Building Effective Local Partnerships for Improved Basic Social Services Delivery in Mali

December 2005

BUILDING EFFECTIVE LOCAL PARTNERSHIPS FOR IMPROVED BASIC SOCIAL SERVICES DELIVERY IN MALI

555 507, Mali, June 2005

T. Hilhorst,
D. Bagayoko,
D. Dao,
E. Lodenstein and
J. Toonen

Royal Tropical Institute (KIT), Maurits kade 63, Amsterdam, The Netherlands
SNV- Mali, BP 2220, Bamako, Mali

Contact :
KIT : T.hilhorst@kit.nl; J.Toonen@kit.nl
SNV-Mali: pdrk@afribone.net.ml or snv@snvmali.org

A French version of this paper was published in November 2005 by SNV-Mali *Dynamiser la santé communale- construire des partenariats efficaces dans l'espace communale pour améliorer la qualité des services de santé*).

ABBREVIATIONS

AMM	Association des Municipalités du Mali
ANICT	Agence Nationale des Investissements des Collectivités Territoriales
ASACO	Association de Santé Communautaire
CCA-ONG	Conseil de Concertation et d'Appui des ONG
CLO	Comité Local d'Orientation
CNO	Comité National d'Orientation
CRO	Comité Régional d'Orientation
CSCOM	Centre de Santé Communautaire
DNCT	Direction Nationale des Collectivités Territoriales
HIPC	Heavily Indebted Poor Countries
MATCL	Ministère de l'Administration Territoriale et des Collectivités Locales
MoH	Ministry of Health
PDIS	Plan de Développement Intégré de la Santé
PMA	Paquet minimum d'activités/Minimal Package of Activities
PNDS	Plan National de Développement Sanitaire
PRODESS	Programme de Développement Sanitaire et Social
PRSP/CSLP	Poverty Reduction Strategy Paper/ Cadre Stratégique de Lutte contre la Pauvreté au Mali
SECO-ONG	Secrétariat de Concertation des ONG maliennes
SNV	Netherlands Development organisation
SWAp	Sector wide approach
TdC	Transfert de compétence

LIST OF CONTENTS

5/DEV/06.00/TH/ag
June 2005, 555 507

1 INTRODUCTION

Improving public sector performance in service delivery is an absolute necessity for alleviating poverty and improving welfare in Africa. Basic services and infrastructure for providing health care, education, water, sanitation etc. often fail the poor because they are either unavailable, inaccessible, unaffordable, or of poor technical quality or dysfunctional. Poor service delivery may result from inefficiencies or poor decision making by central government, for example a failure to spend budgets for essential services, or not supporting frontline health providers. Governments may have inadequate or poorly trained staff, particularly when budgets are tight or salaries are poor. Moreover, demand for services by poor people may be weak because of travelling distance and logistical constraints, levels of formal education and literacy, cost (direct costs, and transaction costs), cultural factors including restrictions placed on movement, or beliefs restricting the use of western health and maternity care. A weak demand for services like health care will not contribute towards a redesign of service delivery or more investment.
In some cases, service providers themselves abuse their position, and are not trusted as a result (World Bank, 2004).

The 2004 World Development Report on pro-poor service delivery introduced the so-called 'accountability framework' or triangle, which centres around the linkages between (poor) citizens, service providers and policy makers. Policymakers (particular when it concerns local government) have a territorial jurisdiction, service providers tend to be organised by function and organisations of citizens represents a social unit acting upon collective decisions. Citizens and their organisations can make use of two ways for holding service providers accountable. When using the 'long route', citizens and their organizations demand central policymakers to exact improved performance and more responsiveness from (public) service providers, using their right to oversight and control over budget allocations. In the short route, citizens approach service providers directly and demand better performance by creating pressure (Campos and Hellman 2005;World Bank 2004). In addition to establishing mechanisms for holding service providers accountable, it is equally important that forums for dialogue and partnerships emerge in order to develop more commitment among all actors to provide adequate and inclusive services (Goetz and Jenkins 2005).

In Africa, institutional changes towards strengthening the role of users were initiated in 1987, when the Ministers of the African Region of the World Health Organisation launched the "Bamako Initiative on Improving Sustainable Public Health Delivery". The Initiative sought to bring primary health care, and vaccination, closer to the people and helped to revitalise around 6,000 District Health Centres across Africa (Uzochukwu et al, 2004). Another development during the 1990s is the establishment of elected local governments in several West African countries. The mandate of these new authorities formally includes responsibilities in relation to basic service delivery, which may result in the strengthening of the accountability triangle.

In Mali, the health sector requires a partnership approach with effective cooperation between local government authorities, the relevant ministries, local associations and other stakeholders. As we have argued above, it is this accountability 'triangle' that may improve responsiveness and coverage of service delivery. Moreover, good cooperation between partner institutions will facilitate a multi-sectoral approach to public health, which does much more than providing health care facilities alone.

In this paper we explore the potential contribution of local government to basic service delivery, with a focus on the public health sector in Mali. Following an introduction to the concepts of decentralisation and deconcentration, a description of the service delivery chain and decentralisation reforms, we make an inventory of recent changes in the organisation of the health sector in Mali and discuss the implications of these for local government. We then analyse the opportunities and challenges for tri-partite partnerships involving local governments, the Ministry of Health, and civil society organisations involved in the management of community health centres. We illustrate this potential with initial research conducted in the Dioïla district and we present some early experiences. In the last section we discuss some of the prerequisites for effective partnerships for health service delivery, and we propose a framework for action- research to move this agenda forwards in Mali.

2 DECONCENTRATION, DEVOLUTION AND PARTNERSHIPS

Decentralisation is the transfer of decision-making powers, functions and resources from a central authority to more than one sub-unit, and is generally a top-down process operating within a legal framework. The term decentralisation has different meanings in different settings and can be used to refer to deconcentration as well as to devolution.

2.1 Deconcentration

Deconcentration is the handing over of some administrative - rather than political - responsibilities to sub-national levels of central government, such as within a Ministry of Health, and is pursued mainly to improve the applicability of national policy decisions. Decentralised levels remain accountable to the central level. Deconcentration does not involve a transfer of authority, even although the sub-national levels may receive a certain degree of discretion. Nonetheless, they cannot operate without continuous reference to the central level which can overrule them, and which continues to control decision making. If there is good vertical communication and organisation some user requests can find their way up to central authority.

Two approaches can be distinguished: vertical and integrated deconcentration. When the integrated approach is chosen, an administrative representative appointed by central government is responsible for all government functions in the area under his or her jurisdiction. This official (a governor, or a prefect/préfet) is generally a representative of the Ministry of Local Government or Ministry of the Interior. An official of a sector ministry (e.g. a regional medical officer) is directly answerable to the governor for day-to-day administrative matters, but remains under the umbrella of the sector ministry for technical matters. In the vertical pattern, the local staff of each sector ministry is accountable only to their ministry. Some form of co-ordinating body may be set up to promote cooperation and to avoid that the various sector ministries operate in isolation. Examples of such bodies are regional or district development committees, usually presided over by an administrative authority.

2.2 Devolution

Devolution involves the establishment of sub-national levels of government that operate independently from the central level and to which a defined set of functions and responsibilities are transferred. The stated objective is reinforcing democratic

structures, narrowing the breach between political/public administrative structures and the population, and making public services more responsive to local needs and demands. Those in charge of local governments are usually elected. Where there are several layers of local government between central and local level, they are related internally to each other but not necessarily according to hierarchical principles.

Laws generally stipulate that central government should transfer a defined set of powers and responsibilities, as well as the resources needed for implementation. The strength of local government, degrees of financial autonomy, existence of robust mechanisms for accountability and transparency vary between countries and over time. In practice, this transfer of power is gradual (geographically and/or in time) with the central level determining the pace. The allocation of resources (human, financial etc.) needed to take charge of these new responsibilities often lag behind or do not materialise at all.

Local government levels are expected to operate in line with national policies and plans, including those of sector ministries. The central level supervises the application of laws and regulations, and the use of public funds. Local governments may have statutory authority to raise revenues and spend these according to locally defined priorities. In some countries, they are allocated a fixed percentage of the national budget or receive a grant from central government, but its use may be earmarked for specific purposes. Sector ministries may also transfer part of their budget to local governments if the latter have sector specific responsibilities.

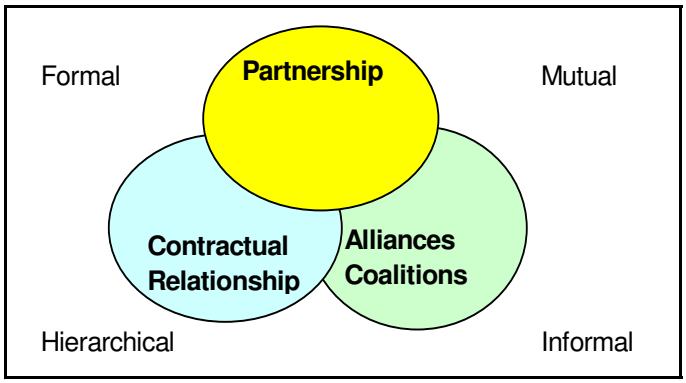
Sector ministries are organised vertically and a policy of deconcentration will deepen this structure. Within the space or territory where local governments operate, horizontal coordination between sectors should be encouraged. Local governments have a certain level of discretion in deciding on what range of services they want to support and where to invest. These decisions may not be in line with sector ministries' priorities[1]. Another challenge is that sector ministries tend to have different levels and catchment areas that may again diverge from the administrative local government units, causing coordination problems for planning and implementation. These and other challenges will be elaborated throughout the paper.

[1] In Uganda, local government authorities invested less in health services following devolution. One reason given was that in their view this sector received enough direct funding (Jeppsson, 2004).

2.3 Defining partnerships in the health sector

Strengthening and institutionalising coordination between local government, the deconcentrated health services and community health associations requires the building and sustaining of partnerships. We argue that a partnership approach is essential in this context. Partnerships refer to an inter-organisational relationship that aim to achieve shared goals, and is based upon close working relationships. These are, in practice, different from market-based relations determined by contract, and to the types of hierarchical relationships found in the public sector (Figure 1). As Figure 1 shows, partnerships can be relatively formalised, but they avoid hierarchical arrangements. This sets them aside from hierarchical contractual relationships, and less formal alliances.

Figure 1: Partnerships and other institutional relationships



Working in partnership involves collaboration and co-ordination between organisations based on trust (Thompson, et al., 1991). Trust requires reliance, mutual dependence and the acceptance of risk. Without a degree of trust it would be difficult to have any form of unity or direction, the key qualities of partnerships. Two qualities are important to sustain trust. Firstly, there needs to be a degree of mutuality and equality between those involved, not least in the attitudes of the partners. Secondly, a partnership implies a mutual commitment to agreed objectives, and reciprocal obligations and accountability, whether this is laid down in a formal contract or is more informally agreed. These two qualities could also be expressed as unity and direction – the unity between individuals and/or organisations, and the direction (or overarching goals) of the partnership shared among its members.

Communication and network attributes are key to effective partnerships. Good communication is a prerequisite to maintaining trust between partners with different, sometimes competing interests. 'Network attributes' need to be kept in mind as relationships evolve. The term refers to the degree of centralisation or openness of the partnership, its stability in terms of its resources, its agenda and the actors involved, and the ability of the partnership to facilitate the acquisition and transfer of resources and to add to the capacity of partner organisations.

3 HEALTH SERVICE DELIVERY IN MALI

In this section, we shall firstly introduce the actors in the health system in Mali starting with the community health associations. This will be followed by a description of the current organisation of the health sector and its policies, and the changes that have taken place during the last decade.

In Mali, a new sector policy for health was adopted in 1990 (Politique Sectorielle de Santé et de Population; Politique sectorielle de l'Action Sociale; PRODESS - Programme de Développement Sanitaire et Social). In the spirit of the Bamako Initiative, the cornerstones of this new policy were a greater role for communities in resource mobilisation and management of community health centres (see 3.1) and deconcentration of certain responsibilities within the Ministry of Health (see 3.2). Political devolution became effective in Mali in 1999. PRODESS started before the establishment of local governments in Mali, although the legislation for decentralisation was already approved, and the future responsibilities for public health that were to be transferred to these new entities were already known.

In 1997, the Sector Wide Approach (SWAp) for the health sector was approved. The essence of SWAp is a strengthening of the technical planning process, financial planning and expenditures system; human resource development; better integration of the various activities related to public health and the promotion of a dynamic partnership between all actors involved in public health management. Negotiations with donors take place at the central level. The funding agreements of 1997 did not take into consideration future local governments' responsibilities for implementing development activities at regional and district level. The question of how funds will be allocated between central and decentralised levels and between institutions at decentralised level was not addressed. Also, whether the financial management system within the MoH has the capacity to ensure a smooth passage of approved funding from national to district accounts was not tackled. PRODESS was reviewed in 2004 resulting in PRODESS-2, which does take into account better the responsibilities of local government with respect to public health.

Finally, the Poverty Reduction Strategy Plan (PRSP, or Cadre Stratégique de Lutte contre la Pauvreté au Mali, CSLP) was approved in 2001. Together with the resources which became available as a result of the HIPC agreement, funding for public health

has increased in terms of percentage GNP allocated, although it is still not enough to cover all needs.

3.1 The emergence of the ASACO (*Association de Santé Communautaire*)

Following the new sector policy in 1990, the Ministry of Health (MoH) promoted the emergence of community health associations to increase the coverage of health services. In Mali, contrary to many other countries, an ASACO (Association de Santé Communautaire) is legally recognised and has authority to employ personnel, hold financial reserves and to possess buildings. This means an ASACO is independent from local government and other bodies. The MoH is responsible for training and supervision of ASACOs, and a series of methods and tools have been developed to support them, such as needs analysis; monitoring indicators; financial management; cost recovery systems; and management of essential medicines2.

One or more communities wanting a community health centre (Centre de Santé Communautaire, CSCOM) are encouraged to set up an ASACO. Membership of an ASACO is voluntary and individual, but in practice all residents of a village become members3. A general assembly of the communities is organised to select the management board and the management committee4. The chef de poste of the MoH becomes a member of the management team5. The district level of the MoH is generally responsible for initiating the establishment of an ASACO. This link with the MoH creates a certain level of dependency in the decision-making and operations of an ASACO.

A health centre is expected to operate with the funds generated by the ASACO, without subsidy from the MoH (except for some personnel, construction and equipment costs). To ensure its financial viability, the health centre has to serve a minimum of 5000 inhabitants; have a maximum reach of 15 km; and have a sufficient potential for cost recovery. The ASACO can initiate the establishment of a health centre with approval from the MoH, if it meets the above criteria. This approval is a condition for the allocation of financial support for construction and personnel. The

[2] However, the regional level of the MoH in Koulikoro thinks that ASACOs do not receive enough support as fewer resources are being spent on training district level health teams how to support ASACOs.

[3] In the cotton zone and the irrigated rice area, membership fees were often paid by a village organisation (*Association Villageoise*).

[4] Board and management committee members are not paid.

[5] Management team members often live in the village where the CSCOM is built.

costs for building the health centre, equipment and a stock of drugs is financed through funds made available from the MoH to it, but the ASACO has first to collect the contre partie of 20% of the total investment from community sources. The MoH will also allocate the minimal personnel required to an approved health centre.

In principle, the ASACO is responsible for the management of a community health centre. The ASACO has to organise local financial support for running the health centre. In particular, the careful management of the funds generated through the cost recovery system for medication is important for the centre's sustainability. A revolving fund is used to finance essential drugs. The ASACO sets the priorities for the allocation of the profit generated by the revolving fund, but such decisions are guided by the advice of the chef de poste of the health centre. Today, the ASACO are responsible for mobilising financial resources. The principle is that the ASACO should be formally consulted over planning matters and the monitoring of service delivery. In practice, however, their role in the management of public health has been limited.

3.2 Deconcentration of the Ministry of Health (MoH)

After the introduction of PRODESS, the programme implementing the new health sector policy in 1990, the MoH was reformed with responsibilities transferred to lower levels. The division of responsibilities and tasks between the four levels within the Ministry is now as follows:

- The central level (Ministry; National Direction and services) is responsible for the general policy orientation, development of overall strategic policies, resource allocation and decides on the delegation of tasks and responsibilities to lower echelons of the Ministry. It is also in charge of management of four specialised national level hospitals. The central level consults with the regional and district level on policy.
- The regional level tasks are to provide technical support to the districts, and be responsible for the 6 regional hospitals. This level is responsible for assisting the operational level (the District), and to ensure that national policy and strategy guidelines are respected. The regional level is mandated to decide on human and financial resource allocation including the distribution of resources between districts within a region and to approve the district's requests.
- The district level is responsible for planning and implementation of activities as well as supervision, and the management of 55 district health centres (centres de santé de reference).

- The community health centre (CSCOM) is responsible for health service delivery (the minimal package of activities, PMA) in a specific catchment area, providing technical support and training to the community health association (ASACO) and mobilising local resources. The CSCOM should provide curative care, oversee essential drugs provision, and organize health education and vaccination campaigns.

Some policy documents were elaborated which describe the tasks to be carried out at each level, but these are not explicitly written down. A study of human resource development in Mali showed, however, that developing clear job descriptions may provide a powerful tool to describe "who, at which level, is responsible for what" (Toonen and Dieleman 2001).

District and regional levels submit annual plans and a strategic plan every five years, according to a strict framework. Planning within the MoH goes through several levels of review. A first plan is made at the local health catchment area involving medical personnel of the community health centre and the ASACO. These plans are then presented to the District MOH, which discusses the health centre's proposals and sets priorities according to the budget. An aggregated District plan is then sent to the regional level where priorities are set and adjustments made with reference to national policy and budget allocation. After approval, the regional plan is forwarded to the central level, which will then develop an overall national plan. These procedures take over 6 months.

Deconcentration has tended to strengthen an organisational culture of risk avoidance, and centralisation. Regional level staff often regard promotion to a job at the central level as the next step in their career, and will not challenge the system by backing new district level initiatives in response to local circumstances but to which central level officials might object. Re-allocating staff between various levels can be difficult too. In Mali, there is no transfer of personnel from central level to the operational levels, even though demand for staff has increased locally. Insufficient personnel is available to work at district level. More expertise in financial-administrative work is now needed, and consumes much staff time at regional, district and community health centre level, often at the expense of technical public health related activities. Overall, the targets set by PRODESS for the increase in use of the health service by its clients have not been met.

4 LOCAL GOVERNMENT'S RESPONSIBILITY FOR HEALTH SERVICE PROVISION

4.1 Emergence of local governments in Mali

In 1999, the establishment of local government authorities in Mali became a reality. The second round of local elections in 2004 showed a doubling in voter turnout.

After several years of conceptual thinking, preparation of the legal and institutional framework and political negotiations, the local elections organized in 1999 signalled the start of implementation of the institutional reform towards decentralisation. The framework law No. 93-008, sets out the conditions for the independent administration of the local government authorities[6]. This law took its inspiration from the Constitution and provides for the establishment of local government authorities, with no hierarchical relationship between them: communes, districts, regions and the capital city of Bamako district, all with their own deliberative and executive bodies (703 communes, 49 districts and 8 regions, plus Bamako District).

The law also provides for the establishment of the Supreme Council of Local Government Authorities (*Haut Conseil des Collectivités Territoriales, HCCT*), as the national representative body for the decentralised authorities. The HCCT does not have deliberative powers like the National Assembly, but it does have authority to advise on all issues concerning local governments. The Constitution obliges the government to seek the opinion of the HCCT and it is protected from dissolution. Local governments have set up their own representative structure, the Association of Malian Municipalities (AMM).
The Ministry responsible for the local government authorities has set up the DNCT (*Direction Nationale des Collectivités Territoriales*), and CCN (*Cellule de Coordination National*) as a tool for promoting, assisting and monitoring them. Technical and financial support mechanisms have been created to help the new authorities in their task of promoting local development.

The powers to be transferred from the State to the authorities are laid down by the law, with resources, means and assets to be transferred simultaneously. However, the

[6] Territorial decentralisation in Mali is based on several documents: the Constitution of 25 February 1992 (Article 98); Law 93-008 of 11 February 1993, which sets the conditions of free administration; Law 95-034, modified on 12 April 1995, which sets out a code of local authorities; Law 93-008, in which Articles 3 and 4 set out the concept of transfer of resource management, and Articles 14, 83 and 131 which set out the code under which territorial authorities can be transferred.

local authorities will still be subject to State oversight, which will be limited to checking the legality, rather than the appropriateness, of local government decisions and actions (see Table 1).

Table 1: Administrative organisation in Mali

Levels	**Elected bodies**	**Supervisory authority (state representatives)**	**Steering committees**
State	Supreme council of local government authorities (HCCT)	Minister responsible for local government authorities	National steering committee (CNO)
Region	Regional assembly	Regional commissioner	Regional steering committee (CRO)
District	District Council	Prefect	Local steering committee (CLO)
Commune	Commune Council	Sub-prefect	

→ Supervision (checking legality of decisions/actions)

⇢ Offering advice

Unfortunately, setting up local government authorities and giving them powers does not mean that such bodies can automatically exercise such powers and have the means to operate. Through its legislation, Mali has provided that "any transfer of powers to a local authority must be accompanied by the simultaneous transfer from the State to the latter of the resources and means required for the normal exercise of such powers"[7].

A first wave of transfers of powers (*transfert de compétence*) occurred in 1999 as soon as the local government authority institutions were operational. The State representatives handed over powers of general administration (registry office functions, municipal police, sanitation, archives and documentation) to councillors elected at the local level. In many communes this has worked well and the setting up of local registry offices, for example, is highly valued. People can acquire birth, marriage and death certificates and identity cards at the administrative centre of the commune, rather than having to travel to the administrative centre of the district.

[7] Article 4 of Law No. 93-008, 11th February 1993.

Communes themselves have to pay for staff and are responsible for recruitment. Some local government authorities, however, are finding it difficult to take over the responsibilities involved in exercising these powers due to problems with recruiting personnel, both in terms of ability and number. Not all communes, particularly those which are remote and relatively poor, have succeeded in employing general secretaries or an administrator. These posts must be filled to ensure a minimum level of management of the communes' administrative and financial affairs. In terms of ability, administrative staff do not always have the technical skills to cope with the management tasks for which they are responsible. Some communes are experiencing a rapid turnover of staff because of low pay, the absence of clear service regulations or conflicts with the mayor.

4.2 Transfer of powers and resources in the health, education and water sector

In June 2002, the government signed the decrees concerning the transfer of powers in the sectors of health, education and water. These decrees cover the detailed exercising of powers set forth in the laws governing local government authorities. They also deal with handing over existing infrastructure to the territorial authorities on the decision of the Regional Commissioner; support and advice from deconcentrated technical departments; and transfer of financial resources to the territorial authorities in the form of earmarked subsidies.

Table 2 shows which tasks in the sectors of health, education and water are to be handed over to the communes when powers are transferred. This does not mean that the local government authorities have a monopoly over carrying out these tasks, but simply that they have responsibility for them. Consequently, it is expected that they should take the initiative and other agencies which are involved in implementing activities must liaise with the local authorities or at least inform them. In addition, the public funds to be devoted to carrying out these tasks should form part of the local authorities' budget.

Table 2: Powers transferred to the rural communes

Health	Education	Water
• Preparation and implementation of health development plan • Establishment and maintenance of infrastructure • Authorisation to set up community health centres (CSCOM) • Conclusion of mutual assistance agreement with associations managing health centres (ASACO) • Subsidy to ASACO • Personnel recruitment • Establishment of an initial stock of essential drugs • Combating illegal sale of drugs • Health information, education and communication • Implementation of national policies and strategies of disease prevention and control • Social mobilisation around health and welfare objectives	• Preparation and implementation of education development plan • Support in drawing up the catchment areas for schools • Construction and maintenance of preschool and school infrastructure • Determination of specific modules not coming under national classification • Personnel recruitment and management • Subsidy to community schools • Organisation and operation of canteens • Organisation of examinations • Production of school statistics • Monitoring literacy centres	• Preparation and implementation of hydraulic development plan (drinking-water supply) • Construction and maintenance of infrastructure • Control and monitoring of approved infrastructure management bodies • Recruitment of operators in charge of infrastructure

Issuing the decrees sent out a strong signal of the government's determination to support the decentralisation process. However, there are still difficulties in making the decrees operational, in particular due to the lack of precision about the role of the different parties and failure to determine both the amount of financial resources to be transferred and the practical procedures for transferring them. In institutional terms, the difficulties stem not only from delays in adapting the statutory framework and policy procedures in the various sectors to take account of decentralisation, but also from the absence of a programme for genuine deconcentration of the various ministries involved in terms of financial, material and human resources. These various constraints have highlighted a lack of deconcentration of the national budget and the absence of decision-making power at deconcentrated levels.

The transfer of powers in Mali from central to decentralised structures has become one of the major challenges of the decentralisation process today, and sometimes even restrict it to declarations of intent rather than concrete actions. This is occurring in the health, education and water services, which are all vital in combating poverty

and meeting the Millennium Development Goals. This is unfortunate as the emergence of local government authorities offers a unique opportunity to the sector ministries to achieve these objectives.

4.3 Policy initiatives to advance the transfer of powers in the health sector

The Directorate in charge of decentralisation, the DNCT (*Direction Nationale des Collectivités Territoriales*) is responsible for drafting and planning support programmes that accompany the implementation of the transfer of powers by the sector ministries. These programmes are supposed to inform the stakeholders concerned, produce clear guidelines for implementation and lead to opportunities for cooperation. DNCT has prioritised three issues: harmonising the financing procedures for investments, development of a clear division of tasks and responsibilities between the various stakeholders, and the promotion of better consultation between these stakeholders.

Discussions on the implementation of the transfer of powers in the health sector started in 2002. In the health sector program PRODESS, there is a working group on transfer of powers and resources in the public health area. The group comprises representatives of the Ministry of Health, Ministry of Local Government and key donors. Issues raised by the group have included the clarification of the division of tasks and responsibilities amongst the various actors involved and the need to revise financial procedures of PRODESS to include local governments.

DNCT was asked to draft adjustments to the PRODESS procedures to take into account the mandate of local governments. DNCT suggested a focus on training of councillors and government administrators on the objectives of the health sector, joint planning, and support for the integration of public health objectives in community programmes. It also proposed regular consultation platforms (*cadres de concertation*) between the different institutions at district and regional level to ensure coherence between activities of local governments and sector ministries. As PRODESS funds are allocated for investment at local level, the DNCT suggested the procedures be adapted to ensure that local government can access health sector funds for investments, and proposed channelling such funds through an existing fund for local governments, the ANICT (*Agence Nationale des Investissements des Collectivités Territoriales*). DNCT further suggested a timeline with respect to local governments'

involvement in the recruitment of health personnel and the transfer of infrastructure to local governments.

The PRODESS steering committee acknowledges that local governments should play a role in health service provision as described by law. Although giving local government more responsibility for the running of the community health centres is a sensitive topic within the MoH, the PRODESS committee has started discussions on how to transfer investment in health infrastructure from MoH to local governments. The committee has not accepted, however, the DNCT proposal to channel funding allocated to local investment through ANICT. Involving local government in recruitment and evaluation of job performance of health professionals is even more sensitive and does not appear to be on the agenda in the near future[8]. Other challenges to managing public health are the so-called vertical programmes (TB, AIDS, Malaria initiative) that are inclined to operate in parallel to the MoH and may also bypass local government authorities.

4.3.1 Challenges for engaging the MoH

The recent transfer of administrative powers under post-1999 decentralisation comes with a legal framework that enables partnerships. But, although local governments have a mandate, they have no means at their disposal to oblige sector ministries or the ASACO to cooperate with them. So this remains a challenge in many regions. One reason for this is that political devolution came relatively late in Mali, in 1999, almost one decade after the reorganisation of the MoH towards deconcentration. As devolution lagged behind deconcentration and health sector policy reform, the planning system and procedures of the MoH do not take into account the local government authorities' functions.

The Administration and Finance Department of the MoH continue to manage investment procedures on behalf of communes, districts and regions, when we would expect local governments to play a much greater role. Resistance has arisen also because it was not long after MoH authorities had acquired new financial-administrative powers as a result of the 1997 sector reform, that they were asked to hand over to local governments. Yet, many local governments have shown that they are capable of managing investments in public infrastructure. Local governments

have been able to absorb around FCFA 30 billion[9] of ANICT funding between 2001 and 2003, of which more than 50% has been spent in the sectors of health, education and water (ANICT, 2004).

Ministerial departments have expressed concerns regarding the shortage of human resources and weak technical capacity of local government authorities. Indeed, many local governments are poorly informed about national health planning principles, and have received no training in health care management. However, the capacities of local government authorities to deal with additional responsibilities differ from community to community. Across the board, there is a need to strengthen capabilities with respect to planning sectoral and inter-sectoral activities, monitoring performance, facilitating effective cooperation with specialist structures and local associations.

Performance will improve further when governments are briefed on how basic service delivery systems are organised (who are the key actors, how they are organised, how they develop a workplan and budget or assess performance, etc). Equally, it is important that actors involved in basic service delivery know more about decentralisation, its institutions, responsibilities, its ways of working, and everyday practice. This type of information exchange is a precondition for the emergence of a climate of confidence and better understanding.

4.3.2 Opportunities for strengthening the ASACO

A challenge for both the ASACOs as well as the commune is to strengthen the voice of the local population, in all its diversity, in internal management and in discussions on health service delivery and performance. The link between ASACO management and communities is weak. Remote rural communities tend to have relatively few members and hardly any are women, compared to those nearer urban centres. ASACO board members are not actively soliciting the public's perception of health service delivery.

---

[8] A specific issue concerns the administration of hospitals and district health centres (*centres de santé de reference)* and the role of local governments in this, and there is a need for a review of legalisation on this matter.

[9] Approximately 46 million Euros (exchange rate 1 Euro= 655,975).

Local government could pressure ASACOs to become more downwardly accountable. ASACOs in turn could lobby local government to prioritise public health. Some ASACOs are doing this when asking local governments for financial support, but it is early days.

In addition, we would suggest that local government councillors could play a more active role in assessing both 'client satisfaction' in general, and whether or not the poorer households are served. Mali has a history of community level initiatives, which established so called '*relais*' (village health committees, hygienists or first help, traditional midwives) since the 1980s. Moreover, some NGOs continue to work with villages, and in these communities additional training is given. These village level resource persons are potentially important entry points for local government councils who wish to monitor basic service delivery, client satisfaction and public health needs.

Finally, a more rapid transfer of powers will depend largely on the political will and commitment of key institutions, including the central state. The institutional set-up, habits, divergent interests and prejudices found in the higher or central levels of government can jeopardize such cooperation. This is an important lesson from Senegal, where a comparative set of constraints and opportunities still hamper local accountability and performance (Box 2). However, even though at central level most effort is still spent on workshops and commissioning studies, the lack of decisive action at the centre does not seem to inhibit local levels exploring new ways of working together (see next chapter).

Box 2: Senegal's decentralisation of health care organisation: a threat or an opportunity?

The mid-term evaluation in 2003 of Senegal's national health plan (PNDS/ PDIS10) included an analysis of threats and opportunities of devolution for the performance of the health sector (and therefore for SWAp) :

<u>The threats</u>
Deconcentration and devolution proceed at different speeds. Deconcentration within the MoH has started already, and some decision-making now takes place by health authorities at operational level, who seek to extend their autonomy. However, higher levels have retained the authority to change such decisions post-hoc, and are reluctant to release more authority to lower levels. The "Bamako Initiative" has provided local level health authorities with a way to bypass the centre: by obtaining the funds resulting from the cost recovery schemes. These funds are always available locally, while funds deriving from the national treasury often come late, or are short. The health associations representing the community are responsible for these funds. However, as these bodies

[10] PNDS/ PDIS *Plan national de développement sanitaire/Plan de développement intégré de la santé*

were set up by the deconcentrated level of the MoH, in practice they can influence the use of these funds, thus enhancing their financial autonomy. Just at a time when local level health authorities are gaining more influence, central government has decided to transfer decision-making power towards local governments or communes. Local level health authorities will become the technical advisors of the local government.

Often, procedures for disbursements of funds towards local government are very complex, resulting in late payments. Therefore transferring funds through them may create an extra blockage. Moreover, funding by local governments in Senegal is calculated on an item by item basis, creating burdensome accounting procedures. In addition, their offices are often located far from the offices of the health authorities, with which they are supposed to consult.

The territory managed by local government differs from that of a functional health unit. A health district may comprise different "communes", while a commune may overlap different health districts. This creates serious coordination problems. When one district includes several communes, the health district management team has to consult with different governments.

According to the health authorities, local government staff are not well prepared to manage the health sector. They have limited financial-administrative skills, and little or no experience in health related affairs. Health authorities argue that councillors are not always defending the population's interest in public health, as their first priority is the exercise and control of power. Health authorities further argue that the population is already involved in public health policy through the community health associations. Therefore, there should be no need for local government to get involved. They even foresee competition between these associations and local government in future, in areas such as cost recovery from revolving credit funds.

<u>The opportunities</u>
SWAp is often regarded as supporting only the health sector. Inter-sectoral activities, like water and sanitation, nutrition, AIDS, etc. must also be supported. Local governments are responsible for all sectors, including health. Working with government may thus present an opportunity for sector organisations, since they are better placed to coordinate the different types of service providers (for-profit private, NGO, mutuelles, public sector) than the MoH.

Deconcentration (and SWAp) also implies an increasing burden of financial-administrative tasks for health professionals – perhaps at the expense of the quality of care. But if local governments assume most of these tasks, then health authorities could dedicate themselves again to what they do best: the management of health care programs. User involvement in health care management may become more active when government staff are empowered and given more lasting roles in needs assessment, priority setting, planning, monitoring and the evaluation of health care services.

Nonetheless, in Senegal, the conclusion is that an equitable and appropriate distribution of resources for health within the context of deconcentration is far from easy. The central level will always tend to decide. If better criteria can be developed to assess levels of poverty, resources may be allocated towards local governments, according to need in their jurisdictions. For example, the personnel budget could be transferred to local government, and personnel could only earn their salary in a given government jurisdiction. It would therefore be almost impossible to lobby centrally for a "convenient" or desirable posting, as it has been in the past.

5 EMERGING COOPERATION

5.1 Promoting dialogue at regional level

A workshop was organised by SNV and held at Koulikoro in October 2003, bringing together representatives of the various echelons of the MoH, the territorial authorities and the government administration (Box 4). This workshop helped to initiate a dialogue among stakeholders directly involved in transferring powers at the regional level. This process will be continued through setting up forums for consultation and direct dialogue between stakeholders at district and commune level. As a follow-up activity, SNV and KIT organised a workshop in Dioïla in September 2004, inviting the various actors involved in public health at commune and district level.

Box 4: Promoting dialogue in the health field

In October 2003, the Regional Health Department, DNCT and SNV organized a workshop in Koulikoro on the transfer of powers in the health sector. In the light of discussions, participants agreed on the following recommendations:

- Draw up a micro-plan of the health centre's catchment area in collaboration with the commune council;
- Take account of this micro-plan within the municipal plan;
- Ensure that the annual plan of the health district reflects all the annual micro-plans and commune plans in the district;
- Give the local government authorities responsibility for validating, monitoring and evaluating the health micro-plan;
- Clarify the responsibilities of the ASACO and commune councils and provide ongoing training for their members;
- Give priority to local funding initiatives for health activities;
- Comply with the disbursement procedures of each agency in cases of co-funding; and
- Pursue periodic consultation to monitor the process of transferring powers.

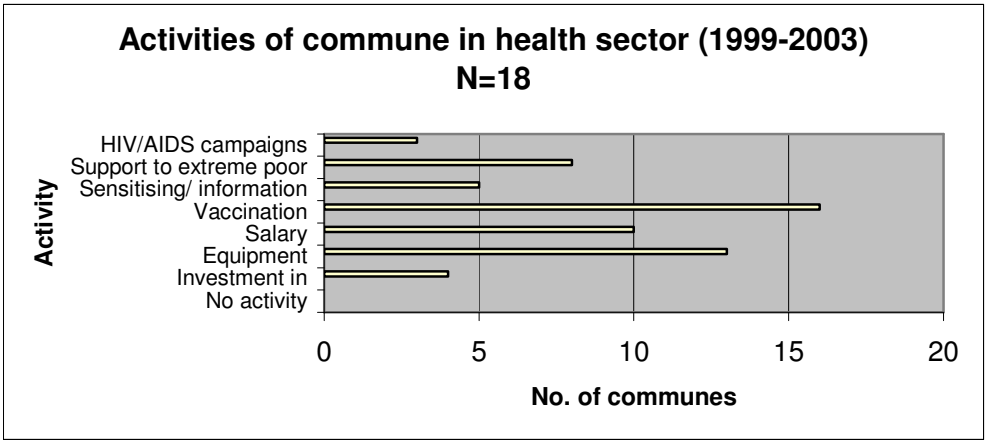
At operational level, ASACOs, MoH and local governments have started to cooperate. Recent research by KIT and SNV in the Districts of Banamba, Dioïla and Koulikoro, all in the same geographical region as the capital, Bamako, proves this point, and we report the details of emerging partnerships to illustrate their potential (SNV and CEDELO, 2004). We conducted a survey of 18 of the 41 local governments in these three districts11. We found that most of the 18 communes (83%) had nominated a commission or a councillor to work specifically on health

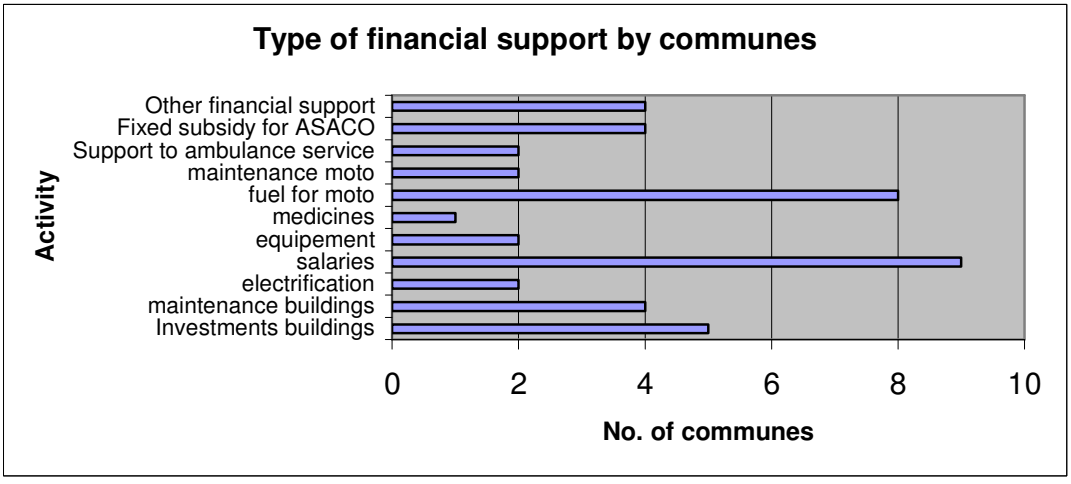
[11] SNV-Mali has been working in the region since 1997, supporting decentralisation processes. An inventory of expenditures was not possible as financial statements of local government are not sector specific, while the recall period proved to be too long.

issues. Around half of the communes mentioned that they maintained regular contacts with the ASACO (53%) and some also with the district health centres (20%).

All communes have been engaged in a health related activity. Support to vaccination campaigns was most often mentioned (89%), followed by financial support for investment in buildings, maintenance, running costs etc (78%), and finally support to information and awareness-raising campaigns. The type of financial support mentioned most often was for salaries and fuel, generally for vaccination campaigns. But the largest amounts concerned investments in infrastructure, which was mentioned by 25% of the communes interviewed.

Figure 2: Local government's activities in health and financial support





HIPC funds, given to Mali because of its status as a highly indebted nation, find their way into the health sector. They are being used for recruiting additional staff for local health centres, and the regional commissioner (haut commissaire) is responsible for recruitment and salaries. Although mayors are not involved in the recruitment process, they are asked to sign the contracts with new staff. Some are reluctant to do so, as they do not want to become responsible for paying these salaries in future should present funding run out – most local governments would not have the resources. Another issue is that since the regional commissioner handles recruitment and contracts, it is difficult for ASACOs or local government to supervise these staff - there is a mismatch between the issuer of the contract and the place of work.

5.2 Cooperation in the District of Dioïla

The District of Dioïla is situated 2.5 hours drive from Bamako. There are 23 communes in the district. In rural areas, there are very few private sector practitioners, possibly limited to traditional healers. Pharmacies and informal medicine peddlers at markets sell products12. Dioïla suffers the problem we mention in the last section: the boundaries of several health catchment areas do not coincide with the commune's administrative boundaries. Within one commune, there may be more than one catchment area with some even straddling two or more communes. This makes it difficult for a commune to support local health centres. At district level there is an initiative to solve this problem with the involvement of the MoH, district assemblies, mayors and ASACOs.

In Dioïla, the vaccination coverage has improved considerably over the last few years and is now around 80%. Both ASACO and local governments have played an active role in mobilising people for vaccinations, and local government has also supplied resources for fuel and per diems, and sometimes personnel costs (see Figure 2). Ten out of eleven communes reported providing active support to the vaccination campaigns, probably at the request of the MoH. To what extent this support by local government contributed to the success cannot be established without more information. UNICEF, for example, gave mosquito nets to vaccinated children as an incentive.

[12] The Malian government is running a campaign involving community health centres and local government to warn people against counterfeited drugs.

In SNV's experience, local governments in Dioïla seem more operational, better organised and respected than in Banamba and Koulikoro. One ASACO president even stated that the population was more inclined to respond to the invitation by the commune to attend public health related meetings or campaigns than when ASACO organised the meeting. Local governments have helped ASACOs with conflict resolution (within the committee or when there have been difficulties with member communities), but there are also cases where local government together with the MoH have dissolved an ASACO which had become dysfunctional due to internal conflict, and then organised new elections. Some local governments have also mediated between communities and vaccination teams when problems arose over the place where people would meet.

One reason given is that the population in Dioïla benefited from well-prepared information campaigns on decentralisation before the first elections in 1999. After the elections, the new local governments received intensive support during the first few years. The project accompanying these communes took care not to alienate the administrators (préfet and sous-préfet) or sector ministry staff by involving them in these processes. Many other support programmes focused during the first mandate (1999-2003) on the 'conseil communal', ignoring state services and civil society organisations. This created a distance between local government and other actors, resulting in some districts of opposition by the ministries' technical services.

Dioïla is a cotton growing area, and village associations were previously established by the cotton parastatal company. The presence of people with some experience in management of formal organisations in the context of these village associations was an important asset for the new local governments. The village associations used their profits for supporting 'community development organisation' and also met regularly within the context of cotton production. These existing relations have helped communication within the newly established local government area.

Dialogue and cooperation in Dioïla between local government, ASACO/CSCOM and MoH is developing, and there is a level of trust. Resource persons could not give a specific explanation as to how and when these collaborations came about, but ASACOs seem to have taken the initiative. Local government support to the community health centres seems of particular importance for emergencies (a blown off roof for example), some operational costs (like fuel) and vaccination campaigns (providing organisational as well as financial support). Funding for 'normal' activities

seems to be available, but not for the unplanned and unexpected activities. In Dioïla, ASACOs have not expressed concern that local government councils will seek to benefit from funds generated by revolving drug schemes, as is mentioned in other places.

One explanation for the good relationship between local government and ASACO may be the 'passivity' of local government with respect to policy making on health. Councillors respond favourably to ASACO's request because they assume that better public health is one of the key demands of their electorate. For most councillors, good public health is the result of a well-managed community health centre. Local governments respond to ASACO's requests without questioning the choices made, but may not offer all the funds requested. They do not monitor spending, but wait for an invitation by ASACO for information on progress and financial management. They have included, again without questioning, all proposals of the MoH in their commune development plan. Possibly, councillors feel less confident in matters relating to public health and think that ASACO and the health centres know best. They may not be aware of possible choices and trade offs. However, this attitude may be about to change. There were several requests by councillors to be involved in supervision visits organised by the MoH, and to receive more information on public health performance indicators.

6 PREREQUISITES FOR EFFECTIVE PARTNERSHIPS

Returning to the themes of partnership, we relate several of the general principles already mentioned in this paper to the situation in Mali.

6.1 Trust

As we have noted, a willingness to collaborate and a level of trust are essential aspects for cooperating effectively. Relations between the state and the population were marked by coercion and a lack of respect in the past, and state administrators were feared. The ministries' technical services would decide whether the population was to be consulted or not, and how. The emergence of local governments since 1999 has changed the institutional landscape, and the relations between institutions and the population. Local government is closer to and more approachable by the population, and can no longer be ignored by the state administrators (e.g. *préfet*, *sous-préfet* etc), or by its technical services staff. The relations between local government and the state administrators are strained in many places, with the latter still regarding local governments as somehow encroaching on their authority. There are exceptions, such as the Dioïla district where projects have purposely invested in establishing working relations and contacts between the various actors, which has produced a certain level of mutual trust.

6.2 Information

Local government can only play a more active role in public health and service delivery when they have an understanding of public health and its inter-sectoral dimensions such as the importance of disease prevention, hygiene, nutrition but also poverty, and also health sector policy, regulations, operational plans and performance criteria etc. This raises the question of what level of knowledge is needed by local government authorities to participate effectively in discussions with MoH, ASACO and other actors with respect to priority setting, planning or supervision of performance?

Even in a well-served district such as Dioïla, local government councillors and the structures that accompany them are not well informed on how the MoH operates, or how its plans are drawn up, and what is included in the district health plan. Equally, those responsible for the community health centre, and ASACO and MoH staff may

have a fragmented understanding of the decentralisation process, the various entities and how they are linked, the responsibilities of local government, etc. Stakeholder cooperation would be much improved if all participants were on equal footing with respect to information and understanding of the health system and decentralisation. This is still a challenge at all levels.

A problem for the MoH, but also for local governments, is dealing with pressure from the population to establish new community health centres even when these are not financially viable. Health centres in these situations can become a bone of contention between the MoH and the mayor, who may have obtained funds for the building through ANICT but needs MoH's support for operational costs. Mayors have no way to assess whether a health centre may be viable but at the same time, they are under pressure from the population to increase the health service coverage. Assessment tools are available within the MoH, however, and should be made available to local government to improve the quality of decision-making[13]. These tools help stakeholders to understand why financial viability of a health centre is important and how this can be assessed.

6.3 Establishing consultation platforms or '*cadres de concertation*'

Effective tri-partite cooperation requires regular consultation, dialogue and mutual decision making and consultation platforms are needed at all levels; commune, district, regional and national. There are no formal forums at local level in the communes. In Dioïla, at commune level, the mayor or his/her representative is invited to the monthly meetings of ASACO and the council will invite ASACO when discussing issues related to public health.

At national level, in May 2004, the government established the Commission Interministérielle de pilotage des transferts de compétences de l'Etat aux collectivités territoriales. The various steering committees established as part of the decentralisation process (CLO, CRO and CNO) now assist in this process (Box 3). A problem for the CLO is that sector ministries are represented by the administrative wing of government, thus preventing direct dialogue and consultation between sector ministries and local governments.

[13] The MoH has developed a simple formula based on expected utilisation of services to determine whether a community health centre could be economically viable.

Box 3: The role of steering committees

Multi-stakeholder steering committees were set up by the State to guide decision-making in respect of the activities of the Commune advisory centres (Centre de conseil communal: CCC), CCC operators and the National co-ordination unit (Cellule de coordination nationale: CCN). These committees offer participants the opportunity to get together and take part in defining policy and support mechanisms. Steering committees exist at three levels:

- Local Steering Committee (Comité Local d'Orientation: CLO) at district level. Its role is to approve the CCC's programme of support to the communes, monitor the tasks entrusted to the CCC operator and pass on information from the regional steering committee. The préfect chairs the CLO, whose members include the commune councillors, district council, chambers of agriculture and trades and an NGO representative. The CCC acts as secretary.

- Regional Steering Committee (Comité Régional d'Orientation: CRO) at regional level. Its role is to define, coordinate, direct, monitor and evaluate the technical support provided for implementation of the economic and social development plans. The regional commissioner chairs the CRO. Amongst its members are the regional assembly, prefects and chambers of agriculture, commerce and trades.

- National Steering Committee (Comité National d'Orientation: CNO). Its role is to ensure the smooth operation of the system of support to the local government authorities and create synergy between their plans and sector-based government programmes, as well as between the various agencies. The members of the CNO, which is chaired by the MATCL (Ministère de l'administration territoriale et des collectivités locales), are the DNCT, ANICT (Agence nationale de l'investissement des collectivités territoriales), the ministries responsible for the various sectors, the chambers of agriculture, commerce and trades, the AMM, and federations of NGOs (CCA/NGO and SECO/NGO).

The composition and functioning of a CLO and a CRO is being discussed at national level. There is a need to include all deconcentrated state-services and civil society organisations to improve the implementation of the mission of these institutions. It was decided that the new CLO and CRO will become the most important consultation platforms. This change will facilitate the establishment of partnerships within different development sectors, as there will be commissions de travail for every sector. This reorganisation is still not effective officially.

Meanwhile in Dioïla, informal meetings and consultations are now the rule: for example between local governments and ASACO, and between district council and sector ministries. There is already consultation and cooperation in the district health centre on ambulance services. This cooperation has been strengthened by the specific requirement in this district of double signatures by médecin chef and the president of the district assembly, who is the chairman of the administrative board (conseil de gestion) of the district health centre. These regular meetings held between MoH and the district assembly over the management of the district health centre are also used for other discussions related to public health. Informal contacts are important for

breaking the ice, building relationships and deciding to work together, but there is a need to work towards institutionalising the relationships, given, for example, the turnover of the persons involved (because of elections, and changes within the MoH), as well as more efficiency and coherence in strategies to improve healthcare services[14].

6.4 Coherent inter-sectoral planning

More coordination of planning between communes and MoH is essential. Commune and district council plans should take into account the health policy guidelines, while communes as well as district councils have to be involved in the MoH planning processes. During the first mandate, this cooperation has started in Dioïla, which resulted in public health being integrated in the commune development plan. Consultation in Dioïla between MoH and communes was much better resulting in more balanced community developed plans. The question is, however, to what extent have communes analysed and discussed the proposals of MoH before including them in their plan. In addition, inter-sectoral aspects of public health, such as clean water, waste management, and nutrition were not well developed.

Elsewhere, coordination was weak in most other districts in Mali. When councils did indeed invite representatives of MoH to their meetings, MoH often did not reply or sent somebody who was not well informed on health planning. As a result, the PDECS *(Plan de Développement Economique, Social et Culturel)* were not considering public health from an integrated perspective and may propose investments which were not foreseen in the district health plan.

6.5 Enhancing capabilities to monitor

Local governments can only contribute to priority setting, decision-making and supervision when they have insight into choices that can be made, progress of work and outcomes. They can contribute to higher quality and more client driven service delivery when having the information required to monitor performance, assess local demands and satisfaction. Within the MoH there is an information system, SIS (Systeme d'Information Sanitaire). Depending on the information needed at local

[14] Dioïla administrative district has two health districts: Dioïla and Fana. During the first mandate, the president of the district assembly (*conseil de cercle*) enlisted the mayor of Fana to maintain contacts with the Fana health district, as it is closer to the district health centre. But now, following the elections of April 2004 a new mayor has been appointed in

level, a selection should be made from within this set of indicators. These should include operational indicators that yield sufficient information to monitor progress, and indicators related to the outcomes for public health. While a minimal package of indicators should be based on the SIS, its presentation has to be tailored to requirements of local governments. Local government needs to build capacity so that it understands the principles behind the selected indicators and can monitor changes.

This system could be linked to performance contracts. The use of performance contracts or conventions on mutual assistance has been developed by UNICEF to clarify responsibilities in partnerships and ensure responsiveness. The performance contract is tri-partite involving MoH, ASACO and local government and describes what the population can expect from the various parties. The contracts describe responsibilities and set performance indicators that will be monitored. A convention on mutual assistance will only involve local government and ASACO, and is piloted by the Ministry of Social Affairs.

6.6 Poverty alleviation and equity

The level of poverty differs within and between communes. To what extent community health centres and local government are responsive to special needs of certain categories of people depends on whether they accept that special efforts are required for more vulnerable groups to ensure that they can express their needs and constraints.

Clearly, those communes that have a better local resource base, that are better organised, include more people with an understanding and experience of the management of local administration are likely to benefit more from decentralisation than communes that do not have such resources. At district level, some correction is possible between health catchment areas by the MoH. Regions can also play a distributional role while the central level designs the allocation criteria. The challenge is to develop criteria that allow for an appropriate (in terms of workload and demand for services) and equitable (in terms of geographical areas and of health needs) distribution of resources. In this regard, the ASACO and their coordinating organisations at district (FELASCOM) and regional (FERASCOM) level will play an important role by promoting an equal representation of women and men on the board.

Fana, who (in September 2004) was not aware of this responsibility and was also poorly informed on the working of the MoH.

7 NEXT STEPS: A PROPOSAL TO IMPROVE PUBLIC HEALTH THROUGH BUILDING LOCAL LEVEL PARTNERSHIPS

Our analysis reveals that the following steps are important to develop effective partnerships between the MoH, local governments and civil society organisations managing community health centres. These may be expanded later to encompass other actors involved in public health:

1. Establish a base of trust between these partners. This involves accepting that some responsibilities will be transferred from MoH to local government, and there is a need to develop effective working relations as this happens.
2. Ensure that all actors are equally informed on matters such as decentralisation and health policy.
3. Design a consultation platform where discussion and negotiation takes place. These forums may start informally, but will have to be formalised over time.
4. Identify catalyst activities. Although building functional working relationships is a long-term process, it is important to start with activities that are important to all actors, and that can be realised within a short period and that are less prone to conflicts of interest. In Mali, cooperation could start with the organisation of vaccination campaigns, financing of health activities by local government or negotiation of boundaries of administrative areas and health catchment areas, before arriving at more complex and sensitive issues such as transferring responsibility for investments and human resources from the health sector to local government.
5. Strengthen the capacity of local government to oversee public health activities from a multisectoral perspective within their commune. The challenge is to build capacity within communes to understand relevant performance indicators, monitor these and act, when needed. Tri-partite performance contracts are another instrument that can be useful in this regard.
6. Strengthen downward accountability, which would enhance the agency of the population, in particular the poor, by stimulating responsiveness of all actors towards local demands and client satisfaction.

Having functional communes is an important condition for entering into a balanced partnership. Beginning pilot action-research by working with certain communes that are more advanced in their administrative capabilities is sensible, and in line with an incremental policy approach to transfer of powers and resources, as advocated by central government. More communes in Mali will get to this stage in the coming years, and it is important to share how the first ones achieved effective partnership and developed competence. Moreover, such communes can also serve as examples and sources of inspiration to others about what is feasible.

An action research proposal has been developed for Dioïla District to facilitate the implementation of the government decisions on the transfer of powers and resources

in the health sector. In Dioïla District, local governments seem relatively better managed and better rooted than in most other parts of Mali, and a certain level of trust between the key actors involved in public health is emerging. Particular attention will be paid to equitable access to health services and participation in decision-making. To see through these steps, a commitment to further work is needed, focussing on the following issues:

- What motivates individuals to work together? When they do so, how are mutual agreements arrived at, and how are tasks and responsibilities agreed upon and divided up? How formal are such agreements?
- How do consultation platforms operate, and with what success?
- How may monitoring and evaluation of agreements best be achieved, with better knowledge and understanding of performance indicators amongst all actors?
- Cases of partnership exist, but how well do they work, what are their objectives, and the values of the partners? How does coherence of actions emerge in such settings and how does communication take place? Are there conflicts?
- Partnerships imply trust, but is this developing effectively in Mali, and how does it manifest itself in when the balance of power is skewed towards certain actors? Do personal relationships play a major role in the work of partnerships in the health care sector, and how stable are they?
- Further questions about partnerships include their financing, coverage, quality of service provision that they deliver, and equity considerations.

The aim of the action-research is to develop both the approaches and advisory practices that will strengthen effective cooperation in future and facilitate the establishment of effective local partnerships in public health. This should also strengthen the performance and accountability of local governments in the country. The past, and the present, provide clues to how this may best be achieved. More concrete actions will also ensure complementarity between the activities and resources of government and partners working with local governments. The results will support further reflection and exchange of views and experiences by the key actors at local, regional and national level.

8 BIBLIOGRAPHY

ANICT, 2004. FICT 2001-2003, rapport de fin d'exercice ANICT. Bamako.

Campos JE and Hellman JS. 2005. Governance Gone Local: Does decentralization improve accountability. In: World Bank, editor. East Asia Decentralizes: Making Local Government Work. Wasington D.C., p 237-252.

Goetz AM and Jenkins R. 2005. Reinventing accountability - making democracy work for human development. Hampshire and New York: Palgrave Macmillan.

Jeppsson, A. (2004). Decentralization and national health policy implementation in Uganda - a problematic process. PhD dissertation. Department of Community Medicine, Lund University, Malmö

SNV and CEDELO (2004) Decentralisation in Mali : putting policy into practice. Decentralisation and Local Governance Series, Bulletin 362, KIT, Amsterdam.

Thompson, G, Frances, J, Levacic, R and Mitchell, J. (1991) Markets, hierarchies and networks: The co-ordination of social life. London: Sage.

Toonen, J. and Dieleman, M. (2001) Towards a policy on human resource development in Mali. Study carried out for the Ministry of Health.

Uzochukwu B.S.C., O.E. Onwujekwe and C.O. Akpala. 2004. Did the Bamako Initiative improve the utilization of maternal and child health-care services in Nigeria? A case study of Oji River Local Government Area in Southeast Nigeria. *Journal of Health & Population in Developing Countries. http://www.jhpdc.unc.edu*

World Bank (2004) World Development Report 2004: Making services work for poor people. Oxford University Press