	Value of reference base (5)	Source	Date of reference base	Objective	Longstop date
Objective 3	Reinforcing institutional capacities and decentralisation									
Activity 3.1	Developing the Public-Private partnership at district level by drawing up performance contracts for the entire minimum activities package (MAP) and information exchange (at the level of the reference CSREFs).	Percentage of contracts drawn up and implemented at district level	Number of private structures with performance contracts at district level	Total number of private structures at district level	Medical Association	0%	CSREF	Dec.2007	50%	2011
Activity 3.2	Reinforcing the process for drawing up an OP at district level (5 days: participation by one person from the DRS, 1 from FELASCOM, 1 from TC, 1 from the NGOs and the Prefect).	Percentage of districts that have benefited from reinforcement for planning	Number of districts that have benefited from reinforcement for planning	Total number of districts	Regional Health Departments	0% (3)	DNS	Dec.2007	1000%	2011
Activity 3.3	Reinforcing FELASCOM's skills	Percentage of FELASCOMs that have benefited from having their skills reinforced	Number of FELASCOMs that have benefited from having their skills reinforced	Total number of FELASCOM	FELASCOM	15 out of 56 i.e. 27%	FELASCOM	DEc.2007	100%	2011
Activity 3.4	Reinforcing the Ministry's capacity to intervene at central level in order to support the health system.	Percentage of technical staff trained in planning/ management and monitoring/ evaluation of public health and made available to the CPS	Number of trained technical staff	Scheduled number of trained technical staff	CPS	0	CPS/MS, DNRH/MS, DAF/MS	2008	100%	2011

* Technical assistant
(1) The CSCOMs are private non-profit-making structures
(2) Performance contracts have been implemented by certain structures with the support of GAVI, Unicef and USAID (ATN, PKC)
(3) The regions do not participate in planning down to district level district.

Indicator	Numerator	Denominator	Data source	Value of reference base (5)	Source	Date of reference base

		Indicator	Numerator	Denominator	Data source	Value of reference base (5)	Source	Date of reference base	Objective	Longstop date
Activity 4.2	Improving the quality of integrated supervision (guide, set-up and regular monitoring of CSCOM/CSREF. supervision).	Satisfaction level (of supervisors, those supervised and users of the CSComs/CSRéfs)	Number of supervisors, those supervised and users of CSComs and CSRéfs who were satisfied with the health services	Total number of supervisors, those supervised and the total population in the health areas of the CSComs and CSRéfs	Supervision reports and survey	ND	Supervision report and survey	ND	80%	2011
Objective 5	**Reinforcing operational research**									2011
Activity 5.1	Assessing the effect of motivation on technical staff in disadvantaged areas.	Rate of take-up of services in disadvantaged areas	New consultations	Target population	SLIS	ND	SLIS	ND	100%	2011
Activity 5.2	Assessing the effect of accreditation on districts that are performing well in particular by taking a patient-centred approach.	Percentage of accredited districts	Number of accredited districts	Total number of districts concerned	Report on implementation, SLIS	ND	- Report on implementation, - SLIS	ND	100%	2011
Activity 5.3	Assessing the effect of mutual aid agreements between the communities and the ASACO regarding the performance of the CSCOM.	Percentage of CSCOM performing well	Number of CSCOM performing well	Total number of CSCOM	- Report on implementation, - SLIS	ND	- Report on implementation, - SLIS	ND	100%	2011
Activity 5.4	Assessing the effect of performance contracts through the Private-Public partnership.	Percentage of performance contracts for private structures	Number of private structures performing well	Total number of private structures	- Report on implementation, - SLIS - IS, Associations of Health Workers	ND	- Report on implementation, - SLIS IS, Associations of Health Workers	ND	100%	2011
Activity 5.5	Assessing the effect of intervention from the DRS on the improvement of district health services in general and in particular the integrated supervision section.	Percentage of districts performing well	Number of districts performing well	Total number of districts in the region	- Report on implementation, - SLIS	ND	Rapport de la mise en œuvre, SLIS	ND	100%	2011
Activity 5.6	Evaluating the local consultation frameworks with a view to reinforcing them	Percentage of quality plans (integrated)	Number of quality plans (integrated)	Total number of district plans	Report on implementation, - SLIS	ND	Rapport de la mise en œuvre, SLIS	ND	100%	2011

F.A.O. any party submitting a proposal

Please present the way you have gathered, analysed and used the data. As far as possible, existing methods for collecting and analysing data should be used. In the last column please indicate the way in which all data are used at a local level and communicated to the other participants (Table 6.3)

6.3 Collecting, analysing and using data

Data will be available directly through the National Health Department (DNS), the National Human Resources Department(DNRH), the PTFs and the NGOs, in more precise form from the GAVI team for HSR wherever they are collected (CSCOMs, CSREsF, regions, immunisation departments, health statistics departments and the Malian Demographic and Health Survey. The table below shows the indicators, productive departments/ organisations, the information-collecting method(s) used, the types of analysis that are useful and the purposes for which the data will be used. The data collected shall be used for:

i) real objectives: satisfy the demands of GAVI Alliance increase monitoring of intervention;

ii) official objectives: help to plan and devise intervention: strategic objective of front-end analyses); provide information for improving, modifying or generally managing intervention (informational objective); determine the effects of intervention (accountability objective); Contributing to advancing knowledge(fundamental objective).

Service/Organisation	Indicator	Data collection	Data analysis	Data use
	Incidence and results			
DNS / DRS /CSREF/CSCOM (GAVI HSR team)	1. National cover for DTC3 (%)	- Use of official documents (SIS routine documents, EVP external review, etc.) - Observation (systematic, interview-related, free, participatory) - Information provided by subjects (free with key informant; directed, semi-structured or questionnaire-assisted))	- Qualitative analysis (preparation and description of rough material; reduction of data, choice and application of modes of analysis, horizontal analysis) - Quantitative analysis (descriptive, analysis connected with hypotheses)	Official objectives: - strategic goals ("Front-end analyses") ; - informational goal ; - accountability goal; - fundamental goal Real objectives - Increase monitoring of intervention -Satisfy requirements of subsidising organisations
DNS / DRS /CSREF/CSCOM (GAVI HSR team)	2. Number/ percentage of districts achieving a rate of cover for DTC3 that is greater than or equal to 80%	- Use of official documents (SIS routine documents, EVP external review, etc.) - Information provided by subjects (free with key informant; directed, semi-structured or questionnaire-assisted))	- Quantitative analysis (descriptive, analysis connected with hypotheses)	IDEM
DNS/DRS/ health district	3. rate of mortality of children below five years (per 100)	- Use of official documents (SIS routine documents, EVP external review, etc.) - Information provided by subjects (free with key informant; directed, semi-structured or questionnaire-assisted))	- Quantitative analysis (descriptive, analysis connected with hypotheses)	IDEM
	Activity			
DNRH, DRS, CSREF	1.Percentage of technicians benefiting from bonus who work in disadvantaged areas	- Use of official documents (SIS routine documents)	- Quantitative analysis (descriptive, analysis connected with hypotheses)	IDEM
DNRH, DAF, DNS	1.2 Rate of cover of staffing needs by category and by specialisation at all levels	- Use of official documents (SIS routine documents)	- Quantitative analysis (descriptive, analysis connected with hypotheses)	IDEM

DNRH, DRS, DNS, NGOs	1.3 Percentage of healthcare staff trained in HR management	- Use of official documents (SIS routine documents)	- Quantitative analysis (descriptive, analysis connected with hypotheses)	IDEM
DNRH, DRS, DNS	2.1 Percentage of framework teams trained in management and according to the requirements for implementing the programme	- Use of official documents (SIS routine documents)	- Quantitative analysis (descriptive, analysis connected with hypotheses)	IDEM
DRS, DNS, DNRH	2.2 Percentage of framework teams trained in management and leadership	- Use of official documents (SIS routine documents)	- Quantitative analysis (descriptive, analysis connected with hypotheses)	IDEM
District sanitaire, ONG	2.3 Percentage of integrated supervisions of CSCOMs carried out each year by the districts' framework teams	- Use of official documents (SIS routine documents)	- Quantitative analysis (descriptive, analysis connected with hypotheses)	IDEM
DPM, DNS	2.4a Average number of medicines per prescription 2.4b average prescription cost	- Use of official documents (SIS routine documents)	- Quantitative analysis (descriptive, analysis connected with hypotheses)	IDEM
CPS, DNS, DAF, DNRH	2.5 Percentage of tools devised and disseminated	- Use of official documents (SIS routine documents)	- Quantitative analysis (descriptive, analysis connected with hypotheses)	IDEM
DNRH, DAF, DNS, ONG	2.6 Percentage de technical staff who may qualify for performance-related incentives at the levels of the CSCOMs, CSREFs and regional public hospitals	- Use of official documents (SIS routine documents)	- Quantitative analysis (descriptive, analysis connected with hypotheses)	IDEM
CADD, FELASCOM, NGO DPM, DNM	2.7 Percentage of accredited districts	- Use of official documents (SIS routine documents) - Use of official documents (SIS routine documents)	- Quantitative analysis (descriptive, analysis connected with hypotheses)	IDEM

			hypotheses)	
Municipality, FELASCOM, CADD, DNS, NGO	2.10 Percentage of CSCOMs run by a doctor	- Use of official documents (SIS routine documents)	- Quantitative analysis (descriptive, analysis connected with hypotheses)	IDEM
Municipality, FELASCOM, NGO	3.1 Application rate of CAM signature	- Use of official documents (SIS routine documents)	- Quantitative analysis (descriptive, analysis connected with hypotheses)	IDEM
Health district, NGO	3.2 Percentage of contracts issued and implemented at CSCOM level	- Use of official documents (SIS routine documents)	- Quantitative analysis (descriptive, analysis connected with hypotheses)	IDEM
DRS/DRDS et CSREF	3.3 Percentage of contracts drawn up and implemented at district level	- Use of official documents (SIS routine documents)	- Quantitative analysis (descriptive, analysis connected with hypotheses)	IDEM
CSREF/ DRS/DRDS ES	3.4 Percentage of districts that have benefited from reinforcement of planning	- Use of official documents (SIS routine documents)	- Quantitative analysis (descriptive, analysis connected with hypotheses)	IDEM
Town hall/ASACO, NGO	3.5 Percentage of municipalities with integrated ASACO micro-plans	- Use of official documents (SIS routine documents)	- Quantitative analysis (descriptive, analysis connected with hypotheses)	IDEM
Town hall/FELASCOM, NGO	3.6 Percentage of FELASCOMs that have benefited from having their skills reinforced	- Use of official documents (SIS routine documents)	- Quantitative analysis (descriptive, analysis connected with hypotheses)	IDEM
CSREF, Town hall/FELASCOM, NGO	4.1 Percentage of monitoring undertaken at the level of each health area	- Use of official documents (SIS routine documents)	- Quantitative analysis (descriptive, analysis connected with hypotheses)	IDEM
CSREF, NGO	4.2 satisfaction level (of supervisors, those supervised and users of CSCOM/CSRéf)	- Use of official documents (SIS routine documents)	Quantitative analysis (descriptive, analysis connected with hypotheses)	IDEM
DRS, DNS	5.1Level of take-up of services in	- Use of official documents (SIS routine documents)	Quantitative analysis	IDEM

	disadvantaged areas		(descriptive, analysis connected with hypotheses) (	
CADD, FENASCOM	5.2 Percentage of accredited districts	- Use of official documents (SIS routine documents)	Quantitative analysis (descriptive, analysis connected with hypotheses)	IDEM
CSREF, NGO, DRS	5.3 Percentage of high-performance CSCOMs	- Use of official documents (SIS routine documents)	Quantitative analysis (descriptive, analysis connected with hypotheses)	IDEM
DNRH, CADD, FENASCOM	5.4 Percentage of performance contracts and private structures	- Use of official documents (SIS routine documents)	Quantitative analysis (descriptive, analysis connected with hypotheses)	IDEM
DRS, DNS	5.5 Percentage of high-performance districts	- Use of official documents (SIS routine documents)	Quantitative analysis (descriptive, analysis connected with hypotheses)	IDEM
CPS/santé	5.6 Percentage of quality plans (integrated)	- Use of official documents (SIS routine documents)	Quantitative analysis (descriptive, analysis connected with hypotheses)	IDEM

F.A.O. any party submitting a proposal

Please indicate if the S &E needs to be reinforced in order to assess the indicators listed and, if yes, specify which indicators in particular require reinforcement (table 6.4)

Please indicate whether the proposal for support from GAVI for HSR covers the operational research elements affected by certain obstacles present in the health systems with the goal of obtaining better information for guiding the taking of decisions and having a better knowledge of results in the area of health (table 6.5)

Les données collectées seront organisées, analysées et consolidées par l'équipe GAVI au RSS, tous les trois (3) mois, dans les rapports sur l'évolution des indicateurs. Ces rapports seront soumis à la Cellule de planification du Ministère de la santé, la Direction nationale de la santé et au Service d'Immunisation, pour approbation préliminaire. La validation finale de ces indicateurs sera assurée par le Comité de pilotage (CP), au nom du Comité de Suivi (CS) du PRODESS.

Les rapports sur l'évolution des indicateurs seront ensuite disséminés aux régions et aux districts à travers le bulletin trimestriel du Ministère et les rapports de rétro information. La diffusion de ces données en dehors des instances du gouvernement sera effectuée lors des réunions du Comite de Pilotage/Comite de Suivi du PRODESS, avec l'aide des PTF, la société civile et les O.N.G.

6.4 Renforcement du système S&E

Afin de collecter, consolider et analyser les données relatives au suivi du soutien de GAVI au RSS du Mali, une équipe du soutien GAVI va travailler au sein de la cellule de Planification du MS, dont les capacités d'intervention méritent d'être renforcées, dans les domaines de la planification/analyses et dans le suivi/évaluation.

Cependant, les problèmes relatifs au système de monitorage et d'évaluation ont été identifiés, et les activités ci-dessous sont planifiées pour les endiguer:

- Renforcer le système de monitorage/suivi au niveau de chaque aire de santé
- Améliorer la qualité des supervisions intégrées (formation et suivi régulier de supervisions des CSCOM/CSRef.)

6.5 Recherche opérationnelle

La recherche devra aboutir à la révision des systèmes de motivation du personnel sur la performance du système de santé, et mieux élucider pour l'action, la problématique de : i) l'accréditation des districts sur la performance des structures et services, ii) conventions d'assistance mutuelles entre les collectivités et les ASACO sur la performance des CSCOM , iii) des contrats de performance à travers le Partenariat Public Privé, iv) des interventions des DRS sur l'amélioration des services des districts sanitaires en général et notamment le volet supervision intégrée; v) des cadres de concertation locaux en vue de leur renforcement.

Le système de recouvrement de coût sera revu pour être plus favorable aux groupes les plus défavorisés (pauvres, enfants, femmes enceintes etc.). Des facilités seront accordées aux groupes les plus pauvres en ce qui concerne le paiement des consultations, des médicaments et des soins préventifs dans les centres de santé et les établissements hospitaliers.

Plusieurs études ont été projetées en tant qu'éléments de cette proposition afin d'identifier les goulots d'étranglement dans certains domaines/secteurs et également pour être mieux équipé, pour cibler et diriger les stratégies en matière de santé. Les études prévues seront réalisées à travers les activités suivantes :

- Mesurer l'effet de la motivation du personnel technique dans les zones défavorisées ;
- Mesurer l'effet de l'accréditation des districts sur la performance des structures et services ;
- Mesurer l'effet des conventions d'assistance mutuelles entre les collectivités et les ASACO, sur la performance des CSCOM ;
- Mesurer l'effet des contrats de performance à travers le Partenariat Public Privé ;
- Mesurer l'effet des interventions des DRS sur l'amélioration des services des districts sanitaires en général et notamment le volet supervision intégrée;
- Évaluer les cadres de concertation locaux en vue de leur renforcement.

7eme partie : Dispositifs de mise en œuvre

A l'attention du proposant

- *Veuillez préciser la manière dont le soutien de GAVI au RSS sera géré (Tableau 7.1). Veuillez indiquer également les rôles et responsabilités de tous les partenaires-clés de la mise en œuvre du soutien de GAVI au RSS (tableau 7.2)*

Note : GAVI soutient l'alignement du soutien de GAVI au RSS sur les mécanismes existants dans les pays. Nous dissuadons fortement les proposants e mettre en place des unités de gestion des projets (UGP) pour le soutien de GAVI au RSS. Le soutien à des éventuels UGP ne sera examiné que dans des conditions exceptionnelles, et sur la base d'une justification raisonnée.

7.1 Gestion du soutien de GAVI au RSS

Mécanisme de gestion	Description
Nom de la personne responsable/groupe responsable de la gestion de la mise en oeuvre du soutien de GAVI au RSS/S&E, etc.	La mise en œuvre des activités de GAVI au RSS sera coordonnée par le Secrétaire Général du Ministère de la Santé à travers la Cellule de la Planification et de Statistique (CPS) qui assure le secrétariat technique du PRODESS et le suivi/évaluation du programme. La réalisation technique relève de la responsabilité de la Direction Nationale de la Santé (DNS). La Direction Administrative et Financière (DAF) assure la gestion budgétaire et financière.
Rôle du Comité de Suivi dans la mise en oeuvre du soutien de GAVI au RSS et dans le S&E	Le comité de suivi est l'instance suprême du PRODESS : • Donne les orientations stratégiques pour le soutien au renforcement du RSS • Approuve les plans d'action annuels des activités financées par GAVI N.B. le Comité de suivi se réunit une fois par an sous la coprésidence du Ministre de la Santé et celui du Développement Social. Il est l'organe de suivi du PRODESS II. Toutefois entre les sessions, le comité de pilotage se réunit chaque deux mois et dont les décisions sont entérinées par le comité de suivi.

Mécanisme de coordination du soutien de GAVI au RSS avec les autres activités et programmes du système	Le mécanisme de coordination retenu est celui du PRODESS , à savoir : • La tenue du Conseil de Gestion pour l'adoption et la validation des plans de développement et plans opérationnels des districts sanitaires au niveau cercle. Il se réunit deux fois par an et regroupe les autorités politiques, administratives locales, la société civile, les PTF locaux et les autres acteurs du PRODESS. • La tenue du Comité Régional d'Orientation, de Coordination et d'Évaluation du PRODESS II (CROCEP) pour examiner et valider les plans et programmes de développement sanitaire de la région et aussi d'assurer le suivi de leur exécution. • La tenue du Comité technique du PRODESS II pour l'examen technique des rapports d'Activity et des programmations annuelles du PRODESS en vue de leur validation par le comité de suivi. • La tenue du comité de pilotage pour suivre la mise en œuvre du programme et examiner les préoccupations émergentes avant la tenue du prochain comité de suivi. • La tenue du Comité de suivi du PRODESS II pour approuver les plans et les rapports d'Activity issus du comité technique, examiner les recommandations de la mission conjointe (Etat, société civile et PTF) et entériner les décisions du comité de pilotage.

7.2: Rôles et responsabilités des partenaires-clés (Membres du Comité de Pilotage pour le Comité de Suivi du PRODESS, et autres)

Titre / Poste	Organisation	Membre du CP Yes/Non	Rôles et responsabilités de ce partenaire dans la mise en oeuvre du soutien de GAVI au RSS
M. Oumar Ibrahima TOURE	Ministère de la santé du Mali	Yes	• Consultation et appui technique ; • Participation aux missions de supervisions/suivi sur le terrain ; • Suivis trimestriels des activités et du budget ; • Etablissement des contrats avec les consultants nationaux et internationaux
M. Abou Bakar TRAORE Ministre des finances	Ministère des finances du Mali	Yes	• Consultation et appui technique ; • Participation aux missions de supervisions/suivi sur le terrain ; • Suivis trimestriels des activités et du budget
Mme Bah Fatoumata Nene SY Ministre de l'Economie, de l'Industrie et du commerce	Ministère de l'économie, de l'industrie et du Commerce du Mali	Yes	• Consultation et appui technique ; • Participation aux missions de supervisions/suivi sur le terrain ; • Suivis trimestriels des activités et du budget
Dr. Fatoumata Binta DIALLO Représentant Résident WHO Mali	WHO	Yes	• Consultation et appui technique ; • Participation aux missions de supervisions/suivi sur le terrain ; • Suivis trimestriels des activités et du budget • Etablissement des contrats avec les consultants internationaux
M. Marcel RUDASINGWA Représentant Résident UNICEF Mali	UNICEF	Yes	• Consultation et appui technique ; • Participation aux missions de supervisions/suivi sur le terrain ; • Suivi trimestriel des activités et du budget
M. Alassane DIAWARA Représentant Résident de la	Banque Mondiale	Yes	• Consultation et appui technique ; • Établissement des contrats avec les conseillers

Banque Mondiale au Mali			internationaux (être déterminé) ; • Suivis trimestriels des activités et du budget
M. Yves Pétillon Directeur de la Coopération canadienne au Mali	ACDI	Yes	• Consultation et appui technique ; • Participation aux missions de supervisions/suivi sur le terrain ; • Suivi trimestriel des activités et du budget
Représentant de la Coopération Technique Belge (CTB) Au Mali	CTB	Yes	• Consultation et appui technique ; • Participation aux missions de supervisions/suivi sur le terrain ; • Suivi trimestriel des activités et du budget
Représentant Résident du FNUAP au Mali	FNUAP	Yes	• Consultation et appui technique ; • Participation aux missions de supervisions/suivi sur le terrain ; • Suivi trimestriel des activités et du budget
M. Souleymane DOLO Directeur	GPSP	Yes	• Consultation et appui technique ; • Participation aux missions de supervisions/suivi sur le terrain ; • Suivi trimestriel des activités et du budget
M. Fadiala KEITA President FENASCOM	FENASCOM	Yes	• Consultation et appui technique ; • Participation aux missions de supervisions/suivi sur le terrain ; • Suivi trimestriel des activités et du budget
Dr. Niananké KONE p/Président	Ordre des pharmaciens du Mali	Yes	• Consultation et appui technique ; • Participation aux missions de supervisions/suivi sur le terrain • Suivi trimestriel des activités
Dr. Adama DAOU p/Président	Ordres des médecins du Mali	Yes	• Consultation et appui technique ; • Participation aux missions de supervisions/suivi sur le terrain ; • Suivi trimestriel des activités
Mme MAIGA Fanta CISSE p/Président	Ordre des Sages-femmes du Mali	Yes	• Consultation et appui technique ; • Participation aux missions de supervisions/suivi sur le terrain ; • Suivi trimestriel des activités

A l'attention du proposant

- *Veuillez présenter les dispositifs de gestion financière pour le soutien de GAVI au RSS. GAVI soutient la* gestion des fonds dans le respect du budget gouvernemental. Veuillez indiquer comment cet Objective *sera atteint (tableau 7.3)*

- *Veuillez présenter les mécanismes d'achat éventuels qui seront utilisées pour le soutien de GAVI au RSS (tableau 7.4)*

7.3 Gestion financière du soutien de GAVI au RSS

Mécanisme/procédure	Description
Mécanisme de transfert de fonds du soutien de GAVI au RSS au pays	Les fonds seront transférés dans le compte programme A du niveau central du PRODESS.
Mécanisme de transfert des fonds du soutien de GAVI au RSS du niveau central vers la périphérie	Les fonds seront transférés du compte programme A vers les comptes programmes B des régions, qui alimenteront les comptes programmes C des cercles.
Mécanisme (et responsabilités) d'utilisation du budget et d'autorisation	Ces comptes programmes A, B et C sont sous la responsabilité du Ministère des Finances respectivement l'agent Comptable Centrale du Trésor, le trésorier payeur de la région et le percepteur du cercle. A la réception des requêtes, les services du Ministère des Finances mettent les ressources à la disposition des services techniques du Ministère de la Santé pour la mise en œuvre des activités.
Mécanisme de déboursement des fonds du soutien de GAVI au RSS	Les mécanismes de déboursement suivent le rythme d'avance et de justification. En effet lorsque l'avance initiale est justifiée à hauteur de 60%, le réapprovisionnement est demandé.
Procédure d'audit	Les fonds GAVI seront audités à travers l'audit externe organisé par la DAF chaque année dans le cadre du PRODESS.

7.4 Mécanismes d'achat et d'approvisionnement

Le mécanisme de fourniture qui sera employé respectera les méthodes d'achat des biens et des services en vigueur sur les marchés publics et aura recours soit à l'WHO, soit à l'UNICEF pour la fourniture de certains biens, si ce n'est pas le cas, ou, si cette approche apporte des avantages importants.

A l'attention du proposant

- *Veuillez présenter les dispositifs pour rendre compte des progrès réalisés dans la mise en œuvre et l'utilisation des fonds du soutien de GAVI au RSS, en y faisant figurer l'entité responsable de la* préparation du RAS. (tableau 7.5)

Note : Le rapport annuel de situation de GAVI, qui doit être remis le 15 mai de chaque année, doit apporter *: la preuve d'un emploi appropriée des fonds du soutien de GAVI au RSS, de l'existence d'audits financiers et d'achats dans les règles (conformément aux règlementations nationales ou par l'intermédiaire de l'UNICEF), la preuve de déboursements réels et réalisés efficacement (du niveau central vers les niveaux internationaux, dans le cadre d'un mécanisme SWAp, le cas échéant), et enfin, des signes de progrès montrant que les* Objectives d'Activity annuels et les Objectives de résultats a plus long terme pourront être atteints.

7.5 Dispositifs d'établissement des comptes-rendus

Les comptes-rendus seront faits à travers le cadre commun du suivi/évaluation du PRODESS, dans un souci d'harmonisation. Les rapports d'activités techniques (donnant l'évolution des indicateurs) et financiers (donnant l'utilisation des ressources) sont produits respectivement par la DNS et la DAF et compilés par la CPS. Ce rapport compilé est validé par le comité de suivi du PRODESS et soumis à GAVI en plus du rapport d'audit externe annuel pour compte rendu.

Les données collectées seront organisées, analysées et consolidées par l'équipe du soutien GAVI au RSS, à la CPS/MS, tous les trois (3) mois dans les rapports relatifs à l'évolution des indicateurs. Ces rapports seront soumis à la DNRH/DNS/DRS, et au service d'immunisation pour l'approbation préliminaire. L'adoption finale de ces indicateurs sera effectuée par le Comité de Pilotage, pour le Comité de Suivi du PRODESS.

Les rapports relatifs à l'évolution des indicateurs seront ensuite diffusés aux régions et aux districts à travers le bulletin trimestriel du Ministère de la santé et les rapports de rétro information. La diffusion de ces données au delà des instances gouvernementales sera effectuée par l'intermédiaire des réunions du Comité de Pilotage et du Comité de Suivi, avec l'appui des PTF et la société civile.

A l'attention du proposant

- *Certains pays auront besoin d'une assistance technique pour mettre en oeuvre le soutien de GAVI. Veuillez préciser le type d'assistance technique nécessaire pendant la durée du soutien de GAVI au RSS, ainsi que son origine si elle est connue (tableau 7.6).*

7.6 Besoins en assistance technique

Activités nécessitant une assistance technique	Durée envisagée	Date envisagée (année, trimestre)	Provenance envisagée (locale, partenaire etc.)
Renforcer les capacités d'intervention du niveau central du Ministère pour appuyer le système de santé Type d'Assistance: locale/Internationale	24 mois	*T4 en 2008 à T4 en 2010	Information non disponible
Mesurer l'effet de la motivation du personnel technique dans les zones défavorisées. Type d'Assistance: locale/Internationale	5 semaines à compter du début du démarrage des activités	T1 et T2 en 2009	Information non disponible
Mesurer l'effet de l'accréditation des districts performants appliquant notamment l'approche centrée sur le patient. Type d'Assistance: locale/Internationale	6 semaines à compter du début du démarrage des activités	T1 à T4 en 2009	Information non disponible
Mesurer l'effet des conventions d'assistance mutuelles entre les collectivités et les ASACO sur la performance des CSCOM. Type d'Assistance : locale/Internationale	6 semaines, à compter du début du démarrage des activités	T2 et T3 en 2009	Information non disponible
Mesurer l'effet des contrats de performance à travers le Partenariat Public Privé Type d'Assistance : locale/ Internationale	6 semaines, à compter du début du démarrage des activités	T3 et T4 en 2009	Information non disponible
Mesurer l'effet des interventions des DRS sur l'amélioration des services des districts sanitaires en général et notamment le volet supervision intégrée Type d'Assistance : locale/ Internationale	6 semaines, à compter du début du démarrage des activités	T2 et T3 en 2009	Information non disponible
Évaluer les cadres de concertation locaux en vue de leur renforcement Type d'Assistance : locale/Internationale	6 semaines, à compter du début du démarrage des activités	T1 et T2 en 2009	Information non disponible

_____

** Abréviation de Trimestre*

8eme partie : Coûts te financement du soutien de GAVI au RSS

A l'attention du proposant

Veuillez calculer les coûts de toutes les activités pendant la durée du soutien de GAVI au RSS. Merci d'ajouter ou de supprimer des lignes/colonnes pour obtenir le nombre exact d'Objectives, d'activités et d'années. (Tableau 8.1).

Note : Veuillez vous assurer que tous les coûts de soutien pour la gestion, le S&E et l'assistance technique sont inclus. Veuillez convertir tous les coûts en USD (au taux d'échange actuel), et vous assurer que les deflateurs de GAVI sont utilisées pour les coûts futurs (voir les directives sur le site Web de GAVI : www.gavialliance.org)

Note : Le total général des fonds du soutien de GAVI au RSS demandés au tableau 8.1 ne doit pas dépasser le total général des fonds du soutien de GAVI au RSS alloués au tableau 8.2. Les fonds peuvent être demandés en tranches annuelles en fonction des coûts annuels estimés des activités. Ces derniers peuvent varier d'une année sur l'autre par rapport aux sommes allouées dans le tableau 8.2.

8.1 Coût de la mise en œuvre des activités du soutien de GAVI au RSS

Domaine de soutien	Coût par année en USD (1 000)				
	Année de la proposition à GAVI	*Année 1 de mise en oeuvre	Année 2 de mise en oeuvre	Année 3 de mise en oeuvre	TOTAL DES COUTS
	*2008	*2009	**2010	***2011	
Coûts des activités					
Objective 1 Améliorer la disponibilité des ressources humaines qualifiées dans les services de santé en mettant un accent sur les services périphériques	93.58		100.60	138.96	333.14
Activity 1.1 Renforcer le système de motivation du personnel à travailler dans les zones défavorisées par la subvention des primes d'incitation financière aux agents techniques	93.58		100.60	138.96	333.14
Activity 1.2 Renforcer le sous-système d'information sur les RH, toute appartenance confondue	0		0	0	0
Objective 2 Améliorer la qualité des services de santé	467.22		745.18	1307.42	2 519.82
Activity 2.1 Former les équipes cadres de districts en gestion, leadership et selon les besoins de la mise en œuvre du programme.	82.57		62.25	60.98	205.80
Activity 2.2.1 Effectuer la supervision intégrée trimestrielle du personnel des CSCOM y compris le contrôle des prescriptions rationnelle et le coût des ordonnances	0		0	0	0
Activity 2.2.2 Effectuer la supervision trimestrielle des relais communautaires	0		0	0	0
Activity 2.3 Contrôler la prescription rationnelle et le coût des ordonnances pendant les audits médicaux internes.	29.47		29.47	29.47	88.41
Activity 2.4 Renforcer la médicalisation des services de santé de premier contact	228.66		533.54	1067.07	1829.27
Activity 2.5 Élaborer et diffuser des outils d'aide à la prescription rationnelle et la prise en charge de la malnutrition	0		0	0	0
Activity 2. 6 Instaurer un système d'accréditation des districts performants appliquant notamment l'approche centrée sur le patient	126.52		119.92	149.90	396.34
Activity 2.7 Recruter un AT pour chaque région de la zone 1 de pauvreté, pour prendre en charge les districts les moins performants	-		-	-	-
Objective 3 Renforcer les capacités institutionnelles et					

décentralisation	376.70	360.94	169.51	907.15
Activity 3.1 Développer le partenariat Public Privé au niveau district, par l'élaboration de contrats de performance sur l'ensemble du PMA et l'échange d'information (niveau CSREF).	98.60	98.60	98.60	295.79
Activity 3.2 Renforcer le processus d'élaboration des PO au niveau du district (5 jours : participation d'une personne de la DRS, 1 personne FELASCOM, 1 personne CT, 1 personne ONGs, le Préfet).	86.34	43.17	43.17	172.68
Activity 3.3 Renforcer les compétences des FELASCOM pour appuyer les ASACO	53.58	71.44	17.86	142.89
Activity 3.4 Renforcer les capacités d'intervention du niveau central du Ministère pour appuyer le système de santé	138.18	147.73	9.88	295.79
Objective 4 Renforcer le système de monitorage et d'évaluation, en mettant un accent particulier sur les services périphériques	-	-	-	-
Activity 4.1 Renforcer le système de monitorage au niveau de chaque aire de santé	-	-	-	-
Activity 4.2 Améliorer la qualité des supervisions intégrées (formation et suivi régulier des supervisions des CSCOM/CSRef.)	0	0	0	0
Objective 5 Renforcer la recherche opérationnelle en santé	183.94	122.95	0	306.89
Activity 5.1 Mesurer l'effet de la motivation du personnel technique dans les zones défavorisées	0	51.81	0	51.81
Activity 5.2 Mesurer l'effet de l'accréditation des districts performants appliquant notamment l'approche centrée sur le patient	64.02	0	0	64.02
Activity 5.3 Mesurer l'effet des conventions d'assistance mutuelles entre les collectivités et les ASACO sur la performance des CSCOM.	109.76	0	0	109.76
Activity 5.4 Mesurer l'effet des contrats de performance à travers le Partenariat Public Privé	0	71.14	0	71.14
Activity 5.5 Mesurer l'effet des interventions des DRS sur l'amélioration des services des districts sanitaires en général et notamment le volet supervision intégrée	0	0	0	0
Activity 5.6 Évaluer les cadres de concertation locaux en vue de leur renforcement.	10.16	0	0	10.16
Coûts de soutien (Sans coûts gestion/S&E/AT)	1121.44	1 329.67	1615.89	4 067
Coûts de gestion (5%)	56.07	66.48	80.79	203.34
Coûts de soutien pour le S&E	103.93	103.93	103.93	311.79
Assistance technique	91.46	45.73	45.73	182.92
TOTAL DES COUTS	1 372.90	1 545.81	1 846.34	4 765.05

** Pour le calcul des coûts du soutien de GAVI au RSS, la première année de mise en œuvre va du quatrième trimestre (Q4) de 2008, l'année de la proposition, à la fin du troisième trimestre (Q3) de la première année de mise en œuvre du soutien de GAVI.*

*** La deuxième année de la mise en œuvre va du quatrième trimestre de la première année (2009) à la fin troisième trimestre (Q3) de l'année 2010.*

**** La troisième année de la mise en œuvre du soutien commence au quatrième trimestre de l'année 2010 et se termine au quatrième trimestre de l'année 2011.*

A l'attention du proposant

- Veuillez calculer le montant des fonds disponibles par année en provenance de GAVI pour les activités du soutien de GAVI au RSS proposes, sur la base du nombre annuel de naissances et du RNB par habitant de la façon suivante (ableau 8.2):

  - Si le RNB < 365 USD par habitant, le pays est habilité à recevoir un maximum de 5 UDS par habitant.
  - Si le RNB > 365 USD par habitant, le pays est habilite à recevoir un maximum de 2.5 USD par habitant.

Note : L'exemple ci-après suppose que la cohorte de naissance de l'année de la proposition de GAVI est égale à 100 000 et donne le total de l'allocation de fonds si le RNB < 365 USD par habitant et si le RNB > 365 par habitant.

Exemples : Calcul de l'allocation du soutien de GAVI au RSS aux pays

Allocation du soutien de GAVI au RSS (RNB < 365 USD par habitant)	Allocation par année (USD)				
	2007	2008	2009	2010	TOTAL DES FONDS
Cohorte de naissance	100 000	102 000	104 000	106 000	
Allocation par nouveau-né	5 USD	5 USD	5 USD	5 USD	
Allocation annuelle	500 000 USD	510 000 USD	520 000 USD	530 000 USD	2 060 000 USD

Allocation du soutien de GAVI au RSS (RNB > 365 USD par habitant)	Allocation par année (USD)				
	2007	2008	2009	2010	TOTAL DES FONDS
Cohorte de naissance	100 000	102 000	104 000	106 000	
Allocation par nouveau-né	2. 5 USD	2.5 USD	2.5 USD	2.5 USD	
Allocation annuelle	250.000 USD	255 000 USD	260 000 USD	265 000 USD	1 030 000 USD

8.2 Calcul de l'allocation du soutien de GAVI au RSS au Mali

Allocation du soutien de GAVI au RSS (*RNB > 365 USD par habitant	Année de la proposition a GAVI	Année 1 de mise en oeuvre	Année 2 de mise en oeuvre	Année 3 de mise en oeuvre	TOTAL DES FONDS
	2008	2009	2010	2011	
Cohorte de naissance	493 683 **	494 551***	502 912***	511 273***	
Allocation par nouveau-né	2.5 USD	2.5 USD	2.5 USD	2.5 USD	
Allocation annuelle	1 234 207.5	1 236 377.5	1 257 280	1 278 182.5	5 006 047.5

Source et date des informations sur le RNB et la cohorte de naissances :

RNB: 440 USD: World Bank (2007): World Development Indicators database

**Cohorte de naissances : DNSI (1998) - RGPH, Perspectives 2005-2010.

9eme Partie : Adoption de la proposition

Ministry of Health :

Name : M. Oumar Ibrahima TOURE

Title/Position : Minister for Health

Signature :

Date :

Ministry for Finances :

Name : M. Abou Bakar TRAORE

Title/Position : Minister for Finances

Signature :

Date :

9.2 Agreement of the Steering Committee on behalf of the PRODESS monitoring committee in the country

The members of the Steering Committee, on behalf of the PRODESS Monitoring Committee, agreed to this proposal at a meeting which took place on 13th February 2008 at 14 hrs (GMT) in the Department of Health meeting room. The signed minutes are attached in appendix 1.

President of the Steering Committee

Name : Dr Lasséni KONATE

Position/Organisation : Secretary General – Ministry of Health

Signature :

Date :

9.3 Contact person for information :

Name : Dr Salif SAMAKE
Title : Director – CPS/Health
Tel. : (223) 223 27 26
Address : Ministry of Health . B.P. 232, Koulouba, Bamako (Mali)
Fax : (223) 223 27 26
Email : samakesalif@yahoo.fr

APPENDIX 1. Documents supporting the proposal for support from GAVI for HSS

For the attention of the proposer

* *Please number and list all documents submitted with this document using the table below*

Note : All supporting documents must be submitted in English or French, electronically as far as possible. Only documents, which are *referred to in the proposal, must be submitted.*

Document (with the name of the equivalent user in the country)	Available (Yes/No)	Duration	No of attached document
Strategic Plan for National Healthcare Sector (or its equivalent)	Yes	2 years	1
PPAc[1]	Yes	4 years	2
CMDT[8]	Yes	2 years	3
DSRP[8]	Yes	4 years	4
Recent assessment documents for healthcare sector	Yes		5
Minutes from CCSS meeting signed by the CCSS President	Yes		6

[1] If available, and if not, provide the National Immunization Plan and the Financial Viability Plan.

[8] If available, please send us pages concerning Healthcare System Reimbursement and this proposal for support from GAVI for healthcare strengthening

.

APPENDIX 2 Banking Form

APPENDIX 2 : Bank Form

GLOBAL ALLIANCE FOR VACCINES AND IMMUNIZATION	Banking Form

PART 1 (to be completed by payee)

In accordance with the decision on financial support made by the Global Alliance for Vaccines and Immunisation dated . . . . . , the Government of . . . . . .

hereby requests that a payment be made, via electronic bank transfer, as detailed below:

Name of institution (Account holder) :		
Address :		
City - Country :		
Telephone :		Fax :
Amount in USD :	(To be completed by GAVI Secretariat)	Currency of the bank account
For credited to :		
Bank account's title :		
Account N°:		
At:		
Name of bank :		

Is the account used to be exclusively for this programme ? Yes ( ) No ( )

By whom is the account audited?

Signature of Government's authorising official

Name :		Stamp:
Title :		
Signature :		
Date :		

PART 2 (To be completed by the bank)

FINANCIAL ESTABLISHMENT	CORRESPONDENT BANK (In the United States)
Name of bank :	
Name of branch :	
Address :	
City – Country	
Swift Code:	
Sort Code:	
ABA N°:	
Telephone :	
Fax :	

The account is to be signed jointly by at least …… *(number of signatories)* of the following authorized signatories:	Name of bank's authorised agent :
1 Name :	Signature:
Title :	Date :
2 Name :	Stamp :
Title :	
3 Name :	
Title :	
4 Name :	
Title :	

COVERING LETTER

(To be completed by the UNICEF representative on letter headed paper)

To : GAVI - Secretariat
Att. Mr Julian Lob-Levyt
Executive Secretary
UNICEF
Palais de Nations
CH 1211 Geneva 10
Suisse

On the …… I received the original of the BANKING DETAILS form, which is attached.

I certify that the form does bear the signatures of the following officials:

	Name	Title
Government's authorizing official	.....	.....
Bank's authorizing official	.....	.....

Signature of UNICEF representative:

Name .....

Signature .....

Date .....

APPENDIX 3. Main activities with the Schedule of Completion and the Managing Bodies

		2008	2009				2010				2011				Managing Bodies
		**T4	T1	T2	T3	T4	T1	T2	T3	T4	T1	T2	T3	T4	
Objective 1	Improve the availability of qualified human resources in healthcare services stressing peripheral services														
Activity 1.1	Improve the system to motivate personnel to work in less favoured areas by granting financial incentives to technicians	x	x	x	x	x	x	x	x	x	x	x	x	x	DNRH, DAF, FENASCOM
Activity 1.2	Improve the HR information sub-system, whatsoever their group	x	x	x	x	x	x	x	x	x	x	x	x	x	DNRH, DAF
Activity 1.3	Train healthcare service personnel in HR management					x					x				DNRH, DAF, Civil Society (GPSP, FENASCOM)
Objective 2	Improve the quality of healthcare services														
Activity 2.1	Train district executive teams in management, leadership and, if required, implementing the programme	x					x								DNRH, DAF
Activity 2.2	Carry out integrated quarterly supervision of CSCOM personnel including inspections of rational use of medicines and the cost of prescriptions		x				x	x							CSREF, Civil Society
		x	x	x	x	x	x	x	x	x	x	x	x	x	
Activity 2.5	Improve medicalisation of first contact healthcare services	x	x												DNS, Profit making private sector
Activity 2.6	Develop and circulate tools to help the rational use of medicines and taking responsibility for malnutrition	x	x	x	x			x	x	x		x	x	x	DNS, DPM
Activity 2.7	Set up an accreditation system for efficient districts using, in particular, the patient centred approach.	x	x	x	x	x	x	x	x	x	x	x	x	x	CADD, Civil Society, DNS
Activity 2.8	Apply recommendations from studies which favour reducing medicine prices, including improved traditional medicines														DNS, DPM, DAF
Activity 2.9	Recruit a technical assistant for each region in the two poverty zones so that responsibility is taken for least efficient districts	x	x												DAF, DNRH, DNS

Objective 3	Reinforce institutional capacities and decentralisation																	
Activity 3.1	Ensure the application and assess the implementation of mutual aid agreements/ contracts between municipalities and ASACOs.	x	x	x											CADD, Civil Society			
Activity 3.2	Develop the Public/Pr413(v)1a(u)14(t)13(e)13( )13(p)1a(u)10(r)14(t)1n																	

Activity 5.5	Measure the effect of DRS operations in improving district healthcare services generally and particularly regarding integrated supervision	x	x				x	x				x	x		DNS, Faculty of Medicine, INRSP,
Activity : 5.6	Assess consultation frameworks in view of reinforcing them	x	x	x	x	x	x	x	x	x	x	x	x	x	CADD, Civil Society

APPENDIX 4. Main activities with implementation and costs elements

Objective 1	Improve availability of qualified human resources in healthcare services stressing peripheral services	Implementation elements	Cost elements in MF (thousands of Francs CFA)
Activity 1.1	Improve system to motivate personnel to work in less favoured areas by granting financial incentives to technicians	Community healthcare associations will be involved in issuing incentives to reinforce good cooperation with personnel. DAF and decentralised communities will carry out monitoring.	The monthly bonus for 2 members of the CSCOM technical personnel (all statuses) will be increased to 40MF and 60MF respectively in zone 1 and 2 and 154 in zone *(number missing)*. Annual growth takes into account extending the geographical cover.
Activity 1.2	Improve the HR information sub-system, whatsoever their group	This mainly concerns training and acquiring management software, which can monitor all personnel, whatsoever, their status.	Calculated based on the CDMT
Activity 1.3	Train healthcare service personnel in HR management	Continuous training in CSCOM, CSREF and DRS. Activities will be carried out in collaboration with the DNS, DAF, FENASCOM and NGO.	Calculated based on the CDMT, or annually CSCOM: 108653 MF, CSREF: 72146 MF, DRS: 15840 MF
Objective 2	Improve the quality of healthcare services		
Activity 2.1	Train district executive teams in management, leadership and, if required, implementing the programme	Training workshop for trainers in 2008, training of 9 regions and 20 districts in 2009, then 20 and 19 districts in 2010 & 2011	Regional workshops are estimated at 5000 MF, those in the districts at 2500 MF
Activity 2.2	Carry out integrated quarterly supervision of CSCOM personnel including inspections of rational use of medicines and the cost of prescriptions	One supervision per quarter is planned by CSCOM, in accordance with PRODESS	Total sums take into account per diems, a fuel allowance for an average distance of 50km and an increase in the geographical cover.
Activity 2.3	Carry out quarterly supervision of community relays	This is a lump sum per head of CSCOM	20 MF per quarter per CSCOM; including the increase in geographical cover
Activity 2.4	Inspect rational use of medicines and cost of prescriptions during internal medical audits.	District executive teams, depending on the provisions in doctors' orders, will carry out this activity.	calculated based on the CDMT
Activity 2.5	Improve medicalisation of first contact healthcare services	This activity will be carried out in collaboration with the country doctor association: 100 doctors in 2009, 200 in 2010	250 MF per month per doctor

		& 300 in 2011	
Activity 2.6	Develop and circulate tools to help the rational use of medicines and taking responsibility for malnutrition	To be carried out centrally	A lump sum, including organising a consensus workshop
Activity 2.7	Set up an accreditation system for cost effective districts using, in particular, the patient centred approach.	In 2008 this will concern developing tools and circulating information and nominating the most efficient district	From 2009: 1000 MF per district per year including 500 MF for the most efficient districts in the regions
Activity 2.8	Apply recommendations from studies favouring reductions in medicine prices including improved traditional medicines	Routine monitoring	
Activity 2.9	Recruit a technical assistant for each region in the two poverty zones so that responsibility is taken for least effective districts	Recruit 4 technical assistants (1/region, in charge of less favoured/less efficient districts in the region)	1500 MF/month per technical assistant
Objective 3	Reinforce institutional capacities and decentralisation		
Activity 3.1	Ensure the application and assess the implementation of mutual aid agreements/ contracts between municipalities and ASACOs.	FELASCOM supervisory tasks to ensure that mutual aid agreement contracts are implemented each year together with an assessment half way through in 2009 and a final assessment in 2011.	20 000 MF each year for FELASCOM and in 2009 and 2011, 30 000 MF and 60000 MF respectively for the assessments.
Activity 3.2	Develop the Public/Private partnership at district level by drawing up performance contracts for the whole of the PMA and by exchanging information (CSCOM level)	This is a grant given to the non-profit making private sector.	The cost also complies with that of the CDMT but increased by 1/3 to take the private element into account; and linear for 2010 and 2011.
Activity 3.3	Develop the Public/Private partnership at district level by drawing up performance contracts for the whole of the PMA and by exchanging information (CSREF level)	This is a grant given to the non-profit making private sector.	The cost also complies with that of the CDMT.
Activity 3.4	Reinforce the process to develop operational plans at district level (5 days: participation of one person from DRS (Regional Healthcare Directorate), 1 person from FELASCOM, 1 person from the Territorial Collectivities, 1 person from NGOs, the Prefect)	An average of 35 participants (ref decree 114) has been upheld given the frequently high number of CSCOMs per district (per example 48 in KOUTIALA).	The unit cost is that for monitoring (600 MF per day for 3 days). 59 districts x 1 800 MF= 106 200 MF.
Activity 3.5	At healthcare area level, integrate ASACO micro plans into the community Collectivity plans	Activities are run at community level (703) with district support.	The community has used an estimated cost of 300 MF.

Activity 3.6	Improve FELASCOM skills to support ASACOs	Activity spread out over 2009 and 2010.	703 Municipalities x 100 MF=70 300 MF .
Activity 3.7	Improve the Ministry's capacities to intervene at a central level to support the healthcare system	The activity covers the whole duration of the support.	3 to 4 qualified and skilled professionals will be mobilised by the CPS and will work full time in implementing, monitoring and assessing the support.
Objective 4	Reinforcing and institutionalising a monitoring and evaluation system		
Activity 4.1	Reinforce the monitoring/follow-up system at the level of each healthcare area	The District executive framework will ensure that all local participants are involved	Calculated based on the CDMT or annually and depending on poverty zones =237006 MF+146718 MF+ 26136 MF
Activity 4.2	Improve the quality of integrated supervision (training and regular follow-up of CSCOM/CSRef supervision)	Training and regular follow-up of CSCOM supervision by the district executive teams (CSRef).	Calculated based on the CDMT or annually and depending on poverty zones =9504MF+9504MF+2376MF
Objective 5	Operational research		
Activity 5.1	Measure the effect of motivating technical personnel in less favoured areas	This concerns a one-off activity but one which is quite long.	Maximum lump sum of 30 000 MF
Activity 5.2	Measure the effect of accrediting efficient districts by using, in particular, the patient centred approach.	This concerns 2 one-off activities but which are quite long.	Maximum lump sum of 30 000 MF
Activity 5.3	Measure the effect of mutual aid agreements between collectivities and ASACOs regarding CSCOM performance	Random sample of 10 areas per region	P U of 700 per area (x 10 x 9 regions)
Activity 5.4	Measure the effect of performance contracts through the Public Private Partnership	This concerns a one-off activity but one which is quite long.	Maximum lump sum of 70 000 MF
Activity 5.5	Measure the effect of DRS involvement in improving district healthcare services generally and particularly regarding integrated supervision	This concerns 2 one-off activities but which are quite long in each region	1500 MF x 9 regions
Activity: 5.6	Assess consultation frameworks in view of reinforcing them	This concerns a one-off activity but one which is quite long.	Maximum lump sum of 30 000 MF

APPENDIX 5. Elements in the detailed budget

5.1 Costs of activities per annum and per source of finance

Area of support	Year 1 of implementation

Activity 2.2 Carry out integrated quarterly supervision of CSCOM personnel including inspections of rational use of medicines and the cost of prescriptions			145,626.25				152,941.25				193,462.50	
Activity 2.3 Carry out quarterly supervision of community relays				68,050.00				75,050.00				103,000.00
Activity 2.4 Inspect rational use of medicines and cost of prescriptions during internal medical audits.	14,499.24	14,500.00	14,500.00	14,500.00	14,499.24	14,500.00	14,500.00	14,500.00	14,499.24	14,500.00	14,500.00	14,500.00
Activity 2.5 Improve medicalisation of first contact healthcare services	112,500.72			112,500.00	262,501.68			262,500.00	524,998.44			525,000.00
Activity 2.6 Develop and circulate rational use of medicines and taking responsibility for malnutrition	0.00		5,625.00	5,625.00			13,125.00	13,125.00			3,750.00	3,750.00
Activity 2.7 Set up an accreditation system for cost effective districts using, in particular, the patient centred approach.	62,247.84				59,000.64				73,750.80			
Activity 2.8 Apply recommendations from studies favouring reductions in medicine prices including improved traditional medicines	0.00											
Activity 2.9 Recruit a technical assistant for each region in the two poverty zones so that responsibility is taken for least effective districts				72,000.00				72,000.00				36,000.00
Objective 3: Reinforce institution capacities and decentralisation												
Activity 3.1 Ensure the application and assess the implementation of mutual aid agreements/ contracts between collectivities and ASACOs.	0.00	57,500.00				27,500.00				85,000.00		
Activity 3.2 Develop the Public/Private partnership at district level by drawing up performance contracts for the whole of the PMA and by exchanging information (CSCOM level)	0.00		107,775.50	107,775.50			107,775.50	107,775.50			107,775.50	107,775.50
Activity 3.3 Develop the Public/Private partnership at district level by drawing up performance contracts for the whole of the PMA and by exchanging information (CSREF level)	48,511.20		97,020.00	97,020.00	48,511.20		97,020.00	97,020.00	48,511.20		97,020.00	97,020.00

Activity 3.4 Reinforce the process to develop operational plans at district level (5 days: participation of one person from DRS (Regional Healthcare Directorate), 1 person from FELASCOM, 1 person from the Territorial Collectivities, 1 person from NGOs, the Prefect)	42,479.28		84,960.00	84,960.00	21,239.64		42,480.00	42,480.00	21,239.64		42,480.00	42,480.00
Activity 3.5 At healthcare area level, integrate ASACO micro plans into the community Collectivity plans	0.00											
Activity 3.6 Improve FELASCOM skills to support ASACOs	26,361.36				35,148.48				8,787.12			
Activity 3.7 Improve the Ministry's capacities to intervene at a central level to support the healthcare system	67,984.56				72,683.16				4,860.96			
Objective 4: Reinforcing and institutionalising a monitoring and assessment system												
Activity 4.1 Reinforce the monitoring/follow-up system at the level of each healthcare area			102,465.00	204,930.00			102,465.00	204,930.00			102,465.00	204,930.00
Activity 4.2 Improve the quality of integrated supervision (training and regular follow-up of CSCOM/CSRef supervision)		21,384.00				22,987.80				25,286.58		
Objective 5: Operational research into healthcare												
Activity 5.1 Measure the effect of motivating technical personnel in less favoured areas	0.00				25,490.52				0.00			
Activity 5.2 Measure the effect of accrediting efficient districts by using, in particular, the patient centred approach.	31,497.84								0.00			
Activity 5.3 Measure the effect of mutual aid agreements between collectivities and ASACOs regarding CSCOM performance	54,001.92				0.00				0.00			
Activity 5.4 Measure the effect of performance contracts through the Public Private Partnership	0.00				35,000.88				0.00			
Activity 5.5 Measure the effect of DRS involvement in improving district healthcare services generally and particularly regarding integrated supervision	0.00									0.00		
Activity 5.6 Assess consultation frameworks in view of reinforcing them	4,998.72				0.00				0.00			

Total cost of the activities	551, 748.48	191 703.50	824,539.25	787,673.00	654,197.64	163,307.30	716,874.25	904,693.00	795, 017.88	223,106.08	750,053.00	1,149,455.50
Management cost (GAVI support)	27 587.42				32 709.88				39 750.89			
Support cost for M&E	51,133.56				51,133.56				51,133.56			
Technical assistance	44 998.32				22,499.16				22,499.16			
Total costs	675 467.78				760 540.24				908 401.49			

5.2 Breakdown of activities per quarter, all sources of finance together

	Year of proposal to GAVI	Year 1 of implementation					Year 2 of implementation					Year 3 of implementation					TOTAL COSTS (in thousands of F CFA)
Area of support	2008	2009						2010									
Costs of activities	T4	T1	T2	T3	T4	TT 2009	T1	T2	T3	T4	TT 2010	T1	T2	T3	T4	TT 2011	
Objective 1 Improve availability of qualified human resources in healthcare services emphasising peripheral services		0	0	0	0		0	0	0	0		0	0	0	0		1,344,929
Activity 1.1 Reinforce the system to motivate personnel to work in less favoured areas by using financial incentives for lab technicians	36,980	36,980	36,980	36,980	36,980	147,920	38,131	38,131	38,131	38,131	152,524	39,397	39,397	39,397	39,397	157,588	495,012

	Year of proposal to GAVI	Year 1 of implementation					Year 2 of implementation					Year 3 of implementation					TOTAL COSTS (in thousands of F CFA)
Area of support	2008	2009						2010									
Costs of activities	T4	T1	T2	T3	T4	TT 2009	T1	T2	T3	T4	TT 2010	T1	T2	T3	T4	TT 2011	
Activity 1.2 Reinforce the information sub-system on HR, whatever grouping they belong to	37,500	35,625	35,625	35,625	35,625	142,500	11,250	11,250	11,250	11,250	45,000	8,750	8,750	8,750	8,750	35,000	260,000
Activity 1.3 Train personnel from healthcare services in HR management	49,160	49,160	49,160	49,160	49,160	196,639	49,160	49,160	49,160	49,160	196,639	36,870	36,870	36,870	36,870	147,479	589,917
Objective 2 Improve the quality of healthcare services		0	0	0	0		0	0	0	0							3,520,874
Activity 2.1 Train district executive managers in management, leadership and, if required, on implementing the programme	10,000	23,750	23,750	23,750	23,750	95,000	12,500	12,500	12,500	12,500	50,000	11,875	11,875	11,875	11,875	47,500	202,500
Activity 2.2.1 Carry out integrated quarterly supervision of CSCOM personnel including monitoring the rational use of medicine and the cost of prescriptions	35,035	36,864	36,864	36,864	36,864	147,455	38,693	38,693	38,693	38,693	154,770	38,693	38,693	38,693	38,693	154,770	492,030
Activity 2.2.2 Carry out quarterly supervision of community relays	15,700	17,450	17,450	17,450	17,450	69,800	19,200	19,200	19,200	19,200	76,800	20,950	20,950	20,950	20,950	83,800	246,100
Activity 2.3 Inspect the rational use of medicine and the cost of prescriptions during internal medical audits.	14,500	14,500	14,500	14,500	14,500	58,000	14,500	14,500	14,500	14,500	58,000	14,500	14,500	14,500	14,500	58,000	188,500
Activity 2.4 Reinforce medicalisation of first contact healthcare services	0	75,000	75,000	75,000	75,000	300,000	150,000	150,000	150,000	150,000	600,000	225,000	225,000	225,000	225,000	900,000	1,800,000
Activity 2.5 Develop and circulate tools to help the rational use of medicine and take responsibility for malnutrition		3,750	3,750	3,750	3,750	15,000	7,500	7,500	7,500	7,500	30,000	0	0	0	0		45,000

	Year of proposal to GAVI	Year 1 of implementation					Year 2 of implementation					Year 3 of implementation		TOTAL COSTS (in thousands of F CFA)
Area of support	2008	2009						2010						
Costs of activities	T4	T1	T2	T3	T4	TT 2009	T1	T2	T3	T4	TT 2010	T1		

	Year of proposal to GAVI	Year 1 of implementation					Year 2 of implementation					Year 3 of implementation					TOTAL COSTS (in thousands of F CFA)
Area of support	2008	2009						2010									
Costs of activities	T4	T1	T2	T3	T4	TT 2009	T1	T2	T3	T4	TT 2010	T1	T2	T3	T4	TT 2011	
Activity 3.3 Reinforce the process to develop Operational Plans at a district level (5 days: participation of one person from the DRS, 1 person from the FELASCOM, 1 person from the CT, 1 person from the NGOs, the Prefect)	106,200	106,200				106,200	106,200				106,200	106,200				106,200	424,800
Activity 3.4 Integrate ASACO micro plans into the Community Collectivity plans at district area level	210,900	52,725	52,725	52,725	52,725	210,900	52,725	52,725	52,725	52,725	210,900	52,725	52,725	52,725		158,175	790,875
Activity 3.5 Reinforce FELASCOM skills to support ASACO		6,788	6,788	6,788	5,997	26,361	8,788	8,788	8,788	8,788	35,150	3,000	3,000	2,787	0	8,787	70,298
Activity 3.6 Reinforce skills the Ministry's central level to intervene to support the healthcare system	0	16,822	16,996	16,996	17,171	67,985	18,171	18,171	18,171	18,171	72,683	4,861				4,861	145,529
Objective 4 Reinforce the monitoring and evaluation system emphasising peripheral services in particular		0	0	0	0		0	0	0	0		0	0	0	0		1,299,238
Activity 4.1 Reinforce the monitoring/follow-up system for each healthcare area	102,465	102,465	102,465	102,465	102,465	409,860	102,465	102,465	102,465	102,465	409,860						

APPENDIX 6. Description of the activities in the support from GAVI for HSS

6.1 Objective 1: its aim is to improve the availability of qualified human resources in healthcare services with the emphasis on peripheral services.

It is more than necessary to have sufficient, qualified and motivated HR to improve the quality of services offered and consequently to increase demand. Data collated using the PRODESS implementation follow-up tool has already shown in 2001 and 2002 a significant relation between the stability of technical personnel in healthcare areas and results in terms of cover and use of the services. Therefore, technical personnel who work in less favoured and impoverished zones must be offered financial and non-financial incentives. New budgetary items will be created in Cercles of regions in zone 1 poverty and in less favoured zones. These budgetary items will be allocated not to the individual who is to be motivated but to the position itself. Preparatory and consultation workshops will be organised as a preliminary for all the affected zones.

The main activity, which is defined for this objective, is (given the GAVI support for healthcare strenghtening):

- Reinforce the system to motivate personnel to work in less favoured zones using financial incentives for technical agents. This concerns contributing to developing new stable technical skills which can be used in peripheral zones to guarantee the quality and continuity of health care. In order for the Healthcare System to run smoothly, it requires sufficient, competent, qualified and motivated HR. The Ministry of Health, through its central directorates (DNRH, DAF), and the territorial collectivities, civil society, and with the technical support of WHO, are the competent bodies responsible for implementing the GAVI support.

Bonuses must be paid to improve availability, stability and motivation of personnel in peripheral healthcare services. Thus, this operation will allow the cover and quality of services offered to be extended since personnel will become more motivated and will do their best for the quality of care and the running of the services. This operation is fully integrated into the national strategic framework of the healthcare sector and its sectoral plans. It would be worthwhile introducing the concept of "means and results contract" for healthcare services and performance contracts for management personnel in the framework of reforming human resources (evaluating the performance of healthcare teams and paying performance bonuses).

This is an innovative activity in the following sense: (i) it concerns a bonus for personnel who are not civil servants, (ii) it is for technical officials; (iii) the bonus level depends on several criteria (rural environment, land-locked zone, poverty zone) and (iv) it is ASACO employers and the Ministry of Health which pay the bonuses to the recipients. Proposed eligibility criteria are as follows:

- Choice of being limited to the head of the centre to facilitate an equitable distribution of available technical personnel rather than there being a concentration in certain centres,
- Choice of favouring rural zones against urban zones, in accordance with the CSLP and data analysis reports from the PRODESS monitoring tool which noted a better situation in urban zones.
- In various reports, it appeared that certain isolated zones experienced more severe problems; thus zone 2 of the CSLP and the zone 1 circles, where more than 20% of the areas have no technical personnel, have been favoured.

Without doubt, introducing such a bonus is equally desirable in the community healthcare sector and in some rare cases, this bonus already exists. However, we feel that it is too early for the general introduction of such a bonuses.

- Reinforce the HR information sub-system, whatever group they belong to. This concerns finalising the HR database and putting it into operation to monitor each healthcare agent in real time, to manage appointments and transfers, to plan careers and recruitment, and also to forecast future HR requirements. The CPS, DNRH, DAF and the DNS with technical support from WHO and other Technical and Financial Partnerships are the competent structures responsible for implementing this operational target.

Certain pre-requisites are needed to implement this operational target and all the secondary targets such as management software, data processing equipment and a network installation as well as technician training in this area, and creating and updating personnel files.

6.2 Objective 2 aims to improve the quality of healthcare services. Three main service dimensions should be taken into consideration: technical, social and economic.

On a structural level, the technical dimension of quality includes: (i) suitability of personnel training (including managers) in

the requirements for their tasks; (ii) updating their technical knowledge and capacity; (iii) security characteristics of material and physical resources, the site where the services are provided. Regarding the process, this concerns the organisation of production, the skill with which the resources are used and the tasks carried out. Regarding results, the technical quality is measured in terms of efficiency, that is, actually producing the planned effects.

The social (or relational) dimension is understood to mean aspects of healthcare services linked to interactions between those involved in production, mainly producers and consumers (reception, humanisation, satisfaction, etc…). Relations between the various categories of producers can also be included here. Regarding the production process itself, social dimension includes the quality of the relationship built by the service providers with the service recipients in terms of respect and empathy shown (listening, understanding needs, expectations, concerns of the users). Regarding results, these can be measured in terms of the satisfaction of the user (which can easily be high even if the technical quality is low and vice-versa), of his entourage and of the producers themselves.

The economic dimension concerns cost elements, which are associated with the production and consumption of services. Production costs, which are kept low by resorting to less costly resources but with the same quality, allow for greater economic accessibility to services.

The assessment can concern: (i) structural elements (components used for production [personnel, equipment, supplies, infrastructure resources]) and also the organisational framework in which the production is carried out; (ii) process elements (methods, operations, way of creating employees so that they produce the services; (iii) results of the production process (service itself and its effects and impacts).

The main activities, which have been defined for this objective, are:

- Train district executive teams in management, leadership and, if required, in implementing the programme. Competent, qualified and motivated executive teams form one of the pre-requisites for improving the quality of services and the continuity of care. It means reinforcing the capacities of district executive teams or creating new capacities both in managing healthcare services and in offering quality health care. This will help to improve the quality of the care offered and consequently will increase the demand for services. The Ministry of Health, through the DNRH, the DAF, CPS, with the technical support of WHO, are the competent bodies to implement all the components (tasks) in this activity. Training workshops will firstly be organised in zone 1 poverty regions and then in the other regions depending on needs.

-Carry out integrated quarterly supervision of CSCOM personnel including inspections of rational use of medicines and the cost of prescriptions. Activities must be integrated to help improve the smooth running of the healthcare services pyramid in order to improve their cover and reduce costs. Integrated supervision is part of the continuous training and feedback framework which is critical for maintaining motivation and productivity; this is a necessary outcome when tasks or responsibilities are delegated from a higher to a lower level.

In order to integrate the targeted objectives, the integrated activities must have the following organisational characteristics: (i) same place; (ii) same time; (iii) same team; (iv) common file. District executive teams are the competent bodies responsible for implementing all components (tasks) which are inherent to this activity. Training workshops will firstly be organised at a regional level for teams at this level and then at a district level for the CSREF teams. Even with few resources, well-trained and motivated teams will help overcome obstacles as well as achieve the main components of the activity.

- Carry out quarterly supervision of community relays. This activity will be implemented using the same process as for activity 2.2 above.

- Inspect the rational use of medicine and costs of prescriptions during internal medical audits. This means not only making a whole range of essential medicines accessible to the populations in the zones in question, continuously and at an affordable cost, but also and especially, managing prescriptions rationally so that the cost of medical prescriptions is not exorbitant. In order to do this, the technical capacities of supervisory teams must be reinforced. DNS teams, with the technical support of WHO are the competent bodies for this purpose. It is possible to carry out the various components in this activity using training/awareness workshops, held for the teams in question and for the prescribing parties, on updates of therapeutic protocols and the list of essential generic medicines and on the organisation of the integrated supervision process.

- Reinforce the medicalisation of first contact healthcare services. Quality services cannot be continuously offered to the population without competent, sufficient and motivated HR. These resources are increasingly rare in the public sector. This means that investment must be made in the profit-making private Mali sector in order to reinforce further Public-Private

collaboration which is one of the pre-requisites for offering quality services and therefore an efficient system of care. The Ministry of Health through the DNS, and healthcare professionals, with the technical support of WHO, are the competent structures responsible for implementing the components in this activity.

Training and awareness workshops for healthcare professionals, signing State performance contracts with the professionals in question and monitoring/evaluation are all tasks which are inherent to the activity and are essential for carrying out the activity.

- Developing and disseminating rational use of medicines and taking responsibility for malnutrition. This means making diagnostic and treatment guides/protocols available to the prescribers and healthcare service managers in question. This would help them rationalise both diagnostics and treatment so that they could be adapted to the context and to local pathologies. The Ministry of Health (through the DNS, CPS) with the technical support of WHO and other Technical and Financial Partners, the civil society and FENASCOM are the competent structures responsible for implementing all components in the activity. A workshop to develop/revise guides/protocols will be organised when work on implementing the GAVI support starts; an annual training/awareness workshop for prescribers with broad circulation will be organised at the start of each support year;

- Set up an accreditation system for efficient districts particularly using the patient centred approach. This concerns setting up a mechanism through which the input of each member in the care network (that is, a network in which several participants are involved, particularly at district level) and also his obligations will be formalised in a contract and whose performance level can be measured. This will allow social and healthcare workers, particularly those at a district level, to: (i) keep their identity whilst being integrated into a care dynamic which is focused at the overall well being of the individual; (ii) share and exchange their knowledge. Structures in the Ministry of Health (CADD, DNRH, CPS), FENASCOM, the civil society, with the support of Technical and Financial Partners are the competent bodies responsible for implementing the activity. The following will be organised to achieve both the operational target and secondary targets: (i) an annual training/awareness workshop on the accreditation system for the players concerned; (ii) a workshop to determine selection criteria for efficient districts and to select the said districts.

- Recruit a technical assistant for each region in poverty zone 1, so that responsibility can be taken for the least efficient districts The Mali population has increased greatly over the last two decades. New needs have become apparent, which are linked to development problems and to developments in the quality of life. In developing countries such a Mali, the effects of globalisation have not allowed for a just response to the problems faced by the populations.

Despite reforms which have been introduced and the results obtained, the healthcare sector is facing a certain number of major issues: (i) availability, quality and management of human resources; (ii) improving the quality of services. Human resources are insufficient in both quantity and especially quality and this is the case at all levels in the healthcare pyramid whatsoever the geographical region, except in the capital where the majority of paramedical personnel can be found. There is a large discrepancy between regions regarding distribution of human resources.

To make up for this discrepancy, support from GAVI must also be sought in the form of a local or even international technical assistant to help the less efficient districts reach the same level as the others.

The competent structures responsible for implementing this operational target are CPS, DNRH, DAF, DRS, CT, with the technical support of the Technical and Financial Partners, particularly WHO.

*6.3 Objective 3.*This aims to reinforce institutional capacities and decentralisation. Despite the weaknesses noted, Mali is resolutely committed to the decentralisation process. With a view to reinforcing further the Mali healthcare system, the responsibility for healthcare administration has been transferred to the “community” collectivity. The country currently has many assets, amongst which are: authorities’ awareness of the need to harmonise practices, to reinforce the capacities of local frameworks by taking part in a certain number of workshops, the need to help players by drawing up a guide on contractualization and most recently the desire to develop a national contractualization policy.

This concerns reinforcing not only the Ministry’s for Health capacity to operate, using its central and regional bodies, but also that of the Territorial Collectivities to whom the Ministry of Health transferred a share of its technical and financial competences (cf decree 02-314) so that they could manage healthcare problems efficiently at a peripheral level. This will greatly help the healthcare services in question efficiently accomplish their task and their redefined role in implementing PRODESS…. Thus, the Mayor is responsible for healthcare administration in his jurisdiction. Support from GAVI to reinforce healthcare systems is part of this framework.

All Mali's social and healthcare policy documents stress the need to involve private players in implementing the various projects, programmes and related plans. This involvement cannot be informal and isolated. All parties, particularly the State, civil society, territorial collectivities and the profit-making sector must enter into contractual relations. A contractual policy, to be used as a regulatory framework and which lays down contracts in this area, must be drawn up because of the great many players and subjects which could be affected by these contractual relations. The better the contractual policy used as a base to outline the public service task, the more the private sector associated with the State will be obliged to respect it.

Non-profit making healthcare centres other than the CSCOM are in fact involved in the public service task. Ministries responsible for Health and Social Development ensure that relations with this category of service providers move towards a form of contract whose spirit is associated with the public service task.

Improving the steering capacities and the orientation of the system should be mentioned amongst the various innovative strategies to achieve this objective; (i) controlling the healthcare system; (ii) improving links with the healthcare information system, the major inquiries (particularly the World Health Inquiry) and the planning process; (iii) improving collaborative efficiency between the Ministry of Health and its partners; (iv) coordinating and evaluating PRODESS by involving other players; (v) monitoring and making work profitable which links the various partners and other departments (youth, education, promoting women, children and family, social development, environment, etc); (vi) coordinating and monitoring CSLP's implementation of healthcare and population measures through a coordination and monitoring unit working with a national CSLP coordination cell; (vii) improving collaboration with civil society through contractualization with NGOs; (viii) promoting accountability of healthcare establishments both regarding their authorities and regarding their populations; (ix) studying the possibility of promoting consumer protection regarding health care through community organisations such as ASACO or through consumer protection organisations; (x) creating a mediation/arbitration structure to solve conflicts between ASACOs, populations, personnel and healthcare authorities.

The main activities linked to achieving this objective are:

- Ensure the application and evaluate the implementation of mutual aid agreements/contracts between municipalities and ASACOs. The aim of contractualization is to improve the performance of the healthcare system. Mutually advantageous contractual relations must be set up so that players in the healthcare system can focus their attention on improving their performance and producing the best results to the benefit of the structures in question and their targets. This will thus allow the various players in the social and healthcare sector to be focused in their processes.

The State must always ensure that its partners provide the best possible service for the population; it must ensure that this contractual freedom cannot be expressed to the detriment of territorial collectivities; it acknowledges contractual relations which already exist by encouraging and reinforcing experiences which are already in progress and which must be integrated into current policy; the populations' interests and their involvement in the running of social and healthcare services must be protected. Thus mechanisms to involve populations which have progressively being set up must not be threatened by contractualization; respecting the public service task remains a essential element of contractualization; contractualization must be implemented against a background of mutual respect between whichsoever players. It is important that players avoid conflicting situations as much as possible and use negotiations to find solutions. Contractual relations must be formed between players who have the legal capacity to sign contracts. Nevertheless, forms of internal contractualization can be developed so long as their specific nature is clearly determined.

The Cercle Council, FELASCOM, CSREF teams and the Prefect are the competent bodies responsible for implementing the activity. To carry out this activity, an annual 2-day workshop will be organised at Cercle level bringing together two (2) ASACO members, one (1) mayor, FELASCOM, the CSref team, the Prefect, the Cercle Council, area AMM, and NGOs. On the first day of the workshop, the obligations of each player in the agreement will be assessed and on the second day: strategies to accomplish the obligations.

- Developing the Public Private partnership at district level by developing performance contracts for the whole of the PMA and by exchanging information (CSREF level). The analysis of the situation has also highlighted that the technical capacities needed for the effective use of contractualization are still not sufficient whosoever the players concerned. The Minister for Health must, because of this, determine a national contractualization policy to:
  i) ensure that the various players use contractualization whilst respecting national Social and Health development policies;
  ii) ensure that the contractual arrangements agreed between healthcare players contribute to improving the performance of the healthcare system;

iii) propose a frame of reference to draw up contracts to improve performance. This does not mean threatening contractual freedom but rather ensuring that this freedom is part of a consistent framework;
iv) encourage players in the sector to use contractualization each time it is demonstrated that it could be a relevant tool;
v) associate better with the private sector in implementing the national social and healthcare development policy in order to create dynamic complementarity of players, by researching their synergy and by using their various experiences;
vi) contractualization has long since been viewed as being a tool which allows daily problems which are encountered by players concerned to be solved whilst maintaining their individual reciprocal interests. The aim of this contractualization policy is that players view their contractual relations from a long-term perspective and emphasise the durability of relations in the interests of populations;
vii) harmonise contractual practices in order to avoid negative effects of experiences on the objectives and agreed methods of implementation and which could bring about inequalities between populations;
viii) improve the quality of contractual relations. Emphasising the need to reinforce the technical capacities of all players, the contractualization policy stresses that this tool must be controlled if good results are to be guaranteed;
ix) identify areas in which regulatory amendments should be introduced to facilitate the use of contractualization;
x) favour decentralisation to allow territorial collectivities to use contractualization to formalise their links with the State on one hand and with civil society organisations on the other, whilst carrying out the competences transferred to them;
xi) help players in the contractual process;
xii) by clarifying the participation of the various players, allow the capacity to assess and monitor contractual mechanisms to be reinforced and thus form a way of improving the social and healthcare system.

DRS and DRDSES are the competent bodies responsible for this activity. Carrying out this activity has been made possible by a regional workshop organised by the DRS and DRDSES on drawing up contracts, signing them at the time of regional monitoring and following them up twice a year during management councils and supervision.

- Reinforce the process to develop Operational Plans at a district level (5 days: participation by one person from the DRS, 1 person from FELASCOM, 1 CT person, 1 NGO person, the prefect). This concerns further reinforcing the district level when developing operational plans. This will help local teams reflect better on local healthcare problems in their district and will consequently help them determine the necessary suitable strategies to be able to deal with them or avoid them.

The CSREF team and the area council are the competent structures responsible for implementing all components in the activity. A preparatory report and development workshop per proposed team in the activity, with management support (use of PRODESS tools developed by CPS/WHO), then a Management council workshop according to decree 115 are planned for this purpose.

- Integrate ASACO micro plans into community Collectivity plans at healthcare area level. Together with the transfer of competence, signing the mutual aid agreement, which had previously been devolved to the healthcare district administration, now falls within the remit of the community. The standard mutual aid agreement has been revised. But there are still two major problems: (i) the non-control of the contractualization process by players; (ii) and the fact that technical services do not play a major role in the Ministry of Health and Social Development in developing, implementing and monitoring contractualization. Technical capacities of municipalities and ASACO must therefore be reinforced. Ministries for Health must be vigilant regarding the involvement of their technical services in developing, implementing and monitoring contractualization whilst guaranteeing that they themselves have the necessary competences to carry out these tasks correctly.

The competent structures for implementation are ASACO, technical personnel and the healthcare committee at the town hall. The activity will be carried out by setting up a development committee at the mayor's decision comprising ASACO members, CSCOM personnel and the Town Hall healthcare committee; developing the draft micro plan and a workshop to validate the

area with re-training after 2 years given the electoral nature of the members in these organisations.

- Reinforce intervention capacities of the Ministry's central level to support the healthcare system. By adopting the resolution of the 56th World Health Assembly which recommends that Member States adopt a contractualization policy, Mali showed its desire to ensure that this tool would indeed lead to an improvement in the performance of the healthcare system and would not act against the general interests of populations for whose social and healthcare sector the Ministries are responsible.

The analysis of the situation has also highlighted the fact that technical capacities are insufficient to use contractualization effectively and to implement operations whosoever the players involved. Thus, implementing the components in the GAVI support, particularly medicalisation of peripheral services and technical assistance to reinforce the least efficient districts, requires qualifications, competences and experiences which are all still far from sufficient at central level. Therefore CPS/Ministry of Health capacities must be reinforced or new capacities must be created regarding planning and monitoring/evaluation to accompany the implementation of the GAVI support for HSS.

The Ministry of Health, through the DNRH, DAF, DNS and CPS, with WHO technical support are responsible for implementing the various components in the activity.
This activity will be carried out through preparatory workshops on implementation and training (one workshop per year) which will be organised at the CPS. These workshops will concern planning/management and monitoring/evaluation of implementation. The duration of each workshop will be determined according to the programme requirements.

Case of micro-planning an ASACO which is to be integrated into the Municipalities

Illustration: Development Committee, composition and mandate – Case of an ASACO

This methodological process is applicable to all levels (local, Cercle, region, national) of the structure in question. All the elements described below must be respected (committee, workshop, participants, procedure, etc).

a) Programming objective in the healthcare area

There are several objectives to the annual micro-programming, some of which we feel must be pointed out:

- Drawing up a statement of programmed actions in order to assess the consistency between intentions and actions in the framework of healthcare policy,
- Planning the micro-plan for the healthcare area for the period to come in accordance with sectoral schedules,
- Linking our planning or programming to that of other development players (technical services, collectivities, technical and financial partners, NGOs, women's and youth associations, etc) for coordinated and concerted management of actions to improve the life conditions of populations (healthcare, education, nutrition, cleanliness hygiene),
- Reinforcing a productive partnership between players based on involvement and participation of everyone in the local development process. This approach favours concerted and transparent management of resources (human, material and financial),
- Giving our management bodies a management and negotiation tool to formalise relations between players against a background of efficient and effective management.

A committee to develop the annual micro plan is set up by a mayoral decision at the proposal of the ASACOs, in order to make collectivities aware of their responsibilities in the management of the healthcare system in the communal space.

b) Composition of the committee

This committee comprises four (4) persons who are:

- The President of the Administration Board,
- The CSCOM technical manager,
- The President of the healthcare committee at town hall level,
- The Treasurer General of ASACO.

NB: The committee can call on any person according to his expertise.

c) Committee's mandate

The Committee's mandate is to:

- Collate all data needed to develop the micro-plan in collaboration with the other players.
- Develop the draft version of the micro plan to be submitted to the workshop for validation.
- Organise the healthcare programming workshop for the area to validate the micro-plan, a copy of which must be sent to the reference healthcare centre, to be used as a base to develop the annual operational plan for the healthcare district, to FELASCOM and to the town hall to be included in their respective operational plans.
- Ensure there is a secretariat of the micro-planning workshop,
- Integrate the workshop's comments into the draft version of the micro-plan and register the final version of the micro-plan with the Administration Board of ASACO.

i) Programming workshop in the area (Micro-programming)

- The micro-plan development committee proposes the date to the community mayor who invites the various players providing an agenda.
- The mayor chairs the workshop meeting, which lasts one or two days.
- The workshop document must comprise two essential parts; these are the report for year n-1 and the programme for the following year (n+1), which are to be presented by one of the development committee members.
- The discussions are to concern shortcomings in the report on one hand in order to find adapted strategies, and mobilising the funds needed to carry out the micro-plan on the other.
- The process must be finished in healthcare areas prior to starting the planning of other players (technical services, OSC, technical and financial partners).

ii) Main players for the workshop

- Relays of villages in the healthcare area,
- Administration Board of ASACO,
- CSCOM management committee
- Members of the supervisory committee,
- Mayors of municipalities affected by the healthcare area,
- Members of the healthcare committee of the town halls in question,
- Administration (sub-prefect),
- A member of the therapist office of the healthcare area,
- Manager of the women's association,
- Manager of the Youth association,
- NGOs or healthcare partners in municipalities concerned,
- CSCOM technical team,
- CSRef support team,
- Support team of the other technical services.

6.4 Objective 4. This aims to reinforce the monitoring and evaluation system. Monitoring and evaluation operations concerning resolving the population's healthcare problems are essential to help assess the performance of the healthcare system, and allow the following to be monitored and assessed: (i) work of a healthcare team from the point of view of the quality of services offered and their results; (ii) progress of the work; (iii) performance of healthcare team members; (iv) efficiency with which resources are used; (v) management of the healthcare team.

In order to collate, consolidate and analyse data related to monitoring GAVI support for HSS in Mali, a GAVI support team will work in the Ministry of Health Planning team whose intervention capacity needs to be reinforced in areas of planning/analysis and monitoring/evaluation.

However, problems related to the monitoring and evaluation system have been identified and the following activities have been planned to highlight them:

The principles, which have been determined to achieve this operational target, are:

- Reinforce the monitoring/evaluation system in each healthcare area: Monitoring is one of the fundamental elements for the smooth running of the healthcare services pyramid; it is an essential consequence of delegating tasks or responsibilities from a higher level to a lower level; it allows the persons involved to be given the advice they need and especially the encouragement which their role needs; finally, it is included in the continuous training feedback framework which is essential to maintain motivation and productivity. This concerns improving ways of observing the progress and quality of the GAVI support work for HSS or each of its components. Monitoring will be carried out using a checklist during supervision visits. It will also be carried out through meetings, discussions and studies of files and reports. The programme can be re-focused as a result of information gathered during monitoring.

The competent structure responsible for this activity is: CPS, DNS, DRS, with the technical support of WHO.

How can follow-up/monitoring be guaranteed? It affects four important areas: implementation, progress of the work, assessing personnel performance, use of resources. To guarantee follow-up of:

i) implementation: two major questions must be posed: are the results the ones which were expected? Can they been assessed?
ii) progress of the work: two fundamental questions to be posed could be: are the results the ones which were expected? If not, why not? Does monitoring progress allow the efficiency of the healthcare team to be measured?
iii) assessing personnel performance: there are two fundamental questions to be posed: Are the results as good as they could be? If not, why not? One of the important goals of assessing performance must be measuring the actual contribution of each individual to the work provided by each of the team members.
iv) use of resources: At this level, monitoring tends to determine the relationship between the resources used on one hand and the results obtained, on the other, during the GAVI support schedule for HSS, in order to answer the following questions: could certain resources allow better results to be obtained? Could certain results be obtained using fewer resources?

- Improving the quality of integrated supervision (guide, training and regular follow-up of CSCOM/CSRef supervision). This concerns developing/updating the supervision guide, training and regular follow-up of CSCOM supervision by district executive teams (CSRef). The competent structures responsible for this activity are the district executive teams, DRS, DNS, civil society and with the support of Financial and Technical Partners, particularly WHO and UNICEF. The strategies to implement this activity are the same as those mentioned for the above activity.

6.5 Objective 5. This aims to reinforce operational research in healthcare. To date, research has not been greatly developed in the care system. There is no national policy or a national research plan. Nevertheless, in the majority of regions, with the support of technical assistants and partners, several operational research themes have been implemented but not all the results have been adequately disseminated and applied. A national research policy for healthcare was drawn up and validated in 2004. The delay in adopting it meant that the Conseil National de Recherche Essentielle en Sante (National Council for Essential Health Research) was not created as planned. Problems can be summarised as follows:

i) inadequacies in mobilising funds for research ;
ii) poor capacity to disseminate and use research results ;
iii) inadequacies in training personnel on an operational level and hospitals in research methodology;
iv) inadequacies in coordinating research activities both on a sectoral and inter-sectoral level.

This concerns developing research to know the determining factors and vulnerability of healthcare problems, to determine, control and optimise the costs of taking responsibility for healthcare problems. Moreover, given that the aim of a care system is to respond to healthcare needs, the effects of using services for these must be measured. This initially concerns whether the services produce the required or predicted effects, or in other words are they effective; an operation can have great potential effectiveness when tested in a laboratory for example, but might only have poor actual effectiveness. Factors must therefore been identified which could 3(o)13(r)1 aen thnedu3( )-orp15(t)14(u)15(o)13(n)16(f)14(i)11(d)13(4213( )-130(b3( )-3( )-130(b)13(e)

But there are still two major problems: the non-control of the contractualization process by players; and the fact that technical services do not play a major role in the Ministry of Health and Social Development in developing, implementing and monitoring contractualization.

In order to guarantee better the accountability of each player and their impact on the CSCOM performance, the effect of the contractual process signed between collectivities and ASACOs must be measured, using operational research, in order to implement partially or totally the tools mentioned earlier whilst still stressing the concept of public service.

- Measuring the effect of performance contracts through the Public Private Partnership. Mali's social and healthcare policy documents stress the need to involve private players in implementing the various projects, programmes and related plans. This involvement cannot be informal and isolated. All parties must enter into contractual relations. A contractual policy, to be used as a regulatory framework and which lays down contracts in this area, must be drawn up because of the great many players and subjects which could be affected by these contractual relations. The better the contractual policy used as a base to outline the public service task, the more the private sector associated with the State will be obliged to respect it.

The contractualization policy stresses the importance that, in future, contractual relations between the Ministry of Health and the private sector must be increasingly centred around reciprocal forms of cooperation based on the concept of "acting together" which better translates the spirit of partnership. Coordination groupings as an interface between the State, financial partners, international NGOs on one hand and local NGOs on the other should be increasingly involved so that these relations develop towards a better partnership.

In order to provide a better service to the population, each player in the healthcare sector must be as efficient as possible. Contractualization is a tool which can be mobilised to achieve this result. It therefore concerns demonstrating, through research, the possible effect of performance contracts signed by the Ministry of Health and the private sector (profit making or not) in terms of helping to improve the state of the healthcare of the Mali population. It would also be useful if internal contractualization were progressively implemented or regularly assessed in order to keep the best experiences and avoid errors.

The Ministry of Health, through the DNRH, CADD, DAF, CPS, civil society, FENASCOM, and with the technical support of financial and technical partners, are the competent bodies responsible for implementing all the components in the activity. The activity will be carried out using the same process described previously for the other research activities.

- Measuring the effect of accrediting efficient districts by using the patient centred approach in particular. The contractualization policy proposes development care networks and appropriate contractualization.

Overall responsibility for a patient is very complex and is becoming increasing necessary; the pursued objective is to coordinate better the chain of care delivered to the patient by healthcare players, particularly at a district level, jointly or successively. The operational response to this logic is increasingly a network of care, that is, a network which links several players. Thus, the input of each member to the network as well as his obligations will be formalised in a contract and the performance level will be measured. This will allow social and healthcare workers to keep their identity whilst being integrated into a care dynamic which is focused at the overall well being of the individual. The objective of the network is therefore to coordinate the care provided by each of the players in the network, and share and exchange their knowledge. The network concept is new to Mali. Nevertheless there are certain experiences in the area of HIV and the social economy.

Therefore this concerns measuring in particular the effect of accrediting efficient districts by using the patient centred approach through research. The competent structures to carry out this activity are CADD, DNRH, DNS, CPS, FENASCOM, civil society, with the technical support of technical and financial partners, particularly WHO. Components in the activity will be implemented using the same process as the other research activities defined above.

- Measuring the effect of DRS operations on improving healthcare district services generally and regarding integrated supervision in particular. Current trends of the Mali administration as a whole aim to introduce the concept of results-centred management, a concept which requires greater accountability from decentralised services and which goes hand in hand with greater decision-making space. It therefore concerns measuring the performance level of DRS operations on improvements in the state of the population's healthcare and therefore on improvements in the quality of health care offered. Components in the activity will be implemented using the same process as for other research activities defined above.

The competent structures responsible for this operational target are CPS, DNS, Mali University, FENASCOM, civil society with the technical support of technical and financial partners, particularly WHO.