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Providing Healthcare in Armed Conflict: The Case of Mali

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This issue brief was drafted by Alice Debarre, Senior Policy Analyst at IPI. It accompanies a policy paper published in 2018 entitled "Hard to Reach: Providing Healthcare in Armed Conflict," as well as a second case study on provision of healthcare in Nigeria. These papers aim to assist UN agencies, NGOs, member states, and donor agencies in providing and supporting the provision of adequate health services to conflict-affected populations.

This issue brief is based on a combination of desk and field research. The author conducted twenty-five interviews in Bamako from April 29, 2018, to May 8, 2018, with representatives from national and international NGOs, UN agencies, and the Malian Ministry of Health.

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Introduction

In 2012, armed conflict erupted in northern Mali. Today, despite a peace deal signed in Bamako in 2015, the situation in central and northern Mali remains unstable due to fighting among armed groups, fighting between armed groups and the Malian armed forces, and criminality.[1] Three foreign military operations are currently supporting the government of Mali: the French Operation Barkhane, the UN Multidimensional Integrated Stabilization Mission in Mali (MINUSMA), and the European Union missions in the Sahel. The recent deployment of troops from the G5 Sahel Joint Force adds a fourth component to an already complicated military landscape.[2] Increasingly, humanitarian actors have also been raising the alarm as to the role of climate change in exacerbating conflict in Mali.[3]

Conflict and insecurity in northern and central Mali has had dire consequences for the health of the civilian population and created numerous challenges for the provision of health services to those in need. The humanitarian situation is complex and volatile. There are approximately 5.2 million people in need of humanitarian assistance and over 77,000 internally displaced persons. Food insecurity remains a major concern, with approximately 2.5 million people still considered "food insecure" in spite of a decrease in affected populations since 2017.[4] Additionally, 1.8 million people require humanitarian health assistance.[5]

This issue brief aims to assist UN agencies, NGOs, member states, and donor agencies in providing and supporting the provision of adequate health services to conflict-affected populations in Mali. It maps and explains the challenges health actors face, the understanding of which is key to ensuring that health policies are adequate. It also looks at the governance structures set up to operationalize those policies, seeks to identify and analyze gaps in policy and implementation, and provides recommendations for bridging those gaps.

1 See, for example, Boubacar Sangaré, "Settling Local Disputes Is Key to Peace in Central Mali," Institute for Security Studies, November 12, 2018.

2 See, for example, UN Security Council, *Joint Force of the Group of Five for the Sahel—Report of the Secretary General*, UN Doc. S/2018/1006, November 12, 2018; Jennifer G. Cooke, "Understanding the G5 Sahel Joint Force: Fighting Terror, Building Regional Security?" Center for Strategic and International Studies, November 15, 2017; Arthur Boutellis, "Shake-up of G5 Sahel Joint Force Starts at Home, in Mali," *IPI Global Observatory*, July 27, 2018; and Aïssata Athie, "Coordinated Response Key to G5 Sahel Joint Force Success," *IPI Global Observatory*, June 19, 2018.

3 International Committee of the Red Cross, "Mali-Niger: Climate Change and Conflict Make an Explosive Mix in the Sahel," January 22, 2019.

4 UN OCHA, *Humanitarian Bulletin Mali*, July–August 2018, available at https://reliefweb.int/report/mali/mali-humanitarian-bulletin-july-august-2018 ; UN OCHA, *Humanitarian Bulletin Mali*, September–mid-November 2018, available at https://reliefweb.int/report/mali/mali-humanitarian-bulletin-september-mid-november-2018 .

5 Mali Health Cluster, *Bulletin du Cluster santé*, janvier–juin 2018, available at www.who.int/health-cluster/countries/mali/mali-health-cluster-bulletin-jan-june-2018.pdf .

It focuses on the coordination of health actors, the prioritization of health services, the sustainability of health services and the transition to development work, context-specificity and localization, and accountability for healthcare providers.

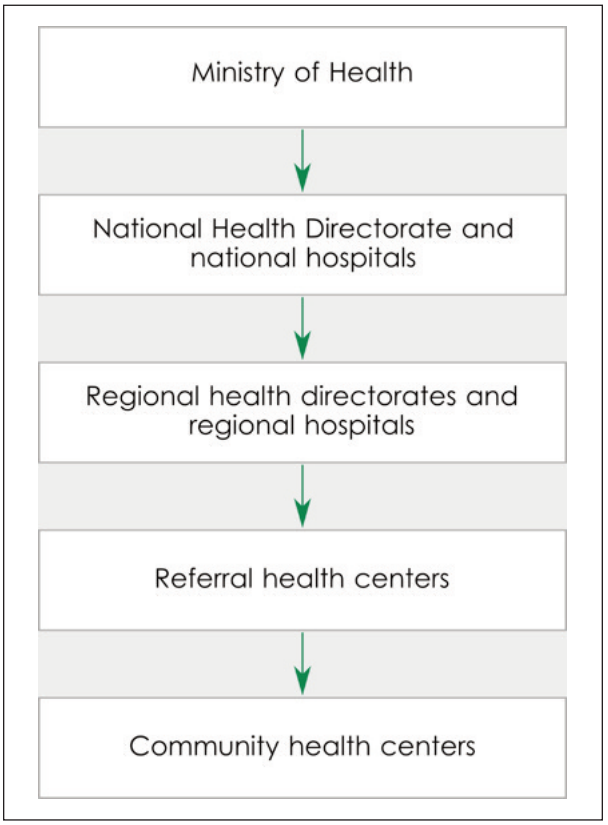
The State of Healthcare in Mali

Mali has a decentralized health system (see Figure 1). The Ministry of Health heads the development of national health priorities, strategies, and policies, which are then implemented by the National Health Directorate (*Direction nationale de la santé*, or DNS). There are three national hospitals, all located in the capital, Bamako. The National Health Directorate also coordinates and controls regional health programs developed by regional health directorates (*directions régionales de la santé*, or DRSs). Seven regional hospitals implement these programs and can provide advanced care. Below these hospitals are referral health centers (*centres de santé de reference*, or CSRs), which provide care at the district level.

Finally, the referral health centers each supervise a number of community health centers (*centres de santé communautaires*, or CSCs). The community health centers provide primary healthcare with a focus on maternity and pediatric care. In bigger villages, community health workers are often present to respond to essential health needs and, if needed, can refer patients to the community health centers.[6] The government set up a community health worker program in 2009 to provide healthcare to populations living five kilometers or more away from the closest community health center.[7] In some areas, these community health workers also have community relay agents (*relais communautaires*) working in small villages who can detect diseases, provide advice, and refer patients to them.

The Ministry of Health has a unit responsible for ensuring the security of health personnel in the central region. This unit collaborates with the Ministry of Security and the Ministry of Defense to ensure health personnel are present in the right areas and able to do their work adequately. There

Figure 1. Mali's public healthcare system



are also more expensive private healthcare providers in Mali, which the Ministry of Health licenses and works with to ensure they meet national standards.

According to a number of interviewees, the health standards adopted by the government of Mali are in compliance with international standards. Mali has ratified the International Health Regulations (IHR) and appointed an IHR focal point. At each level of the Malian healthcare system, there is a point person for epidemiological surveillance who reports to the National Health Directorate. The government is currently working to put a community-based surveillance system in place at the village level. Each level also has a standing committee for the management of epidemics and emergencies (*comité permanent de gestion des épidémies et des catastrophes*) that takes stock of existing capacity, support needed, and potential gaps. The government also created a Department of Emergency Public Health

6 For more on community health in Mali, see Kristen Devlin, Kimberly Farnham Egan, and Tanvi Pandit-Rajani, "Community Health Systems Catalog Country Profile: Mali," Advancing Partners and Communities, September 2016.

7 Mohammad H. Asadi Lari, "In Mali, Innovation Means Access to Lifesaving Healthcare," Canadian Red Cross Blog, July 30, 2018.

Operations for Epidemics (*Département des operations d'urgence de santé publique pour les épidémies*) to detect and lead the response to major public health crises. A 2017 joint external evaluation of Mali's capacity to implement the IHR noted that the country's healthcare system had technical capacity in areas such as vaccination, surveillance, and notification of epidemics but needed to be reinforced across all areas.[8]

Despite progress, notably in decentralizing healthcare and developing community health centers, Mali's healthcare system remains poor. Even the national hospitals, the best facilities in the country, reportedly suffer from overcrowding, lack of up-to-date equipment, and insufficient medical supplies.[9] Regional hospitals also lack equipment, supplies, medicine, and staff.

Access to services and the quality of services are particularly limited in conflict-affected and remote parts of Mali. There are only 3.14 health professionals per 10,000 people in Mali, which is well below the World Health Organization's (WHO) recommended minimum threshold of 23.[10] The lack of health workers in poor and remote areas is of particular concern.[11] In the north and center of Mali, 17 percent of health structures are no longer functioning in line with national standards, and 80 percent of qualified health personnel are paid through international aid.[12] In areas controlled by non-state armed groups, access to government health services is particularly limited. Because of armed conflict and limited access to healthcare services, the population is at greater risk of contracting diseases such as meningitis, malaria, and dengue fever, as well as respiratory infections. There is a particular need for neonatal and obstetric services, mental health and trauma services, and primary healthcare for women and girls, as well as medical care for victims of sexual violence.[13]

Nonetheless, community health structures are reportedly still mostly functional in areas controlled by armed groups, and the Ministry of Health sends supports to community health workers in those areas when possible, although this support is impossible to monitor.[14] A Ministry of Health representative interviewed for the research noted that the ministry is considering extending the community relay agents to conflict zones, as they have proven to be successful in reaching more remote communities.[15]

Given the level of need and the poor state of the Malian healthcare system, humanitarian actors play an important role in the provision of healthcare services in the country, both by providing direct services and by supporting government health structures. The international humanitarian response is led by the humanitarian country team and the health cluster, which was activated in Mali in 2012. The health cluster is co-led by the WHO and the International Medical Corps (IMC) and is active in Bamako and at the regional level. Initially focused on the situation in the north of the country, it has increasingly been responding to health issues in central Mali, where intercommunal conflicts have led to greater humanitarian needs.

There are a number of other humanitarian coordination structures active in the country, including the Common Health Framework (*Cadre commun de santé*) for organizations funded by the European Commission's Civil Protection and Humanitarian Aid Operations department (ECHO); the Technical and Financial Partners of the Health Sector (*Partenaires techniques et financiers du secteur de la santé*) for Ministry of Health partners; and the Humanitarian Assistance Technical Group (*Groupe technique assistance humanitaire*), set up as a coordination body for international NGOs and a link between the humanitarian country team and non-UN humanitarian organizations.[16]

8 WHO, *Évaluation externe conjointe des principals capacités RSI de la République du Mali—Rapport de mission: 27–30 2017*, 2017.

9 Interview with humanitarian expert, Bamako, May 2018.

10 Mali Health Cluster, *Bulletin du Cluster santé, janvier–juin 2018*.

11 Global Health Workforce Alliance, "Mali," available at www.who.int/workforcealliance/countries/mli/en/ .

12 UN OCHA, *Mali: Humanitarian Response Plan (January–December 2018)*, p. 9, available at https://reliefweb.int/report/mali/mali-humanitarian-response-plan-january-december-2018-0 ; Mali Health Cluster, *Bulletin du Cluster santé, janvier–juin 2018*.

13 UN OCHA, *Mali: Apercu des besoins humanitaires 2018*, November 2017, available at https://reliefweb.int/report/mali/mali-aper-u-des-besoins-humanitaires-2018-novembre-2017 ; Mali Health Cluster, *Bulletin du Cluster santé, janvier–juin 2018*.

14 Humanitarian expert, Interview, Bamako, May 2018; Ministry of Health representative, Interview, Bamako, May 2018.

15 Interview with Ministry of Health representative, Bamako, May 2018.

16 See Jopy Willems, "Humanitarian Arena in Mali: A Case Study about the Coordination Structure and Influence of the UN Integrated Mission on the Humanitarian Arena in Mali," Master's thesis, Wageningen University, May 2015.

Challenges to Providing Healthcare in Mali

Humanitarian and health actors face a number of challenges in providing healthcare services to the Malian population. These include both constraints related to the existing healthcare system and the difficulty of accessing those in need.

All interviewees mentioned the insecurity in the northern and central parts of the country as the main challenge. They attributed this insecurity to ongoing military operations, the hyperactivity of radicalized groups, and criminal activity such as vehicular theft. Over the last three years, concerns have expanded from violence by armed groups and criminal elements in the north to terrorist acts and intercommunal violence, particularly in central Mali, which has higher population density.[17] In October 2018, the independent expert on the situation of human rights in Mali described "a real climate of fear and insecurity in the country's north and centre."[18] Several interviewees expressed concern about attacks on humanitarian actors and the kidnapping of health staff for ransom, though humanitarian and health personnel are not generally directly targeted.[19] One interviewee described the destruction and pillaging of health facilities as a challenge.[20] The Safeguarding Health in Conflict Coalition reported fourteen conflict-related attacks on healthcare in Mali in 2017, including the kidnapping of health workers, armed entry into medical facilities, the damage, destruction, and hijacking of health transportation, and security measures that constrained access for health workers.[21]

Tied to insecurity, the difficulty of accessing certain populations is another challenge. In some areas, it is impossible to travel by road due to the prevalence of improvised explosive devices and carjacking. High insecurity has led some humanitarian actors to travel with military escorts to access civilian populations, which creates its own challenges (see below on the politicization and militarization of health activities). There are no commercial flights to the north of the country and only a limited number of flights by ECHO and the UN Humanitarian Air Service. Mali's north is a vast territory, with low population density and huge empty spaces. Nomadic populations in the north are particularly hard to reach, requiring humanitarian health actors to use different means and strategies such as mobile clinics. Populations fleeing violence, as well as those living in areas controlled by non-state armed group, are also difficult to access. Access to these areas must be negotiated, a process complicated by the fragmentation of armed groups.[22]

The lack of qualified health workers in conflict-affected areas was also identified as a challenge. Even prior to the outbreak of conflict in 2012, there were insufficient human resources for health in the north, and things have only gotten worse. For example, due to security concerns, government health personnel responsible for Kidal are instead based in Gao, almost 300 kilometers away.[23] Additionally, there is high turnover of both national and international staff, and the government has little recruitment capacity. Low pay and inadequate resources also lead to the loss of the most qualified health workers to the private sector or international organizations.

Poor governance is another challenge for the delivery of health services. Actors on the ground cited insufficient human resources and expertise among government bureaucrats, slow and arduous procedures to get health projects approved and started, and delays in implementation of health policies and programs. They likewise stressed that weak leadership and governance at the central level lead to insufficient control, supervision, and coordination of the implementation of health policies. There is also little reporting between the

17 Namie Di Razza, "Protecting Civilians in the Context of Violent Extremism: The Dilemmas of UN Peacekeeping in Mali," International Peace Institute, October 2018, p. 3.

18 Office of the UN High Commissioner for Human Rights, "Mali: 'Real Climate of Fear and Insecurity in Country's North and Centre,' Says Expert,"October 11, 2018.

19 UN OCHA, *Mali: Humanitarian Response Plan (January–December 2018)*, p. 24.

20 Interview with humanitarian expert, Bamako, May 2018.

21 Safeguarding Health in Conflict Coalition, "Violence on the Frontline: Attacks on Health Care in 2017," May 2018.

22 See Arthur Boutellis and Marie-Joëlle Zahar, "A Process in Search of Peace: Lessons from the Inter-Malian Agreement," International Peace Institute, June 2017, pp. 26–29.

23 Interview with humanitarian expert, Bamako, May 2018.

various government health structures.

The government tends to accept any aid, whatever the priorities. However, corruption and diversion of funds have led some donors to take projects out of the hands of the government, and some organizations have adopted "zero-cash" policies when working with the government.[24] Government health structures appear not to significantly supervise subordinate levels unless pushed to do so by partners, as is the case with vaccination campaigns.[25] One Ministry of Health representative noted that stringent donor requirements were a challenge, especially the requirement to justify money spent. For example, donors do not allow use of their funds to informally pay individuals or groups for access to certain areas. When the government does not entirely comply with such requirements, this slows down the disbursement of funds and hence the implementation of programs.[26]

All humanitarian experts interviewed expressed concern regarding the politicization and militarization of health activities because of the challenges it creates for principled humanitarian action in Mali.[27] This was mainly attributed to the presence of MINUSMA, in particular its implementation of quick impact projects. These community projects are designed to increase MINUSMA's acceptance by populations and are thus inherently political.[28] Despite policy dictating that such activities should not duplicate humanitarian activities,[29] and despite the mission's mandate to support humanitarian assistance,[30] some quick impact projects—especially those related to health—have encroached on the humanitarian sphere.[31]

This overlap between political and humanitarian activities risks causing confusion among Malians, which could lead to misperceptions of, delegitimization of, or loss of trust in humanitarian work. As a result, Malians might refrain from seeking health services. Given the perception of MINUSMA as a party to the armed conflict, this could even increase humanitarian actors' risk of being targeted. To preserve the humanitarian space and protect themselves from retaliation due to a presumed association with MINUSMA, many NGOs have distanced themselves from the UN.[32]

Finally, most interviewees pointed to a decrease in available funding for health activities in Mali over the past three years.[33] The protracted nature of the crisis has led to donor fatigue, and the 2018 UN humanitarian response plan was only 54 percent funded.[34] As of January, the UN appeal for 2019 was only 3 percent funded.[35] One interviewee also stressed that there is a lack of resources for the south of the country, as most funds go to programs in the north and center. Moreover, in 2018, only 3 percent of the UN Central Emergency Response Fund's (CERF) allocation for Mali was devoted to health.[36] This reportedly frustrates some health NGOs because it gives them little incentive to participate in the health cluster.[37] Given the overall low levels of funding and the CERF's role in filling critical gaps when no other funding is available, it also hinders the ability of humanitarian health actors to implement activities.

International Health Policy and Its Implementation in Mali

The UN and its members states, as well as key international health organizations, have developed a number of policies to enable affected populations to access adequate and appropriate health services.

24 Interview with development expert, Bamako, May 2018.

25 Interview with humanitarian expert, Bamako, May 2018.

26 Interview with Ministry of Health representative, Bamako, May 2018.

27 For challenges for humanitarian actors linked to integration, stabilization, and counterterrorism agendas in Mali, see Alejandro Pozo Marín, "Perilous Terrain: Humanitarian Action at Risk in Mali," March 2017.

28 MINUSMA, "Quick Impact Projects," available at https://minusma.unmissions.org/en/quick-impact-projects-qips .

29 According to the policy, "Priorities for [quick impact projects'] geographic and thematic focus should also take into consideration priority objectives established under relevant UN and humanitarian plans to avoid duplicating and/or undermining them." UN Department of Peacekeeping Operations/Department of Field Support, *Quick Impact Projects (Guidelines)*, UN Doc. PK/G/2017/17, October 1, 2017, para. 32.

30 UN Security Council Resolutions 2100 (2013), 2164 (2014), 2227 (2015), 2295 (2016), 2364 (2017), 2423 (2018).

31 See, for example, Mikado FM, Twitter, January 10, 2019, 11:30am, available at https://twitter.com/mikadofm/status/1083445874401951752 .

32 Di Razza, "Protecting Civilians in the Context of Violent Extremism," p. 19.

33 UN OCHA, *Mali: Humanitarian Response Plan (January–December 2018)*.

34 UN OCHA Financial Tracking Service, "Mali 2018 (Humanitarian Response Plan)," available at https://fts.unocha.org/appeals/638/summary .

35 UN OCHA Financial Tracking Service, "Mali 2019 (Humanitarian Response Plan)," available at https://fts.unocha.org/appeals/716/summary .

36 UN Central Emergency Response Fund, "2018 Allocations by Country," available at https://cerf.un.org/what-we-do/allocation-by-country/2018 .

37 Interview with humanitarian expert, Bamako, May 2018.

While most of the above challenges are out of the hands of health actors on the ground, the proper implementation of these policies can make a big difference. This section assesses how the humanitarian health response in Mali fares in terms of coordination, the prioritization of health services, the sustainability and the transition to development work, and accountability for health services provides.

COORDINATION OF THE HEALTH RESPONSE

Actors on the ground described challenges coordinating through the health cluster. They considered joint planning to be difficult, given that organizations often come with their projects already prepared and with little flexibility to modify them. Donors often have their own priorities, regardless of the humanitarian response plan and humanitarian needs overview or suggestions provided by the health cluster, leading to overlap and duplication of health activities. For one interviewee, better coordination among donors would strengthen the health cluster.[38] Moreover, the numerous actors in the cluster have different mandates, approaches, and management methods. The cluster system's slow and burdensome administrative procedures also make interventions less efficient. Finally, for many on the ground, the multiplication of coordination structures in Mali beyond the health cluster has not been helpful.

There is some coordination between global health and humanitarian health actors in Mali, but it remains limited. Global health actors such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, Gavi (the Vaccine Alliance), and the IHR focal point in the government of Mali are not members of the health cluster. However, they occasionally brief the cluster members, and the Global Fund works through UNICEF, which is a member of the cluster, on certain projects. Ministry of Health departments working on epidemiological surveillance and response do not appear to interact much with the health cluster. Nonetheless, most humanitarian health actors reportedly conduct surveillance and share the information collected with the National Health Directorate. The National Health Directorate keeps the WHO updated on surveillance information, and the WHO shares this information with health cluster members. In line with the 2018 humanitarian response plan, humanitarian actors also provide logistical and technical support to the government for surveillance and response to epidemics.

Coordination with MINUSMA remains challenging given the above-mentioned concerns. For example, MINUSMA initially did not even send out its list of quick impact projects to humanitarian actors. According to one interviewee, the list is now being shared, but it remains up to humanitarian actors to check that they are not operating in the same areas and to minimize risk.[39]

INSUFFICIENT PRIORITIZATION OF NONCOMMUNICABLE DISEASES

According to many interviewees, health services in Mali are inadequately prioritized, which leads to big gaps. In particular, noncommunicable diseases (NCDs) are being neglected, both by international actors and by the government. There is no government policy or strategy on NCDs, and existing services are extremely costly. One Ministry of Health representative pointed out that the ministry is dependent on foreign aid, but donors have little interest in NCDs.[40] Indeed, despite emerging recognition that NCDs have become a medical priority in the country, few organizations are working in this area, and funds are lacking. Santé Diabète, which focuses on diabetes, is one of the few organizations working on NCDs in Mali. Interviewees mentioned the need for more NCD-related activities given the protracted nature of conflict in Mali and the need, therefore, to shift to longer-term health concerns. One interviewee suggested the need to develop mechanisms to ensure a certain percentage of services deal with these chronic diseases.[41] For mental health in particular, there is no government policy or strategy to address the high level of need, and only a few mental health programs are being implemented by international health actors.

38 Interview with humanitarian expert, Bamako, May 2018.
39 Interview with humanitarian expert, Bamako, May 2018.
40 Interview with Ministry of Health representative, Bamako, May 2018.
41 Interview with humanitarian expert, Bamako, May 2018.

A STRONG FOCUS ON SUSTAINABLE HEALTH SERVICES

There is a clear, strong focus on the sustainability of health interventions in Mali. Several interviewees noted a "*faire faire*" strategy, whereby the emphasis is on supporting local actors in providing health services. All humanitarian actors interviewed stressed that they were working through the government to strengthen the country's health system. Because community health centers are in place in many areas and seem to function well, most organizations work through these structures and with local actors to ensure sustainable solutions and the transfer of competencies.

However, there are challenges to ensuring that health interventions are truly sustainable. In some areas in the north, international actors are substituting for—rather than complementing or supporting—government health services, especially given the lack of human resources. International actors often pay the salaries of national staff, and these salaries are generally above what government authorities would offer. One interviewee mentioned that, in response, his organization was thinking about strategies to help the government pay health staff higher salaries.[42] Additionally, there are concerns that providing free services may undermine the community health centers, as they do not receive funds for services provided. According to one interviewee, a 2012 ministerial decree allows free services to be provided for a maximum of six months.[43] Because of these concerns, some organizations have therefore chosen to provide free services only to targeted populations, while others pay the patients' fees for them.

One government representative strongly criticized international partners that, without consultation, come in with predetermined strategies that are not or cannot be sustained by local actors when they leave.[44] He also pointed to some partners' unwillingness or inability to reorient projects despite preliminary results indicating the need to do so. There are nonetheless efforts to transfer the control of projects back to the government. For example, the hospital in Gao is now led by a government representative.

PLANNING FOR A HUMANITARIAN-DEVELOPMENT NEXUS IN HEALTH

One way to strengthen health systems is to ensure that humanitarian health services smoothly transition to early recovery and more development-oriented responses. This has been recognized and put forward in a number of UN (and other) policies, most recently in the New Way of Working (NWOW), which emphasizes the importance of the humanitarian-development nexus (which, where appropriate, also includes peace). The idea behind the humanitarian-development-peace nexus is that humanitarian and development actors need to better coordinate and collaborate to ensure their efforts are complementary and provide continuous care for affected populations. Mali's 2018 humanitarian response plan encourages humanitarian actors to adopt durable solutions together with development actors, and the health cluster was one of the clusters chosen to develop initial strategies for implementing the nexus. However, it seems to remain largely at the stage of policy debate and development, with few programs actually making the link between humanitarian and development efforts.[45]

There are a number of obstacles to better linking humanitarian, development, and peace work in Mali. For several interviewees, the humanitarian-development nexus was not being implemented due to the absence of a common understanding of what it means in practice and what its implications are. For some, the concept itself was debatable. One interviewee noted that development and humanitarian actors are not ready to sit down and work together.[46] More often, however, the main obstacle identified was the lack of adequate, long-term funding. For one interviewee, the decrease in funding for humanitarian activities has made the

42 Interview with humanitarian expert, Bamako, May 2018.
43 Interview with humanitarian expert, Bamako, May 2018.
44 Interview with Ministry of Health representative, Bamako, May 2018.
45 See Inter-Agency Standing Committee, *HDPN Progress Snapshot, Mali*, May 2018, available at www.dropbox.com/sh/zu8rp9tuk27kaf1/AAC6OA3saCkXiaQaiTMmQQgka?dl=0&preview=DRAFT_MALI_Nexus+Progress+Snapshot+v2.pdf .
46 Interview with humanitarian expert, Bamako, May 2018.

need to work with development partners more pressing.[47] However, development actors in Mali are focused on the long term and are reluctant to venture into conflict-affected areas. The peace part of the nexus has received little attention because humanitarian actors are concerned about being associated with MINUSMA's work.

Nonetheless, efforts are underway to tackle these issues. A taskforce on the nexus, co-coordinated by France and MINUSMA, has developed a guidance note outlining what it means in Mali. The European Union, Luxembourg, and Switzerland are providing bilateral technical assistance to the government in a variety of sectors, including health, to determine what types of activities the nexus will entail and in which parts of the country.[48] In 2019, the humanitarian country team will convene a workshop to delineate roles and responsibilities in the implementation of the nexus.[49] Beginning in 2020, it plans to develop a five-year humanitarian response plan aligned in terms of timing with the UN Development Assistance Framework, to which the nexus will be central.[50]

LIMITED ACCOUNTABILITY FOR HEALTHCARE PROVIDERS

While all interviewees stressed the importance of health actors being accountable for the services they provide, most acknowledged a lack of accountability mechanisms, particularly in terms of accountability to affected populations. In terms of performance accountability, many humanitarian organizations appear to monitor program indicators (both qualitative and quantitative), and most can point to internal accountability mechanisms, codes of conduct, or accountability clauses in staff contracts. However, performance accountability remains a gap. Monitoring and evaluating performance is difficult given the challenges of the Malian context, notably the insecurity and the use of local NGOs as implementing partners. For example, in spite of huge investments, vaccination rates are reportedly going down, and there have been sporadic epidemics.[51] A government representative acknowledged that project evaluations are often superficial and look at quantitative indicators rather than impact.[52] However, the government has reportedly successfully piloted results-based financing for health services, which involves consultation with the population and allows for daily monitoring of quality and engagement.[53]

In terms of accountability to affected populations (AAP), few of those interviewed could point to concrete, successful policies. One interviewee stated that very few actors consider this a priority.[54] The health cluster in Mali has committed to AAP, and the global health cluster has developed a tool for implementing it.[55] AAP is reportedly much-discussed in the planning of health activities, but mechanisms ensuring its implementation are clearly lacking. According to some actors on the ground, donors are increasingly asking for such mechanisms, but others stated that donors did not necessarily focus on this. Examples of AAP mechanisms included placing suggestion boxes in communities (though many communities in Mali have low literacy rates), providing telephone numbers that people could call (which were not used much), identifying leaders and designated members of communities to report back, and establishing management committees for project implementation that include locals. The latter two mechanisms were perceived as being more successful and generally helpful in strengthening accountability.

47 Interview with humanitarian expert, Bamako, May 2018.
48 Phone interview with humanitarian expert, October 2018.
49 See "Agenda atelier Mali HDN," 2019, available at www.dropbox.com/s/fak28oukvc6uxh1/Mali%20workshop%20-%20AGENDA%20draft2%2020180829.pdf?dl=0 .
50 Phone interview with humanitarian expert, October 2018.
51 Interview with humanitarian expert, Bamako, May 2018.
52 Interview with Ministry of Health representative, Bamako, May 2018.
53 Ibid.
54 Interview with humanitarian expert, Bamako, May 2018.
55 UN OCHA, *Mali: Humanitarian Response Plan (January–December 2018)*, p. 16; Health Cluster, *Operational Guidance on Accountability to Affected Populations (AAP)*, August 2017, available at www.who.int/health-cluster/resources/publications/AAP-tool.pdf .

Conclusion

Health actors in Mali face numerous challenges in providing adequate services to those who need them, in particular in the conflict-affected areas of the country. Insecurity linked to armed conflict, intercommunal violence, and criminality remains the main issue and will ultimately require improvements in the country's political situation. In the meantime, however, there are a number of ways to improve the provision of health services in Mali:

- **UN agencies, international NGOs, and donor agencies should continue to focus on strengthening and supporting Mali's community healthcare structures.** Mali's infrastructure for community healthcare is extensive and widely perceived as key to reaching poorer and more remote communities. This would also help ensure that services being provided are sustainable.
- **Military, political, and humanitarian actors need to preserve the humanitarian space in Mali.** This is key for humanitarian actors' acceptance by the Malian population and their ability to operate in conflict-affected areas of the country. In particular, MINUSMA should endeavor to better implement its mandate to create the conditions for the provision of humanitarian assistance. For example, it can take an active role in ensuring that its quick implementation programs are not conducted in areas where humanitarian actors are operating. Humanitarian actors should ensure relevant actors understand their mandate and the principled nature of their work, including by distancing themselves from MINUSMA and its work.
- **Relevant UN agencies, local and international health organizations, donor agencies, and the Ministry of Health should place greater emphasis on noncommunicable diseases, in particular mental health.** Existing services for addressing these health issues are limited, particularly in conflict-affected areas. Given the increased awareness of the impact of crisis and armed conflict on a population's mental health and the severe, long-term consequences this can have, there is a need for increased programming on mental health and psychosocial support.
- **Humanitarian health actors and donor agencies, as well as development actors and global health actors, should improve coordination with each other on the health response.** Effective coordination requires being flexible on programming. This will enable humanitarian health actors to better respond to the population's needs and avoid duplication or gaps in services. Donors should endeavor to provide for such flexibility in their funding agreements. Stronger coordination between humanitarian and development-oriented actors will also help ensure complementarity in their work and continuity in health services by improving the implementation of the humanitarian-development nexus.
- **Humanitarian health actors should better ensure that they are accountable for the health services they provide, in particular to affected populations.** They should mainstream mechanisms involving focus group discussions with local communities or engagement with community leaders. Health actors also need to build the capacity of communities to engage with such mechanisms. Ultimately, they should fully integrate the feedback received into the planning and implementation of health programs.

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