HUMAN RESOURCES FOR HEALTH COMMITMENTS: MALI ADDRESSES WORKFORCE SHORTAGES AND DISTRIBUTION

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INTRODUCTION

Over the past ten years, Mali has overcome challenges to strengthen its health system and improve the health status of its people. For example, the maternal mortality ratio decreased from 1,100 to 550 deaths per 100,000 live births between 1990 and 2013 (World Health Organization [WHO] 2015). However, the political crisis of 2012 caused a number of setbacks, weakening a vulnerable economy, prompting health workers to emigrate out of the already disadvantaged northern provinces, creating populations of refugees, and placing additional demands on the health system. In addition, global partners who were providing technical and financial support to improve Mali’s health system—including the US government, Canada, and the European Union—suspended their work in Mali until the severity of the crisis subsided. As of 2013, therefore, many of the gains toward achieving the Millennium Development Goals (MDGs) had been reversed, and average life expectancy was only 55 years of age (World Bank 2015a).

Mali’s government is determined to continue to strengthen its health services in order to regain its losses, improve maternal and child health, and make progress toward eradicating preventable deaths from disease and malnutrition. The government is well aware that broader access to quality health services is one of the main challenges it must address. With a wide disparity in health service availability, the country’s rural and remote areas pose the greatest need. For example, the Mali Demographic and Health Survey (DHS) of 2012–2013 reports that while most women in urban areas are attended by skilled professionals during childbirth (73% by nurses or midwives, and 13% by physicians), only 25% of rural women give birth in the presence of a nurse/midwife, and just 2% are attended by a physician (CPS/SSDSPF et al. 2014). An adequate number and equitable distribution of skilled health workers is vital for meeting the country’s health needs and moving toward universal health coverage. The WHO estimates that 2.3 health professionals per 1,000 people are needed to provide basic health services, but according to 2012 government reports, Mali’s national physician-to-population ratio was .08 per 1,000, with a ratio of .43 per 1,000 for nurses and midwives (WHO 2013).

Facing these critical shortages and wide disparities in health workforce coverage and access, the government of Mali announced four human resources for health (HRH) commitments at the WHO/Global Health Workforce Alliance (GHWA) Third Global Forum on Human Resources for Health (Global Forum) held in Recife, Brazil in November 2013. Mali’s Recife commitments are intended to address the health workforce shortage and the inequitable coverage by establishing infrastructure, practices, and processes to produce more health workers and deploy them where they are most needed. The four commitments are listed below.¹

¹ Mali HRH commitments in original French language: (1) Développer le système d’information et de gestion des Ressources Humaines en Santé à tous les niveaux de la pyramide sanitaire d’ici à l’an 2015; (2) Rendre disponibles les Ressources Humaines en Santé qualifiées (Médecins, Sages-femmes et Infirmiers) dans 60% des Districts Sanitaires d’ici à l’an 2018; (3) Renforcer les compétences des Ressources Humaines en Santé (Médecins, Sages-femmes et Infirmiers) au moins 1 fois par an; (4) Promouvoir un environnement institutionnel favorable à l’engagement des Ressources Humaines
Commitment 1: Develop and decentralize a computerized human resources information system (HRIS) to better manage the health workforce by 2015. This commitment aims to increase and improve the information available to decision-makers through computerized HRH information systems to allow evidence-based HRH policies and strategies.

Commitment 2: Ensure that 60% of health districts are fully staffed by qualified health providers (including physicians, midwives, and nurses) by 2018. Because of the political crisis of 2012, the Ministry of Health’s ability to recruit health workers into the northern regions of the country where the conflict was concentrated was greatly compromised. For example, in 2008, 565 contracted health agents were recruited to the northern regions; after 2009, however, no further health workers in this personnel category were recruited (Ministry of Public Health and Hygiene 2013). Since 2012, the overall level of HRH recruitment in the north has continued to decline each year.

Commitment 3: Offer capacity-building opportunities to the health workforce (physicians, midwives, and nurses) at least once a year. In Mali, continuing professional development (CPD) is not required by law and is generally considered to be the responsibility of professional associations and/or individual health workers. Medical associations and other professional organizations initiate, provide, and promote CPD, and global partners provide in-service training in clinical skills and non-clinical competencies. However, because there are no standard national CPD requirements or regulatory oversight across each cadre, training to refresh skills or update knowledge is inconsistent and inadequate. Moreover, trainings are often held away from health facilities, requiring health workers to travel (incuring a cost for the training partner) and to be absent from already stretched service delivery teams. It is common for the same health workers to repeatedly attend capacity-building workshops on the same topic.

Commitment 4: Promote an institutional environment that enables health worker retention in underserved and difficult areas. To achieve Mali’s national goal of reaching one doctor, one nurse, and one midwife per 1,000 inhabitants, Mali needed to add 14,205 physicians and 15,525 nurses and midwives in 2013. However, its production between 2011 and 2012 fell far below these targets, averaging 274 physicians, 459 midwives, and 1,562 nurses (Ministry of Public Health and Hygiene 2013). In addition to increasing recruitment, training, and deployment of health workers, the Ministry of Public Health and Hygiene understands that is critical to retain existing staff as well as increase the number of health workers. This commitment was intended to ensure that resources and strategic planning would coincide with recruitment and deployment efforts.

This case study shares Mali’s experiences in developing, implementing, and tracking its HRH commitments, focusing on the political environment in which the HRH commitments were made, the interventions that were implemented to meet said commitments, and the progress

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*en Santé à servir dans les zones difficiles.*

Case Study on the HRH Commitments: Mali
that has been achieved to date. The case description also seeks to shed light on the enabling and inhibiting factors toward leveraging the HRH commitments to advance health workforce improvements.

**METHODOLOGY**

Case study authors included a representative from the Ministry of Public Health and Hygiene and advisors from IntraHealth International, who worked closely with the Ministry in achieving its goals. An initial desktop review of relevant documents focused on policy papers and grey literature, with informal review of related publications. Authors also referenced World Bank and WHO databases as well as Mali’s DHS reports. Finally, interviews with key actors at the national and local levels illuminated realities on the ground and supplemented gaps where data were often unavailable. The qualitative information from these interviews was validated with supporting documentation or concurrence from additional inquiries.

**CASE DESCRIPTION**

*Background*

Despite recent improvements, Mali’s health indicators remain on the low end of global rankings. The maternal mortality ratio in Mali is 550 deaths per 100,000 live births (WHO 2015). Child and infant mortality are also high, with 123 deaths per 1,000 live births for children under five (World Bank 2015b) and 78 infant deaths per 1,000 live births (World Bank 2015c). With these indicators, Mali ranks among the countries with the most urgent health improvement needs. The country’s very low health worker density places Mali in the group of 57 “human resources for health crisis countries” that do not have enough health workers to provide basic health services (GHWA n.d.).

At the same time that the country has been in critical need of increasing its number of health workers, it also has been in the midst of a global financial crisis. From 2011 to 2012, Mali’s health expenditures dropped from 3.0% of gross domestic product (GDP) to 2.3%; in 2013, health expenditures still had not returned to 2011 levels (World Bank 2015d). The budget allocated to the Ministry of Public Health and Hygiene’s Department of Recruitment to cover new health worker salaries has declined almost by half over the last five years, falling from one billion CFA francs in 2010 to 600 million CFA francs in 2013—a reduction of 40% over the two years—and then dropping by an additional 40% from 2013 to 2015. To reach the WHO-recommended minimum ratio of 2.3 health professionals for 1,000 inhabitants, the estimated annual budget allocated to the Department for recruitment would need to increase by 333% over the next five years, from 60 million CFA francs to 2 billion CFA francs—twice the 2010 level.
The lack of access to health services is a key factor in Mali’s struggle to improve its health statistics, and the access gap is particularly severe in rural areas. Not only does the maldistribution of health workers exacerbate the problems associated with the inadequate number of health workers, but the political crisis further intensified inequitable access because many health workers left the northern provinces to find better working conditions in more stable areas. In 2009, the ratio of qualified staff to population was eight times higher in urban than in rural health centers, with a particular gap for midwives in rural areas (Ministry of Health 2009a). At the same time, according to the DHS 2012–2013 report (CPS/SSDSPF et al. 2014), the burden of fevers, diarrheal disease, respiratory illnesses, and malnutrition is highest for rural and poor populations. The DHS report also indicates that these same rural geographical areas and low socioeconomic populations show the greatest shortages in public services and have higher unmet contraceptive need, a lower coverage rate for vaccinations, and lower adherence to recommended antenatal care visits.

The government has had little information to inform decision-makers on how many health workers are qualified (with up-to-date licensure), where they are working, and what gaps need to be addressed. This lack of data has impeded efforts to improve the distribution of health workers and health system performance.

**Political Environment**

Needing to make greater progress toward its MDG health targets and wanting to overcome the setbacks caused by internal conflict, the Ministry of Public Health and Hygiene identified HRH as a priority. In 2009, the government approved a national HRH policy, “Development of Human Resources for Health: National Policy” (Ministry of Health 2009a), which included an HRH operational plan, “Development of human resources for health: National strategic plan, 2009–2015” (Ministry of Health 2009b). The national HRH strategic plan was articulated to address four essential HRH management functions:

- Improved training to increase the numbers of qualified providers
- Needs-based deployment to place the right skill set in the right places to meet health needs
- Retention of health workers, particularly in rural areas where attrition rates are highest
- Career development to provide mechanisms for skills improvement and provider motivation.

In 2013, the WHO and GHWA together challenged WHO member-states to develop national HRH commitments to present at the Global Forum in Recife. The commitments publicly declared by each country would serve as a mechanism for transparency and accountability both to national constituencies and to global stakeholders. Because of the severity of the health worker shortage in Mali, the government—aided by external partners—had already begun a number of initiatives to address HRH gaps before the 2013 Global Forum. The WHO/GHWA challenge provided the government with an opportunity, at the midpoint of Mali’s HRH strategic plan, to
renew political support behind the Ministry’s HRH objectives. It was hoped that the Recife commitments would energize continued resources and innovations to improve health worker coverage, particularly in rural areas.

In the months prior to the Global Forum, the Ministry held a stakeholder planning workshop to examine the national HRH plan and formulate proposed HRH commitments that would align with Mali’s vision and help catalyze action to advance Mali’s “Development of Human Resources for Health National Policy.” The commitments drafted in the workshop were then validated at the next Ministry cabinet meeting. A delegation was selected to represent Mali at the Global Forum and was authorized to present the commitments to the global community.

Dr. Adama Diawara, former Ministry of Public Health and Hygiene Secretary General, led Mali’s delegation to the Global Forum and declared Mali’s support to four commitments to strengthen its health workforce. Upon returning from Recife, the Ministry formed a stakeholder leadership group (SLG) (Gormley and McCaffery 2011) and organized an SLG meeting to share the Global Forum recommendations and ensure the inclusion and involvement of all partners in the commitments’ implementation. Although most country stakeholders already were aware of the HRH country commitments because they had participated in the preparatory meetings that contributed to drafting the commitments, the SLG was formed to ensure ongoing support and inclusion in the commitments’ operationalization. To broaden stakeholder support and leverage momentum for action, the Ministry’s HRH Directorate also organized a press conference to share with civil society organizations and journalists both the Mali HRH commitments and the challenges to achieving them.

RESULTS

Progress has been made toward keeping each of the commitments. Even though a reliable monitoring and evaluation process was not developed or implemented to track and consistently report on progress toward achieving the commitments, the authors were able to construct a retrospective qualitative case description, using supplemental reports to understand and convey the actions that have been taken since the commitments were made and some of the outcomes that can be attributed to those actions.

Commitment 1: Develop and decentralize a computerized human resources information system to better manage the health workforce by 2015

To have timely information to manage and plan the health workforce, the government of Mali adopted iHRIS Manage, one component of the iHRIS open source software package (with “open source” meaning that it is available without licensing or purchasing fees). iHRIS Manage is

2 www.iHRIS.org
used to manage health workforce information and was selected by Mali to replace paper-based management and tracking of HRH. In addition, the Ministry of Public Health and Hygiene made the decision to decentralize the management of iHRIS so that data could be gathered at the regional level to feed into national reports.

To accomplish the regional rollout of iHRIS Manage, the Ministry started in one region (Sikasso), with the intention of using the experience gained there to then expand to the country’s other regions. The CapacityPlus project, led by IntraHealth and funded by the United States Agency for International Development (USAID), helped the HRH Directorate to install and update iHRIS Manage by providing the necessary information technology (IT) equipment and training to use the equipment throughout the Sikasso region. After successful decentralization of HRH management in Sikasso, the Ministry continued with decentralized implementation of the system in the regions of Kayes, Koulikoro, Segou, Gao, and the District of Bamako.

In the last quarter of 2014, the HRH Directorate received funding through WHO and the French Muskoka Initiative to expand iHRIS Manage to three additional regions: Mopti, Timbuktu, and Kidal. Data are being collected in Mopti and Timbuktu, but due to security challenges, data collection in Kidal has been slower and the Ministry is considering solutions.

**Outcome:** The Ministry of Public Health and Hygiene has seen that iHRIS Manage is enabling the Ministry to respond to identified needs and is allowing decision-makers to better plan for adequate and equitable workforce distribution. Ministry representatives highlighted four examples of outcomes that illustrate how iHRIS Manage has enabled national and subnational government planners and managers to respond to conflict area needs; more effectively staff health centers; distribute newly trained cadres to regions in need; and respond rapidly to Ebola.

- **Conflict area needs:** After many health workers fled from the north during the conflict in 2012–2013, the Ministry’s HRH Directorate was able to use iHRIS Manage to identify those who had been posted in the Gao region and their telephone numbers. This information enabled the Directorate to contact the health workers and offer them grants to return to the region as part of the government strategy to replenish the health worker staffing that was lost and provide much-needed care for the conflict-affected populations.

- **Health center staffing:** For the opening of a large health center in Bamako’s Kalaban Coura neighborhood, the HRH Directorate used iHRIS Manage to select 26 qualified and experienced providers who could be transferred to supervise the new staff.

- **Deployment of new staff:** In April 2015, the HRH Directorate used iHRIS data to guide the deployment of 185 newly recruited, public-sector health workers (40 physicians, 60 midwives, and 85 high-level nurses) to the regions.

- **Ebola response:** During the Ebola outbreak iHRIS Manage was an effective tool for tracking health worker gaps and availability, which helped Mali to be better prepared to support health centers and effectively deploy new health workers, volunteers, and partners in high-risk zones at the border with Guinea.
Next Steps: The Ministry still faces challenges to optimizing the use and applicability of iHRIS Manage. Although the system is open source, there are costs involved in adapting, interfacing, and overseeing the use of the technology. At this juncture, Mali has not been able to absorb these costs and still depends on external funding to sustain expansion, training, and management requirements. The capacity for using the system and applying the information to strategic planning needs to be improved, particularly within the subnational management teams where informatics competencies are weak. Currently, only a small number of people in Mali are competent in managing the software.

To address these challenges, the HRH Directorate, working with the provincial and district management teams, is planning first to complete the decentralization process through all regions. During this process, the Directorate will continue to document the benefits of using iHRIS Manage and use this evidence to advocate for increased investment in HRH and human resources management (HRM). Subsequently, the Ministry has plans to link the HRM and payroll systems, further improving management efficiencies. Additionally, the Ministry hopes to broaden iHRIS management capacity and engage the iHRIS Qualify component of the iHRIS software package to track health worker training and licensing. (See “Next Steps” discussed under Commitment #2.)

Commitment 2: Ensure that 60% of health districts are fully staffed by qualified health providers (physicians, midwives, and nurses) by 2018

The Ministry of Public Health and Hygiene has developed and initiated several programs to expand the availability of qualified health workers, with support from technical and financial partners. These programs have helped to absorb a portion of unemployed but qualified health workers and post them in rural zones.

L’initiative Médecins de Campagne (the “Rural Doctors Initiative”) aims to support the Ministry and “medicalize” community-level primary health centers by providing equipment, tools, seed funds, and supportive supervision and coaching to recruit and retain young physicians to rural areas. The initiative is financed by the French Cooperation, the European Union, Santé Sud, and the Association of Rural Doctors.

Second, assistance from Gavi, the Vaccine Alliance has enabled the government to recruit and employ qualified health personnel in community health centers in the poorest health districts. According to Ministry representatives, this external funding has enabled the Ministry to recruit 75 physicians per year to rural health services and to transition them to the Ministry payroll after three to five years.

The Ministry has also embraced a targeted training strategy aimed at providers who have inadequate training, skills, and knowledge to meet urgent needs. For example, the national HRH Directorate developed a pilot training program to teach community matrones (midwife assistants) how to provide active management of third stage of labor (AMTSL), thus expanding the reach and coverage of obstetric care closer to rural communities.
**Outcome:** Initiatives such as those supported by Médecins de Campagne and Gavi have enabled Mali to employ and distribute key personnel in areas of need. Further, Mali has been able to absorb some of these health workers onto the government payroll, with a plan to bring more into the Ministry over the next three to five years. The Rural Doctors Initiative, for example, has employed 150 general practitioners, each covering a population of 10,000-15,000 inhabitants in level 1 (poverty) in the remote district areas.

The pilot test of *matrones* providing AMTSL services was so successful that the Ministry adopted a policy to enable all trained *matrones* to provide AMTSL. To date, 65% of all *matrones* have received the training.

**Next Steps:** Along with its focus on employing trained health workers in areas of high need and providing obstetric (AMTSL) skills to lesser-trained providers, the government has developed broader strategies to ensure that rural populations receive essential health services. Mali’s community health worker (CHW) strategy is one of the country’s major accomplishments of the last five years. In addition to the existing CHW cadre (Level 1), the strategy created a second level of more advanced CHWs (Level 2) trained and qualified to treat and prescribe medicines. Two thousand (2,000) Level 2 CHWs have been trained and deployed in villages that are three or more kilometers distant from a health center. The Level 2 CHWs supervise Level 1 CHWs and the outreach workers known as *relais* workers.

Given that there are still a large number of health workers who are qualified, available, and needed but unemployed, the government also is considering various other strategies, such as hiring health workers at lower levels or delegating some tasks to less trained cadres to affordably employ more health workers.

**Commitment 3: Offer capacity-building opportunities to the health workforce (physicians, midwives, and nurses) at least once a year**

To advance toward Commitment #3, a number of training activities have been organized either directly by the Ministry of Public Health and Hygiene or through the support of external partners. These activities have contributed to building the capacities of Mali’s health professionals. Even so, there is still no national policy framework or regulatory requirement for consistent standardized CPD, and there is no monitoring system. As a result, there is no way to track and record which health workers have completed which training, and there is no process for evaluating which training programs were effective or achieved performance improvement goals.

**Outcome:** Due to the aforementioned challenges and weaknesses of the CPD interventions, the actions taken thus far have been inadequate in addressing the needs or achieving impact toward Commitment #3.
**Next Steps:** For successful implementation, commitment #3 needs to be detailed, clarifying what nationally standardized trainings will be made available and whether they will be required. Further, a framework is needed to link capacity-building areas to priority achievement milestones, with specific curriculum content. Finally, milestones for improved capacity or expanded health worker competencies should be measurable and monitored within a monitoring and evaluation process.

Currently, the Ministry's HRH Directorate is developing a national CPD strategic plan, which will establish standards to be followed by all government partners. Included in those standards will be requirements for an assessment of need, a demonstrated link between the learning program and the need, consistent monitoring, and follow-up to reinforce sustained learning. The CPD strategy will also coordinate preservice education with in-service training to create a seamless framework of ongoing capacity building for health professionals. As of July 2015, the in-service trainings of the CPD plan had been outlined in a scope of work, and shared funding had been identified through a partnership between the government and Save the Children.

The government also aims to expand the iHRIS management system to include iHRIS Qualify, which establishes and maintains a registry that allows professional associations and councils to keep track of qualified health workers in the different cadres. Through these registries, the councils and associations can document and monitor which health workers have completed required training or capacity-building interventions, thereby avoiding redundancies and inefficiencies. In addition, planning is underway to develop eLearning and mLearning modules to provide on-site learning and reduce the absenteeism at health facilities that results from off-site trainings. Finally, because iHRIS Manage can interface with iHRIS Qualify, the subnational and national governments can keep track of health workers who are both qualified and available to work.

**Commitment 4: Promote an institutional environment that enables health worker retention in underserved and difficult areas**

The government is pursuing several initiatives to increase health worker retention, focusing primarily on nurses and rural areas. First, the government has strengthened the Gao Nursing School to enhance the likelihood that nursing students will be recruited from the northern Gao region, which is one of Mali’s areas of greatest need. This strategy of training and recruiting nurses near their family homes aligns with WHO policy recommendations for improving recruitment and retention in rural areas (WHO 2010).

**Outcome:** The government partnered with USAID/CapacityPlus to train nurses and, as part of that effort, CapacityPlus continued to underwrite scholarships for 204 Gao Nursing School students. The government is not systematically monitoring retention related to this initiative, however, nor is it investigating health workers’ intention to stay in their posts. As a result, there are no outcome measurements that can be directly attributed to this strategy.
Next Steps: The health workforce in Mali is characterized by geographical disparities. In addition, medical personnel do not always carry out their curative role but may instead focus on administrative matters (Ministry of Health 2009a). In conjunction with increasing the training of nurses in the areas most in need (e.g., Gao), the Ministry anticipates implementing a task sharing strategy that will reduce the heavy administrative burden carried by physicians and nurses so as to optimize their clinical services. Decreasing the administrative workload is expected to improve the working environment and contribute to improved health worker retention.

DISCUSSION

The government of Mali and, more specifically, the Ministry of Public Health and Hygiene, have joined with global, national, and local stakeholders to demonstrate commitment to strengthening human resources for health. However, challenges remain that pose barriers to achieving greater and more rapid improvements in the HRH commitments declared at the Global Forum in November 2013. For example, despite strong political will, resources for implementation remain scarce. The conflict in northern Mali greatly undermined the country’s economy and infrastructure, placing more demands on the budget than can be met and weakening the health system, which will need increasing investment from the government in the years to come.

Commitment 1
The Ministry has made marked progress in workforce planning and in implementing interventions, but documentation is weak. Much of the progress to date has been described in piecemeal fashion in individual reports rather than being consistently tracked and monitored using standardized and reliable data. The national use of iHRIS Manage and other relevant tracking software will improve the monitoring of health workers. However, processes for continual monitoring and evaluation and for evidence-based decision-making need to be institutionalized at the district and national levels so that the impact of various interventions can be understood and progress toward achieving commitments can be validated.

Commitment 2
Efforts to strengthen health outcomes must also address recruitment and retention problems. Coordinating with public and private stakeholders and global partners, Mali has been effective in producing more providers and redeploying unemployed health workers. In addition, it has been able to build competencies in lower-level cadres, such as assistant midwives, to expand coverage of critical skills such as those required at the third stage of delivery. However, the Ministry’s ability to fund new posts or offer competitive salaries is still limited, and the government still relies largely on donor support for both expanded training and for salaries.

Commitment 3
There has been little to no progress toward developing a national framework for continuing professional development and in-service training, which was the intent behind Commitment 3.
There is seldom a clear or documented link between training provided and specific gaps in capacity, and there are few or no processes or practices applied to track the application of training in the workplace or to monitor the impact of training on service quality. Health workers are not required to demonstrate the successful uptake of new skills or competencies, either immediately following training or over time to assess the retention of the knowledge, skills, or behaviors gained. There is no standard framework for linking preservice education to subsequent capacity-building activities and needed improvements in quality services. Further, in-service trainings are not attached to accredited programs and are often not recognized by training institutions or professional councils. The in-service training programs that are provided, which are offered by a variety of local and global partners, are not harmonized to achieve a uniform level of competency or performance.

Commitment 4
Mali’s retention strategy—to recruit and train nurses where they live—is expected to result in more nurses and midwives working in Gao, where the need for nurses is critical and where it is otherwise very difficult to recruit nurses from higher-resourced and more stable areas of the country. However, despite decentralizing preservice education to the regional level, local budgets are severely constrained. As a result, both central and local recruitment occurs in a sporadic manner, and retaining workers is still a challenge. Improved monitoring and evaluation will be needed to track interventions and their impact on health worker satisfaction and longer-term retention.

Commitments Summary

The four HRH commitments announced at the Global Forum articulated specific objectives that would advance Mali’s goals to improve its health system and advance the health of its population. Armed with those objectives, the government and Ministry of Public Health and Hygiene were able to engage stakeholders toward attainable progress, leveraging global accountability to energize action.

Some of the current barriers to strengthening the health workforce will improve over time as the country recovers from the financial setbacks brought on by the 2012 crisis. If the political will demonstrated thus far by the government continues and the Ministry is able to define a clear, benchmarked plan with monitoring and evaluation indicators, Mali should continue to make and demonstrate progress toward achieving its commitments.

In addition, the government may use a performance-based financing (PBF) strategy as a mechanism to identify the HRH strategies that result in the greatest improvements, and then reinforce efforts that advance health system goals. PBF was introduced in Mali before the Global Forum took place, as part of the government’s long-term commitment to strengthening its health system and expanding coverage in rural areas. Beginning in February 2012 as a pilot program, PBF provided funds to reward health facilities (and the health providers in those facilities) for predefined and verified results. Health facilities that attract more patients and provide better quality services receive more incentive payments through the PBF strategy, which
is funded by the Netherlands Cooperation MDG 5 Fund and managed by the Ministry of Public Health and Hygiene. Although the evidence on whether the PBF scheme contributes to health worker retention or performance is still limited, elsewhere (such as in Rwanda) PBF strategies have been shown to improve health worker management and performance efficiency (Meesen et al. 2011). Moreover, as management practices improve, health workers may begin to find their work more satisfying and may stay in their posts with decreased attrition. This consideration will need further investigation.

CONCLUSION

Before the Third Global Forum on Human Resources for Health in 2013, the Republic of Mali had already committed to strengthening its health system and improving its human resources for health. It had included an HRH policy and a specific health workforce strengthening strategy as part of its 2012 plan to rebuild its health system and advance toward its MDG health targets. In remarks at the Global Forum, Dr. Moussa Guindo, the Ministry of Public Health and Hygiene’s head of cabinet, said, “Human resources are the cornerstone upon which the entire health system rests, a system which in fact would not exist without them. They are the health system’s most important resource.” The Ministry designed the four HRH commitments presented at the Global Forum to articulate objectives that would sustain stakeholder support behind the health workforce strengthening strategy and attract resources to enable progress toward an improved health workforce.

The greatest achievement to date has been toward Commitment #1, with the rollout of iHRIS Manage to track health workers and make informed decisions for training and deployment. Plans are in place to expand the information system to include iHRIS Qualify to track the training and licensure of available health workers. Mali has also made progress toward achieving Commitment #2, with increases in the numbers and skills of employed health workers, particularly in the northern regions. However, until economic improvements lead to a stronger health budget and increased funding allocations for local recruitment and salaries of health workers, the government will continue to rely on foreign donors to support its health workforce.

Continuing education, capacity-building, and retention of the health workforce (Commitments #3 and #4) have seen little improvement. Further, the improvements that have been observed have not been part of a comprehensive framework for standardized interventions with measurable indicators to monitor and evaluate results. Mali must establish a framework and operational strategy through which it defines, advances, and monitors progress toward Commitments #3 and #4. Achievement of Commitment #3 requires a national CPD strategy that is linked to preservice education, with the intent to continue building capacity and renewing the qualifications of health providers throughout their service. The strategy should be standardized and institutionalized within regulatory requirements and linked to learning indicators and performance improvements.
To track progress and demonstrate the value of the HRH commitments, the Ministry of Public Health and Hygiene must establish a monitoring and evaluation framework with a process for tracking and reporting progress on indicators for all four commitments. Consistent and regular progress reports to constituents will help the Ministry to leverage the commitments as a vehicle for sustaining political support and recruiting resources for health workforce development.

Finally, efforts to recruit, train, and retain health workers where they are needed must be coupled with a commitment to the quality of service they deliver. To advance its overarching health goals and move toward universal health coverage, Mali will need to be sure that providers are delivering the highest quality care. This can be assessed by tracking health system performance through PBF and other mechanisms, and linking improved services and better outcomes to improvements in recruitment, training, deployment, and support of the health workforce.

REFERENCES


World Bank. 2015a. Life expectancy at birth, total (years).

World Bank. 2015b. Mortality rate, under-5 (per 1,000 live births).

World Bank. 2015c. Mortality rate, infant (per 1,000 live births).


