An Applied Political Analysis of the Targeted Free Care Reform in Mali

This Doctoral Thesis, An Applied Political Analysis of the Targeted Free Care Reform in Mali, presented by Dominique Rouleau, and Submitted to the Faculty of The Harvard T.H. Chan School of Public Health in Partial Fulfillment of the Requirements for the Degree of Doctor of *Public Health*, has been read and approved by:

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Abstract

Introduction - Health financing through out-of-pocket payments is deeply inequitable and imposes barriers and risks for patients. After decades of charging patients for healthcare in Mali, an ambitious primary health care reform was announced in February 2019 that would exempt target populations from payment - "targeted free care" (TFC).

This thesis is an in-depth case study of the policymaking process of introducing TFC in Mali. It aims to apply the methodological toolkit of political analysis and adaptive change to understand where things stand 32 months later (September 2021).

Methods - A literature review traces the history of user fees in Sub-Saharan Africa, distills 14 best practices for removing them, and identifies features of the Malian health care system relevant to TFC. Next, a documentary review, 21 months of participant observation and 19 stakeholder interviews provide the data for a reconstructed narrative of the reform's development and announcement, as well as a political analysis using three frameworks: the 14 best practices for TFC, stakeholder analysis, and Kingdon's Multiple Streams framework.

Results - Several features of the Malian context make implementing TFC difficult: small and contracting health budget, weak state capability demonstrated by existing programs, sector-wide strategic fragmentation and poor coordination, and highly autonomous primary healthcare centers dependent on user fees. These are heightened by the political and security crisis.

Issues with the reform's development, content, and announcement reduced buy-in from key stakeholders. It witnessed a loss of high-level support due to ministerial turnover and two coups' d'états - inconsistent leadership made consensual policy development, coordination, and network building difficult. Stakeholders closest to the operational level with the most discretion around TFC implementation are also the most against it. The reform

window for a national TFC policy has closed, and it is moving forward on a pilot-scale with uncertain ministerial support.

Conclusion **-** The multi-dimensional costs to families of user fees are well known and the need to repeal them urgent. However, Mali's worsening security and political crises appear to be a more pressing priority for those in power. This could provide time to work out the policy's design and build consensus.

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Glossary of Abbreviations and Concepts

ACT	**Artemisinin-based combination therapies** (ACTs) are the recommended treatments for uncomplicated malaria. They were adopted over other molecules because of their relative efficacy, fast action and the reduced likelihood of resistance developing.
Adaptive Challenge	An adaptive challenge is one that requires grappling with normative questions of values, purpose, and priorities, and working with people to experiment solutions, generate learning, and manage loss. The core of the challenge is "the gap between the values people stand for (that constitute thriving) and the reality that they face (their current lack of capacity to realize those values in their environment)." It can also be understood in contrast to a ***Technical Problem***, which is one "that can be diagnosed and solved, generally within a short time frame, by applying established know-how and procedures. Technical problems are amenable to authoritative expertise and management of routine processes." This concept is drawn from the work of Heifetz and Lipsky [1].
AMO	**Mandatory Social Health Insurance** (Assurance Maladie Obligatoire): Mali's compulsory health insurance scheme for civil servants and people working in the private sector (type of "social insurance"). It is managed by the CANAM.
ANAM	**National Agency for Medical Assistance** (Agence Nationale d'Assistance Médicale): the public institution responsible for managing Mali's medical assistance program for the vulnerable (RAMED).
ASACO	**Community Health Association** (Association de Santé Communautaire): the managing body of community health centers (CSCOM), composed of elected community members.
ASC	**Community Health Worker** (Agent de Santé Commautaire): a category of health agent who is chosen by community members or organizations in their own community to provide basic health and medical care, often pro-actively by conducting household visits.
Authorization and Authorizing Environment	*Authorization* refers to the conferring of legitimacy, protection, approvals, or other tangible or intangible support that allows a particular policy or initiative to move forward. The power to authorize is not only located in a single individual or office but is structured into an *authorizing environment.* This "consists of those people who can say yes or no to the 'public value proposition' but also those who can influence those who can say yes or no." In the public sector, it starts within an organizational management hierarchy, and extends to political appointees and other stakeholders who wield influence (professional associations, special interest groups, the media, and citizens). Authority can be rooted in formal, rules-based processes, or in informal, personality, relationship-driven ones. It is often non-linear and very dynamic. This concept is drawn from the literature on Building State Capability [2], and the work of Mark Moore on the strategic triangle [3].
Bamako Initiative	A policy initiative, adopted by African health ministers in 1987 in Bamako, Mali, which involved introducing community management and user fees in order to improve access (especially to drugs) and responsiveness of primary healthcare.
CANAM	**National Health Insurance Fund** (Caisse Nationale d'Assurance Maladie): the public institution responsible for managing Mali's mandatory social health insurance scheme (AMO). It delegates the management of members and their contributions to the Malian Social Security Fund (CMSS) and the National Social Security Institute (INPS).

Capability Trap	A situation where a state is asked to do activities or actions that it is unable to perform, and which over time creates the stagnation, or even deterioration, of its performance and capability. This concept is drawn from the literature on Building State Capability [2].
CFA	**Franc of the African Financial Community (West Africa)** (Franc de la Communauté Financière Africaine): currency of eight independent states in West Africa: Benin, Burkina Faso, Guinea-Bissau, Ivory Coast, Mali, Niger, Senegal, and Togo. $ 1 USD = 561 CFA (Sept 2021).
CHAI	**Clinton Health Access Initiative:** "a global health organization committed to saving lives, reducing the burden of disease and strengthening integrated health systems in low- and middle-income countries" [4]. Founded in 2002, it is a separate non-profit organization from the Clinton Foundation.
CSCOM	**Community Health Center** (Centre de Santé Communautaire): the health facility at the primary health care level (between ASC / rural maternity and CSRéf), which is staffed either by a nurse or a doctor and provides a basic package of services. There are roughly 1400 CSCOM currently in Mali.
CSRéf	**Referral Health Center** (Centre de Santé de Référence): the health facility at the secondary health care level (between CSRéf and regional hospital), which is staffed by a medical team to provide a more complete package of services, including surgery (e.g., cesarians). There are roughly 65 CSRéf currently in Mali.
DGS	**General Directorate of Health** (Direction Général de la Santé Publique et de l'Hygiène): the main technical agency of the Ministry of Health, which includes several sub-directorates and sections.
FENASCOM	**National Federation of Community Health Associations** (Fédération Nationale des Associations de Santé Communautaires): is an umbrella federation of Community Health Associations (ASACO) created in 1994. Its objectives are to respect and defend the interests of ASACO, to provide a framework for orientation, consultation, integration, and coordination of their activities, while respecting their autonomy, and to contribute to the development and expansion of the community health movement.
GAVI	(Officially known as "Gavi, the Vaccine Alliance"): is a public–private global health partnership with the goal of increasing access to immunization in poor countries.
Global Fund	**The Global Fund to Fight AIDS, Tuberculosis and Malaria**: an international financing and partnership organization that aims to attract, leverage and invest additional resources to end the epidemics of HIV/AIDS, tuberculosis and malaria to support attainment of the Sustainable Development Goals established by the United Nations.
Holding Environment	A holding environment consists of "the cohesive properties of a relationship or social system that serve to keep people engaged with one another in spite of the divisive forces generated by adaptive work. May include, for example, bonds of affiliation and love; agreed-upon rules, procedures, and norms; shared purposes and common values; traditions, language, and rituals; familiarity with adaptive work; and trust in authority. Holding environments give a group identity and contain the conflict, chaos, and confusion often produced when struggling with complex problematic realities." This concept is drawn from the work of Heifetz and Lipsky [1].
LMIC	Low- and Middle-Income Countries.
MAP	**Mali Action Plan:** the reform strategy for 2021-2030 developed by Mali's Minister of Health Michel Sidibé in early 2020. It was developed as Mali's response to the WHO's 2019 plan

	"*Stronger Collaboration, Better Health: Global Action Plan for Healthy Lives and Well-being for All"* which outlines a framework for improved collaboration and more streamlined support to countries to deliver universal health coverage and achieve the health-related SDG targets.
MoH	**Ministry of Health**: shorthand for the ministry responsible for health in Mali, which has gone by different names and included different portfolios over the years: • Ministry of Health and Public Hygiene • Ministry of Health and Social Affairs • Ministry of Health and Social Development (current)
Mutuelles	**Mutual community-based health insurance:** Mali's contributory voluntary health insurance scheme targeting people working in the informal and agricultural sectors (type of "community-based health insurance").
OOP	**Out-of-pocket payments**: expenditures borne directly by a patient where no insurance covers the full cost of the health good or service.
PBF	**Performance Based Financing** (Financement Basé sur les Résultats (FBR)): a mechanism by which health facilities are paid on the basis of their performance, which is measured by the quantity and quality of services they provide related to certain target indicators.
PLWHA	**People living with HIV / AIDS**
PPM	**People's Pharmacy of Mali** (Pharmacie Populaire du Mali): the public agency responsible for the procurement, storage, and distribution of essential medicines throughout the Malian territory.
PRODESS	**Health and Social Development Program** (Programme de Développement Sanitaire et Social): Mali's 5-year strategy for the implementation of the national planning strategy for health and social development.
RAMED	**Medical Insurance Scheme for the Vulnerable** (Régime d'Assurance Médicale): Mali's non-contributory health insurance scheme for vulnerable populations (e.g., the indigent, orphans, etc.)
RAMU	**Universal Medical Insurance Scheme** (Régime d'Assurance Maladie Universelle): Mali's forthcoming integrated health insurance scheme, which links the different existing health insurance schemes into one, mandatory and mostly contributory scheme (RAMU = AMO + RAMED + Mutuelles)
Social protection (SP)	**Social Protection** refers to the portfolio of government activities around health insurance and other social safety net programs, which has been under different ministries over the years. • Ministry of Labor, Social, and Humanitarian Affairs • Ministry of Humanitarian Action, Solidarity, and the Elderly • Ministry of Solidarity and Humanitarian Action • Ministry of Solidarity, Humanitarian Action, and Reconstruction of the North • Ministry of Solidarity and Fight Against Poverty • Ministry of Health and Social Development (current)
SSA	Sub Saharan Africa
State Capability	State capability for policy implementation refers to when organizations can effectively "equip their agents with the capacity, resources, and motivation to take actions that promote their organization's stated objectives." This concept is drawn from the literature on Building State Capability [2].

Targeted Free Care (TFC)	A shorthand for the policy of repealing fees paid at the point of care for certain targeted populations or services, and replacing them by another payer (e.g., insurance or government) (also referred to as "exemption schemes").
Technical and Financial Partners (TFP)	Technical and Financial Partners (Partenaires Techniques et Financiers (PTF)): is a grouping of actors in the health system commonly used in Mali to describe international organizations involved in supporting the Government through technical and operational assistance, as well as financing.
UHC	**Universal Health Coverage:** a situation where "all individuals and communities receive the health services they need without suffering financial hardship"[5] .
User fees	"A financing mechanism that has two main characteristics: payment is made at the point of service use and there is no risk sharing. User fees can entail any combination of drug costs, supply and medical material costs, entrance fees or consultation fees" [6] (also referred to as "cost recovery").

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INTRODUCTION

Background and justification

Paying out of pocket for healthcare is a major barrier to access, particularly in countries where most of the population lives in financial precarity. After decades of promoting direct payment from patients, global health discourse has progressively shifted towards exemptions for target groups and striving to achieve universal health coverage.

Mali is one of the poorest countries in the world, and the health of its population is characterized by high mortality and morbidity, particularly among vulnerable groups such as women and children. User fees for healthcare make up a large portion of spending on health and trap many families in a cycle of suffering and poverty.

In response to this situation, the President of the Republic and the Minister of Health announced an ambitious primary health care reform in February 2019. It includes several initiatives to strengthen primary healthcare service delivery, such as health center renovation and the deployment of community health workers, as well as a plan to make healthcare free at point of care for several priority beneficiary categories (referred to as Targeted Free Care (TFC)).

The experiences of other countries that have embarked on similar reforms show that targeted free care is difficult to implement and comes with risks. Indeed, care never really becomes “free,” someone still has to pay for it. The goal is to shift the burden away from the patient during an episode of illness towards a mechanism that provides protection against financial risk. Payment must be provided by another source, such as through government revenue, pre-payment contributions, donor money, or some combination thereof.

Repealing user fees at the point of care cannot be done overnight. It is rife with technical challenges like figuring out payment mechanisms, sustainable financing, appropriate reimbursement rates, robust verification systems, and

effective communication strategies. Disfunctions in any of these can put a major strain on already weak health systems and undermine quality of care, jeopardizing the reforms' expected financial protection and health gains.

However, a targeted free care reform also touches upon questions related to values, ethics, and politics, such as what should be the responsibility of a state in the provision of healthcare? And how should citizens contribute? In this way, it is also an *adaptive challenge* [1] – one which goes beyond applying a technical fix, requiring learning about the problem and solution, and for which the locus of work is with stakeholders, some of whom are likely to bear loses. Not everyone is likely to see the issue of user fees in the same way, much less agree on a solution.

The nature of the change required with introducing TFC is profound, as it is at once pervasive (affecting every aspect of the healthcare system: payment, financing, organization, regulation, and behavior), deep (requiring an important reorientation in thinking and doing around paying for health), and large (affecting a wide range of actors, nationally) [7].

Targeted free care in Mali would be introduced into an already fragile, complex, and dynamic health system with a long history. It implies a redistribution of resources and power and a disruption to the equilibrium of the status quo. Therefore, it is likely to face significant resistance from stakeholders at different levels and runs the risk of being defeated by the system's response to it [8].

Context of this DELTA Doctoral Project

The Clinton Health Access Initiative (CHAI) is a non-profit organization working alongside governments and other partners to improve access to affordable medications and technologies and to help build national systems to provide lifesaving treatment. CHAI is currently working in francophone West Africa with the governments of Mali, Senegal, Burkina Faso, and Benin [4].

Their collaboration with the Malian government began in 2018 when they were asked by the Ministry of Health (MoH) to provide technical support for the design and costing of the presidential primary health care reform announced in February 2019.

Since December 2019, a small team of CHAI advisors has been embedded within the MoH, and later a special implementation unit, to provide technical and strategic support to help operationalize the 2019 reform vision. As a member of this team, the author of this thesis has spent 21 months supporting the Malian government to flesh out the design and implementation strategy for targeted free care (among other work priorities).

This has allowed for a unique vantage point, as both an active participant in and scholar of adaptive large-scale health system change. To borrow a metaphor from Heifetz and Lipsky, when one is busy on the "dancefloor" of policy making, where the action is and work gets done, it can be helpful to step away onto the "balcony" (provided here by academic study), to gain a distanced view and perspective on oneself and the larger system, and to see patterns not visible from the ground [1].

Aim

The overall aim of this project is to support Mali's MoH in their ongoing efforts to implement targeted free care, using the tools and frameworks of applied political analysis and adaptive change. This can be summarized through three specific objectives:

1. To explore the policy design space and learn from the struggles and successes of other countries that adopted TFC policies. The goal is to identify strategic best practices, and to assess how Mali could (and perhaps already has) approach them.

2. To study the Malian context and health care system to identify the features and capabilities relevant to TFC. The goal is to develop insights into how the system and key stakeholders might respond to introducing the policy and how to best engage with this.

3. To assess the reform's current prospects for implementation in a dynamic environment affected by instability and the emergence of the COVID-19 pandemic. The goal is to answer the question: given that so much has changed since the reform was announced, where can Mali go from here?

Methodology

Given this project's focus on a large-scale health system reform, the methodological toolkit employed is applied political analysis. It also draws on theoretical frameworks at the core of the DrPH curriculum, including change management and adaptive leadership.

Several types of data were collected for this study. First, a systematic literature review was conducted of peer-reviewed publications using PubMed and other relevant databases (e.g., Embase, Web of Science). It focused on policy reform processes, as well as user fees and targeted free care programs, specifically in sub-Saharan Africa. Additional articles and publications were identified using Google Scholar, searching bibliographies, and discussions with experts. This was complemented by a documentary review of Malian and regional reports, meeting agendas, workshop minutes, donor and government program evaluations, and national policies, plans, strategies, and laws. Third, participant observation was carried out during 21 months of working for CHAI alongside the MoH in Bamako (January 2020 – September 2021, with 14 months full-time in-country and 7 working remotely). This was documented through contemporaneous field notes. Finally, the author conducted 19 semi-structured interviews with targeted free care stakeholders and key informants (11 Malian, 8 non-Malian) from different levels, both within and outside the national health system. Interviews were conducted during August and September 2021, in French or English, lasting between 50 and 180 minutes. They were transcribed verbatim, translated into English with the assistance of software and verified by the author for accuracy.

This particular combination of data collection methods has been described as "particularly suited for examining public policies" [9], [10]. Data was triangulated and analyzed using a deductive approached rooted in three analytical frameworks: the 14 best practices to implementing TFC developed in Part 2, stakeholder analysis and the Multiple Streams Framework of Kingdon [11] (described in detail in Part 4).

The project protocol was reviewed and approved by the CHAI Scientific and Ethical Review Committee (SERC). Due to its focused Malian policy-maker audience, it received a determination that it was not "research" as defined by DHHS or FDA regulations from the Institutional Review Board of the Harvard T.H. Chan School of Public Health. Finally, it underwent full review and was granted ethical approval from the Comité d'Éthique de l'Université des Sciences des Techniques et des Technologies de Bamako (USTTB) in Mali.

CHAI provided financial and logistical support for this project as a DELTA Doctoral Project host organization and employer. The author maintained a separation between this project and their other work with the Government of Mali, CHAI and Harvard. To protect confidentiality, de-identified notes, interview recordings and transcripts will remain in the sole possession of the author. In addition to this thesis, the results of the project will be shared in the form of a summary report, presentation, or other dissemination products in French for a Malian audience.

The views expressed herein are entirely those of the authors and do not necessarily represent those of CHAI or CHAI's donors.

Overview

This thesis is divided into four parts. The first three parts draw mainly from the literature and documentary review, and the fourth part is informed by the first three as well as the original qualitative data (participant observation and semi-structured interviews).

Part 1 provides a historical overview of the introduction of user fees in health care systems across sub-Saharan Africa in the broader context of global health and economic discourses. It reviews evidence of the harmful effects of user fees and trace the shift in global health policy towards carefully repealing them. It summarizes the current state of knowledge about the benefits and risks associated with their removal.

Part 2 focuses on understanding the policy reform process and walks through 14 best practices for TFC reforms in particular, drawing lessons from experiences of countries in sub-Saharan Africa that have undertaken similar reforms.

Part 3 is a deep dive into the Malian context, including demographic, economic and political trends, as well as the organization and performance of its health system. Particular attention is paid to existing financial protection mechanisms. Features that are relevant for TFC policy design and implementation are highlighted.

Part 4 begins with a narrative description of the development, content, and reception of the 2019 Primary Health Care reform. It then presents the results of three political analyses of the TFC reform in Mali, each using a different framework: an assessment of how closely aligned Mali has been so far with the 14 best practices for TFC, a stakeholder analysis and mapping, as well as an analysis of the evolving situation using Kingdon's the Multiple Streams framework.

The conclusion will discuss the limitations of these analyses as well as attempt to summarize some of the key takeaways related to how and under what conditions Mali could move forward with targeted free care.

LITERATURE REVIEW

PART 1: The history of paying for healthcare in Sub-Saharan Africa

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1.2 A brief history of the Bamako initiative and of user fees

During the time that sub-Saharan African countries were subjected to colonization, health services were "free" at the point of care for users as they were funded by the colonial budget (i.e., taxes garnered from extractive economies). However, the extent and coverage of such services was limited, as they were generally hospital-centric, concentrated in urban areas, or emphasized vertical programs to contain the spread of disease, such as vaccinations [12].

The 1960s and 1970s witnessed the independence of many countries in the region and an era of optimism, self-determination, and grassroots mobilization. This transformed healthcare systems, with the number of health centers rising dramatically, particularly in rural areas [13]. The ethos of this time was captured at an international conference on primary health care that took place in 1978 in the capital city of Kazakhstan, Alma Ata. The Declaration that emerged from that conference, signed by 134 Ministers of Health, put forth a vision of "health for all by 2000" framed in the language of human rights and social justice.

The momentum behind this movement was soon interrupted in the 1980s, when a combination of soaring oil prices and interest rates, along with declining demand for exports from developing countries, triggered an economic crisis. The Mexican government defaulting on its loans in 1982 set off a debt crisis across the developing world [13]. This ushered in a new era of economic austerity and neoliberal reforms, which were inspired by the 1981 World Bank report entitled "Accelerated Development in Sub-Saharan Africa: A Plan for Action" [14]. This influential report argued that stagnating economic development in the region was due to excessive and inefficient government intervention and inappropriate trade and exchange-rate policies, and recommended countries "stabilize, liberalize,

and privatize." Under this new orientation, the International Monetary Fund and the World Bank issued an average of six Structural Adjustment loans to each SSA country during the decade of the 1980s, which were conditional on limiting public spending and undertaking free-market reforms [13]. Mali began reforms to liberalize its economy in the 1980s and received its first Structural Adjustment Credit of $70 million USD in 1990 [15].

This greatly shaped the global health discourse around the role of the state in the provision of health services. At the same time, the World Bank was "tentatively moving into the health sector with little experience, a strong ideological framework based on privatization, cost recovery and big loans" [16].

The vision of Alma Ata was increasingly coming against criticism that it was unaffordable and unattainable. It began to be overtaken by the strategy of *selective* primary health care – which identified and promoted a very limited package of vertical, cost-effective health services that offered a high return in lives saved per dollar spent. The UNICEF program of "Growth monitoring, Oral rehydration, Breast-feeding, and Immunization" – known through the acronym GOBI – was a classic example of this [13].

The effects on health systems were rapidly felt through steep declines in national budgets for health. A crisis in health care delivery developed, with many countries unable to finance even staff salaries and the purchase of essential medicines. Quality of care suffered, and many patients were forced to turn to private pharmacies to purchase treatment [16], [17].

It is in this context that an alternative funding mechanism was proposed, one that aimed to improve access to essential services and drugs by charging patients for services, which became known as the "Bamako Initiative." Several other terms for this approach also exist, such as cost recovery, cost sharing, community-based funding, and user fee for service.

What is the Bamako Initiative?

The main ideas behind the Bamako Initiative were articulated in an influential 1985 World Bank working paper and subsequent report: "Paying for Health Services in Developing Countries: An Overview" [18]. It laid out the case of user fees as a means to finance health systems that favored cost-containment and provided three main advantages. First, they were effective at generating reliable revenues for health centers, which could amount to 15-20% of operating costs. Second, they were efficient, since they reduced overconsumption of health services by those who do not really need them, or what is termed "frivolous demand" from patients. Finally, they had the potential to be equitable, as they can be used to cross-subsidize rural health centers with revenues from urban ones, and to support special measures to benefit the poor [19].

These economic ideas were translated into a health financing scheme by UNICEF which became the Bamako Initiative. It derives its name from the capital city of Mali, Bamako, where the policy was launched and adopted by Ministers of Health of the WHO Africa region in 1987 [13], [20].

The policy was framed as a proposal to relaunch health care and reduce maternal and child mortality and had as its objective the universal accessibility of primary health care [21]. It was also more modestly described as a "pragmatic strategy to implement primary health care in the era of structural adjustment" [16].

Its principal goal was to improve quality, particularly access to inputs like drugs, through more effective financing. The scheme was initially conceived as a kind of "revolving drug fund." Donors provided an initial stock of essential generic drugs to health centers as a seed investment, then these drugs would be sold to patients with a small profit margin. This revenue would be used to buy a new stock of medicines and invest in improvements in infrastructure, equipment, and staff motivation [20], [22].

Communities were not expected to spend more than they already were; this was instead supposed to offer them higher quality services for a fraction of the price they were paying seeking care in the informal or private sector [16].

Cost recovery from out-of-pocket payment was considered more reliable than government funding, which was increasingly shrinking and unpredictable. It was expected that governments would still continue to pay for salaries and some recurrent costs, and donors would also invest in infrastructure to expand physical access, as well as training, supply chain and consumables [16], [23].

Part of the strategy also consisted of decentralizing decision making and enhancing "community control" through participation in management. Through the Bamako initiative, mechanisms for oversight and management were set up with community representatives. These community management committees had considerable discretionary power over the use of their revenues since a large share of it was retained at the facility level. This was expected to improve the accountability and responsiveness of health centers towards users and their needs [24]. By paying, patients were also provided with an incentive "to monitor their local providers and demand better care – to make sure they are getting their money's worth" – a customer-centric argument frequently put forth by the World Bank [25].

The question of equity was addressed by suggesting exemptions for the indigent – or the worst-off – be created. These were described as "solidarity mechanisms under local community control," which would be funded by a portion of the health facility profits (in many countries it was suggested 10% be set aside for this purpose) [21], [26].

The evidence base for the Bamako Initiative was not particularly strong at the time of its launch. It was inspired by several pilot experiments, many having been organized by donors (USAID in Burkina Faso and Niger, UNICEF in Benin, Guinea, and Mali, and by German aid agencies in Cameroun). It was largely exogenously driven by UNICEF and the WHO, as well as by a cadre of health economists and policy makers who aligned themselves with the desire for a reduced role of the state and community empowerment [26], [27].

Evidence available at the time about the effects on demand of putting a price on healthcare services was "mixed and therefore controversial" [25]. In addition, as the policy took hold across Africa, the initial limited role of cost recovery

(to ensure access to essential generic medicines) expanded to include user fees for consultations, which is a much heavier financial burden on the community [28].

The Bamako Initiative was not the subject of unanimous support – in fact many in the academic, scientific, and healthcare community raised alarms about its likely harmful impacts on equity and access to care [26], [28]. Nevertheless, the Bamako Initiative was adopted as a strategy across Africa in the late 1980s. By the 1990s, most African countries, including all the countries in francophone west Africa, had shifted towards charging user fees [27].

1.2 Revisiting the Bamako Initiative: understanding the harmful effects of user fees.

Much has been written about the effects of the Bamako Initiative on health systems. Early assessments lauded clear improvements in access to drugs, and in some cases, improved utilization, provider motivation, access to services like vaccination, and patient empowerment ("client power") [17], [27], [29].

However, problems with implementation soon began to arise, leading to a re-examination of many of the assumptions underpinning this approach. Its implementation in countries with limited decentralized state capacity proved difficult [5].

The community governance mechanisms struggled, particularly in West Africa where they were a common feature of the Bamako Initiative. Their functioning as intended relied on a level of community organization and capacity that did not always exist and was not systematically developed. Surveys revealed that most community members had little familiarity with management committees and the role they could play in them [28]. Their governance was found to have been captured by elites, resulting in "an absence of democracy" [30]. Most of the power was held in the hands of health personnel as patients continued to have few alternatives and lacked information to make demands. In many settings, the concept of "community participation" referred principally to "financial participation" through user fees [27].

An important role of community management committees that was found to have been systematically neglected was that of ensuring care for the worst-off. Exemption measures for the poor did not materialize. They are difficult to design and implement, often because these policies employ "ambiguous operational criteria" or definitions that are difficult and expensive to apply in practice (e.g., requiring household asset measurement) [21], [31]. The people most in need are often living in a state of precarity and social exclusion. This limits their capacity to be identified and surmount the administrative hurdles required. When criteria to identify the worst-off do exist, their targeting accuracy has proven to be limited. Some schemes were found to disproportionately benefit the "non-poor" – with one study uncovering that 70% of subsidies were utilized by those who did not meet the scheme's poverty criteria [32]. Moreover, evidence from existing schemes shows very low coverage, benefiting only a tiny sliver of the population (1 – 3.5%) [31].

The application of exemptions, including those for the worst-off, can also be undertaken on a "discretionary basis" by health personnel or administrators, however these actors may tend to ration care in the face of high levels of need and limited resources [28]. A study in Burkina Faso exposed the inability or unwillingness on the part of management committees to release funds for this purpose, and a clear tendency to hoard financial resources [20].

User fees were also found to be an inefficient way to finance healthcare in several ways. First, they were not found to be as ample a source of income as initially expected (15-20%). A 2004 review of 19 countries found that an average of only 6.9% of the public health expenditure came from user fee revenues [33]; another review found an average of 5% [34]. At the same time, the systems required to collect and manage user fees generate high administrative costs. In some countries, like Zambia, it was found that the cost of administering user fees exceeded the revenues they generated, yielding no additional funds for healthcare [13].

When revenues did remain, they sometimes "barely covered the cost of drugs, staff salaries and equipment maintenance" – allowing little for investments in strengthening or expanding primary health care services [28].

Due to the high fixed costs of providing healthcare (i.e., recurring spending on salaries, equipment, and infrastructure maintenance regardless of the number of patients), a change in demand can have an important effect on the average cost per patient. So, if utilization rates decrease because people can no longer afford care, the fixed costs of maintaining the health center are spread over fewer patients, which could actually mean higher costs per patient for delivering care. This is less efficient, particularly if the revenue is meager [25]. There is evidence from Burkina Faso that under the Bamako Initiative, the reduction in utilization did not allow revenues to keep up with increased spending on drugs (expenditures increased 2.7 times more than revenues) [20].

What is more, assumptions about the effects of user fees on the demand for healthcare proved inappropriate for the context. The elasticity of demand refers to "the percentage change in demand that comes in response from a percentage change in price" [35]. The price elasticity of demand for health is generally considered low - because people will pay a lot for good health, so prices can go up without significantly reducing demand. However, the elasticity of demand among low-income households and children is much higher, meaning that vulnerable people will be most adversely affected by the introduction of fees [25], [35].

Several studies have confirmed that even a small fee deters or strongly limits utilization overall and among the poor in particular. A study conducted in Niger in 1993 found a 32% drop in consultations among the poor after a fee of only 200 CFA (0.27 $) was introduced for care [36]. Another randomized control trial found that charging pregnant mothers even as little as 0.75$ for an insecticide treated bed net reduced demand by as much as 75% [13].

The improvements seen from the introduction of user fees were not sufficient to attract and retain patients. A study in Burkina Faso observed a 15% decrease in the number of consultations for curative care in a district after it adopted user fees, whereas a neighboring district that had not yet implemented the Bamako Initiative saw an increase of 30.5% [20].

Moreover, evidence does not support the hypothesis that decreases in utilization were observed because of the elimination of "over consumption" at low prices, but rather because of under-consumption due to the introduction of a financial barrier [25].

A study of the healthcare consumption habits of families in Mali during the pilot of a free care program found that "frivolous use" (using care when it was not needed) was very rare (3% of cases) – and that in fact, even with free care, the use of health services remained insufficient: 70% of children that needed care did not seek it [37]. There remain important indirect costs to seeking care that prohibit easy access, such as transportation, missed work, and others [19].

A health system that relies mainly on user fees for its financing is inherently inequitable, and precludes risk sharing, since the burden of payment falls mainly on the sick. User fees are also "the most regressive form of health financing available" because they consume a larger share of household income among the poor than the wealthy [38].

Evidence from the introduction of user fees shows overwhelmingly that it reduced service utilization far below levels that would be expected for good public health, and it also increased inequalities in access to care, disadvantaging the poor. In countries where user fees were introduced, utilization rates of healthcare were staggeringly low. In the 1990s in Niger only 11% of the poor and sick went to seek care, in Burkina Faso that rate was 17% and in Senegal 29% [27], [32].

The true cost of paying

Finally, it is important to look at the real cost of "utilization" for the families who still seek care, highlighting the effects on families who are willing to pay for healthcare, but who are limited in their ability to do so. Many of them endure what is termed "hardship spending", which can mean making huge sacrifices to make payments that "disrupt a household's usual consumption patterns or deplete their assets" [39]. Coping strategies can involve using savings, taking on debt, selling assets, or going without essential expenses such as food or school fees. A study of hardship

spending in 40 low- and middle-income countries (LMIC) found that over a quarter (25.9%) of households had to borrow money or sell items to pay for health care, and that this rate was higher in areas like West Africa with limited access to credit and insurance schemes [39].

Healthcare spending can create a dangerous “medical poverty trap” that pushes families into poverty and food insecurity that lasts long after the episode of illness [40]. The term “catastrophic expenditure” is used to describe situations where spending threatens a household’s ability to meet its basic needs. This has been studied particularly in relation to emergency obstetric care, which can be very expensive (requiring ambulances, surgery, blood transfusion, etc.). According to one study, although catastrophic expenditures were found to disproportionately affect the poorest quintile, it was also found that no socioeconomic group was spared, with even some wealthier households becoming financially ruined [41].

Some facilities engage in the illegal practice of medical detentions, where patients who are unable to pay, most often women and children, are not allowed to leave until someone comes to settle their bill. This is an egregious human rights violation and only further exacerbates their vulnerability [42].

Gathering funds, particularly by women who often need to go through other family members to access finances, uses precious time in emergencies that put lives in danger. The most common killers of children – malaria, acute respiratory infection, and gastroenteritis – all require timely access to care and can worsen quickly [43].

To avoid hardship spending, many families have no choice but to take risks, either by seeking care from traditional practitioners (who can sometimes accept informal or flexible payment) or self-medicating with drugs purchased at pharmacies. These products and practices can be ineffective or dangerous. Families may wait and see the progression of the illness, only seeking care when it reaches severe stages. When they do receive care, lack of funds could affect the completeness of their treatment, either by forcing them to purchase only part of their prescriptions or to miss follow-up appointments [44].

User fees act upon “three delays” [45]: the delay in the decision to seek care (e.g., wait and see), the delay in arrival at a health facility (e.g., finding money for transportation) and the delay in the provision of adequate care (e.g., if treatment is withheld before payment).

All of this evidence, summarized in **Table 1** below, forms a compelling case against payment at the point of care by patients and highlight the multiple ways it can contribute to increased morbidity, mortality, and suffering, particularly among the most vulnerable.

Table 1: *Comparison of the expected effects of the Bamako Initiative to evidence from its implementation*

Bamako Initiative Principles	Evidence from Implementation
• User fees are a reliable and effective way to generate revenue and will allow for improved access to primary health care.	• Allowed health centers to overcome funding shortfalls from diminished state budgets for health and improved the availability of drugs. • Revenues generated were below expectations and undercut by high fixed costs and new administrative costs. • Patient utilization rates decreased, particularly among the poor who are most sensitive to increases in price.
• User fees improve efficiency by reducing over consumption – ensuring care is provided for those who need it most.	• Little evidence of over-consumption, indirect costs remain on top of user fees. • Families frequently engage in hardship spending (incurring debts, selling assets, deprivation), delay care seeking, and/or self-medicate or receive partial treatment.
• User fees are a potentially equitable source of funding by subsidizing the poor/rural. • Special measures to protect the worse-off will be put into place.	• Indigent exemption measures complex to create and implement, unable to properly target at scale. • Resulting system is inequitable and regressive, without risk pooling (burden falls on the sick, consumes larger share of income among poor than wealthy).
• Community management mechanisms will improve participation and accountability.	• Community governance mechanisms struggled, sometimes captured by elites. • Accountability limited by inadequate information or alternatives.

1.3 A change in thinking and calls for the removal of user fees: on the road to universal health coverage (again).

In response to the evidence of the harmful effects of user fees on health, and after a decade of the Bamako Initiative, there began to be signs of a shift in thinking.

Calls and declarations in favor of repealing user fees began in the mid-2000s and grew into a chorus. Organizations that had been vocal critics of user fees from the start (e.g., Save the Children, Oxfam, Médecins du Monde, MSF),

were joined by the African Union and aid agencies expressing willingness to help governments that wanted to repeal them (e.g., DIFID, AFD) [46], [47].

Organizations that pioneered the Bamako Initiative (WHO, the World Bank, UNICEF) also began to realign. In 2007, the WHO Director General, Margaret Chan, said "if you want to reduce poverty, it makes sense to help governments abolish user fees" [48]. A few years later, she went further and said that "user fees punish the poor" [49]. The President of the World Bank, Dr. Jim Kim, reaffirmed at the World Health Assembly in 2013 that this form of payment was "unjust and unnecessary" [47]. As for UNICEF, despite earlier calling for action to work towards the elimination of user fees, their 2008 State of the World's Children report celebrated the achievements of the Bamako Initiative (to much condemnation) [26], [50], [51]. A year later, UNICEF declared itself "committed to support governments wishing to remove user fees for children and pregnant women" and funded a group to study how to do it [23]. Even some of the economists who were the Bamako Initiative's architects have come to express support for moving away from user fees [16], [52].

One can now speak of a broad, high-level, consensus against user fees [47], [53], which was confirmed by an analysis of 120 documents published by global health actors between 2005 and 2011 that found barely anyone who was not in favor of repealing them in some way [54]. A 2011 workshop on the topic in West Africa noted that it is "very rare to hear anyone proclaim loudly and clearly that they are against eliminating user fees. Of course, this does not mean that behind closed doors, or in small committees, the resistance to eliminating user fees has evaporated. Publicly, however, no one appears ready to call for re-institutionalizing user fees"[27].

There are indeed signs of the persistence of many of the ideas that led to the Bamako Initiative being developed, including that most patients should pay "something" at the point of care because they do not value and will misuse what is free. This has led to user fees being described as a "zombie idea" that has stubbornly refused to die for the past 30 years in the face of all the evidence of its ill effects [27].

Nevertheless, this paradigm shift began to have effects at the level of African policy around the same time. South Africa was a pioneer, making healthcare free following the end of apartheid in 1994. Uganda was also an early adopter, removing user fees in 2001, and seeing a large increase in outpatient utilization and evidence that it was benefitting the poor. This experience helped to inspire several other countries soon after [46]. By 2011, 17 more countries had removed user fees at least partially and momentum was accelerating [55]. By 2018, 80% of the countries that had introduced user fees (37 of the 41) had implemented reforms to reduce or eliminate them [53].

Governments took this route for a number of different reasons, including international and domestic pressure (and money) to address stagnant health indicators and to reach the Millennium Development Goals. Repealing user fees may also have been considered a policy option that was within reach and relatively "easy to implement in a top down and rapid way with public resources" – especially compared to setting up health insurance schemes like those in Rwanda or Ghana [56], [57].

The specifics of which fees were removed also varied across the continent. Some countries tended towards a more "universal" approach, such as repealing fees for all citizens in public health facilities, although in practice some exceptions remain (e.g., still charging for elective care or diagnostics). This is the case mainly in Anglophone Africa. On the other hand, other reforms focused on specific beneficiary groups, such as "pathology-based exemptions" or "categorical targeting" approaches. These only benefited, for example, people living with HIV/AIDS, cancer, pregnant women (all deliveries or just cesarians), or children under a certain age. This approach was more common in Francophone West African countries, where there has been more resistance to abolishing user fees altogether [26], [58]. Finally, another less common approach used was "geographical targeting" for programs, such as the case of Senegal which targeted rural areas [12], [57].

The third Sustainable Development Goal (SDG), to "ensure healthy lives and promote wellbeing for all at all ages" explicitly sets out the objective of "achieving Universal Health Coverage (UHC)" by 2030. UHC is defined as "ensuring timely access to quality healthcare without financial hardship," and can be assessed along 3 dimensions: the size of the population covered, the proportion of direct costs covered, and the package of services covered [5].

The approach of selectively removing user fees for some groups, or "targeted free care," is often framed as one step on the road towards the long-term goal of achieving Universal Health Coverage, that begins with prioritizing the most vulnerable.

Since the inclusion of UHC as an SDG in 2015, a whole global health apparatus has mobilized around it, including advocacy groups, international programs for policy dialogue, national working groups, research teams, experts, and technical assistants. Governments have ratified national conventions and are making commitments to achieve UHC by 2030 [59].

Okay, remove user fees, but how? A look at health insurance systems

Beyond the "consensus" that user fees are nefarious, there lies a growing debate about what to replace them with. After all, there is always someone who pays, either directly or indirectly.

The WHO particularly highlights the promise of "risk pooling with pre-payment" as a means to ensure financial risk protection [60], [61]. This means that, unlike unpredictable and sometimes catastrophic out of pocket payment by patients during an episode of illness, patients make regular pre-payments into schemes that get pooled with the contributions of others, thus diffusing their risk. There are several options for pre-payment, including tax financed government schemes (e.g., national health service) or contributory health insurance.

The tax financed schemes, where enrollment is generally "automatic," have the potential of extending comprehensive coverage to the whole population, raising revenue from a broader tax base, and containing costs through vertical integration.

On the other hand, health insurance schemes require members to enroll, and their coverage can be conditioned on the payment of premiums, and limited by deductibles, co-payments, or coinsurance [1] (paid either directly or by someone on their behalf). The comparative advantage of these schemes is the revenue they generate directly from their members, sometimes in addition to public funds. Different forms of health insurance exist, including compulsory health insurance (e.g., public social insurance schemes required for civil servants), or voluntary health insurance (e.g., private health insurance) [62].

The health insurance route has gained favor among advocates of pre-payment, including the WHO, and many LMIC are turning towards it as an alternative to out-of-pocket spending. It is also possible to integrate targeted free care within the framework of health insurance, by subsidizing the enrollment fees and contributions of particular patient categories. This is an approach taken by Ghana for pregnant women and by Senegal for the poor [56].

However, setting up health insurance systems in Sub-Saharan Africa (SSA) has proven to be slow and complex and their performance is limited in several important ways.

A recent study of 36 countries in SSA [62], found very weak coverage rates. Only 4 countries had coverage levels of any type of insurance (public, private or community based) above 20%, and only 8 countries above 10%. Overall health insurance coverage across all 36 countries was very low (less than 8% on average). The low coverage of these schemes can be attributed to many factors, including the large portion of the economy that is informal, the high levels of poverty, as well as the relative newness of some of the schemes. In most cases, enrollment is voluntary or becomes "de-facto voluntary" because the enforcement of the laws on the books is ineffective, as in the case of Kenya. Voluntary schemes are known to result in "lower coverage, lower retention, adverse selection, inequity, and questionable financial sustainability" [62].

[1] *Premium*: the amount you pay for your health insurance every month (i.e., enrollment fee). *Deductible*: the amount you pay for covered health care services before your insurance plan starts to pay. *Copayment*: a fixed amount you pay for a covered health care service after you've paid your deductible. *Coinsurance*: the percentage of costs of a covered health care service you pay after you've paid your deductible. [234]

The 36-country analysis also found that enrollment tended to be higher among the rich and better educated [62]. This association with economic status is unsurprising since member contributions create a barrier to access for those with limited means similar to user fees. There is evidence that member contributions depress demand for care even among the enrolled. A study from Rwanda found that removing co-payments for health insurance tripled utilization within a month [63].

Inequity in enrollment is also explained in part by the history of the emergence of the different schemes, with the first and most established being social insurance schemes for government and private sector employees who tend to be better-off. The incremental approach to expanding health coverage generally leads to the creation of multiple risk pools for different groups with different levels of coverage [62]. It can be politically difficult to integrate or harmonize these pools, because it involves a redistribution of resources. Those enrolled in the more generous social health insurance scheme are likely to resist this change, and they generally belong to an influential political and economic elite with preferential access to healthcare and policy makers [35].

Community-based health insurance (CBHI) schemes are those characterized by members of the same community pooling funds together, often on a voluntary basis. This "bottom-up" approach is often referred to by its French name, "Mutuelles." A study of such programs found higher rates of service utilization and lower out-of-pocket payments among members compared to non-members. However, it also found very little evidence of their capacity for broad and equitable population coverage, their cost-effectiveness given high administrative costs, or their financial or technical sustainability [28], [59].

A general review of LMIC experience with health insurance found that the best performing schemes in terms of enrollment tended to be those that were publicly owned and significantly tax funded instead of depending on voluntary contributions, with funding from a mix of general taxes, special taxes, and social security funds. This was the case for three of the four top performing schemes in sub-Saharan Africa (Ghana, Rwanda, Gabon) and several in Asia (Vietnam, Philippines, and Thailand) [62].

However, even these national tax funded schemes are not immune to challenges. Ghana's National Health Insurance Scheme (the NHIS), often heralded as a model to emulate, took a great deal of time to operationalize the free enrollment for the poor - existing on paper since 2004, but fully functional only since 2013 [64]. The NHIS also has an uncertain future. According to a World Bank assessment from 2012, it had "serious structural and operational inefficiencies and (was) on a trajectory to go bankrupt" [65]. These schemes are only as sustainable as the financing and support they receive from the government, and they are very expensive.

Most countries that aspire to offer TFC through a national health insurance scheme are faced with the reality that most of their population is currently uninsured, making their integration challenging. The requirement of beneficiary enrollment to access free services presents an important administrative burden and is likely to be an inequitable barrier. In the face of imperfect evidence of what works, important performance issues, and new implementation challenges, it is unsurprising that there is little consensus on how to achieve UHC [66].

1.4 The effects of removing user fees: positive but not a panacea

A theory of change for removing user fees: how it is supposed to work

From the evidence presented above, it can be expected that removing the financial barrier posed by user fees will not only protect people from financial risk during illness, but it will also improve the utilization, timing, quality, and completeness of care, which will in turn, equitably improve health outcomes.

The economic logic of removing user fees supports this, however it poses several important caveats. For example, it follows that *if all other things are held constant*, and prices are lowered, the quantity demanded for a product or service will increase. Therefore, *if quality and price drop simultaneously*, the effects on demand are unknown, and will depend on the availability of alternatives (i.e., the presence of substitution effects) [67].

Next, it follows that utilization depends on price elasticity of demand, and poor households are more sensitive to price reduction than richer ones, therefore we can expect the poorest will benefit most from removing user fees. However, *if other barriers (geographical, informational) exist and these disproportionately affect the poor*, this may damper or reverse this equity effect. *If the price drop is insufficient to make it truly accessible to the very poor*, it will disproportionately benefit the rich [23].

Finally, the choices of patients are governed by much more than price. The effect size of removing user fees on utilization will also vary based on the perceived quality of care, underlying epidemiology of disease, the subjective perceptions of illness, and the availability and control of resources at the individual level (e.g., women's independent financial decision-making power) [68]. Other factors that affect a patient's choice to use free care are trust, risk awareness, and acceptability [69].

This points to several conditions that need to be met for the theory of change to hold up, and for repealing user fees to have its intended effects. The payments made by patients at the point of care need to be replaced by a sufficient, reliable alternative. In addition, the new payment mechanism must be able to maintain (or preferably improve) quality of care and patient trust. Other barriers that disproportionately affect the poor, such as transportation costs, must not be overlooked if policies are to be equitable.

What have we learned from repealing user fees so far?

We can look at several decades of experience removing user fees across Africa to learn from the processes and effects documented.

First, repealing user fees resulted in a clear increase in service utilization; this was noted across the continent, including studies conducted in Uganda, Ghana, Burkina Faso, Niger, Kenya, Senegal, and Sierra Leone [58], [70]–[72]. In several cases, like Zambia, medium to long-term trends were characterized by a large initial increase, which eroded over time and stabilized above user fee levels [73]. The size of the increase was at times remarkable, such as

in Niger in 2009, where it was found that after removing user fees the proportion of sick children who sought care was 70%, compared to 14% before [74].

Evidence on the equity of the improvements is more mixed and tended to across different settings and different types of fee removal reforms. In some cases, fee exemptions benefitted the poorest, most rural, and least educated [58], [70], [75], [76]. However, they seldom eliminated pre-existing inequities, and at times made them worse [77].

Positive effects were also documented on household spending on health services subject to fee exemptions, for example household spending on cesarian sections decreased by 53% in Benin and by 93% in Morocco. The introduction of exemptions schemes also reduced the incidence of catastrophic spending. However, it was found that households rarely spent nothing at the point of care; being forced to pay for things that were not covered or actually meant to be free [70].

Several studies found reduced mortality among children and lower-income populations following the introduction of user fee exemptions, although their study designs are generally not robust. Repealing user fees was associated with an estimated 9% reduction in the neonatal mortality rate in Kenya, Ghana, and Senegal [72]. There was also evidence from a pilot project in Sierra Leone conducted with MSF that repealed user fees for the entire population – with an observed reduction in overall mortality from 1.7 deaths per 10,000 persons per day to 0.7, and child mortality from 3.5 deaths per 10,000 to 1.3 [71].

However, over two decades of removing user fees also led to calls for "careful action" to achieve the desired health gains and protect against unintended effects [38], [78]. Even activist organizations like Médecins du Monde, who have been against the introduction of user fees since before the Bamako Initiative, acknowledge that there are serious risks:

> *"In many countries, due to lack of preparation and/or any genuine political will, the decision to provide free access to healthcare has soon come up against huge difficulties in implementation with the only final result*

being the further destabilization of health systems that are already largely failing. Initially made to improve access to healthcare, the hasty introduction of payment exemption has sometimes ended in the opposite situation by increasing drug shortages and/or de-motivation of health workers" [79].

Indeed, experiences with the implementation of targeted free care initiatives in West Africa revealed the considerable strain it put on health systems. Many policies suffered from a "triple breakdown: technically, financially and in communication" with "hasty decisions" being taken without sufficient stakeholder involvement [12].

Several significant negative effects of removing user fees have been documented, leading to the critique that it is an undesirable trade-off between quality and quantity [80]. These are discussed in detail in Part 2.

Even if evidence of the benefits of removing user fees is clear and compelling, it is also clear that doing so is difficult and risky. "User fees cannot be removed with the stroke of a pen, the removal needs careful preparation, requires accompanying measures (especially in terms of drug supply and staff motivation) and deserves close monitoring and evaluation" [81]. There remains skepticism and concern, informed by experience, about the capacity of many states to sustainably finance and effectively implement these schemes. As stated by political scientists and sympathetic observers Pressman and Wildavsky, "good ideas are not worth much if they can't be implemented" [82] – and indeed the challenge with TFC lies in its implementation.

PART 2: Understanding best practices for how to remove user fees

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2.1 Removing user fees: what other sub-Saharan African countries can teach us about what to do (and what to avoid).

After many years of sparse evidence on targeted free care reforms in francophone West Africa (by the end of 2009, only a single scientific article had been published), two large-scale multi-country research projects were carried out that provide a rich backdrop of learning for policy makers in Mali [12], [83]. Several authors have also come up with lists of "best practices" [68] and even drafted guidebooks for policy makers (e.g., Save the Children [84], UNICEF [23]).

Nevertheless, an analysis of the policy implementation of targeted free care in several countries across sub-Saharan Africa found that technicians implementing these policies "often face the same operational challenges, sometimes making the same mistakes, and do not draw enough inspiration from similar experiences" [85].

Part 2 presents a synthesis developed by the author that draws from the published guidance and international experiences identified in the literature review, as well as general policy change frameworks such as Getting Health Reform Right [35] and Problem Driven Iterative Adaptation [2]. Since every step is political as much as it is technical, this section also draws on theories of change management [86] and adaptive leadership [1], aiming to marry technical guidance with considerations related to the adaptive nature of the challenge.

The 14 best practices for targeted free care distilled here are listed in **Table 2** below, and roughly categorized into the stages of preparation, design, and delivery. However, they are not intended to be carried out in strict sequential order, nor are they meant to occur independently of one another. Several should be undertaken in parallel, or iteratively together – such as exploring TFC financing (# 9) and ensuring high-level support (# 2) or defining the care package and beneficiary groups (#7).

Every best practice is very important, but some are highlighted as being critical or essential (indicated with **), without which the policy would not only be dysfunctional, but it would simply not work (e.g., having a functioning provider payment mechanism, #11).

Each best practice is described in detail and presented with examples of experiences from elsewhere in sub-Saharan Africa when possible.[2] Afterwards, **Table 3** presents a condensed synopsis of all 14 with their core elements. Section 2.2 at the end provides a summary reflection on the nature of the challenge and capability needed.

***Table 2**: 14 best practices for targeted free care policy reform*

(** = essential)

Preparation	**1** - Conduct a preliminary situational analysis **** 2 -** Ensure high-level national authorization, support, and leadership **** 3 -** Put in place a dedicated, authorized, and well-resourced coordination unit **4 -** Design a sequenced, adaptive plan with learning at each step **** 5 -** Assess revenue sources and plan financing **** 6 -** Actively engage stakeholders throughout the process **7 -** Engage strategically with technical assistants and development partners
Design	**8 -** Assess different options and define the beneficiary population and benefits package **9 -** Ensure harmonization with other reforms **10 -** Develop a clear communication strategy **** 11 -** Design a provider payment mechanism **** 12 -** Define the institutional arrangement and the roles and responsibilities of the payer
Delivery	**13 -** Identify minimal standards and carry out service delivery upgrades **14 -** Set-up M&E systems to generate timely information on functioning and performance

[2] Because countries' user fee removal policies are dynamic, the information provided in the international examples may not always reflect the very latest data or policy specifics.

1: Conduct a preliminary situational analysis

It is important to conduct an analysis of the startup position of the country and its health system to understand how TFC fits into the picture [68].

This analysis should begin zoomed out, taking stock of the country's overall political stability, as well as demographic and economic trends (e.g., external debt, revenue generation capacity, main sources of aid) [85]. After that, reformers should undertake a "diagnostic journey" into the health system, to understand how it looks and performs [35].

To start, a health system can be understood as being controlled by 5 "control knobs" [35]. TFC, like most large reforms, affects several at once, and so it is key to understand their "initial settings." The first two control knobs are financing, which refers to how money is raised, risk pooled, and funds allocated, and payment, which refers to what and how providers are paid.

These dimensions are core to TFC and deserve a good deal of attention, as they will inform what is possible in terms of the scope and design of the reform. This analysis should explore the national budget for health, the size of donor funding, the importance of user fees relative to household income (an indicator of the likely unmet need for healthcare), the effectiveness of existing insurance and exemption schemes, and the relative contribution of cost recovery to financing, including how much is retained at health centers [68], [85].

TFC also affects the three other control knobs. These are organization**,** which refers to how activities in the health system are divided among entities and their relationships (e.g., centralized vs. decentralized); regulation, which refers to how governments try to affect the behavior of actors in the system through rules, incentives, and sanctions; and finally, behavior which refers to how the population behaves related to health and healthcare seeking.

Next, it is critical to undertake an analysis of the performance of the health system to understand its strengths and weaknesses, and to target the goals of the reform. Key dimensions of performance to investigate are the health status of the population, popular satisfaction, and financial risk protection, as well as access, quality, and efficiency [35].

Experts with deep contextual knowledge need to be identified and the history learnt [55]. Site visits are helpful when data are incomplete or unreliable. This will help to figure out what has been tried before, what works and what does not, and why things look the way they do. On this "diagnostic journey" it has been suggested to ask *why* at least 5 times to delve beyond the superficial and descriptive [35], [87].

On this journey, it should become clear if user fees are a problem, how big, and for whom. Data can be used to elucidate the importance of the problem, and a case can be made using benchmarking – that is comparing one's own performance against similar countries or looking at disparities in equity within the country between regions, income levels or ethnic groups.

However, the salience of the problem is also created through national social and cultural forces, as well as changes in the broader global ecosystem of international agencies and their agendas. To address a problem, it needs to be "constructed as a problem that matters" [87]. The issue needs to be "ripe" – which is "when the urgency to deal with it has become generalized across the system" [1]. The situational analysis needs to determine the ripeness and sense of urgency around the issue [86], because it will inform the strategic approach to take.

This is complicated because not everyone sees a problem the same way, and their view is often based on their interests and relationship to it. Some may confuse a problem with the absence of a particular solution or fail to define it in terms of outcomes. Heifetz and Lipsky warn against "a myth that drives many change initiatives into the ground: that the organization needs to change because it is broken" [1]. In fact, the system in question is the way it is because those with the most power or leverage in it want it that way. It may only appear "dysfunctional" to some

factions in the system or to outsiders – to others, it is preferable to change "where the consequences are unpredictable and likely to involve losses" [1].

To explore this, it is helpful to conduct a rapid stakeholder analysis. This will help to understand the ways in which the problem of user fees is one that is "routinely ignored or accepted as normal or unavoidable (or too difficult or risky to address)" [87]. Stakeholder analysis is discussed in more detail in Part 4.

After the diagnosis and problem construction, it is also paramount to consider what is technically, financially, administratively, and politically possible in the context. It is advisable to roughly estimate how much the reform would cost based on the likely service package and expected increase in utilization. It must be determined how appropriate TFC is as a policy option to address the causes of poor performance, and its relative advantage/disadvantage compared to alternatives for removing user fees (e.g., the health insurance route).

In exploring the design space for TFC, reformers can look to other countries' experiences, which can provide inspiration and cautionary tales, as well as look outside of the health sector (e.g., when free primary school education was introduced). The golden rule of "imitate but adapt" is sometimes only nominally followed, with many policies looking in effect strikingly similar across contexts [88]. It is also important to look nationally at existing practice and search for positive outliers, and to identify home-grown innovation worth amplifying [87].

International examples:

- **Niger**: prior to introducing the total fee exemption for children under 5, no budget studies or feasibility studies were carried out ahead of time. A World Bank study which highlighted the considerable cost of these measures and many conditions to be met to make it successful was "dismissed by the Ministry of Health" [12].
- **Ghana**: it appears that no comprehensive estimates of the cost of folding the delivery exemption policy into the NHIS was conducted before the reform was introduced. Most respondents in one study seemed

unaware of the lessons learned from the earlier phase of maternal delivery exemptions, despite this still being in force at the time of the NHIS-based exemption policy, and despite it having collapsed due to lack of funding. Many of the same problems were identified in the old and new policies [89].

2: Ensure high-level national authorization, support, and leadership

When undertaking a reform like TFC, it is important to assess ones *authorizing environment*, that is the support available from actors in positions of authority who can confer legitimacy, backing, protection, approvals, and ultimately "say yes or no" to allow the reform initiative to move forward. TFC may cross over several jurisdictional domains (health system, but also local government, finance, labor, etc.) [87]. The spaces for political decision may vary – depending on the relative role of political parties, executive actors, legislative bodies, and bureaucracies.

It is important to delineate what authority is needed, where it can be found, and how it can be expanded in order to effectively carry out change. It is vital to think strategically about all authorization needs, not just the gaps, in order to avoid "authority blind spots" [87]. The person commonly called "the champion" or identified as "the leader" most often plays three functional roles: authorizer, motivator, and convener. They very seldom can play more.

To start, for a targeted free care reform to succeed, a credible national vision is necessary [55], [86]. This should ideally be carried and owned by national leadership, as it will provide the essential support (including financing), political cover, and authorization for those undertaking the reform and help them to overcome resistance. This vision requires crafting a narrative that goes beyond statistics and data and appeals to values and interests.[3]

[3] For instance, it could be more powerful to communicate the maternal mortality ratio of 587 deaths per 100,000 live births as 4449 maternal deaths per year – or 12 mothers lost every day – to reinforce the sense of urgency.

Executive level support, either from a President or Prime Minister, can be instrumental for consolidating buy-in and alignment across government, especially from the Ministry of Finance. High level leaders are also able to obtain major donor commitments that may be out of reach for a single ministry.

However, high-level support also carries risks and must be cultivated carefully. A president may have limited experience in health financing, which could lead them to underestimate the technical difficulties involved. They also operate with a different time horizon and set of incentives than Ministry of Health technicians, preferring bold change and speed, motivated by populist impulses that could be heightened around an election (or political crisis). Coordination around the timing and content of the announcement is ideal to avoid creating expectations that cannot be met [85].

Ministers of Health often play a critical role in TFC reforms. However, it should not be assumed that their office sits atop a typical Weberian hierarchical bureaucracy, in which decisions are made at the top, communicated effectively downwards, and implemented as ordered. In reality, local authorizing environments are often fragmented, dynamic, informal, and relationship driven. Making progress on an adaptive challenge like TFC requires going beyond a single authority figure, as the locus of work is mainly with stakeholders [1]. Ministers of Health will need to actively develop their own authorization to lead the policy effort, both within an around their ministry. To do this, they will not only need to garner political will, but also exercise political skill [35]. Those active in the reform trenches will need to help them to secure and expand their legitimacy – by providing them updates about progress made, learning, achievements - what one can call “soundbite legitimacy” [87].

The interaction between the political and technical realms can generally take on two directions. “Politicians first and technicians second” is when the political decision comes first, and technicians are then asked to flesh it out and implement it. Alternatively, “technicians first and politicians second” occurs when technicians develop a reform idea and bring it to politicians for authorization and support [90]. A hybrid is also possible, and each approach carries risks. The former may not fit the reality of the context, and the latter may potentially fall on deaf ears. It is helpful to look at the history of recent reforms to see which channel was used and why.

It should also be noted that ministers in sub-Saharan Africa often remain in their position for a remarkably short amount of time: often less than a year, frequently less than two. Turnover can interrupt the momentum and continuity of reform efforts. When a new actor enters the political system, they may want to create their own vision or legacy. Alternatively, if they feel their mandate to lead is weak, they may seek to conserve political capital and opt to protect the status quo [35].

International examples:

- **Uganda**: after several studies highlighting the issue, the problem of user fees was brought up during a presidential election campaign by all opponents of the incumbent president, who promised to remove user fees if elected. The Ministry of Health had been working on ways to abolish user fees for some time before the announcement but had not reached a consensus on the way to approach the reform or garnered sufficient political support [46], [91].
- **Ghana**: the presidential announcement of free care for pregnant women through the National Health Insurance Scheme in 2008 came following a visit from the president to the UK where he was able to secure funds to support the policy. It needed to be prepared quickly as the president announced that it would be launched on a fixed date – July 1st, a public holiday [89].
- **Niger, Burkina Faso**: reforms in these countries came from the president as a sudden and top-down decision, taken in the context of elections. These announcements took the Ministry of Health and health experts by surprise, coming "out of the blue." Most actors interviewed expressed deep skepticism of the state's ability to effectively finance and implement targeted free care policies and described the choice to adopt them as "political" [12].

3. Put in place a dedicated, empowered, and well-resourced coordination unit

A unit of capable technicians to shepherd the policy making process is critical. This group must be sufficiently protected and resourced in terms of their time, decision rights, authorization, and legitimacy to lead the reform work. This group can also be a focus for performance related accountability [55]. It may be beneficial for the group's creation to be formalized, such as through a legal edict, to ensure these conditions are met.

It can take different forms and names: policy implementation unit (PIU), change team, task force, steering committee, technical working group, etc. Some such groups may already exist and could provide a template for what works (or does not). The roles it must perform are both technical and managerial and include coordination and process management, data gathering and analysis, and technical decision making [85]. These could be split among different complementary groups connected through a central core (e.g., snowflake shape).

Its location vis à vis government can vary. It could take the form of an advisory group to the President's office, a congressional commission charged with drafting new legislation, or an ad hoc committee to advice the Minister of Health. Some common traits of successful "change teams" identified in the literature included ideological cohesiveness, high technical skills, and the ability to work in isolation and use policy networks [35].

It may be difficult to immediately achieve consensus around technical questions. It takes time to elicit and resolve the disagreements under the surface of a policy consensus. For example, some actors who have piloted a particular scheme may expect their model to simply be scaled up. The adaptive leadership of this group must be able to create a "holding environment"[4] that fosters a safe space for active, constructive problem-solving work [1]. To be effective, the change team must also be allowed to work "outside of formal boundaries, expectations and protocol" [86]. This may not be easy in government bureaucracies.

[4] The concept of "holding environment," borrowed from Heifetz and Lipsky [1], refers to the bonds (e.g., rules and norms, or affiliation and familiarity) that serve to keep people engaged with one another and to contain conflict, despite the divisive forces generated by adaptive work.

Its composition should ideally be multi-disciplinary due to the technical complexity of free care reforms. Global health policy making tends to be dominated by economists and doctors, and perhaps increasingly, management consultants. Ministry of Health technicians are often physicians who are self-taught managers. Therefore, providing technical assistance or coaching around management could be helpful, in addition to other under-represented specialized skills as needed (e.g., actuarial analysis, health financing modeling, computer system design). A gap analysis is helpful to ensure the required capacity and skillsets are available.

The group at the core of the reform should be able to tap into different perspectives (front-line workers, mid-line managers, etc.) to work out the reform's technical "implementability" and political acceptability. This provides reality-checking to "help protect experts from becoming prisoners of their own enthusiasm" [35]. An inclusive process also lends legitimacy to the policy it produces and minimizes hostility and suspicion. "Change moves at the speed of trust [92]" and so the group must cultivate this actively in how they approach their work. They should strive to form a "powerful guiding coalition"[86] to unite people behind TFC. However, inclusivity must also be skillfully managed, to prevent a loss of forward momentum or deadlock, and knowing that "large groups of people are seldom capable of serious analytical work" [35].

International examples:

- **Sierra Leone**: working groups and a steering committee were established following the presidential announcement but before the pre-determined launch date, and this helped to structure the preparation for their Free Health Care Initiative (FHCI). The different working groups were organized around the health system strengthening package that was to be delivered alongside free care and included: financing; infrastructure; drugs and logistics; monitoring and evaluation; human resources; and communications [71].
- **Niger**: the free healthcare services steering committee was created in 2010, five years after the implementation of the user fee exemption for cesareans and 4 years after the exemption for children under 5 [93].

- **Burundi**: the coordination mechanisms set up in response to the presidential announcement of free care led to "better coordination between the Ministry of Health and its partners" [57].

4. Assess revenue sources and plan financing

Significant medium to long-term commitments from governments to fund a TFC reform are crucial and unavoidable [55]. The state must be ready to pay a significant portion of fees instead of patients and offset lost revenue to providers. Without this, the policy cannot properly function. Insufficient funding is a root cause of most of the negative effects of free care policies, and yet underfunding was an issue seen across nearly all countries studied [94].

Targeted free care announcements must be accompanied (or preferably preceded) by increased funding for health. Opportunities to expand the fiscal space to take on TFC must be explored, which could include increasing the domestic budget for health, ringfenced health funding, or cross-subsidizing from health insurance contributions. "Innovative financing mechanisms" are another category that can include among others special or earmarked taxes (e.g., "sin taxes" on tobacco or alcohol, or taxes on airlines or financial transactions) [71], diaspora solidarity bonds [95], and the G8 debt cancellation initiative known as the Heavily Indebted Poor Countries (HIPC) Initiative, which was utilized by Uganda, Senegal, Ghana, and Burundi, to fund user fee removal [46].

The 2001 commitment made by African Union member states to spend at least 15% of government budgets on health, known as the Abuja Declaration, is a helpful but seldom followed advocacy tool (in 2018, only 2 countries in Africa had met it [96]). Fiscal space is generally limited by having large portions of the population who work in the informal economy and narrow tax bases [62]. Other considerations are around the state's public financing capability – including absorption and disbursement.

In addition, it must be highlighted that most financing discussions around TFC will happen outside of the Ministry of Health. The Ministry of Finance generally decides what is possible as it relates to "overall macro-economic policy

and commitments made by the state to its external partners, including the International Monetary Fund" [94]. Financing for TFC programs in the national budget are subject to competition from other sectors, possibly resulting in amounts voted into budgets that are not sufficient to meet demand [93]. Involving the Ministry of Finance early in the design and costing of TFC would be preferable.

External donor funding should be taken on cautiously, given its unsustainability. Although it can help to cover essential upfront development and implementation costs, it is concerning when program functioning is highly donor dependent. Donor funds may tend to be easier to mobilize for free care initiatives that target a disease aligned with a donor focus, most clearly exemplified by HIV (i.e., PEPFAR, Global Fund, UNAIDS). For non-disease specific programs targeting vulnerable populations, the funding has more often been national in origin (e.g., the elderly in Senegal, pregnant women in Burkina Faso) [93] (working with international partners is discussed further in Best Practice #7).

International examples:

- **Uganda**: the government secured initial funding of $12.5 million USD for the first fiscal year of their universal free care scheme, and an initial purchase of medicines worth $ 500,000 USD. The country stands out, according to one review, as the only country to have "secured a larger annual budget for the health sector." Subsidies for recurrent expenditure (non-salaries) increased by 165% for health centers and 66% for hospitals. It appears in recent years that this has declined. [46], [58].
- **Ghana**: The NHIS is funded by a specific value-added tax (VAT) of 2.5%. An early evaluation of integrating the free delivery program into the NHIS in 2008 found that no pre-launch costing and budgeting process was done, the Ministry of Finance was not aware of any additional allocation to the Ministry of Health for this policy, and no government budget line for this policy existed. Although the UK supported this policy, their amount of aid allocated to the country did not increase, so "in reality there was no new money for this policy" [89].

- **Burundi**: donor money was mobilized as "emergency" support to their targeted free care programs following the unexpected presidential announcement, an approach described as "damage control" [57].
- **Niger**: funding for targeted free care reimbursements came from the state budget and emergency budgetary aid from France (2006-10) – however, not only were these reimbursement levels insufficient to cover the annual costs, but the state also did not honor its commitments. Of an estimated $14 million USD required in 2007, only $ 5 million USD were assigned under the Finance Act, and only 37% of this amount was disbursed. The accumulated debt owed to health facilities by the government of Niger was estimated to have reached over $35 million dollars in 2013 [12].

5. Design a sequenced, adaptive plan with learning at each step

Like any reform, TFC needs a clear plan to understand what needs to be done, in what order, and by whom. Given its complexity, TFC must be "deconstructed into a problem that is manageable" – or one that is broken down into a "manageable set of focal points for engagement" [87].

When considering the sequencing of activities, one can assess them along three dimensions: authority (the support needed to effect the change), acceptance (the extent to which those affected by the change accept the need for it and its implications), and ability (the practical elements: time, money, skills) [87].

Actions should be sequenced in a way that allows for pursuing short- and medium-term successes, or "quick wins", which are vital when dealing with a big problem like user fees [86], [87]. It makes sense to first take on and consolidate activities which are easiest in terms of authority, acceptance, and ability, to create momentum [86].

However, when beginning to plan how to tackle TFC, one must also acknowledge when information is deficient, and knowledge is limited. For example, how much is known about the intended policy design, its likely performance, and its likely interaction with existing processes?

The classic approach of "plan and control," in which project management is akin to following a recipe or list of activities set out in a GANTT chart, will inevitably confront limitations in a dynamic context full of "unknowns".

A more flexible and adaptive work plan is likely to be more successful. One such example is a *Searchframe* [87], which unlike a Logframe, does not specify every action step that will be taken. Instead, it consists of a structured process of finding and fitting solutions, organized into a "schedule of iterations between focal points," where the aspirational end point captures "what the problem looks like solved." It provides built-in flexibility and learning for those at the center of the work.

International experience has shown that some TFC implementation steps are systematically underestimated in terms of their time and complexity, such as drug purchasing, where it can take several months for drugs to be ordered, delivered, duty exemptions to be negotiated, and storage space to be available. Other examples include developing and disseminating clear guidelines for frontline workers and adopting new legislation or regulations [12].

To pilot or not to pilot?

An important question that is often addressed at this stage is whether to conduct a pilot (in cases where one has not been done). A pilot project can provide an opportunity for learning, adaptation, and gathering contextualized evidence. It allows for tools and systems to be tested in-vivo, and for weaknesses in capacity and design to be worked out.

The most compelling evidence of the benefits of removing user fees in West Africa comes from pilot projects that received significant technical support from NGOs, including MSF in Mali, Terre des Hommes in Burkina Faso, Médecins du Monde in Niger, or from longer term partnerships like that of Muso in Mali [97].

Despite generating design insights and evidence of impact that are critical for advocacy, there are pitfalls to NGO-led pilots. In addition to their inherent temporality, they often circumvent the real-world constraints of dysfunctional public drug procurement and output-based payment systems. The package of measures included to enhance quality creates conditions that are completely divorced from the reality of an average health center. Of course, the infusion of resources, training, and enhanced supervision make sense to include in a pilot design, as those leading the reform are aiming for the best possible version of health care provision – which is core to their mission.

The problem comes when these "pockets of efficiency and plenty," which are dependent on external support, exist outside of the national bureaucracy. They effectively mask all the "practical norms, limitations, shortcomings and contradictions" that are omnipresent in the health system [97].

Without the extra assistance, the new ways of working at the pilot site cannot be sustained, jeopardizing the hard-earned gains at the end of the pilot period. In addition, when the capacity of the state to provide the same level of inputs is simply absent, the national scaling of these models is impossible by design. This effectively limits what can be learned from them for national implementation, with some going as far as arguing this "makes them irrelevant to the scaling-up process" [97].

To maximize the usefulness of a TFC pilot, it should be strongly government led, its design should be integrated as much as possible within "ordinary" health system capacity and existing national processes, as well as be rigorously evaluated.

How to roll-out or scale?

An alternative to an NGO-funded pilot is a strategy of progressive national policy scale-up [27]. This gradual scale-up approach may be necessary in some contexts for practical reasons, such as in particularly vast countries, where implementation capacity is limited. This approach can relieve some of the pressure on technicians who are spread thin [57]. However, with TFC, a progressive roll-out may create unanticipated effects, such as patients moving massively from one catchment area without targeted free care to one with it, which complicates planning [85].

On the other hand, sometimes a "big bang" approach – with national scale up at once - may be unavoidable. This could be because a new law is adopted or because progressive scale-up is unpalatable to politicians who need to manage optics and constituents [27], [57]. Nevertheless, the challenge and risks of this "explosion" approach (where an intervention is devised and scaled with haste), are evident. One cannot effectively scale something when they do not know exactly what they are scaling, how it will fit the many contexts they are scaling to, or when they lack trust and acceptance from those who have to adopt and then live with the new thing they are scaling [87].

International examples:

- A review of TFC in 6 SSA countries found that policy implementation occurred in a "rather unplanned way," as well as a split between national implementation and progressive scaling strategies. Among countries that opted for a gradual roll-out, the review did not find "significant evidence that countries which proceeded gradually really took benefit from the possibility to learn from early steps" [57].
- **Niger**: where the policy announcement caught specialized staff in the ministry "completely off-guard", measures were "rushed through" with hastily defined mechanisms, procedures and texts being produced in a "piecemeal and usually incomplete basis, and in some cases belatedly." The targeted free care policy for children under 5 was introduced nationally without waiting for the results of NGO-funded experiments in two districts to be available [12].

6. Actively engage stakeholders throughout the process

The adoption of TFC will be influenced by the power, skills, and resources of its advocates and its opponents. Relevant stakeholders include state actors both at the central and peripheral levels, and within and outside the Ministry of Health, such as in the Ministries of Finance, Local Government, and Labor. They also include actors outside of government, such as beneficiaries, civil society groups, NGOs, and international actors [98].

As mentioned in Best Practice 1, conducting a TFC stakeholder analysis is a helpful way to identify who the key stakeholders are that stand to gain or lose from the reform, to assess their alignment along a spectrum of support, as well as to identify what levers exist to obtain their required endorsement, acceptance, or non-resistance.

This must inform an active, continuous stakeholder engagement strategy that uses several tools and approaches. These can include a combination of one-directional informational formats (news stories, supervision visits, guideline dissemination, trainings), and of more interactive two-directional formats (meetings, workshops, participatory design activities).

The distribution of power among TFC stakeholders is often unequal, with influential organized interest groups with a large stake in the status quo tending to be opposed (e.g., healthcare providers), and the main beneficiaries tending to be less powerful and organized (e.g., underserved patient populations).

As discussed previously, systems look the way they do because they tend to suit the interests of people in power, and they are hard to change. The stakeholder analysis should help to identify and focus on agents with high levels of power, interest, and influence over the policy making process [35].

Advocacy oriented stakeholders should be identified, such as international NGOs or local patients' groups, as they are often well resourced and skilled at using the media and able to organize events to amplify the voices and

demands of otherwise marginalized beneficiaries. This can be valuable for establishing a sense of urgency behind the issue.

Another important group is "centrally located elites," or health system leadership at the central and regional level. These actors achieved their positions of prominence by playing by the rules of the game and are deeply embedded in the system. Because of this, the "paradox of embedded agency" [99] suggests although they are best positioned to lead change, they are paradoxically unlikely to regularly perceive the need for it, have access to change ideas, or risk their interests in pressing for change. They are seldom appointed to foster dramatic transformation, and so are unlikely to spontaneously initiate it, being instead quite change averse [87]. However, they can be inspired to follow others who are willing to shoulder the risk and expend the political capital to lead it (e.g., policy entrepreneurs, discussed in Part 4).

A third crucial group to engage in any public policy reform is "street-level bureaucrats." They are agents who have "regular and direct interaction with recipients of government services," and as such have the power to exercise discretion over how these services are effectively delivered [100]. In this way, the actions and decisions of street-level bureaucrats effectively "make policy," as they are the real-world manifestation of something that is otherwise intangible [100].

For TFC, healthcare providers and managers are the powerful patient-facing street-level bureaucrats of the health system. Engaging with them and getting their buy-in is crucial, given the discretion and degrees of freedom provided to them in their work [101].

An important dimension of engagement with this group is understanding what potential losses are at stake for them – such as wealth, status, competence, and control. "Naming the losses at risk" is vital to move people through a period of adaptive change and overcome resistance [1]. Furthermore, this group is probably not truly contented with the status quo, and so identifying their needs and priorities (higher salaries, better equipment, training) and addressing them together with the implementation of TFC would be an effective strategy.

Unfortunately, the description of TFC reforms as being "top-down" is very common, and examples of meaningful engagement with front-line workers at any stage are rare. In many countries, frontline workers learned by "surprise" about TFC policies, at the same time as they were announced to the public, and without all the conditions being met for their implementation (clear guidelines, inputs, resources).

The widespread disillusionment and frustration experienced by health care providers and managers in the face of limited policy engagement is a major concern [102]. Co-production activities must be undertaken, as much as logistically and financially possible, to create empowering co-ownership, and to diffuse tension.

International examples:

- **Sierra Leone**: an original budget for communication and engagement of $ 3 million USD was promised, however it did not materialize, and this hampered the intensity and reach of activities. The policy was announced to the population before it was communicated to health workers. This was described as a "grave mistake because it led to health workers going on strike" [71].
- **Burkina Faso**: International NGOs were active in advocacy efforts to promote TFC, such as Médecins du Monde who produced a video that was broadcast on national television and Amnesty International who organized a "caravan to travel to rural areas and to draw the attention of regional authorities and decision-makers" to TFC. The latter was able to get the President to "commit to free care" in 2010, although this was not actually adopted as a policy until 6 years later [103].
- **Benin, Burkina Faso, Mali, and Morocco**: the majority of health staff had not received any guidelines on the operation of the policies (69%) or received any training (78%) [70].

7. Engage strategically with technical assistants and development partners

External partners are a part of the stakeholder landscape that deserves special mention. This engagement can take several forms, depending on what is requested or required.

Partner support can come with several advantages, such as being able to provide more flexible financial resources, particularly to absorb start-up costs or fund unplanned activities. They can also provide valuable political support and broker preferential access to decision makers [90].

International actors also have an important role to play to support knowledge management around TFC. In Francophone West Africa, national policy makers and technicians are doubly disadvantaged in terms of their access to peer reviewed literature and evidence, which is often locked behind a paywall and written in English [85], [104]. Global health actors can help to facilitate access to these resources, as well as facilitate regional collaborations and communities of learning [55].

In addition, the limited time, staff numbers and types and level of expertise within governments is also an area where international partners can play a role. Hiring technical assistants or consultants to fill this gap may be particularly helpful for TFC, especially to design and carry out heavy technical analyses (e.g., forecast and costing analysis) and a robust monitoring and evaluation plan.

However, according to a 2009 review of best practices for repealing user fees, the role of donors was “apparently rather limited” in Ghana, Burkina Faso, Liberia, Senegal, Burundi, and Uganda. The report identified “an urgent need for them to play a more active role in this process” [81].

Nevertheless, engagement with technical and financial partners must be undertaken carefully, as it can also complicate leadership, coordination and agenda setting. History is rife with examples of exogenous policies being heavily promoted by donors and partners – the Bamako Initiative is a clear example. The significant power imbalance

at the heart of it traces its roots back to colonization and colonial medicine. Still today, certain global health actors have an outsized influence on national policy making and create strong incentives that shape the decisions of organizations and individuals [13]. Governments can gain legitimacy and access to important external funds by agreeing to adopt a reform, and bureaucrats can further their own careers by working on it either from within or outside of government (contributing to a domestic "brain drain") [87], [88].

Several studies point to other "soft power"[5] practices commonly used by international agencies as a means of influence, such as organizing international study tours and workshops, which diffuse ideas and create powerful networks among ministry policymaking elites. This was the case with Integrated Community Case Management (ICCM) in Burkina Faso [105], [106] and PBF in Chad and Cameroun [107], [108].

The practice of spending resources to influence national actors trickles down to the operational level as well. The payment of "per diems" – a Latin term meaning "by the day," refers to an allowance paid to an actor to offset their travel or meal expenses while they attend a program activity. This practice is rampant in health programming and has even been codified in national laws, which set different rates based on hierarchy and circumstances (e.g., distance traveled) [109]. Such a law was passed in Mali in 2016. In practice, however, they have become an important supplementary source of income. In Burkina Faso for example, earnings from these "top-up's" can exceed the salaries of some health workers [109].

Per diem payment can be a tool used by international organizations to ostensibly "buy the involvement" of local stakeholders, by sometimes offering above market rates [110]. This is convenient for programs that measure their success in terms of training sessions held and participants present [111]. But the use of per-diems is also problematic because it can lead to sub-optimal worktime allocation and warped priorities. Their distribution can be a source of

[5] Soft power can be understood as a persuasive approach to international relations, typically involving one country or entity using cultural or economic influence to affect another, as opposed to using a more coercive approach (hard power, e.g., military might).

intra or inter-organizational conflict, and create a culture where people expect to be paid for all activities and refuse to work without them [112] (such as halting vaccination campaigns in response to reducing their rates).

The use of per-diem in the context of TFC policy reform may prove to be an unavoidable part of stakeholder engagement, but should be undertaken thoughtfully to minimize their harmful, "tainting" effects [109].

International examples:

- **Ghana**: a donor "appeared to play a catalytic role in kick-starting the policy, but then played no further role in funding or providing technical support for it" [89].
- **Niger**: exemption measures were strongly advocated for by the World Bank and were agreed to as part of negotiations around loans that were "conditional on the immediate provision of free healthcare for children under five"… "apparently with undue haste" [12].
- **Sierra Leone**: donors provided the majority (60-80%) of new funding for the Free Health Care Initiative (FHCI), with DIFID making up between 40%-55% of new direct FHCI funding. "Apart from some DIFID and Global Fund support to salaries through budget support, much of the external financing in the sector is off-budget and outside public control" [71].

8. Assess different options and define the beneficiary population and benefits package.

The process of selecting beneficiary groups and the package of services to be included in a free care policy should be transparent and based on criteria such as ease to implement, budgetary incidence, health impact (Daily Adjusted Life Years[6]), and cost effectiveness (lives saved per $) [55]. Helpful guidance exists around this particular task (e.g., "What's in, what's out? Designing Benefits for Universal Health Coverage" [113]).

[6] *A Daily Adjusted Life Year (DALY)*: "One DALY represents the loss of the equivalent of one year of full health. DALYs for a disease or health condition are the sum of the years of life lost to due to premature mortality (YLLs) and the

However, the choice of who benefits is also inherently political, and the political pay-off of prioritizing certain groups or services may not align well with cost-effectiveness (cancer treatment), stakeholder need (serving the poor), or social mores (access to safe abortion services).

The goal is to flesh out options, estimating the impact of fee removal on utilization and cost under different conditions. This could involve tweaking geographic coverage (all or just rural), the level and type of health facility included (community health center or hospital; public or private), the individual eligibility criteria, and/or the benefits package (full cost or subsidy, both care and drugs or just one of the two). Not all details need to be considered, but there must be an eye towards the effect of different choices on implementation complexity and risks [85].

For every additional rule or specification about the conditions for access, there is an additional risk of misapplication, misunderstanding, and a barrier to care. Administrative complexities require bureaucracy, which cost money, and therefore can make a program less efficient and effective. Indirect costs are also passed on to beneficiaries, such as when a policy benefitting children under 5 requires a birth certificate to prove their age before receiving treatment or a clinically confirmed pregnancy is required to obtain free antenatal care [85].

In addition, if targeted free care is to truly be considered a step on the road towards universal health coverage, the package of care and population of beneficiaries should be progressively broadened. Therefore, creating a process to regularly review this should be embedded in the policy and carefully planned.

years lived with a disability (YLDs) due to prevalent cases of the disease or health condition in a population." It allows for the comparison of the "burden" of different diseases. [235]

International examples:

- **Ghana**: shortly after the policy to provide free care under the NHIS for pregnant women was announced in 2008, free membership was also offered to people under 18 years old. However, this was done without specific guidelines being issued at the time or a robust assessment of its impact on the NHIS. Since nearly half (49%) of its registered identity card holders are under 18 (and 5% of them were pregnant women) this would have a major financial impact on the policy [89].
- **Rwanda**: the mandatory Mutuelle schemes, which provides coverage for 81% of the population, includes exemptions for the most vulnerable. Its managing body, the Rwanda Social Security Board (RSSB), is often pressured to include new services to its benefit package, which are very expensive (e.g., dialysis services, oncology drugs) and could strain its financial viability and performance. In response to this, the RSSB is leading a process to systematically use a participatory, equity-focused, and evidence-based processes to progressively expand its benefits package.

9. Ensure harmonization with other reforms

Reforms should obviously be based on what is already there – and not assume that things are a blank slate. TFC must therefore be informed by a review of existing health financing and social protection policies, ongoing parallel reforms or pilots, and national strategies and legal frameworks, with an eye towards opportunities for integration. This will diminish competition between reform initiatives and provide gains in efficiency, which is likely to be appreciated by front line providers who often have to manage fragmented policy through heaps of paperwork. Integration may mean changing established ways of working, and so it could encounter resistance.

It is important to remember that if targeted free care is selected over universal free care, there will be at least two parallel systems in place in health centers: one collecting payments directly from patients for some services, and the other providing services free through an alternative payer. This can lead to “two parallel operating systems” for

drugs, reporting, administrative documents, and supervision – essentially leading targeted free care to become "a vertical program, like vaccination" [12], [114].

A close look at existing exemption and pre-payment schemes can generate design ideas or reveal systemic dysfunctions and weaknesses that are likely to threaten the effective implementation of targeted free care.

Finally, a conflict can arise between voluntary contributory health insurance and targeted free care if the two are not integrated. If the latter exists and is functional, it could discourage enrollment in voluntary health insurance schemes that are not free. The articulation between these schemes will need to be worked out and could provide an opportunity for re-launching the debate and eliciting a more coherent vision and path forward for health financing.

International examples:

- **Burundi**: interesting synergies were found between performance-based financing and targeted free care early on. After TFC was introduced in 2006 with very little preparation, delays experienced with reimbursements and the increase in workload led to a series of month-long health worker strikes. An ongoing pilot of PBF was scaled nationally in 2010 and integrated with TFC. This was associated with improved staff motivation, reduced drug stockouts, and shortened reimbursement delays (the average time for payment with TFC in 2006 – 07 was 6 – 9 months; the addition of PBF cut it to 45 working days) [115].
- **Uganda**: the country's community health insurance schemes, which had been promoted prior to the launch of universal free care, suffered following its introduction in 2001 [58].
- **Benin**: the official decision to abolish payment for care for children under 5 had its implementation delayed "partly because Mutuelle health insurance (CBHI) providers are resisting" [58].
- **Ghana**: stopped its free delivery program and folded it into their national health insurance scheme as a subsidized membership [89].

10. Develop a clear communication strategy

A well-informed public and health workforce is vital to the success of a targeted free care policy. It can help to create demand, protect beneficiary's rights, improve enforcement, and manage expectations [68].

Clarity on the content of the reform is essential, such as exactly which services are free at the point of use and which ones are not, and for whom. For a complex reform, it is particularly important to ensure it is described accurately and consistently, explicitly laid out in standard operating procedures or guidelines [68]. However, sometimes the development and distribution of instructions on fee exemption policies took months, or even years, if they happened at all. In most countries, policies were implemented without them [12].

Misunderstandings about what is free by the public led to tension between patients and health care providers, the former accusing staff of misappropriating products or corruption [12].

The strategy should "use every vehicle possible" to communicate information about the new policy [86] and should be carefully adapted to the context, including considering the equity implications of a media strategy that relies on access to technology and literacy. There has been a general reliance on radio and television announcements, and communications to local leaders and authorities (village chiefs), but other channels such as "traditional town criers" have also been used [116]. Official government-sanctioned posters in health centers that communicate this in pictures can also help to create a shared understanding.

It is important to empower community communicators whose incentives are aligned with increasing utilization of health services to ensure effective information flow (e.g., women's groups). Front line workers concerned about lost revenue may have a conflict of interest and could withhold information about free care to be able to continue with cost recovery or manage increase demand.

Unfortunately, communication is rarely funded to the level required, and in most cases "little or no funding was provided for dissemination of key information to the health facility level" [116]. Information bottlenecks are usually found where the funding ends.

International examples:

- **Uganda**: the success of their universal free care reform has been attributed in part to their communication strategy, which was reflected by support at the highest level from the president, who enjoys an elevated media platform and whose promotion of the reform served him politically. It also helped that the message being communicated was a simple one: everything is free for everyone in government health centers [68].
- **Burkina Faso**: Efforts to communicate the reforms were "hampered due to lack of funds," despite a budget of 2% of the program meant to be set aside for this. The specifics of the reform (e.g., what was included in the package) was often confused and led to its different interpretation across the country, which reflected the limited access to information in rural and less well-off areas [93].
- **Kenya, Senegal, South Africa**: health system actors were insufficiently informed about the policy, including the amount of fees charged or services exempted, and practical modalities such as the system for allocating funds, the duration of the use of funds and the calendar for payments [58].

11. Design a provider payment mechanism

An effective and timely payment mechanism is critical to replace the lost revenue from direct payment by patients and avoid jeopardizing health center functioning. The disbursement process, regularity, and timetable must be aligned with the expenditure needs of health centers [94]. For example, bi-annual reimbursements are unlikely to be easily managed.

Many healthcare payment mechanisms exist, and this section will not provide an exhaustive overview of each.[7] Instead, it presents a simplified overview of two approaches for TFC: input-based and output based, and their respective limitations and advantages [23].

Input-based systems are those where "free" drugs, consumables, and other inputs (e.g., fixed staff salaries) are supplied directly to health centers. This is the case with free anti-retroviral drugs in many countries for example.

The central level decides the composition of the inputs, sometimes in the form of "kits," as well as how many to distribute based on expected consumption or the population in a catchment area. This can lead to the over- or under-provision of inputs. The composition of kits can be tricky to establish, and their different items are often procured separately, leading to a high risk of incompleteness. Input-base systems also require a strong supply chain, and investment in transportation and stock management systems to avoid misuse, including "artificial stockouts" caused by free products being diverted and sold or used for other purposes.

Importantly, since these products are no longer sold to patients, their provision is not linked to a clear financial incentive for providers (although they can at times be provided alongside other "non-free" products and services to compensate). They are also less flexible than cash for meeting health center needs.

Output-based systems are those that compensate health facilities, in cash, according to the quantity of drugs and services they deliver, similar to a fee-for-service arrangement. Payment can be based on a fixed rate per act, or on proof of itemized expenses or a mix.

This reimbursement system presents a major administrative workload and must be clearly described in a manual or contract, including the procedures, rights, and responsibilities of facility managers to gain access to resources (e.g., required documentation) [23]. It is essential to have an appropriately trained and equipped person in place at health

[7] For a description of PBF, see Section 3.3

centers to do this work, as it is quite different from the management of direct payments from patients. Delays or errors in the submission of documentation contributes to slow reimbursements. In Niger, it was reported that bills often sat for months in health facilities before being submitted for reimbursement [12].

An output-based approach requires robust verification systems to ensure the accuracy of reported data, and to identify instances of the fraudulent inflation with "ghost patients." Verification activities are labor intensive and expensive to implement at scale (e.g., checking that data reported corresponds to patient registers, or the gold standard of regularly sampling a few users, tracing them to their community and interviewing them to verify their actual use of services) [23]. It is recommended to separate the roles of provider and verifier to limit conflicts of interest, with the latter ideally being independent from the health pyramid. This is the approach taken in PBF programs in Rwanda for example, where verification is shared by local government and an NGO. Nevertheless, a review of several national free care verification systems found them to be "very bureaucratic and vulnerable to fraud" [23].

In an output-based system, the rates set for reimbursements influence provider behavior, but are difficult to calculate. If the reimbursement rate is higher than the unit cost, it can incentivize staff to treat more patients. For example, in Senegal, the reimbursement sum per C-section is much higher than the actual cost of the service [46]. This introduces the risk of provider moral hazard, whereby clinicians over-deliver services that are not appropriate. Conversely, if the rate is too low, it could de-incentivize service provision. In Niger, they appear to have underassessed the cost of services to children under 5, leading to debts and diminished incentives to provide care [93].

In both input- and output-based approaches, it is preferable to pre-position inputs or financing ahead of starting the program, rather than expecting health centers to pre-finance these [93]. The capacity and willingness to do this may vary across health centers, leading to uneven early implementation. Ensuring these necessary start-up conditions are in place can also be a signal to providers of the trustworthiness of the state as a payer and boost confidence.

Finally, even if payments arrive on time and in the right amount, both approaches represent a loss of autonomy and power for health center staff compared to user fees [117]. Under an input-based system, they can no longer purchase their own supplies when and where they choose. With an output-based system, they lose the control over prescribing and charging what they want for services.

Whichever approach is chosen or combined, it is important to ensure its risks and unintended effects are understood so they can be minimized as much as possible.

International examples:

- **Ghana**: the free delivery program within the NHIS repays health facilities based on monthly claims, with reimbursement amounts separated into service costs (which vary based on facility type) and drugs. The process of vetting claims is laborious and slow. They recently attempted to implement payment by capitation[8], but this was resisted by service providers [118].
- **Burkina Faso** shifted from an input-based financing system to one where payment is done on a "fee-for-service" output basis using detailed monthly activity reports, which summarize all the services, products, and consumables (e.g., drugs and vehicle fuel), the cost of each, along with supporting documents and receipts [119]. The reimbursement rate for normal deliveries is considered considerably higher than the real cost [46]. The additional workload required to process the invoices and billing is considerable (taking health centers between one or more days to compile) and led to dissatisfaction among staff [70], [119].
- **Senegal** the introduction of targeted user fee exemptions resulted in a loss of 4-15% of district level health facility revenue, which was compensated for by increasing the costs for other health services [120].
- **Niger**: free care is paid based on a lump sum for each treatment administered, which is different according to the level of the establishment in the healthcare pyramid. At the launch of the policy, facilities were asked to pre-finance inputs and care, which led to all but one health district in one region boycotting the launch

[8] In a capitation scheme, providers are paid a fixed amount of money based on the number of patients enrolled for delivering a range of services.

of the program. Since the launch, facilities have experienced enormous delays in getting reimbursed for these services, lasting between 9 to 24 months. A study conducted in one district revealed that between 2007 and 2010, on average only 30% of invoices forwarded to the state payer had been reimbursed. Not a single reimbursement was received by any health center in the district in FY 2009-10. Since the TFC policy was introduced, most health centers experienced higher expenditures than revenue (which was reversed before its introduction). By 2009, "most of the health centers subsequently declared bankruptcy" [12].

12. Define the institutional arrangement and the roles and responsibilities of the payer

The agency playing the role of payer or purchaser of health services is vital since it is the body through which money flows into health centers. This can be housed within a new entity (like in Niger) or an existing entity (e.g., health insurance management agency, like in Ghana or social security agency like in Rwanda). Its legal status can also either be a government agency attached to the Ministry of Health or not, a private firm, or some other type of public administrative institution. The form it takes may reflect the source of financing – tax funded schemes being linked to treasury, and subsidized health insurance schemes being linked to insurance agencies.

The multiple roles played by the paying institution are complex and require diverse specialized capabilities. The decision of which agency or agencies to use should be informed by a capacity assessment.

- financial and performance management (establishing dedicated funds and capacity at the central and decentralized levels).
- planning, risk management and actuarial analysis (projecting revenues and costs over time, allowing for the revision of benefits packages and tariffs to ensure financial sustainability).
- provider management and payment (selecting and contracting providers, verifying reimbursement claims, carrying-out payment process, and detecting and addressing irregularities including fraud).

The agency responsible for TFC tends to be quite centralized, but some functions are outsourced or delegated. Every additional step and actor along the payment chain introduces a possible bottleneck. In Burundi, it was reported that money disbursed by the central level was being withheld at the provincial level [46].

Payment processes can be formalized in a blanket national policy or in a contracting agreement between the state and health centers that are included in the program [23]. Contracting arrangements can help to ensure minimal conditions are met, such as contracting with only accredited facilities for example.

International examples:

- **Niger:** the volume of services to reimburse is large and the system cumbersome, and yet the team in place to process these reimbursements is small, understaffed, under equipped, and low in the health system governance structure (reporting to the department for healthcare organization which reports to the General Directorate of Health). They are responsible for checking the reimbursement claims, transmitting them to the ministry of economic and financial affairs, who then forward them to the national treasury for transfers to the accounts of health committees. This process is meant to take one month, but in practice it takes several months or in some cases years [12].
- **Burkina Faso:** the verification and evaluation functions of the TFC program are performed by a consortium of NGOs, contracted by government, and spread across the country's 13 different regions. They are meant to visit at least a third of all the facilities in their respective areas each year, and combine a document review (comparing patient registers and accounting information) with interviews with a sample of patients in the community [119].
- **Burundi:** as part of their early TFC program, staff had to fill out documents detailing all the services provided and consumables used for every patient. For the average community health center, this meant on average 2000 photocopied pages per month. After integrating the TFC reporting with PBF, which has a robust verification and counter verification system, they only submitted a 2-page report on the total number of covered acts performed [115].

13. Identify minimal standards and carry out service delivery upgrades

Since repealing user fees is a demand-side reform, it is important to counterbalance it with a package of supply-side reforms or "accompanying measures". Otherwise, the increased demand for health services – a core goal of repealing user fees – can strain the functioning of health centers and undermine quality [55].

An initial assessment of service delivery challenges should have been undertaken during the preliminary situational analysis, but it is necessary to go deeper. Understanding existing bottlenecks and their root causes is valuable information to inform design decisions and their solutions should be the subject of iterative experimentation to respond to learning.

Service delivery upgrades should be substantial and sustained, and ideally undertaken before the launch of the program [38]. The main areas likely to need a boost essentially map onto the WHO Health System Building Blocks: procurement and supply chain, staffing, infrastructure and equipment, financial administration and governance, and information systems [121].

Drugs tend to be the greatest recurring expenditure for health centers. This is also a cost easily passed on to patients when there is a disruption in "free" input availability. Worsening stock-outs of drugs and other consumables were frequently documented following the introduction of TFC, either due to weakness in pharmacy management at the facility level, or weaknesses in the centralized distribution system, or both [58]. A 2013 review of studies on the effects of TFC on the quality of maternal healthcare found that the availability of inputs was worsened in 5 of the 9 studies (the remaining 4 found either neutral or inconclusive effects) [67].

In addition to drugs, human resources are an important element of quality service provision and source of expenditure for health centers. The skills mix and density needed to meet increased numbers of patients is a critical consideration, particularly in rural areas which tend to already be understaffed [102]. In many countries, maldistribution is a greater problem than overall shortage [117].

Healthcare workers and administrators commonly report increased workload with the introduction of TFC, and their complaints of diminished morale, and feelings of inadequacy and exploitation must be taken seriously [108]. The impact on workload is real, with increases in patient per provider ratios documented across settings. In Uganda for example, the number of deliveries per staff went up by 46.9% [58]. This change was sometimes accompanied by measures to improve "extrinsic motivation" (i.e., bonus payment, increased salaries), but this was not always the case. In the face of increased workload, staff can engage in behaviors to ration access to healthcare, such as limiting their working hours.

However, some evidence exists that even with increases, workloads remained generally manageable, and that the working hours and patient ratios reported by staff exceed those observed by researchers, making it hard to know the true adequacy of workforces. A study of TFC in Burkina Faso, Benin and Mali observed that productivity remained low, with around one patient seen per hour worked or less. This same study found that outputs (services delivered) increased more than hours worked, which signified an efficiency gain [70].

International examples:

- **Sierra Leone**: a "distinguishing feature of the FHCI (Free Health Care Initiative), compared to previous user fee removal policies in the region" is its systematic approach and proactive identification of health system pillars needing strengthening. These included: health financing, governance, human resources, drugs and medical supplies, infrastructure, M&E and communication. A six-year evaluation of the initiative found that "some important areas such as improvements to pharmaceutical procurement and distribution were not effective, ad in other areas such as human resources, reforming momentum was lost over time" [71].
- **Burkina Faso**: the identification and planning of accompanying measures was not ready at the time of the budget allocation from the Council of Ministers towards free care, which was perceived as "rapid" by Ministry of Health technicians. No personnel were added to handle the additional administrative burden generated by the policy [46].

- **Niger**: no accompanying measures were introduced, despite glaring existing deficiencies. A study conducted in one district found that the average number of days per year with a stockout of 5 key drugs more than doubled after the introduction of TFC, going from 116 days to 312 days [12].
- **Ghana:** with the free delivery program, all health professionals' salaries were increased, and certain regions introduced incentive bonuses for each delivery carried out. This bonus made up 19% of midwife salaries [58].
- **South Africa:** There is evidence of "crowding out" of preventative activities by the increased demand for curative health services they free care was introduced [68].
- **Senegal**: health workers were found to have managed demand from elderly patients entitled to free care by giving them appointments in the very distant future or limiting the number of patients seen per day [93].

14. Set up M&E systems to generate timely information on functioning and performance.

Understanding whether a policy worked, how, why, and for whom, and in which conditions should be critical for any policy maker. Monitoring and evaluation (M&E) processes help to ensure that TFC is being implemented correctly and achieving its intended goals – beyond just increasing utilization – such as improving population health and financial protection.

However, this is often thought of last or neglected altogether (perhaps because, like in this list, it figures at the end of policy development cycles and guidance [35]). This leads to missed opportunities for robust design and learning to enact course corrections.

Information systems are the eyes and ears of the policy. At a minimum, these systems are needed to manage provider payments, but they can also track program performance. It is important to remember that data gathering consumes scarce resources and should be done strategically, balancing cost against usefulness. The cost of data

collection typically falls on people doing the reporting, and therefore if the cost is too high and benefit insufficient (or consequences too insignificant), they will collect poor quality data, leaving core questions unanswerable [35].

Existing capacity may be inappropriate or spread thin. The reporting required by fee exemption schemes is added on top of other cost recovery management systems and health insurance claims processes. The teams and facilities in place, particularly in rural areas, may not have the ability to take more on. Information systems are a clear area for integration as discussed in Best Practice #9.

The tools developed must also be adapted to the actual realities on the ground in terms of the basic enabling conditions and amenities (internet access, electricity, security). These can be simple paper forms or software solutions. Either one requires investment – and often basic elements (printers and paper, available transportation) are overlooked in planning.

TFC evaluation could be entrusted to an external research team or consultant, for objectivity and rigor. They will likely be faced with design challenges, since before and after data or a control area without the reform (or some other counterfactual) is not always available.

Implementation quality and unintended effects are important dimensions for policy makers to evaluate (e.g., corruption, staff coping mechanisms), and yet they are difficult to assess from activity data. Evaluation methods should ideally involve a mixed methods approach with periods of direct observation to understand dynamics not easily captured by numbers. This could also include patient interviews and community evaluation.

Ideally, those handling the information should also be those who are tasked with solving problems – this could be most effectively done at a decentralized level. M&E can be part of a participative stakeholder engagement strategy, giving staff an outlet to describe challenges (vent frustrations) and empowering them to co-create solutions [38].

International examples:

- A multi-country review found that most governments in SSA overlooked the importance of information on their free care programs and the central level had limited access to basic indicators – such as the increase in utilization overall, or between preventive and curative services, or the frequency of drug stockouts [23].
- Another multi-country review found a lack of M&E of TFC described as "appalling" [46].
- **Niger, Burkina Faso, Senegal**: all established a "technical unit, coordination unit, and a working group to develop monitoring tools." However, due to these bodies not being adequately funded, they did not function for longer than 6 months. Other challenges observed were the absence of appropriate M&E tools being developed (Senegal), their absence at the health facility level (Burkina Faso, Niger) and their difficulty of use (Burkina Faso) [116].
- **Sierra Leone**: the country worked with high-level researchers to study their policy (the Health & Education Advice & Resource Team). A national comparison group was not available given the country's all-at-once scale up. Instead, the team conducted a two-part mixed-methods evaluation: pre-post evaluation and theory-based evaluation. The "poor data availability and/or quality (especially related to the HMIS (health management and information system) pre-2010) (…) constrained the extent to which they were able to conduct" their planned analyses (interrupted time series method) [71].
- **Burkina Faso**: a specific software was developed and deployed to collect information on the free care policy, but it experienced serious performance issues. "The software crashed several times, forcing district managerial teams to re-code all the individual forms of the beneficiaries dating back to the beginning of the policy" [70]. It ended up taking years for the management software to become operational. Reimbursements were then "made conditional on filling out the new IT tools a posteriori"[116].

***Table 3**: Summary of the 14 best practices for TFC policy reform and their core elements*

	Best practices (** = essential)	Core elements
Preparation	**1** - Preliminary situational analysis	• Examine how TFC fits into the picture – study national political, economic, and demographic trends as well as health system structure (5 control knobs) and performance (health status, financial risk protection, access, etc.). • Conduct rapid stakeholder analysis and preliminary costing to assess feasibility and acceptability, investigate issue ripeness. • Explore design options from domestic and international experiences.
	** **2 -** High-level national authorization, support, and leadership	• Assess the level of support and authorization needed for TFC and develop a plan to cultivate and expand it – look beyond MoH. • Craft a compelling vision that is carried by high-level leaders and encourages alignment within government and donors. • Beware of risks associated with political pressures and turnover.
	** **3 –** A dedicated, authorized, and well-resourced coordination unit	• Establish a core group (or groups) with the appropriate composition and structure (skills mix, time, resources), and formal authorization and positioning (protection, leadership, legitimacy, decision rights) to be able to carry out technical and management work. • Strategically include stakeholders to generate legitimacy and trust and to test "implementability" – while guarding against pitfalls of large groups (deadlock, slowness, conflict).
	** **4 -** Revenue sources and financing plan	• Evaluate the current fiscal space for health and opportunities to expand it (state budget, innovative financing, donors), working with the Ministry of Finance. • Estimate cost and secure solid medium- to long-term TFC financing commitments from government.
	5 - A sequenced, adaptive plan	• Create a clear roadmap of what needs to be done, by whom, and in what order – assessing each step based on the authority, acceptance and ability needed. Prioritize and consolidate "quick wins." • Maintain a flexible and adaptive plan that structures learning and sharing. • Carefully consider a pilot and scaling strategy.
	** **6 -** Actively engaged stakeholders	• Informed by the stakeholder analysis (best practice #1), carry-out an engagement strategy that focuses on actors with high power, interest, and influence. • Link with TFC design and communication efforts, undertaking interactive co-production activities when possible. • Pay particular attention to activists, centrally located elites, and street-level bureaucrats (care providers).
	7 - Strategically engaged technical assistants and development partners	• Utilize coordinated donor support, particularly around areas of start-up financing, knowledge management, and targeted technical assistance. • Beware of outsized influence on policy making choices and government staff time use (e.g., workshops and per-diems).

Table 3 (Continued)

Design	**8 –** Criteria-based population and benefits package	• Establish transparent criteria to define the beneficiary groups and package of services (e.g., health impact, priority, cost, context), and a process to regularly review (and broaden) them. • Flesh-out options to compare and consider impact on implementation complexity.
	9 - Harmonization with other reforms	• Integrate TFC into existing health financing and social protection systems, legal frameworks, and national vision for UHC – to gain efficiency and minimize disruptive parallel systems.
	10 - Communication strategy	• Communicate clearly to both providers and the public about the content of the reform, using all possible means and vehicles (avoiding information bottlenecks).
	**** 11 -** Provider payment mechanism	• Carefully design a provider payment system (input-based, output-based, or mixed), including clear administrative processes – weighing the pros and cons of each approach, and minimizing opportunities for diversion and fraud. • Preferably pre-position inputs or financing ahead of program launch.
	**** 12 -** Institutional arrangement of the payer	• Identify the agency responsible for being the payer / purchaser for TFC, based on an assessment of the capacity of existing agencies (possibly creating a new agency). • Identify which functions could be outsourced, delegated, or decentralized. • Define the relationship between the payer and provider (i.e., contracting).
Delivery	**13 -** Minimal standards and service delivery upgrades	• Assess the current health system bottlenecks: procurement and supply chain of drugs, staffing, infrastructure and equipment, financial administration and governance, and information systems. • Pay special attention to supply chain, and staff motivation and workload.
	14 - M&E systems	• Design a monitoring and evaluation process to track TFC implementation and impact, using tools adapted to the capacity and conditions on the ground. • Consider outsourcing program evaluation early for objectivity and rigor.

2.2 What does this tell us about the nature of the challenge and the capability needed?

The 14 best practices lay-out the scale and scope of the work to be undertaken to repeal user fees. At the most essential level, TFC needs to have an agency set up that can replace the patient as the payer, and can funnel money through a new payment mechanism to compensate providers in the right amount and at the right time for delivering a clearly defined package of services. To do this, the program needs to be sufficiently financed, be undertaken

through broad stakeholder engagement, and be managed by an appropriately skilled coordination unit with high-level support.

Ideally, this policy should also be developed based on an analysis of the situation, working strategically with development partners, and ensuring that it is integrated with existing systems and processes. It should be laid out in a flexible plan and its content communicated clearly to both providers and beneficiaries. To protect against negative effects on quality of care and unintended consequences, service delivery upgrades should be carried out beforehand (particularly to strengthen the drugs supply chain and human resources for health), and a robust monitoring and evaluation plan should be in place.

However, the synthesis in this section highlights how profoundly difficult these best practices are to follow, across a variety of countries and contexts, despite at times seeming obvious. The review confirms that TFC reforms are often implemented with little time for rigorous preparation, implemented in a top-down fashion, and despite often having presidential-level support, are poorly communicated and routinely underfinanced, with disruptively delayed reimbursements. Even "success stories" show that repealing user fees is a long process with many pitfalls, moving ahead in fits and starts.

The 14 best practices and their examples also underscore how the challenge of designing and implementing TFC is clearly *technical,* but it is also deeply *adaptive* [1], because it requires a change management strategy that can evolve in a constantly shifting environment and requires continuous learning and engagement. It necessitates mobilizing a range of stakeholders to solve a collective problem over an extended time horizon, and for some to accept losses – of autonomy, power, financial stability, and profits. According to Heifetz and Lipsky, "the most common cause of failure in leadership is produced by treating adaptive challenges as if they were technical problems" [1]. This problem has important technical and adaptive elements intertwined and must be approached as such.

Furthermore, the *state capability* needed for TFC to accomplish its policy objectives is complex and broad [2]. This is evidenced by the fact that its successful implementation requires activities that are complex and transaction

intensive, both between patients and care providers (service provision), and between care providers and a payer / verifier (obligation imposition). These activities are also discretionary, as healthcare service delivery involves the use of specialized professional training, clinical judgements, and experience. Finally, although clinical care draws from a known body of knowledge, the payment system that will be required of TFC will be new and unknown to the Malian primary health care context [2].

Capability for policy implementation refers to when organizations are able to effectively "equip their agents with the capacity, resources, and motivation to take actions that promote their organization's stated objectives" [2]. When states with weak capability are required to perform tasks that they are not able or ready to do, this can lead to what is termed a "capability trap" [2]. When too much pressure is added to the system, what limited capability exists becomes overwhelmed, and this usually makes things worse.

When this is repeated over time, it can lead to "premature load bearing" and a loss of institutional integrity and coherence. This also creates a widening gap between the de-jure (what policies say should happen) and the de-facto (what actually happens). The failure to meet expectations can dangerously erode legitimacy and trust, both within the state and between the state and the population, breeding disengagement, cynicism and even turmoil [2].

PART 3: Contextual analysis of Mali and its healthcare system

The previous two parts provided an overview of the history that led removing user fees to be on the global health agenda (Part 1), as well as a summary of the steps and options to undertake it, and their potential risks and difficulties (Part 2). The complexity of the task, being both technical and adaptive, as well as the state capability required, should lead any would-be reformer to proceed with caution.

A core take-away of the best practices and international experiences with TFC is also that strategic design and implementation choices must be informed by the specific national context and capability.

Part 3 therefore seeks to contribute to satisfying this requirement. It aims to analyze the Malian context and to understand the history, processes, structures, and systemic weaknesses and dysfunctions into which TFC would be introduced. The content is drawn from the literature and documentary review, at times supplemented by stakeholder interviews.

It begins with a summary of the demographic, economic, and political trends in the country (section 3.1), followed by an overview of the health status of the population, and the health system's governance, access, and quality (section 3.2). It then takes a deeper dive into health financing and payments, and the importance of user fees as a source of expenditure for families and revenue for health centers (section 3.3). Finally, it takes a close look at what systems are in place to protect Malians facing illness from financial risk – either health insurance schemes or targeted free care programs. Each section identifies features and lessons relevant to the design and implementation of TFC, and possible risks and unintended consequences (section 3.4).

3.1 General Context: Demographics, Economics, and Politics in Mali.

The national trends related to demographics, economics, and politics are important to consider related to TFC in Mali, as they point to national capacity and priorities. Key points are summarized here, and a full analysis is included in **Appendix A**.

Mali is currently experiencing significant pressures from rapid demographic growth and a weak, undiversified economy. Close to half (42 %) of the population is estimated to live below the national poverty line [122], and its population is very young, with 47 % aged under 15 years old [122]. A majority (80%) of jobs in the country are in the informal sector [123], leading to a narrow tax base. Mali ranks near the bottom of the Human Development and Social Capital Indexes, lagging on education and health.

Mali has faced over a decade of political turmoil and security crises, heightened by a military coup d'état in 2012. A complex and shifting landscape of rebels, jihadists, and bandit groups are responsible for waves of violence that have spilled from the north of the country into the center. Despite Mali currently having active UN peacekeeping and French Military missions, the peace agreement signed in 2015 has been stagnating and instability continues to spread.

The last two years witnessed a particular decline in stability and democracy, with the government resigning in April 2019, and a military-led coup d'état toppling an increasingly unpopular President Ibrahim Boubacar Keita in August 2020. Ten months into the mandate of the transition government, a countercoup was carried out by the transitional Prime Minister, Col. Goïta on May 24, 2021, who was inaugurated as the new transition President on June 7th. Mali's place in the Fragile State Index and World Governance indicators confirm a worsening picture across all dimensions of state capability (e.g., rule of law, control of corruption, government effectiveness).

The security crisis has led to tragic loss of life and large movements of population, with the number of internally displaced reaching over 380,000 in August 2021 [124]. Roughly one in three people in Mali are dependent on

emergency aid [125]. In addition to these acute humanitarian needs, the crisis has seriously disrupted the supply of healthcare – with many health professionals in the North being repatriated to the capital and government health facilities being looted or damaged. The proportion of functioning government health centers continues to decrease, from 88% in 2012 to 78% in 2019, dipping as low as 35% at the height of the crisis.

In 2012, the MoH formalized an agreement with a consortium of NGOs to provide emergency free healthcare for six months in the North. Despite being intended as a short-term initiative, the arrangement continues to this day, with important challenges around coordination, service coverage, drug availability and financing [126].

This has led to a situation in large swaths of the country where health service delivery and population health are deteriorating, and where responding to urgent humanitarian needs trumps longer-term development priorities. The continued dependence on foreign intervention risks contributing to the image of a dysfunctional and incapable state in the eyes of the Malian population.

3.2 Mali's health system: health status, governance, access, and quality

Several features of Mali's national health system performance and organization are important to explore for TFC policy making. These include how healthy the Malian population is, how the system is governed and structured, and how accessible quality care is to those who seek it – in terms of geography and the availability of staff and minimal amenities. The following section provides an analysis of these dimensions and attempts to tease out relevant points.

Underperforming population health indicators

Health indicators in Mali are worrisome across the board, and consistently show inequities across wealth, gender, and geographic location.

After three decades of steady decline, the mortality rate of children under the age of 5 actually increased from 95 deaths per 1,000 live births in 2012 to 101 deaths per 1,000 live births in 2018 [127]. This means that over 10% of children are likely to die before they reach their 5th birthday. This risk is higher among the poorest wealth quintile compared to the richest (143 per 1,000 vs. 57 per 1,000), and in rural compared to urban areas (111 per 1,000 vs. 61 per 1,000). Roughly a third of these deaths occur during the first month of life, (33 deaths per 1,000 live births), a rate that has barely changed in 30 years [127]. This can be explained in part by mothers who tend to have children young and closely spaced, as well as deficiencies in the quality of obstetric and neonatal care. According to the latest Demographic and Health Survey, 33% of births occurred without skilled birth attendance and 46% of newborns received no post-natal follow-up [127].

Maternal mortality is a major concern in Mali, and despite improvements over the last 20 years, it has one of the highest rates in the region, with 325 maternal deaths per 100,000 live births. The lifetime risk of maternal death today is such that roughly one woman in 50 is at risk of dying from childbirth during her reproductive life. Similarly stark geographic and economic inequities are apparent in maternal health [127].

The prevalence of modern contraceptive use in Mali is very low (16%) and nearly one in four married women (24%) reported an unmet need for family planning. Mali has the highest adolescent age-specific fertility rate in the world, with 8% of girls aged 10-14 and 36% of girls aged 15-19 having already given birth in 2018. The rate of teenage mothers is higher in some regions of Mali than others (e.g., 42% in Kayes vs. 20% in Bamako) and among girls with no schooling (40% vs. 17% among those with secondary education) [127].

Malnutrition is a persistent concern – despite improvements since 2001 – with 27% of children found to have stunted growth in 2018. This prevalence increases to 1 in 3 among the poorest quintile of the population, and in at least three regions of the country (Gao, Sikasso and Mopti). Nearly a fifth (19%) of all children in Mali are clinically malnourished and 9% suffer from emaciation [127]. Malnutrition is identified as the number one risk factor driving death and disability in the country among people of all ages [128]. According to the United Nations, due to the

ongoing security crisis, the prevalence of acute food insecurity has increased by 130% in the country compared to the average of the last five years [125].

Malaria and diarrheal disease are the largest causes of death from infectious disease in the country, with Malaria alone accounting for nearly a quarter of all deaths of children under five. The HIV prevalence rate in the country is low compared to other countries in sub-Saharan Africa, but similar to other West African countries, with an estimated 1.1% of adults living with HIV/AIDS [128].

Weakly coordinated health system governance

Since the 1990s, the country adopted a national planning strategy comprised of 10-year Health and Social Development Plans (PDDSS), which are split into two 5-year implementation plans, called the Social and Health Development Program (PRODESS). Each PRODESS plan is structured in three parts, reflecting the three different ministry portfolios concerned: the ministry responsible for health, the ministry responsible for social development, and the ministry responsible for women, family, and children. The process required to draft the PDDSS/PRODESS is laborious, as it involves lengthy consultations with involvement from "all stakeholders in the health sector" down to the regional and district level [56].

The latest iteration, PRODESS IV (2019-2023) was released a year late, in January 2020, and adopted by the cabinet thereafter. It spans 239 pages and includes 11 strategic objectives, 63 strategic results, and 189 priority activities, demonstrating little real prioritization [129] ("As the adage goes, if an organization has more than three goals, it has no goals" [130]).

According to this authors analysis, the document also lacks strong internal coherence. It cites as the health system's guiding principles both Alma Ata and its commitment to "universal access to care" alongside a commitment to the Bamako initiative. The performance framework and costing also do not include all of the priority activities listed [129].

The evidence-base for the strategies it contains is questionable. A modeling of the proposed interventions in the PRODESS III to reduce the mortality of children under 5 revealed that their application as planned would yield a mortality rate 30% higher than the target set. This was because many of the most effective child health interventions (breastfeeding, insecticide treated bed nets, etc.) were not included. No combination of maternal health interventions (included or possible) could attain the targeted reductions in maternal mortality [131].

The lack of prioritization within the PRODESS in part explains challenges with its implementation. It is arguably rational for Mali to maximize the number of "priorities" to attract the greatest amount of financial aid. It can also reduce rivalry among ministries to include all of their (at times competing) priorities [88].

Donor coordination in Mali is described by all stakeholders as "very weak." Despite technical and financial partners aligning themselves with the PRODESS and having a specific coordination group set up to meet monthly, most of them continue to have separate implementation units, different operating procedures, and similar projects running in silos [132]. The struggle to coordinate activities and donors was starkly evident during the COVID-19 response.

The health system governance landscape is further complicated by the fact that the portfolios of health and social protection (covering among other things, health insurance) were split between two different ministries between 2000 and 2019. During this time, social protection received only between 5-15% of the PRODESS budget and benefitted from much less donor support [56]. In 2019, these were fused back together under the Ministry of Health and Social Affairs. This history of ministerial re-shuffling has made coordination between these two areas, ostensibly the supply and demand sides of health services, quite difficult [133].

Decentralized health system pyramid

The national decentralization strategy, written into the 1992 constitution, also applies to health. It was undertaken in the context of renewed democratic life in Mali and was meant to foster popular participation in governance. This was undertaken while the Bamako Initiative was formally adopted as a national strategy. A 2002 decree details the

powers transferred from the central government to local authorities as they relate to health, which is supposed to be accompanied by the annual transfer of financial resources. In practice, however, these financial transfers are "struggling to materialize" with only a fraction (29%) of funding being received [134].

The Malian health pyramid is comprised of three tiers[9]. The tip of the pyramid is comprised of five specialized teaching hospitals and six public scientific and technological establishments, which offer advanced care. At the second tier, Mali has eight regional public hospitals, which are points of referral for the 65 district-level referral centers (called CSRéf).

The base of the health system is comprised of over 1400 community health centers[10] (called CSCOM). The primary health care level is modeled on the Bamako Initiative. CSCOM are "private" non-profit structures that offer a basic essential package of healthcare activities. Each one is created and managed by a community health association (ASACO), which is composed of elected community members who act as a kind of board of directors, and who are all volunteers receiving no formal salary. The ASACO ensures the administrative and financial management of its CSCOM and is responsible for covering operating costs and hiring some staff [30].

CSCOM are the health facility type most often (55%) visited by patients needing care [135], and the majority of patients seen for curative or preventative healthcare are children under 5 and pregnant women (according to stakeholders interviewed this made up over 80-90% of their patient visits).

Data on CSCOM finances are hard to find as they are not systematically collected or centralized. Their relative organizational autonomy, along with inadequate accounting practices, creates both an inability and reluctance to share transparent accounting information [136].

[9] Alongside these public health structures exists a poorly regulated and yet apparently growing private sector, which includes medical, pharmaceutical, and traditional medicine providers. According to a 2019 national household survey, 29% of the contacts of the population with health facilities were with a private establishment [135].
[10] The number varies from one source to another.

Two studies of a sample of CSCOM found that the majority of their revenue was generated from user fees, specifically the sale of drugs (70% in one study, 57% in another) and charges for medical acts (30% in one study, 25% in another) [136], [137]. Revenue from the government (central and local) did not exceed 7%, and other sources of financing also contributed small portions, such as ASACO membership fees collected from people in the catchment area (1%) and donations from local NGOs (10%) [137]. These studies found that income was higher than expenditures, showing the CSCOM visited to be profitable, but with high fixed costs and slim margins. All of this revenue is retained at the local level.

The governance of ASACO has been consistently identified as an issue. They have been found to be failing to meet standards of democratic representation, with only 35% of ASACO meeting the minimum representation of women on their Board, and nearly a quarter (24%) considered non-functional as they do not hold regular board meetings [137]. The management capacity of ASACO members is variable and not well documented. In rural areas, some ASACO presidents are illiterate. It was also found in the context of CHAI's work that within a sample of 38 ASACO in districts outside of Bamako, only one president spoke French (the rest spoke exclusively local languages). Some CSCOM in rural areas without a manager on staff have health care providers assume this role in addition to their clinical work. The management tools used are often on paper and are not standardized or regularly filled [138]. According to one stakeholder interviewed, over 20% of ASACO do not have a bank account.

ASACO are represented by a National Federation of Community Health Associations (FENASCOM), which also has organizational infrastructure at the regional and local levels (FERASCOM, FELASCOM). In practice, this federation has little capacity to enforce or monitor minimum standards or quality. No national CSCOM accreditation system exists. One had been piloted for 5 years with USAID funding, but it has since been discontinued [139].

The national drug supply chain in Mali is meant to be handled by the Pharmacy Populaire du Mali (PPM), a parastatal entity that can aggregate CSCOM and CSRéf demand and provide economies of scale to achieve competitive pricing. However, in practice their prices are uncompetitive, and they do not offer last mile deliver to CSCOM (instead they

serve a district level depot). This has led their share of the market to shrink to close to 25% and a handful of private wholesalers to take over [137].

Limited access to healthcare: geography, human resources, and quality

The geographic accessibility of health centers has consistently improved in Mali, with more CSCOM being built every year (55 were added in 2018 alone) [140]. More than half (57%) of Malians lived less than 5 km from a CSCOM and 87% less than 15 km in 2018. Nevertheless, the density of health centers by population remains well below the WHO target of 2 facilities per 10,000 population, with a national average of 0.7 CSCOM per 10,000. There are also issues with the appropriate distribution of CSCOM over the territory. The national norm sets the minimum catchment population size of 5,000 people, but 13% of CSCOM (mostly in rural areas) don't meet that threshold [137].

Despite the heavy burden of disease in the country, the health workforce in Mali is insufficient in number and by type. Mali has one of the lowest densities of health professionals (doctors, nurses, and midwives) in the world, with 5.2 per 10,000 population, which is well below the WHO recommendation of 23 per 10,000. The maldistribution of this workforce is also a major issue, with health worker ratios under 5 per 10,000 in seven of the country's eleven regions and nearly half (44%) of health professionals working in Bamako (including 54% of doctors) [141]. The pipeline for human resources for health appears to be constricting, with the number of medical graduates being recruited decreasing from 456 in 2013 to under 250 between 2015 and 2017, while the rate of people retiring is increasing [142].

The country also has a limited number of community health workers, which are called "Agents de Santé Communautaire" (ASC). The ASC workforce is comprised of individuals with a basic level of education who are trained to deliver a minimal package of preventative and curative services and conduct proactive case finding in the communities where they live, each covering roughly 700 to 1000 people [143]. However, the program is currently small, with only approximately 3100 ASC deployed in select parts of the country. It is also entirely donor funded,

albeit with recent gaps caused by the withdrawal of two major donors. Currently, 1243 ASC (40%) have not been paid since the end of 2020 according to a key informant.

The management of staff at the CSCOM level is complicated by the mixed contracting arrangements in use, including with ASACO, mayors or local government, and centrally paid civil servants or contractors [137]. A study in several districts found that the majority (90%) of staff were recruited and paid by ASACO but national level data on this is unavailable [136]. This leads to inconsistencies in terms of the regularity and rates of remuneration and makes central planning and management of human resources for health a challenge.

If a patient is able to reach a public health facility in Mali, the quality of the care they receive is likely to be suboptimal, due to a lack of basic amenities, material, and personnel. National health information system data found that only a quarter of CSCOM have access to a reliable source of water, with the majority (93%) of those without being in rural areas [137]. A 2018 survey on service readiness found that less than a third of CSCOM had all essential equipment required to deliver the minimal service package, including a thermometer, scale, blood pressure cuff, and light source, with rural facilities being even worse off (22% had all essential equipment) [144].

In the area of maternal and child health, it was found that just 4% of facilities surveyed had all the basic inputs required to provide prenatal care, and only a single CSCOM had all the basic elements for child health care (including personnel, medications, and diagnostic tests) [144].

Unsurprisingly, the utilization of health services to combat common deadly diseases in Mali is low, with only 53 % of children under five with a fever being taken to a health facility. Less than a quarter (21%) of children experiencing diarrhea were treated with oral rehydration salts [127].

In summary, several features of Mali's health system organization and performance identified in this section point to possible bottlenecks to effective TFC implementation. Malian health indicators are troubling, particularly among the most vulnerable populations who suffer the greatest burden of illness and mortality. The sector's overall

governance lacks a strongly focused and coherent vision, and this is further undermined by a historic separation of the supply and demand sides and poor donor coordination. The highly decentralized structure of the Malian healthcare system is also likely to make implementing TFC in CSCOM and ASACO difficult, particularly due to their relative functional autonomy, dependence on user fees (especially from maternal and child healthcare), and weak capacity around governance and financial management. Their inadequate geographic distribution, staffing and available amenities already undermine effective access to care and are likely to be further stretched by a large increase in demand from patients benefitting from TFC.

3.3 Health financing in Mali

Since TFC is mainly a financing reform, this next section focuses on this dimension of Mali's national health system. It includes a review of general attitudes towards payment, trends in levels of government spending on health and possible opportunities to increase it, and a particular look at Performance Based Financing (PBF), a financing approach currently being piloted in Mali. From this examination, considerations related to TFC design and implementation are highlighted.

Entrenched Bamako Initiative

Similar to the regional history outlined in Part 1, beginning in the 1980s, Mali experienced a retreat of state financing and growing demand, which led to worsening health system performance. The first CSCOM/ASACO opened in Bamako in 1989, and this model gradually spread across the country [30]. The principles of the Bamako Initiative, particularly community management and cost-recovery, have since become deeply anchored in the Malian context.

A survey of Malian health care providers and the public confirmed that most find that payment for health services is "normal" and that it is accepted in a "pragmatic way" to ensure quality of care (including the availability of drugs), efficiency, and financial viability. A third of respondents strongly believe "if patients don't pay for services, they don't value them." Universal free care was perceived as being an undesirable "step backwards" from the Bamako Initiative. However, survey respondents were largely in favor of a more targeted approach which carves out pockets of free services within the cost recovery system, without scrapping it outright. All remained skeptical about the capacity of the state to fund and sustain such programs [145].

Underinvestment in health from government

The divestment of the state from paying for health continues to this day, especially at the primary health care level. Mali has very low overall spending on health, with current health expenditure per capita, combining all sources,

hovering between $ 30 - $ 40 USD per person per year since 2000, one of the lowest rates in the world. Health spending as a proportion of GDP is also low - reaching a peak in 2006 at 5.46% of GDP, and by 2018 falling to 3.88% [146].

Only a sliver of the national budget is going towards health, falling short of both the PRODESS and Abuja declaration target of 15%, and this appears to be shrinking. Average government expenditure towards health from domestic revenue between 2012-2015 in Mali was almost half the sub-Saharan African average [147]. Infrastructure, education, and defense and security are clear national priorities, representing 55% of the approved budget between 2015-2017. The country's overall nominal approved budget increased during that period, but most of this surplus went towards defense (85% increase over 3 years) [147]. According to one analysis, "public spending on health relative to the national budget declined between 2015-2019, showing a nominal growth barely above inflation of 2% per year." Health received the smallest proportion of the government budget in 2019 (5.1%) compared to defense (17.5%) and education (15.6%) [137].

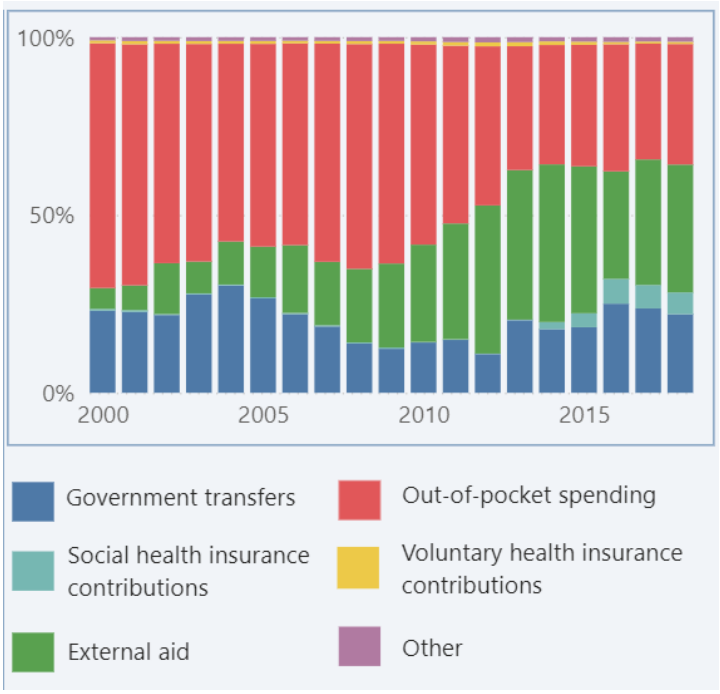
The absorptive capacity of the health sector between 2015-2017, that is the government's ability to execute or spend the budgets allocated, was 91%, which is below that of other sectors [147].

Of Mali's government spending on health, only a tiny fraction goes to finance primary health care. The MoH contributed only 5% of its 2019 budget toward CSCOM (compared to 18.4% to the hospital sector). This is the equivalent of 0.2% of the national budget, or 0.04% of GDP [137]. The government provides grants to CSCOM as a flat rate (200,000 CFA, or $ 358 USD) regardless of size, location, staff, or volume of service. Most of this money goes to staff costs, and the non-staff specific portion of this grant is given to the commune level rather than directly to health centers, at which point the MOH has little visibility or authority over its effective distribution. This commune level allocation from the state was the equivalent on average to 0.46 $ per capita [137].

Unsurprisingly, out of pocket (OOP) spending makes up a large portion of total spending on health. Direct payments from Malian households made up 65% of total health expenditure between 2009-2010. This proportion shrunk to

about a third (34%) in 2018. As illustrated in **Figure 1** below, this decreased share can be attributed to the modest growth of Social Health Insurance and an increased share of donor funding, rather than government spending, which remained relatively similar during this period between 22-28% (with a dip in 2012 to 11%) [146].

***Figure 1**: Sources of health expenditure in Mali 2000-2018*



(Source: WHO Global Health Expenditure Atlas Online Database [146])

This reliance on donor and OOP means that pre-payment and risk pooling, particularly among the poor, is virtually non-existent. The growth in insurance contributions towards overall health spending grew steadily following the introduction of the country's civil/private sector health insurance scheme in 2009, but this has plateaued since 2015 around 6%.

Limited alternative sources of financing: donors and innovations

Donor contributions to health in Mali are significant. In 2018, resources from financial partners corresponded to more than 60% of the total budget allocated to health [137]. According to Health Accounts (illustrated in **Figure 1**

above), donors have outspent the government in terms of contribution to total health expenditures every year since 2008 [146]. Due to capacity limitations, the absorption of donor money is poor. Unspent donor funds totaled $ 17.2 million USD in 2017 and $ 5.7 million USD in 2018 (representing 7% and 2% of all planned funding respectively), leaving large sums unspent [137].

The risks of the outsized role of donors in health financing was highlighted when Mali experienced a major corruption scandal involving one of the country's largest donors, the Global Fund, between 2010 and 2012. An investigation revealed that an estimated 53% of the funding from grants for Malaria and TB was misappropriated (amounting to $ 5.2 million USD), and this led them to be frozen [148]. A subsequent investigation led to another major HIV grant being suspended. Other donors such as USAID had to step in for drug procurement continuity. However, actors such as those providing psychosocial support for patients went unpaid for months [149]. Although funds have long since been unfrozen and national agencies have resumed their roles in management and procurement, concerns around donor dependency and the sustainability of these programs remain salient for many in the health system who remember this difficult time [150].

Alternative "innovative financing mechanisms" to expand the fiscal space for health in Mali are generally limited in scope and have not yet been utilized. A 2015 WHO supported workshop explored potential avenues for innovative financing – and identified 5 of 24 which received an in-depth analysis: new taxes on alcohol, telephone, airline tickets, financial transactions, and mining resources [151].

The first four are limited because Mali is a member of the West African Economic and Monetary Community, which provides a harmonized tax framework with limits on specific taxes (tobacco products and alcoholic drinks, for instance) and has standard taxation rules for certain sectors, such as banking and aviation [151]. The Ministry of Finance also considers these areas already overtaxed [134].

The option of taxing the mining industry to fund health is tempting, as extractive industries contribute 21% of government revenues nationally. Gold alone represents around 60% of total exports, making Mali Africa's third-

largest gold producer [152]. However, this was deemed "difficult" by the WHO analysis, pointing to a "lack of transparency on the taxes paid by these companies and on the quantities actually extracted. … The mining sector has enormous potential but requires strong political will to implement a tax." Their conclusion was that creating an additional tax on mining resources was "not feasible in the current economic and political context" [151].

Mali has already benefitted from the Highly Indebted Poor Country (HIPC) initiative between 2000 and 2003, with $ 49 million USD of debt relief funding disbursed to support different government strategies. This money mainly went toward reforms in the cotton sector, education sector, privatization, and health – which included funding for human resources for health and building health care facilities [153].

Finally, Mali's large diaspora population could theoretically be mobilized in some capacity (e.g., diaspora solidarity bonds), as personal remittances received, or money received from Malians living abroad, made up between 5 - 6% of GDP over the last decade [122]. However, only two countries have managed to turn this kind of initiative into a large-scale success : India and Israel [95]. It seems unlikely that a state-run scheme would supplant or replace direct transfers to families given the low level of trust in the state.

Performance-Based Financing in Mali: third pilot's a charm?

Performance-based financing (PBF) is a "mechanism by which health facilities are paid on the basis of their performance, which is measured by the quantity and quality of services they provide" [154]. It aims to improve service provision by linking certain indicators (e.g., number of vaccines administered, community satisfaction score) to "subsidies" that can be spent on staff bonuses and health center infrastructure. The scheme also includes robust monitoring and evaluation, which use several tools and counter-verification processes to promote transparency and autonomy with these infusions of funding. In 2020, a majority (32/46) of countries in SSA had at least piloted PBF, often with the support of the World Bank [155].

In Mali, PBF has undergone several phases of experimentation, with three different pilots over the last decade.

The first pilot (2012-2013) lasted 16 months and involved implementing PBF in 3 districts of the Koulikoro region (26 CSCOM and 3 CSRéf) with Dutch funding. A first evaluation by program consultants found increased utilization of services and quality of care [156]. However, a second independent evaluation that used more robust methods compared trends in maternal and child health indicators before, during, and after PBF with a comparison group. It found that its introduction and removal had no significant effect on the utilization of services [157]. Another study found that the project had weak sustainability, with many activities or routines ceasing or rapidly diminishing after it ended, including some low-cost ones such as supervision and meetings [158].

Despite these modest results and concerns raised about the program's sustainability, PBF was included as a priority area in the PRODESS III. In this context, a second pilot (2016-2017) was launched that included all 10 districts in Koulikoro region (205 CSCOM, 10 CSRéf) with World Bank funding. It was supposed to start in 2011, but due to the political crisis in 2012 and changes on the World Bank PBF team, it was unable to start till 2016, lasting only 8 months. This second pilot was described by stakeholders as more rigid and less government-led, as it was managed by an implementation unit set up by the World Bank [154], [159].

In part due to its very short timeframe, the second pilot phase did not benefit from a robust impact evaluation and is considered by some as "unsuccessful" [160]. A study of its implementation found long delays with the payment of bonuses (6 months) and only one payment and verification cycle, which let to staff disengagement. Other challenges related to the inappropriate distribution of bonuses and community M&E were reported [159], [161].

In response to these shortcomings, a third pilot phase (2019-2023) of PBF was introduced by the World Bank by conducting a randomized control trial in all 10 districts of Koulikoro and 7 new districts in other regions (402 CSCOM, 16 CSRéf). It also increased the number of indicators linked to subsidies from 10 to 43, and made their subsidy rates more generous, ranging from $ 0.27 to $ 32 USD [162].

The program includes several equity measures, including additional top-ups for districts and health centers that are "vulnerable" and with higher subsidies for care provided to the indigents (up to 3-4 x higher). Health care providers

can identify the vulnerable on a discretionary basis (i.e., formal documentation of indigent status not required) but this is capped at 10% of all beneficiaries to avoid abuses [162]. According to one stakeholder interviewed, so far, the proportion of indigents receiving care has remained low (closer to 3%).

A state agency (the CANAM, described below) acts as the managing body of two contracting and verification agencies, but the role of PBF payer is played by the World Bank Program Implementation Unit [162]. This round of PBF requires that bank accounts be co-managed by ASACO and CSCOM leadership for improved transparency, but this requirement led to 20-25% of ASACO refusing to be part of the pilot program. According to a stakeholder interviewed, the initial analysis of health centers found that few were financially viable, falling below the World Bank revenues threshold of 7$ per person in their catchment area per year, and many ASACO presidents were unfamiliar with computers and unable to speak French.

PBF is not designed to change the prices of care or drugs charged to patients – the subsidies are paid to health centers on top of their existing revenues. However, in some situations where the subsidies are much higher than the fees charged to patients, some health centers waived the user fees or even provided incentives in order to attract more patients (e.g., in one CSCOM, women who completed 4 pre-natal visits, now without consultation fees, also received a bar of soap) [159].

In summary, several features of Mali's health system financing are concerning for the successful implementation of TFC. The principles of the Bamako Initiative, including charging user fees, are strongly anchored in the healthcare system and Malian popular opinion. The health sector remains chronically underfinanced by government and highly dependent on donor and out of pocket spending. Recent trends show increasing crowding-out of health spending in favor of other sectors, particularly defense. Alternative or innovative financing avenues appear limited. PBF is still in a pilot phase, having shown quite modest results in past experiments. It exposed operational challenges related to weak CSCOM/ASACO governance and opaque financial management and underscores the difficulty of implementing a complex program in a timely way, even in a single region with significant donor funding.

3.4 Mali's financial risk protection: health insurance and fee exemptions

This final section will examine the financial impact on Malians of seeking care and analyze in detail the systems in place (or in development) to minimize these financial risks. These include the three national health insurance schemes and three main targeted exemption schemes. The history, design and performance difficulties facing each of these schemes illuminate important systemic weaknesses and dysfunctions in the Malian health system capability that will likely also affect the TFC reform. The section concludes with a summary of the key take-aways, a reflection on where Mali is on the road to Universal Health Coverage, and what challenges lie ahead.

User fees in Mali are a problem

There is ample evidence that out-of-pocket payments create a major barrier to care for Malians. High cost was cited by 55 % of Malians as the main barrier to care in a 2019 household survey [135]. The outsized impact of this barrier on the poor is evident across every health indicator – where the wealthier quintile has higher utilization rates than the poorest quintile [127].

To estimate the relative magnitude of the barrier posed by user fees in a particular context, it has been suggested to use a rough categorization based on the average GNP per capita. A low barrier is when fees are less than 1 day's average GNP per capita; medium is 1-5 days average GNP per capita; and high above 5 days average GNP per capita [68]. Following this logic, Mali's user fees are high. According to the 2012 DHS survey, household health expenditures amounted to 15,904 XOF ($ 27.40 USD) per inhabitant. The latest GNP per capita for that same year is $ 677, which is $ 1.85 per day[11]. The expenditure rate therefore translates to over 14 days average GNP per capita, well over the threshold of 5.

[11] This analysis used GNI per capita (constant 2015 US$) from the World Bank Data [122]

Another analysis in a sample of CSCOM found that the average rates charged for curative care visits (which do not include spending on drugs) were at or above the daily income of a household living at the poverty line [137].

Measuring the significance of financial risk for patients depends on the size of the risk and the baseline economic status (income, assets, access to credit) of the person incurring the risk. Therefore, financial risk can be judged by "the probability or the frequency that individuals will be impoverished by illness or prevented from obtaining adequate treatment by their lack of income" [35].

By this metric, Mali's current OOP system imposes enormous financial risks for families. Mali has one of the highest rates of catastrophic spending on health in the world, at 19%, meaning that spending on health threatens the ability to meet basic needs of nearly one in five households [163]. To cope with user fees, nearly one in three (29%) of Malians low-income households resorts to hardship spending, by borrowing or selling assets [164].

This leads to high levels of impoverishment. In 2015 alone, more than 400,000 individuals were impoverished from OOP health expenditures, which corresponds to a 2.3% increase in the national poverty headcount [165].

A qualitative study that followed patients in Mali confirmed the multifaceted dangers of user fees for the health and wellbeing of families. They were associated with "late treatment initiation, inappropriate or dangerous home-treatment, extended illness without treatment, inability to work, loss of food security, a decline in women's agency, and compromised access to education" [44]. The 2006 DHS populational survey also found that for those who sought care at a CSCOM, 20.5% of patients did not purchase or only partially purchased the prescribed medicines [166].

What financial risk protection measures are in place?

Currently, health insurance and user fee exemption schemes in Mali make up a patchy and confusing landscape. Many exemptions that exist on paper are rarely used (e.g., subsidized dialysis) and some have no legal provisions to manage or enforce them at all (e.g., cancer treatment) [167]. For schemes that are codified in legal texts, there exist

several inconsistencies between them, as new initiatives are often introduced without considering existing ones [168].

The three national health insurance schemes and the three main user fee exemption schemes in Mali require close examination and are analyzed in the two next sub-sections.

3.4.1 A close look at the performance of health insurance schemes

The three health insurance schemes in Mali are each described in detail below and summarized in **Table 4**. Each one targets a different population segment (civil servants and formal sector workers, the indigent and vulnerable, and the rest of the population). The management of these three schemes is fragmented across six different agencies, which creates high and duplicative transaction costs, as well as un-harmonized benefits, record keeping, accounting, and auditing systems. Human resources are spread thin between them, and "erratic sectoral dialog" undermines their coordination. There are also no financial links between the schemes, meaning that risk pooling is minimal and there is effectively "little solidarity and little redistribution between mechanisms and between social strata" [134], [163].

Despite the existence of these three schemes for over a decade, the majority (83%) of the Malian population is uninsured [169]. Even if the ambitious goals set out in the PRODESS for health insurance coverage were to be achieved, that would still leave 69% of the population, or over 16 million people, without any protection in 2023.

***Table 4**: Overview of Mali's three national health insurance schemes*

Scheme	Managing bodies	Target group (% of population targeted)	Proportion of target population reached (% of population enrolled), challenges faced.
AMO - Mandatory Social Health Insurance *Compulsory contributory scheme (members pay enrollment + copayment, alongside state/private employer contribution).*	**CANAM** - National Health Insurance Fund *Public institution that delegates some functions to the Malian Social Security Fund (CMSS) and the National Social Security Institute (INPS).*	**Formal sector**, civil servants, and their families (This scheme is meant to cover roughly **17%** of the population)	AMO has enrolled **48%** of its targeted group. (This is **8.2%** of the total Malian population) • Developed slowly (9 years), and implementation initially resisted. • Compulsory nature questionable, but enrollment increasing. • AMO less established at CSCOM level (30-40% centers not registered in scheme).
RAMED - Medical Insurance Scheme for the Vulnerable *Voluntary non-contributory scheme (100% state subsidized, split between 85% central government, 15% local authorities).*	**ANAM -** National Agency for Medical Assistance *Public institution, which pays for RAMED beneficiary. Enrollment done by local authorities.*	The **indigent** (any person who has no resources and is recognized as such by the local authority to which he or she belongs), orphans, prisoners, persons of no fixed abode, persons injured in armed conflicts/disasters. (This scheme is meant to cover **5%** of the population – based on estimated state capacity)	RAMED has enrolled **72%** of its target population. (This is **3.6%** of the total Malian population) • Financing from local governments difficult to collect, mostly centrally funded. • Administrative hurdles limit enrollment, but recent efforts have boosted numbers. • Enrollment often insufficient to benefit from free care in practice. • CSCOM experience very long reimbursement delays, many do not accept RAMED.

Table 4 (Continued)

Mutuelles –Mutual community-based health insurance scheme *Voluntary contributory scheme (enrollment fees subsidized 50% by state + copayment).*	**UTM** - Technical Union of Mutuality *Body in charge of "managing the health risks on behalf of Mutuelles members."* **AMAMUS** - Malian Agency for Social Mutuality *Administrative body in charge of controlling the legal creation and monitoring operations of Mutuelles.*	**Informal and agricultural** sectors (This scheme is meant to cover 78% of the population)	Mutuelles currently cover **6%** of their target population (This is **4.9%** of the total Malian population). • Heterogeneous scheme considered unattractive due to voluntary-contributory nature and limited benefits package. • Efforts to boost enrollment (state and donor subsidies, harmonized benefits) failed to produce expected mutuelle creation or enrollment. • Only 193 registered, unevenly distributed across the country, not all functional.

AMO: Mandatory social health insurance for the formal sector

The emergence of AMO was slow and undertaken mainly by technicians in the ministry responsible for social protection. According to stakeholders interviewed, it took 9 years (2001 – 2009) to formalize its design, with the team working on it first sharing their progress with government only in 2005. By the time a new president assumed power (President Touré), the policy had matured for 6 years and was ready to take on executive level support. The policy development process benefitted from uncharacteristic leadership continuity, having the same director of social protection in place for 11 years, who was later named director of the CANAM for 7 years.

The AMO scheme was formalized in law in 2009, at the same time as its managing body was created, the CANAM [56]. It was officially launched in 2011 with great difficulty. There was widespread reluctance on the part of its

intended beneficiaries, in part due to poor communication of its advantages, concerns about the quality of services available at public health facilities and skepticism of the ability of the CANAM to manage it effectively [163]. A lack of trust in the state bread hostility and “fierce resistance” to its mandatory nature, making enforcement difficult [59]. Shortly after its launch, the scheme was rejected by certain socio-professional categories, including higher education teachers who demanded the deductions be stopped and paid back, and the police who ransacked the CANAM headquarters [168], [170].

The government was forced to back down. A press release from the president “questioned (…) the compulsory nature of AMO, leaving workers free to choose whether or not to join AMO.” In September 2012, this led to the withdrawal of the equivalent of 17% of affiliated members. The law stipulating that it is mandatory, however, remained unchanged [168].

It initially struggled to provide services due to its limited capacity. Expenditures on benefits reimbursed to health facilities in 2011 was only about $ 1.1 million USD, and this represents a very weak claims ratio of 4% (amount in benefits paid / contributions) [168].

Over time its capacity was built and today the AMO is established and more popular, after demonstrating improved effectiveness. It also made its benefits more generous. The list of medicines covered by AMO was initially a limited set of generic drugs, but in 2012 this was expanded to include 95% of the products on the market [168]. Despite challenges around planning due to its fuzzy “mandatory” nature, the number of enrollees continues to grow.

However, the presence of AMO at the CSCOM level is less established and functional. According to stakeholder interviews, currently, between 30-40% are not registered to be part of the scheme. The heavy paperwork burden, slow reimbursement, and small beneficiary numbers have led several centers to suspend it because it is not cost-effective.

RAMED: Voluntary insurance for the worst-off

This scheme was developed slowly alongside the AMO and formalized by law in 2009 with its managing body, the ANAM. The 5% coverage target is not based on a census of the indigent, which has never been done, but on "the maximum capacity of the state to meet this financial burden" [168]. The scheme is entirely funded by government, with the financing split between central and local authorities. The enforcement of this split proved to be difficult, with local governments failing to pay and demanding their contribution be revised down from 35% to 15%, leaving the central government today responsible for the majority (85%) of RAMED financing. The care package offered is equivalent to the AMO, but with a more limited generic list of medications [168].

The scheme is confronted by several challenges. First, like many such schemes across sub-Saharan Africa, the application of the targeting criteria is difficult. These were only clarified in 2017, 8 years after the law was adopted, by a decree that also specified a long list of requirements for RAMED candidates: a written application, a birth certificate or equivalent formal judgement, a certificate of residence, and a certificate of indigence [171]. Unsurprisingly, that poses a serious administrative hurdle to indigents, who are often in a precarious administrative situation, and find themselves excluded.

Enrollment is further challenged by the fact that the ANAM has no decentralized representation. Instead, they delegate the identification and registration of indigents to commune level technical service agents of the ministry of Labor, Social Affairs and Humanitarian affairs, without providing them a specific budget for this [168].

These operational challenges led to low enrollment numbers. An evaluation in 2016 found that among the 134,875 people registered in the scheme (which is only 15% of their target), only 10,043 cases of free care were paid by the ANAM, which left 81 % of their allocated budget untouched [163].

Since then, significant efforts have been deployed to boost registration numbers, including through synergies between the RAMED and other donor supported schemes to benefit vulnerable populations (e.g., a cash transfer

scheme supported by the World Bank). This led the number of people enrolled to more than double by March 2018, to 290,416 enrollees [163]. A single social service registry (Registre Social Unifié, RSU) is being developed to help centralize data and assess eligibility for different social schemes, and to ensure the efficient enrollment and utilization across them (i.e., avoid redundancy and double-dipping). Challenges with the tool design are being worked out [172].

However, a 2017 study revealed that enrollment was often insufficient to provide effective access to care for RAMED beneficiaries. A phone survey conducted of 310 people enrolled in RAMED found that only 39% had in their possession the card or receipt issued by the ANAM that is required to access free care. Among the RAMED beneficiaries who were ill and sought care, 71% ended up paying for both their consultation and medication, including one third of RAMED beneficiaries who presented their cards or receipts at health centers. The root causes of the non-application of these benefits was not sufficiently explored in the study, and attributed in part to the "lack of information on the operation of the scheme by some health centers" [173].

According to stakeholders interviewed, the functioning of RAMED at the CSCOM level is undermined by very long delays in reimbursements (far worse than AMO). It was revealed during a workshop in April 2021 that the ANAM was still working on reimbursements for claims dating back to 2019. In practice, rare are the CSCOM that accept patients enrolled in the RAMED.

Mutuelles – voluntary contributory community-based insurance schemes

Mutuelles are the oldest formalized scheme in the country, with the first one being founded in 1980 by Alpha Oumar Konaré, who would go on to become Mali's first democratically elected president following the 1991 coup. The Technical Union of Mutuality (UTM) was created in 1998, with French and Belgian technical assistance, to provide a regulatory system to govern Mutuelles [56].

Despite this early start, Mutuelles have largely failed to take root. These schemes are considered “unattractive” to most Malians for a number of reasons. First, there is a problematic lack of harmonization across Mutuelles. There are generally unequal benefit packages between urban and rural Mutuelles, and they tend to be less generous than what is covered by AMO and RAMED. They are also voluntary and contributory, with unstandardized membership fees that vary from 1,500 to 5,520 CFA according to one study. This limits their capacity to pool risk [168].

A USAID funded study of Mutuelles in 4 districts in Mali between 2000-06 found that enrollment did improve healthcare utilization, even among the poor, compared to the unenrolled. The cost for families of 1 year of premiums and copayments for a household averaged $29 – $54 per year, which represents 2 – 3% of annual household income at poverty line. However, Mutuelle membership was found to yield no reduction in health care spending or savings in terms of overall spending (savings only occurred for the treatment of fevers). This limits their ability to retain members over time [174].

In response to this situation, Mali attempted to reboot the Mutuelle scheme by launching in 2010 the National Strategy to Extend Health Coverage to the Agricultural and Informal Sectors through Mutuelles Health Insurance (2011 – 2015). As part of this plan, they implemented a three-year pilot phase in three regions (2012-2014) with financial support from several donors, including France and Belgium, amounting to 20 million euros. In this scheme, the state subsidized 50% of the membership fees to Mutuelles (the equivalent of $5.40 per person) and required a package of benefits in alignment with the RAMED. The execution of this pilot phase was difficult given the security and economic situation in 2012, which led to the inadequate payment by the state of the subsidy (only 19% was financed) and insufficient communication. The impact on Mutuelle creation was unsatisfactory (of 150 hoped for, 30 were set up) and enrollment was disappointing, with less than half of the target 25,000 members enrolled, though retention was found to be good during the study period [168].

The French development agency (AFD) has been funding since 2017 an extension of the pilot model of subsidized and strengthened Mutuelles in the central region of Mopti. The AFD adds an additional 30% subsidy on top of the 50% of enrollment fees covered by government, leaving 20% of fees to be paid for by Mutuelle members (this

amounts to 2,000 CFA ($ 3.54 USD) per person per year). There are conflicting accounts from stakeholders about how unanimously this approach was supported during the conception phase by different actors involved [133].

This program encountered implementation challenges and delays in the planned health center renovation work and will end at the end of 2021. Unfortunately, although no formal evaluation has yet been conducted, according to stakeholder interviews, it does not appear to be yielding the desired results. Their enrollment target of 45% of the population was revised down to 15%, but enrollment has not exceeded 5% of the population.

In 2020, Mali had 193 registered Mutuelles, unevenly distributed across the country and with variable levels of functioning. These cover roughly 6% of their target (or 4.9% of the whole Malian population) [163]. In addition, it was found that Mutuelle enrollment numbers may not always accurately reflect functionality. In Ségou for example, there are 24 Mutuelles, but only 37% of their roughly 33,000 members are up to date with their membership dues.

RAMU: universal health insurance scheme (still in development)

The country's plan to remedy this situation is outlined in the National Health Financing Strategy for Universal Health Coverage (2018-2023), which was developed with support from the WHO and adopted by the Council of Ministers [147]. It advocates for increasing government spending on health and reducing fragmentation. A core goal is to create a single "universal" health insurance scheme known as the RAMU, into which the different health insurance and targeted free care schemes will be progressively folded. The RAMU will be contributory, but with exemptions given to RAMED beneficiaries, and provide a harmonized basic benefits package. The CANAM will oversee a single pooled fund, with some management delegated to different bodies: INSP, CMSS, ANAM, UTM.

The work to integrate these schemes into the RAMU has been underway by the ministry responsible for social protection since 2014. A high-level group of experts was created by legal decree to work on developing it in 2016. This RAMU expert group, led by the architect of the AMO and RAMED, is composed of 32 senior government agents from both the ministries of health and social affairs split into 5 thematic groups. The involvement of donors or

technical assistants has been limited beyond certain commissioned studies and workshops. The state has committed to making $ 100 million USD available for operationalizing the RAMU, which includes financing the work of this group [134].

The Council of Ministers adopted a law formalizing the creation of the RAMU in December 2018. However, the multiple "decrees of application" required to make it operational are still being developed. According to stakeholder interviews, these include different legal texts to detail the new role of the CANAM, to harmonize the tariffs and content of the basic benefits package, and to integrate existing TFC (beginning with cesarian sections), and others. A costing analysis of operationalizing the RAMU nationally is also underway.

3.4.2 A close look at the performance of existing free care initiatives

Alongside the RAMU framework, several programs exist to abolish user fees for targeted populations or illnesses. Some of them pre-date independence (e.g., leprosy) and not all of them are formalized with legislation [168]. The most important existing TFC programs are related to HIV, malaria, and cesarians. All three were announced during the presidency of Amadou Toumani Touré. They are managed by different vertical programs, benefit from different levels of donor support, and employ different combinations of input-based and output-based approaches.

The performance of these schemes can teach us a great deal about the stress placed on health centers and the staff coping mechanisms developed in response to free care reforms in Mali. This can help to anticipate how the same dynamics might play out with the newest TFC reform, and to think through different design trade-offs. Each is described in detail below and summarized in at the end in **Table 5**.

Free HIV/AIDS treatment

This policy emerged in 2004 after a decade of grassroots activism and leadership by Malian civil society, particularly ARCAD Sida and Groupe Pivot. These groups had both been providing free anti-retroviral therapy long before the state and were skilled at using the media. ARCAD Sida's CESAC clinic (Center for listening, care, animation, and advice) was a particularly important proof of concept and inspiration for policy makers [150], [175].

A medical technical committee was also set up as an "informal think tank on the issue of free treatment," which combined Malian physicians with international experts. They were able to leverage scientific evidence that free treatment was associated with improved patient compliance [150]. The policy was also made possible thanks to a substantial decrease in the cost of anti-retroviral therapy worldwide and pushes from the WHO and UNAIDS to improve access to treatment [175].

Around this time, an important new financing partnership was created: the Global Fund to Fight AIDS, Tuberculosis and Malaria (often referred to as the "Global Fund", launched in 2002). The decision to proceed with free HIV treatment was taken at the same time as the country was preparing a grant application to the Global Fund, allowing them to consolidate their plan with (the assumption of) significant funding. This was essential to launching the free care program, as the largest donor to HIV at the time in Mali, the World Bank, was against the idea [150].

The president announced free access to care for people living with HIV/AIDS (PLWHA) on April 7, 2004, citing the Global Fund first in the list of donors supporting the initiative, before Mali had received any funding from them. The announcement was described by many in the health care system as "unexpected." At the time, no feasibility study had been conducted [150].

Eleven months passed between the national policy declaration (April 2004) and the decree defining its application (March 2005). The decree specified that the program would cover medications, care, and treatment of opportunistic infections, however the list of opportunistic infections remains unclear [150].

The program is generally considered successful and manageable due to the relatively small number of PLWHA in Mali (adult prevalence is around 1.1%). At the time that the reform was announced, the country only had 750 patients on anti-retroviral therapy [150]. The program has been growing every year in terms of both the number of patients treated and sites providing care, as the strategy continues to decentralize and expand [176]. Today, more than 56,000 adults and children are receiving therapy in Mali, which is still only 52% of PLWHA [177]. In addition, as part of the significant support provided by external partners, – not only the Global Fund, but also PEPFAR, UNAIDS and others - important technical assistance has been provided to strengthen service delivery. Processes such as supply management, M&E, and training must meet a higher standard of rigor imposed by donors. This often creates vertical, parallel systems that are dependent on donor funding and poorly integrated within the broader health system [149].

Free cesarian sections

Unlike the exemption related to HIV, the decision to repeal user fees for cesarian sections came about with very little donor funding or grassroots mobilization. The decision was taken at the "highest level" with seemingly little consultation with technicians or donors. Its emergence on the national agenda has been attributed to the first lady being a midwife, and the Minister of Health being a woman - both animated to address stagnant maternal health indicators [150].

The reform was announced through "an official correspondence" to health facilities in June 2005, sent 4 days after the presidential announcement, asking them to pre-finance procedures and the cost of consumables, even before the kit of inputs was defined [178]. The implementation guide that specified more policy details was released over a year after the announcement (August 2005), but its dissemination was limited – a survey found that only 12% of health staff said they had it at their disposal [145]. The policy guide was further clarified nearly 4 years later with an inter-ministerial order that specified the terms of reimbursements [150].

This policy has had a major impact on the rate of cesarian sections. A decade after its introduction, the number of cesarians more than doubled, from 12,680 in 2007 to 25,934 in 2017. The number of cesarians tripled in some regions. This translated to an overall cesarian rate of 2.17% of births in 2008, up from 0.9% in 2005, but still below the WHO recommended rate of 5% - 15% [179]. The benefits of this policy were found to be relatively equitable, with a reduction in education-related inequalities in access after the policy was introduced. However, differences in rates between rich and poor and urban and rural areas persist (e.g., Bamako: 2.72 – 7.11% compared to Kayes: 0.45 – 1.47%). The policy was also found to positively affect the rate of normal deliveries occurring in facilities, and post-cesarian maternal and neonatal mortality rates [180].

However, government funding for the program has not followed the increased number of cesarians. After an initial increase between 2005-2009, with an average annual increase of 40% according to the MOH [150], funding between 2010 and 2017 plateaued at or below $ 1.8 million USD per year [167]. This was felt at the service delivery level as the state failed to "ensure sufficient supplies and the reimbursement of the sums due to the centers (…) rapidly leading to indebtedness" and fears of bankruptcy – a view shared by stakeholders interviewed. Delayed payments to the central pharmacy (PPM) have led to an accumulation of debts "which dangerously compromise the survival of the PPM and consequently the sustainability of the free cesarian section strategy" [178].

The policy stipulates that "kits" of medication and supplies are provided to health centers, and that they are reimbursed at a flat rate for each cesarian – with differences made between "simple" and "complicated" cesarians. However, both aspects have proven to be difficult to manage.

The use of "kits" of medical products is attractive to rationalize expenses and standardize procedures. They are quantified according to prevalence and population, based on an average hospital stay of 5 days. They are distributed twice a year, whereas cash reimbursements for services happen quarterly. Their content is established according to Bamako hospital standards – leading to concerns around expiring unused products, and inappropriate drugs to manage pain, infection, and high-risk cases (e.g., patients with hypertension) [178]. The kit was reviewed in 2007 to allow for a "complicated cesarian kit" – however, the distribution of these kits often has little to do with actual need.

The management of kits is weak and untransparent, leading to inputs that are "often diverted." No actual unitary "kit" exists; they are meant to be reconstituted by health centers based on a list of products. In practice their stocks are irregular and provided by different suppliers, making their rational management difficult [150].

Another major shortcoming of the policy is the ineffective financing of the referral evacuation system from CSCOM to higher echelons of care. Government financing for emergency referrals was removed from the budget during the design negotiation phase, following push back from the Ministry of Finance. Instead, referrals are to be co-financed by several community actors in a "solidarity fund." However, in practice these funds are rarely sufficient (only 21% of funds were contributed in 2009) and up to half of them are not functioning [178]. A study of obstetric emergencies in one region found that 67% of women paid for transportation. This is on top of the cost of travel from the household, which must always be paid for by families [41].

There is evidence that the policy was effective at reducing the cost of cesarians for families. However, due to issues with the availability of kits and transportation, large costs are still born by families. A study in one region found that 91 % of women still had to pay something for their treatment, and that costs averaged $ 163 [181]. Another study found average expenses of $ 151 and revealed that between 20 % and 53 % of households still experienced catastrophic expenditures, according to different thresholds of annual income consumed [41]. The greatest share of expenses (70%) was for treatment, including medications not in the kit or out of stock, and for transfusion (which is generally not available outside of the capital) [41], [181].

Another challenge facing the free cesarian policy relates to the reimbursement rates, which are 30,000 CFA ($ 60) for a simple cesarian and 42,000 ($ 84) for a complicated one. A MoH estimate of the true cost found this to be "largely insufficient" [167]. Indeed, prior to the introduction of the policy, the costs for cesarians were very high and variable – ranging in Bamako in 2006 between 51,000 and 121,000 CFA ($ 91 – $ 216 USD) [178].

The adoption of the kit system and the low fixed reimbursement rate has generated a financial loss for specialists, particularly gynecologists, who formerly could charge and prescribe what they wanted, often selling products

directly to patients (for a profit). An observational study found that this created a situation where "qualified medical personnel now have little to gain from each act, and tend to withdraw, especially if they can intervene in private clinics." Significant task shifting to junior trainees or interns was taking place for surgeries. For other types of personnel who can less easily delegate their work, an important increased workload was observed, including for anesthesiologists, pharmacists, and accountants [178].

The monitoring of the policy was meant to be integrated into the existing supervision system financed by the state, but due to underfinancing, only one supervision visit was conducted in 2006, one in 2007 and none in 2008. The data captured through supervision and M&E by the central level did not allow for an understanding of the impact of the policy on household spending, hospital finances or input management [178].

Free malaria care for children under 5 and pregnant women

The targeted free malaria care reform was the last to be introduced in May 2007. It came about following several important changes in the context. First, like many countries concerned with increasing drug resistance, the government was planning to change national treatment standards away from chloroquine to Artemisinin-based Combination Therapy (ACT). There was concern at the time that the price of ACT, which is three times higher, would negatively impact care seeking [150]. At the same time, there was also a great deal of donor funding available to combat malaria, including the Global Fund, the US President's Malaria Initiative, the World Bank, and Roll Back Malaria [175]. "There was no lack of money for malaria funding at the time, but rather a lack of absorptive capacity and skill at the national level" [150].

Finally, an influential pilot project was carried out in one district by MSF-Belgium (2005-2006). This experiment generated compelling evidence to support repealing all user fees for children under 5 and treatment for all pregnant women with fever. It showed a direct positive impact on malaria treatment utilization (3.5 x higher among children, 5 x higher for pregnant women), on overall children's consultation visits (5 x higher) as well as on maternal and infant mortality. It also found the cost per treatment episode to be very low (3.24$) and cost-effective [182]. "Despite

overall higher total costs, the cost per person treated fell, based on economies of scale." This was due to the improved use of existing human resources (a fixed cost), who were only seeing 4-7 patients a day before the program was introduced [183]. These results were disseminated domestically and internationally and became a source of pride for Mali [150].[12]

The announcement in a presidential speech came as a surprise to many. It was framed as "a year-end gift from the President to women and children during his December 2006 wishes" [175]. According to stakeholders interviewed in a study of the reform, the initial announcement was "vague" and suggested the policy would be inclusive of the whole treatment [184]. However, the fear of lost revenue for CSCOM, "incoherence with the Bamako Initiative," and donor dependence led it to be scaled back [150]. In the end, the policy only provides the following: for children under 5 with "uncomplicated malaria" only free ACT and rapid diagnostic test (all other drugs and fees are not free); for children and pregnant women with severe cases of Malaria a free kit of supplies was provided; for women undergoing prenatal care visits only preventative treatment was free.

This decision was made despite very firm conclusions from the MSF team leading the pilot: "providing proper malaria care with effective drugs and diagnostics is not enough nor effective if this is isolated from free care at the health center level. We found that the strategy of targeting too narrowly (subsidizing tests and drugs only) was self-defeating" [183].

Nevertheless, the narrower policy was deployed in all the 1400+ CSCOM in the country and 65+ CSRéf. It faced real resistance from the operational level right from the start [149]. Following the policy announcement, ASACO were asked to pre-finance inputs and care, which led many to refuse until drugs were available. One CSCOM in a rural district that did go ahead lost 80,000 CFA (143$) in a single week, which was deemed "suicidal and immediately

[12] Unfortunately, when MSF-B withdrew at the end of the pilot, despite having put several measures in place, it was "faced with the steady collapse of the facilities it has put in place (and a decline in the number of visits), the MSF-B took the decision to extend their infusions of aid (…by) outsourcing to a local NGO" [97].

suspended" [185]. The first supply of ACT came relatively quickly, within a month of the announcement. However, the delivery of rapid tests, technically required to provide free ACT, came much later.

The policy succeeded in increasing the rate of curative consultations for Malaria among children under 5. This went up quickly in the first two years (consultation rates went up 72% and 65% respectively), and then decreased and "stagnated" following 2009 [185]. The effect size was nowhere near the one observed in the MSF pilot, which had a more generous care package [182].

Malaria treatment represents a large portion (51%) of medical visits for children in public health centers [150]. It is an important source of income for facilities and a lucrative business for those involved in the sale and purchase of medicines (ASACO and health care providers) [184]. Interestingly, the effect of the policy on health center financing was found to be positive, with increased drug and consultation revenue effectively offsetting the lost profit from selling ACT [136]. Indeed, the policy also had a limited effect on household spending on malaria treatment. The before-after savings averaged about 500 - 1000 CFA ($ 0.90 - $ 1.79) for simple cases, and 1500 - 3500 CFA ($ 2.69 – $ 6.27) for complicated cases. A review of a sample of patient treatments revealed that many more products than ACT were being prescribed, including the systematic inclusion of antibiotics (indicating possible provider moral hazard).

Other serious implementation challenges were observed, including reports of severe recurring drug stockouts, with two studies of a sample of CSCOM finding ACT to be unavailable between 122 and 200 days a year [182], [185]. Stakeholder interviews confirmed that this is a ubiquitous problem and highlighted that the delivery of kits for severe malaria treatment has essentially stopped in recent years (none were reportedly received in 3-4 years, and 8-9 years respectively). At the same time, input management is also undermined by health facilities providing reports "late and very irregularly" [184] and by the diversion or theft of free products. Although data on this practice is unavailable, all operational level stakeholders described seeing "free products" (mosquito nets, drugs, tests) for sale in private pharmacies.

Around communication, it was discovered that ASACO leaders, who had been charged with disseminating the policy with the communities they represented, reportedly withheld information from local political leaders and patients, as well as health professionals, for fear of the effects of the policy on their finances [185]. This particularly penalized patients living in poor areas with less access to the media. Other health providers behaviors were documented to ration care, such as only offering free drugs and tests during the morning hours of weekdays (other times patients were directed to the “for profit” pharmacy) [184].

Finally, monitoring and evaluation of the policy is integrated into the quarterly supervision visits of the district management teams. Unfortunately, these visits are rare and were suspended nationwide between 2008-2009 due to lack of funding [185].

***Table 5**: Summary of Mali's three main targeted user fee exemption schemes*

	What is "free", for whom and where?	Characteristics
HIV (2004)	**What:** Covers medications, care, and the treatment of opportunistic infections. **Who and Where:** People requiring testing and counselling for HIV and those with a confirmed clinical diagnosis (beneficiaries = 56,000, sites roughly = 239).	**Relatively manageable and successful.** - Driven by strong civil society and grassroots mobilization. - Progressively expanding and decentralizing. - Benefiting from important donor support (financing and M&E).
Cesarians (2005)	**What:** "Kit" of medications and products for cesarian sections (2 types: simple or complicated) + cost of the service reimbursed as flat rate by government. Transportation costs from CSCOM to CSRéf assumed by community actors in pooled "solidarity fund" **Who and Where:** For obstetric emergencies requiring a cesarian section at referral, regional or teaching hospitals (57 sites country wide, not at CSCOM level) [179].	**Encountering important implementation challenges, especially underfunding.** - Funded almost entirely by the Malian government - Contents and supply of "kits" challenging. - Delayed or insufficient reimbursements to health centers and central pharmacy causing financial strain. - Dysfunctional "solidarity funds" for ambulance transportation. - Effectively increased number of c-sections and reduced expenditures, but significant costs still born by families, continued catastrophic spending. - Low reimbursement rates leading to task shifting to less qualified personnel. - Weak M&E.
Malaria (2007)	**What and who:** - For children under 5 with uncomplicated malaria: free ACT medication and rapid diagnostic tests. - For pregnant women and children under 5 with severe malaria: treatment kits. - For pregnant women at prenatal care visits: free preventative treatment and mosquito net. **Where:** At all levels of health pyramid (+1400 CSCOM, 65 CSRéf, hospitals).	**Encountering important implementation challenges, especially input stockouts.** - Significant donor funding for malaria allowed for ACT subsidy. - Decision to adopt policy influenced by MSF-led pilot showing health benefits and efficiency gains, but package adopted more limited. - Pre-financing requirement rejected by some CSCOM, considered impossible. - Drug and test supplies very irregular, management poor, frequently out of stock, especially kits for severe malaria. - Narrow benefits package leads to continued OOP for families, does not lead to lower CSCOM revenue. - Rationing of care observed by limiting information and operating hours. - Weak M&E, communication bottlenecks.

In summary: where is Mali today on the road to Universal Health Coverage?

As things currently stand, the financial risk born by Malian families facing health care needs is significant. The majority (83%) of the population is not covered by any health insurance, and each scheme is facing its own challenges with enrolling and serving beneficiaries [169]. The vision to integrate the fragmented and duplicative system exists but its realization is slow. The RAMU appears to be several years from being fully operational and will likely struggle against popular resistance to mandatory schemes and the weakness of the Mutuelles component, which is meant to cover most of the population (78%). Equity issues will also arise due to the financial barrier imposed by enrollment fees and the weak diffusion of the schemes at the CSCOM level.

At the same time, the existing user fee exemption schemes are very narrow and pathology specific, offering limited financial relief to families due to their design and implementation challenges. There is a clear gap between the promise of what they should do (de jure) and the reality of their performance (de facto) – pointing to weak state capability in this area. The scheme that appears to be the worst performing and encountered the most resistance from providers, free Malaria treatment, shares important features with the new proposed TFC (e.g., implemented at CSCOM level, concerns about impact on ASACO finances). Except for the free HIV-AIDS treatment scheme, which generally performs well thanks to parallel donor-supported systems, the health system's structural weaknesses around supervision, supply chain, communication and payment greatly undermine program effectiveness. Frontline workers may welcome efforts to expand access for patients, but program dysfunctions have led them to engage in coping mechanisms to compensate for lost revenue and autonomy (e.g., task shifting, input diversion, care rationing).

Nevertheless, the PRODESS IV (2020-2023) includes the UHC-related goal of increasing coverage of populations by social protection systems (strategic result 9.4). Among the several "priority interventions" listed to achieve it, both

increasing health insurance coverage[13] and generously expanding targeted free care beneficiary groups[14] are included alongside each other, as well as "the gradual integration of free services into universal health insurance". However, the costing estimated to achieve strategic result 9.4 reflects none of these interventions.

Regrettably, Mali is far from its goal of UHC. In fact, according to a 2019 UHC index ranking done by the WHO, the country was ranked in the bottom 10 countries in the world [186]. The road ahead to UHC appears long, and the work required to integrate and broaden health coverage will not be easy or straightforward in the medium term.

[13] "Extend the social coverage of the population through social protection mechanism (social security branches, Mutuelle insurance schemes, AMO and RAMED)."

[14] "Removal of barriers for vulnerable groups (pregnant women, children under five years of age, people aged 70 and over, emergency first aid and victims of gender-based violence) through free care (prenatal consultations, assisted deliveries, post-natal consultations, vaccination, curative and preventive care, family planning and dialysis)."

PART 4: Results

Part 3 offered a deep dive into Mali's healthcare system and highlighted key dimensions to consider when thinking about TFC. It identified systemic weaknesses and dysfunctions that can inform design trade-offs and flag potential risks facing policy makers.

This final portion of the thesis, Part 4: Results, builds on the previous three parts and contains the core of the political analysis work. It is divided into four results sections, each building upon the other. Their aim is to elucidate meaning and strategy for policy makers in Mali.

Section 4.1 is a reconstructed narrative description of the lead-up to, content of, and response to the major primary health care reform announced by the president of the Republic in 2019. It covers roughly 32 months from the announcement to the end of the study period.

Section 4.2 builds upon the narrative description and contextual analysis and evaluates the extent to which Mali has been (so far) able to follow the 14 best practices for implementing TFC outlined in Part 2. It also proposes some ways to move forward strategically.

Section 4.3 attempts to contribute to part of the Best Practices by presenting the results of a stakeholder analysis and mapping, including a comparison of the past and current positions of key stakeholder groupings vis à vis TFC along two axes – support and power.

Finally, Section 4.4 presents an analysis of where the policy stands at the end of the study period (September 2021) by applying Kingdon's Multiple Streams framework. It explores the interactions of three dynamic processes (or

streams): the problem, the policy, and the politics, and assesses the existence of a window of opportunity to implement the policy.

As described in the methodology, the multiple sources of data used are peer-reviewed literature and documentary review, over a year and a half of participant observation documented with contemporaneous field notes, and 19 stakeholder interviews. This data was triangulated and synthesized for each of the analytical frameworks used, which are described in each section alongside their results.

4.1 Narrative account of the 2019 Primary Health Care Reform in Mali

The following section presents a narrative account of the emergence, content, reception, and first steps towards implementation of the presidential primary health care reform announced in 2019. It is reconstructed based on a triangulation of the documentary review, participant observation, and stakeholder interviews.

It describes important contextual events related to the policy, covering the period from mid-2019 till the end of September 2021. The key events covered, which include political and ministerial changes, new donor funding, and policy-making developments, are summarized in a timeline at the end of the section (**Figure 2**).

4.1.1 The lead-up, content and reception of the reform

The reform takes shape

The challenges facing the Malian health system were evident to those working in it and there had long been talk of the need for reform. Some perceived it to be a crisis requiring "sounding the alarm." Professor Samba Sow was one such person who voiced that a change was due [187].

Professor Sow is a Malian physician and epidemiologist trained at the London School of Hygiene and Tropical Medicine, who has taught at the University of Maryland and in Bamako [188]. For many years, he was the head of the Center for Vaccine Development (CVD) in Mali, working to improve laboratory capacity and introduce novel vaccines. He was celebrated by many as being central to the country's effective response to the 2013-2014 Ebola outbreak in West Africa. Prof. Sow is also a collaborator and contributor to the US-based Global Burden of Disease project of the Institute for Health Metrics and Evaluation (IHME). In 2017, IHME awarded him the prestigious Roux prize for his work with the CVD using evidence to save lives in Mali. That same year, Prof. Sow was asked by the President of Mali to serve as the country's Minister of Health [188].

In the first year of his tenure, Minister Sow and his cabinet team began to craft their reform vision, writing terms of reference for the process and engaging with several donors and stakeholders. He was inspired by the "Saving One Million Lives" initiative to expand access to essential primary health care services for women and children launched by the President of Nigeria in 2012. He adapted this to the context, crafting a preliminary concept document for the "Saving One Million Lives" presidential initiative in Mali.

Through a colleague from IHME, Minister Sow was connected to CHAI. He invited them to send a small team to conduct a week-long scoping visit in the fall of 2019, which included meetings with him, the Minister of Finance, senior cabinet officials and donors. A subsequent working session took place between Minister Sow and CHAI at the 2018 Global Financing Facility replenishment conference in November in Oslo. At this event, Minister Sow publicly announced his intention to reform the Malian health care system, without yet presenting any specifics [189]. This also set the stage for a more formal collaboration with CHAI to help to flesh-out the reform vision into a concrete, evidence-based document.

In January 2019, an 8-person CHAI team arrived in Mali and joined a small, centralized reform group around the Minister, composed of cabinet level advisors and directors. More inclusive thematic working groups were also created alongside it to generate content and contextual insights to feed into the analyses underway. The work led by the smaller reform writing team included analyzing financial data with the Ministry of Finance, conducting a donor resource mapping, and analyzing epidemiological data with the country's main statistical and planning body. They also conducted site visits and reviewed documents; most of this engagement was one directional (upward).

This analysis and writing process was very short and intensive – lasting only about 4 weeks at the start of 2019. The intention of the Minister was to move quickly and act boldly. A consensus emerged between the writing team and the working groups around the main themes and priorities to tackle, especially around primary health care. An analysis using LiST, a modeling tool that can be used to estimate the impact of a package of services on the number of lives saved, found that it would be impossible to save a million lives due to the relatively small population of Mali, and so the reform was "rebranded" from saving one million lives to "the Primary Healthcare Reform."

Content of the reform

The reform document entitled "Framework document for health system reform in Mali - A presidential initiative for the progressive reform of the Malian health system (2019-2022)" describes the progressive roll-out over four years of an ambitious plan to strengthen the primary health care (PHC) system [137].

The reform document announces the intention to repeal user fees for three priority groups: children under 5, pregnant women, and people needing family planning, but it does not define how this should be done (payment system, service package, etc.). It also presents a plan to train and deploy a national ASC[15] workforce to provide essential services for free at the community level, as well as to carry out a package of 9 primary health system strengthening (HSS) reforms.

1. Renovate and rehabilitate CSCOM, and ensure they have the minimum equipment.
2. Redraw the map of CSCOM to better reflect norms and catchment populations.
3. Rationalize central government contributions to PHC and harmonize health service tariffs.
4. Align CSCOM staffing contracts "through a central authority to allow for rational distribution of staff and increase accountability."
5. Strengthen the governance and management of ASACO: rework laws and decrees, revise and refocus their role and responsibilities, enforce governance norms.
6. Create a new accreditation body to set and enforce minimal standards and benchmarks for CSCOM.
7. Strengthen and better integrate the existing health information system at the PHC level.
8. Overhaul the MoH's planning process, budgeting, and coordination (including of donor resources).
9. Create a new National Public Health Institute.

[15] ASC or "Agents de Santé Communautaire" are the Community Health Worker in Mali. They are described in more detail in section 3.2.

This would be rolled out gradually, with TFC being introduced after the health system strengthening measures, particularly renovation and ASC deployment. A 4-year scale-up roadmap was to begin with a small number of CSCOM and expand to cover the country (2019 (Y1): 61 CSCOM and 1,780 ASC… 2022 (Y4): 1,346 CSCOM and 27,576 ASC.

The plan included a costing model of 3 targeted free care scenarios (care as usual, all services are free for all, or services are free only for the 3 target groups). Projections of future domestic and external resources fed into a fiscal space analysis and a proposed funding plan for the reform, which included increasing the national budget allocation for health from 4.53% in 2019 to 5.72% in 2022 (alongside a call for donors to match this). The preliminary cost estimate for implementing TFC and ASC was $ 12 million in 2019, increasing progressively to $ 124 million USD in 2022. This did not include capital expenditure for renovation and inputs like drugs already supplied for free by donors.

Reform announcement

Once the reform document was drafted, Minister Sow began to plan for a dissemination workshop with MoH and development partners to present the results of the analysis and reform recommendations. The scope and profile of this workshop evolved rapidly over the course of two weeks into a high-level workshop with the President of the republic.

On February 25th, President Keita's opening speech included the announcement that the reform would include providing care free for 6 beneficiary groups: children under 5, pregnant women, those needing family planning, healthcare for people aged over 70, dialysis services, and emergency care for people affected by accidents, catastrophe, or war. This was met with a standing ovation.

A video compilation followed with several national and international leaders and figures, congratulating Mali on its new reform initiative, including the executive directors of the WHO, Gates foundation in Africa, Global Fund, UNAIDS,

and health director of the World Bank. Mali's Minister of Finance at the time, former World Bank health economist Boubou Cissé, also explicitly voiced his support.

The week-long workshop that followed was one of the nation's largest ever organized around health and included hundreds of people from across the health system, including Ministers, Secretary Generals, and high-profile Malians who came out of retirement. The goal was to gather all the key stakeholders to spend time familiarizing themselves with the reform and discussing how to operationalize it. Participants were divided into three working groups: provision and quality of health services; governance and communication; and health financing. This workshop resulted in a more "macro" reform framing document which added contextual elements.

The initial reception of the reform

The announcement of the reform was followed by a period of great optimism and what some stakeholders described as "euphoria." It was lauded in the international press, including several partner websites [190], [191], opinion editorials [51], and an article in the Lancet medical journal [192]. A Guardian article from March 7, 2019, ran with the headline ""Incredible moment": impoverished Mali to give free healthcare to under-fives" and goes on to herald the President's announcement of the reform as a "turning point" [187].

It was frequently framed in the historical context of user fees, with one article asserting for example that "the reforms effectively end a 30-year practice known as the Bamako Initiative, which required patients to pay for their own healthcare costs" [51]. It should be noted that this framing misrepresents the fact that although this new user fee exemption initiative is more generous than what currently exists, it does not fundamentally eliminate cost recovery from the Malian healthcare system, since most of the population are not included in the beneficiary groups and still need to pay out of pocket for services.

The Malian press was also largely positive, covering the high-level announcement and workshop with fanfare. An article featured on the MoH website has the headline "New health system reforms: primary, curative and preventive

health care now free" – making no mention of the plan for a progressive roll-out over 4 years [193]. It frames the reform in its domestic context, as being part of a "presidential social emergency program."

A feature common to both the international and domestic media coverage identified by the author during this study is its inconsistency about the intended beneficiary groups of TFC. Most focus only on the three included in the reform document (children under 5, pregnant women, family planning), overlooking or only partially including the three others added during the presidential announcement (people over 70, dialysis, emergency care).

Coverage of the President's announcement created the impression that free care would be provided right away to beneficiaries, and this let to people going to health centers the next day, creating confusion. The MoH issued several press releases to clarify that the vision was first to improve the quality of care and service delivery, and later, to make care free.

According to stakeholders, criticisms of the reform, initially more muted, began to come to light in the following weeks and months from government and technical and financial partners. Much of it centered around the process of its development, specifically its haste and lack of inclusivity [133]. The style of working during the reform writing caused friction in a context accustomed to slow, participatory work. There was also confusion and mistrust around the role of CHAI in the context of the reform, particularly from other more established donors and technical partners. This led many stakeholders within and outside of government to temper their buy-in.

The content of the reform was critiqued by some for not being explicitly in synch with the ongoing strategic frameworks and initiatives, such as the PRODESS IV or the RAMU (neither is mentioned in the reform document presented at the high-level workshop). Concerns about its cost and financial sustainability and the risk of exacerbating donor dependency were also frequently raised [133], with many behind closed doors saying it was not feasible. For others, the reform touched upon sensitive political issues around the decentralized powers and autonomy of community health actors vis-à-vis the central government (how they generate revenue, how they hire and manage their staff, etc.), and raised red flags.

4.1.2 Since the reform's launch: turnover, turmoil, and fragmentation

New Minister, new money, and a workshop

Less than two months after the reform was announced, on April 19, 2019, the Prime Minister and his cabinet resigned, including Minister Sow [194]. Three weeks later, to the surprise of many, Michel Sidibé was named Minister of Health on May 5th.

Michel Sidibe is a high-profile public health leader from Mali with a remarkable 40-year career, trained in economics and international development. He had previously spent nearly two decades with UNAIDS, including 11 years as its Executive Director in Geneva. In this role, he championed bold global target-focused initiatives that boosted the number of people on anti-retroviral treatment, such as the "90-90-90 treatment target" initiative [195].[16] His departure from UNAIDS was tainted by allegations of mismanagement [196].

Minister Sidibé inherited a MoH that had newly re-integrated the social protection portfolio after 19 years of it being under a different ministry, as well as the Primary Health Care reform announced just three months earlier.

The MoH secured catalytic funding to launch the reform from the Global Fund and GAVI, under their strategic axis of Health System Strengthening (HSS grants: $ 10 million and $ 12 million respectively). There was initially a plan to create a 3-donor partnership with the World Bank, but this did not come to be, the latter preferring to proceed in a separate but complementary way. The focus of this catalytic HSS funding was around renovating and equipping CSCOM, developing an accreditation system, funding the deployment of ASC, and in the case of one grant, providing subsidies to CSCOM for TFC.

[16] Countries push to achieve 90% of people living with HIV knowing their status, 90% of people who know their status are accessing treatment, and 90% of people on treatment having a suppressed viral load.

In June 2019, a workshop was financed and facilitated by UNICEF for the "operationalization of the community-based health system reform in Mali." The objectives of the workshop included defining the package of care and estimating the cost of free services. The workshop was led by one of the sub-directorates of the General Directorate of Health (DGSHP), the main health technical agency of the MoH. It was attended by many government actors (though none from the cabinet level), and few partner organizations.

The outcome of this workshop reveals several deviations from the content of the reform as announced. It includes offering targeted free care services in private health centers, and proposes a different scaling strategy and timeline (shifting from a progressive scale up by CSCOM clusters between 2019-2022, to an all-at-once national scale-up progressing by beneficiary group, starting with children under 5, then women, then the others from 2019 to 2025). In addition, the service packages for 5 beneficiary groups (dialysis being left out) were broadly defined, but their costing data limited. For example, for people 70 years or older, all "consultation fees, complementary examinations, medicine, and consumables" are to be free, but the average cost per episode of care was estimated to be only 2500 CFA ($ 4.48) [197].

A second large workshop was planned but did not occur. Instead, smaller ones took place to draft legal texts (November 2019 and January 2020). In the case of TFC, the preliminary draft decree has yet to move forward.

New direction: the Mali Action Plan

A few months into his tenure, Minister Sidibé began to focus on having Mali be the first country in the world to put forth a national initiative in line with the WHO "Global Action Plan for Healthy Lives and Well-being for All" [198]. He began developing the contours of the Mali Action Plan (MAP), which would draw significantly from the 2019 reform strategy, but put forth his own vision for strengthening Mali's health care system.

In mid-December 2019, CHAI assembled a new team to work in Mali, with 4 full-time in-country staff and 3 part-time internationally based staff[17]. They began work on supporting Minister Sidibé and his cabinet team with crafting the MAP and launching the HSS work. Less than a month into 2020, the Minister presented an overview of the MAP to Mali's technical and financial partners. A full draft of the MAP was shared in the following weeks for feedback.

Minister Sidibé's vision in the MAP draws on the 2019 reform, but with some new ideas. It structures the work to be undertaken into 5 pillars: primary healthcare; secondary healthcare; diagnostics and laboratory services; pharmacy procurement and distribution; and solidarity and social protection. TFC is included in the MAP as an overall goal, within the framework of "100 – 100 – 50 – Plus" whereby 100% of services provided by ASC will be free, 100% of services will be free for children under 5, pregnant women, and women in need of family planning, and 50% of services will be free for all at CSCOM (this last element was new and undefined). The "Plus" referred to "a radical renovation and upgrading of the national health sector," which was akin to the reform's HSS package [199].

Minister Sidibé requested UNICEF and the World Bank collaborate to undertake a more detailed costing of TFC. Following a delay with the World Bank team, UNICEF went ahead by contracting a US-based team of consultants to begin work on a costing model in February 2020. One of the consultants hired happens to have been a lead proponent of the Bamako Initiative in the 1990s and 2000s.

Confusion, COVID-19, and a first coup d'état

In early 2020, several different parallel "reform" workstreams were underway. Following the announcement of the Primary Health Care reform in early 2019, UNICEF worked with MoH technical agencies to move its "operationalization" forward by facilitating workshops. Meanwhile at the cabinet level, Minister Sidibé was developing and later introduced his vision of the MAP. This led UNICEF to reorient its work toward costing TFC for the MAP. At the same time, the national unit responsible for planning and statistics (CPS) was finalizing the PRODESS

[17] The author arrived as part of this team in January 2020.

IV, which would also be released in early 2020. Finally, actors from social protection, who had passed the RAMU law only three months before the 2019 reform was announced, were continuing their work to operationalize the RAMU but now from within the MoH.

Around this same time, reports were beginning to gain global attention of a novel corona virus outbreak in Wuhan, China. The WHO declared the outbreak a Public Health Emergency of International Concern on 30 January 2020, only 14 days after the launch of the MAP.

Over the weeks that followed, the true extend of the COVID-19 public health threat came into focus. The energy and attention of the MoH began to shift towards preparing a National COVID-19 Response strategy and mobilizing funds to execute it. A portion of the catalytic funds from GAVI and the Global Fund to launch the reform were redirected to the procurement of personal protective equipment. An inventory of public hospital capacity revealed that Mali had fewer than twenty intensive care beds with ventilators ready to take on COVID-19 patients in the whole country. The MoH and National Institute of Public Health began holding daily crisis committee meetings in mid-March. Mali detected its first two COVID-19 cases on March 25, 2020.

Alongside this emerging health crisis, a political crisis was simmering. As described earlier in part 3, the first and second round of legislative elections were held despite mounting insecurity and fears of COVID-19. As borders closed to international travel around the world, many foreigners (including this author) began to leave on repatriation flights. National protest movements and civil unrest grew in intensity over the summer, coming to a head in August 2020 with the coup d'état that removed President Keita.

For three months after the coup, the Secretary General of Health assumed the role of interim Minister. In October 2020, it was announced that Minister Sidibé would be replaced by Dr Fanta Siby, a Malian physician and public health expert who previously worked as the head of Prevention of Mother-to-Child Transmission of HIV and pediatric care for UNICEF in Mali.

UNICEF takes the lead on TFC – from costing to piloting

Just prior to the appointment of the new Minister, the UNICEF global consultant team had completed their first round of TFC cost modeling requested by Minister Sidibé, which they had been able to continue despite the pandemic. They used an adapted version of a UNICEF owned analytical platform designed to help decision-makers develop strategies to improve health and nutrition (EQUIST [200]). They generated different TFC costing scenarios, using EQUIST's global standards for health provider time and drug costs, but adjusting these using some local costs (e.g., transportation distances, ASC salaries). They modeled service coverage targets and included a generous package of EQUIST's high-impact and cost-effective reproductive, maternal, and child health services that spanned community-based, outreach and clinical levels, up to the CSRéf.

Prior to taking on her role as Minister of Health, Dr. Siby had attended a validation workshop of the costing work as part of the UNICEF team. Once she became Minister in October 2020, she agreed to have UNICEF undertake a new phase of work, which included further developing the costing scenarios and launching a TFC pilot in 5 demonstration districts of the chosen scenario. Given that the MAP had never been formally adopted as ministry-wide strategy, it was largely abandoned during Minister Siby's tenure.

The second iteration of costed TFC scenarios varied based on the package of care covered (full package free for all; or free care only for the "poor") as well as by reimbursement mechanism (output-based plus 30% margin on drug prices; or through PBF). In all the scenarios, the government was responsible for paying for staff salaries, consultation fees, supervision, transportation, and the administration of the program. Donors would cover the costs of free drugs as well as infrastructure amortization. Drugs being the main cost driver, in all scenarios, more than 60% of the estimated cost of the program was to be assumed by donors through their provision of free drugs.

The proposition of limiting TFC beneficiaries by poverty segmentation in some scenarios came from the international consultants. To determine who the fee exempt "poor" would be, it was suggested that being malnourished could be used as a criterion for beneficiary inclusion in the TFC program, as an easier to measure "proxy" for poverty.

Part way through the second round of modeling work, a technical working group on targeted free care was established by a sub-directorate of the General Directorate of Health. It initially included mainly members of their team, and representatives from two or three partner organizations, but it later expanded.

Two of the 18 scenarios produced by the international consultant team were presented to a group of senior cabinet advisors in early April. They selected the "free for all" scenario to be piloted, rather than the option that benefited only "the poor" because of difficulties in the identification of the poor in the Malian context. Five of the 8 districts in the region of Ségou were also chosen for the TFC pilot (which include 114 CSCOM). This selection avoided areas part of the ongoing randomized control trial of PBF underway in the same district.

Progress on other reform fronts and COVID-19

Other areas of the reform have also continued to move ahead despite the challenges encountered since its announcement in early 2019. For example, the renovation and equipment of 100 CSCOM will be either completed or underway by end of 2021 and a preliminary CSCOM accreditation tool has been developed and will be piloted shortly.

In addition, a draft decree to formalize the integration of ASC into the national health workforce is moving forward, thanks to a coalition of donors and government actors that pre-dated the reform. It proposes to have over 12,000 ASC deployed by the end of 2025 (up from roughly 3000 in 2021), according to different coverage targets by region. The estimated budget required to scale-up over 5 years is more than $ 58 million USD (32 billion CFA). This covers the cost of ASC salaries, but does not include costs related to their recruitment, training and supervision or the management of the program [201]. The decree was recently reviewed during a high-level inter-ministerial meeting and the national assembly of the transition government, and although it was rejected in its current form in May 2021, the group leading the work remains engaged and optimistic.

Between April and August 2021, the implementation unit responsible for the Global Fund and GAVI catalytic HSS work began to prepare a grant application for a generous new COVID-19 funding opportunity. In early September 2021, Mali was awarded roughly $ 45.6 million USD to support the national COVID-19 response over 3 years, which is nearly double the current Global Fund HSS grant covering the same period.

A coup within a coup – more turnover and uncertainty

Less than a month after the TFC pilot work commenced, a second military-led coup took place on May 24th that removed the President and Prime Minister of the transition government. The ministerial reshuffling that followed led to Minister Siby being replaced by Ms. Diéminatou Sangaré, the former head of the Malian social security agency, as the new Minister of Health.

By the end of September 2020, UNICEF had hired a new team of consultants to lead the design and operationalization of the TFC pilot, some of whom were involved in the cost modeling work, for a period of 14 months. The team aims to launch the pilot in November 2021 and run it for 12 months. They are still exploring areas such as the cost and financing of the pilot, its M&E strategy, which payer to use, and how to integrate it with health insurance systems. As of September 2021, they had yet to meet with Minister Sangaré to discuss these plans and secure government funding.

***Figure 2**: Timeline of selected key events between 2018 – 2021 in Mali*

DATE		POLITICAL EVENTS AND POLICY ACTIVITIES	
2004		***HIV / AIDS related user fee exemptions introduced.***	
2005		***Cesarian related user fee exemptions introduced.***	
2007		***Malaria related user fee exemptions introduced.***	
2009		***AMO and RAMED laws passed.***	
2012		***March: Coup d'état** removes President Touré, triggering security and political crisis.*	
2017		***April**: **Professor Samba Sow** becomes Minister of Health and Public Hygiene.*	Tenure of Minister Sow (24 months)
2018	**Jan**		
	Feb		
	Mar		
	Apr		
	May		
	Jun	**June-July**: Minister Sow reaches out to CHAI for technical support on "Saving a Million Lives" initiative for Mali, already a presidential initiative.	
	Jul		
	Aug		
	Sep	**September:** 1-week scoping visit conducted by CHAI leadership, meetings with high-level Malian government officials and technical and financial partners.	
	Oct		
	Nov	**5-6 November:** Minister Sow formally announces his intention to lead a reform of the health care system, with a focus on primary health care, at the Global Financing Facility replenishment event in Oslo.	
	Dec	**18 December**: RAMU law passed.	
2019	**Jan**	**January (+ Feb)**: CHAI team in Mali to support writing reform.	
	Feb	**25 February**: reform announced by the president, followed by week-long high-level workshop.	
	Mar	**March**: Global Fund seeks extraordinary HSS grant from their board to support the reform's implementation.	
	Apr	**19 April:** Malian government resigns (including Minister Sow) in protest of civilian massacre.	
	May	**5 May: Michel Sidibé**, former executive director of UNAIDS, named Minister of Health and Social Affairs (which now includes social protection portfolio).	Tenure of Minister Sidibé (15 months)
	Jun	**17-19 June**: workshop organized in Ségou by UNICEF on "operationalization of the community-based health system reform in Mali." **June**: GAVI health system strengthening grant application submitted ($12 million USD).	
	Jul	**July**: Global Fund health system strengthening grant approved ($ 10 million USD for 2019-2020), high level visit from Global Fund to Mali.	
	Aug		
	Sep		
	Oct		
	Nov	**November:** contract signed between CHAI and MOH-Global Fund fiduciary unit.	
	Dec	**Late December**: new CHAI-Mali team members recruited to begin work in Bamako.	
2020	**Jan**	**16 January:** Minister Sidibé presents the MAP to technical and financial partners. **30 January**: WHO declares the COVID-19 outbreak a Public Health Emergency of International Concern.	
	Feb	**February:** Mali begins drafting and costing its COVID-19 response strategy. **February**: UNICEF and World Bank asked to cost TFC for 3 priority groups.	

(Figure 2 Continued)

	Mar	**11 March:** WHO declares COVID-19 to be a global pandemic. **20 March:** Mali closes borders and ceases flights from countries with confirmed COVID-19 cases. **25 March:** first 2 COVID-19 cases detected in Mali. **26 March**: leader of the opposition party, Soumaila Cissé, kidnapped while campaigning in the north of the country by jihadi rebel group. **29 March**: first round of parliamentary elections held, marred by violence and low voter turnout.	
	Apr	**19 April**: second round of parliamentary elections held, very low voter turnout, widespread protests.	
	May		
	Jun	**5 June**: M5-RFP popular protest movement created. **June – July:** protests intensify, with widespread strikes, calling for the resignation of the president.	
	Jul	**25 July:** Mali announces borders re-opened.	
	Aug	**18-19 August: coup d'état** leading to the resignation and exile of president Keïta.	
		19 August: Secretary General for health established as interim Minister of Health.	
	Sep	**25 September**: former Defense Minister and retired Col. Maj. N'daw named the transitional government President, with Col. Goïta as his Vice-President. **30 Sept- 9 Oct:** UNICEF shares first round of TFC costing scenarios.	
	Oct	**7 October: Dr Fanta Siby** named as new Minister of Health and Social Development.	Tenure of Minister Siby (8 months)
		October: Minister Siby approves shift from costing to also piloting TFC.	
	Nov		
	Dec	**9 December**: major cabinet reshuffle changes technical advisors and Secretary General of health.	
2021	**Jan**	**1 January:** six prominent Malian figures, including former Prime Minister Boubou Cissé, charged with attempting to destabilize the transition government.	
	Feb	**26 February**: New Global Fund Implementation unit formally operational.	
	Mar		
	Apr	**April 2**: UNICEF TFC costing scenario selected by group of senior MOH health advisors to be piloted. **April 5-9**: UNICEF hosts a workshop in the 5 districts where pilot to be held.	
	May	**May 14**: government dissolved by transition president N'Daw.	
		May 24: new government announced, immediately followed by President N'Daw and his Prime Minister being arrested in second **coup d'état** led by the Vice-President, Col. Goïta.	
	Jun	**7 June:** Colonel Goïta inaugurated as new President of the transition government.	
		11 June: **Diéminatou Sangaré** named Minister of Health and Social Development.	Tenure of Minister Sangare
	Jul	**20 July**: President Goïta survives assassination attempt.	
	Aug		
	Sep	**3 September**: Global fund awards Mali over € 37 million for COVID-19 response, to be managed by the implementation unit responsible for Global Fund and GAVI.	
	Oct	*End of study period*	
2022	***Feb***	***Date by which the transition government must organize elections, according to the charter of the transition.***	

4.2 The 14 Best Practices for TFC: how is Mali doing?

The 14 best practices presented in Part 2 provide a framework for how to approach the technical and adaptive work of designing and implementing TFC.

The analysis presented in this section applies this framework to the context of Mali, drawing from the narrative account of the early steps towards the TFC policy in the previous section, as well as the key features of the Malian health system identified in Part 3 and the qualitative data collected (observation and interviews).

For each of the best practices, this section analyses the extent to which they have or have not been followed (so far) in Mali and recommends possible avenues for action to move forward strategically. A summary table at the end of the section (**Table 6**) provides an assessment of the status of each best practice at the conclusion of the study period (September 2021) and recommendations.

1. Conduct a preliminary situational analysis

The very short timeframe for the reform design (occurring most intensively over 4 weeks) condensed the steps of problem identification, diagnosis, and solution exploration. As such, it placed practical constraints on the scope and depth of the situational analysis that could be undertaken.

Beyond a small core of senior ministry actors, engagement with many key stakeholders was relatively one-directional. This may have been necessary for expediency, but it undermined learning and shared ownership. This is particularly relevant given the limited contextual knowledge of the technical assistants supporting the design process.

The situational analysis in the reform document focuses deeply on several dimensions of the health care system – particularly its performance, governance, and financing. These issues are elucidated compellingly with evidence and data and are generally seen as important problems by most actors in the healthcare system.[18] The reform also acknowledges the need for continued learning and diagnosis (e.g., recommending further targeted studies).

The analytical work also touches upon important dimensions of the technical feasibility of TFC as a proposed solution (cost, fiscal space for health, and pragmatic scaling strategy). This reflects the analytical expertise brought to the table by many on the technical assistance team. Unfortunately, this will likely need to be redone given important changes in the context and macro-economic outlook.

However, other technical dimensions were "blind spots", such as the performance of existing systems and their potential interoperability with TFC. The reform document makes no mention of the country's RAMU framework or of existing TFC initiatives, nor the 30-year history of the PRODESS planning system.

These omissions, though glaring to some, do not necessarily give rise to incoherence or threats to ongoing processes. However, they feed into the perception of an "exogenous" reform [133] and one that misses, or mis-represents the true complexity of its implementation, leaving big questions of how it would work untouched. This in turn likely affected the political acceptability and support for the reform.

Finally, the situational analysis's primary focus on the healthcare system misses some important aspects of the bigger picture, including the security and humanitarian crisis and the ongoing provision of free care in the North.

More consideration of these points could have informed not only the scale of the ambition, but more importantly the timeframe to make change to avoid a capability trap and premature load bearing.

[18] The extent to which user fees in particular are seen as a problem, and one that should be solved with TFC, is discussed later in section 4.4.

2. Ensure high-level national authorization, support, and leadership

Several conditions were met early-on that made the reform vision credible and provided a space for change: strong Minister of Health leadership, presidential buy-in, support from the Minister of Finance, and endorsements from the international community.

However, the local authorizing environment in Mali is complex and constantly shifting. Although things were far from stable at the time of the reform's launch, the months that followed were exceptionally volatile. Since its conception in late 2018, people in key authorizing roles changed repeatedly, with four different Ministers of Health and three Presidents. Turnover of key technical positions throughout the MoH was equally disruptive to the continuity of work, knowledge, and relationships, with multiple changes of Secretary Generals of Health, Directors General of Health, and senior cabinet advisors.

Despite the turnover, a lot can be learned about the authorization strategy required for the reform to succeed. For instance, it is important to reflect on the type of authorization needed from the highest levels around this reform, notably the president of the republic. This includes not only prominent and visible commitment, which was (vitally) provided, but also patience, protection, and time, which unfortunately were not. The fact that a different Minister of Health was appointed three months after the announcement is indicative of this.

Presidential support ended up being a mixed blessing, as it was difficult to harness in a way that met all the authorization needs. The reform was an accelerated version of "technicians first, politicians second" [90] – but in which the reform endorsed was different from what was planned. The presidential announcement deviated from the strategy of progressive scale-up and included new beneficiary groups whose costs had not been calculated. This created the expectation that implementation would begin immediately and led to confusion and frustration.

This exposes not only the risks of engaging with high-level political authorizers, but the importance of fully defining the nature of the support needed. The political calculus of a leader seeking enhanced legitimacy may still lead them

to ignore calls for time and cover from policy makers; however, highlighting the danger this poses to them by creating a capability trap is still important.

As for the authorization and leadership of the Minister of Health, the context reveals that this position is far from sitting atop an ideal Weberian bureaucracy "characterized by effective downward authorization mechanisms" [87]. In practice, any Malian Minister of Health has limited scope and depth of influence. There are breaks or weaknesses in the chain of downward authority, particularly around the primary healthcare level where there is a lot of autonomy and strong competing authority coming from local governments.

The MoH is also an environment of near constant reshuffling and internal competition among a small group of health system elites, and therefore the Minister takes on a great deal of personal risk in the process of initiating change to an entrenched status quo. Ministers Sow and Sidibé both brought considerable external knowledge and networks, but their "outsider" status may have diminished their degrees of freedom within the system. The highly centralized writing processes for the 2019 reform and the MAP did not sufficiently allow for them to grow the authority and trust required to lead transformative change. The lack of continuity between the two plans (though not necessarily in substance) created a vacuum and fragmented the ongoing work.

Since the coup and countercoup d'état, the authority of Ministers of Health to be change agents has likely been further eroded due to the "transitional" nature of the government. Importantly, the strength of the anchoring of the reform on the national agenda is unclear, given that it was never formally adopted by government – either by the Council of Ministers or through specific legislation. It is therefore unclear how enduring the initial authorization provided by the presidential announcement is in practice, and this allows people to distance themselves from the need to prioritize implementing it – particularly the Ministry of Finance.

As for authorizing the TFC pilot, this was facilitated under Minister Siby thanks to her familiarity with UNICEF's plan, which pre-dated her ministerial role. However, the team leading the pilot has yet to meet with Minister Sangaré,

now three months into her 9-month tenure (assuming the 2022 elections take place). The high-level support for this initiative is therefore unclear in the short and medium term.

3. Put in place a dedicated, authorized, and well-resourced coordination unit

The loss of strong ministerial leadership and uncertain authorization around TFC make it difficult to assemble a dedicated, authorized, and well-resourced team to lead it.

A look at the technical working group on TFC, and the wider context in which it operates, provides insights. In its current form, this group lacks the time, decision rights, or clear mandate to steer the process. It is largely disconnected from the Minister of Health, instead seeking legitimacy and authorization at the senior cabinet advisor level. It functions in relative isolation, with no formal links with other key networks such as the RAMU expert group, or the Ministry of Finance.

Its terms of reference have not yet been adopted, leading to unclear governance and membership. In practice, it meets irregularly, often on an ad-hoc basis, and there is little continuity around who participates. The ministry technicians in charge of leading it are frequently unavailable due to travel for activities outside of the capital. Its meeting style is typical for Mali, with a very hierarchical and formal structure. It is not generally expected that participants come prepared (e.g., pre-reading a document), and so important amounts of time are often used reviewing documents line by line with a projector.

The core of the group is made up of MoH technicians and a few partners. Despite the technical complexity of TFC, the skillsets needed to answer essential design questions are missing or stretched thin, especially around areas such as health financing or economics. A holding space that fosters technical work and evidence-based debates is not currently created, and the lack of trust and ownership that surrounded the reform design are being reproduced in a tense dynamic. Consensus around basic questions is difficult to elicit (e.g., which beneficiaries to include).

The plan to create a second higher-level steering committee is promising. However, the current proposed level of inclusivity is likely to pose operational challenges. The eleven ministries suggested for inclusion include education; agriculture, animal husbandry and fisheries; cooperation and foreign affairs; rural development; and communication.

There are models that currently exist that could serve as possible examples for re-imagining this group and its steering committee. The RAMU expert group stands out as having several key features: it is ratified by law and funded by government, which provides it clear legitimacy, continuity, and protection from donor influence. It is also entirely composed of actors from the MoH and social protection, including well respected heavy hitters. They have proven to be persistent and now have the RAMU law as a tangible example of their work. The downside of the group is their very slow pace, which at times leads to them being overtaken by new reforms.

4. Assess revenue sources and plan financing

How much will it cost, and can it be done, are two major questions that the reform document sought to address through its costing projections, fiscal space analysis, and donor mapping. Theoretically, if the government stuck to its commitment to increase spending on health, and donors pitched in, it showed that it could be done. This was enough to get the president and Minister of Finance to publicly say “we will do it” and to mobilize catalytic donor funding.

At this stage, however, the macro-economic picture needs to be reexamined to take into consideration important changes in the national and global context. The fiscal space for health has constricted compared to when the reform was announced and there is a far less positive outlook on economic growth, a dynamic global COVID-19 pandemic and recession, and uncertainty surrounding a fragile transition government with an election in less than six months.

Recent experience suggests that spending on security, a critical national priority, will continue to crowd-out spending on health. Other expensive health policies are also competing with TFC to get onto the budget agenda, which have a more solid foothold in national plans and processes, such as ASC, RAMU and PBF.

The revenue generating capacity of contributory schemes (especially voluntary ones like Mutuelles) is likely to be limited and undercut by heavy administrative costs and the need for subsidies. Options for innovative financing have been discussed for years without being adopted, and some, like debt forgiveness programs (HIPC), have already been used. Initiatives like new taxes are unlikely to be adopted in the current context.

The experience of past TFC initiatives, have revealed a concerning pattern of underfunding, not only of their core activities (supplying drugs and reimbursing services) but also of vital supportive activities such as supervision, training, and communication.

A more in-depth costing analysis remains necessary, particularly as the contours of the policy evolve. The costing modeling undertaken by UNICEF is an important, ongoing contribution to this.

The availability of financing for the TFC pilot remains unclear – the scenario selected to pilot involves the state co-financing roughly 40% of operating costs, with donors only financing drugs and infrastructure amortization (the remaining 60%). Challenges with getting the government to commit to their part may jeopardize its viability. It remains to be seen if other donors will join UNICEF to provide the vital upfront capital to launch the TFC pilot, without a convincing roadmap for state appropriation in the near future.

5. Design a sequenced, adaptive plan with learning at each step

The plan for the reform as initially designed includes embedded opportunities for learning and iteration in several areas. Many features of TFC were not yet defined but instead intended to be developed later. In light of this, the reform roadmap, and its timeline from 2019-2022 seem remarkably tight.

In the vacuum around the reform after the departure of Minister Sow, it appears that it evolved significantly in terms of its scope and strategy. This created confusion around some basic points related to TFC, such as who is care meant to be free for? Is it three beneficiary groups, or six? Is the strategy to scale-up progressively by region as outlined in the reform, or is it national scale-up by beneficiary group as chosen during the "reform operationalization workshop"?

Many points are being revisited by people who were not involved in its design but are working on its implementation. This kind of evolution should be welcomed, as it can improve its political and technical feasibility. However, if these changes are not being appropriately negotiated and authorized, they could compromise its legitimacy.

Several stakeholders argued that the planned progressive regional scale-up would not be possible, citing issues of equity, political acceptability, and the precedent set by existing free care initiatives launched nationally at once. An approach that chooses some regions first and other second could be acceptable for an NGO, but not for the state, and would be unlikely to get the votes from the council of ministers needed to pass. This issue is fundamental to planning and needs to be resolved.

In the strategic sequencing of the reform's implementation, the CSCOM renovation work – arguably the least controversial and most tangible of the HSS package – was meant to be a "quick win," essential to lock-in momentum and generate buy-in [87]. However, its catalytic funding was not available until the second half of 2019, and the technical assistants to support this work were not hired until the end of the year. In practice, this took very long to get off the ground, not only due to turnover and heavy bureaucratic hurdles on both the government and donor

sides, but also because of the disruption caused by the COVID-19 pandemic. By the end of 2021, rather than having 617 CSCOM renovated as the reform had projected, only 30 will be completed (though 70 more are underway). This first "win" has unfortunately not been quick.

In addition, the leadership challenges described in the previous section have led to a fragmentation of the reform's implementation. Some parts are moving ahead faster than others, and not always in a strategic, integrated way. For instance, the first wave of renovation and rehabilitation of CSCOM has taken place in some areas where ASC deployment is not being prioritized (e.g., Bamako), and TFC is being piloted outside of these areas as well. This fragmentation undermines the conditions required for TFC to have its desired effect – if the system is not strengthened, the increase in demand could seriously endanger quality.

The pilot currently underway has unclear strategic sequencing, with the interventions it identified to remove bottlenecks to effective service utilization and improve quality not necessarily getting implemented before TFC is introduced. The pilot also has a very tight timeline for implementation, with a current launch target of November 2021, despite important design questions still being explored and financing being uncertain.

6. Actively engage stakeholders throughout the process

Limited stakeholder engagement is a big weakness of the reform design phase. The presidential announcement in February felt "sudden" to some policy makers and came as a surprise to the majority of direct service providers.

Despite the week-long high-level workshop that followed the presidential announcement and subsequent dissemination activities, there remains a weak level of ownership and familiarity with the reform and lack of clarity around its contours.

CSCOM and ASACO staff, as the street-level bureaucrats of the health system, are among the most powerful when it comes to affecting the implementation of TFC in practice. Their work is also the most directly affected by the change, and they have the most to lose if it is poorly implemented.

Their lived experience before the reform was generally one of weak state capability, which they encountered daily through dysfunctional supervision systems, delayed reimbursements, and underinvestment. Past TFC reforms, implemented with haste and few accompanying measures, disrupted their work, and caused tension with their patients.

Moving forward, engagement with this key stakeholder group must aim to rebuild this relationship and to create a new dynamic. The planned progressive roll-out of the reform, which begins with new investments in infrastructure and systems, is a promising opportunity for real engagement (if this strategic sequencing is maintained). It could potentially generate real buy-in and create opportunities for multi-directional learning and empowering in-vivo experimentation that will strengthen the design. This is key for transforming them from opposition to supporters.

The experience of engaging with frontline workers during the early phase of pilot planning underscores the complexity of doing this in practice. The team leading the pilot encountered real skepticism about whether the state could (and would) pay for TFC and its sustainability. They faced tough questions about the effects of delayed payments on their ability to function, and "what is in it for them" if they shift towards TFC. Given that many aspects of the pilot's design are still being explored, they were not always given clear answers to these questions.

The stakeholder analysis presented in the following section (4.3) reveals a dynamic landscape. This mapping must be repeated and broadened in order to engage with important actors from outside or on the periphery of health service delivery (mayors and local government, social protection agencies, Ministry of Finance).

7. Engage strategically with technical assistants and development partners

Challenges with technical and financial partner coordination in Mali certainly pre-existed the 2019 reform effort. A lack of collaboration is common, whether due to mistrust, preference, or structural barriers (e.g., being siloed in separate implementation units). The PRODESS is meant to provide a framework for coherence and alignment, but it is too broad to adequately do this, and frequent ministerial turnover undermines strong continuous leadership.

Around the 2019 reform and MAP, new and more integrated governance mechanisms were conceived that could have helped to better manage or even resolve some of these issues, but they were not implemented.

There are palpable signs of a power imbalance between international financial and technical partners and the Malian MoH. The proportion of health spending from donors, which continues to increase, is evidence of this. In terms of staffing and resources, some partners dwarf the very technical structures they support, often outnumbering them in meetings. Capacity gap analyses are difficult to carry out holistically, especially when the recruitment of additional technical assistants is rarely ministry-led, more often being proposed by partners to serve the operational goals of their projects.

Around questions of health financing strategy in Mali, there are different approaches being promoted by different partners, and this is exacerbating fragmentation. Although well intentioned, each actor deploys different levers of influence, whether it be sending government agents on international study tours, supporting the writing of strategy documents that reflect their expertise, or organizing workshops with generous per-diem rates [132]. In Mali, the activities organized around introducing PBF were described as “results-based dinners” – based on the recurring practice of paying for meals at upscale hotels in Bamako [59].

As elsewhere in the region, there is a real issue with access to scientific evidence and some forms of knowledge on TFC – it is often in English, behind a paywall, or inappropriate for the context (e.g., “in Rwanda, XYZ works very well …”). On top of issues of access are also the limited time and interest of some individual actors for consuming

evidence. This reduces opportunities for objective debate and evidence-based decision making; it is instead replaced by advocacy or anecdote.

There have been some attempts to create a regional community of learning, with research projects gathering experts and government officials from several West-African countries to reflect on the question of user fees [27]. However, these networks have not been proven to last. Others now emerging around UHC should be explored.

Currently, the donor enthusiasm behind the reform has cooled, and the broad donor coalition to finance TFC has not materialized. Many donors are forced to engage cautiously with the post-coup government, for legal as well as pragmatic reasons, and this impacts their direct budgetary support, programming, and strategy. Many have refocused on more practical activities, preferring to "wait and see".

8. Assess different options and define the beneficiary population and benefits package.

As previously described, the contours of the reform are fuzzy – especially around the beneficiary groups and package of services. A multiplicity of scenarios has been introduced, including those in the reform, and the ones added in the subsequent workshops and modeling exercises.

Given the weaknesses in state capability demonstrated by existing systems (health insurance, existing free care), a more complex system is likely to be hard to implement and gamed by health care providers. For example, segmenting beneficiaries both by population category and by poverty status, would not only be redundant with the RAMED, but it would likely reproduce many of the challenges it encountered with beneficiary identification and exclude people from care.

Experience from existing exemption policies has shown the propensity to select very narrow packages (e.g., a few inputs for only some kinds of cases of a single disease) thus leading to limited impacts on financial risk protection

and health. The new TFC reform could present an opportunity to ensure some deficiencies with existing policies could be addressed, such as including reliable financing for transportation in the case of obstetrical emergencies.

Clear, transparent criteria to select which beneficiary groups to cover and for what package of services would be helpful. The EQUIST tool does propose a suite of interventions considered most equitable and cost-effective. However, exactly what services are covered is not clear or well understood by most Malian stakeholders interviewed. Nevertheless, the UNICEF modeling work provided helpful insights into the cost implications of certain other choices (e.g., only providing care to some beneficiary groups, and only providing care to "the poor" among them). The scenario selection by government actors has consistently tended to favor the less restrictive options for TFC.

Looking ahead, it could be helpful to set up a formal process, with a committee of Malian health system actors dedicated to defining options and selecting a benefits package, which is based on the application of clear, consensual criteria [113]. This process could then be repeated regularly to ensure the package is financially sustainable and eventually expanded. Importantly, a parallel process of benefits package design is currently being carried out by the RAMU expert group, and so learning from this would be valuable.

These criteria could lead to the exclusion of the three "additional" beneficiary groups added after the reform's initial conception (dialysis, the elderly, victims of emergencies). The politics of excluding them will need to be addressed, and therefore transparent criteria and process can help.

9. Ensure harmonization with other reforms

Mali currently has a highly fragmented health financing system with unintegrated information management and supervision. At the same time, many of these parts are still in development and dynamic. For example, there are the ongoing efforts to try to strengthen the Mutuelles, which have yet to prove to be a reliable source of financial risk protection for the majority of Malians. There are the slowly forthcoming operationalization decrees of the RAMU,

which include plans to eventually integrate existing TFC initiatives (beginning with cesarians). And there is the ongoing experimentation of PBF in selected districts, with an unclear pathway to national adoption and scaleup. The integration of these workstreams with TFC is further complicated by the current lack of legal texts to formalize its contours and content.

Establishing a collaboration between the RAMU expert group and those working on TFC is an obvious place to start. Many stakeholders see a tension between the two approaches unless they are integrated: a scheme that provides care for free will undermine enrollment in a voluntary scheme where you must pay (RAMU is contributory for all except RAMED beneficiaries). Despite contact having been initiated as early as fall 2019, formal meetings between the two groups continue to be elusive.

Now that the Ministry of Health and Social Development encompasses both health (supply side) and social protection (demand side), there should be an opportunity for joint reflection and integrating parallel work around health financing. It remains to be seen what form this new ministerial leadership will take.

The TFC pilot could provide an opportunity for integration with ongoing efforts and the national system. However, many opportunities to do this may be missed. First, the choice of payer remains open, but the weak coverage and performance of existing health insurance schemes, particularly at the CSCOM level in the pilot sites, limits this integration. The currently favored option would be to hire an external agency to manage the TFC funds, payment, and verification system, rather than going through a national agency like the CANAM, thus creating an entirely new parallel system. What is more, the sites selected for the TFC pilot were purposefully different from those where PBF was being implemented in the same region, to avoid interfering directly with the ongoing PBF RCT. Finally, as mentioned previously, the sites benefitting from renovation, equipment and accreditation are outside of the TFC pilot districts, which were selected based on the burden of disease and health inequalities.

10. Develop a clear communication strategy

As discussed previously, the presidential announcement raised the profile and awareness of the health reform. However, the impression it created that services would be free right away, led to people going to health centers to demand services. Most health providers learned about the reform on television and on radio at the same time as their patients, leading to confusion and frustration. This same unproductive pattern occurred with past TFC reforms.

Despite quick efforts by the ministry to correct the record and clarify the plan, the damage was done. Now 32 months after the announcement of the reform, TFC remains far from being a reality in CSCOM. Many frontline workers and even technicians at the ministry no longer believe it will happen. Once hopeful beneficiaries likely feel disillusioned.

In light of this, should TFC undergo a major national implementation push, it would require a serious public relations strategy akin to a "re-launch" and "reframing." Its association with the past president would need to be handled carefully.

Some lessons can be learned from past communication efforts, which relied mainly on communication through radio announcements, televised press conferences, and the (imperfect) dissemination of guidelines. It could be simpler to communicate this TFC reform compared to past ones, since it is less narrow, however information around its operationalization, such as who pays for referrals, remains important.

Equity in the communication strategy should also be an important consideration, with rural areas being consistently disadvantaged in terms of access to information. This should rely as much as possible on local actors without a conflict of interest. Past experience with relying on ASACO for dissemination revealed instances where information was retained out of fear of the financial impact on their CSCOM. Other local actors who have a stake in community health, such as ASC, mayors and women's groups, are important to involve.

11. Design a provider payment mechanism

Given the massive share of CSCOM revenue from out-of-pocket spending to be replaced, the performance and appropriateness of the TFC payment mechanism are critical. The impact of TFC on the health financing of CSCOM/ASACO will be unprecedented. Past TFC reforms had a limited impact on their financial health, but this was due to the narrowness of the package (disease specific treatment - sometimes only a single molecule) and provider coping mechanisms (making patients pay during stock-outs, over-prescription of antibiotics). This will no longer be the case when the majority of services provided fall under the umbrella of the new TFC.

Past TFC initiatives were launched hastily, asking health centers to pre-pay for care. This was deeply unpopular with health center managers and undermined the scheme's effective implementation, with many either boycotting or stopping this out of fear of decapitalization. With this new TFC reform, asking CSCOM to pre-finance it would simply be impossible given how much the "free" services represent in terms of their activity volume and profits, and the expected increase in demand. Pre-positioning financing and/or inputs is vital, not only for the program to effectively launch, but also as an important signal to providers of the seriousness of the program and to earn their trust and buy-in.

The different health financing systems operating in Mali (OOP, government grants, health insurance, existing TFC, PBF) each take different approaches to paying providers for consultation fees and drugs. Therefore, they also provide an opportunity to learn from their relative strengths and weaknesses (e.g., delayed payments, below market reimbursement rates).

Unfortunately, none has yet been found to work well at scale at the CSCOM level. PBF, which may be the most robust and expedient, still only exists in pilot form and relies heavily on external support to function. According to stakeholder interviews, discussions with frontline workers during the pilot development revealed a flat-out rejection of using the RAMED as a payment mechanism for TFC, given its well-known dysfunctionality and outstanding debts.

Providing kits of inputs has proven to be challenging, especially in the case of Malaria treatment and cesarians. This input-based approach is likely to be even more problematic to manage with an expanded and diverse service package, and with important seasonal variations in health care needs and divergent CSCOM catchment areas. The potential disruptive effects of the planned "free" provision of drugs and other inputs by donors should be considered, as the margins on their sale are the most important source of CSCOM revenue. In addition, this will likely disrupt the regular procurement and stock management systems of health centers, given that they must continue to run in parallel a "for profit pharmacy" for non-TFC beneficiaries (e.g., lost economies of scale).

On the other hand, designing the output-based scheme to reimburse providers for their healthcare services and to cover CSCOM operating costs will also be technically difficult given the heterogeneity of pricing, service delivery capacity, and staffing mix across CSCOM. Current regulations empower ASACO to determine their own tariffs in order to reflect the paying capacity of the communities they represent. The work of setting reimbursement rates (should that approach be chosen) would be confronted by these structural challenges, as well as a lack of routinely collected data available on CSCOM pricing and finances. This should be undertaken as much as possible in coordination with the similar tariffication work being led by the RAMU expert group and the PBF team.

A payment schedule that would allow for the smooth functioning of CSCOM may need to be more frequent than that of other TFC programs, such as cesarian reimbursements, which are theoretically done quarterly. Stakeholders interviewed at the operational level suggested monthly payments.

The approach currently envisioned for TFC, a mixed output and input design, will be complex to manage. The experience of insurance schemes, which provide reimbursements based on the itemized submission of receipts and documentation, has demonstrated the need for clear guidance and appropriate staffing and materials at CSCOM to manage this workload. There are currently important capacity gaps, with many ASACO teams facing language, literacy, and technology barriers, understaffing, limited access to transportation, and a lack of formal bank accounts.

12. Define the institutional arrangement and the roles and responsibilities of the payer

Early conversations about the institutional arrangement for Mali's national TFC policy identified the CANAM to play the role of paying / managing agency (it is also in the draft TFC decree). This is coherent with the plan for it to become the main financing, planning, and paying institution for the RAMU, into which existing TFC will be integrated as part of one cross-subsidized risk pool.

However, it remains to be seen what the CANAM will look like under an operationalized RAMU policy, in terms of staffing, skills-mix, budget, and decentralized presence, and when this transition will be complete. A robust capacity assessment is needed as the agency takes on new and more responsibilities if TFC is to be added as well.

The track record of the CANAM and other paying agencies is mixed, and particularly underperforming at the CSCOM level. Optimizing the flow of finances for TFC from the CANAM through decentralized agencies should be integrated as much as possible with other systems (a possible medium- to long-term option would be PBF if it becomes a national policy), as this would provide economies of scale in terms of verification and supervision as well.

Creating a TFC contracting agreement between CSCOM and the payer, to ensure minimal conditions are met and roles and responsibilities are clear, could be necessary. This is the approach taken by PBF and health insurance, and is likely to be preferable to existing TFC programs which "de-facto" operate in all health centers regardless of their starting capacity. The reform had envisioned launching TFC only in accredited CSCOM, which is a sound idea. However, this system is still under development, and its national launch could be several years away; its 2021-2022 pilot phase is not planned in the TFC pilot districts.

As previously mentioned in best practice #9, the TFC pilot is likely to go ahead with an institutional arrangement that is separate from the state and the CANAM, due to its limited functionality in the CSCOM in the pilot districts. However, if this approach is to be taken, a clear plan to simultaneously develop the CANAM's capacity is needed in order to be able to eventually integrate TFC when it is scaled as a national program.

13. Identify minimal standards and carry out service delivery upgrades

The health system strengthening (HSS) package outlined in the reform identified a number of priority areas to strengthen in order to prepare CSCOM for TFC. As proposed in the reform document, more careful study is needed to understand the underlying challenges in these areas, and the capacity gap to bridge ahead of implementing TFC.

The ongoing renovation work being supported by partners (CHAI and others) is generating useful information about infrastructure and maintenance challenges that impact safety and service availability (e.g., water, electricity, sterilization equipment). It has also uncovered issues around land ownership and legal conflicts between ASACO and clinical teams that had not been previously considered. Other national systems being launched, such as the WHO supported Health Resources and Service Availability Monitoring System (HeRAMS), could generate additional insights into the level of investment needed to meet minimal standards. Finally, the CSCOM accreditation system being developed will also provide a valuable source of routinely collected information that can be utilized for TFC planning.

CSCOM level data about other key areas is harder to come by, such as human resources (by contracting type); financial and accounting information; procurement and stock management systems (with rates of diversion); information technology; and governance. Available information is detained by actors scattered throughout the MoH, such as the Directorate for Human Resources, the Cell for Statistics and Planning, as well as by technical partners who perform ad-hoc data collections for their specific projects (e.g., the PBF baseline study).

The TFC pilot is taking a different approach. Using the EQUIST framework of bottleneck and root-cause analysis, CSCOM in the pilot districts are being supported to generate “Operational Plans” which identify strategies to use to improve service availability, accessibility, utilization, and quality; drawing from a list of 29 health system strengthening strategies (of which user fee exemptions is one). This is being costed separately from the TFC program. It is unclear whether the implementation of these plans will precede the launch of TFC, and if they will allow for minimal conditions to be met consistently across CSCOM.

In order to plan for a national-scale TFC program, information around these key areas will need to be centralized, triangulated, and complemented by targeted studies, ideally under the leadership of the TFC management group.

14. Set up M&E systems to generate timely information on functioning and performance

This dimension of TFC policy planning and delivery has not yet been approached, either in the reform document or by actors involved in designing the policy or pilot.

The health information landscape in Mali involves multiple actors and systems, both within and alongside government. The main national digital platform, called District Health Information Software or DHIS-2, is a work in progress with mixed evidence of its utilization at the CSCOM level. It is limited by infrastructure and network issues, as well as by the lack of capacity and incentives for timely data entry. Other tools are being used or piloted in parallel (e.g., for ASC).

When evaluating what approach to take for TFC, international and local experience shows that simple is better. A new software solution is unlikely to be simple or fast to pilot across CSCOM in Mali, and its integration into DHIS-2 should be seen as a medium- to long-term goal (as is the case with the PBF data portal for example).

Financial management skills and tools are currently heterogenous across CSCOM. Considerable development in this area is likely to be needed, especially in centers where no external payment system is being used (e.g., they do not have an active contract with AMO or RAMED). Some degree of resistance to transparency is to be expected, as it could expose illicit practices and corruption. Stakeholders interviewed attribute this as a likely reason why nearly a quarter of ASACO refused to join the PBF pilot.

Experience with existing programs in remote CSCOM reveals the challenges of using paper forms that require physical transportation to be processed, particularly during the rainy season when some roads become impassible.

In response to this, the CANAM decentralized paperwork processing to the regional level to simplify the journey. The PBF program also accepts some forms being submitted as photos sent on WhatsApp [162].

However, it appears as though very little effective M&E is done of existing TFC programs - this is generally limited to irregular and superficial supervision visits, or routinely collected data about service utilization. Only independent, in-depth research projects were able to quantify problems (e.g., stock outs) and document coping mechanisms (e.g., task shifting). Performance and impact related questions could best be outsourced to an independent evaluation team involved early to allow for robust methodology.

Despite an imminent planned launch, the TFC pilot still needs to develop an M&E strategy. The planned timeframe for implementation and preliminary evaluation is 12 months.

Summary of Mali's progress on the 14 best practices for TFC

The analysis presented in this section and summarized in **Table 6** below shows that Mali has not yet been able to fully follow through on any of the 14 best practices.

Some were off to a good start at the time of the reform's announcement but are either no longer current because of changes in the context and need to be redone (#1 preliminary situational analysis, #2 high-level authorization, #4 assessment of financing), or require further development (#13 identifying minimal standards and #8 a benefits package). The dedicated coordination unit for TFC (#3) formed since the reform's launch also needs to be re-conceived if it is to perform as needed.

Other best practices in the framework were not able to be followed due to the rapid policy development process, or the stalled momentum behind TFC after the ministerial and presidential changes that followed its launch. This made progressing on core design questions challenging, particularly without a focused, highly performing and authorized operational unit and clear financing. This applies to launching into operational planning (#4), and engaging with stakeholders (#5), donors, and technical assistants (#6), ensuring harmonization with other processes (#8), and putting together a communication strategy (#10), payment mechanism (#11) and paying agency (#12).

This analysis identified concerning issues around the lack of integration of TFC with other ongoing processes (RAMU, PBF), which reflects larger structural issues around the dynamic and fragmented health financing sector. It also flagged important unresolved debates about the national scaling strategy and beneficiary groups, as well as, in the case of the pilot, around the choice of paying agency and assurance of minimal standards.

Table 6 *Summary of status and recommended next steps for the 14 best practices*

	Best practices (** = essential)	Summary of status and recommendations
Preparation	**1** - Conduct a preliminary situational analysis	***Partially done, needs development*** • The deep but narrow and time-compressed preliminary analysis during the design phase led to blind spots that undermined the policy's political acceptability and realistic timeframe. • Due to major contextual changes, many assessments will need to be redone to reassess feasibility (fiscal space analysis, donor mapping, etc.). • A deepened situational analysis should focus on stakeholder positions and options for inter-operability with existing and emerging systems (RAMU, PBF, existing TFC, PRODESS). *NB: this thesis is intended to address some of these gaps*
	**** 2 -** Ensure high-level national authorization, support, and leadership	***Achieved but lost, needs rebuilding*** • Important support and authorization were lost since the launch, which must be rebuilt and broadened. This should be solidified first throughout the MoH, and later expanded to include other key actors (ministries of finance and local government, the executive). Broader authorization will help to "turnover-proof" TFC. • The long timeframe and protection required for effecting change must be put forward more prominently when seeking high-level authorization. • Current support behind the reform and the pilot are unclear due to the transitional government.
	**** 3 -** Put in place a dedicated, authorized, and well-resourced coordination unit	***Not in place, needs reboot*** • The current TFC working group is not fit for purpose and should be re-conceived. A formal anchoring closer to the minister of health and an official mandate would facilitate its functioning and networking with other key actors. Targeted management and technical support could help to fill skills gaps and strengthen the capacity of its members. • RAMU expert group could serve as model.
	**** 4 -** Assess revenue sources and plan financing	***Initiated, needs reassessment*** • The additional national budget for health required for TFC is unlikely to become available under a military transition government and with a less positive economic outlook (COVID-19 and competition from military spending). • The donor landscape and fiscal space analyses need to be reassessed following the upcoming election. • Ongoing TFC cost modeling helpful but financing available for the TFC pilot is unclear.
	5 - Design a sequenced, adaptive plan with learning at each step	***Not in place, needs development*** • An operational plan is needed with a longer timeline and a roadmap that includes the pilot. Consider renovation as a delayed "quick win." • Debate around the political acceptability of a progressive scale-up that would allow for meeting minimal standards first. • Concerning fragmentation among the different HSS components (ASC, renovation, TFC pilot).

Table 6 (Continued)

Preparation (cont.)	**** 6 -** Actively engage stakeholders throughout the process	***Insufficient, needs reboot*** • Stakeholder engagement was insufficient during the design phase. There is a need for a more robust and participatory approach with frontline service providers to counteract a baseline level of mistrust and resistance, as well as to improve ownership and technical feasibility**.** • Stakeholder mapping in Section 4.3 should be repeated and expanded.
	7 - Engage strategically with technical assistants and development partners	***Insufficient, needs reboot*** • Need for improved donor coordination around health financing generally, and TFC specifically, under strong ministerial leadership. This is a systemic issue that goes beyond TFC. • More should be done to support evidence-based decision making and knowledge management around TFC. Networking with regional UHC communities of learning should be explored and built into the reimagined TFC coordination unit.
Design	**8 -** Assess different options and define the beneficiary population and benefits package	***Partially done, needs development*** • The TFC service package and beneficiary groups are not yet sufficiently defined at the national level (although pilot work could be helpful). • A more robust and transparent process is needed, that draws from, or ideally integrates with, the work being done to select a universal benefits package for the RAMU. • The limited state capability to implement and monitor TFC suggests that a more simple and inclusive approach may be more technically feasible.
	9 - Ensure harmonization with other reforms	***Not done, needs development*** • Efforts to integrate TFC with health insurance and PBF are important but difficult to undertake as neither system is yet operational at scale. • The continued fragmentation of health financing reform efforts is concerning (e.g., pilot looking to use non-state payer) and requires strong national leadership to structure and incentivize (or require) this integration. • Closer collaboration with the RAMU group and social protection actors are important.
	10 - Develop a clear communication strategy	***Insufficient, needs reboot*** • The sudden and top-down communication during the reform's announcement was problematic, even vexing, for many key stakeholders. • The perceived lack of forward movement creates the need for an eventual communication "reboot" that will better manage expectations and rebuild trust. • Equity considerations are important in this context. Past experiences suggest not exclusively going through CSCOM/ASACO.

Table 6 (Continued)

Design (cont.)	** **11 -** Design a provider payment mechanism	***Not done, needs development*** • The TFC payment mechanism needs to be developed carefully given its large potential impact on CSCOM financing and functioning. • Pre-positioning of funding and inputs prior to launch is essential. • Multiple parallel payment systems exist at CSCOM (OOP, government funds, health insurance, PBF, existing TFC) – none appears to be ideal for integrating TFC in the short term (i.e., limited functioning or scale). • Input kits are likely to be challenging to manage, and yet the infrastructure required for an accountable, transparent, and timely output-based system of payment is considerable, currently not in place nationally, and would require major capacity development and investment.
	** **12 -** Define the institutional arrangement and the roles and responsibilities of the payer	***Not done, needs development*** • Should be informed by a capacity assessment of the CANAM and collaboration with the RAMU expert group. • Concern around pilot potentially creating additional parallel agency, furthering fragmentation.
Delivery	**13 -** Identify minimal standards and carry out service delivery upgrades	***Initiated, needs development*** • The reform identified important needs across key areas of CSCOM healthcare supply, but data on scale and causes are incomplete. Targeted studies and centralization of evidence are needed to ensure appropriate planning prior to TFC scale-up. • Contracting only accredited CSCOM to implement TFC should be explored to ensure minimal standards are met, but the limited reach of the program (preparing to be piloted) could limit this option.
	14 - Set-up M&E systems to generate timely information on functioning and performance	***Not done, needs development*** • Area not yet addressed for the policy or pilot. • Explore possible integration into DHIS-2 health information system as longer-term solution; short term – simpler is better (i.e., paper forms). • Routinely collected data at CSCOM level is sparce, outsourced evaluation preferable.

4.3 TFC Stakeholder analysis

Stakeholder analysis is a basic building block of designing political strategies for reform [35], [202]. It also appears in the TFC Best Practices to be undertaken early-on as part of the preliminary situational analysis (#1) and as informing the TFC stakeholder engagement strategy at the heart of addressing this adaptive challenge (#2).

This section is an attempt to address this need and aims to offer some preliminary tactical insights. It can also serve as a blueprint to be repeated or expanded to reflect the latest in the changing stakeholder landscape and could be developed later into a stakeholder management strategy by policy makers.

This stakeholder analysis is not intended to be exhaustive, and provides a simplified, integrated description of heterogeneous and complex groupings of actors. It draws from the qualitative data (interviews, observation) as well as the dynamics uncovered in the analysis of Mali's health system (Part 3).

It was undertaken in three stages. First, relevant groups and individuals were identified who had a vested interest in the targeted free care policy in Mali and the potential to influence its design or implementation. "Stakeholders are actors (persons or organizations) with a vested interest in a specific policy and the potential to influence related decisions. They can be individual actors and organizations (i.e., a government ministry or a particular labor union)" [202]. Second, through triangulated data, their roles, resources (tangible and intangible), commitment, and power were analyzed [203]. Finally, the past and current positions relative to the policy of key stakeholder groupings were summarized along two axes (support and power).

The results are presented in two parts. First, **Table 7** details the different positions, resources, and evolving positions of each main type of stakeholder. This is then presented graphically in two stakeholder matrices (**Figure 3**) which allow for a visualization of the shifting power and support of key groupings. Key take-aways are summarized at the end of the section.

T*able 7: Analysis the main stakeholders of Mali's TFC reform policy*

National Executive	***At the time of the announcement***: ***high power - high (but inconsistent) support.*** • Strongly and publicly in favor of TFC, though minimally involved in design and implementation. • Aligned with political aims of increasing legitimacy and strengthening social contract. • Level of commitment shown to be inconsistent with replacement of Minister Sow three months after announcement. ***32 months later***: ***high (diminished) power – low support*** • Following coups, level of support is unknown, but national priorities do not mention health; focus instead on political and security crisis and corruption. • Currently no stated intention to meet domestic health financing targets set in the reform or other national strategies. • Mali has a strong presidency, but the two coups have led to diminished legitimacy due to transitional nature of the government and uncertainty around the coming elections.
Ministry of Finance	***At the time of the announcement***: ***high power – high support*** Supportive health economist as Minister, made public declaration that budgetary constraints would not prevent TFC from happening. ***32 months later: high (diminished) power – low support*** Level of support reduced due to difficult macro-economic conditions likely to limit fiscal space for health: security crisis, donor retreat, and COVID-19. Multiple competing priorities, among which health is but one.
Ministry of Health: *leadership*	***At the time of the announcement: high power – very high support (champion)*** • Central advocate and architect of the TFC policy, provided strong leadership although centralized and undiffused. • Health sector has weak state capability, interrupted downward authority channels (i.e., largely autonomous CSCOM) and high dependency on donors. ***32 months later: diminished power – variable support, currently unknown*** • Variable levels of support depending on who is Minister. After the coup, the reform's position on the national agenda for health unclear. Ministry likely to be risk averse during transition. • Confronted with an unfocused, incoherent strategy for the sector (and UHC specifically), further confused by integration of social protection into health. • Likely shrinking budget for health, new focus on COVID-19 response.

Table 7 (Continued)

Ministry of Health: *senior staff*	***At the time of the announcement: mixed power – mixed support*** • Small circle around the Minister during writing very in favor, empowered by their proximity. • Majority of centrally located policy elites more cautious, prefer to wait and see, skeptical of policy making process or product, frustrated by haste. • Some possibly attached to the Bamako Initiative (for personal or professional reasons) see TFC as a threat. ***32 months later: mixed power – low support*** • Main proponents of the reform scattered by turnover, no longer working directly on it. • Opponents more vocal. • Some cautiously supportive, prefer to wait and see. • Cabinet now being "kept informed" and the object of advocacy related to activities occurring outside of their direct involvement.
Ministry of Health: *technicians*	***At the time of the announcement: low power – mixed support*** • On the periphery of the reform writing process. Share similar views as majority of senior staff. • The main technical institution restructured 2-3 years ago, still not considered "fully operational." Wide-ranging mandate that includes several large areas of work. Very limited resources: small number of staff, spread thin with frequent travel, under-resourced work environment (no functioning toilet in their satellite MoH building). • Closer to the reality of dysfunctional existing systems, and history of rushing to put out guidelines for "surprise" policies. ***32 months later: increased power – tepid positive support*** • Ascribe themselves broad "lead" role in TFC implementation (design, planning, resource mobilization, operationalization). Are main government actors engaged on TFC pilot – concerned by what will happen when money runs out. Almost exclusively physicians who are self-taught managers. • Lead TFC working group. As yet unable (unwilling?) to effectively collaborate with full network of people working on health financing. Limited opportunities for cross-sectoral learning.
Social protection actors	***At the time of the announcement: low power – low support (concern)*** • Generally, on the periphery of the reform writing process (reform announced 2 months after RAMU law passed). Marginalized outside the MOH in different ministry. • Concerned: see TFC as potential threat that without proper integration could deconstruct the RAMU and undermine its development and operationalization. • Worried about financial impact of TFC, see it as unsustainable. • RAMU group's strength comes from legislation backing its creation, government funding (autonomy), seniority and track record (AMO and RAMED). • Understand slow approach needed given weak state capability and limited appetite for change.

Table 7 (Continued)

(Cont.)	***32 months later: increased power – low support*** • Their integration into the MOH not immediately accompanied with staffing and resources – took time. Continue to work on RAMU, undeterred, in relative isolation. • Position strengthened because RAMU is the law of the land: every Malian will (in theory) be subjected to the scheme, therefore TFC entitlements for target groups must be given through a health insurance subsidy. • Also see that linking the two could be an opportunity to improve the viability of RAMU (i.e., boost enrollment). • Individual actors peripherally involved with technical working group and pilot, no formal relationship. • Focusing on integrating existing TFC into RAMU and not new reform TFC from 2019 – easier since contours are known, that has been their plan since 2018.
Donors: ***early adopters and allies***	***At the time of the announcement: high power – high, pragmatic support*** • Hopeful and supportive, aligned with the overall vision, focused their support on health system strengthening. • Looking for collaboration, prioritizing different dimensions of health system reform that could be integrated and synergistic. ***32 months later: high power – low, pragmatic support*** • Concerned by unlikely political commitment, need to re-evaluate engagement with questionably legitimate government. • Re-focusing their strategy more narrowly on HSS that can achieve tangible results. Also involved in COVID response.
Donors: ***others***	***At the time of the announcement: high power – more skeptical, passive support*** • Not directly involved in the writing, limited visibility into the process, but contributed inputs. Unhappy about their lack of direct involvement in policy design. Attached to other health system governance structures (i.e., PRODESS). • See opportunities for alignment, but skeptical about TFC sustainability, prefer to wait and see, focused on their existing programming priorities. ***32 months later: high power – skeptical, passive support*** Unchanged.
Technical and financial partners: ***co-designers***	***At the time of the announcement: High power – high support*** • Power conditioned on privileged access to minister and high-level cabinet level officials. • Worked on specific requests for support in relative isolation. Trust and protection did not extend far beyond the executive. Style went against the grain: moving fast "behind the scenes" - caused mistrust. • Seen as outsider, low level of contextual knowledge but highly specialized analysis skills, temporary team, and limited network (mainly transactional). • Ambivalent about pushing a particular health financing or UHC strategy or "agenda." • Confusion about the role post-design given the limited skillset, team size and resources.

Table 7 (Continued)

(cont.)	***32 months later: low power – minimal, passive support*** • Delay with getting financing to hire in-country team (arrived ten months after announcement). High transaction costs with being in "start-up" mode (first two months without an office). Nearly full team turnover since late 2019 start, months spent working remotely due to COVID-19. • Power diminished with each subsequent ministerial turnover. Senior management presence in the country scaled back significantly. • Shifted to working on a few smaller focused areas of the reform with tangible impact, with developed specialized capacity (e.g., renovation). • Deprioritized work on TFC, mainly observing pilot with limited support.
Technical and financial partners: *activists*	***At the time of the announcement: low power – high support*** • Not directly involved in the writing, limited visibility into the process, but contributed inputs. Actively provided feedback and highly mobilized for implementation. • TFC part of their core mission and values which combine service delivery with activism. Strong presence nationally, important linkages at the technical level. • See reform as an opportunity for increased visibility and higher-level action and impact. ***32 months later: increased power – high support*** • Role gained prominence around TFC in the post-Minister Sow turnover vacuum. • Imperfect appropriation of its content, taking initiative to re-shape it, working on multiple dimensions of it in addition to TFC. • Used to operating outside of the "normal" health care system, low familiarity with certain dimensions of the context (e.g., social protection). • Want to keep the momentum going and strongly motivated to pilot TFC. Continue to prioritize engagement at technical rather than ministerial level (pragmatic more than strategic). • May not have sufficient resources (e.g., no FTE dedicated to working on TFC). Rely on internationally based consultants, missing opportunities to learn from within their own organizations. Limited success with building broader coalition.
Technical and financial partners: *other*	***At the time of the announcement: high power – passive support*** • Not directly involved in the writing, limited visibility into the process, contributed fewer inputs. Focused either on pre-existing activities that were either aligned with reform (e.g., health system strengthening, governance) or on different priority areas such as humanitarian response and more vertical programming (e.g., sexual and reproductive health). • Prefer to wait and see, continue what they were doing. ***32 months later: high power – passive support*** Unchanged.

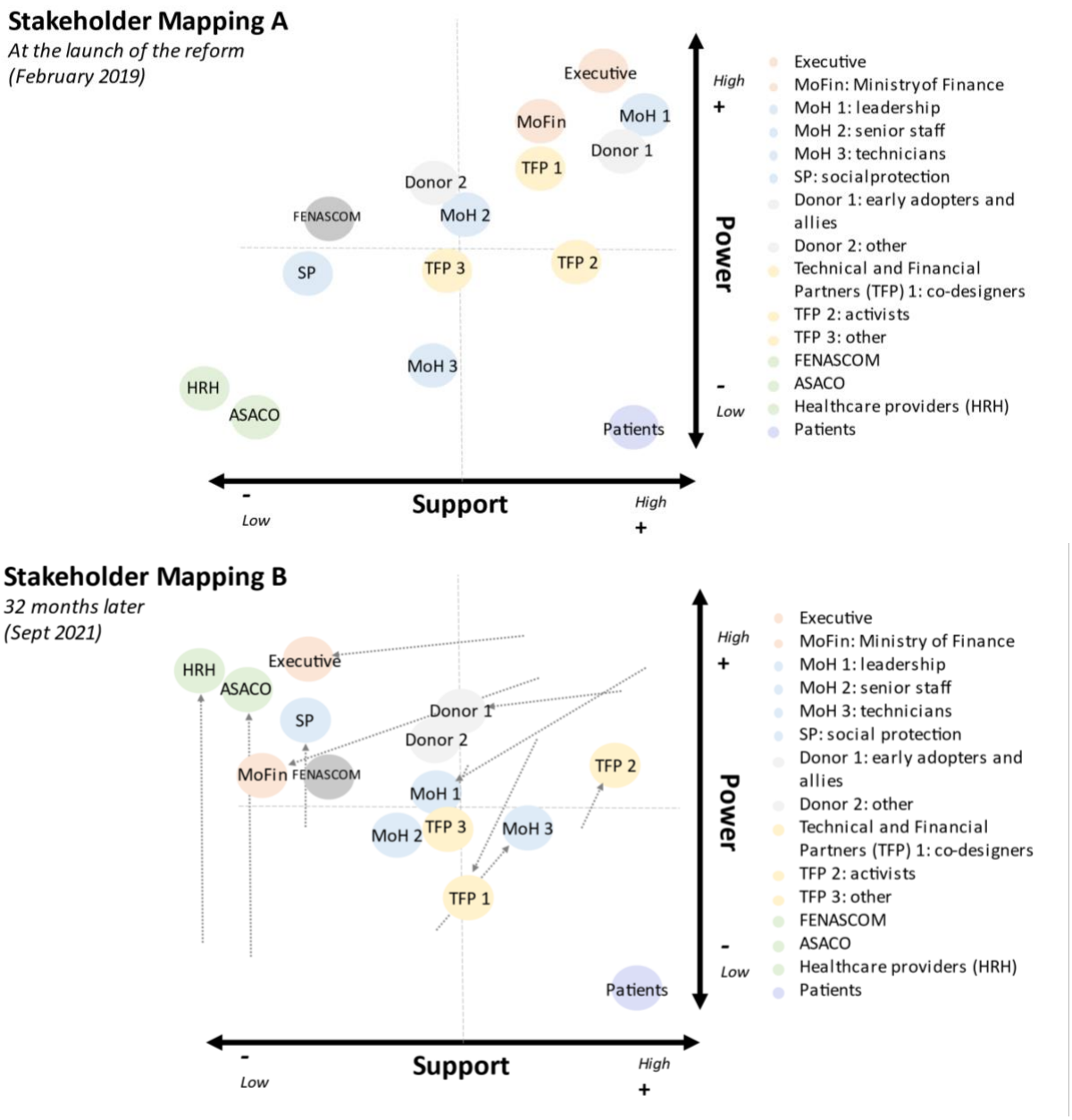
Table 7 (Continued)

FENASCOM	***At the time of the announcement: moderate power – low (pragmatic) support*** • Had a seat at the table and involved in all formal meetings – but limited ability to shape the reform's design. • In practice have limited power over ASACO and limited data on how they operate. • Sometimes frame role as part of "civil society," but perform role of lobbying group or embedded political actor trying to influence policies to ensure they benefit ASACO. Ensuring the application of legal texts on decentralization is at the center of their work. • Very negative view of TFC from experience in the North, more reassured by experience with other disease specific TFC (e.g., Malaria). • Acknowledge huge risks for their members given the current level of capacity (of state and within ASACO). ***32 months later: increased power – low (pragmatic) support*** • Would like a place at the center of the TFC policy design process, to create opportunities for increased resources and authority for ASACO. • Mainly focused on risks - "if it doesn't work, it's the ASACO that will suffer." Aware of challenges of delayed payment from existing schemes (AMO and RAMED). • Have precedent of suing the government to ensure the rights of ASACO are respected. • Areas of possible concern with the reform not as much about TFC but other areas: proposed recentralization of CSCOM staff contracting (most contracts are with ASACO, so they would lose influence and managerial authority over them); proposed harmonization of tariffs and redrawing the CSCOM map (could lead some CSCOM to need to move or be shuttered); vaguely worded "re-work the laws and decrees to ensure better functioning of ASACO and clearer division of responsibilities."
Community health associations / health care providers	***At the time of the announcement: low power – very low support (opposed)*** • Not involved in the reform writing process, most learned about it without warning during presidential announcement. Had to face tense relations with patients given expectations created. • Resistant, highly skeptical, dismissive. • Daily experience of weak state capability and dysfunction (delayed or incomplete payments, stock-outs of free products, absent supervision, corruption). • Have the most to lose with TFC: financial losses (given the share of revenue to be replaced by new payer, and illicit kickbacks through drug sales), and losses of autonomy, flexibility, control (clinical/prescribing practices, hiring). • Majority of CSCOM employees are hired by the ASACO. This category is likely to experience effect on their paychecks if TFC affects financial health of ASACO. This will be different for civil servant employees – could increase tension between these two staffing categories, and between ASACO and CSCOM clinical teams. • Existing capacity (administrative and clinical) is maladapted to the burden put on the health system. Workload increase likely to be unevenly distributed between CSCOM/ASACO and among their staff (efficiency gain for some, overburden for others). • Dislike financial transparency.

Table 7 (Continued)

(cont.)	***32 months later: high power – very low support (opposed)*** • Gain ultimate power during implementation phase as street-level bureaucrats at the heart of applying the TFC policy. • Absence of signs that policy will be implemented reinforce low trust in state capacity, frustration. • Generally unaware of planned overall HSS package strategy, even in sites that benefitted from renovation work. • They will likely try to "ride out the storm" [11] of TFC or oppose it through inaction, which for some may be their only source of power. • Very likely to use existing coping mechanisms to divert or shape the policy to continue to provide them with financial advantages in a context with weak supervision. • Significant risks regardless of selected payment mechanism: demanding informal payments from patients, diversion of free inputs, provider moral hazard (over-prescription), ghost patients, information retention. **NB**: TFC will affect CSCOM already providing free care in conflict affected areas differently. This is deeply unpopular among ASACO, who might welcome a more "measured" and coherent approach.
General population	***At the time of the announcement: low power – high support*** • Have the most to gain from the reform. Experience the negative effects of user fees in their daily lives with resourcefulness and resilience given absence of alternatives. Used to a low level of quality of care in public health facilities. • Welcome alternative to precarity and risk. Hopeful and expectant following the announcement, but confused, frustrated, disillusioned when nothing materialized. • Had pre-existing frustration with weak state capability and corruption. • Low power from generally weak civil society and media institutions in Mali. Strong community organizations often around religious or spiritual leaders – not necessarily focused on health. • Excluded from elite circles making policy, voices not heard, spoken for. Can be poorly represented by weak governance of many ASACO ***32 months later: low power – high support*** Unchanged.

***Figure 3**: Mapping of key stakeholders along the axes of power and support, both at the time of the reform's announcement (A) and 32 months later (B).*



Support = degree to which they either actively support or oppose the TFC reform.
Power = influence they have over the policy, and to what degree they can help to achieve or block it

Summary and key take-aways from the stakeholder analysis

The analysis and figures above illustrate a withdrawal of support from the high-power / high-support stakeholder groupings that occurred in the months following the reform's announcement (executive, Ministry of Finance, MoH, certain early donors and partners working on the design). Into this vacuum moved technical and financial partners whose "activist" stance and core operating priorities strongly align with it and who want to maintain the momentum behind TFC. MoH technical actors also stepped-up to work on implementation, but with much weaker links to and support from senior MoH leadership and staff.

The power of healthcare providers and community health associations (street-level bureaucrats), once very low during the design phase that mostly excluded them, dramatically increased during implementation. As they have the most to lose, they are the least supportive.

The positions of other actors, either who have the most to gain, such as patients, or whose work has not been fundamentally changed by the reform (some donors, partners, ministry staff), have not changed.

4.4 The three streams of TFC: problem, policy, politics + an entrepreneur

This final section of applied political analysis explores where the targeted free care reform in Mali currently stands, at the end of the study period (September 2021).

It uses John Kingdon's Multiple Streams framework of political change and agenda setting [11], which has been effectively applied to study policy making in Africa [9], [107], [108], [204]. The analysis is structured around three dynamic processes and their interactions, known as "streams:" problem, policy, and politics. The framework,

- The problem stream looks at whether an issue has become a "problem" that is salient and recognized by the public as being a priority requiring government action. This can be triggered by a focusing event (e.g., a crisis), or a change in indicators or feedback (e.g., a study showing alarming health indicators).

- The policy stream refers to the ongoing debates and analyses about the problem and its proposed solutions. A range of policy options can compete for acceptance and supremacy in the policy stream, based on a number of factors including their "value acceptability, technical feasibility, budgetary constraints, and future ramifications." The framework's application in low-resource and donor dependent contexts has led to additional consideration being paid to the role of international organizations in the policy stream (and arguably in the problem stream) [9].

- The politics stream is comprised of swings in the national mood, changes in government, and campaigns by interest groups, which can create a favorable environment with sufficient popular alignment.

According to Kingdon's framework, when the three streams couple to form a "policy window" there is a fleeting opportunity for a problem and its policy solution to emerge onto the national agenda in the right political moment

and be adopted. This window eventually closes, and it becomes necessary to "wait for another time when conditions and alignments are appropriate."

The framework also highlights the role of "policy entrepreneurs" who seize windows of opportunity to push their preferred solution into policy. These individuals act as power brokers who deploy their skills, political capital, and resources to achieve their policy goal, and who are often distinguished by their persistence. They have a "claim to a hearing" in the realm of policy making, either based on their expertise, position, or ability to speak for others.

This section will examine TFC in relation to each stream, attempt to identify policy entrepreneurs, and to assess whether there currently exists an open policy window for TFC. Complementary concepts drawn from Problem Driven Iterative Adaptation are also included during this analysis [87].

4.3.1 Problem stream

The problem in question here is that out-of-pocket payments are limiting access to healthcare and causing inequitable, at times devastating, financial and health effects for Malian families. Is this a good problem (to solve)? A good problem is one that can be broken down into easily addressed causal elements, one that allows for real, sequenced, strategic responses, and one that cannot be ignored [87].

The history presented uncovers some causal elements, including the introduction of the Bamako Initiative and the divestment of government from primary healthcare financing that followed. The narrow focus or limited reach of existing financial protection schemes also explains why this has not changed for the majority of patients. The widespread economic precarity in Mali puts many at great risk of hardship, particularly the vulnerable.

The best practices outlined in Part 2 suggest a number of clear steps to undertake to address the problem, though they are far from easy to implement.

But lastly, is it a salient issue that demands imperative government action? In many ways the evidence of the negative impacts of user fees in Mali is undeniable, even glaring. The rate of catastrophic expenditure, the share of per-capita GNP consumed by payments, and the proportion of people living under the poverty line speak to this. The dramatic increase in service utilization seen with repealing user fees speaks to a massive unmet need for care being held back by these expenses. At the same time, many aspects of the distress they bring upon families are largely invisible in the data, happening in private, through missed care and incurred debts.

This is part of the lived experience of so many Malians who have limited means to tackle the dangers of illness. The inequitable effects of user fees mean that those who bear the heaviest burden are also those with the least power – whose voices are least often heard.

Many healthcare providers routinely encounter the effects of user fees in their work and recognize the importance of the problem. One physician interviewed in the context of the cesarian user fee exemption recounted what it was like before:

> *"The paid C-section period, that was the kamikaze method, a disaster at the time, I tell you. But you had to do it at any risk, because the parents mostly couldn't pay for all the supplies. So, the conditions in the surgical block were really catastrophic. (…) And I tell you there are women, for lack of means, the parents or the husband refuse the cesarean section and often the child comes stillborn; other women even flee and come back all tired and usually the child is dead and often we can lose the life of the woman"* [178].

National health indicators show the scale of mortality and morbidity. According to any global benchmark, Mali is not performing well. If one looks at Mali's remote regions, the situation is even starker.

However, there has been no recent user-fee related focusing event or high-profile crisis in Mali; the "user fee problem" has been ongoing for decades, during 29 years of operating the Bamako initiative. It remained largely ignored, allowed to fester. Among the people with the power to make policy to change it, the status quo was

considered tolerable, or too difficult or risky to address. It has been overshadowed by a decade of dramatic political and humanitarian crises.

Nevertheless, in pockets of the policy elite and their activist partners are many who want to act. In addition to the human suffering that moves many, a simple cost-effectiveness calculus convinced others of the high return on investment of making preventative health services completely free. The unacceptably high, stagnant health indicators and the negative impact of this financial barrier made new bold action seem urgently needed. Minister Sow, for example, considered the need for change to address this "long overdue" [187]. This view aligned with the shift in global health orientation and the growing "consensus" in the global health community that rejected the Bamako Initiative and embraced UHC in its SDGs.

However, this shift has not fully penetrated into the national Malian context. In fact, a disconnect exists, with the Bamako Initiative still being deeply anchored in the country, in its national plans, as well as in people throughout the ministry who began their careers working to implement it, who remember the drug stock-outs and the unpaid salaries, and who remain invested in it. It still fundamentally structures the relationship between the government and primary care providers, and between providers and patients. The ideas that "people should pay something" and "payment is normal" are commonly held [205].

As elsewhere, willingness to pay and capacity to pay are at the heart of debates around the place of user fees in health. There is some consensus around the idea that the "poor" should not pay for care, but applying this principle in practice becomes fraught when trying to agree on who is poor and what it would mean for policy – a meaningful debate in a country where half the population lives below the poverty line.

Closer to the operational level, there are certainly those who prefer the status quo, and who benefit in different ways from the autonomy and opacity it provides them. There is also the inescapable experience of weak state capability – the underinvestment, the unenforced laws and absent supervision, the empty stockrooms, and the corruption. Through a mix of pragmatism and self-interest, actors closer to the front line take the view that user fees

are necessary because they see no evidence and have no trust in the capacity of the state to deliver an equivalent alternative – much less something better. They may not want the patient to pay, but the patient paying is better than no one paying. They might also ask: why add something new instead of consolidating what already exists?

Overall, most would agree that user fees are a problem that matters in Mali, however there is a gradient of agreement about whether it is a priority that requires urgent action.

4.3.2 Policy stream

Behind the (imperfect) agreement that relying on user fees to finance healthcare is a problem, there is a strong disagreement about what to do about it. Many get stuck in discussions of what is possible, feasible, realistic, or ideal to replace them with.

TFC is one solution among many to the issue. It has is proponents, and some who argue its targeted nature does not go far enough. It also has critics and skeptics who describe it as a "political fantasy", "utopic" and impossible for the state to afford. They are concerned that TFC will weaken the system and undermine the functioning of CSCOM as occurred with free care in the north, which several stakeholders described as "savage".

Within the policy stream, there are also alternatives being worked on and promoted by others to solve the problem of user fees. Although they are far from incompatible in theory, these different visions for the country's path to UHC reflect global debates, and also national divisions between the supply (MoH) and demand (social protection) sides of the healthcare system.

For instance, contributory health insurance is an alternative to user fee exemptions that also minimizes exposure to risk through pre-payment and risk pooling. This is promoted as more "sustainable" because it includes the contributions of those who "can pay," and as less donor dependent and more sovereign. Mali has demonstrated

some degree of path dependency in this direction, with nearly two decades of working on building these systems, first with the AMO and RAMED and later with the multiple efforts to re-launch the Mutuelles. This approach is the core of the national UHC financing strategy and is the raison d'être of social protection actors with a strong claim to a hearing among policy makers – due to their expertise and its legal framework (RAMU group for example).

The true viability of the RAMU strategy remains to be seen, but there is evidence of the weakness of some assumptions underpinning it (e.g., that people will accept a mandatory scheme and want to enroll, and that the state will be capable of managing and enforcing it). Promoting enrollment will be complex and administratively burdensome and efforts in this direction have yet to produce results despite considerable sunk costs. It is likely to be mandatory and contributory de-jure, but voluntary de-facto. The limited purchasing power of most Malians means that it will require a lot of subsidies to be attractive. This raises real issues about the cost effectiveness of collecting enrollment fees, which remain, as small as they may be, a cost barrier for many who are neither "indigent" nor financially secure.

It does not help that these solutions (RAMU, TFC, others) are being debated, evaluated, and compared in a fraught and fragmented policy making landscape. Pre-existing structural issues that undermine ministerial leadership have been exacerbated by a volatile context of turnover and short-term transitional planning. Effectively, a strong national decision-making apparatus is lacking; one which can weigh evidence objectively, see the system wholistically, and ensure (or force) integration of these processes so they do not compete with or cannibalize each other.

As previously discussed, the low level of collaboration among donors also exacerbates the fragmentation of workstreams. Their various means of exercising influence are especially potent in a context of weak state capability, be it through paying for dubiously scalable pilot projects, training a cohort of well-placed experts tied to a particular solution, or organizing generously paid workshops to "validate" decisions without strong appropriation of their content. Despite good intentions, and without easy alternatives, these practices nevertheless contribute to the Malian capability trap. In the current context, partners rarely hear "no."

The choice to move forward with TFC as a core part of the 2019 reform should have allowed for a more aligned and focused vision. However, as the events since have shown, the announcement itself was not enough to cement the way forward. In the months that followed, when support for it was strongest, turnover came to interrupt this momentum before a coalition within government and among donors could be assembled. Since then, the legitimacy of the reform has been undermined by the departure of the president and the absence of legal texts to formalize it.

Many acknowledge the need for a "TFC decree" to address the issue, as the process of adopting such a text would clarify its place on the national agenda and allow the Ministry of Finance to allocate it a budget. But drafting this text, even if it is broad, requires clarity around key aspects of its design which still need development (what is free, for whom, who does what, how, how much it will cost). It took 6 years for the AMO law to be developed, over 3 years for the general RAMU law to be passed (its operationalizing decrees are still forthcoming), and 2 years for the ASC decree to be ready for legislative review[19]. The timescale for developing TFC legislation is likely to be equally long. In addition, it must be highlighted that the adoption of a law or decree does not guarantee that the government will fund it to the full extent required.

The adoption of TFC suffered from the fact that the policy was not ready. Due in part to the speed with which it was designed, the 2019 reform did not address how to do it or what it should look like. The time, resources, and leadership to "soften up" the policy [11] were constrained by turnover and the fragmented national policy landscape. A clearly mandated and properly resourced group did not come together to do technical work, and much of this was outsourced to internationally based consultants. There are few easily adaptable and suitable options within existing practice - TFC and health insurance are both widely acknowledged as not working well at the CSCOM level, and PBF is still experimental. Among the Malian team leading the work, most were unfamiliar with international experiences with TFC.

[19] This comes at the end of a decade of discussions around the status of the ASC within the health system pyramid and the need to engage domestic financing. Unfortunately, the draft decree was rejected by an inter-ministerial meeting in mid-May 2021 and will require revision and resubmission.

The planned TFC pilot is an opportunity to work through these issues and could help to get the policy ready for national scale-up. This is a common approach in Mali – a program is "tested" in the field, proof of concept is demonstrated, and this is used to convince stakeholders and decision makers. This pathway, from pilot to policy, applies to past TFC (malaria, HIV to some extent), and it is the current trajectory hoped for ASC and PBF.

As previously mentioned, the risk of this approach is that the government may not be able or willing to engage in national scale-up, even if the piloted design is adjusted. Many ask with frustration, what happens when the money runs out? Why pilot something the government cannot take on? The Millennium Villages project and others were mentioned by Malian stakeholders as examples of disruptive and in their view tautological experiments. In the case of ASC, which remains to this day an almost entirely externally funded initiative, the government took so long to act on absorbing them into public service that two important donors pulled out. This has nearly half (40%) of ASC without regular pay since 2020, waiting for another donor or the government to step in.

TFC is a policy whose technical complexity makes it hard to flesh out, and it was subsumed in the volatility of the context and fault lines in policymaking. The policy was not ready to be the subject of acceptable agreement. Its coupling with the other two streams was brief.

4.3.3 Politics stream

President Keita first took office following the 2012 coup, with the promise that he would provide stability and address the ongoing crisis. In 2018, he modestly won a second term, but was struggling to revive the faltering peace process and turn the tide of escalating violence and insecurity. He initiated in December 2019 an 8-day "Inclusive National Dialogue" process that gathered thousands of participants in Bamako, with the goal of generating resolutions that would help to end the crisis in Mali. However, the tone of this event was tense, and high-level leaders from the opposition and unions boycotted or attacked the process as being "staged" and "pure political communication" [206].

The time leading up to the reform can generally be characterized by a crisis in trust between the population and government. Consistent with many worsening state capability indicators, Malian stakeholders interviewed spoke of a loss of confidence in the system, the perception of worsening corruption, and the failure of a political class focused on infighting. Therefore, the desire to relieve vulnerable Malians of the financial burden of paying for healthcare can be understood in this context as an attempt to strengthen the social contract between the government and its people, an essential ingredient for stability, social cohesion, and peace [133].

The political stream at the time was also defined by Minister Sow assuming the role of change maker at the head of the MoH. In global health, the reform agenda initiated in the politics stream is often very influenced by donors, who can create windows of opportunity by infusing funding and lobbying. Interestingly, in the case of Minister Sow, the reform vision came first, and requests to donors came second (e.g., catalytic funding applied for after the reform's announcement, in mid-2019).

Nevertheless, this powerful political coalition of Minister and President was also fragile and came together in a volatile context of instability and short ministerial mandates. Committing to the reform made sense given the urgency of the need and the potential to boost political favor, but also carried great risks given the limited state capability. Announcing a new reform, when nothing was really in place and technicians were left scrambling, is a formula that had essentially worked (albeit imperfectly) for president Touré when he announced the past TFC reforms. However, for this new iteration of TFC, given the scope and scale of this promise and the nature of the very plan being proposed (progressive roll-out with HSS first), it would be impossible to reproduce on any politically expedient timeframe. Instead, it instantly created a confusing, frustrating, disillusioning capability trap, possibly further delegitimizing the state. Stakeholders often reflected this, by saying things along the lines of "this reform is only political" or "a lot is piloted, and a lot of documents are written, but not a lot is implemented."

The national mood at the time may not have been sufficiently focused on health. Every stakeholder interviewed identified security and stability as the primary national priority, one going so far as to describe it as an existential battle for the very survival of the Malian state. This prioritization is evident with the recent trend of security spending

crowding out health spending. The now military-led transitional government clearly states its priorities are security, political and institutional reforms, the election in 2022 and the fight against corruption. At the same time, the government has to operate with the double financial constraints of post-coup economic disruption, and the global COVID-19 recession.

Within the arena of health policy, there is a small and shrinking fiscal space with many competing priorities. Despite this, the capacity of the government to take on the many expensive programs being developed will soon be tested. Here are three illustrative examples on the horizon:

The coalition working on having the state absorb ASC into the public service have a fairly straightforward and clearly costed proposition, and their decree has made significant advances towards passing despite recent setbacks. The cost to government of running the program at scale, which includes only the payment of ASC salaries, amounts to roughly $ 16.6 million USD per year, or nearly 15% of the 2017 budget for health.

At the same time, PBF has been part of the health reform discourse for nearly a decade in Mali and it is identified as a priority in national strategies (e.g., PRODESS III and IV). The current RCT will end in 2023, though it is hoped that the government will begin contributing to the scheme even before. There has not yet been a detailed costing of deploying the policy nationally, but the World Bank estimates costs of $ 3-4 per person per year to operate the program, which in Mali would be close to $ 80 million USD, or roughly 60% of the 2017 budget for health.

Finally, the cost of the RAMU is not yet known, but it is clear that the contributions of government are likely to be high given the level of subsidies needed for RAMED and Mutuelles beneficiaries. The introduction of the multiple decrees and acts to operationalize is likely in the next two years. These will also come with a major budgetary impact. The proportion of government expenditure on health that went to health insurance schemes in 2017 was only 4% [169].

In addition, it is worth mentioning that COVID-19 in Mali today may be a dormant crisis. The low number of detected cases and deaths (15,165 and 547 respectively on October 1st) are more a reflection of the country's very young likely asymptomatic population and their limited testing capacity (roughly 1000 tests done per day, including for traveler certificates). A recent study of COVID-19 exposure in Mali that measured the presence of antibodies in over 2,500 Malians, found a cumulative exposure rate of 58.5% and a rate of 73.4% in their urban community sample [207]. The planned shift from a passive detection strategy to one of active community-based case-finding using rapid tests could create the impression of a large surge in cases, simply by better measuring what is already there. It is also possible that in the coming months and years, the pandemic will put pressure to invest further in tertiary care over primary health care to boost the national ICU bed capacity, or to invest in the purchase and deployment of vaccines.

4.3.4 The TFC Policy entrepreneur

Minister Sow was the most instrumental policy entrepreneur for TFC in this context. His unique championing role was underlined by most stakeholders, as was his drive to make meaningful, courageous change. He "stuck his neck out" and harnessed his political capital both domestically and internationally to achieve the kind of authorization needed for his vision to seem plausible - the president, his government and the international community got behind him.

However, his sudden departure, less than two months after the reform's announcement, led to a loss of momentum. Minister Sidibé was also positioning himself to be a major proponent and activist for reform, but again, turnover cut this short. The core group around the reform has scattered and moved on to other things today. Some of them describe themselves as "waiting for the right time," but none of them was identified as being able to easily fill this role.

4.3.5 Where are the streams now? What is next?

In early 2019, a policy window opened that allowed for TFC to appear prominently on the political agenda. Minister Sow acted as a crucial policy entrepreneur to elevate the chronic *problem* of user fees to one worthy of bold and urgent action. He captured the *political* moment and framed the reform vision within one of a government reinvesting in the health of its people after decades of languishing. The *policy* solution of TFC was chosen, though its contours remained to be determined and the plan to have it rolled out progressively after first strengthening the system was missed by many.

Unfortunately, this coupling of the streams was brief. With the departure of Minister Sow, the policy lost its entrepreneur. The coup d'état further diminished the political stream, and the importance of the problem faded in the shadow of the COVID-19 pandemic and acute political instability. The policy of TFC was not ready to seize the moment, due to its complexity and confusion around its articulation with other systems, and it is now stuck somewhere between a donor-funded pilot project and a draft decree. Without strong government leadership, it lacks the appropriate environment to mature. There is currently no one working exclusively, full-time on TFC based in Mali, whether in government or among its partners (though this could change in the context of the pilot launch).

Signs that TFC would still be on the national agenda are few: it has no allocated budget, a small group is technically responsible for it but they have weak decision-making power, the media is not covering the issue, there are no regulatory mechanisms around it, and although some civil society organizations who have been pushing for it for a long time continue to, only sporadic conversations at the MoH include this topic. It can be concluded, therefore, that the window is now effectively closed.

What is on the horizon for Mali? In the near future, an election is scheduled to take place in February 2022, but whether this happens on time remains to be seen. Past legislative elections were delayed because of the threat of violence, and there appears to have been little to prepare for what is only six months away.

If it is delayed, that could mean civil unrest and a prolonged constitutional crisis. It could also further isolate Mali internationally, and force donors to further recalibrate their engagement with the government. Following the second coup d'état in May 2021, France "suspended its joint military operations with Malian forces and stopped providing defense advice because of the ruling junta's failure to give guarantees to hold free elections." In June 2021, French president Emmanuel Macron announced a "drawing down of French forces battling Islamist militants in Mali" promising that it would occur in "an organized way" though the timeline remains unclear [208].

When the next election does eventually happen, electoral promises are more likely to focus on security and stability than on transformative change for health – given that it was the main grievance motivating the three latest coups. As things stand, another policy window for TFC in the coming years seems highly unlikely.

4.4 Study limitations

This analysis has several limitations. The first relates to its timeliness and relevance given the volatility of the context [203].

As the past 32 months have shown, this is a dynamic and unpredictable environment, both within Mali and internationally. Many of the health system dysfunctions and capability weaknesses pre-existed these recent changes, but they have been intensified through turnover and political uncertainty. The priorities and alignment of stakeholders are also constantly shifting, particularly those further away from the operational level. Activities around the RAMU law and TFC pilot appear to be poised to move forward quickly. Finally, the specter of COVID-19 is far from disappearing, and new variants and vaccine inequity are obscuring how it will look in the future.

All these factors mean that some of the information and recommendations presented here may quickly become of limited strategic value or obsolete. Nevertheless, even if the next window of opportunity is many years away, they may still be of use to technicians and advocates to become better prepared while they wait.

The volatile context also imposed logistical constraints on the scope of this project. Access to certain stakeholders and processes was limited due to security concerns, time constraints and political sensitivities. The interviews did not include politicians, anyone from the ministries of finance or labor, regional and district level actors (especially those from local government, such as mayors), and people working in health centers outside of Bamako. No CSCOM patients were interviewed as part of this study, and so it must be acknowledged that data, publications, or the words of people speaking for them can only do so much to truly communicate their experience at the center of the story.

The second important limitation comes from the challenge of conducting analytical work from the “outsider-insider” threshold, given the multiple roles being played: student, experiential learner, technical expert, and international advisor. The embeddedness of a participant observer may lead to a loss of neutrality or objectivity while carrying out this work.

During stakeholder analyses, an analyst who is internal to the reform process "may bring their own bias to the analysis or bias the answers of respondents due to their pre-existing relationships. On the other hand, an internal analyst brings their in-depth knowledge of the local context, can know which questions to ask, and can interpret answers with nuance" [202].

Throughout this work, efforts were made to practice self-reflexivity about the unique positionality of this role and the values, ideas, and personal history the author brings to the questions being studied [35], [209]. For example, the author is aware of having been an active participant in work that reflected the problematic power dynamics related to global health described in this thesis. The author also carried around the sometimes-palpable baggage associated with CHAI in Mali, which pre-dated her arrival. Finally, being a white, French-speaking Canadian affiliated to a prestigious American university brings with it educational, financial, diplomatic, and racial privileges that were surely lost to none. The "emergency evacuation" of the author in April 2020, during the COVID-19 and political crisis, made this acutely evident.

An awareness of the different dynamics at play was cultivated to acknowledge and when possible, minimize and address them. The nature of the unusual role was explained to colleagues and interview participants, and efforts were made to fortify objectivity by triangulating descriptions and analysis through rigorous documentary review, interviews, and contemporaneous note taking.

Despite the Malian health policy environment being at times confusing and contentious, with shifting alliances and allegiances, the participants in this study proved extraordinarily open and collaborative.

Finally, during the 7 months of remote work (April – October 2021), access to the full scope of ongoing work on TFC was more limited. In addition, as CHAI's technical assistance on TFC was deprioritized over the course of the past two years, the time available to follow day-to-day activities was also reduced. Nevertheless, this also provided a valuable generative space, and an opportunity to take a step back, observe from a distance, and see the action on the dance floor from the balcony instead [1].

CONCLUSION

This thesis tells the story of a policy making failure – or at the very least, a policy making false start on what is likely to be a long reform journey.

Looking at the situation from a distance, one might first point to Mali's political instability, increasingly fragile state, and limited resources to explain why TFC failed to launch in the nearly two and a half years since its announcement. These macro-level factors are certainly fundamental in understanding the policy making challenges facing the country. However, beyond these larger forces, this thesis provides a more nuanced and comprehensive deconstruction of what is holding back TFC – and seeks to understand how to overcome these obstacles.

An evident take-away from the analysis presented is that designing and implementing targeted free care is very complex – and that it is both a serious technical and adaptive challenge that requires sophisticated leadership and state capability. The review of international experiences found that TFC policies often suffered from poor preparation, rushed implementation and under-financing, even when they were undertaken by smaller, better resourced, and more stable countries.

The reform involves changing every core dimension of the health system – financing, payment, organization, regulation, and behavior – and the scale of the transformation is pervasive, deep, and large. It took Mali 30 years to build the system that is in place now, and so it should be expected to take a long time to move it through a period of change, even if all the conditions for this are met.

The fact that user fees are currently the lifeblood of CSCOM and ASACO, means that the stakes of implementing the policy in Mali are very high. TFC requires different ways of paying for health, and a different distribution of power, autonomy, and control between the state and providers. This relationship is already fraught, as frontline workers do

not trust the state to follow through on their end of the arrangement - with the government's existing track record as a delinquent payer informing this apprehension.

This thesis also presents through its analysis that essential enabling conditions for TFC to be adopted are not currently in place.

First – financing for TFC is unclear.

Crucially, since free care is not really free, the state ultimately needs to be able and willing to pay for it. Despite commitments and targets, the fiscal space for health is small, even tiny at the primary healthcare level, and is more likely to shrink than expand in the coming years. The transition government, and perhaps the general population, is concerned with safety and the very survival of the state.

Donors and partners are also unlikely to move boldly in a time of political uncertainty, and in a context of global health aid realignment in a post-COVID-19 world. Their attention and resources in Mali are being divided between humanitarian response and development.

Second – TFC lacks strong leadership.

Support from key high-level leaders has been lost due to changes in the context and turnover. Three different Presidents and four ministers of health evidently do not create the proper conditions for enacting slow and complex large-scale change.

The reform was heavily carried by a policy entrepreneur (the Minister of Health) at the time of its launch and momentum was lost at a crucial time with his departure. Without as strong a champion, the policy's implementation has entered a phase of uncertainty, fragmentation, and stagnation. The national salience of the issue of user fees

was not elevated by any clear domestic event or change in the national mood – and so it will likely need to be championed by a policy leader again.

Its many technical and adaptive issues seem insurmountable without capable and focused leadership. This is undermined by sector-wide disfunctions and a lack of coherent, focused strategy – preventing alignment, and coordination. This dynamic is playing out on a smaller scale within the TFC working group, which does not currently provide an adequate space for working through tough questions.

Third – TFC does not have sufficient stakeholder support

There are pockets of resistance throughout the MoH, most evidently at the operational level from service providers. Resistance from street-level bureaucrats with wide discretion and autonomy is a real concern, not just for the policy's adoption, but also for its effective implementation. The analysis presented here suggests that many are likely to engage in the same coping mechanisms as with existing TFC and health insurance: care rationing, input diversion, task shifting.

At the same time, other higher-power stakeholders are invested in an alternative approach to achieving UHC – the RAMU – and are weary of TFC. Those who support TFC are currently spread thin in an environment of competing needs, and insufficient resources and collaboration.

Finally – Mali is in a weak starting position

Mali's healthcare system is currently under-resourced and underperforming in important ways. It is already struggling to provide primary healthcare services, with every health system building block suffering from decades of underinvestment. An influx of patients from introducing TFC would be a big strain on already weak health service delivery systems. The capacity needed to effectively run TFC – even in terms of things as fundamental as infrastructure and staffing – would need to be built considerably.

Signs of the government's weak capability are apparent, with large disparities between what should be happening and what is actually happening throughout the health system, including dysfunctional health insurance and existing fee exemption schemes. Few existing systems can be used as a model or scaffolding for TFC without serious caveats. In some regions affected by insecurity, the state's role in health service provision has essentially collapsed.

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And yet, every day, paying for healthcare extracts multi-dimensional costs from already strained Malian families. In a country with widespread poverty and ill health, and with inadequate financial protection measures, the vulnerable are harmed the most. The problem has been allowed to fester, holding back a massive unmet need for healthcare. User fees are delaying care, leaving families in ruin, and taking lives. For many Malians, patients first among them, the need to end out-of-pocket payments at the point of care is urgent.

This assessment is likely to feel frustrating. It is hard to reconcile a sense of urgency with a reality that requires slow, careful action - especially after the remarkable optimism around the 2019 reform.

However, it is undeniable that the stress TFC would put on the system is high and would very likely lead to a capability trap. This would result not only in the failure to reach its objectives of protecting the wellbeing of families; it could also make things worse. This is dangerous in a context of state fragility.

Nevertheless, the conclusion should not be that TFC is simply too hard or that it can never be done. After all, Burkina Faso implemented TFC only two years after a coup d'état and with an even weaker economy. Sierra Leone undertook its FHCI program only seven years after its nearly decade long civil war and had far worse health indicators at the time.

The timeframe for TFC in Mali must be rethought given a fuller appreciation of the context. Progress will be slow, and less immediately transformative. Unfortunately, larger trends – such as new COVID-19 variants and continued spreading political instability suggest this might be a long time horizon. However, it is very much possible.

Mali's 2019 reform was an imperfect but promising start. Thirty-two months later, this thesis can conclude that the policy is no longer on the agenda. However, the precedent set by this ambitious attempt may yet have a lasting impact. The public adoption of TFC (despite its failed implementation so far) could have "established a new principle." According to Kingdon, a bold policy announcement can fundamentally shift the policymaking conversation, "because succeeding increments are based on the new principle, future arguments about the policy are couched in different terms" [11]. The extent to which this holds for TFC remains to be seen.

Until the next policy window appears, time should be utilized as much as possible to work out the policy design and to build collaboration. Hopefully the tactical advice contained in this thesis can help provide a roadmap to do so.

APPENDICES

APPENDIX A: Detailed analysis of the demographic, economic and political situation in Mali

Demographic situation

Mali's last general census was conducted in 2009 and estimated its population to be 14.5 million. Based on an annual growth rate of 3.6% [134], it can be estimated today to be close to 22.2 million people. The country's demographic growth rate is faster than other countries of comparable income level. This population growth is driven by a very high fertility rate of 6.06 children per woman, which is the 4th highest in the world. It has remained high over time, only decreasing by 0.91 since the 1960s [192].

Most of the country's population lives in the south, with the northern regions of Tombouctou, Gao and Kidal making up less than 10% of the population [123]. Mali is a large country, covering an area of roughly 1.24 million square km, or 61 times the size of Massachusetts. It is also one of the least densely populated countries in the world, with an average of 16 people per square km – a ratio that goes down to 2 per square km in northern regions [123].

The country is urbanizing quickly, at an approximate rate of 5%, which means that by 2030, urban areas will hold 49% of inhabitants. The capital city's planning and water and sanitation infrastructure are already strained today [137].

The population is young, with 47% aged under 15 years old [122], resulting in a high dependency ratio. Economic growth and opportunities have not kept up with demographic growth, which has produced high rates of poverty. Mali is among the 25 poorest countries in the world, with close to half (42 %) of the population estimated to live below the national poverty line [122].

According to the latest World Bank Human Capital Index, a composite that measures the health, knowledge and skills of citizens, Mali ranks near the bottom, with a score of 0.32, making it the 5th lowest ranking country out of 100 [210]. Mali also does not fare well according to the UN Human Development Index, ranking 184th out of 18 countries [211]. The average number of years of formal education in the adult population is 2.4. Literacy rates have improved slightly in the past 10 years but remain very low, with only about a third (34%) of the population being able to read. This rate for women is half what it is for men [123].

Economic situation

Mali's economy grew at a rate of roughly 5% of GDP annually since 2005, with two episodes of negative growth during the two political crises of the past decade: 2012 (- 0.84%) and 2020 (- 1.65%). GDP per capita is low, under $ 860 in current USD per person in 2020 (down from closer to $ 900 in 2018) [122].

The economy remains undiversified and dependent on commodity exports and extractive industries, with gold representing close to 60% of its total exports, alongside cotton products (18%) and livestock (14%) in 2019 [212].

A majority (80%) of jobs in the country are in the informal sector [123]. Mali's tax revenues are low, at 13% of GDP in 2020 compared to the regional standard of 20% [213]. Mali is at "moderate risk of public and external debt distress", with a public debt making up 40% of GDP in 2019 [212].

The government is highly dependent on aid, with Overseas Development Assistance (ODA) making up nearly 11% of Gross National Income in 2019 [214]. It has been suggested that countries with ODA making up more than 10% are likely to have "questionable sovereignty in key policy areas" [215].

Political situation

Mali's history reveals a fragile democracy. The post-independence socialist government, led by President Modibo Keita, was overtaken by a coup d'état in 1968, which heralded a period of military dictatorship that lasted until 1991, when another coup finally introduced democratic reforms and the writing of a new constitution a year later [134].

More recently, after years of stability, Mali has been plunged into an acute political and security crisis. Historic ethnic tensions, fueled in part by development inequalities between regions, led to the emergence of a pro-independence Tuareg rebellion led by the Mouvement National pour la Libération de l'Azawad (MNLA) and Tuareg-led jihadist group Ansar Dine. At the same time, following the collapse of Libya in 2011, well-armed foreign jihadi groups were dispersed in the region and established themselves in Mali, including the Al-Qaeda in the Islamist Maghreb (AQIM) and its west African counterpart the Movement for Oneness and Jihad in West Africa (MUJWA) [216]. This volatile mix of actors led to an eruption of violence in the north of Mali in January 2012. These actors exploited popular dissatisfaction with the government and increasing lawlessness in the area to promote brutal acts of violence and banditry, which were further exacerbated by episodes of inter-community violence.

In March 2012, the government's inability to address the growing crisis in the north led to a coup d'état that removed president Amadou Toumani Touré. However, this only exacerbated instability and led to the retreat of the Malian army from the four northern regions and the takeover of regional capitals by rebel forces. In the face of escalating violence, the Malian government, and the Economic Community of West African States (ECOWAS) requested a French military intervention, known as Opération Barkhan. This succeeded in securing a short-lived cease-fire and de-escalating the conflict in the north and was followed in early July 2013 by the deployment of a UN peacekeeping mission, known as the United Nations Multidimensional Integrated Stabilization Mission in Mali (MINUSMA) [216].

In the lead up to the 2012 crisis and since, the donor community has been accused of helping to "consolidate a regime that grew increasingly unpopular and discredited" while "exerting weak controls over the national strategy that they were funding and ignoring signals of growing dissatisfaction" [217].

Following the 2012 coup d'état, many major international donors suspended their development assistance to the country and shifted program operations away from government agencies towards NGOs. The suspension of budget aid depleted the state treasury and led to dramatic cuts in operational and investment budgets. The resumption of aid was generally slow and for months lacked coordination [218].

A peace agreement was signed between the Malian government and rebel groups in April 2015, known as the Algiers accord. Its weakness is that it was signed with two distinctive coalitions of rebel groups with divergent claims against the state of Mali. It also does not formally address issues happening in the central region of the country [219].

Democratic elections brough a legitimate government back in 2013, with the election of President Ibrahim Boubacar Keïta. Nevertheless, the crisis in the north continued and the peace process stalled in 2017. Security risks and militant attacks are no longer limited to the north, having spread into central Mali, creeping towards the capital of Bamako, and including a fractured landscape of new extremist and criminal groups unassociated with the peace process. A climate of insecurity and impunity has developed along the porous border area joining Mali with Burkina Faso and Niger, and risks spreading further across the region [220].

President Keïta modestly won a second term in 2018. It was the first time in the country's history that a presidential election with an incumbent was forced into a runoff, and both rounds were marred by violence and tensions [221]. Signs were evident of widespread popular discontent with the president early in his tenure. In April 2019, the Prime Minister and his cabinet resigned in response to the deteriorating national security situation that was marked by a particularly cruel massacre [194].

After several delays, two rounds of legislative elections took place in March and April 2020. These occurred despite the leader of the opposition having been kidnapped by a jihadist group while campaigning, allegations of voter fraud, and increasing fears of violence and COVID-19 [222].

Recurrent strikes and protests in the capital continued after the elections, and in early June 2020, the "June 5 Rallying of Patriotic Forces Movement (M5-RFP)" was formed. The M5-RFP is composed of political parties, trade unions, religious organizations, and civil society. Its grievances related to corruption, bad governance, nepotism and impunity, and the movement was explicitly calling for the president to resign. Confrontations between protesters and state security forces were tense, at time leading to loss of life [223].

These tensions eventually escalated to a military-led coup in August 2020 that forced the removal of President Keita and his government. A transitional government was put in place with an 18-month mandate to lead and organize democratic elections by February 2022. Tensions between the transition government and members of the M5-RPF movement remain, with the latter allegedly feeling excluded from key decisions and nominations [224].

Ten months into this mandate (May 24, 2021), less than thirty minutes following the announcement of a ministerial re-shuffling, a second coup occurred that forced the resignation and arrest of the transition President and Prime Minister [225]. The leader of this latest putschist effort, the transitional government's vice-president, Colonel Goïta, was inaugurated as the new president of the transition government on June 7th promising to keep the commitment to hold democratic elections in February 2022. He survived a seemingly improvised assassination attempt on July 20th, 2021, during a religious event at a mosque in the capital [226].

The internationally appointed transition mediator, Goodluck Jonathan of Nigeria, expressed concern during a visit to Bamako in early September 2021 about "the lack of concrete action in the effective preparation of the electoral process [227]. Hostilities and intrigue within the transition government continue [228].

State capability

According to the Fragile State Index for 2021, Mali is the 19th worst ranked country in the world (score of 96.6), just before Libya. This index also highlights a trend of deterioration, as Mali was ranked 3rd in terms of "long-term most worsened" country between 2011-2021 [229].

Similarly, the 2019 World Governance Indicators paint a worsening picture for Mali from 2009 to 2019 across all six components (voice and accountability, regulatory quality, political stability and absence of violence/terrorism, government effectiveness, rule of law, and control of corruption). The country performs particularly poorly in terms of political stability and government effectiveness (with percentile rank scores of 4.29 and 13.94 out of a range from 0 to 100) [230]. Other metrics confirm that corruption is widespread, and a majority of Malians believe the problem is getting worse – with perceptions of increasing corruption rising dramatically in Mali (from 31% in 2014-15 to 74% in 2019-20) [231].

Finally, the domestic news media landscape in Mali exhibits structural issues that undermine its role as the fifth estate: it has limited investigative capacity, it operates in a small market with a readership that has low purchasing power, and it has high costs of production. The press is therefore mainly fed by reports on political news and communications and press conferences organized by state institutions. On issues of health, media coverage generally does not include any serious policy analysis or scrutiny, nor does it provide a space that gives voice to the "voiceless" [232].

Implications of the political situation on health

The devolving security crisis is greatly affecting the health and wellbeing of people living in the North and center of the country. The number of people internally displaced by the conflict has risen from 140,000 in March 2019 to more than double, reaching over 380,000 in August 2021 [124]. The number of people needing humanitarian assistance rose from 4.3 to 6.8 million between January and August 2020. This has led to a situation where roughly one in three people in Mali are dependent on emergency aid [125].

This crisis has seriously disrupted the supply of healthcare – with many health professionals in the North being repatriated to the capital in the wake of the 2012 crisis due to the anti-government nature of the tensions, as well as three quarters of government health facilities being looted or damaged [126]. The proportion of functioning government health centers continues to decrease, from 88% in 2012 to 78% in 2019, dipping as low as 35% at the

height of the crisis. The presence of skilled health workers has been reduced by 31% and the majority of those in place are paid through international development assistance [219].

In 2012, the MoH formalized an agreement with a consortium of NGOs to provide emergency free healthcare for six months in the North. Despite the original period agreed to having expired nine years ago, this emergency assistance continues to this day, and the evaluation of it that was supposed to take place after the initial trial period took place three years late. The implementation of this policy has been found to vary from one NGO to another, and from one region to another, resulting in incomplete coverage that leaves some health centers without assistance and others receiving overlapping benefits [126]. Despite drug procurement at times being done directly by NGOs from international suppliers, the rate of essential medicine stock-outs increased in one district during this period (from 11% in 2011 to 45% in 2014) [233]. One stakeholder interviewed also described the mismanagement of supplies leading to the proliferation of private pharmacies selling diverted products. NGO-financed free health care in the North also reportedly undermined the functioning of health centers, by providing reimbursements insufficient to cover the operating costs, leading to widespread frustration and some reinstating user fees.

The coordination of actors and activities has been challenging, despite the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) cluster system being activated in 2012. There are more than 150 organizations operating across multiple sectors to provide services, including protection, shelter, food security, health, and education. This work, often outsourced to local NGOs, is dangerous – with over 85% of staff from these organizations reporting experiencing physical violence, theft or carjackings in 2017 [219].

The disruption of services has been associated with several serious measles outbreaks in Northern Mali between 2012 and 2016, and again in 2018/19 (950 cases in 14 months). It has also worsened health equity across a number of indicators, either with rates of improvement being weaker in conflict affected areas (e.g., access to modern contraceptives) or being negative in conflict affected areas while improving in the rest of the country (e.g., deliveries attended by skilled professionals) [216].

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