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MALI PRIVATE HEALTH SECTOR ASSESSMENT

December 2017
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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
AMLM	*Association des Médecins Libéraux du Mali* (Association of Physicians in Private Practice of Mali)
AMM	*Autorisation Mise en Marché*
AMO	*Assurance Maladie Obligatoire* (Mandatory Health Insurance)
AMV	*Assurance Maladie Volontaire* (Voluntary Health Insurance)
ANAM	*Agence Nationale d'Assistance Médicale* (National Agency for Medical Assistance)
API	*Agence pour la Promotion de l'Investissements au Mali* (Agency for the Promotion of Investment in Mali)
ASACO	*Associations de Santé Communautaires* (Community Health Associations)
CANAM	*Caisse National d'Assurance Maladie* (National Health Insurance Agency)
CHE	Current Health Expenditure
CPS	*Cellule de Planification et de la Statistique* (Planning and Statistics Unit)
CROCEPS	*Comité régional d'orientation, de coordination et d'évaluation du PRODESS* (Regional Committee for Guidance, Coordination and Evaluation of PRODESS)
CSCom	*Centres de Santé Communautaires* (Community Health Centers)
CSRÉF	*Centres de Santé de Référence* (Referral Health Centers)
DHIS	District Health Information System
DNS	*Direction National de la Santé* (National Health Directorate)
DPM	*Direction de la Pharmacie et du Médicament* (Division of Pharmacy and Medicines)
DPS	Social Welfare Department
FCFA	*Franc de la Communauté Financière de l'Afrique* (Franc of the French Colonies of Africa)
HFG	Health Finance and Governance (project)
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HSA	Health Sector Assessment

IFC	International Finance Corporation
INPS	*L'Institut National de Prévoyance Sociale* (National Institute of Social Protection)
IUD	Intrauterine Device
MSHP	*Ministère de la Santé et de l'Hygiène Publique* (Ministry of Health and Public Hygiene)
NGO	Non-governmental organizations
NHA	National Health Accounts
PDDSS	*Plan Decennal de Développement Sanitaire et Social* (Ten-Year Health and Social Development Plan)
PFP	Private for-Profit
PPM	*Pharmacie Populaire du Mali* (Central Medical Store)
PPP	Public-Private Partnerships
PRODESS	*Programme de Développement Sanitaire et Social* (Health and Social Development Program)
ProFam	*Protection de la Famille* (Protection of the Family)
PSA	Private Sector Assessment
PSI	Population Services International
RAMED	*Régime d'Assistance Médicale* (Indigent Medical Services Plan)
SDAME	*Schéma Directeur D'approvisionnement et de Distribution des Médicaments Essentiels* (Essential Medicines Supply and Distribution Master Plan)
TB	Tuberculosis
UEMOA	*Union Economique et Monétaire Ouest-Africaine* (West Africa Monetary and Economic Union)
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UTM	*Union Technique de la Mutualité* (Technical Union of Mutualities)
WHO	World Health Organization

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EXECUTIVE SUMMARY

Since 1985, the Government of Mali has been engaged in the promotion of private sector practices in the health sector. Growth of this relatively young private sector has been slow due to lack of effective support from various stakeholders. Several laws and regulations have specified the role and responsibilities of the private for-profit (PFP) sector. Mali's Ten-Year Plan for Social and Health Development Plan (*Plan Decennal de Développement Sanitaire et Social*, PDDSS) 2014-2023 and the Health and Social Development Program (*Programme de Développement Sanitaire et Social*, PRODESS III) 2014-2018 are two key government documents that refer to the private health sector and are discussed in this report.

A few studies have been conducted on the private health sector in Mali in the last few years. One of these studies – the World Bank Private Sector study, completed in 2011 – was a comprehensive assessment that enabled the Ministry of Health and Public Hygiene (MSHP) to collectively identify strategies to improve the private sector's contribution to health goals and to develop public-private partnerships (Lamiaux, Rouzaud, and Woods 2011). However, the conclusions and recommendations of the study are not well known by officials and their implementation has been delayed. Further, overall knowledge on the nature, operation, and potential contribution of this sector and on opportunities for integration of the private sector into the health system in Mali remains insufficient among health stakeholders. A comparative study of the private sector in members states of the Economic Community of West Africa was conducted in 2013 (Ballo 2013). This report situates each member state against each other and helps to understand the progress made in this sub-region.

More recently, a Health System Assessment (HSA), conducted in 2015 by the Health Finance and Governance (HFG) project, highlighted the need to address specific concerns with the primary objective of increasing the contribution of the private sector to the overall performance of the national health system. After completion of the HSA, the MSHP and USAID requested an assessment of the private sector. The purpose of this assessment was to gain an in-depth understanding of the private sector in this case defined as for-profit service and pharmaceutical providers to foster a dialogue around solutions to:

i. the lack of involvement of the private sector in governance of the current health system
ii. the poor collaboration between the public and private sectors in the public health system, and
iii. the lack of participatory, legal and financial mechanisms to strengthen the role of the PFP sector, with a view to extending universal health coverage.

The Private Sector Assessment (PSA) team comprised four experts from the HFG project. One local consultant was involved to complete an inventory of the private sector in Mali in order to develop an updated database of private sector providers accessible to the MSHP. A review of the literature and secondary data analysis of the Demographic and Health Survey and from other sources was done to guide the assessment and inform the content of the key informant interviews. The PSA team interviewed approximately 50 in-country key informants from different organizations, including private providers, private sector representation bodies, professional associations, trade unions, and regulatory structures, and collected other data to inform the PSA findings. The findings are focused on four technical areas: policy and governance, service delivery, medicines and supplies, and financing.

The assessment identified significant opportunities for the private sector and outlined cross-cutting recommendations to strengthen collaboration between the public and private sectors, and coordination and contracting for the private sector. Key findings and recommendations are outlined in Table ES-1.

Table ES-1: Key Findings and Recommendations

Technical Area	Findings	Key Recommendations
Policy and Governance	• There is a lack of accountability and coordination between the public and private sector. • Current system for oversight, standardization, and accreditation of practices by national health authorities is weak. • Collaboration between private and public sector providers is ad hoc and often based on personal relationships.	• Conditions and mechanisms to enable and strengthen collaboration between sectors should be implemented. • There should be representative of the private sector on PRODESS Committees to identify roles beyond the provision of free services. • The MSHP must engage the Private Sector Alliance for Health Promotion in Mali (*Alliance du Secteur Privé pour la Promotion de la Santé au Mali*) as a key interlocutor and engage private associations on critical issues.
Service Delivery	• The volume and quality of services in the private sector is closely linked to access to financing for equipment, continuing medical education and training, and better regulation and oversight of private practice. • There is potential for expanded collaboration in the area of key services (HIV, tuberculosis (TB), family planning), epidemiological surveillance, prevention, and services for poor and rural communities. • Increased collaboration between the private and public sector requires a better represented PFP sector in alliances and associates, with increased opportunities to grow.	• The MSHP must roll out the Alliance and engage private associations on critical issues. • There must be increased public sector compensation mechanisms for private facilities providing HIV/AIDS, TB, and family planning and preventive services. This may be through their increased participation in the Mandatory Health Insurance (*Assurance Maladie Obligatoire*, AMO), including the Indigent Medical Services Plan (*Régime d'Assistance Médicale*, RAMED). • Moreover, public facilities should be able to contract services to the private sector.
Medicine and Supplies	• There is a lack of accurate information on private sector pharmaceutical providers, which hinders the MSHP's efforts to inspect, supervise, and educate private providers. • In addition, central structures of the MSHP do not fulfill their role to support and oversee private pharmaceutical practices, or to disseminate information and organize appropriate training.	• The MSHP should promote the active participation of PFP pharmacist representatives in MSHP technical committees, such as those for essential medicines, pharmacovigilance, and the authorization to bring drugs to market (*Autorisation Mise en Marché*, AMM). • The MSHP should focus on on-the-job training for the PFP representatives and promote their access to financing so they can establish pharmacies in underserved populations.

Technical Area	Findings	Key Recommendations
Financing	• Growth and increased coverage of the AMO provides opportunities for private health providers to increase their resource base and quality of services. • Private insurance will likely evolve into supplemental insurance coverage and thus, private providers will need to participate in the AMO to be able to stay competitive. • Although contracting of health services is needed, desired, and permitted, it is not used due to lack of knowledge and detailed instructions. • Private health providers face challenges accessing financing and require skills to prepare a business case. • Because the government does not prioritize the health sector for investment, it does not receive additional incentives (waiver of duties for inputs and tax holidays).	• Efforts to enroll private providers in the AMO should be encouraged and facilitated. • RAMED should expand its enrollment of private providers to cover 'free' services and should consider contracting with community-level private providers. • The National Health Insurance Agency (*Caisse National d'Assurance Maladie*, CANAM) should include private insurance companies in discussions on the new architecture of the AMO. • Contracting framework and guidelines should be disseminated and their use encouraged through best practices and success stories. • Additionally, contracting opportunities should be identified and their implementation supported. • Opportunities for private providers to develop their business skills and to increase access to financing must be provided by government and private investors

1. BACKGROUND

1.1 Demographic and Health Conditions

Located in West Africa, Mali has an estimated population of more than 17 million in 2015; approximately 75 percent of the population lives in rural areas, and the remaining 25 percent lives in urban areas (World Bank 2015). The total fertility rate is among the highest in the world at 6.9 per woman in 2012 (UNICEF 2013) and population annual growth was estimated at 3 percent in 2015 (World Bank 2015). As in most sub-Saharan countries, Mali faces substantial health challenges such as high maternal mortality (587 maternal deaths per100, 000 live births) (WHO 2015), under-five child mortality (114.7 deaths per 1,000 live births), and infant mortality rate (58 infant deaths per 1,000 live births) (World Bank 2015). Preventable diseases such as malaria, acute respiratory infections, and diarrheal diseases continue to be major contributors to the disease burden in the country (IHME 2015). These diseases are often linked to poverty, food insecurity, poor water and sanitation, low levels of education, and lack of access to quality and affordable health care services.

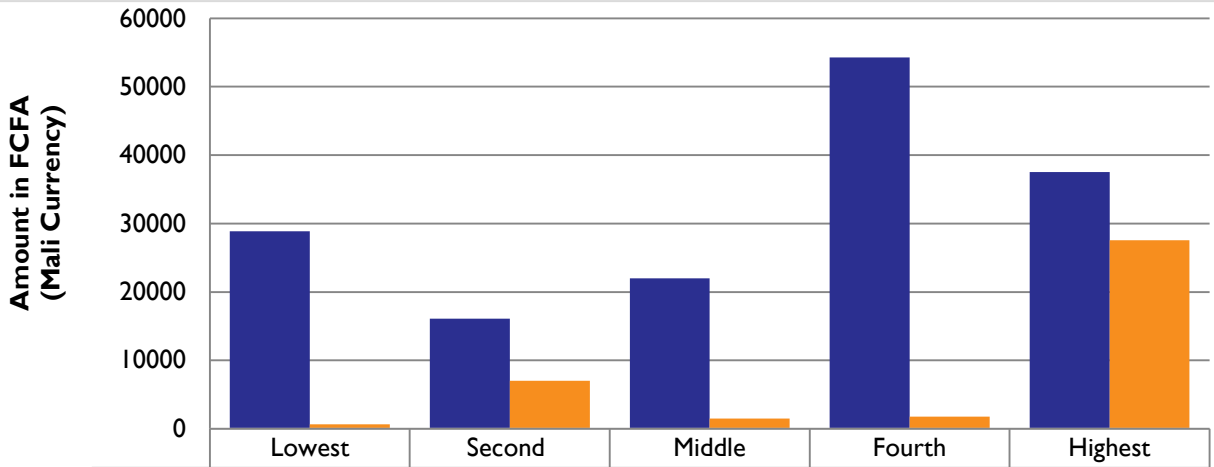
1.2 Economic and Health Expenditure Indicators

Although the annual growth of the gross domestic project (GDP) remains robust at 5.3 percent in 2016, Mali is one of the world's poorest nations, ranking 175th out of 188 according to the Human Development Index (UNDP 2016, p. 200); GDP per capita is US$724 (World Bank 2015). As reported by the World Bank, poverty is much lower in urban areas, with 90 percent of all poor living in rural areas in the south, where population density is highest (World Bank 2015). It is estimated that 50.4 percent of the population lived on less than $1.25 per day from 2007 to 2011 (UNICEF 2013), making it very difficult for most Malians to afford health care.

According to the 2013 National Health Accounts (NHA), household expenditure on health represents a little over half (53.9 percent) of Mali's total expenditure on health (CFA 183 billion) (MSHP 2015); 31.6 percent of household health expenditure is spent at private health care providers, and 87.7 percent is spent on curative care. While the typology and categorization of providers in the NHA report does not allow in-depth disaggregation of these figures into private for-profit and nonprofit, it is possible that private for-profit (PFP) providers represent a significant portion of household expenditures for curative care. In contrast, the NHA findings show that most funding for priority diseases goes to the public sector. Malaria-related payments to private providers are estimated at 8.7 percent of total expenditure for malaria, while for tuberculosis (TB) it is 23 percent of total expenditure for TB; nearly 100 percent of HIV/AIDS-related expenditures go to public hospitals and other public entities. This shows that public health interventions against these priority diseases do not involve PFP providers significantly. An NHA study using a more explicit definition of PFP providers and PFP-specific data could present a more detailed financing landscape and help to build sound strategies for private sector participation.

In 2014, Malian household's out-of-pocket payments for health was approximately 48 percent of household income (World Bank 2014), which is considered a financial catastrophe as defined by the World Health Organization (WHO), exceeding 40 percent of household income (Xu et al. 2005). The level of expenditure on health care varies based on the level of income and whether care is delivered by private or public health facilities. As indicated in Figure 1, those in the highest wealth quintile spend significantly more on private health services than those in other quintiles (CPS/SSDSPF et al. 2014). This is likely due to their better economic means and residence in urban areas, where private services are more concentrated and readily available.

Figure 1: Public vs Private Health Sector Expenditure on Treatment of Last Illness by Household Wealth Quintile (FCFA)



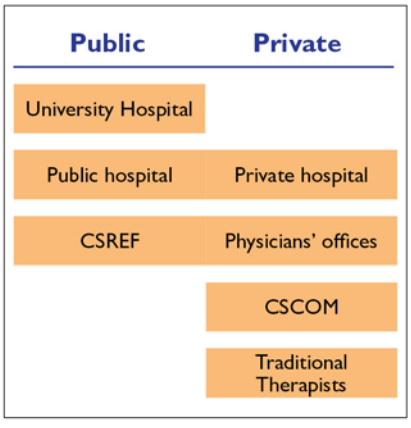
	Lowest	Second	Middle	Fourth	Highest
Public	28859	16107	21979	54304	37507
Private	650	7016	1479	1772	27559

1.3 Structural Characteristics of Mali's Health System

Public sector health care (Figure 2) is delivered via community health initiatives and comprises four levels:

- *Level 1*: Private nonprofit Community health centers (*Centres de Santé Communautaires*, CSComs) run by community health associations (*Associations de Santé Communautaire*, ASACOs) that provide a Minimum Package of Activities and are governed by principles that guide cost recovery and community participation, in terms of financing and management.
- *Level 2-first referral*: Referral health centers (*Centres de Santé de Réference*, CSRÉFs) in each commune (prefecture) where CSComs can refer patients.
- *Level 3- second referral*: Regional Hospitals, located in the regional capitals that provide care to complex cases for which the Minimum Package of Activities is insufficient.
- *Level 4- third referral*: Public and university hospitals.

Figure 2: Organization of the Health System



Source: Lamiaux, Rouzaud, and Woods (2011, p. 4)

Note: Figure 2 is a simplified representation of the organization of the health system and is not meant to be exhaustive, as it does not include pharmacists, wholesalers, etc.

Mali legally authorized the private practice of health professions in 1985. The first laws and regulations directly focused on the privatization of health professions were also adopted at that time. This liberalization occurred after a long period of a socialist, planned economy, during which the health system had been entirely managed and organized by the central government.

Mali's private health sector includes for-profit clinical practices and hospitals, and non-profit facilities, which together account for 64 percent of all clinical contacts between the population and the health system. In 2008, nearly half of the 2,546 licensed physicians in Mali were practicing in a private facility (Lamiaux, Rouzaud, and Woods 2011). This number may have increased. The size of the non-state market for health-related services may actually be much larger because there are reportedly many informal providers in Mali. There is no official estimate of the size of the informal market, which includes unlicensed providers, and licensed physicians or technicians with an unregistered practice.

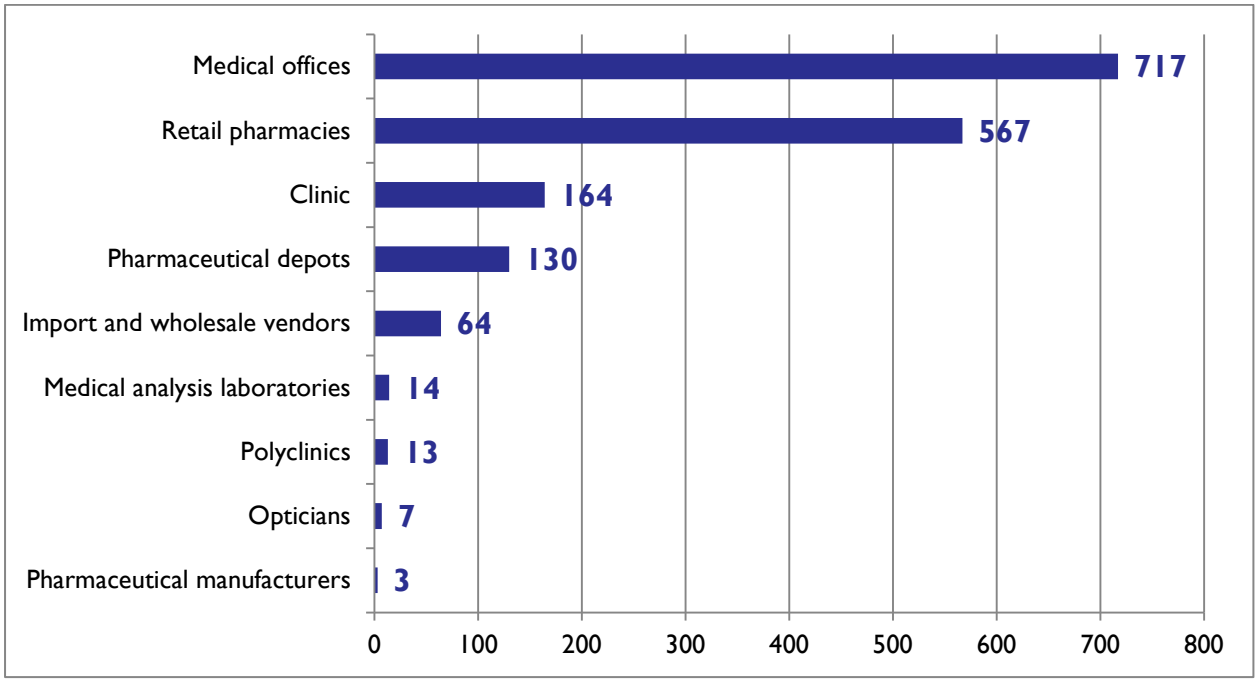
Private polyclinic in Katy

Nonprofit facilities consist primarily of CSComs that are managed by community health associations and are predominantly located in rural areas. About 200 private physicians were employed by a CSCom in 2008.

For-profit facilities account for 24 percent of the contacts between patients and health establishments. Of the 70 private hospitals in Mali, 49 are located in Bamako. Three-quarters of health providers working in the private sector in 2008 were either in private practice or employed by a private hospital (850 in total).

A 2017 inventory of private health facilities in Mali found 1,670 total structures, 56% of which are based in Bamako (Traore, 2017) (Figure 3).

Figure 3: Private For-profit Health Providers



Medical products, vaccines, and technologies constitute a key health system component. In the 1980s, Mali aimed to increase the physical access to and affordability of quality medicines nationwide. This was to be done by reforming the Central Medical Stores (*Pharmacie Populaire de Mali*, PPM), the main source of medicines and medical supplies for the public and CSCom health facilities.

The performance of the PPM failed to achieve the objectives set out for it in the Pharmaceutical Sector Reform plan of 1989. Although the PPM had a monopoly on the supply of medicines, it was unable to meet national supply targets. This situation forced a series of reforms and resulted in the liberalization of the medicines market: import restrictions were lifted, allowing the supply of medicines via for-profit pharmacies (including drugstores and wholesalers) and allowing for the promotion of alternative supply routes, with a new group of NGO health actors mandated to supply the CSComs. A second round of PPM reform in 1995 focused on generic medicines and supplying CSComs and public hospitals.

The poor performance of the PPM and the opening up of the medicines market to private suppliers led to an expansion of PFP pharmacies and was correlated with the growing number of graduates trained in the country's new faculty of pharmacy. These important reforms improved physical access to pharmaceuticals, reduced stock-outs, and enhanced the quality of medical services. However, they did not improve affordability. Other important challenges were the country's high dependency on imported medicines, and their transport and logistics given the size of the country. Also, there is a lack of financing and mechanisms to support new pharmacists who want open a pharmacy.

Table 1: Distribution of Main Pharmaceutical Structures Supplying Medicines to Public and Private Sector in Mali by Region

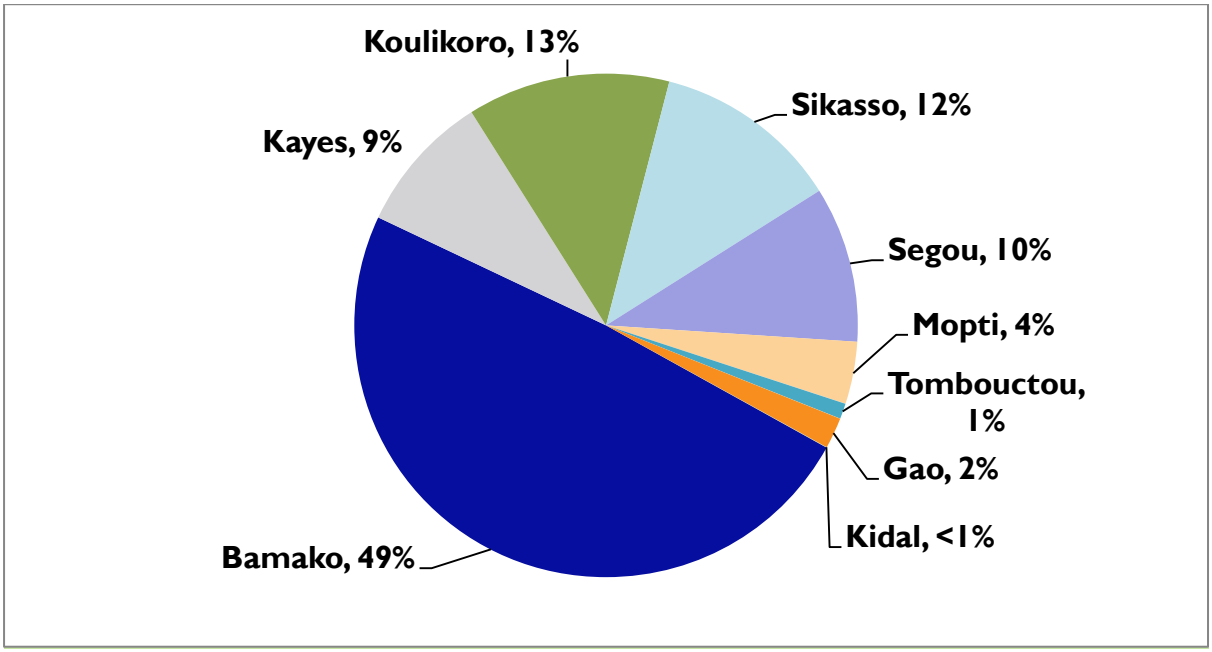
Region	Dispensing Pharmacies	Licensed Pharmaceutical Retailers ('Dépôts')	Wholesalers	Industry
Bamako	279	2	49	3*
Kayes	50	22	0	0
Koulikoro	46	31	0	1
Sikasso	61	28	2	0
Segou	47	16	0	0
Mopti	24	15	2	0
Timbuktu	3	6	0	0
Gao	9	0	0	0
Total	519	120	53	4

Source: *MHHP/Inspection de la santé (2017).* Data for the regions of Kidal, Taoudenit, and Menaka are compiled from the statistics provided for Gao and Timbuktu.

*UMPP (Usine Malienne de Produits Pharmaceutiques); UGC Pharmaco Sma SA Unite de Conditionnement; Human Well Pharma Afrique

Half of pharmacies (50 percent), most wholesalers (95 percent), and three private factories are located in Bamako. Ninety-five percent of the 'dépots[1]' operate in Kayes, Koulikoro, Sikasso, and Mopti. Figure 4 displays the distribution of pharmacies by region in Mali.

Figure 4: Distribution of Pharmacies by Region



Although fewer than in other regions because of civil unrest since 2012, there are pharmacies in the northern regions of Timbuktu and Gao. Only six (2 percent) of the retailers are in those regions, all in Timbuktu. All are private for profit. There are no wholesalers in these regions, making resupply of pharmacies difficult and expensive.

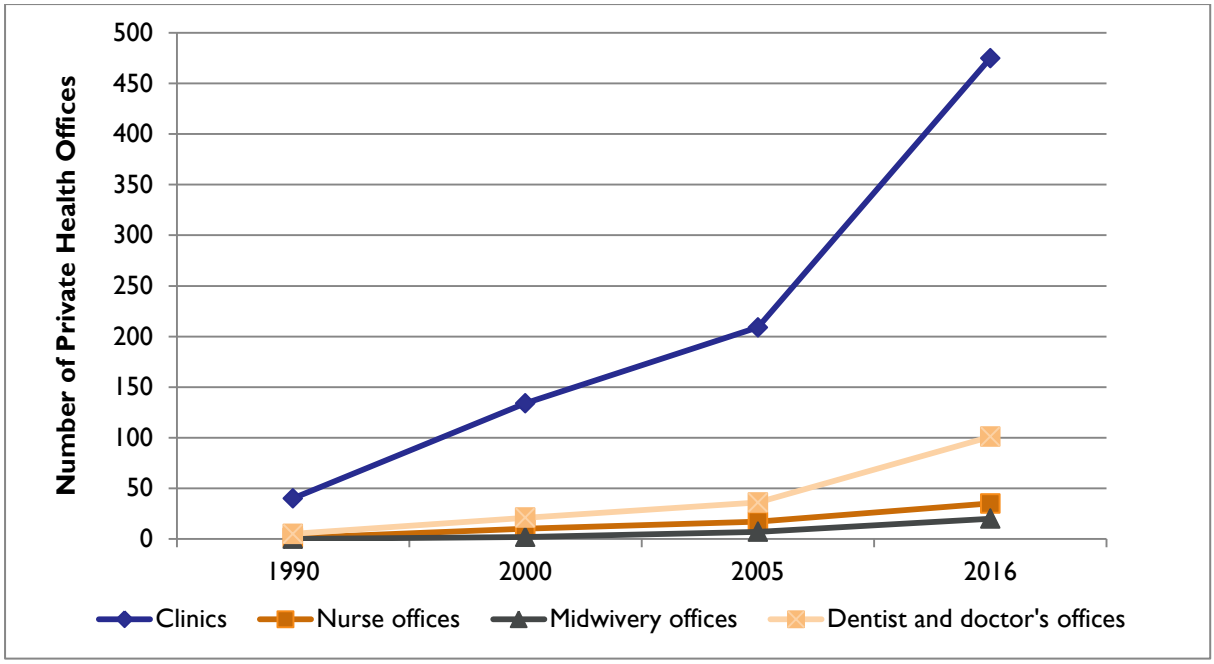
Forty-nine of the country's 53 wholesalers are located in Bamako. This total greatly exceeds the total found in neighboring Cote d'Ivoire (6) and Senegal (4-5) and cannot be explained by Mali's level of economic growth or the size of its demand and consumption of medicines and health commodities. In Mali, most of these entities respond to a public call for tenders and only a few work with the network of private pharmacies. The Mali National Board of Pharmacists envisages reducing the number considerably as the bulk of these wholesalers are seen as virtual companies. Part of the increase in numbers is due to the stream of foreign investors who develop joint ventures with Malian entrepreneurs, as observed following a training session of board members organized by the European Union.

[1] Dépôts are pharmaceutical establishments authorized to retail pharmaceutical products in localities without pharmacies. They are allowed to sell a limited number of drugs (drugs on the essential list) and are kept by paramedical or other personnel and not pharmacists

1.4 The Evolution of the Private Sector in Health

Legalization of the PFP sector in 1985 was considered a victory for the market economy and a rebuttal of the socialist principles under which the country had operated until then (health as a public good, free care, investment by the government in its role as guarantor and steward of health care services). It presented the government with a dilemma: some government workers resisted this change; diversification of health care delivery would force the government to relinquish its dominant position in the heath sector; and it would end the principle of free care for all. At the same time, many young, newly qualified people were entering the job market and opening up a private sector would reduce the growing unemployment among these young people who previously had not been able to set up their own practice. This situation explains in part the barriers to acceptance of private practice and the slow growth of the PFP sector since 1990 in respect to private offices for dentists, doctors, licensed midwives, and nurses. However, as illustrated in Figure 5, the number of private licensed pharmacies has increased exponentially.

Figure 5: Development of the PFP Health Structures in Mali (1990-2016)



Source: Mali PSA Inventory (Traore, 2017)

1.5 Ministry of Health Key Plans and Programs

The Malian government has developed two major documents to guide the national efforts to reduce the health burdens; both mention collaborating effectively with the private health sector in order to strengthen the national health system and in turn improve the health of all Malians.

The principal objectives of Mali's Ten-Year Plan for Social and Health Development Plan (*Plan Decennal de Développement Sanitaire et Social*, PDDSS) 2014-2023 are to: i) improve the health of the population, ii) increase health coverage, and iii) find ways of improving the viability and performance of the health system. To achieve these goals, the PDDSS recommends expanding the role of the private sector in several areas of health, e.g., contracting private clinics to provide specific services in health districts with limited public service coverage, and reinforcing the partnerships between the public and private sectors and civil society for improved coordination of HIV prevention, testing, and treatment.

The Health and Social Development Program (*Programme de Développement Sanitaire et Social*, PRODESS) III 2014-2018 notes that the private sector must become a central partner if the health sector is to achieve credible results. For this to happen, it is recommended that:

- The Ministry of Health and Public Hygiene (*Ministère de la Santé et de l'Hygiène Publique*, MSHP) and its Technical and Financial Partners reflect on the role of the private sector in achieving objectives and define a framework of specific partnerships with different private sector actors (medical providers, training institutions, etc.).
  - PFP providers should be included in the mandate of PRODESS III and private providers included in the Mandatory Health Insurance (Assurance Maladie Obligatoire, AMO) program. The document concludes that the private sector is currently only weakly involved in the execution of the PRODESS.
  - Partnerships with the private sector should improve private sector contributions to national health information systems (HIS) and the generation of data for decision making, which will help achieve program aims.

1.6 The Role of the Private Sector: What is Known?

Two main assessments were conducted in Mali to deepen understanding of the national health care system and the private health sector: the Health System Assessment (HSA), conducted by the USAID-funded HFG project in 2015 (Juillet et al. 2015) and the World Bank Private Sector Study in 2009 (Lamiaux, Rouzaud, and Woods 2011).

1.6.1 USAID Health System Assessment in Mali

As noted in the HSA report, although Mali has a long history of coordinated health planning, the private sector was not sufficiently taken into account, especially with regard to political dialogue and service statistics. The assessment provided recommendations in the following areas:

- *Service delivery*: Reinforce the system of accreditation for both for- and nonprofit public and private facilities.
- *Governance:* Develop public-private partnerships (PPPs) in a framework of mutual trust and collaboration, with the active participation of private sector representatives in political dialogue.
- *Financing*: Involve the private health sector in the National Policy on Health Financing to achieve universal health coverage.
- *Human resources for health*: Put in place an inspectorate to ensure quality of teaching and availability of training materials.
- *Pharmaceutical industry*: Establish a platform that includes both public and private representatives to ensure a common strategy for upholding the quality of commodities.
- *Epidemiological surveillance*: Develop better synergies to ensure more complete data collection from private and public health sectors.

1.6.2 The World Bank Private Sector Study

This comprehensive assessment of the for- and nonprofit private health sector, which had never been previously done in Mali, enabled the MSHP to collectively identify strategies for improving the private sector's contribution to health goals and developing PPPs. By enlisting broad and active participation, the assessment facilitated communication between the public and private sectors. The study's findings fed into the PDDSS discussed above.

The study identified reform and partnership in the following key areas: policy and regulation; delivery of care, medicines, and other health products and services; education and training of health professionals; and health financing. The assessment found that 50 percent of all health care goods and services in the country were supplied from the private sector.

Summary findings focused on the following domains:

- **Treatment:** Eighty percent of curative consultations took place in private (for- and nonprofit) facilities and 50 percent of physicians worked mainly in the private sector.
- **Pharmaceutical sector:** Private actors accounted for 80 percent of turnover (at selling price), and 50 percent of public entities' needs were covered by private wholesalers.
- **Education and training:** About 50 percent of individuals who passed the Superior Health Technician (TSS) examinations were educated in private schools, as were 90 percent of those who pass the Health Technician (TS) examinations.
- **Health insurance:** All mutual insurance programs (*'Mutuelles'*) were privately organized.

The study's recommendations (see italics below) form part of this study's scope and are discussed further in chapters 4-7 (Lamiaux, Rouzaud, and Woods 2011: 62):

- *Create a public-private dialogue and consultation committee*, organized along the lines of the future Dialogue Committee. The committee's role could be rendering opinions on regulatory proposals that affect the private sector and helping to enrich the body of law relative to public health care.
- *Improve integration of the commercial private sector into the PRODESS.*
- *Create a structure representing the whole private health sector.*
- *Strengthen self-regulation capacities of professional associations*. For instance, the reinforcement of staff within these professional associations needs to be addressed.
- *Give initial support to Malian Technical Union of Mutuelles (Union Technique de la Mutualité, UTM) scale-up* to expand coverage in the context of initiatives for overall expansion of health care insurance. The study explained that one of the options involved initiating a two-year trial in one or two regions. Lessons drawn at the end of this trial would have allowed the means of expansion to be adapted to the Malian context. This scale-up would have been done through support to the UTM and social mobilization efforts.

1.6.3 Other studies

Additional studies targeting the PFP health sector conducted in Mali include:

- A 2015 survey conducted by the SIAPS Program focused on the sale of specific tracer drugs by private health facilities in Mali (Kone et al. 2015).
- An assessment of the pharmaceutical sector in Mali was conducted (Maiga et al. 2003);
- A survey of quality assurance and accreditation in health care institutions (including private sector) in Mali (Ballique et al. 2014)
- A comparative study of the private health sector in member states of the Economic Community of West Africa was conducted in 2013 (Ballo 2013)

Despite all these studies, health stakeholders' knowledge of the private sector and opportunities for integration into the health system in Mali remains insufficient. In particular, the MSHP is not familiar with the conclusions and recommendations of the World Bank study, which has delayed their implementation. Additionally, after the completion of the HSA conducted in 2015, the MSHP and USAID asked HFG to conduct this private sector assessment (PSA) to increase understanding of the nature, operations, and potential contribution of this sector to the overall national health care objectives and outcomes.

2. SCOPE AND OBJECTIVES

Discussions with various actors and health officials carried out during the HSA highlighted the need to address concerns about increasing the contribution of the private sector to the overall performance of the national health system.

The aim of this assessment is to improve the understanding of the private sector, in order to foster a dialogue around solutions to the following problems:

- Lack of involvement of PFP service and pharmaceutical providers in the current health system.
- Poor collaboration between the public and private sectors in the public health system.
- Lack of participatory, legal, and financial mechanisms to strengthen the role of the PFP sector with a view to extending universal health coverage.

The specific objectives of this assessment are to:

- Identify obstacles that limit (i) collaboration between stakeholders (private sector, public sector, professional organizations) and (ii) the contribution of the private sector to public health actions initiated by the government within the framework of its health development program.
- Analyze the effectiveness of existing efforts to strengthen the partnership between the government and the private sector, such as contracting and local PPPs
- Identify reasons for the low level of adherence of private practitioners (doctor's offices, clinics, pharmacies) to priority public health equity (such as user fee exemptions) and quality initiatives.
- Analyze in a more effective manner the opportunities for PPPs, in response to investment needs in the health sector, and other opportunities such as universal health coverage and performance-based financing.
- Analyze the adequacy of the current institutional and regulatory framework.
- Analyze the contribution of the private sector in achieving the objectives of national priority health programs[2] and of the PRODESS and identifying barriers to this contribution
- Analyze the relationship between the MSHP, private health providers, private sector representation bodies, professional associations, trade unions, and regulatory structures from the point of view of governance and the barriers to effective collaboration.

[2] Family planning, availability of and access to medicines, vaccines, and technology in order to fight priority diseases such as AIDS, malaria, tuberculosis

3. METHODOLOGY

This PSA is part of a larger activity that, in conjunction with the HSA conducted by HFG in 2015, will provide the MSHP with a comprehensive view of the health system and furnish data to identify and mobilize untapped private sector resources and opportunities for public-private collaboration. The PSA focused on the legislative and governance context, and institutional relations between the MSHP and private sector. It examined contracting and financing, service provision, universal coverage, and insurance as well as PPPs. Its principal aim was to identify opportunities through which the private sector, particularly the PFP subsector, could increase its contribution to public health outcomes, including through improved collaboration with the public sector.

A concept note on the scope of the assessment was developed in December 2016 prior to initiating work. The HFG PSA team then began the assessment by conducting a comprehensive literature review to understand the landscape and context, as well as the key challenges and gaps in information, related to the private sector in Mali. The literature review helped to inform the content of the key informant interviews that followed and this report.

Following the literature review, the HFG PSA team prepared an initial list of potential stakeholder interviewees. The list was prepared by drawing on lists of individuals who were initially identified for inclusion in the HSA study (2015) and of individuals who are frequently included in the Assessment to Action Tool developed by USAID's SHOPS (Strengthening Health Outcomes through the Private Sector) project. In addition, initial discussions in country helped the team to identify other stakeholders who were not included in the initial list. HFG Mali's Chief of Party, Dr. Bokar Touré helped to identify any other influential individuals in the private sector who were not included in the list. The team ensured that not only the more well-known or longer-established providers, like some hospitals, were included, but also that smaller private providers, such as community-based ones, were represented. Alongside preparing a list of potential interviewees, the team prepared a key informant interview guide, which had been fine-tuned through previous PSAs from over 30 countries. Prior to data collection, the team developed an initial outline of the assessment report.

The team, which comprised Ms. Francoise Armand, Dr. Sarah Castle, and Mr. Yann Derriennic, traveled to Bamako to conduct key informant interviews and collect data on February 13–24, 2017. The team was accompanied by Dr. Bokar Touré and HFG consultant Dr. Boubacar Traoré, who was tasked with updating and harmonizing existing databases of private sector health providers into a comprehensive database. Upon arrival in country, the team held preliminary meetings with the MSHP and USAID to confirm the aims and methodology of the PSA. Then, with the help of HFG Mali, the team identified and arranged meetings with an initial set of interviewees. Using the key informant interview guide, the assessment team conducted approximately 50 interviews and discussions with stakeholders from the public and private for-profit and nonprofit health sectors, including government officials, donors, USAID implementing partners, private umbrella organizations, private insurance companies, members of providers' national governing and regulatory bodies, PFP providers,[3] and those active in the domains of health insurance and financing and involved in PPPs. A complete list of the stakeholders interviewed is included in Annex A. The team supplemented interviews with a collection of relevant documentation including plans, programs, strategies, and organizing principles for the private sector. Concurrent with the data collection, the PSA team began conducting preliminary analyses, sharing information, vetting initial findings, and forming actionable recommendations for both USAID and the MSHP, at the end of the in-country visit.

Following the trip, the team synthesized all findings from the literature and interviews and incorporated feedback from USAID and the MSHP.

[3] Private NGO and other non-profit providers were not included.

4. POLICY AND GOVERNANCE

4.1 The History of Private Practice in Mali

The PFP health sector (defined in this report as 'the private sector') was formally established in 1985 by the promulgation of the law n°85-41/AN-RM related to the PFP practice of professions across the entire health system. This was the first legal document defining the guiding principles and orientation as well as legal provision for private practices and occurred within the context of the structural adjustment programs agreed upon between Breton Woods Institutions and the Government of Mali. The main purpose of the law was to reduce the burden of public expenditures. Following its passage, the government initiated a series of reforms aimed at increasing the performance and productivity of public services and at creating an enabling environment and conditions for a market economy in several social sectors, including health.

4.2 Policies, Mechanisms, and Governance Supporting the Private Health Sector

The National Constitution sought to guarantee universal, equal, and equitable access to health care for all Malians. This vision was inspired by the Health for All Strategy, adopted by the Alma Ata Primary Health Care Conference (1976), the Bamako Initiative (1987), and subsequently the WHO Lusaka Three Phases Health Development Scenario, which reiterated the importance of central, regional, and local operational levels and brought forward the concept of district-level health (WHO Africa Regional Office 1985). This state-driven strategy for provision of heath care did not have a role for the private sector.

Since March 1991, Mali has entered a new era of democracy after an extended period of socialism and autocratic regimes. In addition to the privatization of the private for-profit health sector, this new context has allowed for more active participation of civil society and community participation in health management and in the health policy setting. Later the government adopted a decentralization policy that transferred power to the local communities. The health sector was seen as a pioneer in implementing the decentralization policy. So far, the decentralization process and the privatization are not convergent and not conducted with the same speed although some of the responsibilities of the central government to oversee the health and education sectors were transferred to local authorities.

The 2015 HSA revealed that the MSHP has long experience with health strategic planning and microplanning at the local level. Unfortunately, PFP providers have not been involved in these processes. Nor are they included in policy formulation exercises and policy implementation although they are targets of or affected by certain decisions. According to the firm DALBERG, which the government hired to revise the PRODESS manuals and procedures in 2015, the PFP professionals do not participate in the PRODESS steering committee or technical committee, nor in the regional committees for evaluating the PRODESS (CROCEPS), where their concerns are often discussed and views could be relevant to resolving problems with implementation of the public programs. In addition to not participating in local and national debates about health strategies and policies, they are not involved in monitoring progress of health indicators. The HSA further noted that the country has been attempting to put in place an HIS with several subcomponents, which is expected to enhance disease surveillance, and improve knowledge about the stock, flow, and the use of resources within the national health system. Currently, the private sector rarely releases timely, reliable data to national authorities.

One of the negative consequences of this was the outbreak of Ebola disease in 2014. A case reported by a private clinic whose referral to the national crisis group was delayed led to a rapid increase of the number of Ebola cases among health professionals working in the clinic.

Several central entities of the MSHP, such as the Health Inspectorate, the Division of Pharmacy and Medicines (Direction de la Pharmacie et du Médicament, DPM), and the Laboratory of Quality Control, are collaborating with private pharmacies, distributors, and wholesalers through the Association of Pharmacists. The responsibilities of these public entities include oversight, control, supervision, technical information sharing and guidance on the interpretation of national and regional regulations, the delivery of AMM, and the quality control of medicines and commodities.

4.2.1 Laws and regulations

There are specific legislations and standard procedures adopted by national authorities to regulate the role of the private health sector (see text box). The National Health and Population Policy of 1990, which addressed the private sector as an alternative means of accessing care, was updated in 1995.

Laws and Decrees Regulating the PFP Sector

12 April 1986 Law creating the National Board of Physicians

12 April 1986 Law creating the National Board of Pharmacists

The Code of Ethics, annex to the above law n°86-36/AN-RM

15 March 1991 Decree n°92-106/P-RM (chapter VI) organizing PFP practice in health

22 July 2002 Law 02-049, 'Health Orientation'

22 July 2002, Law 02-050, 'Hospital Law'

4 December 2017 Decree n 2017-0952/P-RM setting the conditions for the private practice in public hospitals

Despite adoption of these laws and regulations, the pace of growth of the private sector was hampered by the following factors:

- Insufficient experience of national public health authorities/cadres in drawing up policy, legislation, rules and procedures, and governance related to the private sector.
- Dual challenges of implementing community-level approaches comprising the CSComs (based on community engagement and private nonprofit services) with the expansion of the private sector.
- New graduates from medical school were not expected to work in a competitive environment nor to work for themselves (previously, new cadres were trained to become civil servants) and lacked the training or skills to set up private practices.
- Public health cadres and health professionals were oriented to provide services to the CSComs, which are owned by ASACOs.
- The CSCom model was more attractive to most development partners because it had potential to increase universal access to essential care and basic services. The International Monetary Fund, the World Bank, and the African Development Bank were among the few partners that financially facilitated the promotion of the private sector.
- Increased support from the development partners to develop the Community Health initiatives, such as financial assistance delivered by the World Bank's Health, Population, and Rural Water project (*Projet Santé Population et Hydraulique Rurale*, PSPHR) meant that attention and resources were primarily focused on scaling up the CSComs.
- The MSHP had no mechanism or service responsible for coordinating the expansion of the private sector.

4.2.2 Government support for the private sector

MSHP core responsibilities include developing national health policy including for the PFP sector, strategic planning, doing overall oversight of health systems, setting norms and standards, and ultimately ensuring optimal provision of both preventive and curative services. These responsibilities are aligned with the 1990 National Health and Population Policy that, as described above, outlined both community health and private sector programs and policies for the first time.

The MSHP is responsible for establishing regulations, authorizing professional practice, setting standards, and overseeing the private sector through assigned entities such as the National Health Directorate (Direction National de la Santé, DNS), the Health Inspectorate (Inspection de la Santé), the DPM, and Regional Directorates for Health (Direction Régionale de la Santé). However, there is no established hierarchy between them and the private sector actors, and no one service that is responsible for the dialogue with the private sector.

As the private sector developed, no administrative entities focusing on its expansion were established within the MSHP. As a result, the national councils of various orders assumed this role and, to date, no division or department within the Ministry is able to give a clear picture of the private sector.

4.2.3 Health information systems

The rapid expansion of the private sector has not been monitored and its impact is not integrated into HIS. This is because the obligation to report is not known to all private sector providers; in addition, the paper reporting forms are onerous for smaller providers and the electronic forms are cumbersome for larger providers that use the software. Thus, private sector providers do not provide data regularly, and most collection of private sector data is done by individual public facilities that go to private sector providers and request the data. Finally, the current structure of the health management information system (HMIS) aggregates the private and public sector data, making it impossible to accurately measure the private sector contribution.

4.2.4 Representation of private service providers

Several associations represent key actors in the private health care sector (see text box). Some support and defend the interests of health professionals such as physicians and midwives, while others represent industry groups (such as diagnostic laboratories or health care schools). These associations have a critical role to play but tend to be limited by insufficient resources and a lack of influence with the public sector and at the health policy level.

Private Health Care Associations in Mali

- Association of Physicians in Private Practice in Mali
- Association of Rural Physicians
- National Union of Pharmacists
- Collective of Young Pharmacists
- Association of Diagnostic Laboratories
- Nurses Association
- Midwives Association
- Association of Private Health Care Schools

4.2.4.1 The role of the professional boards

Since their creation, the professional boards for physicians, pharmacists, and midwives have played an active role for the development and expansion of private health care provision in Mali. They also play an important role in facilitating the establishment and regulation of clinical practice, and are well positioned to communicate with the MSHP about the needs of the profession. They are not, however, designed to advocate for specific industries or interest groups and therefore are not a substitute for strong private associations.

The MSHP has made the national professional boards autonomous. They are all independent professional bodies under the tutelage of the MSHP. They are in charge of oversight of professional practices, establishing rules of conduct, enforcing a code of deontology and ethics, ensuring discipline and solidarity among members, defending members, taking disciplinary measures, and organizing in-service training. Members are drawn from among private for-profit and nonprofit pharmacists, civil servants, and training and research institutions. In addition to selected members, the National Board is also composed of the representatives of the Ministry of Justice and of the MSHP, as well as academics and a number of observers.

The National Board of Physicians has 4,536 members, 55 percent of whom are from the private sector. These boards address professional ethics and deontology, resolve disputes among members, encourage solidarity and mutual assistance, and execute disciplinary decisions and sanctions in cases of malpractice, misconduct, or illegal activities among their members. They depend on a government subsidy for their functioning as the dues they collect do not cover their operating costs. The boards are decentralized, with regional boards that also face financial and organizational challenges.

The National Board of Pharmacists has 1,130 members, 648, 57%, of whom practice privately. It is divided into the following sections: A (Dispensers), B (Wholesalers), and C (Industry). The majority of these (over 90 percent) are members of these sections. Section D is composed of civil servants, NGOs, and laboratory technicians. The National Board of Midwives has 1,473 members, only 26 of whom practice in the private sector, and out of which 10 are licensed.

The first chairmen of the National Board of Physicians were civil servants. However, for the last 10 years, the chairmen have come from the private sector. Thus, the influence of the private sector is increasing. However, the boards do not represent only the private sector as the professional bodies represent members in both the private and public sectors.

The boards collaborate with the structures of the MSHP, especially the Health Inspectorate. The Minister regularly invites the board chairmen to participate in cabinet meetings and to attend fora and activities that it organizes. The collaboration with the Health Inspectorate happens upon request of one of the parties, for example, if is suspected that a facility is not legally compliant.[4]

Aside from the financial constraints mentioned above, the National Board of Physicians has identified barriers to its optimal functioning. These include:

- Slow communication/dissemination of information (for example, of MSHP communiqués or policy decisions) from the National Board of Physicians to its members, especially those in private sector
- Inadequate or inconvenient training for private providers. This has been mentioned previously; training schedules do not take into account private sector practitioner's constraints on availability

[4] In 2013, inspection data revealed that of 744 structures inspected, 257 owners did not have licenses (and therefore, in theory, were not authorized to operate). By 2015, 68 of the 257 had rectified their status.

According to the Physicians' Board, these issues are compounded by the fact that:

- The budget allocated by the government is insufficient to cover all the costs of the board's actions and activities.
- The number of staff employed by the board is insufficient to carry out all of the board's activities.
- A significant number of members are overdue paying their membership dues (recovery rate at 38 percent in 2016), especially compared with members of the National Board of Pharmacists (recovery rate 70 percent in 2016) and the National Board of Midwives (8.35 percent of the 1,473 members).
- The confined working space allocated to the boards limits efficiency. The new building that the government has pledged to the boards is not yet ready.

The 30-year-old law that resulted in the creation of the National Board is being revised to better respond to the current context and challenges. The board initiated this revision at the request of its members. A new version of the Law is ready to be transmitted from the Government's Secretariat General to the National Assembly. This new law includes, for the National Board of Pharmacists, new categories of members including military pharmacists and those working in laboratories. It also addresses the Economic Community of West African States (*Communauté Economique des Etats de l'Afrique de l'Ouest*) and West Africa Monetary and the Economic Union (*Union Economique et Monétaire Ouest-Africaine*, UEMOA) instructions and new legislation.

4.2.4.2 Private Sector Alliance for Health Promotion

The Private Sector Alliance for Health Promotion (*Alliance du secteur privé pour la promotion de la santé*), created in 2014, is a federal structure of private for-profit and nonprofit health sector stakeholders designed to represent the interests of those stakeholders. The Alliance has the following mission:

- Foster a framework for partnership and exchange between the private for-profit, private not-for profit, and public health authorities;
- Help make quality health services and services available to the entire population of Mali;
- Strengthen the capacity of Alliance members and private sector actors;
- Promote communication between the Alliance, and its members and partners;
- Promote PPPs in the health and social sectors; and
- Facilitate the involvement of the private sector in the development, implementation, and evaluation of socio-health policies and the promotion of the well-being of populations.

The Alliance conducts various activities. It organizes periodic exchanges of good practices. It facilitates access to health service provision programs. It mobilizes its own resources and conducts accreditation, self-assessment, and monitoring and evaluation of its own activities. And it organizes continuing education sessions for health care professionals, promotes good governance and accountability, and monitors any agreements signed with its partners.

Members of the Alliance are structures or groupings of structures belonging to the private for-profit and nonprofit sectors. Medical and pharmaceutical associations, mutual health organizations, nongovernmental and faith-based organizations, traditional medicine groups, Community Health Services, and others are all represented. (For a detailed list of the member organizations, please see Annex B.) Members must adhere to the Alliance Charter, statutes, and rules of procedure. Ex-officio members are development partners and representatives of each board.

For example, the Association of Physicians in Private Practice of Mali (*Association des Médecins Libéraux du Mali,* AMLM), a member of the Alliance, was founded in 1993. It brings together young doctors to work toward improving their working conditions and careers, and improving access to new funding windows. Based on our discussions with management, this organization needs to enhance its governance. According to their statutes, one of the self-assigned tasks of the AMLM is to contribute to enhancing dialogue between the public authorities and the private sector practitioners. The young members of the AMLM have not yet acquired skills and experience to undertake such high-level negotiation, and they lack experience and knowledge to manage institutions of such a nature. Therefore, the AMLM members are seeking support from the World Bank/International Finance Corporation (IFC) Health Private Sector program. Collaboration between the AMLM and the Alliance has been weak since the death of the Alliance chair. With the new management committee, this situation is steadily improving but is not stable. However, the AMLM is a dynamic, confident, and enthusiastic group of individuals, which is keen to increase their role to be more engaged with the Alliance.

According to interviews done for this PSA, the Alliance has struggled to fulfill its role due to the various interests of its members, who are from both, the for-profit and nonprofit private sectors, the lack of human and financial resources, and finally, the recent, untimely death of its first chair (the Alliance is currently being led by an interim president). Nevertheless, this Alliance is a potential solution to bring together private associations for the purpose of engaging in dialogue with health officials and policymakers. The Alliance attracted initial participation from several associations but interest and attendance have reportedly waned, due to limited resources, the absence of a governance framework, and the passing of its president. There is, however, continued interest, particularly from the Association of Physicians in Private Practice, in making this organization a strong representative body for the private commercial sector.

4.3 Collaboration between the Private and Public Sectors

The 2015 HSA and 2009 World Bank Private Sector Study revealed an insufficient presence of private sector actors engaged in policy dialogue and strategic planning. As a result, private sector concerns are not reflected in the design, revision, or adaptation of key policies and indicators, and private sector actors often miss opportunities to acquire comprehensive knowledge about them. For example, discussions during field interviews revealed that many private providers are not familiar with the policy regarding the free treatment of diseases, such as TB, and are unaware of the National Health Strategic Plan, National Health Policy, and new standards and treatment algorithms to address existing or newly emerging health conditions. This makes it difficult for private sector providers to support the implementation of the government's health strategies and may impact quality of care provided.

The MSHP often organizes fora, conferences, and meetings but few of these include private actors' participation or representation. Private providers are only rarely invited to meetings of the National Council of Medicine or the professional boards. There is a need for the MSHP to engage more actively with the private sector providers by enhancing coordination and collaboration via these various structures.

The World Bank (2013) lists four key factors driving governments worldwide to use the PPP model for health sector improvement:

- The desire to improve operation of public health services and facilities and to expand access to higher-quality services;
- The opportunity to leverage private investment for the benefit of public services;
- The desire to formalize arrangements with nonprofit partners who deliver an important share of public services; and
- More potential partners for governments as private health care sector matures

To increase collaboration between the public and private sectors, it is important to have a formal, functioning platform for the collaboration. The private sector must be able to organize its representatives and broad interests in order to effectively engage with the public sector. Mali has made some progress on both points.

In Mali, PPPs can be formed in the health sector (between public and private providers) and between the health sector and commercial private enterprise. In 2009, the World Bank recommended that private institutions in Mali wishing to participate in public service missions, especially in public hospitals, should be authorized to do so subject to agreement by the public provider in question. At the local level (health area or region), a scheme can be created to share available equipment and specialties to avoid transferring patients to a higher level of care. For example, an agreement allows associated private institutions that follow the prescribed procedures (cold chain, personnel training, etc.) to be involved in national vaccination campaigns. Another agreement authorizes private hospitals to provide public sector interns practical training.

Collaboration among key actors in the pharmaceutical sector is discussed in Chapter 7.

The 2009 World Bank Private Sector Study (Lamiaux, Rouzaud, and Woods 2011) proposed a design and implementation mechanisms for the creation of a platform for dialogue between the private and public sectors. Its aim is to strengthen public-private collaboration by creating a Dialogue Committee with members from both sectors. The committee would be a consensual platform that could formally, systematically, and routinely help to take the private sector into account in formulating and implementing health policies and programs.

A Charter (Constitution) for the platform was drafted in 2014. It lays out the vision, mission, objectives, guiding principles, governance, and administration of the Public-Private Partnership in the Health Sector in Mali. It also lays out the structure of the Public-Private Dialogue and Collaboration Committee: the committee is to have seven members from the public sector, five members from the PFP sector, three members from the private nonprofit sector, and one representative of the health development partners as follows:

- Public (7 total): Health (2), Social Development (1), Promotion of the Family (1), Education (1), Finance (1) and the Ministry in Charge of the Private Sector (1)
- PFP (5 total from): Health providers AMLM, Malian Rural Doctors' Association (*Association des Médecins de Campagne*, AMC), traditional healers, nurses, midwifes), private nursing schools, pharmaceutical sector, companies providing health services
- Private nonprofit (3 total from): National Federation of Community Health Associations (*Fédération Nationale des Associations de Santé Communautaire*, FENASCOM), *Groupe Pivot Santé Population*, UTM
- Development partners (1): Head ('Chef de File') of a health development partner

The committee proposes to have three thematic working groups centered on the main action plan develop to promote PPPs:

1. Political dialogue for private sector engagement
2. Reforms to improve the regulatory framework
3. PPP to increase accessibility and quality of services

The committee is closely linked to the PRODESS and members must report to the PRODESS structures. Committee meetings are timed to the PRODESS meetings in order to facilitate reporting and integration into the PRODESS.

The committee will elect a President, Vice President, and, eventually, a Treasurer and a Secretary. Various sectors fill the posts in alternating for two-year mandate. Committee functioning and meetings are supported by a permanent secretariat. The secretariat has four permanent members and a representative of the Division of Health Infrastructure and Regulation (*Division des Établissements Sanitaires et de la Règlementation*, DESR), a department of the DNS. The remaining staff of the secretariat is undefined.

A government framework to support the public-private dialogue has been drafted in support of the Charter and the Dialogue Committee.

4.4 The Mapping of Health Service Coverage

Increasing geographical and financial access to health care is one of the objectives outlined by the government in the PDDSS 2014-2023 (Section 1.2 of this report). One of the responsibilities of the MSHP is to monitor this extension of coverage; a health service map (‘*carte sanitaire*’) is to be updated annually to reflect progress. The map can be used for planning purposes and to guide the establishing and location of additional facilities. Unfortunately, the map is not updated regularly, and even though the number and location of CSComs may be fairly accurate, the mapping of private facilities is limited. This is due to a lack of involvement and insufficient incentives for private sector actors to declare themselves and to report their activities, to problems with the legal status of a number of private cabinets, and to difficulties faced by partners in acquiring funding for carrying out survey. For these reasons, data collection is frequently oriented toward community facilities rather than toward private providers. This challenge is acknowledged by the Dialogue Committee, which emerged from the 2009 World Bank Private Sector Study discussed in Chapter 1 of this report.

4.5 Principal Findings and Recommendations

4.5.1 Principal findings

- The PFP sector has grown extensively over the last 20 years. However, a robust system for oversight, standardization, and accreditation of practices by national health authorities has not developed commensurately. Insufficient oversight results in lack of coordination between the public and private sectors, missed opportunities to use the motivation, expertise, and capacity of the private sector, and inconsistent quality of health services provided to the population. While there is a clear mandate for the government to regulate, authorize, set standards, and oversee private sector providers, enforcement has been weak resulting in lack of accountability between the public and private sectors. Coordination among private practitioners is greatly needed. The creation of the Alliance is an important step toward better coordination but since its launch and first few meetings, it has difficulties functioning due to lack of resources and weaknesses in governance.

- Timely communication with private providers and frequent inspection is a challenge. Investment in these activities is needed as private providers are often the primary source of health care in outlying areas. Current resources dedicated to inspection outside Bamako and to the Regional Boards are insufficient to respond to the growing role of private sector sectors.
- The Private Sector Alliance needs to establish itself and function as the privileged interlocutor for the private sector. It needs governance support to manage its disparate membership and bring together the interests of private for-profit and nonprofit stakeholders. Some Alliance members already have working relationships with the public sector, which could produce useful lessons learned. The Alliance needs the above-mentioned PPP Dialogue process and Committee to function and to give it a platform to interface with the public sector. With support, the Alliance could function as the secretariat for this Committee.
- The proposed Charter and supporting decree for the public-private Dialogue Committee are needed. The secretariat of the Dialogue Committee is undefined; it is unclear how it would function and be financed.

4.5.2 Recommendations

For the MSPH

- Engage with private associations on critical issues (current and proposed regulations in the area of clinical practice, access to finance, fiscal treatment).
- Facilitate the signing of the Act creating the Dialogue Committee, as recommended by the World Bank Private Sector Study in Mali (Lamiaux, Rouzaud, and Woods 2011).
- Ensure effective representation of the private sector in the PRODESS committees by increasing and broadening the private sector participation.
- To improve and scale up operational collaboration:
  - Document and disseminate these initiatives, including successes and challenges
  - Formalize these efforts: guidelines, instructions, and indicators
  - Go to scale
- Create enabling conditions to motivate private providers to collect and report key data (e.g., utilization data, methods of payment of users) that the government needs for policy and planning, and possibly develop schemes to compensate providers for income they lose during time spent in training – such as reimbursing them for their expenses or a preferential per diem rate that accounts for their lost income. The private sector could also be compensated for their participation by including the participants' facilities in the distribution plans of specific inputs such as mosquito nets, family planning commodities, vitamin A, and other inputs which are normally only distributed to public sector facilities. Formalize collaboration in the area of data reporting and consider developing software for use in the private sector (such as the adapted DHIS 2 module for the private sector) along with the training to use this software.
- The MSHP and the Ministry of Justice in collaboration with the professional boards need to address judicial matters relating to malpractice, especially within the private sector, to help improve the quality of services provided by the private sector and improve their credibility.
- For the Alliance: Based on the experience of supporting private sector platforms/structure such as the Alliance in West Africa, the Private Sector Alliance in Mali should seek a sponsor to provide financial and technical assistance for a period of not less than three years. This would enable the Alliance to hire a full-time coordinator to manage day-to-day business and to represent the Alliance in its interaction with multiple partners. The Alliance needs a rudimentary presence: a headquarters (even if housed in one of its member's facility), staff (coordinator and an assistant), web presence, regular meetings, and an annual work plan.

5. THE ROLE OF THE PRIVATE SECTOR IN HEALTH FINANCING

5.1 Financing

5.1.1 Objectives of health financing policy

The PRODESS III Strategic Objective 9 aims to "*develop financing strategy aiming at increased resources mobilization and more efficient use of resources, better access to health services and encouraging providers and users to be more*[5] *efficient.*" The five strategic outcomes are:

- Greater resources mobilization and allocation taking account of disparities;
- An improvement in the sector financial management;
- Strengthened social assistance;
- Increase in population coverage by social protection systems;
- Better social organizations performance.

In connection with these expected outcomes, four strategic areas have been defined in the health financing policy developed in 2013:

- Improve the level of public funding for the development of universal coverage;
- Ensure better allocation of resources;
- Implement the mandatory contributory insurance program, AMO, by means of a coherent and comprehensive scheme;
- Improve financial governance.

The health financing policy's mission is to outline the path of access to quality health care regardless of financial ability of patients for the entire population of Mali, as needed, and by protecting them from health risks. It is evident that Mandatory Health Insurance, the AMO, is a key government strategy toward better quality care and social protection.

The National Policy for Financing Universal Health Coverage 2014-2023 (*Politique Nationale de Financement de la Santé pour la Couverture Universelle* 2014-2023) facilitates a way forward for developing universal access. At the heart of this initiative is a financial strategy for health insurance which is under the auspices of the Ministry of Labor, Social and Humanitarian Affairs.

[5] PRODESS III, page 150.

5.1.2 Implementation of Health Insurance for Universal Health Coverage

Until 2009, the National Institute for Social Protection *(L'Institut National de Prévoyance Sociale*, INPS) provided social protection for four kinds of workers and employers by financing their contributions (and thus only applied to those employed in the more formal sectors). These were:

- The family benefit regime;
- The regime for compensation and for prevention of accidents at work and professional illness;
- The regime for insurance in old age, incapacity, and death, and
- Health insurance. However, this last element has been replaced with the roll-out of the AMO, which was established in 2009 for groups previously covered by the INPS. At that time, the National Health Insurance Agency (*Caisse National d'Assurance Maladie*, CANAM) was created to finance the AMO.

The AMO, for formal sector employees, was introduced in 2009 and began implementation in 2010. Due to the lack of preparation and communication, its introduction was controversial and led to some unrest. The then president, Amadou Toumani Touré, 'suspended' its mandatory element, giving employees the option to opt out. The AMO was not abandoned, however, and implementation of both the AMO and its associated scheme for the indigent population, the Indigent Medical Services Plan (*Régime d'Assistance Médicale*, RAMED), continue.

The AMO aims to cover 12 percent of the population. It aims to mobilize contributions from beneficiaries into a pool and have a major impact on the quality of services. According to PSA interviews with the CANAM manager, the number of beneficiaries increased by 120,429 in 2016, for a total of 1,015,911. The principal to beneficiary ratio is 3.5. All public secondary and tertiary hospitals, half of CSRÉFs, and a few CSComs are participating.

The AMO is funded by contributions from or on behalf of participants. Private sector employees contribute 3.1 percent of salary and their employers contribute 3.5 percent. Public sector employees contribute 3.6 percent and their employers contribute 4.4 percent. The self-employed can join. They contribute approximately almost 6.6 percent of their income. There is no information on the number of self-employed who have joined AMO. Quarterly revenues of self-employed persons are classified into five categories of income that determine the amount of contributions for family benefits, pensions, and AMO.

In 2017, the CANAM budget is 53 billion CFA and it does not expect to receive any state funding. The government supported investments in management systems in the past. As CANAM's performance has improved, contributions have increased and CANAM has become more self-sustaining. As CANAM's investment in claim management systems has increased, and premium contributions have increased, government has reduced its financial support from 1 billion CFA a year to 50 million CFA in 2016. The CANAM projects to spend 63.7 percent of the budget on improving its capacity, its technical platform, and fraud management.

The CANAM has approximatively 50 private clinics under contract and around 80 percent of 596 private pharmacies have signed a convention with the CANAM. The approved list of drugs and medical consumables is extensive (it covers brand name drugs and toothpaste, for example) and the director of the CANAM wishes to reduce the number of drugs and inputs covered to control costs. He estimated that 80 percent of CANAM disbursements are for drugs.

The CANAM's reimbursement of providers within acceptable timeframes has led to more private providers wishing to contract with CANAM. For larger private providers, joining the CANAM does not entail great additional expenses as they already cater to private insurance mechanisms. Smaller private providers may find it a challenge to set up systems to track beneficiary eligibility and bill the CANAM, but their investment should pay off by increasing their clientele. For these private providers, accepting RAMED beneficiaries would be a logical addition to accepting the AMO. Private

provider's participation in the RAMED will depend on the evolution of the scheme and it's financing. The threat to private providers is that private insurance will evolve into supplemental insurance coverage and thus private providers will need to participate in the AMO to be able to stay competitive.

The RAMED aims to cover 900,000 of Mali's poorest residents (5 percent of the population). Managed by the National Agency for Medical Assistance (*Agence Nationale d'Assistance Médicale*, ANAM), the RAMED has not yet reached its coverage target, but not for lack of national government funding – the biggest problem is identifying and certifying indigents. The RAMED had registered 58,595 people by the end of 2016, 6.5 percent of the target (National Agency for Medical Assistance 2017). Of these, 32,963 (56 percent) were enrolled through the social safety net program 'Jigisèmèjiri,' funded by the World Bank. An additional 9,854 (17 percent) were enrolled via UNICEF, and 14,606 (25 percent) were enrolled via the services of the National Directorate of Social Protection and Solidary Economy of the Ministry of Humanitarian Action. Utilization of the RAMED is increasing as the program becomes better known.

The PSA team identified additional challenges to building the program:

- Inadequacy of funding provided by local communes and towns; local governments are expected to reimburse 30 percent of health claims of the RAMED, but this target was reduced to 15 percent in 2016 due to lack of local government resources;
- Lack of resources available to the local offices of the Social Welfare Departments (DPS) to conduct household surveys to identify beneficiaries; and
- Resistance of local councils to issue certificates of indigence.

The RAMED has received approval from its Board to contract with private pharmacies and, although this has not officially been launched, several pharmacies are participating and seeking reimbursement. Under the RAMED, eligible drugs and medical supplies are full covered. In 2016, the RAMED processed 10,128 claims (9,963, 98 percent, were deemed payable). Breaking down originators of claims by provider type, 7,688 claims (76 percent) came from public hospitals, 2,102 (21 percent) from CSRÉFs, 297 (2.9 percent) from CSComs, and 41 (0.4 percent) from pharmacies; only four private pharmacies submitted claims. 33.6 percent of the value of the claims was for medicines, 23.0 percent for imaging, 18.5 percent for procedures, 14.0 percent for lab services, 7.5 percent for hospitalization, and 3.4 percent for consultations. The average reimbursement was CFA 1,903 for consultations, CFA 11,353 for lab services, CFA 13,250 for medicines, CFA 18,006 for hospitalizations, and CFA 20,453 for procedures.

Although the delays have improved substantially, delays for reimbursements from both the AMO and RAMED threaten the operational budgets of some, mostly smaller or nonprofit, health facilities and explain the low level of participation of CSComs in the schemes. For the AMO, claims management and reimbursement is decentralized to the regional level. Organizations that are contracted to do claims management – the Malian Social Security Fund for civil servants and INPS for private workers – process the claims and directly reimburse providers. The RAMED claims management and reimbursement is centralized at the ANAM, in Bamako; claim files are transmitted by the Regional Directorates for Social Development and Economic Solidarity (*Direction Régionale du Développement Social et de l'Economie Solidaire*). Claims sent to the claim management agencies are checked at two levels. The first is to update the contributions of the beneficiaries. The second check is a medical and financial audit, the medical audit for the appropriateness of care and prescribed medications and the financial audit to ensure the schedule of services and drug prices have been respected.

The AMO and RAMED use the same reimbursement schedule for services and medicines. This schedule is negotiated annually by the CANAM with medical councils (*Ordres des médecins*) and the MSHP. To promote acceptance of the program by the wealthiest people who are used to be covered, the list of covered drugs has not been limited to generics as planned initially. In addition, the rate of reimbursement of benefits in the private sector is higher than for the public sector and is determined in negotiations with the medical councils.

5.2 Mutuelles

The 2010 government strategy for extending health coverage to people in the informal and agricultural sectors aims to cover almost 80 percent of the population through *Mutuelles*, with an interim target of 40 percent for 2023 (*Ministère du Développement Social, de la Solidarité et des Personnes Agées Secrétariat Général* 2010). The *Union Technique de la Mutualité* (UTM) is the structure responsible for the advancement of the *Mutuelles*.

The strategy proposes that most informal sector workers be covered by *Mutuelles*. At the end of 2015, 186 *Mutuelles* were identified, but only 101 were functional, covered a population of 308,354 people (or 4.5 percent of the target[6] population). Of the 101 mutual organizations that were operational in 2015, 87 (86 percent) were members of the UTM. Membership in UTM makes *Mutuelles* eligible for technical support from UTM. *Mutuelles* who are UTM members can also receive state subsidies equivalent to 50 percent of premiums.

In 2000, in an effort to make *Mutuelles* more attractive, UTM launched an insurance mechanism, to support urban *Mutuelles*; the Voluntary Health Insurance (*Assurance Maladie Volontaire*, AMV) program. Participating *Mutuelles* are networked and have access to more providers and services. AMV has contracted 80 public facilities, 34 private pharmacies and four private providers. The initial cost of joining is CFA 2,500 per family and the premiums are CFA 575 per person per month. At the end of 2016, according to UTM's 2015 annual report, the AMV is characterized by poor enrollment, low premium payment, and low use of the insurance by the insured. Although the AMV has not met expectations, it is not bankrupt: its premium to payout ratio (*taux de sinistralité*) is 36.9 percent. According to the director of the UTM, UTM is following the evolution of the AMO to see if it will need to shift the AMV toward supplemental coverage as AMO grow to provide primary coverage.

As in many other West African countries, *Mutuelles* in Mali are struggling to provide significant insurance coverage to their target populations. Although there is a subsidy program in place, the lack of resources, both financial and human, has constrained the growth of coverage. As mostly a community based organization, *Mutuelles* typically contract with CSComs, community owned nonprofit facilities, and very few contract with private providers. UTM's AMV scheme did not meet expectations. If and when *Mutuelles* become a significant factor in health insurance, they could contract to private providers.

5.3 Private Health Insurance

The private insurance market caters to the formal sector, with most of the policies taken by private sector companies and other organizations (embassies, multilateral organization, etc.) for their staff. In 2014, there were 11 active insurance companies. These companies worked through 222 intermediaries: 33 brokers, 104 agents, and 85 life insurance advisors. The non-life insurance market in Mali is dominated by Saham Insurance (27.5 percent), Lafia Insurance (17.3 percent), and Allianz Insurance (14.5 percent). There are five other insurance companies offering health insurance on the market. Health insurance is 14.3 percent of the non-life insurance market. To identify private providers, the health insurance companies respond to the requests of the companies and their staff. The insurance companies usually ensure quality of the providers through the site visits. The largest companies thus accredit private provider and the smaller ones adopt their certifications. Specific coverage varies greatly from policies with no co-payments, to co-payments with maximum payout coverage. Insurance company staff process claims received from the providers.

The insurance companies are following the evolution of the AMO as their clients are starting to question the need to buy full coverage, since they must contribute to the AMO[7] and are asking the companies to develop supplemental insurance packages. The insurance companies have expressed their desire to collaborate with the CANAM to rationalize coverage. In return, the insurance industry could provide technical assistance to the CANAM in reviewing the insurance package/coverage.

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[6] UTM Evaluation team, November 2015

[7] The suspension of contributions was only for the employees, thus employers have been contributing their share.

Funding from employers is through direct provision of health services and employer contributions to the AMO. According to the 2013 NHA, payments or reimbursements are estimated at FCFA 1,312,453,878 (0.36 percent of the Current Health Expenditure (CHE)). The employer contribution to the AMO was FCFA 2,929,504,550 (0.81 percent of the CHE) (MSHP 2015). These amounts reflect the very modest share that formal sector employers contribute to total health expenditure in Mali.

5.4 Contracting

One common mechanism of public-private collaboration is contracting. In the context of the health sector, "contracting out" refers to the use of external entities to perform health services. For example, the government could contract private providers to deliver specific services such as radiology or laboratory services. "Contracting in" refers to private organizations who provide services inside public facilities. For example, one private clinic visited contracts their laboratory and radiology services to a provider inside their facilities.

On the basis of the PSA visits and interviews, neither contracting out nor contracting in is being used for medical services in Mali's public sector; that is, private providers are not contracted to provide publicly financed services, nor do they provide services in public facilities, except for the above-mentioned AMO. This is not due to the lack of a regulatory framework – such a framework for contracting exists. One public sector informant expressed his frustration: "I received approval from our board, but when it went to the Ministry, we never received any responses." This informant wanted to contract out laboratory and imaging services, because the high costs of inputs and maintenance made it difficult for his facility to operate these services.

5.5 Principle Findings and Recommendations

5.5.1 Principal findings

- The AMO is evolving in a positive direction although there are some inefficiencies and medium- and long-term structural risks. The immediate challenge is to reduce the overly generous drug benefit package to rein in the costs. The agency responsible for managing this scheme, the CANAM, has challenges in verifying and auditing reimbursement to control fraud.
- The differing reimbursement schedule between public and private providers may come under pressure.
- Global experience is clear: pay (fee) per service will lead to overuse and thus the AMO needs to develop a strategy to move to more strategic purchasing mechanisms such as a capitation payment system for primary care and DRG (Diagnostic Related Group) or other mechanism for hospital care in order to create the right incentives for providers and to control costs.
- Assessment of the current social health protection architecture shows duplication of administrative functions. There is an initiative to redesign the Mandatory Health Insurance scheme (AMO/CANAM) to absorb the medical assistance scheme for indigents (RAMED), and effectively abolish the ANAM. The CANAM would then manage the entire insurance fund pool.
- The CANAM is currently self-financing, but this may not last. The RAMED is underfunded, although actual provider payments (a total of 97,181,602 CFA for 2016) are 60 percent of expenses and personnel costs are 14.45 percent of expenses for 2016. The bottleneck to increasing enrollment is still the certification of the indigence status by social services.
- At the operational level, there is a need and desire to contract services between public and private health providers (both contracting in and out). This is permitted by the regulations but they are not known, no guidelines are available, and thus, contracting is under-used.

5.5.2 Recommendations

- The increase in population coverage of the AMO provides opportunities for the private health providers to increase their resource base and quality of services by meeting accreditation requirements and participating in this scheme. Current efforts to enroll private providers in the AMO should therefore be encouraged and facilitated.
- The RAMED should expend its enrollment of private providers in order to cover 'free' services, as many community-based private providers provide free services and this is a stress on their bottom line.
- The CANAM should include private insurance companies, including brokers and agents, in discussions on the new architecture of the AMO as they have a good knowledge of the insurance market and practices and want to have a rational healthy national scheme.
- The CANAM should exchange information with private insurance so that they can develop supplemental insurance products to insure efficiency and that there is coherence in the insurance sector.
- MSHP contracting capacity should be built so public providers can benefit from the expertise and capacity in the private sector. The Ministry should identify high-value contracting opportunities in public sector facilities (hospitals) and support the implementation of contracting out and contracting in services with the private sector. Illustrative services which could be contracted out are: laboratory and imagery services (scans and radiology). In other countries, such as Ethiopia, there is discussion surrounding contracting out clinical services, but currently, only nonclinical services are contracted out; for instance, laundry, security, and cleaning.

6. SERVICE DELIVERY

6.1 Overview

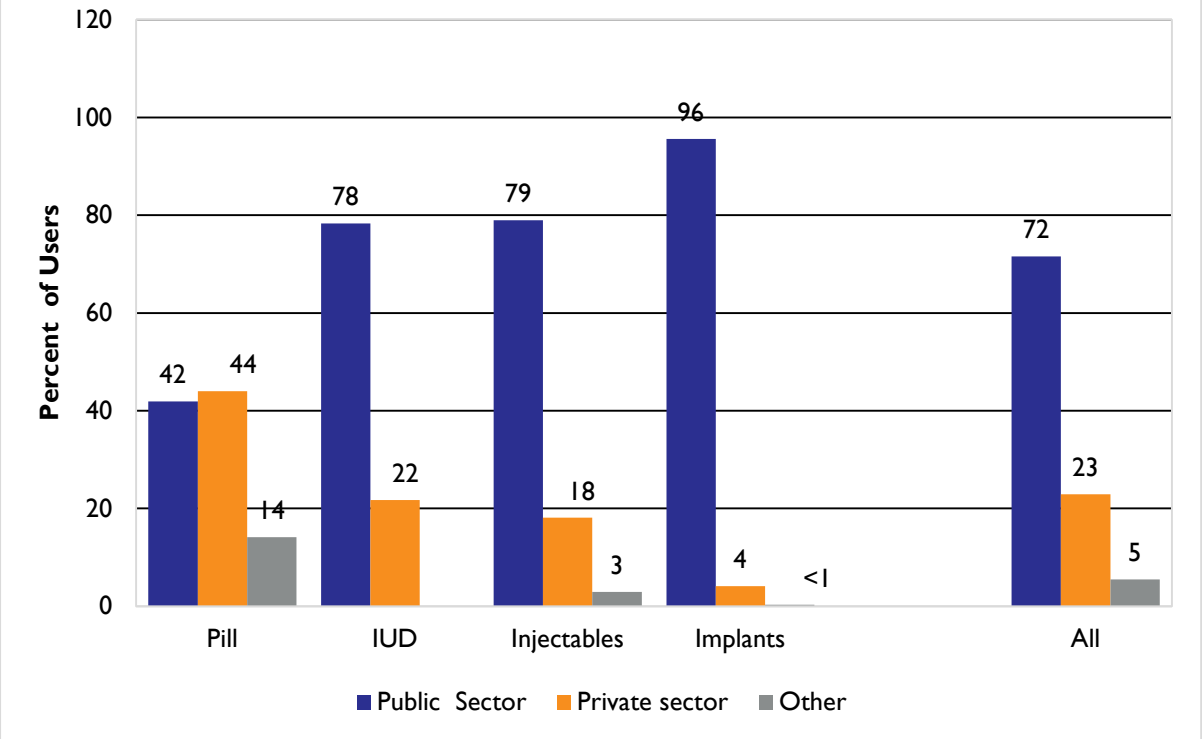
The private medical sector in Mali plays a considerable role in the country's health system. For-profit and nonprofit facilities, however, tend to differ sharply in their ability and willingness to collaborate with the public sector. Community- and faith-based facilities often work in partnership with national and local health authorities, but private clinics and hospitals operate according to market rules and usually have limited involvement in public health programs. This section updates earlier findings about the PFP providers, and further explores potential solutions and opportunities to improve its contribution to national health goals.

6.1.1 Users of private health services

A large proportion of Malians from all wealth quintiles and both urban and rural areas report obtain health services from the private sector (Over 60 percent of all contacts with the health system occur at private providers). As in many other countries, the sourcing of specific services from private providers is higher in the area of curative services, where the private sector may offer value that justifies paying a higher price (such as perceived quality of care, personalized treatment, shorter wait time, and proximity). In areas where the public sector offers free services, the private sector generally has a much lower participation rate.

For family planning services, for example, Figure 6 shows how users of oral contraceptives are about as likely to obtain this method in the private sector (typically a pharmacy) as from a public facility. In contrast, implants and IUDs that are free create an incentive to obtain these methods from the public sector, and a strong disincentive for private providers to offer them at all.

Figure 6: Source of Contraceptive Method by Sector among Women Aged 15–49



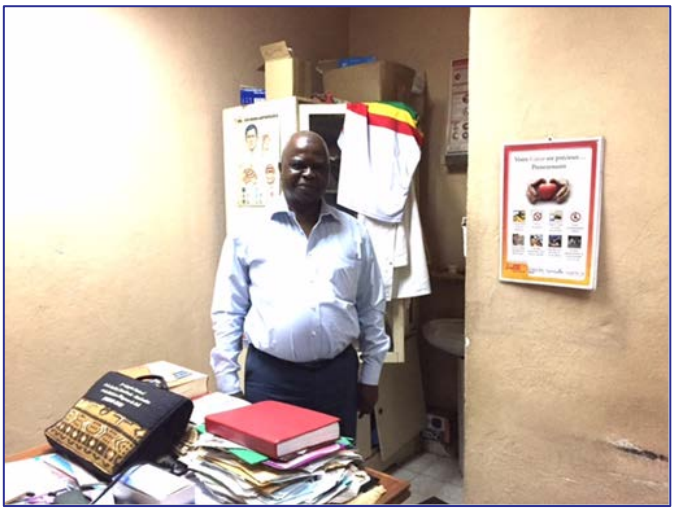
Source: Mali Demographic and Health Survey 2012-2013 (CPS/SSDSPF et al. 2014)

6.2 Practice of Medicine in the For-Profit Sector

6.2.1 Human resource development

Unless they plan to work for a large public facility, many health practitioners must set up, or work for, a private practice. Their career becomes linked to the success of that private practice. This success is linked to multiple factors beyond clinical competency, such as the owner's business skills, ability to access financing, availability of trained staff, and opportunities for continuing education. The World Bank Private Sector Study noted that in Bamako District, where there is a high concentration of private providers, the market for private health facilities was becoming saturated, with 175 health offices and 49 hospitals operating in 2009 for an estimated absorption capacity of 194 and 50, respectively (Lamiaux, Rouzaud, and Woods 2011). Although donor support for the establishment of private practices in CSComs helped attract young doctors to rural areas in the early 2000s, the precarious conditions in which they were operating suggested this was not a viable career option (Juillet et al. 2015).

In addition to young doctors' difficulties in finding employment or opening a practice, the private health sector also experiences a shortage of specialists, in part because of the cost of education. For example, one provider reportedly financed the education of his young doctor in Senegal in exchange for the promise of serving several years in the practice.



Owner of a private clinic in Bamako

For most clinics and polyclinics, the best way to offer specialty services is to employ a public sector specialist on a part-time basis. This practice, though it fills a real need on both sides, has been heavily criticized for depleting public facilities of the presence of its specialists, especially in their capacity as mentors and teachers to younger doctors. In the private sector, the dependency on public sector specialists sometimes leads to the latter dictating their conditions and sometimes failing to meet commitments to patients.

On the whole however, there seems to be an understanding that dual-practice is inevitable but requires more regulation. However this dual practice is one way: while public sector providers often provide services in private facilities, private providers have few opportunities to do the same in public facilities because there is no legal framework for them to do so. Perhaps there is a perception that they are not needed since public facilities are full of highly competent and experienced skilled health professionals. In addition, there is no regulatory provision on this. In addition, in 2017, the government adopted a decree authorizing the private activities of doctors, pharmacists and dentists in public hospitals. The situation is different for the CSComs, which benefit from providers contracted by the regional directorate with Heavily Indebted Poor Countries initiative funding.

Systematic and regulated collaboration for human resource distribution and training between public health authorities and the private health care workers using National Boards or the Alliance intermediary may lead to cost efficiencies and better health service quality provision in both sectors.

PFP facilities do not appear to have any difficulty attracting lower-level health workers, such as nurses and midwives. This may be explained by better working conditions offered to these staff in the private sector. The Global Health Workforce Alliance noted in 2016 that low motivation among public health care workers was causing a migration of the most qualified health workers from the public to the private health sector (Strategic Human Resources for Health Development Plan (PNS/RSS), 2009-2015). It should be noted, however, that few PFP practices can afford to hire a large staff and therefore are unlikely to absorb many of the health workers who may be looking for better working conditions.

Doctors in private practice are responsible for maintaining their clinical skills. There is no legal requirement for physicians to receive continuing medical education once they have graduated from medical school. Because it is not mandatory, there is low demand for fee-based continuing education and few sources to turn to. In contrast, the public health sector and donor-funded health projects typically provide multiple and frequent training opportunities to their salaried providers. With the exception of programs involving private providers (such as the ProFam franchise), private providers rarely benefit from training programs designed specifically for them. Although they are sometimes invited to workshops designed for a public sector audience, they may not always be able to leave their practice or spare a critical staff member during the clinic's opening hours.

As just noted, there is no system in place to ensure that licensed and practicing providers are regularly updating their clinical skills. The PRODESS III document notes that quality assurance in the private sector remains a "major concern," possibly reinforcing the perception that collaboration with this sector is inherently risky. To be sure, poor access to financing, equipment, training and experienced health professionals, combined with weak enforcement of legal norms regarding clinical practice, does not bode well for the general quality of services in this sector. It does not imply however that private providers do not care about or have no means of their own to ensure that they are providing high quality services. Providers interviewed for this assessment mentioned attending international medical congresses overseas, seminars sponsored by the pharmaceutical industry, and subscribing to medical journals. However those practices where resources are insufficient to support provider continuing education are much more likely to be dependent on invitations by the public sector to attend training programs and these invitations are rare.

There is little or no collaboration or coordination on disease surveillance and no structured program to ensure private providers' participation in training. Although some private providers are invited to public sector trainings, the trainings are not always adapted to their needs/availability. As mentioned above, there are occasional collaborative efforts with private providers. These are based on personal relationships and individual initiatives and cover such public health-oriented activities as giving vaccinations, refrigerators, and vaccines. Other collaboration efforts are centered on activities such as vaccination and polio campaigns, TB control efforts, and Insecticide Treated Nets (ITN) distributions. However, because these are public health prevention-oriented activities, private providers are only compensated beyond inputs.

6.2.2 Financing of installation and medical equipment

Poor access to financing for new practices was documented by the 2009 World Bank Private Sector Study (Lamiaux, Rouzaud, and Woods 2011) and these challenges still exist. This serious barrier to the expansion of the private sector was mentioned by many clinic owners and providers. Well-established providers have little problem accessing credit from local banks as this credit can be in part guaranteed by existing infrastructure. However, smaller or less-established private providers find it difficult to access credit due to lack of collateral and lack the business knowledge and skills to prepare a loan request.

One facility in Bamako reported experiencing a high level of difficulty trying to finance its expansion from a two-provider gynecology/obstetrics practice to a polyclinic. Because leasing is not available in Mali, the facility must procure second-hand medical equipment that tends to break down within a few months. Malfunctioning equipment is a pervasive problem in private clinics, leading to a high volume of clients referred to other facilities for diagnostic testing. It is also a problem in public facilities opening up opportunities for contracting in.

In small facilities located in low-income areas, the lack of resources to buy equipment leads to systematic referral to the public sector. For example, a recently opened practice in a peri-urban area of Commune III reported referring patients needing an ultrasound to another clinic, and all cases of pregnancy complications to the nearest CSRÉF, in part because the clinic lacks basic neonatal and warming equipment. The lack of financing for equipment prevents private facilities from accepting new patients and offering new services, leading some to a state of permanent precariousness.

Not all private facilities have trouble raising funds for infrastructure expansion and equipment. A prominent diagnostics laboratory in Bamako has been procuring state-of-the-art equipment and maintenance services from manufacturers in France and Germany, using private investment, bank loans, and funding from the World Bank. The laboratory also purchased two generators, a high voltage power line, and its own water supply. In the context of the country, this case is exceptional; it shows that that the possibility exists to improve infrastructure and equipment, but the conditions and arrangements are not clear enough to build financing strategies to expand this business model.

Examination room in a private clinic

High-voltage unit in a diagnostics facility

The Investment Promotion Agency (*l'Agence de Promotion de l'Investissement*, API) facilitates communication between investors and the private sector in Mali. While the health sector is not a priority sector, investments by private providers can benefit from incentives (tax breaks, lower import duties) if they are sufficiently large. API reported having recently facilitated one health investment; a large tertiary private hospital built with Turkish funds. This hospital aims to cater to clients who are currently evacuated to Morocco or Tunisia for health services. It also anticipates getting medical tourism clients from West Africa. Private providers may benefit from increased information and communication by the API on existing incentives and current tax regulation, potentially facilitated by the Private Sector Alliance.

6.3 Contributions of Private Facilities to Public Health Goals

Collaboration between the public and private sectors is common, typically including routine reporting, surveillance and community services. This type of collaboration, however, is not systematic or formalized. It also varies significantly depending on the type of facility and the community where it operates. Like CSComs, private facilities communicate with the CSRÉF of their respective commune. Private hospitals and polyclinics, which are at the level of a public hospital, also appear to communicate primarily with the CSRÉF (Figure 7). Occasionally, a private facility owner may communicate directly with the Ministry on a high-level matter, such as a policy concern or proposed PPP.

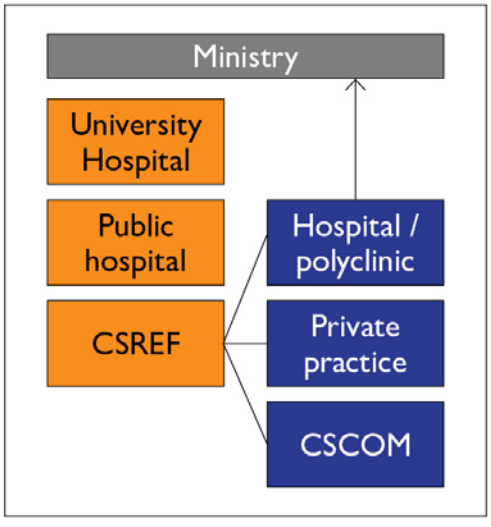
6.3.1 Reporting of service delivery data

The production and sharing of service statistics contributes to accurate and timely monitoring of public health priority indicators.

Although most private providers interviewed for this assessment said that they report service statistics to the MSHP, our findings show that private providers do not regularly report timely data. Larger clinics typically have administrative staff tasked with filling up the data reporting book but in small facilities, providers must maintain the book themselves. Some clinic owners admitted that they cannot always keep up with the process. A private facility's failure to report data is not subject to sanctions, leading to a perception that it is not mandatory, but essentially a goodwill gesture (text box). Data reporting can be the subject of an unofficial (but not illegal) quid pro quo that earns the facility a reputation of being a good collaborator, and increases its chances of receiving free commodities or invitations to training.

> *"We collect data on individual activities of our doctors but we don't synthesize them or analyze them – why should we? No one has ever asked for them. We are just here to cure people.*
>
> Owner of a private clinic in Bamako

Figure 7: Channels of Communication between the Public and Private Health Sectors



6.3.2 Epidemiological surveillance and vaccination campaigns

Storage of donated vaccines in a private clinic

Private providers and facility owners interviewed for this assessment were not aware of any formal mechanism for reporting cases of infectious diseases. Most of them stated however that collaborating with the public sector on surveillance is easy to do through the CSRÉF. Likewise, there is no formal protocol to assist with the coordination of vaccination campaigns between the public sector and PFP facilities. However, facility owners and providers reported collaborating with the CSRÉF tasked with coordinating campaigns in their commune, and some also reported receiving vaccines. Maintaining the cold chain can be a problem for some facilities: one clinic had to drop out of the campaign because it could not afford to keep a refrigerator continuously powered to store the vaccines.

For clinics serving higher-income and privately insured patients, collaboration with the public sector on vaccination campaigns does not appear to be a common occurrence. This may be due to the compensation (limited to the cost of inputs only) that is provided by the government.

6.3.3 Community services

In Mali, PFP facilities specialize in providing curative services because those are the services that patients, employers, and private insurance plans are most likely to pay for. This does not imply that private providers can never provide preventive services, or treat low-income people without insurance, but it must remain the exception for the practice to remain viable. There is currently no mechanism to compensate private providers for treating the poor or providing services that the law says must be free (such as HIV, TB, vaccination, or family planning services). As a result, collaboration with the public sector in these areas has been and is likely to remain limited. Devoting a high percentage of staff time to non-revenue-generating services is very risky for private facilities, unless they are compensated under a health financing mechanism, such as a national insurance scheme for indigent patients.

Improved contribution of the PFP sector to key services such as maternal and neonatal health may be possible by expanding the number of facilities current accredited by the Mandatory Health Insurance program for the formal sector (AMO) and the medical assistance scheme for indigents (RAMED). Some key services, however, are legally free, and not covered by the RAMED. The reimbursement of services provided to the poor, however, may be possible through the RAMED. One facility in a poor neighborhood community of Commune III reported close collaboration with the CSRÉF on vaccinations, patient referrals, and other preventive activities, as well as regular participation in the Marie Stopes-managed family planning outreach program. Because these activities do not generate an income, and up to 30 percent of its patients have no ability to pay, this facility recognized that it is unable to generate a profit and is currently using debt to help cover its operating costs.

6.4 Principal Findings and Recommendations

6.4.1 Principal findings

- Many providers in private practice in Mali continue to experience significant barriers in their daily operations and expansion plans. They have limited skills to prepare a business case and limited collateral, which hampers their ability to access financing to grow.
- The volume and quality of services in this sector is closely linked to access to finance for equipment, continuing medical education and training, and better regulation and oversight of private practice.
- There is operational-level collaboration between private and public sector providers but these efforts are ad hoc and are often based on personal relationships. This operational collaboration is focused on free service provision, thus adding costs for these private providers – instead of helping the providers to generate income, providing the services can cost them.
- There is potential for expanded collaboration in the area of key services (HIV, TB, family planning), epidemiological surveillance, prevention, and services for the poor and rural communities.
- Increased collaboration between the private and public sectors requires a better-represented PFP sector with increased opportunities to grow and greater support to promote the establishment of private providers in difficult zones.

6.4.2 Recommendations

- Increase the participation of private providers in public sector training programs and updates through a more tailored approach (shorter in duration, themes applicable to the private sector such as business planning).
- Increase public support for the financing of new medical practices, potentially through promoting the health sector as a priority sector so that it is eligible for financial incentives such as tax breaks and lower import duties.
- Explore compensation mechanisms for facilities providing HIV/AIDS, TB, and family planning services, and participating in prevention programs.
- Increase the participation of private providers in the AMO, including the RAMED.

7. MEDICINE AND SUPPLIES

7.1 Background: Policy and Guiding Principles Underpinning the Public-Private Sectors

The National Pharmacy and Medicines Policy was drawn up in 1998 and specifies the government's vision, which is "to ensure geographic and financial access to safe, quality essential medicines by all the population." The National Policy also defines i) the roles and mission of the each of the actors in terms of responsibility, rights, and obligations; ii) the place of the pharmaceutical sector in the health pyramid; iii) the framework for supply of essential medicines (*Schéma Directeur d'Approvisionnement et de Distribution des Médicaments Essentiels*, SDAME); iv) the contract between PPM and the government to supply generic medicines in the country; and v) the relevant legislation and regulation. The law on the practice of pharmacy professions defines and organizes the role of the PFP providers within the pharmaceutical sector.

There is a shared responsibility between the MSHP and the private for-profit and nonprofit pharmacies and dispensers to implement the vision stated in the national policy. The Ministry is responsible for formulating policies and strategies; delivering agreements and licenses; setting the standards such as the List of Essential Medicines; delivering authorization to bring drugs to market (AMM); carrying out quality control; verifying observance of the national and regional regulation and instructions; and standardizing and harmonizing practices. These national strategies, policies, and regulations are not well known by the majority of private pharmaceutical providers. In order to improve their knowledge, the National Board of Pharmacists has tried to organize trainings and sensitization workshops, but, to date, this remains at very small scale due to lack of resources.

7.2 Supply within the Public-Private Sectors

PFP wholesalers and private pharmacists are the main suppliers of medicines in the country. Private pharmacies supply medicine to households paying out of pocket. Wholesalers supply private pharmacists and, indirectly, public facilities by participating in government tenders. The majority of them are located in Bamako.

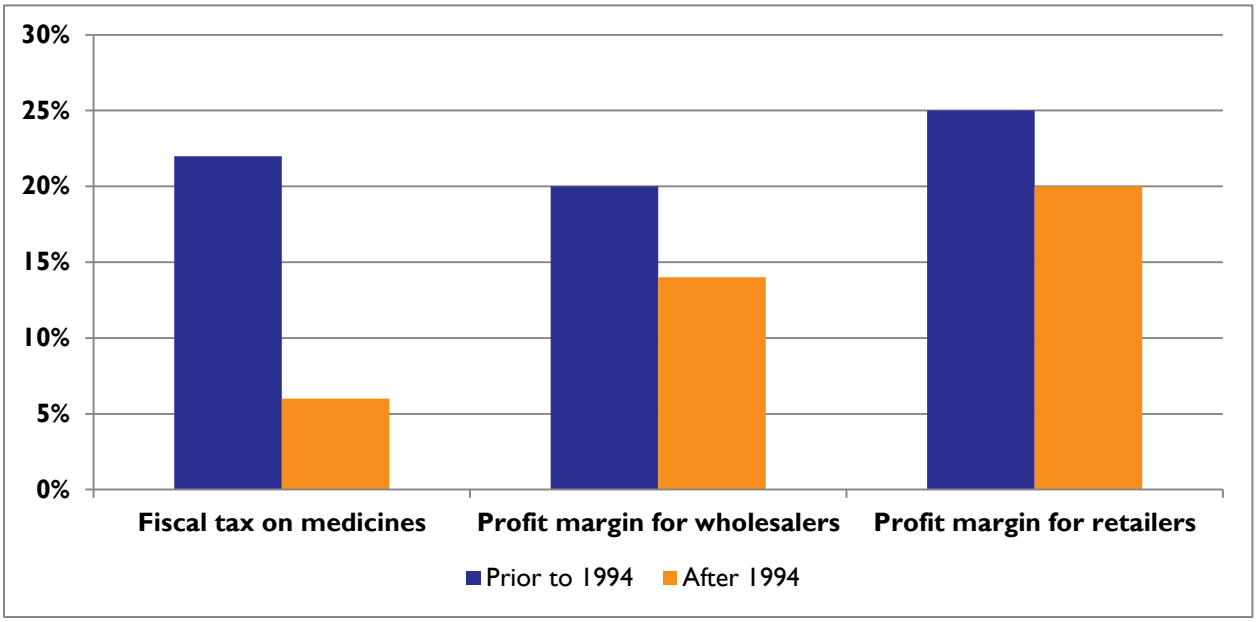
The central medical stores (PPM) imports and distributes generic medicines to public facilities. According to the framework for supply of essential medicines, all medicines and medical supplies for the public sector (including the CSComs) should be purchased through the PPM distribution network, through pre-existing contractual arrangements. In case of a shortage of medicines in PPM and its warehouses, the framework for supply of essential medicines allows private sector procurement. However, it is not clear how, for how long, and what inputs are covered by this exception. As the PPM distribution system has challenges in ensuring supplies, this 'exception' opens the possibility of private procurement for public sector facilities. The government has made arrangements so that private dispensers and retailers can supply generics to public facilities with a margin.

The majority of the medicine dispensers are concentrated in the capital city of Bamako. It should be noted that the PFP dispensers are the only ones operating in the insecure areas in the north of the country, where government administration is largely absent. It seems that national authorities do not acknowledge this important role of the private pharmaceutical sector and do not reward it for the support it has given these at-risk populations.

Several global initiatives are providing medicines such as antiretroviral drugs, malaria treatment, condoms and other family planning commodities, medicines for emergency obstetric care, vitamin therapy for children, and antibiotics. For most of the priority diseases, the global initiatives provide funding for procurement of medicines. PFP pharmacists sell medicines for these diseases, but due to lack of interaction with the government, are not always aware of evolving treatment protocols. Thus, they may not comply with the prescription norms and standards, potentially leading to drug resistance.

One of the challenges that the national public health authorities have faced is a large increase in the price of medicines, which can limit their affordability. Such an incident took place in Mali in 1994, when the CFA franc was devalued (Tefft et al. 1997). Anticipating such a situation, the government took measures to control the price of medicines, including reaching an agreement between private dispensers and the MSHP for a maximum margin to be applied to generic essential medicines. The new benefit margin structure adopted is shown in Figure 8.

Figure 8: Government Efforts to Increase the Affordability of Drugs Before and After Devaluation of the CFA



Source: Tefft et al. (1997)

A decree setting the maximum price for 107 prescription drugs in order to increase the penetration and affordability of these drugs was also adopted. A study carried out in 2006 (Maiga and William-Jones 2010) showed that this decree did not have a negative impact on the availability of the drugs for the wholesalers and retailers. Another decree, 94-350/P-RM, provided an exemption from customs taxes on essential medicines, reagents, and stomatology products, and equipment and products for diagnostics and care. In *Les Prix des Médicaments au Mali* (2005), Ouattara et al. noted that prices of medicines became expensive; in the long run, the market regulation of the price has not worked as expected. The generic medicines, sold at their highest price in the private sector, remain unaffordable for the majority of population. In the same article, Ouattara et al. suggest revising the price policy and its implementation to allow affordable and sustained access to generic medicines.

Since 1996, the SDAME decides the generic medicines supply policy for the country. Its decentralized warehouses supply the CSComs, CSRÉFs, and others public facilities such as hospitals. The SDAME works within the framework of the National Pharmaceutical Policy and supplies the public sector and private for-profit and nonprofit entities such as community health facilities. With regard to the supply of generic medicines, the role of for-profit pharmacists is not significant. It is felt that private sector could play a more influential role that it does now in the implementation of the SDAME.

Local production of pharmaceuticals is limited. A for-profit Chinese factory is currently producing a range of 31 medicines. Information on its management, staffing, and production process is hard to find. The majority of the factory workers are Chinese. A second production facility, the *Usine Malienne des Produits Pharmaceutiques*, is in need of refurbishment and on the verge of bankruptcy. A buy-out by the former workers has been delayed pending a government decision.

7.3 Coordination among Key Actors in the Pharmaceutical Sector

The many actors that promote, regulate, or oversee the PFP pharmaceutical sector need to better coordinate their interventions and efforts. The main actors are the MSHP (licensing, accreditation, oversight); the Ministry of Commerce (importation, customs operations); the Ministry of Industry (factories); the Ministry of Private Investment and Promotion of Public-Private Partnership; the Agency for the Promotion of Investment (API); funding agencies and institutions; and the National Board of Pharmacists' Association (deontology, ethics, rules of conduct, and professional corporate issues). They need to address many issues pertaining to PFP pharmacists' activities in particular and the pharmaceutical sector in general. The MSHP struggles to coordinate all these stakeholders; its efforts are piecemeal and have only limited impact on the development of private practice. As result, the work is done through minimally effective collaboration among actors. For example, the PFP actors are not included in the meetings of the committee that authorizes medicine consumption (AMM); furthermore, negotiations on tax matters between the Ministry of Economy and Finance and PFP professionals do not include the MSHP, which might wish to address some specific issues.

MSHP-private sector pharmacist communication on policy issues is weak and does not allow the pharmacists to become acquainted with the country's health policy and strategy or to work proactively with national priority health programs and projects. The National Board of Pharmacists is criticized for not disseminating MSHP policy documents and statements such as the PRODESS and PDDSS or even the National Pharmaceutical Policy. Occasionally, the Board organizes trainings for private pharmacists on specific themes or subjects, often with the support of development partners (REMED, World Bank/ICF, European Union), but they are not based on a structured plan. The government's budget allocation to the National Board of Pharmacists seems to be the main constraint to expanding this training program. Although the percentage of the members paying fees to the organization is higher (70 percent) and the rate of recovery higher than for other professional organizations, the amount collected is not enough to cover activities the association wants to carry out, such as corporate training.

Interactions with other partners relate to specific issues such as rules and procedures, which in general are specific to commercial activities (customs, interest, revenue tax, VAT, loans, etc.) and for which the MSHP does not have competence. As a consequence, private sector pharmacists are not well supported. In 2014, a workshop on PPPs was organized; it also looked to further implement the recommendations of the 2009 World Bank Private Sector Study in Mali (Lamiaux, Rouzaud, and Woods 2011). Through the Health in Africa project (World Bank and IFC 2011), the World Bank has initiated an important partnership, which intends to train 100 pharmacists on the Business Edge and Small and Medium Enterprises (the SME kit). This is part of an ambitious plan to improve the management capacity of PFP health practitioners.

Subregional economic commissions, such as the Economic Community of West African States (ECOWAS) and the UEMOA, are active in pharmaceutical sector reforms, regulation that gained growing interest for economy integration (establishment of regulatory agency, harmonization of custom tariff, integration of regulation, harmonization of practices, homologation, bulk purchasing, etc.). This area is progressing rapidly, but the lack of coordination among ministries hampers the follow-up of new initiatives and rules.

Another problem is communication among actors on PFP pharmacists' activities. Confidentiality concerns around financing and accounting operations limits communication, even for activities that require the authorities to anticipate public health decisions, such as undertaking prospective analysis to inform the development of policies and strategies to anticipate and prevent pharmacists' bankruptcies in unstable areas where there is need to maintain the presence of a medicine suppliers. This could affect all five northern regions, where civil unrest has been endemic.

7.4 Compliance with Regulations, Norms, and Standards

The DPM is the MSHP entity in charge of drafting regulations and setting norms and standards for the pharmaceutical sector, including those relating to the control of the imports of medicines in country.

Expert committees for the authorization to sell on the market (AMM) provide authorization for the sale of new products on the market and inform dispensers and care providers of banned medicines. The coordination of AMM is an important function performed by a committee under the coordination of the DPM. The number of AMMs delivered yearly is shown in Table 2.

Table 2: Evolution of the Delivery of AMMs

Year	2012	2013	2014	2015	2016	Total
AMM requested	535	481	871	301	367	2551
AMM delivered	397	301	717	267	217	1899

Source: Data supplied directly by DPM (2016)

Before new medicines are authorized for public consumption, they have to comply with a number of standards. A request has to be submitted to an independent committee in charge of delivering the AMM that meets every quarter.

Another committee is in charge of revising the list of generic medicines periodically upon request of the national authorities. In practice, the National Board of Pharmacists represents the private pharmacists in this committee. Although the promotion of generic medicines is not the first responsibility of private providers, they have been closely associated with national health authorities in the implementation of the new generic medicines policy adopted.

Obtaining agreements and licenses to open a private pharmacy or dispensary often takes a long time. This frustrates young graduates who are seeking a first employment or starting a new business, which results in large numbers of dispensers operating without formal authorization. In 2014, a joint activity to address the number of unlicensed pharmacists was undertaken by the Health Inspectorate of the MSHP and the National Board of Pharmacists. In 2013, 35 percent of the 744 operating dispensers were not able to show their license, and only 68 (27 percent) of them were able to normalize their situation by the deadline given.

In many cases, regional or local health authorities were not able to organize the site visits (a requirement before granting the license). The staff of all the PFP dispensaries and factories are required to be checked regularly; in most of the stores inspected, the number and qualifications of the staff were below the standard.

A large number of illegal unrequested suppliers who do not comply with rules and supply chain norms have been identified throughout the country. This practice has a negative impact on the implementation of the SDAME and has led to the proliferation of the trafficking of counterfeit and fake medicines, which bypass the official quality control mechanisms and are sold illicitly. This growing phenomenon has negative implications for the revenue of the dispensers and retailers and jeopardizes the health of the population.

7.5 Supervision

The MSHP through its Regional Directorates of Health and the District Health Teams is responsible for oversight and supervision of private sector pharmacists at the regional and local levels. Unfortunately, the number of pharmacists in post in the public sector is not adequate to carry out this assignment. In addition, the PFP pharmacists believe that they are independent of public health authorities and are not subject to supervision except on certain issues by the inspectors accredited to the boards. This results in a lack of dialogue and exchanges with the PFP pharmacists, and supervision is not carried out properly.

At a more basic level, regular inventory, or mapping, of public and private health facilities including pharmacies, while mandatory, is outdated and does not accurately represent dispensaries, pharmaceutical stores, warehouses, and factories. In addition to impeding supervisory visits to private sector pharmacists, such maps would help the government ensure nationwide coverage of health services and response to potential epidemic diseases outbreaks and other emergencies.

7.6 Principal Findings and Recommendations

7.6.1 Principal findings

- The lack of accurate information on private sector pharmaceutical providers (mapping) hinders efforts to understand national coverage of pharmaceutical goods and ensure quality services through supervisions, inspections and education.
- Central MSHP structures do not fulfill their expected role, i.e., to support and oversee private pharmaceutical practices, and to share information and organize appropriate training.
- PFP pharmacists should have a place within various technical committees established by the MSHP such as the one for the list of essential medicines, pharmacovigilance, and AMM.
- Private sector pharmacists have a potential to play a greater role in public health interventions addressing priority diseases through actions such as preventing drug resistance and ensuring continued supply in case of a shortage of vital medicines.

7.6.2 Recommendations

- The MSHP should organize a mapping of health facilities that includes the private pharmaceutical sector under the coordination of the Planning and Statistics Unit (*Cellule de Planification et de la Statistique*, CPS) and in collaboration with the National Agency for Telehealth and Medical Informatics *(l'Agence Nationale de Télésanté et d'Informatique Médicale*), the Health Inspectorate, the National Board of Pharmacists, the Directorate of Human Resources, DNS, and DPM. This mapping should be updated regularly, for example, annually, to understand national coverage.
- The MSHP should promote the active participation of PFP pharmacist representatives in technical committees such as AMM, list of essential medicines, pharmacovigilance) in addition to the National Board of Pharmacists already represented. Similarly, systematically include the private sector in discussions to promote the availability and access to appropriate medicines to treat priority diseases, fight against fake medicines to avoid microbial resistance, facilitate affordability of medicines, provide appropriate advice to patients, and better coordinate with epidemiologist and public health authorities to order adequate medicine according to the epidemiological trends.
- In accordance with the UEMOA and African Union resolution, Mali should establish a national regulatory authority for medicines.

- The MSHP should consider changing the licensing requirement with the objective of reducing the number of wholesalers and maintain the most experienced operators through objective analysis involving DPM, the National Board of Pharmacists, and a group of experienced pharmacists with strong knowledge of the subject.

8. CONCLUSION

Two decades ago, after Mali shifted toward a market economy and subsequent reforms, the Health and Population Policy (1990) set out the strategic direction for the development of the private health sector. The government adopted texts relating to private health providers and instituted professional boards. The growth of the private sector developed in step with these initiatives in a context marked among others by:

- A lack of a dedicated public administrative entity to promote the private sector and to monitor its development (despite the statements of successive development plans for the private sector);
- A concentration of state investments skewed to the development of the private *nonprofit* primary care sector (CSComs), public hospitals, and prevention-oriented actions;
- A lack of sustained financial support for the installation of new graduate for-profit providers in the private sector;
- Marginalization of the PFP sector in relation to strategic decision-making processes for health;
- The almost non-existent dialogue and listening, which has led to mutual distrust between actors in both sectors; and
- The low participation of PFP providers in government-sponsored insurance.

These constraints have resulted in actors and stakeholders not being able to seize the many opportunities to strengthen PPPs. This PSA confirmed that the institutional dysfunction and a lack of dialogue highlighted by the World Bank Private Sector Study published in 2011 remain just as pervasive and relevant today. Five years later, some but not all of the recommendations in this first study have not implemented. The recommendations of this PSA build on and complement those of the World Bank.

Efforts to promote and strengthen collaboration between the public and private sectors necessitate knowledge and awareness of their importance and their effective implementation. Some of the recommendations listed below may provide some immediate benefits:

- The adoption of the Private Sector Charter and the establishment of the Dialogue Committee. By signing the Act establishing the Committee, the MSHP will institute a framework for communication and permanent dialogue on issues of strategic interest to both sectors.
- Central administration, regional bodies, and local bodies need to have a dedicated or designated office or focal point to facilitate collaboration between the private and public sector and to support the development of the private sector. This office or individuals need to have the knowledge and capacity to assist the private sector without substituting or duplicating the role of the professional boards, associations, or professional associations.
- Expand the participation of PFP actors to the different fora for planning and decision making and the standardization of technical standards.
- Enable the recently created associations, such as the Private Sector Alliance for Health Promotion in Mali and the Association of Liberal Doctors of Mali, to fully exercise their prerogatives and participate in debates.
- Support increased contracting of private providers in the AMO and RAMED.
- Increase the cooperation between the social insurance bodies (CANAM and ANAM) and the private insurance companies for better complementarity between social and private health insurance.

A significant part of this evaluation was to update the inventory of the PFP sector in health. Some of the data from this inventory have been used in this report. This inventory was done by exploiting a large number of databases, managed by separate institutions, collating different datasets, and correcting for many duplicates. These databases are not related and do not communicate with each other. It would be in the great interest of all stakeholders if these databases were combined, or interrelated, leading to a single consolidated database that would meet the expectation of the actors.

The experts who participated in this evaluation noted among both public and private sector actors, a growing awareness of the need to and willingness to collaborate. In this regard, this report is timely and could provide an opportunity to intensify the dialogue on collaboration between the private sector and the MSHP, which could lead to a better-performing health system for the benefit of all Malians.

ANNEX A: STAKEHOLDERS INTERVIEWED

Organization	Interviewee Name	Interviewee Title
USAID		
USAID Mali	Daniel Moore	Mission Director
USAID Mali	Sidi Cissé	
Ministries and Government Agencies at the National Level		
MSHP	Dr. Bakary Diarra	Secrétaire General
Direction Régionale de la Santé de Koulikoro, MSHP	Dr. Simaga Ismaila	Médecin-Chef
MSHP and Conseil National de l'ordre des Médecins du Mali and Conseil Régionale de l'ordre des Médecins du District de Bamako	Dr. Traore Aguibou	Secrétaire Général
MSHP	Mme Djiguiba Zènèbou Touré	Conseiller Technique Chargée des Questions Juridiques, MSHP
DPM	Dr. Yaya Coulibaly	
Direction Nationale de la Protection Sociale	Aliou Ouattara	
DNS	Dr. Mama Coumaré Aïssata Ly	Directeur Secrétaire
Direction Nationale du Développement Social et de l'Economie Solidaire	Mme Koné Sissi Odile Dakouo	
DNS/DESR	Dr. Boureïma Pléa	
Haut Conseil National de Lutte contre le Sida Présidence de la République	Malick Sene	
Institut National de Formation en Sciences de la Santé	Mme Dicko Fatoumata Maïga	Academic Director
Inspection de la Santé	Dr. Nama Magassa	Inspecteur en Chef
Programmes Prioritaires: Cellule Sectorielle de Lutte Contre le Sida	Mme Diallo Fanta Siby	Coordinatrice
Conseil National de l'Ordre des Pharmaciens	Dr. Abdou Doumbia	
	Dr. Bokary Diallo	Conseiller en charge des Etablissements Hospitaliers
Conseiller en charge du Secteur Pharmaceutique	Dr. Sekou Oumar Dembélé	

Organization	Interviewee Name	Interviewee Title
CHU-Gabriel Toure	Pr. Kassoum M. Sango	Directeur Général
CPS	Dr. Amadou Sogodogo	Directeur Général
CPS/SS-DS-PF	Dr. Sidiki Kokaïna	
CPS/SS-DS-PF	Guindo Keïta	
CPS/SS-DS-PF	Mme Touré Bintou Kané	
CPS/SS-DS-PF	Oumarou Alou Maïga	
CPS/SS-DS-PF	Alpha Mahamoud Touré	
CPS/SS-DS-PF	Atumarou Alan Maiga	
CPS/SS-DS-PF	Touré Bintou Konate	
Professional Boards		
Ordre Des Médecins Du Mali Le Conseil National (CNOM)	Dr. Lassana Fofana	Président Chevalier de l'ordre du Mérite de la Santé
l'Ordre des Sage Femmes	Aoua Guido Mme Yalcouyé	Présidente
Private Sector Associations		
Santé Sud Association de solidarité Internationale	Dr. Cheick Mohamed Mansour SY	Directeur Santé Sud Mali
Alliance Du Secteur Privé Pour La Promotion de la Santé au Mali	Dr. Nimaga Karamoko	
Association des médecins libéraux du Mali Moustaphe Cissé	Moustapha Cissé	
Association des Médecins Libéraux du Mali /Liste Réunion du 21/02/2017	Boureïma Afo Traoré	
Association des Médecins Libéraux du Mali /Liste Réunion du 21/02/2017	Dr. Mamadou Dienta	
Association des sages-femmes	Mme Yelcouyé Aoua Guindo	Coordinatrice
Insurance Companies and Structures		
Ministère de la Solidarité et de l'Action Humanitaire CANAM	Akoundio Luc Togo	Directeur Général
CANAM	Dr. Ankoundio Luc TOGO	Directeur Général
ANAM	Modibo Diarra	Chef département Communication et Partenariat
Assurance Médicale Gras Savoye Mali Willis Towers Watson	Maryvonne Sidibe	Directrice Générale
Mutualité Malienne	Issa Sissouma	Directeur Général
Private Polyclinics and Other Clinics		
Clinique ALDY	Abdel Karim Coulibaly	Directeur

Organization	Interviewee Name	Interviewee Title
Clinique Algi	Dr. HN Algiman	
Clinique médico-chirurgicale "Source de Vie"	Dr. Sanogo Félix	DES Gynéco-Obstétrique
Clinique ODJENE	Dr. Sidi Yaya Doumbia	Directeur
DNS Clinique FARAKO	Mme Richard Marcelle	Founder / Midwife Directrice
Polyclinique Guindo	Anaguiré Guindo	Directeur Général Adjoint
Polyclinique Pasteur	Pr. Diarra Mamadou Bocary	Cardiologue
Foundation Pour L'enfance (Hôpital—Mère Enfant—Le Luxembourg)	M. Baby Abdoul Kader	Directeur Administratif et des relations extérieures
Public Hospitals and Reference Centers		
CSREF Commune III	Mme N'Diaye Aoua Thiam	Directrice
CSREF DE KATI	Dr. Ismaïl Simaga	Directeur
Banque Mondiale/IFC Spécialiste du Secteur Privé	Alexandre Laure	
Groupe de la Banque Mondiale Santé, nutrition, et population	Tshiya A. Subayi	Operations Officer
Palladium KJK	Badara Konate	Social Marketing Team Leader
Projet KJK	Dr. Issiaga Daffé	Directeur
PSI-MALI	Alex Brown	Représentant
Other		
Ecole Privée Issa Paul Diallo	Issa Paul Diallo	Directeur
Issa Paul Private nursing school (La Chaine grise)	Issa Paul	Founder
API Mali Agence pour la promotion des investissements	Moussa Bouaré	Project Analyst
CATEK groupe	Marc Ibrahim Traore Mr. Thiam	Directeur Général
	Dr. Boubacar Diarra	
	Dr. Adama Issa Kone	
	Dr. Ramondon Dienta	

ANNEX B: MEMBERS OF THE PRIVATE SECTOR ALLIANCE

The component members of the Private Sector Alliance for Health Promotion in Mali are:

A) Medical:

1) Association of Liberal Doctors of Mali
2) Malian Rural Doctors' Association
3) Association of Liberal Midwives.

B) Pharmaceutical:

4) Autonomous Syndicate of Private Pharmacists of Officine (SYNAPPO)
5) Association of Private Pharmaceutical Wholesalers

C) Training:

6) Association of Private Schools of Health Training (Association des Ecoles Privées de Formation en Santé, AEPFS)

D) Company-provided health services:

7) Coalition of the Private Sector for Health and Sustainable Development (CSP)

E) Mutuality (Mutual Health Organization):

8) Technical Union of Mutualities (UTM)

F) NGOs working in the field of health:

9) Santé Sud, Groupe Pivot Santé et Population (GP/SP), PSI, Horizon Vert, etc.

G) Traditional medicine:

10) Malian Federation of Associations of Traditional Therapists and Herbalists (FEMATH)

H. Community health services:

11) National Federation of Community Health Associations

I) Faith-based health providers

12) Muslim Confessional Health Structures
13) Catholic Health Facilities.
14) Protestant Health Facilities.

J) Medical biology:

15) Association of Physicians and Pharmacists Biologists of the Private (AMPBP)

ANNEX C: BIBLIOGRAPHY

Avenir Health /Track 20. 2015. Family Planning Program Effort Scores in 2014: Mali. Retrieved from: http://www.track20.org/download/resources/track20_materials/FPE%20Policy%20Briefs%202014/FPE%20brief%202014%20Mali.pdf

Balique, H. Simpara, C. T., Koita, N., Diabate, O., Diallo, B. 2014. Rapport de la Mission d'Analyse du Processus D'Accreditation et D'Assurance Qualité au Mali. Rapport Final. Bruxelles: Agence Européenne Pour le Développement Et la Santé.

Ballo, B, Haidara A. 2013. The Profile of the Private Health Sector in Member States of the Economic Community of West African States.

Brunner, B., Carmona, A., Kouakou, A., Dolo I., Revuz, C., Uwamahoro, T., Miles, L., and Kotchofa, S. 2014. The Private Health Sector in West Africa: Six Macro-Level Assessments. Bethesda, MD: Strengthening Health Outcomes through the Private Sector Project, Abt Associates Inc.

Canavan, A., Toonen, J., and Elovainio, R. 2008. Performance based financing: an international review of the literature. KIT. Development policy and practice. Retrieved from: http://www.bibalex.org/search4dev/files/305434/135297.pdf

Castle, S. 2011. A Pre-service Training Assessment of Family Planning Curricula in Mali. A Report to the Institute of Reproductive Health, Georgetown University.

Cellule de Planification et de Statistique (CPS/SSDSPF), Institut National de la Statistique (INSTAT/MPATP), INFO-STAT, et ICF International. 2014. Enquête Démographique et de Santé au Mali 2012-2013. Rockville, Maryland, USA: CPS, INSTAT, INFO-STAT et ICF International. Retrieved from: http://dhsprogram.com/pubs/pdf/FR286/FR286.pdf

Diarra, B., Goita, D., Tounkara, S., Sanogo, M., Baya, B., Togo, A. C. G., ... and M'Baye, O. 2016. Tuberculosis drug resistance in Bamako, Mali, from 2006 to 2014. BMC Infectious Diseases 16(1), 714.

Franco, L. M., Simpara, C. H. T., Sidibe, O., Kelley, A. G., Diop, F. P., Makinen, M.,… and Burgert, C. R. 2006. Equity initiative in Mali: evaluation of the impact of mutual health organizations on utilization of high impact services in Bla and Sikasso Districts in Mali. Bethesda, MD: Partners for Health Reform*plus* Project, Abt Associates Inc.

Haut Conseil pour la Lutte contre le VIH/SIDA. 2013. Cadre Stratégique National de Lutte Contre le VIH et le Sida (CSN 2013 - 2017.

Health Finance and Governance Project. 2014. Case Study: l'Union Technique de la Mutualité Malienne: Premium collection for community-based health insurance. Retrieved from: https://www.hfgproject.org/wp-content/uploads/2014/06/14-0613-Mutuelles-Mali_Case-Study_Final.pdf

Health Finance and Governance Project. Forthcoming, 2017. Mali PSA Inventory.

IHME. 2015. Mali GBD Profile. Retrieved from: http://www.healthdata.org/mali

Institut National de Statistiques du Mali, Santé, Emploi, Sécurité alimentaire et dépenses de consommation des ménages. 2015. Enquête modulaire et permanente auprès des ménages (EMOP).

Juillet, A., Toure, B., Ouedraogo, H., and Derriennic,Y. 2015. Evaluation du Système de Santé Mali 2015. Bethesda, MD: Health Finance and Governance Project, Abt Associates Inc.

Kone, D., Rutta, E., Diarra, S., Doumbia, S, Konate M, Yattara, A., and Toure, C. 2015. Etude de faisabilité de l'élargissement de l'accès aux TDR et CTA dans les pharmacies du secteur privé au Mali: Rapport de recherche. Washington DC: USAID/SIAPS. Retrieved from: http://apps.who.int/medicinedocs/documents/s22065fr/s22065fr.pdf

Lamiaux, M., Rouzaud, F., and Woods, W. 2011. Private health sector assessment in Mali: the post-Bamako Initiative reality (No. 212). World Bank Publications. Retrieved from: http://healthsystemshub.org/uploads/resource_file/attachment/41/Mali_PSHA.pdf

Maïga, D., and Williams-Jones, B. 2010. Assessment of the impact of market regulation in Mali on the price of essential medicines provided through the private sector. Health Policy, 97(2), 130-135.

Maïga, Minkaila, Amara Chérif Traore, and Diadié Maiga. 2003. "Evaluation du secteur pharmaceutique au Mali." Ministère de la santé/ OMS/WHO. Retrieved from : http://collections.infocollections.org/whocountry/en/d/Js6887f/

Mbengue, C., Senauer, K., and Rosensweig, F. 2012. Scaling Up Community-Based Health Insurance in Mali. Brief. Bethesda, MD: Health Systems 2020, Abt Associates Inc.

MHHP/Inspection de la santé. 2017. Répertoire en chiffres des établissements de santé privés du Mali. Mali.

Ministère de la Santé, de la Solidarité et des Personnes Agées. 1990. Déclaration de Politique Sectorielle de Santé et de Population, Article 36, Réédition 1995. Retrieved from: http://mail.cnom.sante.gov.ml/index.php?option=com_content&view=article&id=161:declaration-politique-sectorielle-sante-1995&catid=58&Itemid=87

Ministère du Développement Social, de la Solidarité et des Personnes Agées Secrétariat Général. May 2010. Stratégie Nationale d'Extension de la Couverture Maladie par les Mutuelles de Santé au Mali.

Ministère de la Santé et de l'Hygiène Publique. 2014. Plan d'action National de Planification Familiale du Mali 2014-2018.

Ministère de la Santé et de l'Hygiène Publique et Ministère du Travail et des Affaires Sociales et Humanitaires. 2014. Politique nationale de financement de la santé pour la couverture universelle 2014-2023.

Ministère de la Santé et de l'Hygiène Publique et Ministère du Travail et des Affaires Sociales et Humanitaires, et Ministère de la Promotion de la Femme, de la Famille, et de l'Enfant. 2014a. Programme de Développement Socio-Sanitaire 2014-2018 (PRODESS III). Retrieved from: http://www.sante.gov.ml/docs/PRODESS%20III%20Version%20finale.pdf

Ministère de la Santé et de l'Hygiène Publique, Ministère du Travail et des Affaires Sociales et Humanitaires, Ministère de la Promotion de la Femme, de la Famille, et de l'Enfant. 2014b. Plan Décennal de Développement Sanitaire et Social (PDDSS) 2014-2023. Retrieved from: http://extwprlegs1.fao.org/docs/pdf/mli147674.pdf

Ministère de la Santé et de l'Hygiène Publique, Pharmacie Populaire du Mali. Octobre 2014. Plan Stratégique 2015-2019 de la Pharmacie Populaire du Mali.

Ministère de la Santé et de l'Hygiène Publique, Cellule de Planification et de Statistique Secteur Santé, et Développement Social et Promotion de la Famille. 2015. Comptes de la santé du Mali, édition 2013.

National Agency for Medical Assistance (ANAM). 2017. ANAM 2016 Activity Report.

Ouattara, O. and R. Ag Tachrist,. 2005. Les Prix des Médicaments au Mali in WHO/HAI Report. Retrieved from: http://www.who.int/medicines/areas/coordination/mali_prices.pdf

Ouattara, O., R. Ag Tachrist, M. Maïga, C. Chorliet, A Diawara and S. Chorliet. 2004. Les Prix des Médicaments au Mali. WHO/ Ministère de la Santé et de l'Hygiène Publique

President's Malaria Initiative. 2016. President's Malaria Initiative Mali Malaria Operational Plan FY 2016. Retrieved from: https://www.pmi.gov/docs/default-source/default-document-library/malaria-operational-plans/fy16/fy-2016-mali-malaria-operational-plan.pdf?sfvrsn=5

Programme National de Lutte contre la Tuberculose. 2012. Plan stratégique tuberculose 2013-2017, Relance de la lutte anti tuberculose au Mali. Retrieved from: http://www.initiative5pour100.fr/wp-content/uploads/2013/06/Plan-strat%C3%A9gique-tuberculose-2013-2017-final.pdf

Tefft, J., Coulibaly, S., Dioné, J, and Diarra, A. 1997. La dévaluation du FCFA sur le secteur de la santé en Afrique de l'Ouest. Quel bilan apres trois ans? Impact de la dévaluation du FCFA sur le secteur de la sante du Mai. Institut du Sahel/CILSS. United Nations Children's Fund (UNICEF). 2013. Mali Statistics. Retrieved from: https://www.unicef.org/infobycountry/mali_statistics.html

United Nations Development Programme (UNDP). 2016. Human Development Report 2016, Human Development for Everyone. Retrieved from: http://hdr.undp.org/sites/default/files/2016_human_development_report.pdf

USAID-Mali. 2013. Health Strategy: October 1, 2013 to September 30, 2018. Bamako Mali: USAID. Retrieved from: https://www.usaid.gov/sites/default/files/documents/1864/USAID-Mali%20Health%20Strategy%202014-2018.pdf

The World Bank. 2013. Public Private Partnerships for Health. Africa Health Forum – Finance and Capacity for Results Working Paper. Washington DC: The World Bank.

The World Bank. 2014. World Bank Mali Data. Retrieved from: http://data.worldbank.org/country/mali

The World Bank. 2015. World Bank Mali Data. Retrieved from: http://data.worldbank.org/country/mali

The World Bank. 2017. World Development Indicators: Mali. Retrieved from: http://databank.worldbank.org/data/reports.aspx?source=2&series=SH.STA.MMRT&country=

World Bank and International Corporation. 2011. Partenariat pour la santé: comment l'Etat collabore avec le secteur privé pour améliorer la santé en Afrique. Résumé analytique de 16 pages.

World Health Organization. 2009. WHO, Stratistiques Sanitaires Mondiales 2009. Chapter 6, Personnel de Santé, infrasctructures sanitaires et medicaments essentiels, page 95, 105 pages. Retrieved from: http://www.who.int/whosis/whostat/FR_WHS09_Full.pdf

World Health Organization. 2015. Mali – Tuberculosis Profile. Retrieved from: https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO_HQ_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&ISO2=ML&LAN=EN&outtype=html

World Health Organization. 2016. Global Health Work Force Alliance: Mali. Retrieved from: http://www.who.int/workforcealliance/countries/mli/en/

World Health Organization. 2017. Achieving the health-related MDGs. It takes a workforce! Retrieved from: http://www.who.int/hrh/workforce_mdgs/en/

World Health Organization Africa Regional Office. 1985. AFRO 35th Regional Committee proceedings, 1985: A strategy for the three phase's health development scenario.

Xu, K., D.B. Evans, G. Karan, A. Mylena, and A.Rivera. 2005 (2). "Designing Health Financing Systems to Reduce Catastrophic Health Expenditure." *Technical Briefs for Policy Makers*. Retrieved from: http://apps.who.int/iris/bitstream/10665/70005/1/WHO_EIP_HSF_PB_05.02_eng.pdf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