

COMMENTARY

Aid for health in times of political unrest in Mali: Does donors' way of intervening allow protecting people's health?

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Mali has long been a leader in francophone Africa in developing systems aimed at improving aid effectiveness, especially in the health sector. But following the invasion of the Northern regions of the country by terrorist groups and a coup in March 2012, donors suspended official development assistance, except for support to NGOs and humanitarian assistance. They resumed aid after transfer of power to a civil government, but this was not done in a harmonized framework. This article describes and analyses how donors in the health sector reacted to the political unrest in Mali. It shows that despite its long sector-wide approach experience and international agreements to respect aid effectiveness principles, donors have not been able to intervene in view of safeguarding the investments of co-operation in the past decade, and of protecting the health system's functioning. They reacted to the political unrest on a bilateral basis, stopped working with their ministerial partners, interrupted support to the health system which was still expected to serve populations' needs and took months before organizing alternative and only partial solutions to resume aid to the health sector. The Malian example leads to a worrying conclusion: while protecting the health system's achievements and functioning for the population should be a priority, and while harmonizing donors' interventions seems the most appropriate way for that purpose, donors' management practices do not allow for reacting adequately in times of unrest. The article concludes by a number of recommendations.

Keywords Aid, effectiveness, donor coordination, donor policies

KEY MESSAGES

- Donors reacted in a non-harmonized way to political unrest in Mali.
- Donors have not been able to intervene in view of safeguarding the investments of co-operation in the past decade, and of protecting the functioning of the health system.

- Donors' procedures and management practices do not allow for reacting appropriately in times of political and social unrest.
- Principles of aid effectiveness (harmonization and collaboration with functioning national institutions) should definitely keep being a common thread even in times of crisis.
- Donors' financing should be more flexible.
- The development and humanitarian aid must definitely be better articulated.

Background

Mali has long been a leader in francophone Africa in piloting health sector reforms (Maiga *et al.* 2003) and in developing systems aimed at improving aid effectiveness (Samaké 2009). The Ministry of Health (MoH) and its partners launched a sector-wide approach (SWAp) in support of its national health programme in 1999 and this led to important progress in terms of aid efficiency, health system strengthening and results (Maiga *et al.* 2003; Samaké 2009; Paul 2011; Paul *et al.* 2013). Mali was the first francophone country to join the International Health Partnership and related initiatives (IHP+) and to sign a country Compact. Thanks to its good relationships with the donor community, Mali received large amounts of budget support over the first decade of the 2000s, which benefited social sectors (Lawson *et al.* 2011). But on March 22, 2012, following the invasion of the Northern regions of the country by terrorist groups, the president was dismissed by a coup, and the largest part of the country fell overnight into chaos. Despite the formation of a transition government and international support to reconquer the Northern regions in early 2013, the central power in Bamako was for a long time once reinstated strong leadership. How have donors reacted to the political unrest? Have they been able to intervene in a coherent and co-ordinated fashion in view of protecting the functioning of the health system? This article describes and analyses the management of the crisis in the health sector in Mali after the coup and terrorist invasion.

Political reactions after the coup

As soon as the coup was declared, donors suspended most official development assistance. The European Union quickly developed a consensual approach to the coup and agreed to suspend financing and technical assistance to the central State, but to pursue humanitarian aid, support to civil society and local governments, including for supporting social sectors. Some bilateral donors suspended all aid to the country and others re-examined contracts with non-governmental organizations (NGOs). While bilateral agencies were all impacted by the political fall-out of the putsch, the multilateral agencies went into a 'Fragile States' mode. Suspension of budget support contributed to the depletion of the Treasury accounts, jeopardizing the continuation of public services. The Treasury followed a prudent policy, hailed by the International Monetary Fund, thus it has been able to keep paying civil servant salaries, but operational and investment budgets were dramatically cut. Besides, most donors' attention turned to the North, leaving the South of the country—where the majority of the population

lives, and many people from the North sought refuge—without adequate support.

The military soon transferred power to a civil transition government, but the political scene did not stabilize until after a long time. Many bilateral donors were not allowed by their headquarters to have an official meeting with the interim government for months. The 'national union' government was only effective in August 2012, which enabled those donors to resume political dialogue with the national authorities. Despite the European Union's phased approach to resuming co-operation, every donor actually decided on an individual basis whether to resume which forms of aid and how, based on its own political agenda and constraints. It is more than 7 months after the coup that a retreat with all donors was organized to harmonize on a gradual resumption of co-operation.

Operational consequences in the health sector

The functioning of the public health sector was disrupted in the North, as the regional directors and district chief medical officers were repatriated to Bamako; some critical central directorates were looted during the coup, but the bulk of the MoH went on functioning normally at central level and in the South of the country. The MoH has even been able to manage an epidemic of cholera in Gao (North) in July 2012. Right after the coup, as all donors focused on short-term humanitarian actions, they regrettably did not co-operate with MoH managerial staff through meetings and joint activities as they did before, neither did they pay sufficient attention to the 'normal' functioning of the health sector. This contributed to weakening national leadership over crisis management. Donors tried to find other ways to provide aid—but still, on a bilateral basis and with long delays. For instance, the Netherlands contracted NGOs to manage part of their sector budget support funding—but this was effective only in September 2012—while the US Agency for International Development and Canada channelled an important part of their funding through the United Nations Children's Fund. The United Nations (UN) agencies continued their direct implementation and NGO support as well as the work with government, with more restrictive financial procedures.

In addition to aid to the health sector, Mali has benefited from humanitarian assistance, co-ordinated by the Office for the Coordination of Humanitarian Affairs (OCHA). Following the March/April 2012 events, the OCHA cluster system rapidly tried to take care of the refugees inside Mali and the population that had stayed in the North. The cluster system is co-ordinated by the UN system, while much of the work on the ground is

carried out by NGOs. The cluster focused on the Northern regions, but the humanitarian principle of ‘impartiality’ led to an incoherent approach, with a large number of actors shunning the public system as a whole.

The crisis considerably disturbed the long-standing MoH–donor collaboration in the sector. Some bilateral and UN representatives met among themselves at first and were later co-ordinated by the lead health donor (Canada) who resumed the co-ordination meetings and policy dialogue with the MoH. This enabled them to work jointly again on the finalization of the new national plan and its joint processes and implementation instruments, including priority goals and strategies, district functioning, coherence of specific interventions, health system strengthening, etc. The steering bodies of the SWAp were interrupted, and it is only after a few months that some joint programming activities were able to take place. Moreover, the co-existence of two health partner co-ordination structures which are rather incompatible (development and humanitarian aid) led to confusion, and made it practically impossible to ensure coherence in health planning. Focal persons within donor agencies may sit in different parts of the system, while MoH focal persons were different, which led to separate planning processes with different time frames and organization. At the bottom line, MoH managerial staff have lost the leadership over crisis management, which has been prejudicial in two respects: (1) the technical one: the MoH and its decentralized institutions were bypassed while they were probably in the best position to ensure intervention co-ordination, equity and consolidation of the health system, and were maybe even most efficient to deliver humanitarian assistance and (2) the political one: while improvements in health services and systems help to strengthen civil society and to restore legitimacy to governments (Newbrander *et al.* 2011), the way donors intervened outside of the health administration in Mali lacked legitimacy and contributed to degrading the image of the State among populations.

Discussion

Over a decade ago, Waldman (2001) reckoned that ‘it is simply not enough for the relief community to do the right thing – it must also do it right’. Yet, the few lessons identified from past experiences in humanitarian aid are not being consistently applied. Despite its long SWAp experience in the health sector and international agreements to promote aid effectiveness, donors in Mali reacted to the political unrest on a bilateral basis, stopped working with their ministerial partners as they used to do, departed from the objective of supporting State building, interrupted support to the health system which was still expected to serve populations’ needs and took months before organizing only partial solutions to resume aid. Yet, even if Mali became overnight a ‘Fragile State’, it is acknowledged that effective engagement with those States to inform the design of health programmes and selection of interventions depends on donor co-ordination and an understanding of health system challenges (Newbrander *et al.* 2011); the Busan New Deal for Engagement in Fragile States also recommends to support inclusive country-led and country-owned strategies (IDPS 2011). Mali’s recent history illustrates that a country can

quickly be destabilized and that each crisis is different. It was clear in Mali that while protecting health systems achievements and functioning should be a priority, and while working in the spirit of a SWAp—providing concerted support to a national strategy, including responding jointly to governance problems and supporting MoH and district capacities—was obviously the most appropriate way to respond to the crisis, donors did not have the right instruments to react appropriately, to take decisions on the field and to evaluate and use existing systems functioning properly despite the crisis.

What can be done to avoid such a damaging situation occurring elsewhere? Harmonization and collaboration with functioning national institutions should definitely keep being a common thread—both managerial staff who should keep leadership over intervention co-ordination, as well as NGOs, local authorities and district officers at the operational level. Hence, donors’ representatives in countries should be given more room from headquarters to quickly find solutions together and be delegated more decision power, to allow donors’ financing to be more flexible so as to be quickly diverted, in a co-ordinated way, to alternative channels (e.g. NGOs, local governments, district hospitals and health centres) during the transition when central government budget channels cannot be used. The development and humanitarian aid must definitely be better articulated, with appropriate roles devoted to the national and international constituencies. The humanitarian principle should not be a goal in itself, but rather be evaluated on a case-by-case basis, in view of being most efficient in reaching populations—which could mean using government’s decentralized institutions. The national system also needs to go on leading critical activities such as immunization campaigns. In sum, donors need to revisit their ways of intervening to better serve populations’ needs and adjust to situations of crisis rapidly and in a country-specific way.

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Conflict of interest

None declared.

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