An excerpt from:
Better Health & Social Care: How are Co-ops & Mutuals Boosting Innovation & Access Worldwide?
An International survey of co-ops and mutuals at work in the health and social care sector (CMHSC14)
Volume 2: National Cases

For the research framework, the analysis of the national cases, and other research components, including a description of the research team members, refer to Volume 1: Report.

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BURKINA FASO

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HEALTH SYSTEM

In Burkina Faso, the public social protection scheme covers less than 10% of the total population, primarily workers in the formal sector, public and private. The rest of the population (many of them poor and vulnerable people) enjoys no form of social protection. They are mainly people employed in the informal and rural sectors.

To meet their basic needs, households organize to ensure their own health management and in time themselves assume responsibility for other types of risk and social concern. Many organizations based on solidarity, mutual aid, and democracy have been created to provide populations with forms of social protection not covered by the social security system. In Burkina Faso, the most successful organizations of this type are the Mutual Health Organizations (MHOs).

Population (in thousands): 16,460

Population median age (years): 17.01

Population under 15 (%): 45.66

Population over 60 (%): 3.88

Total expenditure on health as a % of Gross Domestic Product: 6.2

General government expenditure on health as a % of total government expenditure: 11.9

Private expenditure on health as a % of total expenditure: 45.7

MUTUAL HEALTH ORGANIZATIONS

In its 2009 regulations, the West African Economic and Monetary Union (WAEMU)[1] defined the MHO as a social group which, through contributions from its members, proposes to conduct in their interest and in the interest of their assigns, an action of foresight, support, and solidarity for the prevention of social risks related to the person and to repair their consequences.

MHOs have been active in Burkina Faso since its independence. Indeed, the first MHO, the Mutual of Customs of Upper Volta, was established in 1963. But it was after 1991 that the movement really began to expand and diversify, in accordance with the principles of the Bamako Initiative (1987)[2] and with the support of NGOs and technical and financial partners.[3]

Nowadays, Burkina Faso counts many MHOs. Their most common types of membership are family mode (nearly 53%) followed by individual mode (30.8 %). The majority of MHOs (86%) charge an insurance fee of less than $1 USD (500 FCFA) per month. But fees in the range of $4-10 USD (2,000-5,000 FCFA) are becoming more commonplace.

The main reasons for membership in MHOs are financial access to care, quality health services, and geographical accessibility of health centres. The benefit package offered by MHOs primarily concerns primary care services (although some urban MHOs are covering all levels of health care). In general, these services include the management of ambulatory care, medical care, and evacuations. The support from MHOs to their beneficiaries is generally 80% of the cost of service. But certain MHOs cover only 70%, while a minority covers 100%.

The last inventory of social mutuals (July 2013) counted 188 active MHOs with 103,373 members and 256,015 beneficiaries. Among these MHOs, 105 (56%) are standard organizations, 38 (18%) are professional organizations, 22 (10.7%) are systems cost-sharing, 9 (8%) are prepayment systems, and 2 are solidarity funds, representing 2% of MHOs in Burkina Faso.

Government Promotion of MHOs[4]

The development of MHOs is on the agenda of the Government of Burkina Faso. In recent years, it decided to extend social protection to all strata of the population. Indeed, MHOs are listed in the National Policy for Social Protection, which itself is part of Axis II of the Strategy for Accelerated Growth and Sustainable Development, "Human Capital and Consolidation of Social Protection." On account of the government's decision to introduce universal health insurance (2008), and to facilitate its deployment for the benefit of the entire national population, it was decided to build upon the experience and know-how of MHOs in reaching populations in the informal and agricultural sectors.

MHOs will be delegated responsibility to play roles in mobilization and social control. To this end, community MHOs will

be created in all towns in Burkina Faso, as well as unions of MHOs in each region, and a federation of MHO unions at the national level.

The creation of professional MHOs will also be promoted in various sectors. To do this, it will be essential to establish a close relationship between the system of universal health insurance and the development of MHOs, which involves the creation of an institutional and legal environment.

CASE STUDY

Burkina Faso, one of the poorest countries in the word, has chosen as a strategic priority the reduction of poverty in the population. This struggle involves, among other tasks, the establishment and proper functioning of a system of social protection. Among these social protection benefits, coverage of health needs is a central priority. Indeed, coverage of health needs has a substantial impact on household resources and on the economy in general.[5]

In Burkina Faso, 38.35% of total health expenditure is borne by households. (According to WHO, 100 million people fall below the poverty line when they are forced to pay for their health care.[6]) The country's current Autonomous Pension Fund provides retirement benefits, disability, death, and more recently, accident insurance for civil servants, the military, the judiciary, as well as contractors of the Public Service. The National Social Security Fund is governed by Law No. 015-2006, enacted May 11, 2006, to establish a social security scheme applicable to employees. Both plans cover the formal sector and do not take into account disease.

Through the Office of Workers' Health (OWH) the government also developed health services for workers in private and para-public services. This structure provides two types of service: curative care and annual medical examinations. In terms of curative care, up to 80% of the cost of services to employees is covered in OWH facilities, with or without a cap, depending on the company. OWH has infirmaries and a clinic in Ouagadougou which offers all outpatient services. However, weaknesses in the technical facilities and inadequate staffing currently do not permit the practice of Occupational Medicine. OWH tends to deviate from its primary mission by providing health services at fees comparable to those charged by private hospitals.

To overcome shortcomings in the coverage of health care costs by OWH and the state budget, mechanisms for solidarity funds with a health component were developed within companies and in public and semi-public services. Until recently, such mechanisms were not available in the education sector, particularly in primary schools. Recognizing the importance of access to health care for the welfare of its members, the national union of primary school teachers (public and private) in Burkina Faso (SNEAB) made contact with the Mutuelle Générale de l'Education Nationale of France in 2013.

This action was taken at a time when the political climate was favourable. At the national level, the National Social Protection Policy was adopted in September 2013. Since 2008, the government has been thinking about the establishment of universal health insurance (AMU[7]) for all. The role of MHOs in the deployment of this health insurance will enable the families of rural, informal, and formal workers to benefit from the packages offered by the AMU scheme.

For the informal sector, the establishment of communal MHOs, regional unions, and a national federation of MHOs is envisioned.

The establishment of an MHO by and for education professionals, and public awareness of the issues of social protection, can have another important impact: the education sector is in a position to become a transmitter of knowledge and expertise on the issues of health and social protection. This applies to children and youth through education programmes on health and social protection and prevention activities. But it is also true for whole communities which can develop solidarity tools in the context of national policy. Professional education could play a role in the training and support of other audiences as well.

The MHO for teachers will be implemented with and for 40,000 primary school teachers in the public and private sectors, as well as the administrative and support staff of the Burkina Faso Ministry of Basic Education. The MHO also benefits the families of these education professionals, which in turn will benefit the wider communities in which these families live. More broadly, through education and awareness of social protection measures, and the support that educators can bring to other local MHOs, the project may have a significant impact on entire communities.

This initiative is also of interest because it is part of a national expansion of the welfare system. If Burkina Faso maintains its focus on this issue, in several years the government may well go one step further and implement universal coverage, based at the local level and specifically for the informal sector, which accounts for nearly 90% of the population.

The project's success depends on the support and participation of public authorities, including the ministries of Social Affairs, Public Service, and Finance. This institutional support should also be financial, because without seed funds, it will be difficult to create MHOs.

The awareness of the Ministry of Education of the connection between quality of education and the health care of education professionals must be maintained over the course of the project. It must be accompanied by a willingness to make education and prevention in health matters a priority, not only for teachers but also for educational programmes. If civil society and government join forces to transmit values, principles, and good practices in health and social protection to future generations, a major driver for the future development of the country will have been established. It is equally important that international actors and partner countries join the effort through training, support, and funding.

Currently, the project is following its normal course. The MHO for Burkina Faso's teachers will soon be implemented.[8]

SOURCES

[1] See Annex 6 on this subject in Volume 1: Report.
[2] Launched in 1987 by the WHO and UNICEF, the Bamako Initiative sought to ensure universal access to quality primary health care. It had three principles: that patients contribute to the sustainability of service through payment of a fee; that access to better medicine, especially generic pharmaceuticals, is essential; and participation of community members in the governance of health care centres. See p. 383 of Churchill, Craig Farren. 2006. *Protecting the Poor: A Microinsurance Compendium*. Vol. 1. International Labour Organization.
[3] Tadjudje, Willy. 2013. "Le développement des mutuelles sociales en Afrique: la nécessité d'un environnement juridique approprié." *Mosaïque – Revue panafricaine des sciences juridiques comparées* 4:139-167.
[4] Faso.net. 2014. "Les mutuelles sociales au Burkina Faso : une passerelle pour l'assurance maladie universelle (AMU)." *Revue internationale de l'économie sociale*. Retrieved August 18, 2014 (http://recma.org/node/3931).
[5] This is generally the case in countries where there is no public insurance system.
[6] World Health Organization.
[7] From the French, "Assurance Maladie Universelle."
[8] For more details on Mutual Health Organizations in Burkina Faso, please contact: Mrs. Juliette Compaore, Executive Secretary NGO ASMADE, 09 BP 903 Ouagadougou, Burkina Faso Juliette@ongasmade.org, Phone: (226) 50 37 03 66, Site: (http://www.ongasmade.org).