Health co-ops around the world

MALI

Coordination of the global project

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Introduction

Health co-ops around the world are a series of publications showing the contribution of health co-ops in the health system from a national perspective. The project has been conducted under a mandate of the International Health Co-operative Organisation (http://www.ica.coop/ihco/).

Each case includes a snapshot of the national health system, information on the presence of health co-operatives and practical references. It is based on a survey conducted in 2007 with the kind collaboration of many people involved in health co-ops and other relevant organisations located in targeted countries. The series includes the following national cases:

- ✓ Canada
- ✓ United States of America
- ✓ Benin
- ✓ Uganda
- ✓ Mali

The relation between this research project and the very important study conducted in 1995 and 1996 by the United Nations (published in 1997 under the name *Cooperative Enterprise in the Health and Social Care Sector A Global Survey*), as well as the methodological framework are presented in the document:

- ✓ Global background and trends from a health and social care perspective.

Country Statistics[1]

Total population: 13,518,000

Gross national income per capita (PPP international $): 1,000

Life expectancy at birth m/f (years): 45/47

Healthy life expectancy at birth m/f (years, 2002): 37/38

Probability of dying under five (per 1 000 live births): 218

Probability of dying between 15 and 60 years m/f (per 1 000 pop): 475/409

Total expenditure on health per capita (Intl $, 2004): 54

Total expenditure on health as % of GDP (2004): 6.6

Figures are for 2005 unless indicated. Source: World Health Statistics 2007

[1] WHO, http://www.who.int/countries/mli/en/, viewed 12/2007.

Snapshot of Mali's Health System

Organizational Structure of the Health System

The sectoral policy on health and population adopted in 1991 by the government of Mali is based on decentralized access to health care and community participation. Its general objective is the extension of medical coverage and universal access to medication for the whole population[2].

To achieve these goals, the following strategies have been adopted[3]:

- ✓ Differentiating the roles and missions of each level of the health system which consisted in evolving from a hierarchical and administrative system to a more functional design.
- ✓ Guaranteeing the availability and accessibility of essential drugs, reform of the distribution and the prescription of drugs due to changes in the pharmaceutical sector.
- ✓ Community participation in the management of the system and the mobilization of financial resources for the health system including cost recovery and the optimization of their use.
- ✓ Promotion of a dynamic and community-oriented private system complementary to the public system.

The plan is to create in each Health Zone a health unit capable of providing a quality package of services. The zone consists of population numbers ranging between 5000 and 10.000 inhabitants in a radius of 15 km; a density supposed to guarantee the viability of the health center.

The development of this plan involves the Community Health Associations (ASACO), which are in charge of creating Community Health Centers (CSCOM). Additionally, the revitalization of the old District Health Centers (SCA-R) is an integral part of the program.

Health care financing and expenditure[4]

In Mali, the total health care expenditure represented approximately 6.6% of the GDP in 2004. Government expenditure represented 49.2% and private expenditure 50.8% of the total expenditure on health. Of the total private expenditure, 99.50% came from out-of-pocket payments.

[2] Ministère de la santé du Mali (2006), **Annuaire SLIS 2005**, page 9.
[3] ANAIS Bamako, **La politique sectorielle de santé et de population au Mali : Ses premiers résultats**, http://www.anaisbko.org.ml/reformes/sante.html, reference updated in October 2008.
[4] WHO statistics – Core health indicators (2007), http://www.who.int/whosis/database/core/core_select.cfm, viewed 11/2007.

Health Care Provision[5]

The medical system has three levels of responsibility.

The central level is composed of five Public Hospital Establishments (EPH) as well as a maternal-child hospital. The intermediate level has six EPH and finally, the operational level has 2 components. The first component or first level of access to care, offers the Minimum Activity Package (PMA) – referring to a basic care package - in the Community Health Centers (CSCOM). There are other health structures such as para-public, religious, dispensaries and private which complete the first component. Certain aspects of the care package are supplemented by non-governmental organizations. This refers especially to reproductive health, child survival and the fight against HIV/AIDS. In addition, it is important to note the existence of traditional medicine whose collaboration with modern medicine is being organized. The second component or second level of access to care consists of reference health centers (CSREF) in each Health Circle or Zone.

In 2004, the physician density per 1000 population in Mali was of 0.08 and the nurse density, 0.45. The statistics for hospital beds per 10 000 population are not available.

Developments and issues[6]

If in principle the Minimum Activity Package includes curative, preventive and promotion actions, to this day, little has been done with regards to health promotion. The viability of the CSCOM was central to the development of the peripheral health system. However, because of the delay in defining the legal framework necessary to clarify the conditions for the creation of the CSCOM and the responsibilities of the State and the communities involved, Mali saw the proliferation of centers that were not legally conform.

Many efforts were made to carry out these policies. It is now a question of consolidating assets, especially concerning the hospital sector, the staff training, research, social protection and community participation.

Cooperatives Health Services in Mali

Community Health Centers (CSCOM) were created based on the Bamako Initiative and because of a deficiency in public health administration. This initiative was adopted by the government in 1990 as an element of its "sectoral policy" as financed by the World Bank. Associations made up of local

[5] Ministère de la santé du Mali (2006), **Annuaire SLIS 2005**, page 9. The statistics in the box are from WHO - core health indicators.
[6] ANAIS Bamako, **La politique sectorielle de santé et de population au Mali : Ses premiers résultats**, http://www.anaisbko.org.ml/reformes/sante.html, reference updated in October 2008.

populations create and manage the CSCOM. It is the Associations that in fact recruit and pay the personnel. The resources come from service fees, from the sale of essential drugs and from subsidies[7].

The Malian National Federation of Community Health Associations (FENASCOM)[8]
(Fédération Nationale des Associations de Santé Communautaire du Mali)

The FENASCOM was founded in 1994. It groups together 850 Community Health Associations (ASACO)[9] the oldest of which was founded in 1988 and the most recent in 2007. All of them are user-owned. The ASACO operate community health centers (CSCOM) distributed throughout the country. Each ASACO employs between five and 20 people and the number of members is estimated at roughly 10% of the region's population per ASACO. One membership card is valid for an entire family. In 2005 the CSCOM attended to approximately 2 771 701 consultations[10].

The creation of the FENASCOM – which contributes to the implementation of a decentralized policy in social and health actions with the active and responsible participation of the population – was sparked by the fact that the first ASACOs experienced difficulties in terms of management as well as technical services and social development. They also had problems accessing essential medications. Its development was marked by the implementation of a legal framework to regulate community health, the establishment of the poverty alleviation strategy (2000), the decentralization process and the new convention for mutual assistance (2007). Its main achievements have included the multiplication of the CSCOM throughout the country meaning greater access to health services for the population. In addition, all the ASACOs have learned the basics of democratic association and a strategic plan has been designed to strengthen the organisation.

Currently, the main sources of financing for the FENASCOM are the premiums paid by the member ASACOs, 30% from government funding and various other donors. For example, the Embassy of the Netherlands (2005-2009) is funding the strategic plan.

The FENASCOM identifies its main strength as being the fact that it is one of the most important civil society organisations in Mali. It represents an impressive network over the entire Malian territory with

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[7] Sanogo, Youssouf (2003), **Développement local et économie sociale au Mali,** CRDC, Université du Québec en Outaouais, http://www.uqo.ca/ries2001/creation/par%20pays/mali.pdf, page 11 viewed 12/2007.

[8] Information on the FENASCOM was obtained through the survey answered by Professor Tiémoko Malé, General Treasurer of the FENASCOM in November 2007.

[9] The ASACOs are not registered as cooperatives but they operate under such similar principles that they can be considered as cooperative health services in the framework of this study. "An ASACO is a non-profit private association made up of inhabitants of the same geographical area (urban district or group of villages), called "health zone", which ensures the management of a community health center and carries out health protection and promotion activities. It is linked to the sate through a convention which engages it in the delivery of public health services and defines its participation. Adhesion with the ASACO is individual and at its base is the reinforcement of citizenship. Minors and spouses can benefit from the adhesion of the head of the household. The legal existence of the ASACO results from its legal entity; its social identity rests on the number of members and the degree to which they are involved in it. Its strength lies in its general assembly which gathers at least once a year all its members in order to make important decisions regarding its activities and more precisely the operation and the development of its health center".
(Balique, H., A. Ag Ikhane et O. Ouattara (2001), DIX ANS D'EXPÉRIENCE DES CENTRES DE SANTÉ COMMUNAUTAIRE AU MALI**, Revue Santé Publique, Volume 13, page 35-48,** http://www.cairn.info/revue-sante-publique-2001-1-page-35.htm**), viewed 12/2007.**

[10] Ministère de la santé du Mali (2006), **Annuaire SLIS 2005**, page 64.

its 850 ASACOs. On the other hand, its main weakness is the fact that its financial resources are limited and therefore it cannot satisfy all its members' needs. Its main challenges include adjusting its services to suit the needs of its members by hiring a team of professionals to support the elected members, improving the coordination between all actors working in community health, and the development of strategic alliances to improve access to quality health services.

The FENASCOM understands that people become members of an ASACO in order to improve the health of their community and to take responsibility for the organization and administration of their health services. Members of the ASACOs have the advantage of paying half price for consultations and essential medication at the CSCOMs. All CSCOMs offer services to non-members and according to the FENASCOM people chose to use the services without becoming members because they do not understand the advantages.

The Minimum Activity Package offered in all 850 community health centers involves curative, preventive and health promotion activities for the whole population where as specific programs are targeted towards children under 5 years of age and women of reproductive age. All ASACOs deliver their health services in centers but some also have a network of peer educators that are involved in promotion or prevention activities in the community.

The ASACO's have contracts with the government for the delivery of health services to the population through the Mutual Assistance Agreement.

With respect to the future of the Community Health Associations (ASACOs) in Mali, the FENASCOM states that they are currently the first level of access to services in the country. It foresees that the number of associations will keep growing and that the quality of curative, preventive and health promotion services will continue to improve.

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