# Health

# Sectoral and Thematic Report

**January – December 2016**

***A health staff is immunizing an under-one-child against measles during an outreach session*** **(credit photo Alima Naco, Health Specialist/UNICEF) November, 2016, UNICEF Mali**

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# ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| ANC | Antenatal care |
| ARI | Acute respiratory diseases |
| ART | Antiretroviral Therapy |
| ASACO | Community Health Association (Association de Santé Communautaire) |
| ASC | community health agents /community health agents |
| BEmONC | Basic Emergency Obstetrical and Neonatal Care |
| BR4MNCH | Birth Registration for Maternal, Newborn and Child Health |
| BSS | Basic Social Services |
| C4D | Communication For Development |
| CHC | Community Health Centers |
| CHWs | Community Health Workers |
| CSO | Civil society organization |
| DHIS2 | District Health Information Software (version 2) |
| DHS | Demographic and health Survey |
| DTC Hep-Hib | Vaccine against Diphtheria, Tetanus, Pertussis, Hepatitis B, Haemophilus influenza |
| DTC | Technical Director of Center (Directeur Technique de Centre) |
| EmONC | Emergency obstetrical and neonatal care |
| eMTCT | elimination HIV mother-to-child transmission |
| ENAP | Every New-born Action Plan |
| EPI | Expended program of immunization |
| FENASCOM | Federation of community health center association |
| GAVI | Global Alliance for Vaccine and Immunization |
| GDP | Gross Domestic Product |
| GFAM | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| GSAN | Nutrition Activities Support Groups |
| HACT | Harmonized Approach to Cash Transfer |
| HII | High Impact Intervention |
| HIV | Human Immunodeficiency Virus |
| HSS | Health System strengthening |
| ICCM | integrated community case management |
| IMCI | integrate management of childhood illness |
| MORES | Monitoring Results for Equity System |
| MOU | Memorandum Of Understanding |
| NGO | Non-Governmental organization |
| PCR | Polymérase Chain Reaction |
| PMTCT | Prevention of mother to child Transmission of HIV |
| PRODESS | National quinquennial Health & social program |
| PSI | Population Services International |
| SDG | Sustainable Development Goal |
| SEC | Essential Care in the Community |
| SMC | Seasonal Malaria Chemoprevention |
| SSGI | USAID-Project for High impact Service de Santé à Grand Impact |
| UHC | Universal Health Coverage |
| UNAID | United Nations Programme on HIV/AIDS |
| UNDAF | United Nations Development Action Framework |
| UNFPA | United Nation funds for population |
| UNICEF | United Nation Children's Funds |
| USAID | United States Agency for International Development |
| WASH | Water, Sanitation and Hygiene |
| WHO | World health organization |

# EXECUTIVE SUMMARY

As part of the 10-year health and social development program (PRODESS), the health component of Mali / UNICEF 2015-2019 co-operation program will contribute to child survival and realization of the full potential of a great number children aged from 0 to 59 months, especially in underserved communities. It will also contribute to reduce maternal and neonatal mortality risk. Technical assistance will be provided to institutions that supports universal health coverage (UHC). Programmatically, emphasis will be placed on increasing access to quality and high-impact interventions. Quality of health care and services, including elimination HIV mother-to-child transmission (eMTCT) and the pediatric care for children born to HIV-positive mothers, will be improved through identification and removal of existing bottlenecks. Priority will be given to struggle against preventable diseases by vaccinating children and pregnant, strengthening the cold chain and improving micro-planning and decentralized monitoring. 800,000 under five children will be reach by intensifying integrated community case management of childhood illness (iCCM) between 2015 and 2019. In the north, the health component will contribute to rehabilitate Health infrastructure and improved access and use of services.

Specifically, the expected results of the health program are: (i) strengthening the governance framework, funding and accountability for maternal, newborn and child, include in emergencies; (Ii) improve access and use of minimum package of health services for 90 % under five children (boys and girls), especially those living in the most disadvantaged communities include in emergency; (Iii) 90 per cent of pregnant including those exposed to or infected by HIV received care during pregnancy, labor and postpartum period, including in emergencies.

It contributes to achieving UNDAF goal number 4 "People, especially most vulnerable women and children and those affected by crises, have an increased and equitable access to and use high quality of basic social services (BSS) ". This component is in line with the sectoral health policy (PRODESS II 2014-2018). For 2016, the biannual plan 2016-2017 is expected to meet the following results:

- Output 1: Governance framework, funding and accountability for maternal, newborn and child health is strengthened, including in emergencies;
- Output 2: 90% of children <5 years of age (boys and girls), especially those living in the most disadvantaged communities, have access to and use a minimum package of health services including, emergency;
- Output 3: 90% of pregnant women, including those exposed or infected with HIV, receive care during pregnancy, labor and the postpartum period, including in emergencies.

## STRATEGIC CONTEXT OF 2016

Mali has a total population of 17.8 million in 2015 of which 21.6 per cent (3.84 million) are children under five and 5 per cent (890,000) pregnant women. Although progress has been made in regards to maternal and child mortality, it still remains high in some regions. The under-five mortality rate is 95 child deaths for every 1000 live births and there are significant regional disparities. Indeed, under five mortality rate is higher in Kidal, Timbuktu, Gao and Mopti regions (DHS survey 2012-2013). Moreover, the risk of death of young children is higher in rural than in urban areas (113 ‰ against 64 ‰). For instance, in Mopti the mortality rate is higher than in other regions (111 ‰ against a minimum of 59 ‰ in the District of Bamako). The rate for Kidal Timbuktu and Gao is very high.

With less than 10 per cent of GDP spent on maternal and child health, the realization of children's rights in Mali is hitting serious roadblocks. In each of these sectors, social policies and budgets do not reflect sufficient concern for reaching the most vulnerable populations. Information systems capable of providing disaggregated and gender-sensitive data are poorly developed. Unfavorable social norms, lack of human and organizational resources, limited availability of services and household poverty affect supply of and demand for services.

In addition, the crisis in the North has compounded the dire health situation for women and children in the North and the health care system in Mali needs to be revitalized. During the crisis, about 80 per cent of the health centers including districts hospital and community health centers were destroyed and/or vandalized. Also, the northern regions cover 2/3 of the total surface area of the country and contains 15 per cent of the population. The population in the north is dispersed are particularly vulnerable as there is a limited number of health facilities in these areas. Evacuation is not easy and it's important to provide necessary equipment to health facilities to deliver quality health care in order to save life of mothers, new born and children.

At least 40 per cent of the population lives more than 5 km away from a functional health facility. A woman living in a rural area is half as likely to be assisted by skilled health care providers during childbirth as a woman living in an urban area. Even when these services are available, the quality of care and the rate of curative care utilization (0.33 per capita per year) remain low. Neonatal conditions, malaria, pneumonia, diarrhea and undernutrition still cause 70 per cent of deaths among children under five. Almost no decline has been observed in rates of neonatal and maternal mortality since 2000.

UNICEF is committed to engage with all relevant partners to ensure that more children survive and reach their full potential, particularly in underserved communities. With 70 per cent of deaths of children aged 0 to 59 months occurring in communities, in 2007, Mali introduced a national policy of community-based health care. The initiative, which was based on a network of community health workers, has increased service coverage since its inception. A 2014 evaluation showed that 42,000 under-five deaths were avoided between 2007 and 2012 through the introduction of a package of services at the village level. The new UNICEF country programme (2015-2019) will leverage this experience with a focus on stronger integrated programming at the community level, and on improving governance frameworks and sectoral decentralization to expand access to basic services for the most disadvantaged.

# RESULTS IN THE OUTCOME AREA

***Key Results achieved and progress made***

In line with UNICEF's Country Programme Document 2015-2019 and UNDAF Plus 2015-2019, the Health Outcome is dedicated to support the Government of Mali to increase equitable access to basic social services, strengthen the resilience of communities and systems, support service delivery systems and promote policies and budgets that are sensitive to the situation of the most disadvantaged groups and children. The goal is that By the end of 2019, boys and girls aged 0-59 months, pregnant women and breastfeeding mothers, particularly those living in the most disadvantaged communities, have access to and use an essential package of high-impact preventive, curative and promotional health interventions, including in emergency situations.

The Health Outcome is underpinned by three outputs related to (i) governance, funding and accountability framework for the health of mothers, new-borns and children, including in emergency situations (Enabling Environement), (ii) service delivery for children under five (children under five (boys and girls), particularly those living in the most disadvantaged communities, have access to and use a minimum package of health services, including in emergency situation), (iii) Health service delivery for maternal health includind those exposed to or infected with HIV (pregnant women, including those exposed to or infected with HIV, receive care during pregnancy, childbirth and the postpartum period, including in emergency situation).

**Output 1 – Enabling Environment: By 2019, the governance, funding and accountability framework for the health of mothers, new-borns and children is strengthened, including in emergency situations**

The implementation of the Programme Décennal de Développement Socio-Sanitaire (PRODESS) was facilitated by the development and use of the manual of procedures. The developed strategic plan to improve the quality of EPI data was used to analyze the coverage data and the Medium-term expenditure Framework was used to mobilize resources for health. The birth registration system was enhanced through its integration at health facilities and a rapid assessment of obstetric and neonatal emergencies in health facilities was performed using a global standard tool. This assessment will serve as a baseline to develop the Every New-born Action Plan (ENAP), together with WHO and UNFPA.

Program monitoring has been enhanced through the integrated reviews of EPI, IMCI, PMTCT and periodic consultation meetings between regional health director teams and district and community health facility teams. Data collection, analysis and utilization were improved through the capacity building of 33 officers and the deployment of DHIS2, supported by UNICEF and USAID. Knowledge of the status of 2015 health indicators was made available through the development and dissemination of the National Statistical Yearbook, with UNICEF financial and technical support. The health situation for populations living in the northern regions was analysed through the development and dissemination of Statistical yearbooks for the regions of Mopti, Gao and Timbuktu and reports from humanitarian actors. With UNICEF financial support, a study carried out by the support unit for decentralization of the Ministry of Health (MoH) on the use of funds transferred by the government to the decentralized territorial authorities has improved the knowledge of actors about flow management procedures and the use of these funds.

Implementing partners' skills related to UNICEF's cash transfer procedures (HACT) were improved. Through this capacity building, spot check visits, programmatic visits and follow-up missions by UNICEF staff, the quality of requests, reports, resource management and implementation of activities have greatly improved.

A key challenge under this result is the delay in producing the National Statistical Yearbook. It is expected that the deployment of DHIS2 will reduce this constraint.

**Output 2 : By 2019, 90% of children under five (boys and girls), particularly those living in the most disadvantaged communities, have access to and use a minimum package of health services, including in emergency situations.**

In 2016, out of 735,249 children under one, 71% received Pentavalent 3 vaccine. While 82% of the 63 health districts reached 80% coverage, in 62% coverage was over 90%.

Curative service utilization rate for children under five decreased from 0.64 to 0.47 contact/habitant. This apparent decline is due to incomplete data linked to the change from DESAM to DHIS2. Over 90% of under five children received four doses of malaria preventive treatments during Seasonal Malaria Chemoprevention (SMC). As part of Integrated Community Case Management, 42% of cases of uncomplicated malaria, 27% of ARI cases and 11% of cases of diarrhoea, were managed by Community Health Workers (CHWs). Compared to 2015, CHWs' contribution to managing diarrhoea decreased, probably due to improved hygiene practices linked to Ebola awareness-raising campaigns.

These results were achieved through increased cold chain equipment in health facilities, intensified outreach and mobile vaccination strategies, and partnerships in conflict areas.

Thanks to contributions from Canada, GAVI and the United Arab Emirates, UNICEF increased and strengthened vaccine storage capacity through the installation of 5 cold rooms at the central level and 15 in regions and districts. 574 community health centers (CHC) were equipped with solar and electrical refrigerators. Vaccine quality was ensured through remote temperature monitoring materials installed in all cold rooms and continuous temperature monitoring in all refrigerators. Vaccine supply chain from central to decentralized level improved thanks to the provision of two refrigerated trucks. UNICEF supported MoH with cold chain maintenance equipment (6 vehicles, 8 tool kits and 2 furnishing kits). The supply of immunization services was strengthened with logistical resources at regional and district levels (28 vehicles) and CHCs (270 motorcycles). To improve quality, immunization managers and vaccinators were trained on vaccine technology (Effective Vaccines Management (96), Surveillance Management (667), and Logistics (95), cold chain maintenance (95), monitoring and micro-planning of immunization (299)).

IMCI supply was scaled up with new treatment sites created and existing ones strengthened, with UNICEF and WHO joint-support through skills strengthening of health providers, drugs and equipment provision. UNICEF contributed to establishing 33 IMCI sites. With funding from GFAM, USAID and UNICEF, Mali conducted 4 SMC campaigns for children under five, with UNICEF support in 11 health districts.

CHWs contribution to managing childhood illnesses was strengthened by USAID and UNICEF, UNICEF providing inputs and building capacity for CHWs, including a vehicle for central level supervision and 135 computers with solar kits to health facilities to facilitate birth registration and follow up of pregnant women and children under five. Health facilities were lit through donations of solar kits. Emergency health interventions were implemented in the north (Timbuktu, Taoudénit) through agreements between UNICEF, NGOs and CSOs.

In Sikasso and Mopti, actors, through MoRES, identified bottlenecks, determined corrective strategies and developed micro-plans to improve coverage of HII.

Main constraints remained poor performance of the health system on both supply and demand sides.

In 2017, UNICEF will continue to enable and strengthen the health supply chain, build capacity and improve service delivery at community and facility level.

**Output 3: By 2019, 90% of pregnant women, including those exposed to or infected with HIV, receive care during pregnancy, childbirth and the postpartum period, including in emergency situations.**

Routine data for pregnant women receiving at least 3 antenatal care consultations is not yet available. Partial first semester data indicate coverage rates of 34% for Kayes, 38% for Mopti, 18% for Gao and 37% for Sikasso. The proportion of births with skilled attendants present at delivery was 48%, 47%, 14%, and 32% for these regions respectively (source: SLIS). This trend, if confirmed, shows an improvement compared to 2015.

Out of 710,117 pregnant women expected for the year, only 19% were counselled and tested for HIV. The apparent decline compared to 2015 is due to a change in calculation method, which now includes all expected pregnant women in the year. Considering only women seen in prenatal care, 65% were counselled and tested for HIV; 95% of pregnant HIV-positive women received prophylactic ART and 98% of children born from HIV-positive mothers received prophylactic triple therapy.

Out of 1,241 community health centers, between 2015 and 2016, Basic Emergency Obstetrical and New-born Care (BEmONC) sites increased from 183 to 210 and PMTCT sites increased from 436 to 652. 74 out of 80 reference centers ensured HIV paediatric care, the PCR test was performed for 1,853 children and antiretroviral therapy initiated for 4,609 children.

These achievements were supported by UNICEF jointly with MUSKOKA, BR4MNCH and other partners such as Global Fund. With UNICEF support, results are as follows: a national conceptual framework was developed for the organization of reference / evacuation in the country, the reference / evacuation system was organized in all health districts, maternal deaths audits were institutionalized at hospitals and gynaecologists and paediatricians were deployed in district hospitals. UNICEF, WHO, UNFPA, UNAIDS and USAID supported minimum equipment in all health districts (ambulances, medical and surgical equipment) and strengthened health workers' skills. UNICEF ensured capacity building of 196 Emergency Obstetrical and New-born Care (EmONC) providers. 21 health districts out of 63 and 318 community health centers were supplied with EmONC kits and 11 district hospitals were equipped with ambulances. Standard EmONC data collection tools were updated. UNICEF supported the ongoing EmONC evaluation in collaboration with UNFPA.

Regarding PMTCT and HIV paediatric care, UNICEF supported the dissemination of the e-PMTCT national plan for universal coverage of HIV management for pregnant women and new-born care. 652 PMTCT sites were operationalized. UNICEF also contributed to PMTCT site assessment and training of PMTCT service providers, PCR test and HIV paediatric care providers. In the northern regions where insecurity prevails, UNICEF signed an agreement with ONG IEDA to implement EmONC and PMTCT services.

MoRES sessions in Sikasso and Mopti allowed actors to identify bottlenecks, determine corrective strategies and develop micro action plan to improve coverage of HII.

In keeping with UNAIDS' new vision and to achieve the SDGs, adjustments should be directed towards scaling up the B + option, implementing a delegation of tasks strategy, and eliminating mother-to-child transmission of HIV with greater involvement of the community. However, inadequate funding for HIV and the scaling up of the B + option remain major obstacles.

**Intersectorial work**

The main integration activities were carried out with several components:

- With nutrition and WASH, the Health component has developed integrated interventions with the Nutrition Activities Support Groups (GSAN) with essential care in the community (SEC). A harmonized training module taking into account nutrition, health and WASH interventions at Community level has been developed, made available to operational structures and training courses in this field.

- With the WASH, the health component worked on the WASH project in health centers to improve availability of drinking water, hygiene and sanitation in health facilities.
- With child protection the aim was to develop interoperability between the health and the civil registration services. For example, CHWs and DTCs have been trained in birth registration at health facilities and health facilities have been provided with computer kits to enable registration. The ultimate goal is that every child born in a health facility should be systematically declared in the civil register to increase the number of children with a birth certificate.
- With the C4D component, the health component worked on the implementation of communication activities in polio immunization campaigns, the implementation of the MUSKOKA project for the reduction of maternal and neonatal mortality.

**Monitoring survey and evaluations**

- In 2016, the health component contributed to the preparation of the in-depth review of the EPI, which will be carried out in the first quarter of 2017.

**Strategic partnership**

- In 2016, Health section developed a strong partnership with the UN agencies and with other bilateral partners.
- In immunization, the health component continued to work with GAVI ALLIANCE's local partners in implementing Health System Strengthening (HSS) and Immunization activities. In maternal and newborn health, UNICEF, in partnership with WHO, UNFPA and UNWOMEN, together conducted integrated activities supported by French funds MUSKOKA.
- In implementation and scaling up iCCM the health section has developed a strategic partnership with USAID / SSGI, Save the Children and PSI. This strategy aimed to reducing inequity through scaling up in interventions in Koulikoro, Kayes, Ségou, Sikasso and Mopti, it led to a significant reduction of mortality due to children main killers diseases.

**Funding**

Flexible funding such as RR and thematic funds from 2016 contributed greatly to achieving these results across all outputs especially Output 1, Output 2 (iCCM) and Output 3 (PMTCT).

Thematic funds were the main sources of financing for addressing activities in Output 2 (IMCI and SMC) during the 2016 cycle where ORE funds were lacking.

In fact, access and use of health services in the northern regions remains critical due to the non-functionality of state health structures that have been aggravated since 2012 by the conflict. The health sector in Mali faces a real challenge to meet both structural and humanitarian needs while trying to build bridges between the two types of interventions. The approach to rehabilitation and recovery is hampered by a refocusing of resources for humanitarian donors on emergency rescue activities while development donors remain reluctant to finance structural programs in this very volatile environment.

**Challenges and constraints**

The main constraints to the implementation of the program are:

- Weakness of the health and nutrition information system; It is difficult to obtain quality data for decision-making at different levels. The deployment of the DHIS2 platform will eventually solve this issue.
- Delay in justification of the outstanding funds by the government counter, which slowed the implementation of the program.

- Difficulties in ASCs' drug commodities and equipments distribution at the regional level, districts and Cscom.
- weak decision making and coordination at national level which delay effective implementation and sustainability of iCCM strategy;
- Timid commitment of local communities and ASACOs in funding health activities (reference/evacuation ,immunization strategies);
- Insufficient qualified human resources, especially in landlocked areas and remote places ;
- centralization of government decision-making and implementation makes the process more difficult and slow the successful implementation of the various sub-components (Regional Health Directorate vs. Health Districts)
- Growing insecurity in the northern regions is not conducive to the implementation and regular monitoring of activities.
- Inadequate funding for the implementation of EmONC, PMTCT and pediatric HIV care

## Result Assessment Framework

| **Outcome HEALTH** | By the end of 2019, boys and girls aged 0-59 months, pregnant women and breastfeeding mothers, particularly those livingin the most disadvantaged communities, have access to and use an essential package of high-impact preventive, curative andpromotional health interventions, including in emergency situations. | | |
|---|---|---|---|
| Outcome Indicators | Baseline (2010) | Target (2019) | Progress (2016) (January to September) |
| Percentage of children under five with malaria / diarrhea / acute respiratory infection treated | Malaria 32%, diarrhea 26%, ARI 42% | 80% | (Administrative Data: 60%, 45%, 50%) Data not yet available, the results of the 2015 MICS |
| Percentage of districts with Penta 3 coverage> 90% | 58% | 80% | Administrative data: 39%). Data not yet available, MICS 2015 results |
| Percentage of births attended by skilled health personnel | 55% | 70% | Administrative data: 60%). Data not yet available, MICS 2015 results |
| **Output 1** | By 2019, the governance, funding and accountability framework for the health of mothers, new-borns and children is strengthened, including in emergency situations | | |
| **Output Indicators** | **Baseline (2015)** | **Target (2019)** | **Progress (2016) (January to September)** |
| Number of policy and strategy papers developed | 2 | 18 | 5 |
| Number of statistical yearbooks developed | 9 | 36 | 5 |
| Number of HACT formations carried out | 0 | 56 | 5 |
| **Output 2** | By 2019, 90% of children under five (boys and girls), particularly those living in the most disadvantaged communities, have access to and use a minimum package of health services, including in emergency situations. | | |
| **Output Indicators** | **Baseline (2015)** | **Target (2019)** | **Progress (2016) (January to September)** |
| % of children <5 years of age with malaria / diarrhea / Acute Respiratory Infections treated with CHW | 17%/29%/24% | 30%/30%/30% | 42% of cases of uncomplicated malaria, 27% of ARI cases and 11% of cases of diarrhoea, were managed by Community Health Workers (CHWs). Compared to 2015, CHWs' contribution to managing diarrhoea decreased, probably due to improved hygiene practices linked to Ebola awareness-raising campaigns. |
| % Children <1an who received pentavalent 3 | 44% | 95% | According to the administrative data for the period from January to September 2016, 71% of children under one year were received at least three doses of DPT-containing vaccine |
| % Children <1an who received VAR | 45% | 95% | According to the administrative data for the period from January to September 2016, 68% of children under one year were immunized against measles |
| Utilization rate of curative care for children under 5 years | 0.64 | 2 | 0.47 (This apparent decline is due to incomplete data linked to the change from DESAM to DHIS2) |
| Lethality due to severe malaria in children under 5 years | 2 pour 1000 | 0 pour 1000 | 1.26 pour 1000 |
| Number of circles implementing the MORES | 1 | 8 | 2 |

| **Output 3** | By 2019, 90% of pregnant women, including those exposed to or infected with HIV, receive care during pregnancy, childbirth and the postpartum period, including in emergency situations. | | |
|---|---|---|---|
| **Output Indicators** | **Baseline (2015)** | **Target (2019)** | **Progress (2016) (January to September)** |
| % Pregnant women with at least 3 antenatal care (ANC) | 19% | 85% | Routine data for pregnant women receiving at least 3 ANC is not yet available. Partial first semester data indicate coverage rates of 34% for Kayes, 38% for Mopti, 18% for Gao and 37% for Sikasso (source: SLIS) |
| % Births assisted by skilled health personnel. | 35% | 85% | The proportion of births with skilled attendants present at delivery was 48%, 47%, 14%, and 32% for the regions of Kayes, Mopti and Gao respectively (source: SLIS) |
| % of pregnant women who received counseling and HIV testing | 67% | 85% | 19% were counselled and tested for HIV. The apparent decline compared to 2015 is due to a change in calculation method, which now includes all expected pregnant women in the year. Considering only women seen in prenatal care, 65% were counselled and tested for HIV |
| % Children born to HIV positive mothers put on ARVs | 97% | 100% | 98% of children born from HIV-positive mothers received prophylactic triple therapy. |
| Number of EmONC | 272 | 297 | 210 (This number relates only BEmONC) |
| Number of circles implementing the MORES | 1 | 8 | 2 |

# FINANCIAL ANALYSIS

**Table 1: Planned budget by outcome area**

| Intermediate Results | Funding Type | Planned Budget |
|---|---|---|
| OUTPUT 1 [CADRE DE GOUVERNANCE SANTE] | RR | 655,360 |
| | ORR | 2,325,000 |
| OUTPUT 2 [CHILD HEALTH] | RR | 655,360 |
| | ORR | 4,045,500 |
| OUTPUT 3 [PMTCT] | RR | 737,280 |
| | ORR | 769,110 |
| **Total Budget** | | **9,187,610** |

**Table 2: Country-level thematic contributions to outcome area received in 2016**

| Donors | Grant Number | Contribution Amount | Programmable Amount |
|---|---|---|---|
| Polish National Comm for UNICEF | SC1499010100 | 209,534 | 195,826 |
| **Total** | | **209,534** | **195,826** |

**Table 3: Expenditures in the Outcome Area**

**2016 Expenditures by Key-Results Areas (in US Dollars)**

| Organizational Targets | Expenditure Amount | | | |
|---|---|---|---|---|
| | Other Resources - Emergency | Other Resources - Regular | Regular Resources | All Programme Accounts |
| 01-01 Immunization | 451,340 | 4,389,678 | 340,105 | 5,181,123 |
| 01-02 Polio eradication | 55,539 | 8,582 | 124 | 64,245 |
| 01-03 Maternal and Newborn health | 6,873 | 754,503 | 404,741 | 1,166,118 |
| 01-04 Child health | 900,016 | 1,472,887 | 1,314,733 | 3,687,636 |
| 01-05 Health systems strengthening | 813 | 496,818 | 521,056 | 1,018,687 |
| 01-06 Health and emergencies | 324,079 | 1,716 | 393 | 326,189 |
| 01-07 Health # General | 83,475 | 4,361,263 | 2,214,295 | 6,659,032 |
| **Total** | **1,822,135** | **11,485,448** | **4,795,447** | **18,103,030** |

**Table 4: Thematic expenses by programme area**

| Programme area | Expense |
|---|---|
| Other Resources – Emergency | 331,133 |
| 01-01 Immunization | 73,028 |
| 01-04 Child health | 258,105 |
| 01-06 Health and emergencies | |
| Other Resources - Regular | 49,349 |
| 01-04 Child health | 49,349 |
| **Grand Total** | **380,482** |

**Table 5: Expenses by Specific Intervention Codes**

| Row Labels | Expense |
|---|---|
| 01-01 Immunization | 5,181,123 |
| 01-02 Polio eradication | 64,245 |
| 01-03 Maternal and Newborn health | 1,166,118 |
| 01-04 Child health | 3,687,636 |
| 01-05 Health systems strengthening | 1,018,687 |
| 01-06 Health and emergencies | 326,189 |
| 01-07 Health # General | 6,659,032 |
| **Grand Total** | **18,103,030** |

**Table 6: Planned budget for 2016**

**Planned Budget and Available Resources for 2016**

| Intermediate Result | Funding Type | Planned Budget | Funded Budget | Shortfall |
|---|---|---|---|---|
| OUTPUT 1 [CADRE DE GOUVERNANCE SANTE] | RR | 3,276,800 | 1,558,290 | 1,718,510 |
| | ORR | 11,625,000 | 2,557,108 | 9,067,892 |
| OUTPUT 2 [CHILD HEALTH] | RR | 3,276,800 | 2,138,620 | 1,138,180 |
| | ORR | 20,227,500 | 10,210,540 | 10,016,960 |
| OUTPUT 3 [PMTCT] | RR | 3,686,400 | 491528 | 3,194,872 |
| | ORR | 3,845,550 | 1,575,966 | 2,269,584 |
| **Sub-total Regular Resources** | | **10,240,000** | **4,188,438** | **6,051,562** |
| **Sub-total Other Resources - Regular** | | **35,698,050** | **14,343,614** | **21,354,436** |
| **Total for 2016** | | **45,938,050** | **18,532,052** | **27,405,998** |

# FUTURE WORKPLAN

The future action plan for the health component will be developed with on integration of health component with other sectors:

- Strengthen availability of health data, including the revision of the national health information system through the deployment of the DHIS2 platform.
- Improve the cold chain capacity for vaccine conservation.
- Support implementation of under five children malaria chemoprevention campaigns.
- Extend implementation of iCCM (SEC) to improve access to essential care for the most marginalized populations.
- Support the extension of EmONC sites and PMTCT sites.
- Capacity building of stakeholders in priority areas on child and maternal health.

**Table 7: Estimated funding for 2017**

| Funding Type | Approved Programme Component | Planning 2017 | Available Resources | GAP |
|---|---|---|---|---|
| Regular Resources (RR)** | 2,048,000 | 2,048,000 | 2,048,000 | 0 |
| Other Resources, Regular (ORR)* | 7,677,000 | 31,424,414.793 | 18,357,849.81 | 13,066,564.98 |
| **Total** | **9,725,000** | **33,472,414.793** | **20,405,849.81** | **13,066,564.98** |

For 2017, the overall estimated budget for the Health outcome is 33,472,414.793$US of which 20,405,849.81$US have been mobilized at this date. The overall gap of 13,066,564.98$US hides significant disparities between health outputs and areas of intervention. While the EPI is well financed to surpass by this year the initial 2019 targets, the Malaria control, PMTCT and EmONC is widely underfinanced.

Despite a strong performance for resource mobilization for the Health section in general (257% of planned OR resources already mobilized as of 1 March 2017), all Health outputs are not funded equally, with the majority of the funds (GAVI, Canada) supporting vaccination-related activities. Funding gaps exist for maternal and new born health (Output 3), with Emergency obstetric and new born care being exclusively funded through the French Muskoka Fund, expiring at the end of 2017. Today, IMCI, malaria prevention, PMTCT and HIV paediatric care are almost exclusively funded through Regular Resources (RR). Looking forward, it is worth noting that some major health grants are expiring at the end of 2017 (GAVI, Muskoka), calling for a need to start negotiating a potential continuation of current projects, or to look into alternative sources of funding

# EXPRESSION OF THANKS

UNICEF Mali would like to take this opportunity to acknowledge the valuable contributions from the Polish National Committee for UNICEF through thematic funds and sincerely thank all donors for their commitment to the the health program of Mali. These funds are committed to ensuring that children have access to quality health services, but ultimately contributing to the overall social, cultural and economic development of the country such an investment in the children of Mali will prove critical to combating risks and negative cultural practices that confront children and young people, particularly from the most deprived communities and the areas of Northern Mali affected by conflict.

The support to focus areas that thematic funding provides helps to ensure that UNICEF has resources to target specific areas/issues that the government sector programme does not adequately address or cover. UNICEF appreciates the flexibility that the thematic contributions provide, which has made it possible to address gender and equity gaps that exist in the provision of health services, particularly in marginalized areas.

UNICEF also takes this opportunity to acknowledge the good collaboration the organization enjoys with the Government of Mali, the UNICEF National Committees, bi-lateral and multi-lateral donors, NGOs, UN Agencies, and local partners including communities who play a major role in facilitating the implementation of activities on the ground.

# ANNEX: REPORT FEEDBACK FORM

**PBA No. : SC149901**

**UNICEF is working to improve the quality of our reports and would highly appreciate your feedback. Kindly answer the questions below for the above-mentioned report and return to our office as indicated below. Thank you!**

**Please return the completed form back to UNICEF by email to:**

**Alessandra Dentice, Deputy Representative**
**E-mail: adentice@unicef.org**

**SCORING: 5 indicates "highest level of satisfaction" while 0 indicates "complete dissatisfaction"**

1. To what extent did the narrative content of the report conform to your reporting expectations? (For example, the overall analysis and identification of challenges and solutions)

| 5 | 4 | 3 | 2 | 1 | 0 |
|---|---|---|---|---|---|
| | | | | | |

If you have not been fully satisfied, could you please tell us what we missed or what we could do better next time?

2. To what extent did the fund utilization part of the report meet your reporting expectations?

| 5 | 4 | 3 | 2 | 1 | 0 |
|---|---|---|---|---|---|
| | | | | | |

If you have not been fully satisfied, could you please tell us what we missed or what we could do better next time?

3. To what extent does the report meet your expectations in regard to the analysis provided, including identification of difficulties and shortcomings as well as remedies to these?

| 5 | 4 | 3 | 2 | 1 | 0 |
|---|---|---|---|---|---|
| | | | | | |

If you have not been fully satisfied, could you please tell us what we could do better next time?

4. To what extent does the report meet your expectations with regard to reporting on results?

| 5 | 4 | 3 | 2 | 1 | 0 |
|---|---|---|---|---|---|
| | | | | | |

If you have not been fully satisfied, could you please tell us what we missed or what we could do better next time?

5. Please provide us with your suggestions on how this report could be improved to meet your expectations.

6. Are there any other comments that you would like to share with us?