MAPPING HEALTH RESOURCE PARTNER INSTITUTIONS (HRPI):

Modeling a sustained approach for strengthening health governance and stewardship in low-income countries

Mali Report

African Center for Global Health and Social Transformation (ACHEST)

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Mapping Health Resource Partner Institutions (HRPIs): Modeling a sustained approach for strengthening health governance and stewardship in low-income countries

Foreword

The global study on supporting the leadership of Ministers and Ministries of Health and its report "Strong Ministries for Strong Health Systems", undertaken by ACHEST and the NYAM recommended that countries develop effective governmental and non-governmental Health Resource Partner Institutions(HRPIs) to support health system stewardship and governance functions of the ministries of health. The study pointed out the importance of organizations both in and outside of government that can provide needed expertise and resources to ministries of health. The study noted that every country needs to cultivate and grow a critical mass of individuals, and institutions that interact regularly among themselves and with their governments, parliaments, and civil society as agents of change, holding each other and their governments to account, as well as providing support. These include professional associations, national academies of medicine and science, universities, free standing think tanks, research and development organizations, business, private sector, NGOs and the media.

As a first step towards marshaling the HRPIs in the countries, a protocol and framework for mapping HRPIs, other governmental agencies and non-governmental organizations was developed and implemented in five countries namely Kenya, Malawi, Mali, Tanzania and Uganda. The purpose of these mapping studies was to identify and characterize HRPIs active in countries as a prelude to understanding how best they can work better with their respective governments especially the Ministries of Health to advance health system governance in sub-Saharan Africa in particular. As can be seen in the detailed country reports, it was found that while many such institutions were found in all the countries studied, they were strong in some countries and are used effectively by MOHs. In other countries, they were weak and rarely worked with the governments. In all countries these institutions need to be strengthened to provide the level of intellectual and human resources necessary to support effective health systems performance and governance. Ministries of health on the other hand were in some cases seen as insular and reluctant to collaborate with HRPIs.

During the 2nd Congress on Health Systems governance in March 2012, all the five countries presented and discussed their respective mapping study reports. It was unanimously agreed and recommended that all the five countries and ACHEST: 1) Develop mechanisms to link the work of HRPIs to Ministries of Health in order to utilize their expertise. 2) Make arrangements to develop the capacity of HRPIs so that they can play support roles to their governments more effectively. 3) Develop a new tool to be used for modeling a stronger working relationship between HRPIs and MoH as the next steps in implementing these recommendations. 4) The reports of the five countries to be widely disseminated. 5) Modify and adapt the mapping tool for use by other countries in mapping and collaborating with HRPIs.

We would like to recommend these reports to all who those who grapple with strengthening health systems in LMICs and welcome comments on the reports and are available to engage in further dialogue on how this stream of work can contribute to the achievement of better health outcomes.

In conclusion we wholeheartedly thank the Rockefeller Foundation, the government and people of Norway through NORAD for the financial grants that made it possible for this work to be undertaken.

We also thank the governments of Kenya, Malawi, Mali, Tanzania and Uganda for their willing participation in the study and commitment to strengthen their respective health systems.

Prof. Francis Omaswa

Executive Director

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Acknowledgement

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I would like to acknowledge the support of my colleagues at ACHEST who provided valuable insights and supported this work in various ways. In this regard I would like to recognize the tireless efforts of Dr. Patrick Kadama, Ms. Solome Mukwaya and initial contribution of Dr. Sam Okuonzi, former research fellow at ACHEST. The finance team Mr. Ebaju Johnson and Mr. Ogwapit Francis, administrative team Ms. Harriet Malinga and Ms. Sylvia Adiochi also contributed towards the success of this work. My appreciation also goes to Ms. Lucy Crawford who spent her internship at ACHEST analyzing this series of reports.

This work benefited immensely from the critique of the Second African Health Systems Governance Congress which took place in Kampala, March 2012.

ACHEST is immensely grateful to our development partners namely the Rockefeller Foundation and NORAD for the generous grants and encouragement that enabled this work to be carried out.

Dr. Peter Eriki

Director of Health Systems

African Center for Global Health and Social Transformation.

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Acronyms and Abbreviations

ACHEST	**African Center for Global Health and Social Transformation**
AMC	**Association of Country Physicians** *(Association des médecins de champagne)*
AMM	**Mali Towns' Association** *(Association des municipalités du Mali)*
ANTIM	**National Agency for Telehealth and Medical IT** *(Agence nationale de télésanté et d'informatique médicale)*
APD	**Public Aid for Development** *(Aide publique au développement)*
ASACO	**Mali Community Health Association** *(Association malienne de santé communautaire)*
ASDAP	**Association to Support the Development of Population Activities** *(Association de soutien au développement des activités de population)*
ADB	**African Development Bank**
ARI	**Acute Respiratory Infection**
CADD	**Support Cell for Decentralization and Devolution** *(Cellule d'appui à the décentralisation et à la déconcentration)*
CNAM	**National Center to Support Disease Control** *(Centre national d'appui à la lutte contre la maladie)*
CNOP	**National Council of the Pharmaceutical Society** *(Conseil national de l'ordre des pharmaciens)*
CNOS	**National Center of Odontostomatology** *(Centre national d'odontostomatologie)*
CREDOS	**Centre for Research and Documentation on Child Survival** *(Centre de recherche d'études et de documentations sur la survie de l'enfant)*
CROCEP	**Regional Steering, Coordination and Evaluation Committee of PRODESS** *(Conseil régional d'orientation, de coordination et d'évaluation du programme de développement sanitaire et social)*
CSCOM	**Community Health Center** *(Centre de santé communautaire)*
CSP	**Private Sector Coalition** *(Coalition du secteur privé)*
CSREF	**Referral Health Center** *(Centre de santé de reference)*
CIT	**Communications and Information Technology**
DGB	**Budget Directorate** *(Direction générale du budget)*
EVP	**Expanded Vaccination Program**
ECOWAS	**Economic Community of West African States**
FEMATH	**Malian Federation for Traditional Practitioners and Herbalists in Mali** *(Fédération malienne de tradithérapeutes et herboristes du Mali)*
FENASCOM	**National Federation of Community-based Health Associations** *(Fédération nationale des associations de santé communautaire)*
GPSP	**Health/Population Central Group** *(Groupe pivot santé population)*
HHA	**Harmonization for Health in Africa**
HRPI	**Health Resource Partner Institution**
IHP+	**International Health Partnership and Related Initiatives**
INPS	**National Institute of Social Welfare** *(Institut national de prévoyance sociale)*
INRSP	**National Institute for Public Health Research** *(Institut national de recherche en santé publique)*

IOTA	**African Institute of Tropical Ophthalmology** *(Institut d'ophtalmologie tropicale d'Afrique)*
UH	**University Hospital**
PSU	**Planning and Statistics Unit**
SFGPR	**Strategic Framework for Growth and Poverty Reduction**
INN	**International Non-proprietary Name**
PD	**Paris Declaration**
NHD	**National Health Directorate**
PHF	**Public Hospital Facility**
INFSS	**National health sciences training Institute** *(Institut national de formation en sciences de la santé)*
MLI	**Ministerial Leadership Initiative for Global Health**
MoH	**Ministry of Health**
MDG	**Millennium Development Goal**
MTBF	**Medium-term Budget Framework**
MTEF	**Medium-term Expenditure Framework**
NGO	**Non-Governmental Organization**
NYAM	**New York Academy of Medicine**
OP	**Operational Plan**
OOAS	**West African Health Organization** *(Organisation ouest-africaine de santé)*
OSC	**Civil Society Organization** *(Organisation de la société civile)*
PCIME	**Integrated Mother and Child Health Program** *(Prise en charge intégrée de la mère and de l'enfant)*
PDDSS	**Ten-year Health & Social Development Plan** *(Plan décennal de développement sanitaire et social)*
PMA	**Minimum Assistance Package** *(Paquet minimum des activités)*
PPM	**National Pharmacy of Mali** *(Pharmacie populaire du Mali)*
PPP	**Public-Private Partnership**
PRODESS	**Social and Health Development Program** *(Programme de développement sanitaire et social)*
RESADE	**Health and Development Expertise Network** *(Réseau d'expertises en santé et développement)*
RGPH	**General Population and Housing Census** *(Recensement général de la population et de l'habitat)*
RH	**Reproductive Health**
STI	**Sexually Transmitted Infection**
SWBS	**Sector-wide Budget Support**
TFP	**Technical and Financial Partner**
TB	**Tuberculosis**
TOR	**Terms of Reference**
UMPP	**Malian Factory of Pharmaceutical Products** *(Usine malienne de produits pharmaceutiques)*
UNICEF	**United Nations Children's Fund**
WAEMU	**West African Economic and Monetary Union**
WHO	**World Health Organization**

I. Executive Summary

The mapping of Health Resource Partner Institutions (HRPIs) in Mali produced important insights into their strengths, weaknesses, and impact on the stewardship and governance capacity of the Ministry of Health (MoH). The recommendations stemming from this study can, and should, be implemented through tangible actions, including good governance and reliable leadership; stronger human resource development policy; better access to funding and good healthcare; and, stronger involvement on the part of all stakeholders by harmonizing actions and supporting mutual accountability and responsibility.

Specific recommendations regarding management issues focus on improving the operation of the MoH's Human Resources Directorate and strengthening the national policy for human resource development. Study respondents recommend that to avoid the politicized management of human resources, managers and staff in the MoH should receive decent salaries and benefits. Strengthening the development, implementation and monitoring of national health policy is also necessary for both HRPIs and the MoH. Health policies, norms, and procedures should be widely disseminated and understood by all stakeholders to ensure the harmonious implementation of the national health policy. In addition, the roles of the actors involved in policy implementation must be clearly defined and the regulatory framework for public and private interventions in the health sector must be improved, in part by training all stakeholders in terms of the sector-wide policies and the decentralization process.

Other recommendations resulting from this study are to improve health sector coordination, improve the research capacity of the health sector, and increase resources to the health sector by identifying additional sources of funding and developing mechanisms for improved resource mobilization. Building the leadership and governance capacity of the MoH is highly recommended as it the increased involvement of Civil Society Organizations (CSOs).

II. Study Background

The Republic of Mali is a large, West African country which shares almost 4,500 miles of borders with seven countries: Algeria on the north, Mauritania on the northwest, Niger and Burkina Faso on the east, Senegal on the west, Guinea–Conakry and the Ivory Coast on the south. This position makes Mali a "pivot" country between Arab-Berber North Africa and sub-Saharan Africa. The territory, two thirds of which are desert, includes three climate zones: the Sudanese zone, the Sahel zone and the Saharan zone.

The relief shows little elevation and few hills, it consists of plains and low plateaus with an average altitude of about 1,600 feet. Mali has great agricultural and agro-pastoral capacity, but the country is subject to the vagaries of drought, which contributes greatly to the desert's advance and the deterioration of the populations' life conditions.

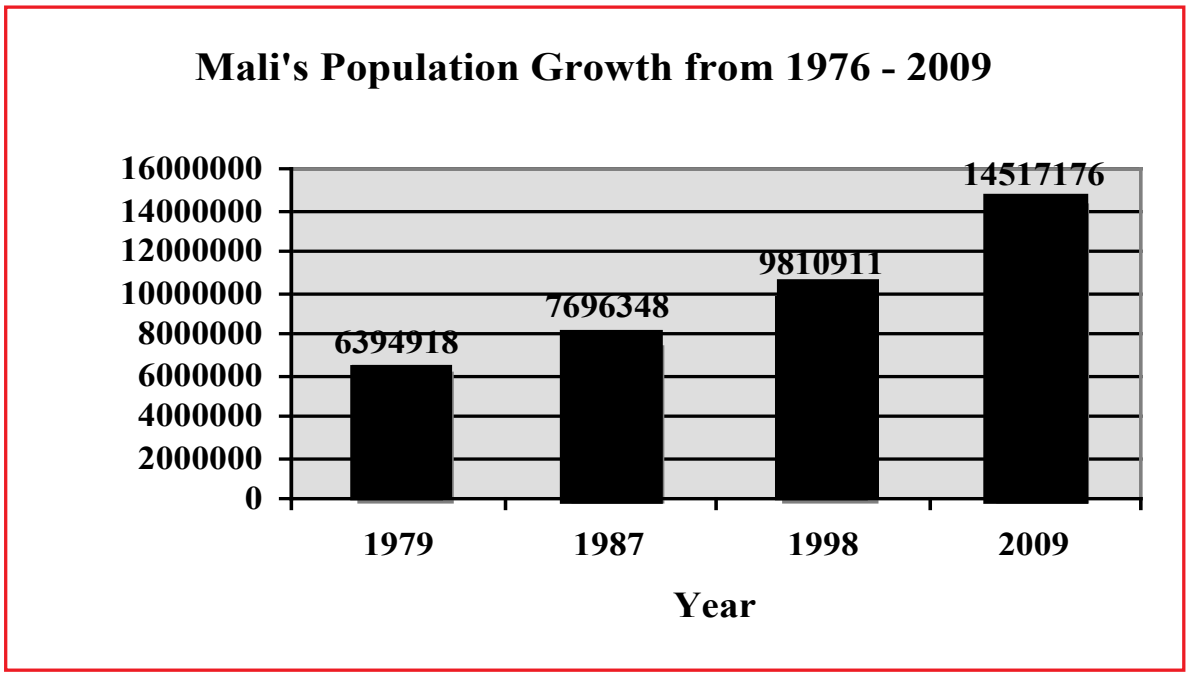
Mali is divided into eight administrative regions (Kayes, Koulikoro, Sikasso, Segu, Mopti, Timbuktu, Gao and Kidal) and one district (Bamako), which is also the nation's capital city.

Culturally, Mali has a very rich, complex, background, dating back to the time of the African empires. Modern Mali was established on September 22, 1960, following the split of the Mali Federation. This mixing of nations was at the origin of the formation of greatly interdependent human groups whose respective contributions are for Mali one of the most envied riches in the sub-region. Indeed, the country is a crossroad of civilizations with numerous ethnic and linguistic groups, each one a source of cultural treasures.

In 2009, the population of Mali was 14,517,176 inhabitants spread across 2,369,866 households (General Census of Population and Habitat – (RGPH) - 2009). The population has increased

by approximately 50% since 1998, which represents a 3.6% average annual growth rate. Women were 50.4% of the population, and men 49.6%. This population remains unevenly spread across the territory. This population momentum, characteristic of an extremely young Malian population, is indicative of the importance of unmet needs in terms of nutrition, health, education and employment. Since 2009, consensus-based policies and programs have been implemented by the government and its partners, a method which has often led to satisfactory results, but the greatest satisfaction comes mostly from the impression Malian people now have of participating in the development of their country, and the excitement they get from it.

Figure 1: Mali's Population Growth



Source: 2009 General Census of Population and Habitat, Mali (instat.gov)

Organizing and operating the health system

The constitution of the Republic of Mali guarantees the right to health care and the country's health policy is, on one hand, in accordance with the guidelines of the World Health Organization (WHO) and, on the other hand, consistent with the country's socioeconomic and cultural realities. The policy of free health care is based on the principle of universality, which makes health the fundamental right of any Malian and a social work of solidarity between the government, communities and individuals.

The Government has instituted a decentralization policy that is used as an implementation framework for all development measures. Two major tendencies were brought about by this decentralization reform. Firstly, local communities organized themselves to compensate for the lack of public social services, by creating community schools, Community Health Centers (CSComs), and other facilities. Secondly, decentralization was quickly established in sometimes hurried and challenging conditions.

Until 1980, access to health services was free in almost all peripheral structures and the State provided free consultations and medications to the entire population. Health measures were applied by priority in rural and peri-urban areas to address disease prevention and promote public health and family welfare. Given that health is an integral part of socioeconomic development, it

is therefore a component of capital investment and thus should be governed by the law of rational use of resources.

To ensure the durability of health care, its planning should take into account available resources and mobilize all actors, and most of all the populations themselves. The various sector-wide policies of the Health Department made it possible to consolidate assets, taking into account emerging concerns such as the gender-based approach, the development of the hospital sector and the fight against poverty. These policies were developed with the aim of harmonizing and rationalizing the development of services and on a pyramid system of service use.

The network of health delivery structures is organized as a pyramid with three levels of coverage, each level being used as a source of referral and support for the level immediately below it:

The **Operational Level** (base of the pyramid) functions at the District level and offers a minimum assistance package (PMA) in CSComs, of which there were 993 in 2009. As of 2009, there were approximately 1,000 structures which complemented the operational level coverage, including semi-public facilities, private facilities and faith-based organizations. Non-Governmental Organizations (NGOs) support some aspects of health care delivery, mainly reproductive health, child survival, sexually transmitted infections (STIs), and HIV/AIDS. It is important to note the existence of consultation rooms for traditional medicine practitioners, whose collaboration with modern medicine is currently being arranged.

The second level of service is the **Intermediate Level** which functions at the Regional level and provides technical support. This level comprises the 60 Referral Health Centers (CSREFs) located in each town. The intermediary level brings together seven Public Hospital Facilities (PHFs), which constitute the second referral and are each located in the following regions: Kayes, Koulikoro (Kati), Sikasso, Segu, Mopti, Timbuktu and Gao.

The top of Mali's health pyramid is the **Central Level** which deals with policies and norms and consists of four PHFs, including two specialized hospitals: the African Institute of Tropical Ophthalmology (IOTA) and the National Center of Odontostomatology (CNOS).

The private health sector, while it has developed in the Districts and in large cities, follows a separate evolution and its data are not integrated into the various sub-systems of health information. However, at the end of 2009, there were 363 pharmaceutical dispensaries, 128 pharmaceutical warehouses, 30 retailers, 8 laboratories, 8 herbalists and 4 pharmaceutical product manufacturing facilities. The Army health services, which, strictly speaking should not be included in this sector, include hospitals-sick bays and garrison maternity wards.

These levels (except for the Army health services) are all under the supervision of the Ministry of Health, whose mission it is to develop and implement the national health policy. As such, it is responsible for: extension of the country's health coverage; promotion of the policy of health for all; health education of populations; prevention and control of endemic diseases and conditions that are public health issues; reproductive health; development of community-based health structures; monitoring and supervision of health training programs; supervision of the private practice of medical and paramedical professions; and, sustaining an adequate supply of drugs for the country.

Moreover, the MoH, which operates at the central level, determines the health sector's investments, operations and standards based on the principles of effectiveness, efficiency, equity and durability. The central level is also responsible for the application of these standards by all partners in the health delivery system. It strives to raise resources from the private sector, the State and donors, for the funding of quality care accessible by all. It must consistently ensure the availability and accessibility of essential drugs, and has implemented a series of measures to do so, including: reforming the National Pharmacy of Mali (PPM) and the Malian Factory of Pharmaceutical Products (UMPP), lifting the import monopoly and thus rationalizing the distribution, prescription and reimbursement of medications.

The MoH must also strengthen community participation in the management of the system by helping individuals, households and communities ensure their own health. Despite their modest buying power, these communities, through the development of new, low-cost techniques can greatly enhance the survival of their children and reduce the impact of disease. Finally, the Ministry of Health must mobilize all the resources necessary to funding the health system, including ensuring cost recovery for health training, and rationalizing the use of these resources at all levels.

Health systems have the power and ability to make tremendous progress in health care monitoring and delivery. When they are fully functional, they can offer each country a database of facts, which can be used as a decision-making tool to improve quality of care and rationalization of resources. Mali's health system is in a period of critical reflection, as it needs to achieve the Millennium Development Goals (MDGs). Currently, the relationship with stakeholders in the health system is sensitive because health programming in Mali is done in the context of a budget program integrating department structures at all levels (central, regional and local). This represents an important evolution for the success of the health sector in terms of better use of resources, whether human, material or financial. The priority in terms of expenditures is now granted to investment expenses, infrastructure maintenance and human capital (i.e. education, health).

Also, human and institutional capacities have a critical influence on development efforts and their durability. They influence chances of success and results, not only in terms of better economic management, but also of the better ability to face the harsh and ever-changing realities of the global economy.

Contextual framework of the study

Numerous efforts have been led over the past ten years that aim to improve and strengthen health systems so that they become more efficient. In many developing countries, particularly in Sub-Saharan Africa, the health sector has long been the beneficiary of extensive assistance originating from numerous donors. In 1998, in order to coordinate these numerous sources of assistance and benefit the most from them, Mali launched a Sector-Wide Approach (SWAp) to support the Social and Health Development Plan (PRODESS). The SWAp is managed by permanent structures of the Malian government using a process that is well institutionalized and several financial tools have been developed to enable the management of external funds with national systems. The MoH has thus begun to develop its Medium-term Expenditure Framework (MTEF), which covers all available resources to finance the sector and is updated regularly. There are PRODESS-specific procedures allowing management of a common pool, and several technical and financial partners became involved with the Sector-Wide Budget Support (SWBS) in 2006.

Mali, for a certain number of years, has been a country where new international health sector partnership initiatives abound, including: the Paris Declaration on Aid Effectiveness; International Health Partnership and Related Initiatives (IHP+); Harmonization for Health in Africa (HHA) and, the Ministerial Leadership Initiative for Global Health (MLI). These initiatives rest on the pillars of country ownership or programs, harmonization and alignment of development partner funds, results-based approaches and mutual accountability. The implementation of these partnerships is accompanied by significant changes in the approach and tools that are used for cooperation in general. For instance, Mali developed its own national action plan for the efficiency of development aid, the 2007 – 2009 Paris Declaration Development Plan. Currently, the majority of public assistance for development must fall within the national priorities stipulated in the 2007-2011 Strategic Framework for Growth and Poverty Reduction (SFGPR) and its Medium-Term Budget Framework (MTBF) developed by the Ministry of Finance. In addition, budgetary support has become one of the preferred funding instruments for the Malian government.

In addition to the traditional partners in this sector, awareness of the urgency of tackling global health problems and of pooling all these efforts to reach the Millennium Development Goals has given rise

over the past few years to a multitude of initiatives and organizations active in the field of global health. Many of these initiatives actually go beyond the strict governmental or UN frameworks and consist of Public-Private Partnerships (PPPs) such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, or purely private organizations such as the Bill & Melinda Gates Foundation; both forms of initiatives have their own priorities and modes of operation. As the expiration date for the MDGs draws near, these initiatives, programs and organizations in the global health sector have recently multiplied which has led to an increased need to coordinate the various activities and align around a single program, led by the governments of the beneficiary countries.

The current context of this study is that the Ten-year Health & Social Development Plan (PDDSS) will be coming to an end in 2011, and the new ten-year plan to replace it is being developed. With this perspective, assessing the results of the ending PDDSS and its five-year operational phases (PRODESS), including PRODESS II, becomes a necessary step. Even though the latter was extended until 2011, lessons can already be drawn from the implementation of the 1998-2003 and 2005-2009 periods, which will accelerate the process and provide a new operational plan as early as January 2012.

It is in the context of all these initiatives and the expiration of several health policy programs in Mali that this study was conducted. This HRPI assessment project follows the recommendation of the previous January 2010 report, “Strong Ministries for Strong Health Systems” conducted by ACHEST and the New York Academy of Medicine (NYAM).

III. Summary Of The Terms Of Reference

By translating the Terms of Reference (ToR) (Annex I: complete ToR) into actions we can develop investigations for the benefit of some HRPIs, or stakeholders, in the Malian health sector such as professional associations, national academies of medicine and sciences, universities, independent think tanks, research and development organizations, corporations, the public and private sectors, and NGOs. These HRPIs can all work with ministries to create a culture of evidence-based policies and practices, and to support activities that strengthen the health system but also make each actor in the health system accountable for their part in the overall results of the system.

While such institutions are widespread and well established in some countries (and used efficiently by the ministries of health), they sometimes need to be encouraged and gathered together so that it is possible to collaborate with them, and they can be considered as health resources complementary to the MoH.

Consequently, in the framework of a three-year program aiming to strengthen health system governance and stewardship in low-income countries, ACHEST is conducting this study to identify and better understand HRPIs in order to develop a strategy which will give them the appropriate power and capacity to support health system governance and stewardship. The goal of the study is to identify, locate and characterize HRPIs in Mali.

The study has been entrusted to a country consultant. The data gathered on HRPIs will include their name, location, area of work, background, geographic scope, networks and relationships, resources, sources of funding, accomplishments and impact. In the end, the study will produce models to reinforce the governance and stewardship of the national health system with the help of the HRPIs.

IV. Data Collection And Analysis Methods

Letters of introduction signed by the Director of the Planning and Statistics Unit of a sector that includes health, social development and advancement of the family were sent to all HRPIs identified for the detailed study. Attached to the letter was the study questionnaire (Annex 2: Study Questionnaire), designed by ACHEST, both in hard copy and electronic format. Periodic meetings and follow-up calls were conducted as needed, which made it possible to gather HRPIs' answers as well as define intervention parameters based on the aim of the study.

Information on the HRPIs that were not the subject of a detailed study was also obtained via telephone inquiries, data retrieval from administrative correspondence addressed to the Ministry or a visit to their installations. (Annex 3: HRPI information).

Excel and Microsoft Word were used for HRPI data compilation and analysis. The report's structure and architecture were based on the framework of the study's ToR and research on Mali completed the situational analysis, so that the study would have a local context and take into account all of the country's endogenous and exogenous realities.

V. Findings

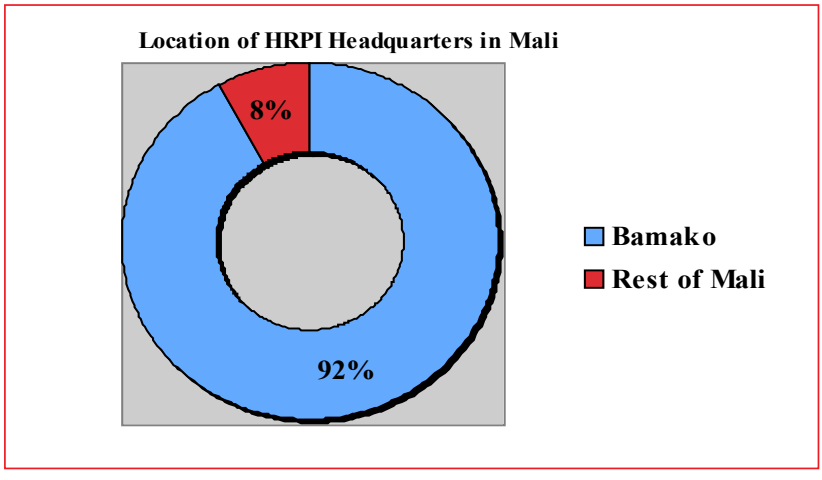
Detailed analysis of the data provided by the HRPIs produced a range of information that distinguished each HRPI based on its missions and objectives, but primarily on its contributions, prospects, challenges and recommendations to strengthen the overall health system. These are all important elements to capture in order to ensure that each actor fully contributes to the wellbeing of the Malian population.

This study deliberately sought to gather a maximum of information in order to support and improve health policy implementation. Because of this, twenty-four HRPIs were identified for the study, as opposed to a sample of ten to fifteen HRPIs suggested in the ToR.

a. Location

From the twenty-four HRPIs studied in detail, 92% had their headquarters in Bamako (Graphic 2). This shows that these institutions are unevenly spread throughout the country, but also that their headquarters are situated for practical reasons in the capital city. It is important to note that a majority of the HRPIs have intervention and implementation areas that cover all of Mali and, in some rare cases, cross national or even regional borders.

Figure 2: *Location of HRPI Headquarters*



b. History

The compilation of information regarding the creation date of HRPIs was sequenced taking into account three important reference points in the evolution of Mali's health policy. The first reference point is the period preceding the easing of restrictions on private health practice in Mali (1986). The second reference point extends from the easing of restrictions on private health practice to the Millennium Declaration (1986 to 2000). The third reference point is the period from 2001 until the present.

Analysis shows that a majority of the HRPIs studied were created after the easing of restrictions on private practice in the health sector, during the periods of the second and third reference points. From 1986 – 2000, 41.7% of the HRPIs were established, and the same percentage of HRPIs were established from 2001 to the present. The 16.6% created before the easing of restrictions consist of public entities involved in bilateral or multilateral assistance. It is worth noting that HRPIs are relatively new in Mali. (Table 1: Dates of HRPI Creation).

Table 1: Dates of HRPI Creation

Year	Before 1986	1986 - 2000	2001 - present	Total
# HRPIs (% of all HRPIs in study)	**4** (16.6%)	**10** (41.7%)	**10** (41.7%)	**24** (100%)

c. Geographic scope

The activities and scope of all twenty-four institutions studied are essentially national and occur within the geographic limits of the country. Few institutions have activities beyond the national territory and reach the sub-region, or beyond.

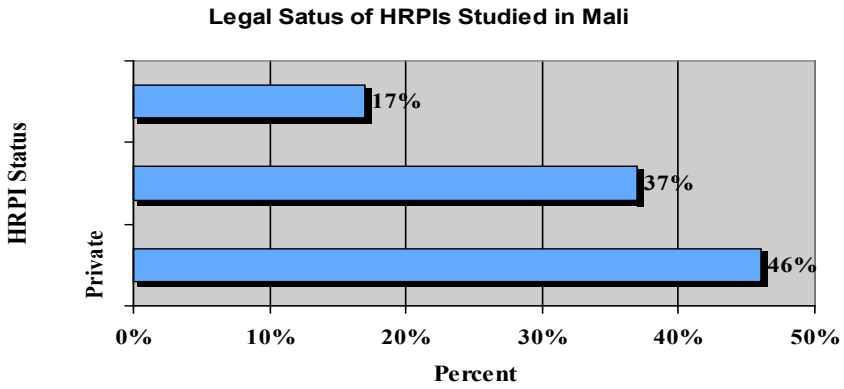
d. Legal status

The HRPIs in this study are either public or private institutions. Private institutions are fairly heterogeneous, some being for profit and others not-for-profit. Overall, the HRPIs can be categorized as:

- Academic Institutions
- Professional Organizations
- Public Institutions
- Research Institutions/Organizations
- Think Tanks
- Corporations/NGOs/Private Sector
- Development Partners

As Figure 3 shows, 46% of the HRPIs studied were private; 37% were public; and, 17% were public but without a national dimension (technical and financial partners supervising health policy implementation)

Figure 3: *Legal status of HRPIs*



e. Governance of the institution

One or more of the various types of governance listed in Table 2 apply in part or wholly to several institutions. As a rule, there are no significant differences between the types of governance in effect within the HRPIs studied. However, the following categories are the most common: General Assembly, Board of Directors and Other. These types of governance give stockholders and board members the opportunity to be heard and offer their advice on proper running of the institution. One institution can have one or several types of governance.

Table 2: *Governance of HRPIs*

Governance Structure	Number of HRPIs (multiple categories allowed)
Board of Directors	12
Other	11
Administrators	9
Annual General Assembly	7
Executive Council/Committee	7

f. Founders (institutions/individuals)

The twenty-four institutions studied in detail are formally recognized by Malian law and considered to be public utility institutions. Funding sources for the HRPIs include state funding for institutions receiving predominantly public funds to sustain their activities, some private institutions receiving government subsidies, and technical and financial partners receiving government resources. Public Aid for Development (APD) provides funding to some public and private nonprofit HRPIs. Private funding such as dues, contributions and personal resources applies specifically for profit institutions. Table 3 provides detailed information about HRPI funding.

Table 3: *Funding sources for HRPIs*

Institution	Funding source		
	State	APD	Private
National Center to Support Disease Control (CNAM)	89%	7%	4%
UTM	40%	30%	30%
Malian Federation for Traditional Practitioners and Herbalists in Mali (FEMATH)	80%	10%	10%
National Agency for Telehealth and Medical IT (ANTIM)	70%	15%	15%
National Health Sciences Training Institute (INFSS)	83%	14%	3%
National Council of the Pharmaceutical Society (CNOP)	30%	50%	20%
Centre for Research and Documentation on Child Survival (CREDOS)	90%	10%	--
Support Cell for Decentralization and Devolution (CADD)	90%	10%	--
DNS	50%	50%	-
LUX-DEVELOPMENT	35%	65%	-
Association of Country Physicians (AMC)	--	20%	80%
Health Population Central Group (GPSP)	--	100%	--
Budget Directorate (DGB)	100%	-	-
Association to Support the Development of Population Activities (ASDAP)	N/A	82%	N/A
Health and Development Expertise Network (RESADE)	--	--	N/A
United Nations Childrens Fund (UNICEF); National Federation of Community-based Health Associations (FENASCOM); World Health Organization (WHO); IAFPRESS; National Institute for Public Health Research (INRSP); AMESA	N/A	N/A	N/A

g. Partner institutions, institutional links and networks

The HRPIs studied have close relationships with one another; however, the institutions with the strongest links share complementary missions and spheres of work. HRPIs that are research organizations have relatively close links with universities and academies. Alternatively, public HRPIs develop networks with government structures and technical and financial partners. Links, networks and partnerships are built and developed based on affinities, but above all on spheres of intervention. Specifically, HRPIs collaborate with institutions generally located in Mali, and a brief description of these partner institutions follows.

i) **Universities:** Collaboration occurs essentially with the School of Medicine, Pharmacy and Dentistry at the University of Bamako and to a lesser extent with foreign universities.

ii) **Other academic institutions:** Collaboration exists between the social workers institute, private schools, the Training Institute for Health Sciences, and French-speaking medical schools from Western Africa and France.

iii) **Research institutions:** Collaboration sited include those with the Center for Public Health Research, the National center for the support of disease control, the Center for Research, Studies and Documentation on Child Survival, Antwerp's Institute of Tropical Medicine in Belgium and other research institutes abroad.

iv) **National government:** This relationship is primarily with the Ministry of Health but includes

certain other departments in government.

v) Foreign governments: This type of collaboration occurs exclusively via bilateral cooperation.

vi) Multilateral organizations: This partnership is deeply influenced by United Nations systems, multilateral lending agencies, sub-regional organizations, and health partnerships.

vii) Non-Governmental Organizations: Collaboration exists with numerous NGOs and associations active at the local, regional, national, sub-regional and international levels. Among others are: the International Health Economics Association (IHEA), the African Health Economics and Policy Association (AfHEA), the West African Health Economics Network (WAHEN); the French Health Economists Association (CES-France) and NGOs such as the Groupe Pivot Santé/Population and the Red Cross in Mali.

viii) Civil society: Collaboration with civil society has become very popular and it occurs with, among others, the Federation of Community-based Health Associations (FENASCOM), NGOs such Health Population Central Group (GPSP), Mali Towns Association (AMM) and other private sector institutions.

ix) Others: These partnerships are with foundations, the private sector, and university hospitals.

h. Technical details, and areas and types of work

Most of the HRPIs studied intervene in all the technical areas and types of work listed in the study tool. HRPIs involved with bilateral and multilateral cooperation are better indicated to cover all areas of the health sector through sector-wide technical and financial support. They support all dimensions of the system, including:

Health policies

HRPIs support health policies by participating in discussions on health policy planning and budgeting and assisting with development of the resulting documents. Similarly, HRPIs work with the MoH on developing community-based health policy to support the decentralized system by making communities accountable for the implementation of health policy. HRPIs have also developed plans for the monitoring and evaluation of policy and used Communications and Information Technology (CIT) capabilities to improve health policies. Overall, HRPIs have been involved in mobilizing a network of experts at the national and international levels who bring proven skills in adapting policies to the national, regional and local levels all with the aim of strengthening performance in health and development.

Health system

The HRPIs in this study support Malian health system through CIT capabilities as well as providing planning, training, and medical care to rural and at risk areas as well as assisting with monitoring and evaluation, all in an effort to improve health systems management and coordination. HRPI's help foster the MoH's relationships with technical and financial partners, often working to harmonize and strengthen the health system.

Health care programs

HRPIs assist in the development and monitoring of health programs and also report working with the MoH to improve research on preventive, curative, and promotional health care. HRPIs support the implementation of many health care programs including the Integrated Mother and Child Health Program (PCIME) as well as programs focused on HIV, nutrition, and Acute Respiratory Infection (ARI). Additionally, HRPIs report increasing access to health coverage by improving access to and strengthening the Minimum Assistance Package (PMA). HRPIs

also help foster and improve dialogue between health stakeholders and beneficiaries. As the HRPIs in the study reported, all of this is done while complying with standards and systems of reference.

Programs to control specific diseases

HRPIs support programs to control specific diseases by developing modules and multi-year plans to control certain diseases while also insuring consistency of programs with the sector-wide health policy. HRPIs also report working to improve the perception of certain diseases and eliminating, eradicating or controlling diseases such as epilepsy, sickle-cell anemia, high blood pressure, HIV/AIDS, malaria, tuberculosis, STIs and neglected tropical diseases.

Human resources

In terms of human resources, HRPIs offer substantial support by training physician candidates prior to assignments in rural areas and training human resource personnel in teaching skills, operational research, and assessment in the field of health sciences. HRPIs also reported using CIT capabilities to improve human resource management and establishing a network of experts to share experiences and best practices. Additionally, HRPIs report providing career development to staff and developing Human Resources for Health (HRH) policy and strategic implementation plans.

Health funding

HRPIs support health funding by pursing advocacy activities with health sector technical and financial partners to raise their financial resources and also by developing funding strategies for the sector-wide health policy. HRPIs work to strengthen public-private partnerships to mobilize the private sector to reach public health goals. Also, they develop alternative health funding mechanisms and support systems such as the mutuelles (community-based health insurance). HRPIs also report conducting cost studies for some strategies as well as transferring financial resources.

Community involvement

HRPIs are involved with communities through their support of health policy implementation, their work to develop productive partnerships in rural and community environments, and by enabling social mobilization through community-based approaches to support health activities. HRPIs also reported strengthening and training the Mali Community Health Association (ASACO).

Economic policy, commerce and health

Support brought by the HRPIs to economic policy, commerce and health includes: assessing health policy consistency with the country's macroeconomic options while also supporting implementation of the public-private partnership in the health sector; including the notions of equity, rights and ethics in health policy implementation; and, seeking better access to care at a lower cost.

Technical assistance/consulting

HRPIs have great potential in terms of technical assistance and consulting for the health sector, namely in supervising, providing, and monitoring medical care and conducting action research within the sector. HRPIs report providing technical support to other health sector structures at the national, regional and local levels in terms of planning and programming for better health policy implementation. HRPIs in this study report providing technical support to decentralized services and consulting support to civil society partners and NGOs in addition to using CIT capabilities to improve technical assistance/consulting.

Advocacy

HRPIs advocate for the health system by conducting advocacy activities targeted to the actors involved in health policy implementation. Such advocacy activities include focus on better quality medications, resource mobilization and health policy implementation. Advocacy efforts also focus on using results from studies, surveys and action research to inform policy. Efforts also focus on increasing decision makers' awareness of health care programs in order to get their support.

i. Support to the Ministry of Health

HRPIs bring much to the Ministry of Health. Some work to strengthen the system and implement collectively defined policy. Alternatively, some HRPIs have difficulty navigating the MoH. HRPIs report that they provide direct support to the MoH in the form of technical and financial contributions as well as work with the MoH to improve training, research and capacity. HRPIs also reported conducting studies and surveys to provide the system with reference data in order to make better decisions, improving the implementation of Mali's sector-wide health policy at the operational level, conducting better advocacy, and facilitating increased mobilization of internal and external resources for the health system.

HRPIs provide assistance to the MoH by participating in the development of national health policies to control and address HIV/AIDS, malaria, tuberculosis, hepatitis B, occupational health problems, and several reported that they assisted in drafting the PDDSS. HRPIs also have been involved in the coordination and preparation of policy documents such as the national mental health policy and the national policy for the development of human resources, nutrition and equipment maintenance.

HRPIs assist in **monitoring the process and development of legislation** by developing codes of ethics for health professionals, marketing of breast-milk substitutes, and health and sanitation. HRPIs work to ensure adherence to international health regulations and also assist in developing guides for the implementation of partnerships with nongovernmental organizations in the context of PRODESS and for analyzing the health section of environmental impact studies.

Although research is not the main activity of any of the HRPIs studied, they report occasionally **conducting specific research to support policy and health system development** via the following: Providing medical care and training trainers in teaching skills and operational research for the health sciences while also developing physicians loyalty in rural and at risk areas; developing research strategies on financial supports for the health system; conducting action research on providing medical care, including the quality-based approach; conducting qualitative research on essential family practices for integrated coverage of childhood illnesses; and, implementing pilot projects and operational research on themes such as adolescent and child health, gender and health, and community-based services and subsequently developing policies to control and address the issues. HRPIs reported a specific focus on research to improve sexual and reproductive health to help achieve MDG 5.

HRPIs also **develop management rules and procedures** such as: best clinical practices for tests, clinical work and surveys; developing and monitoring the ethics code and making sure health professionals adhere to it; and, training physicians to manage health centers and developing a procedures manual for services including the management of ASACOs, decentralization and transfer of competence, and guides for the national health accounts.

HRPIs work with the MoH to **development strategies for staff attraction, compensation and retention.** To foster a work environment that encourages executives and staff to show initiative and fully express their abilities and skills, HRPIs advocate for, and help develop, fair

and transparent distribution of lawful service-based rewards; an incentive system for staff punctuality; regular meetings to keep staff informed; grants for vehicles, fuel and supplies; funding for scholarships and participation in continuing education workshops and seminars. HRPIs in this study recommended that attractive compensation package with medical insurance.

Intra-sectoral collaboration is quite developed in Mali and almost all HRPIs have developed **partnerships with other stakeholders, reinforcing the SWAp in Mali.** These collaborations go beyond the health sector and create partnerships, even networks, outside the national health system.

HRPIs assist in **organizational reforms,** including restructuring and decentralization. HRPIs also have reporting obligations to stockholders, agents, or sponsors regarding the use of funds placed at their disposal to bring results for the health system; therefore, HRPIs **support the accountability process of health services** by providing financial and accounting management systems.

Monitoring and evaluation is of particular importance to the HRPIs in this study as it is an essential part of a system that seeks steady performance in policy implementation. Monitoring and evaluation activities include: holding PRODESS statutory bodies meetings; and, compiling, producing and disseminating tools and indicators for program monitoring and assessment.

HRPIs also provide assistance by **aligning individuals and institutions with goals and processes agreed upon at the national level.** Most HRPIs have activity profiles conducive to making coordination one of their anchorage points in the health system. This is generally done by reminding stakeholders of the health sector's commitment to ensure better intervention coordination in order to align with the goals and processes collectively agreed upon at the national and sometimes international level.

VI. Suggestions from HRPIs on Strengthing Stewardship and Governance

HRPIs suggest various methods for strengthening health sector stewardship and governance. Common among all responses was the recommendation to put into to practice the provisions contained in the mutual assistance agreements through a strong involvement of structures in the political dialogue, the planning, implementing, monitoring/ assessment and participation in various proceedings and meetings for the coordination of interventions in the health sector. Additionally, HRPIs stressed the importance of timely implementation of programs and mobilization of funds as well as the importance of organizational strengthening in line with the framework for concerted action of civil society organizations that partner with PRODESS.

Other suggestions include: develop tools for analysis, decision-making, and follow-up support for health plan and policy implementation; strengthen advocacy for the sector-wide health policy; establish communication channels, in part via CIT applications, to improve coordination with various ministry structures; conduct studies on new strategies to reduce child and infant morbidity and mortality; develop a community of best practices by sharing with ministries of health from other countries and engaging in dialogue with the private sector; and, publish, distribute and disseminate research results on health sector stewardship and governance. Moreover, HRPIs there should be more clearly defined the roles and responsibilities of each stakeholder in the health system which accompanying supervision, and monitoring and evaluation systems. HRPIs suggest that such systems should include guidelines for the various actors in the health system and adherence to those guidelines so undeserving actors are sanctioned and deserving actors motivated.

VII. Discussion: Analysis and Interpretation

Analysis of the collected data presents the difficulties and bottlenecks that HRPIs face while working towards better health sector stewardship and governance. Analysis also revealed

potential for improvements that could assist HRPIs and the MoH to work together in creating an environment conducive to stronger health system governance and stewardship.

Challenges

HRPIs, in their quest for better governance and good stewardship, have encountered significant challenges, perhaps most pressingly is raising financial resources, strengthening capacities and motivating various actors in the health sector to make sure activities laid out in operational plans are completed. Compounding this challenge is the difficulty in developing a culture based on results, performance and accountability in which all technical and financial partners adhere to the principles of the Paris Declaration and Mali's IHP+ compact.

Issues related to health financing are the source of many challenges discussed by HRPIs in this study. Financial issues range from insufficient health funding from the government and development partners to difficulty implementing free health care services and policies, which have the potential to improve the quality of service and general health of individuals by lifting fees that as financial barriers to essential health care. Additionally, burdensome management procedures have, according the HRPIs in the study, made it challenging to use resources to meet needs at the operational level and such procedures create the potential of misuse of funds.

Implementing results-based approaches is another significant challenge sited by many HRPIs. Challenges in this regards include: integrating established study results and data from the private health sector as decision-making tools; using analyses on the efficiency of health expenditures and results-based management to inform technical and policy decisions; and, monitoring health strategy implementation through results-based performance.

Developing productive partnerships between the public and private sectors has proved challenging due to poor coordination systems resulting in a lack of confidence between government structures and development partners. Similarly, there are significant challenges in terms of widely disseminating information regarding policy and administrative or scientific research to all actors in the system. The management capacity of CSOs and community health centers is another challenge made more difficult as a result of poor information systems and lack of the appropriate technology that could enhance services and health records.

Prospects

In the face of the numerous challenges listed above, HRPIs have several prospects enabling them to partly conquer these difficulties. One important and timely prospect is the **influence in drafting the next ten-year plan using lessons-learned and proven results gained from the implementation of the previous ten-year plan.** Suggestions for improvement include strengthening collaboration with the private sector and civil society in health policy planning and implementation and improving MoH leadership in its relationship with technical and financial partners and civil society.

Other prospects include **strengthening health institutions to better address the needs of the population at each level of the health system, particularly at the community level.** Pursuing a transfer of skills, resources and responsibilities to decentralized communities remains a serious prospect to improve the management of first line health services.

There is also great potential **for improving women's health by integrating a gender-based approach in policy** and identifying the specific health needs of women and of other vulnerable groups through collaboration with women's organizations and associations. These efforts can complement and support the implementation of the roadmap for maternal and neonatal mortality reduction through free caesarean delivery programs, referral-evacuation improvement by taking into account the village-CSCOM circuit, and the increased prevalence of assisted births.

HRPIs in the study discussed the prospect of improving human resources for health by operationalizing the management team so that it is capable of responding quickly to all HRH management issues, ensuring better training and motivation in the health sector. Great potential also lies in improved technology and making computer-based tools accessible for information technology management and development.

VIII. Recommendations

In view of these challenges and prospects, HRPIs made a certain number of recommendations that would benefit the health system in Mali by strengthening and improving its stewardship and governance. These recommendations consist of the following:

To ensure better coordination of activities in the health sector, the missions at each level must be more clearly defined. An increased participation of civil society and the private sector in health policy development and implementation is recommended in part to help ensure local and decentralized governance of the health policy and strengthen the capacity of beneficiaries to participate in the development and implementation of health policies and identify best practices

Mali should also continue to lead advocacy efforts on implementing health sector coordination commitments made by the government and its technical and financial partners, such as the IHP + Compact, Abuja Declaration and Paris Declaration on Aid Effectiveness.

HRPIs recommend the MoH dedicate a greater part of the national budget to research activities and health measures and that they implement an internal and external monitoring system while sharing budgetary supports with all stakeholders. It is also recommended that they institutionalize proven assessments methods in order to develop various approaches that are results-based and rely on decision-making tools.

Identify additional sources of funding for the health sector to help ensure greater accessibility to care for the population, develop and implement permanent monitoring and evaluation guidelines for impact assessments of health sector funds, and develop mechanisms for improved mobilization of resources for the timely implementation of activities.

The HRPIs in this study also recommend that the MoH continue to strengthen the government's leadership, capacity, and strategic vision and cultivate transparency by ensuring monitoring and evaluation at all levels of the health sector.

IX. Conclusions

It is widely known that the health sector, like all other sectors, has been affected by issues related to globalization and the harmonization of interventions. The many international health initiatives in Mali vary in type, scope and scale and have increased in size and number during the last decade. These initiatives have a fairly significant impact on the strengthening and durability of systems' governance and stewardship and are, therefore, transformational in terms of the relationships and operations at various levels of the health sector. As a result, there is a change of direction in political and economic structures toward a more disciplined organization, as well as strong pressures from a global system imposing more constraints but also, fortunately, more openings.

The Malian health system is going through a period of critical reflection because it is conditional on the country's commitment to implementing and supervising these different initiatives. In

Mali, health services are provided by a wide range of providers from both the public and private sectors, each playing an extremely important role in offering and funding health services. To strengthen the synergy of efforts and improve public health goals, it is essential to find methods and means in order to increase the ties between all active participants in the system and government leadership. This study presents ways to leverage stewardship and governance in order to strengthen and improve strategies for successful health policy implementation and attainment of program results. This leveraging can take place by answering the challenges, taking into account HRPIs' perspectives and applying their recommendations.

This study on Health Resource Partner Institutions in Mali added to the current knowledge and understanding of the country's health situation by highlighting the perception of many HRPIs on the state of health systems governance and stewardship in the country.

Annex 1. Terms of Reference

ACHEST STUDY TERMS OF REFERENCE FOR THE COUNTRY CONSULTANT

Mapping Health Resource Partner Institutions (HRPIs) in selected African countries to Model a Sustained Approach for Strengthening Health Governance and Stewardship in Low income Countries

Introduction

As part of a three year program to strengthen health stewardship and governance in low income countries, African Centre for Global Health and Social Transformation (ACHEST) is conducting a study to map out Health Resource Partner Institutions (HRPIs) to understand them better so that a strategy can be made to empower and give them appropriate capacity to support health system stewardship and governance. The goal of the study is to identify, locate and characterize HRPIs in five countries of Kenya, Malawi, Mali, Uganda and Tanzania. Each country study will be done by a Country Consultant. Information gathered on HRPIs will include name, location, area of work, history, geographical scope of operation, networks and linkages, resources, funding, achievements and impact. Ultimately, the study is expected to recommend models for strengthening the national health stewardship and governance using HRPIs.

Study Objectives

The study has the following objectives:

1) To gain better knowledge and understanding of HRPIs, their activities, strengths and weaknesses, needs, and impact on health stewardship and governance
2) To identify, locate and characterize HRPIs
3) To identify different ways and methods by which HRPIs can strengthen health governance and stewardship
4) To recommend models by which HRPIs can be facilitated to strengthen health governance and stewardship

Tasks for the Country Consultant

1. To participate in the development, modification or country adaptation of the study tool in consultation with the ACHEST Project Coordinator of the study
2. To identify, locate and administer questionnaire to all indigenous HRPIs that are involved or have the potential to participate in national health stewardship and governance
3. To draw a table listing all possible HRPIs in the country including information on their location, their key areas of work, how they have worked in health stewardship and governance, and how they can be supported to strengthen national health stewardship and governance.
4. To carry out a pre-test of the tool and revise the tool in consultation with the Project Coordinator
5. To carry out detailed study and follow-up of 10 – 15 HRPIs by administering the tool, collecting and recording data using the questionnaire
6. To compile data from the core 10- 15 HRPIs and from other HRPIs which manage to submit reasonably well completed questionnaires, analyze and present the data for easy interpretation
7. To write a clear and concise report
8. To present the report at a joint workshop.

Report Format

The report will cover the following key elements:

- Executive summary including clear actionable recommendations
- Background of the study
- A summary of the ToRs in the consultants understanding
- The methods of data collection and analysis
- Findings; to be arranged under the following sub-headings:
    1. Location
    2. History
    3. Geographical scope
    4. Legal status
    5. Governance of the institution
    6. Founding institutions/ individuals
    7. Partner institutions, institutional links and networks
    8. Technical and areas and types of work
    9. Involvement in health stewardship and governance
    10. Support to Ministry of Health (MoH)
    11. Publications: number, types, content, stewardship and governance issues etc.
    12. Suggestions from HRPIs on how to strengthen stewardship and governance issues
- Discussion: analysis and interpretation
- Recommendations
- Conclusions
- Annexes to include ToRs, the study tool, detailed tables etc.

Deliverables
The expected deliverables are:

1. A table with a comprehensive list and key information on all HRPIs in the country
2. A list of 10 -15 HRPIs selected for a close follow-up and detailed study
3. A report on pre-test of the tool, with recommendations for revising or improving the study tool
4. A report with detailed recommendations

Country consultant
The consultant should have at least a master's degree in medical / health or social sciences, with a minimum of 5 years of research experience. Familiarity with and a special training in qualitative methods and health leadership and governance or health system development will be useful. Knowledge and familiarity with the country will be essential.

Timing
The consultancy covering the entire study will take 60 calendar days or two calendar months from the day of signing the contract. In any case, it should start not later than the June 30 and end not later August 31, 2010.

Coordination of study
The country studies will be coordinated at ACHEST by the Study Project Coordinator, located in Kampala, Uganda.

Annex 2. Questionnaire

ACHEST STUDY INSTRUMENT

Mapping Health Resource Partner Institutions (HRPIs) in selected African countries to Model a Sustained Approach for Strengthening Health Governance and Stewardship in Low income Countries

Background

This study is part of a bigger project on strengthening health stewardship and governance in Africa and other low income countries as a strategy to strengthen health systems. It is a follow-up to implement the findings and recommendations of a study report: "Strong Ministries for Strong Health Systems". One of the seven recommendations of the study is that "countries should develop effective governmental and non-governmental Health Resource Partner Institutions (HRPIs) to support the health system stewardship and governance functions of the ministries of health". As a way forward, it was recommended by stakeholders that HRPIs be identified and characterized to provide the necessary knowledge and understanding to design a mechanism for involving them to advance health and health system governance. The purpose of this study is to determine which institutions and individuals are active or have the potential to be effective HRPIs in 5 African countries. The HRPIs may be academic institutions, NGOs, think tanks, public and private sector institutions, development partner institutions or individuals.

The five countries selected for this study are Kenya, Malawi, Mali, Uganda and Tanzania. Information gathered is expected to include name, location, area of work, date of commencement of work, membership, resources available, funding sources, achievements and impact in the countries, region and world-wide.

The objectives of this study are to:

1) Gain better knowledge and understanding of African health policy and strategy organizations, their activities, impact, strengths, and needs;
2) Identify and characterize the HRPIs;
3) Identify different ways and methods by which HRPIs can strengthen health governance and stewardship; and
4) Recommend models by which HRPIs could be facilitated to strengthen health governance and stewardship in Africa.

Key definitions

Health system: personal health care services, public health services, health research systems and health in all other policies.

Stewardship: governments are stewards or protectors of public interest and have the ultimate responsibility to assuring conditions that allow people to be as healthy as possible.

Governance: is the alignment of multiple actors and interests to promote collective action towards an agreed goal.

Leadership: The ability to and the process of scanning of the environment, creating attractive vision and strategies, and inspiring and aligning actors and interests for action to achieve an agreed goal

Management: Involves planning, including scheduling activities, mobilizing and using resources, implementation, monitoring and evaluation, and feedback.

CONTACT INFORMATION

1	Name of respondent	
2	Title of respondent	
3	Contacts of respondent: Telephone Email Postal address	
4	Name of the institution in full	
5	ACRONYM	
6	Street address	
7	Province and / or district	
11	City or Town	
12	Country	
13	Telephone	
14	Email	
15	Website	

INSTITUTIONAL HISTORY AND GEOGRAPHICAL SCOPE

16	In which year was the institution established?	
17	In which country is the institution's headquarters located?	
18	Are there any branches??	
19	If so, where (which countries)?	
20	In what countries does the institution operate?	

LEGAL STATUS

21	What type of institution is it? Government NGO Bilateral organization Multilateral Other (specify)	
22	What is the legal status of the institution? Established by law Registered Other (specify)	

GOVERNANCE OF THE INSTITUTION

23	Which of the following organs apply to the governance of the institution? Tick as applicable.	
	Board of Trustees	
	Governing Council/Committee	
	General Assembly/ Annual General Meeting	
	Directors	
	Others (specify)	

FOUNDERS

24	Who or what organizations were the founders of the institution and which are their countries of origin or of current location	
	Name of founding institutions or individuals	Countries where these institutions are located. Also indicate the nationalities of the individual founders
	1.	
	2.	
	3.	
	4.	
	5.	

FUNDING SOURCES

25	What are three main sources of funding?	Approximately what percentage of funding of funding is from each source?

LINKS WITH OTHER INSTITUTIONS

26	Does the institution have links with other institutions? Indicate by yes or no	
27	If yes, what type of institutions is it linked to? Tick as applicable	
	University	
	Other academic institutions (specify)	
	Research institution	
	National government	
	Foreign government	
	Multilateral organization	
	Other (specify)	

AREAS OF FOCUS / NATURE OF WORK

28	Which of the following are the principal areas of the focus of work? Tick as applicable	In what specific aspects?
	Health policy	
	Health systems	
	Health care programs	
	Disease specific programs	
	Human resources	
	Health financing	
	Community participation	
	Economic policy, trade and health	
	Technical assistance/advice	
	Advocacy	
	Other specify	

INVOLVEMENT IN HEALTH GOVERNANCE

29	In what ways has your institution participated in national or regional health governance?	Explain and give some examples
	Policy: Health policy development	
	Oversight: legislation process and development	
	Research: Health policy and systems development	

	Regulation: Development of rules and procedures of management	
	Incentives development and application: Staff payment, attraction and retention strategies	
	Partnership with other stakeholders: SWAP and networks	
	Organization: Organizational reforms, including restructuring and decentralization	
	Accountability: Consultancy or research to track funds with outputs or amount of work done	
	Monitoring and evaluation: Assessing the level of performance against program objectives and planned targets	
	Coordination: alignment of individuals and institutions to nationally agreed goals and processes	
	Others (specify)	

INDIVIDUAL HEALTH RESOURCE PARTNERS

30	List names of outstanding individuals who have made significant contribution to health governance and stewardship in the country or region		
	Names	Area of contribution	Email and telephone contact

PROBLEMS AND CHALLENGES OF WORKING WITH MOH IN GOVERNANCE AND STEWARDSHIP

31	List down the challenges your organization has faced in working with the Ministry of Health in health stewardship and governance. (What are the challenges you have faced in efforts to enhance health stewardship and Governance?

WAYS BY WHICH HRPIs CAN ENHANCE HEALTH GOVERNANCE

32	Suggest ways by which your organization could better facilitate health sector stewardship and governance.

PUBLICATIONS

33	Please list publications, if any, which depict your involvement in health policy, stewardship or governance.

ACHEST

AFRICAN CENTRE FOR GLOBAL
HEALTH AND SOCIAL
TRANSFORMATION

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