Social Participation in the Development of Mutual Health Organizations in Senegal

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Abstract

Mutual health organizations (MHOs) are currently being promoted as a means of expanding financial access to health care services to the informal sectors and poorer populations in developing countries. Social participation has been a key element in the development of the MHO movement, yet it has been little researched. This qualitative, exploratory study examines the processes used to engage communities and the role social participation currently plays in MHO creation and functioning. The study presents a conceptual framework for the inputs, processes, and intermediate outcomes of social participation, proposes a series of dimensions of participation and criteria to assess the level of participation, and then examines qualitative data from focus group discussions with eight MHOs in Senegal. The findings indicate that although the structures developed and strategies used during the creation phase of the MHOs (encouraged by the various MHO promoters) do engender active engagement of internal stakeholders, participation tends to wane with time, and newer members are not as likely to show the same commitment. Leadership worthy of trust and decentralizing management structures appear to be key elements for maintaining participation. The need to maintain social participation throughout the life of the MHO is critical to its long-term viability and its ability to provide critical access to health care for its members and beneficiaries. MHOs themselves need to explore explicit strategies for encouraging participation of its membership, and promoters need to examine ways to support and strengthen these efforts. However, the importance of political, moral, and logistical support of external stakeholders (such as local governments, health districts, and the ministry of health) should not be underestimated – they play a key role in ensuring the viability of the MHO, which is necessary for its continuity.

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Acronyms

BIT-STEP	Bureau International de Travail
CAMICS	*Cellule d'appui aux Mutuelles de Santé, aux Institut de Prevoyance Medical, aux Comités de Santé* (Office to support MHOs, social security systems, and health committees)
FGD	Focus Group Discussion
GA	General Assembly
MHO	Mutual Health Organization
NGO	Nongovernmental Organization
PHR*plus*	Partners for Health Reform*plus*
Promusaf	*Programme d'appui aux Mutuelles de Santé en Afrique* (Program to Support MHOs in Africa)
USAID	United States Agency for International Development
WHO	World Health Organization

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Executive Summary

Mutual health organizations (MHOs) are currently being promoted as a means of expanding financial access to health care services to the informal sectors and poorer populations in developing countries. Social participation has been a key element in the development of the MHO movement, yet it has been little researched. This qualitative, exploratory study examines the processes used to engage communities and the role social participation currently plays in MHO creation and functioning.

Social participation is defined as the extent to which internal and external stakeholders play their respective roles in the design, set-up, promotion, and ongoing development of the MHO. Internal stakeholders include MHO management organs, but also the general membership. External stakeholders include providers, the ministry of health, and local governments. The paper presents a conceptual framework for social participation in MHO functioning, including:

- Inputs: provider approaches, MHO management and governance structures, pre-existing community factors, provider factors, and the institutional and regulatory environment
- Processes: who participates and in what activities
- Intermediate outcomes: member knowledge, trust in management, responsiveness to member aspirations, sense of ownership, and social solidarity.

Although social participation is often mentioned in discussions of MHOs, a clear mechanism for measuring social participation did not exist. The paper outlines a series of dimensions of participation related to the MHO's social basis, set-up/design, and governance, and proposes criteria to assess the level of participation within a particular MHO.

The study sought to answer the following questions:

1. What are the forms and intensity of social participation of various stakeholders in the MHOs studied?
2. How are MHO management and governance structures related to social participation?
3. How do pre-existing community factors facilitate or inhibit social participation?
4. What are the results of social participation in MHOs?

Qualitative data were collected from eight MHOs in Senegal, using focus groups with MHO management, founding members, and new members, and individual interviews with providers and promoters. The conceptual framework provided the grid to analyze the results.

The eight MHOs studied had fairly strong levels of participation, but the patterns of participation varied. The findings indicate that the structures developed and strategies used during the creation phase of the MHOs (encouraged by the various MHO promoters) do engender active engagement of internal stakeholders. However, those MHOs which did not have formal promoter assistance during set-up (and consequently lower participation these early phases), but which had strong community ties, were able to have strong participation in other dimensions. In all cases, participation tends to wane with time, and newer members are not as likely to show the same commitment. All MHOs started with similar management and governance structures, but leadership worthy of trust and decentralizing management structures appear to be key elements for maintaining participation.

Participation of external stakeholders was generally limited, and MHO managers lamented the lack of moral, financial, and logistical support from the technical and political branches of government. Perceived poor relations or unfavorable behavior of some providers discouraged members, and some providers did not necessarily see an advantage to their engagement with the MHO.

With respect to intermediate results, the research methodology used in this study did not allow for assessment of changes over time, and many of these intermediate results were not explicitly targeted in the focus group guide design. However, numerous spontaneous remarks during the focus group discussions in many MHOs indicate that these "effects" or results are related to social participation. Knowledge about MHO benefits and procedures appeared weaker in new members than in founding members. Trust in the MHO and its management seemed to be more strongly linked with those in the leadership positions than specific transparency mechanisms put in place, and the eight MHOs studied had generally maintained the same leadership since the beginning of the MHO. The concept of social solidarity appeared generally stronger in founding members than in new members, but many individuals in the MHOs had developed informal mechanisms for supporting others within the MHO.

The need to maintain social participation throughout the life of the MHO is critical to its long-term viability and its ability to provide critical access to health care for its members and beneficiaries. MHOs themselves need to explore explicit strategies for encouraging participation of its membership. Decentralizing management structures and general assemblies provide one mechanism that appears effective in broadening the base of those participating. Promoters need to examine ways to support and strengthen these efforts, including consideration of how their technical assistance can be used to support ongoing participation and how they can contribute to clarifying the roles of and fostering the dialogue with external stakeholders. The importance of political, moral, and logistical support of external stakeholders (such as local governments, health districts, and the ministry of health) should not be underestimated – they play a key role in ensuring the viability of the MHO which is necessary for its continuity and for the members' desire to join and participation in the future of their MHO.

1. Introduction

Community-based health insurance, or mutual health organizations (MHOs), have been recently advocated as a strategy to extend protection against the financial risks of health care to relatively poor populations in developing countries. The Commission on Macroeconomics and Health reported that such schemes appeared to be the most promising domestic financing strategy in low income countries (Sachs, 2001). Several countries in Africa have mandated some form of community-based financing schemes, and others are on the brink of formal promotion of such schemes. Yet, particularly in West Africa, such schemes have evolved from community initiatives, and it is unclear how successful they will be if mandated by governments, and rolled out rapidly across countries without the same degree of community consultation and participation. This report describes the results of qualitative research conducted in Senegal on social participation in MHOs. The research is exploratory in nature and seeks to further understanding of the processes used to engage communities and the role social participation currently plays in MHO creation and functioning.

1.1 Development of MHOs in Senegal

A mutual health organization can be defined as an "autonomous, not-for-profit organization based on solidarity between members and that is democratically accountable to them. Its objective is to improve members' access to good quality health care through risk sharing based on their own financial contributions. It also aims… at promoting democratic decision-making" (Atim, 1998). MHOs function like insurance schemes. Members pay a small contribution or premium on a regular basis, which then guarantees the member (and other beneficiaries such as family members) highly subsidized or free access to health care services in the event that they fall ill. The contributions made by members are used to meet the costs of health benefits for all beneficiaries and any administrative costs. Membership is voluntary and insured members are involved in the management of the scheme.

Senegal provided some of the first experiences with MHOs in West Africa. Early attempts to start work-based MHOs in 1973 were undercut by legislation establishing mandatory workplace insurance funds. In 1989, the first rural MHO, Fandene, was created in the Thiès Region, with assistance from the Catholic Diocese and the St Jean de Dieu Hospital (CAS/PNDS, 2004). The apparent success of this MHO, managed and run by villagers, provided the basic model, as well as simple administrative and management tools for nearly all the later MHOs in Senegal.

Other communities in Thiès and other regions learned from Fandene and began to set up their own MHOs, starting in 1994. In the Dakar area, various types of associations (teachers' organizations, community associations, women's groups, and credit unions) began to establish their own MHOs, using the basic principles of the pioneering schemes of Thiès. Many of these schemes became the subject of studies (Massiot, 1997; Atim, 1998) and generated interest of both external technical support agencies and the Ministry of Health (MOH). In 1999, many West African partners came together to set up the Concertation, a forum, based in Dakar, of promoters and partners for the development of MHOs. Meanwhile, the Senegalese government established an agency at national level, the CAMICS, to coordinate and support the promotion and development of MHOs throughout the country, with financial support from a World Bank health loan. A significant number of the

MHOs emerging outside of Thiès after 1998 received support from either the CAMICS or one or several of the development partners. In 1997, there were 19 functional MHOs in Senegal. By 2003, this number had expanded to 136, based on inventories conducted by the Concertation.

1.2 Organization of This Report

Section 2 of this report presents a framework for conceptualizing and assessing social participation in the context of MHOs. Section 3 outlines the research questions and describes the study itself, while section 4 presents the eight MHOs studied. The results are discussed in sections 5 through 7, using the model for social participation presented in Figure 2: Section 5 examines participation of a range of internal and external stakeholders, and the intensity of participation within the MHO itself. Section 6 analyzes the various factors that can influence participation. Section 7 looks at the results related to social participation. Section 8 presents a brief summary of the data in relation to the conceptual framework. Section 9 discusses these results and how they relate to the broader literature on participation and development. Section 10 draws conclusions.

2. Social Participation in MHOs

2.1 Models for Assessing Social Participation

Several frameworks exist for understanding the key aspects of social participation and many of these were developed in the context of obtaining community buy-in and participation in actions initiated by governments and donors. One of the most diffuse models is that developed by Rifken et al. (1988), which views community participation as organic, with multiple aspects: leadership (representativeness and responsiveness); organization (involvement of existing organizations into new structures); resource mobilization (generation and decision making over use); management (engagement of new structures in operational decision making and supervision); and participation in needs assessment (to reflect community interests and priorities). Others (e.g., Eyre and Gauld, 2003) have suggested examining additional aspects: sustainability of participation (particularly related to resource mobilization), equity of participation, and the dynamic (changing) nature of the socio-political context. Other approaches to modeling participation view it as a hierarchy of levels of involvement, starting with information sharing and awareness, to consultation and discussions, to collaboration and influence, to control and empowerment (Tikare et al., 2001).

With any of these participation models, there still remains the question of whose participation is of interest, and what activities or actions these actors are participating in. Distinctions between internal and external stakeholders clarify the various kinds of involvement that might be examined or desired (Arhin-Tenkorang, 2001). Within the context of MHOs in West Africa and particularly Senegal, the internal stakeholders who are directly responsible for crucial decisions regarding the design, function, and future of the MHO are MHO managers, MHO management and governance organs, and MHO members. External stakeholders include health facilities that provide services to the MHO, local health committees with which the MHO signs agreements, and government actors such as the ministry of health. Such external stakeholders also have an important role supplying services to beneficiaries and promoting the MHO, as well as creating a favorable context and environment for the development of the MHO.

2.2 Defining Social Participation in the Context of MHOs

For the purposes of this paper, social participation in the context of MHOs is defined as: *The extent to which internal stakeholders (MHO management organs and members) play their respective roles in the design, set-up, promotion, and ongoing development of the MHO. Specifically the extent to which internal stakeholders are engaged in and influence:*

- *Design and set-up of the MHO*
- *The making of key MHO policies (dues rates and collection procedures, benefits package),*
- *MHO management,*

- *Ongoing problem-solving related to MHO issues.*

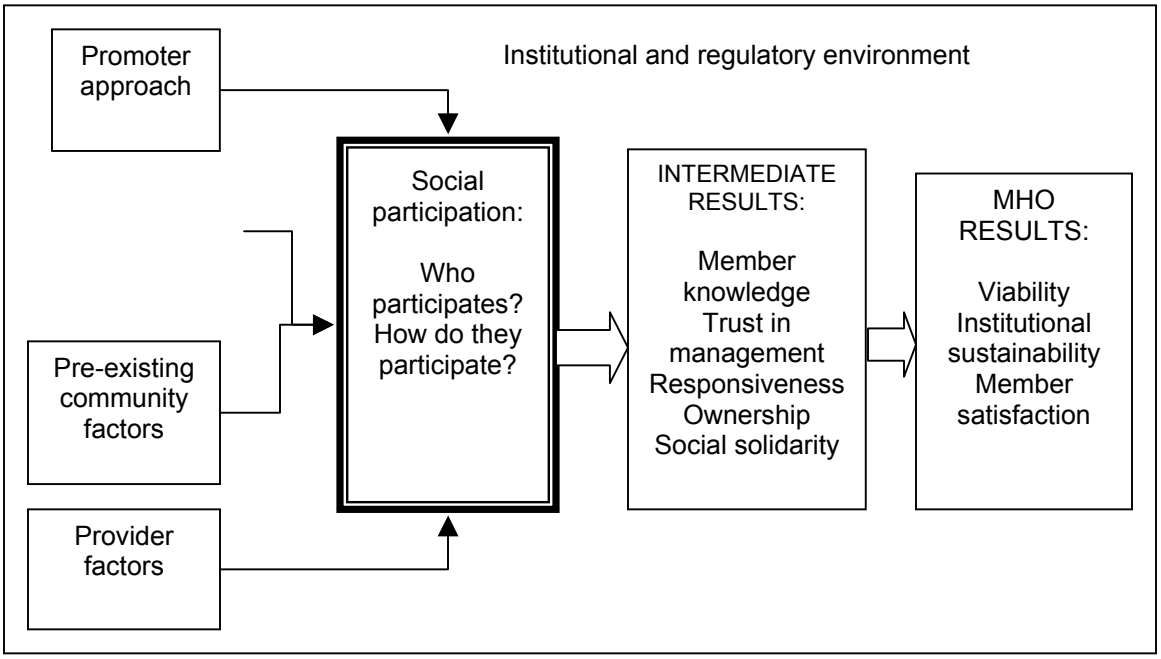
For external stakeholders, participation in the context of MHOs is defined as: *The extent to which external stakeholders (providers, the ministry of health, and local governments) play their respective roles vis a vis MHOs in*:

- *MHO promotion and sensitization*
- *Contributing to information collection in the design phase*
- *Negotiating contractual relationships with the MHO*
- *Creating a favorable socio-economic and/or legislative environment for the development of the MHO*

2.3 A Conceptual Framework for Social Participation and MHOs

Figure 1 illustrates the conceptual framework underlying this paper.

Figure 1: Social Participation in MHO Functioning



Key determinants of the extent and breadth of social participation in MHO functioning include: the promoters' approaches, the nature of MHO management and governance structures, pre-existing community-level factors, and factors related to providers. These determinants operate in an institutional and regulatory environment that can be favorable or unfavorable to the creation of MHOs. The promoters' approach can affect social participation in MHOs, through their technical advice and financial support. The management structures put in place are also partially determined by the promoters' technical advice as well as by the communities themselves, and the functioning of these management and governance structures will affect who participates and how. Pre-existing

factors in the community that affect how inclusive participation is include leadership capacity and prior experiences with other associations or MHOs. The existence of providers offering quality services and willing to cooperate with the MHO also affects how the community perceives the utility of the MHO (Criel and Waelkens, 2003). All of these functions will affect the nature and extent of social participation.

It should be noted that external stakeholders play a dual role: they are participants themselves in specific aspects of MHO design and functioning and their behaviors and attitudes also influence the participation of internal stakeholders.

Figure 1 suggests that social participation will have direct effects upon MHO functioning (intermediate results) including contributing to levels of member knowledge related to MHO structure and functioning; trust in management; responsiveness of MHO policies to member and beneficiary needs; ownership of MHO by membership; and sense of social solidarity.

The intermediate results in turn contribute to MHO viability and institutional sustainability, as well as member satisfaction. Viability refers to the capacity of the MHO to function on its own, independently of its sponsors and supporters, and depends on community capacity and financial stability. Institutional sustainability exists when the MHO is capable, over successive periods of time, to reproduce its systems of knowledge, established norms, and compliance with rules, structures, and external relationships. While social participation can contribute to financial sustainability, financial sustainability is determined by many factors, including adequate membership, effective collection of premiums, transparent and careful management of funds, and membership compliance with scheme rules. Certain dimensions of equity, such as whether the scheme design addresses the needs of the poor and encourages poorer members of the community to join, can be facilitated by broader social participation. The intermediate results just mentioned have the potential to contribute to both financial sustainability and equity, by helping ensure continuous and full payment of premiums, gaining new members, maintaining effective managers, and commitment to the social goals of the MHO.

3. Research Questions, Design, and Methods

3.1 Research Questions

The research described in this report is exploratory in nature, and seeks to understand better the role of social participation in the development and implementation of MHOs in Senegal. By examining the processes used to engage the communities and look at the effects this has on member trust and commitment to the MHOs, this study seeks to highlight key factors that should be created and sustained through the development and implementation process, and to understand the role that social participation plays in MHO functioning.

Research questions were as follows:

1. What are the forms and intensity of social participation of various stakeholders in the MHOs studied?
2. How are MHO management and governance structures related to social participation?
3. How do pre-existing community factors facilitate or inhibit social participation?
4. What are the results of social participation in MHOs?

3.2 Study Site, Sample, and Sample Selection

This study was conducted in eight MHOs in Senegal. MHOs were selected such that the sample included MHOs:

- Supported by one of three major promoters of MHOs in Senegal (BIT-STEP, PROMUSAF, and PHR*plus*)
- Located in both urban and rural populations
- Embedded in existing associations as well more broadly community-based
- Managed exclusively by women and ones managed by either men or women
- in operation for a long time and ones that were more recently created

Table 1 outlines the characteristics of the eight MHOs in the sample. The specific names of the MHOs have been removed to maintain anonymity.

Table 1: Study Sample

MHO	Promoter	Zone	Affiliation	Gender	Start Date
A	PHR*plus*	Rural	--	Mixed	1996
B	PHR*plus*	Urban	--	Mixed	2002
C	PHR*plus*	Rural	--	Mixed	2002
D	BIT-STEP	Urban	Association of women's groups	Women	1998
E	BIT-STEP	Urban and rural	Association of women's groups	Women	1998
F	BIT-STEP	Peri-urban	Association of women's groups	Women	2001
G	PROMUSAF	Rural	--	Mixed	1994
H	PROMUSAF	Urban	--	Mixed	1999

The MHOs selected were all functional, and, as will be seen in Section 5, had reasonable levels of participation. Thus, they do not represent the full range of MHO experiences in Senegal.

3.3 Data Collection Procedures

Two data collection methods were used in the study: focus group discussions and individual interviews. All data collection took place in December 2003.

For each MHO, separate focus group discussions (FGD) were conducted with:

- MHO management or executive committee
- Founding members of the MHO
- New members of the MHO

The FGD guides used can be found in Annex A. Participants in focus groups with founding and new members numbered between 10 and 12, and were selected randomly by PHR*plus* staff from MHO records and invited to participate. All focus groups were conducted in the local language by a PHR*plus* staff member (not associated with the MHO development in Senegal), and were recorded on audiotape. The content of these tapes were translated into French and transcribed into electronic documents, which were then compared to notes taken and corrected by the FGD facilitator.

Individual in-depth interviews were also conducted with providers, promoters, and promoters' local implementing partners (local nongovernmental organizations, NGOs). No provider interview was completed for MHO F, and MHOS A, E, and G used a single provider (who was interviewed once).

3.4 Analysis Procedures

The transcripts of all focus group discussions and individual interviews were reviewed, and key concepts extracted. These were used to refine the conceptual framework (Figure 1) and criteria for measuring participation presented in Section 5. The data were then reviewed a second time to mine supporting elements for these concepts, which were then ordered into an outline of results. The preliminary results were subsequently presented at a workshop (June 2004) attended by

representatives of all eight MHOs, the three promoters, the Ministry of Health, USAID, and other stakeholder organizations in Senegal. Input from these discussions led to additional analyses of data.

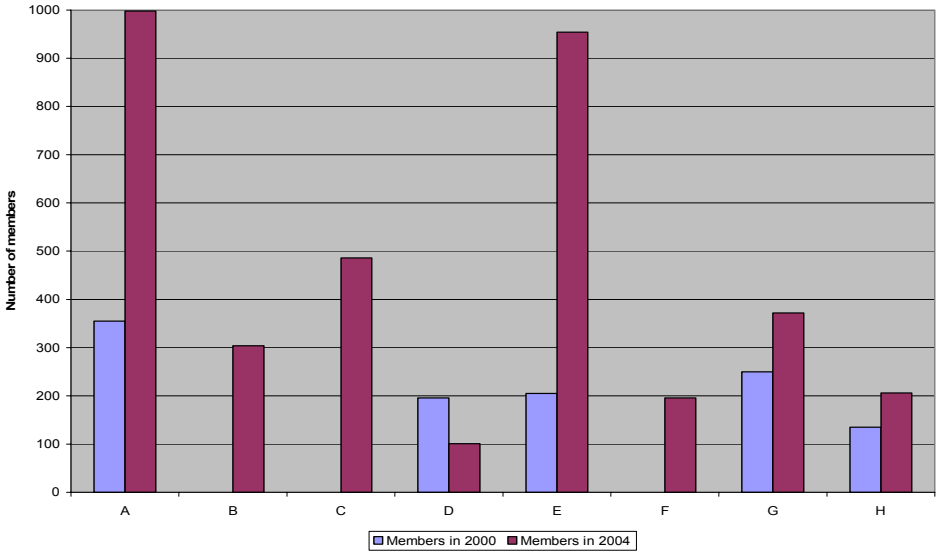
The information presented in this report is based on self-reporting by MHO members and management, but in many cases, triangulation of data was possible between various members, promoters, and providers.

It should be noted that the FGD guides did not cover all aspects of the framework. The framework and criteria were refined through the analysis process, often using factors revealed through spontaneous remarks of FGD participants or interviewees that were not included in the FGD guides. The data collection instruments did not allow in-depth assessment of some aspects of the framework, such as promoter approach and provider factors. However, some discussions during the focus group sessions did provide insights, and these are presented in the following sections, along with the more robust results.

4. Description of the Eight MHOs and Approaches Used by Promoters in Their Creation

Annex B summarizes key information about the eight MHOs participating in this study, including starting date, membership, benefits package, and current premium levels. Figure 2 provides some comparisons on size and growth of membership and shows that the sample includes both large and small MHOs. Note that while membership numbers are relatively low, there is typically a considerably greater number of beneficiaries, with number of beneficiaries per MHO ranging from about 300 to 6,300 (see Annex B).

Figure 2: Comparison of Membership Numbers over Time



NB: MHOs B, C and F started after 2000.

In addition to differences specifically targeted in the sampling (see Table 1), the eight MHOs differ in multiple other respects. For example, while some offer benefit packages that include secondary care such as hospital services (e.g., MHO A, E), others focus much more on covering the costs of primary care services (e.g., MHO C, H). The MHOs also vary in the percentage of members who are up-to-date in their premiums: while MHOs E and G have 70 percent or more of their members up-to-date in premium payment, MHO F only has 11 percent up-to-date.

5. Level of Social Participation in the MHO

This section examines the process of social participation (the central box in Figure 1 representing the conceptual framework) and attempts to describe the range, forms and intensity of participation of internal and external stakeholders in MHO-related activities in the eight MHOs studied.

5.1 Internal Stakeholders

Table 2 outlines different dimensions of social participation by internal stakeholders in MHOs. It builds on Rifkin's (1988) multi-dimensional model for community participation, the literature on MHOs, and the data collected. Table 2 identifies three broad components of social participation in MHOs:

- The social basis of the MHO: the extent to which the origins of the MHO are embedded in the local community
- Design and set-up of the MHO: such that community members are directly engaged in the design and growth of the MHO
- Governance: such that members are fully informed and engaged in electing their representatives and making policy decisions about the MHO

Within each broad category, specific dimensions related to social participation are identified and criteria to distinguish whether participation is more or less intense are presented. More detailed descriptions of these dimensions of social participation are provided in Annex C.

Table 2: Dimensions of Social Participation by Internal Stakeholders (managers, boards of directors, members)

Activities	Low Participation	Medium Participation	High Participation
SOCIAL BASIS OF MHO			
Origins of MHO – extent to which embedded in target community	Idea for MHO initiated by external individual(s) or body(ies) then 'sold' to community	Idea for MHO initiated by influential individuals in community	Emergence of MHO in response to needs independently expressed by existing community-based organizations / social entities in community or hitherto excluded social groups
Inclusiveness of current membership	Membership only open to specific ethnic or religious group(s)	Membership open to all members of an association or village, but no one else	Membership open to all within geographic or administrative catchment area beyond just one village

Activities	Low Participation	Medium Participation	High Participation
DESIGN AND SET-UP OF MHO			
Needs assessment/feasibility study	No formal or informal feasibility study, or study conducted exclusively by the promoter	Small select committee working under the direction of the promoter or acting informally	Large committee with or without promoter guidance
Initial definition of scenarios (design)	Single option adapted from elsewhere	Collected provider information, worked through possible options	Large committee working on possible scenarios; information collected from providers
Initial policy decisions	Single option proposed by working group to general assembly (GA) or only premiums put before GA	GA debates at least two options (premiums, providers, benefits package)	Widely attended GA debates multiple options
Sensitization	MHO management only carries out efforts to gain new members	MHO management tasks themselves and associations to try to gain new members	Individual members active in recruiting new members and see it as their role
GOVERNANCE OF MHO			
Autonomy of MHO	MHO decisions/ parameters subjected to control by outside authorities – local/central govt, provider(s), donor	MHO embedded in parent association, but decisions concerning MHO made by parent association, or president of MHO is also president of association	MHO enjoys independence in decision making from all external bodies
Operational/ management decision making	MHO manager (president or administrator) makes decisions	Management committee meets regularly to deal with issues	Board of directors or expanded management committee* meets regularly to deal with management issues
Frequency of elections (MHOs > 2 years old)	Once or less since start of MHO	Elections held more than once but not regularly since start	Elections regularly held since start
Frequency of general assembly meetings	Met only once or less since initial GA (MHO > 2 years old)	Met more than once but not every year since initial GA	Meetings every year since initial GA
Frequency of activity reports to members	Presented once or less since initial general assembly (MHO > 2 years old)	Presented more than once but not regularly since initial GA	Presented regularly without fail since initial GA
How reports are presented	No reports presented or only written reports in non-local or technical language	Presented verbally in non-local language	Written reports backed by verbal presentation in local and layman's language
Solving members' problems and issues	No mechanism for members to communicate their issues; no action taken by management to solve them	Management identifies issues and attempts to solve them	Problems identified and communicated to management; members' ideas debated at GA (or board meetings)
Ongoing policy	New policy decisions made by management committee	New policy decisions made by board of directors or expanded management committee	New policy decisions made during zonal or GAs

* Management committee plus delegates, community extension agents, or collectors

Table 3 presents the intensity of participation of internal stakeholders (members, managers, boards of directors) in the eight MHOs, using the categorization and criteria presented above. Some criteria outlined in Table 2 are not included: data on frequency of activity reports and report presentation were not available from the focus group discussions in this study.

Table 3: Level of Social Participation in Key MHO Activities*

Dimension/ /MHO	A	B	C	D	E	F	G	H
Social Basis								
Origins	XXX	XX	XX	XX	XX	XX	XXX	XX
Inclusion	XXX	XXX	XX	XXX	XXX	XXX	XXX	XXX
Set-up/Design								
Feasibility study	X	X	XXX	XXX	XXX	XXX	X	XXX
Scenario design	X	XX	XX	XX	XXX	XXX	X	XXX
Initial policies	X	X	XXX	XXX	XXX	XXX	X	XX
Sensitization	XXX	XX	XX	XX	XX	XX	XXX	XXX
Governance								
Ongoing mgmt	XXX	XX	XXX	XXX	XXX	XXX	XXX	XXX
Autonomy	XXX	XXX	XXX	XX	XXX	XX	XXX	XXX
Freq. elections	XXX	--	--	X	XXX	XX	XXX	XXX
Frequency GA	XXX	--	--	X	XX	XX	XXX	XX
Problem solving	XXX	XXX	X	XXX	XXX	XXX	XXX	XXX
Policy changes	XXX	--	--	XX	XX	XXX	XXX	XXX

* X = low participation; XX = medium participation; XXX = high participation

Social participation in these eight MHOs was quite extensive across the various dimensions, but Table 3 also reveals certain patterns of participation. Two of the MHOs in the study (A, G) were established in the early phase of Senegalese MHO development and built upon experiences in a neighboring MHO (Fandene), and did not apply what are now widely accepted mechanisms for social participation in the early stages (e.g., formalized initial working group, feasibility study, development of alternative scenarios). However, through existing networks and experiences of the initiators and use of more informal groups, both these MHOs have been able to effectively tap into their members for sensitization and policy making, and their members (old and new) appear engaged. In contrast, the newer MHOs (B, C, H) created their legitimacy through formal working groups representing the various groupings in the community, participation in feasibility studies, and other activities. The MHOs embedded within an existing association (D, E, F) had high levels of participation during the Set-up/Design phase, building on their already existing associative structures which facilitated delegation, engagement, and democratic processes. In addition, the BIT-STEP model of the feasibility study was very participatory. However, several of the MHOs have had difficulty holding general assemblies (a key mechanism for social participation) and larger MHOs (in terms of size or geographic expanse of their catchment areas) that have not created specific decentralized structures appear to have more difficulty maintaining participation.

There was an overwhelming sense from the focus group discussions that members and MHO management had not really thought through the role that the general membership could or should play in awareness raising and recruitment of new members. Most members felt that they could play a constructive role in this regard, and most management supported that idea. Many regular members admitted, however, that they had never taken advantage of opportunities to raise awareness or recruit new members. In one MHO, the president seemed to realize during the focus group discussions the potential roles that members could play to help the MHO succeed (see box).

> "All these people you are seeing here are just regular members and they play a role in the sensitization… there are sectors, women's groups, public areas for young people, the senior citizens, the women and we use them to pass on information." Founding member, MHO H
>
> "For the moment, we do not do anything for the MHO. Rather, it is the MHO which helps us; the only thing we do is pay our 5000 FCFA premium." New member, MHO H

For MHOs with greater social participation in governance, members seemed to know how to ensure that their voice was heard (A, G). As one founding member of MHO A said: "I have many opportunities to discuss and give my opinion: during the General Assembly, whenever I meet members of the executive committee, and when I go to pay my premium."

> "They can sensitize their friends and relatives. We can invite them to help us in the sensitization to recruit more members. Thus, they would learn the work we do and why not become part of the Board later." President and Secretary General, MHO B

5.2 External Stakeholders

Table 4 examines the types of MHO activities in which external stakeholders and promoters participated, and indicates that providers and government external stakeholders generally had limited involvement. It also indicates the extent of promoter involvement in initial and ongoing activities. It should be noted that external stakeholders have a role to play themselves, and their participation (amount and nature) is a determinant of participation levels of internal stakeholders (MHO managers and members).

Table 4: Forms of Participation of Various Actors in the MHOs*

	PHR*plus*			BIT-STEP			PROMUSAF	
Form/ /MHO	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**
Providers								
NA		X						X
De	X	X	X					
IP								X
OM								
OP								
Se	X	X						X
Ministry of Health and local government								
NA		X	X					X
De								
IP								
OM								
OP								
Se								
Promoters								
NA		X	X	X	X	X		X
De		X	X	X	X	X		X
IP		X	X	X	X	X		X
OM	X	X	X	X	X	X	X	X
OP						X		X
Se	X	X	X	X	X	X		X

NA needs assessment/feasibility study
De development of proposed contributions, benefits package and providers
IP initial policy decisions related to contributions, benefits package and providers
OM ongoing operational management of funds and member services
OP ongoing policy decision-making (related to changes in contributions, benefits package and providers; expansion)
Se sensitization (awareness raising, recruitment of new members)
* FGD data provided the basis for this table, and reflects perceptions of the participants.

5.2.1 The State (Ministry of Health and Local Government Structures)

> The only thing that I deplore is the absence of the State. The major counterpart for the MHO is the health dispensary, which has civil servants as staff. They gain benefits from this MHO, and in return the State should be more present with workshops or other forms of assistance but they ignore us completely. This is not good." President, MHO H
>
> "No directive or recommendation has come from the Ministry. We only see the MHO managers who come here regularly." Health provider, MHO H

The Ministry of Health and local government structures are important in terms of creating an institutional and regulatory environment conducive to the MHOs and providing political and financial resources that facilitate the viability of the MHO. The absence of the state in the ongoing support to MHOs was an oft-heard lament of MHO managers, members, and providers. MHO officials saw many ways in which the "state" could help them. The Senegalese Ministry of Health, as a central body, has made significant efforts to provide the regulatory environment necessary to facilitate MHO creation and functioning. The central government passed a law to regulate the setting up and operations of MHOs in the country.

Despite these efforts, it is not clear that these decrees and regulations have been heard and understood by MHOs or grassroots level stakeholders. In most MHOs, the Ministry or its de-concentrated units (the regional or district health offices) were not involved with MHO creation or functioning in their areas, with the exception of one region, where the regional and district authorities participated directly in the creation of MHOs and sought to ensure future continuity of technical assistance, and for MHO H where the health district was engaged in the MHO development.

MHOs also sought assistance from local government structures, which they felt could provide a variety of possible subsidies: help with provision of office space, sensitization, and support for premiums for poorer families in the community who have difficulty in joining the MHO because the membership fees and/or premiums are too high. However, many MHOs mentioned that, although local governments had promised support, none had come through with anything concrete, in terms of financial or political support to MHO operations.

In one exception, MHO A had developed successful collaboration in which several of the rural councilors are members of the MHO and they support its functioning by letting the MHO manager make presentations at their meetings, and by raising awareness and asking people to join the MHO while they are making their own visits to the communities.

5.2.2 Health Care Providers

Few MHOs engaged local-level stakeholders from the health system in their feasibility studies or initial design. Exceptions are MHOs B and C: in these cases, the initiative to launch the MHOs came through the regional authorities, and involved collaboration with the regional and district health offices. Providers were engaged in determining average cost/patient at the primary care level, which became the method for determining co-payments and premiums, and MHO reimbursement of providers for services to members.

> "In terms of utilization, the health post is the winner; MHO members come first to the post which is good, because during a certain period the people had deserted the post. Now they find basic health care delivered here and it is good for us... During our consultations, we explain to people who pass through the advantages of the MHO because with the MHO we are secure." Health Provider, MHO B

Simply being involved in the MHO creation process does not necessarily lead to the

> "We would like the [nurse] to be much more attentive to us because, if things continue as it has been, we will not see the utility of being part of a MHO. We would really like things to be easier for us so that people would want to join, but for the moment at health facilities, they take non-members before they turn their attention on us, and this is not normal." Member, MHO C

conviction that the MHO is good for the health post. For example, in MHO B, the provider believed the MHO played an important role in the functioning of his health post, and, similarly, for MHO A, one health post in-charge sought to have the population in his catchment area become part of the MHO, as it would facilitate their utilization of his post when they needed care. However, in MHO C, the person in-charge and the *matrone*[1] were less sure that the MHO provider reimbursement arrangements were beneficial to them. The matrone generally received a direct "motivation" payment from the facility or client, but the MHO reimbursement calculations had not included it, and the person in-charge appeared somewhat skeptical about whether the fixed average cost reimbursement system covered the costs of care he provided.

In the case of MHO C, the provider's behavior towards MHO members and beneficiaries led to MHO member discouragement: members felt they were paying for a service but were receiving differential (and less preferential!) treatment. It should be noted that while the matrone stated clearly that she was "disadvantaged" by the MHO, there were also unspoken aspects to the disadvantages providers might experience with respect to their ability to ask for under-the-table payments. Some allusions were made to this in several of focus group discussions and in the feedback workshop discussions.

> "[MHO members'] utilization is very weak. They may bring 70,000 FCFA per trimester or semester, and this is insignificant compared to the 10,000,000 FCFA in revenues that we make every month. Sometimes, even I tell them not to pay, because it happens that we take on social cases that are more expensive than the MHO members' costs." Provider, MHO D

Contracts signed with large providers with frequent staff turnover often meant that facility staff did not have knowledge of the contract signed with the MHO and the benefits members have the right to receive. In addition, where the MHO contributions to overall provider revenues were small, providers saw few advantages from their contract with the MHOs (see box). Yet, the large mission hospital in Thiès, which served many MHOs (A, E, G) supported the MHO movement by providing a discount in fees charged to MHO patients.

The relationships with the facility Health Committees[2] varied and some MHOs complained that with changes in committee membership, things were no longer going smoothly. MHOs used various strategies to facilitate cooperation. In MHO G, where a new health post was being created, they used this opportunity to have the MHO represented on the health committee. In others (B and H), MHO managers were also involved in the facility's heath committee itself. Integrating into the health committees is not always easy: the MHO D management mentioned that membership on these committees had not changed in 10 years so there was no opportunity to become a member.

In MHO C, some junior facility staff were part of the MHO management committee. Although this overlap of facility personnel and MHO management facilitates advice and orientation of MHO members at the facility, it should be noted that it did not necessarily facilitate relations with the provider. In this case, the subordinate role of the MHO management committee members within the

[1] The matrone refers to a traditional midwife who has received training. This is not a qualified midwife.
[2] Health committees are elected bodies that co-manage the health facilities with the health staff. Contracts with MHOs are usually signed by the health committee in the presence of the providers.

health facility often made it difficult for them to confront the person in-charge when there were problems.

One of the most interesting aspects of the relationships between MHO and facility (provider and/or health committee) was the ability of the MHO to effectively negotiate with the providers to make changes in the quality of services provided to MHO clients. Although information on this was not directly sought in the FGD guide, MHO C spontaneously mentioned their resolve to come to grips with the issue of drug availability:

> "Drugs were not in stock and our members were going to the health post without receiving drugs. I did my own little investigation and I came to the conclusion that the problem was in the ordering of drugs. When a health post places an order, it is delayed. I often saw arguments between MHO members and [the nurse]… I went to see the nurse in-charge to ask for an explanation. I also informed his superior, who assured me this would never happen again." Vice president, MHO C

6. Factors Affecting the Levels of Social Participation

This section presents data related to determinants of social participation shown on the left-hand side of the conceptual framework (Figure 2): promoter approaches, MHO management and governance structures, and pre-existing community factors.

6.1 Promoters Approaches

Over time, the three promoters represented in the study have explicitly built many participation elements into the MHO creation process which they supported, including:

- Facilitating the creation of a local, broadly representative working group to spearhead the process of setting up the MHO, including assisting with carrying out the feasibility study
- Supporting a participatory process to determine the basic design of the scheme, usually centering around a formal or informal feasibility study, including collecting information from households (willingness to pay, socio-economic information), investigating local associations, and collecting cost information from providers[3]
- Assisting in defining possible scenarios for premiums and benefits packages
- Supporting a general assembly with newly joined or prospective members to engage the community in decision making on the premiums, providers, and benefits package, and in electing the various management organs (management/executive committee, board of directors, etc.).
- Facilitating negotiations with providers to agree the terms of a contract for the future relations between the MHO and provider(s).

Most of the MHOs studied (B, C, D, E, F, H) received assistance from promoting agencies for carrying out these initial steps, as well as in the printing of membership booklets, training and provision of management tools for the operation of the MHO, and financial assistance with sensitization activities. The two others (MHOs A and G) received their assistance later in their development, during their expansion.

Promoters did vary in their targets for MHO development: BIT-STEP focused on MHOs embedded within existing associations, while the other two promoters concentrated on supporting the

[3] Or in the case of informal studies, perhaps undertaking a study visit to a neighboring MHO to find out useful data about how it works; in the same context, and especially with very poor communities, the working group may also undertake a consultation exercise to determine what is the maximum amount that people in the community can afford to pay as dues, and, on that basis, suggest appropriate benefits packages.

development of community-based MHOs. Yet even as strategies varied among promoters or over time, there was a fairly consistent emphasis on creating structures that represented local communities/ association membership and on creating participatory processes for MHO development and governance. However, promoter emphasis beyond the initial stages appeared to focus more on technical tools rather than strategies to foster ongoing participation.

6.2 MHO Management and Governance Structural Factors Influencing Social Participation

MHO structures provide the vehicle through which members and management participate in MHO design and functioning. These structures are generally established during the set-up/design process, and are influenced by input from promoters (or other MHOs used as models) and existing practices in place in the various associations involved in the MHOs. Each MHO had a series of management organs which it used to administer and manage the MHO. Most MHOs established an ad hoc design committee or *comité d'initiative.* This was followed by a set of permanent organs for ongoing operations: a board of directors, a management or executive committee, and usually a control committee. Not all MHOs had all of these, and even for those who did, not all were operational.

6.2.1 Design Committee or Initial Working Group (*comité d'initiative*)

Most MHOs, with guidance from promoters, formed some kind of working group which participated in the set-up/design phases of the MHO. The working groups collected information, sensitized the population, and developed options to put forth to the General Assembly. In all cases where a formal working group was formed, representation of key associations, neighborhoods, or women's groups was achieved. In most MHOs, these individuals went on to staff the various permanent management organs. MHOs A and G, which were initiated without initial promoter assistance and were modelled on another existing MHO, engaged a geographically representative group of individuals to form their "working group." Specific membership of these working groups can be found in Table 5.

Table 5: Working Group Composition in the Eight MHOs Studied

MHO	Type of Assistance from Promoters
A	Informal working group, originally formed by the ex-president and treasurer of an existing MHO, but gradually enlarged with delegates from participating neighborhoods
B	Representatives from the various associations and women's groups in the area
C	Representation of the various neighborhoods
D	Representation of the various women's groups that make up the parent association
E	Representation of the various women's groups that make up the parent association
F	Representation of the various women's groups that were part of the parent network of women's groups
G	Informal working group including the Young Men's association and other interested parties
H	Representatives of the various associations and women's groups in the neighborhood; the current president was *not* part of the working group

6.2.2 MHO Management Committee and Board of Directors

Generally speaking, the MHO management committee had 5-7 members, while the boards of directors varied from seven to 23 members. Positions in these structures were most often filled by individuals who had been part of the initial working group. Such practice was often encouraged by the promoters who felt these individuals were the most competent to continue, given the investment

in training and the experience they had acquired. All members of all MHO management committees and boards of directors worked as volunteers, although MHO A managed a small "motivation" payment for their zonal managers. Two MHOs (D, E) had a salaried manager (technically not part of the management committee), but funding for this position came from the parent association.

The board of directors has the role of overseeing administration and management of the MHO by the management committee. These boards were often structured to include important groups, associations, and/or neighborhoods, and, for the eight MHOs studied, these associations or groups were often represented by regular members (not their presidents).

> "Every [women's] group sent a representative [that can be just a regular member of the group] that we then co-opted into the Board of Directors in such a way that when their groups meet, they are the ones who do the sensitization, aided by other board members who come and participate." Management, MHO D

The process for electing individuals to the different organs varied. In MHO C, the management committee was elected by the Board of Directors, not the General Assembly. In MHO H, the entire management committee resigned and elections were held. In MHO F, empty positions were filled, and then the remaining members were put to a confirmation vote, and one gets the impression that they were not expecting to have a contested election. However, it should be noted that no one participating in the focus group discussions ever mentioned that the selection of management committee members was imposed. In fact, many said explicitly that no management organ members were imposed on the membership.

> "Many presented themselves as candidates and unfortunately there were more candidates than available positions. Another date was set to organize a vote, and those members meeting the predetermined criteria were chosen." Founding member AF

> "The comments that I have heard especially about MHO B lead me to believe that the choice [of the executive committee] was basically democratic, there is trust, and the one chosen to be president is dynamic and things work." Provider, MHO B

From the experiences of these eight MHOs, one sees a tendency for the communities to stick with the people they elected in the beginning, with relatively little turnover. Table 6 shows the changes in management in the eight MHOs studied.

Table 6: Turnover in Management Structures in the Eight MHOs Studied

MHO	Start Date*	Changes in President or Manager	Changes in Management committee	Changes in Board of Directors
A	1998	No	Yes?	Yes
B	2002	No	No	No
C	2002	No	No	No
D	1998	No	Not officially	Not officially
E	1998	Yes	Yes	Yes
F	2001	No	Yes	Yes
G	1996	No	No	Yes
H	1999	No	Yes (few)	Yes

* This refers to the first election of the management organs.

It is remarkable that of the eight MHOs, seven still have the original president. The only exception is MHO D, whose president applied for one of the MHO's paid positions and had to step down. Frequently changes in the membership of the management committee or

> "There was some change, but the key positions are still held by the same people. It is the general membership that reappointed the same people because they liked the work that they did. Despite this trust, we do not want to fall into a trap, so the whole Board resigns, someone else leads the debates, and then a vote is taken. It has to be said that the members of the executive committee are currently prisoners of the MHO; they cannot withdraw – even if you are not present at the General Assembly (for a valid reason) but you are re-elected in your absence. [Committee members] are obligated to continue because the people have confidence in them." Secretary General, MHO H

board of directors appear to be due to an individual leaving the area or not being able to continue, rather than real rotation of positions. However, there also appear to be some cases where individuals were replaced because they simply were not doing their job. MHO D, for example, had coopted individuals to replace committee and board members who were no longer active. However, because no general assembly has been held since the initial one, these changes are not official yet.

While stability demonstrated in Table 6 does allow for continued confidence in management by keeping those "you know you can trust," it also poses dangers, as there is no expansion of competency. As one provider who serves several MHOs in the Thiès area says,

> "There should be term limits. It is true that it is difficult in a village to ask for such a thing because the people either do not want them or they can not ask for them or they do not have the experience or understanding of its importance. In these structures, the people do not prepare for the future: when they leave there is nothing."

Among the promoters, there was concern that this lack of turnover would affect social participation in the long run, as the number of people actively participating will remain small or even diminish, and that institutional sustainability will be jeopardized. The promoters' concerns were not mirrored in the outcomes of the focus group discussions, where participants in several MHOs mentioned that, if those in management positions did not show themselves to be honest and competent, they would be replaced, and that there were other competent and dynamic individuals who could take their place. Yet, it is often the members themselves who insist on maintaining the same (competent) people in these management positions.

In terms of gender representation in the management organs, for those MHOs associated with women's organizations (D, E, F), all management positions were held by women, as being female was a requirement for membership. In MHOs B, C, and H, the leadership was mixed (men and women). However, the two older MHOs (A and G) have almost exclusively male leadership.

The management committee and the boards of directors were initially established with specific and distinct roles. However, for most of the eight MHOs studied, over time these organs became more like a single unit. In MHO F, because of difficulties getting people to show up for meetings, they reduced the board of directors to seven members (the five of the management committee and two additional people), with the result that the board no longer reflected the range of women's groups that made up the parent network of women's groups. In other MHOs, the management committee and active members of the board of directors met together, forming a merged management organ, rather than two separate organs.

The control committee, although sometimes mentioned in listing the various organs, was not brought up in the discussions about the functioning of the MHO management structures, and it appeared that few of them were functional.

6.2.3 The General Assembly

The general assembly (GA) is the principle mechanism for the broader membership to be informed of the status of the MHO, to (re)elect their leaders, and to participate in policy decisions. This mechanism becomes

> "In my opinion everything should be dealt with at the General Assembly, you should take the opportunity to express your opinion on the different issues. Other than the General Assembly, I do not see where we could bring up our grievances. The leaders also do a good job, and if this was not the case I would be the first to complain." New member, MHO H

especially important for newer members who were not present in the original debates and discussions. Because there is relatively little turnover in the management structures, the GA sometimes becomes the sole mechanism for broader membership participation. New members in MHOs which had not had a GA in several years complained that they were not really informed.

> "During the General Assembly we decided on the amount to pay as premiums, and to sell [membership] booklets at 500 FCFA. As for the amount of coverage, we didn't discuss that -- we were just informed and I complained about it, because in my opinion we should have discussed it. The amount of coverage was decided at the moment we could receive services."
>
> "We invited everyone [to the last General Assembly], even the neighborhood leaders were there…a lot of people were present… The decisions are first taken by the executive committee, they are then submitted to the assembly which gives its opinion and then they are definitively adopted." New member, MHO F

The study methodology did not permit assessment of actual participation at general assemblies, either in terms of attendance or in terms of debate. However, from focus group discussions, the delicate balance between how the opinions of the general membership are solicited and the role of the management in proposing options was revealed. In some cases, the GA serves as a rubber stamp on management committee proposals. Yet, in other cases the GA really serves as a forum to debate the issues and members felt themselves to be part of the decision making.

> "Nothing escapes us; the executive committee informs us individually of everything that is happening and it organizes discussions in the women's groups. For each decision we can be in agreement or not, and the executive committee takes our opinion into account… we hold a meeting of the whole network each month… If the president or a member of a committee has news to tell, they take part in the meeting and discuss the issue with the general membership about the decisions that need to be taken. Each group sends five members to the network meeting. The five members are responsible for updating their group, and, in the same way, they also update the directorate of issues of the members of their group." Founding member MHO D
>
> "Not all groups come to the General Assembly... There are many groups and it would be difficult to gather everyone. This is why only the delegates were present and voted on the members for the different management structures." Member, MHO E

6.2.4 Decentralization and Delegates

The standard structures described above met some of the needs of the MHOs. However, given that those managing the MHO (with few exceptions) were volunteers, most MHOs developed strategies to address operational issues arising from their increase in size and the consequent increase in workload. The management committees of most MHOs identified or arranged to elect delegates or "extension workers" to collect the premiums, recruit other members, and take care of other business. In one case, these delegates became the board of directors. In another, they were invited to attend board meetings but were not board members (MHO D). In others, they were co-opted to help but were neither part of the management committee nor the board of directors (MHO B).

> "We do not have a telephone here, we do not have any means of transport, and we do not have time to go everywhere. This is why [the delegates] are invited and they are the essential link in the chain of the MHO. If they are not doing their job well, everything falls apart; they are the ones that provide timely information to the people." President, MHO G

In some cases, the delegates represented various women's groups that were part of the association supporting the MHO; in others, they were selected to represent a village or neighborhood. However, despite the fact that they were often elected they did not always carry out their duties or appear to be committed to the MHO; for example in MHO A, some of the original delegates in one zone never even joined the MHO.

> "At the beginning we just had 12 women's groups. [We] went around after work and collected the premiums and read publicly the names of the members who were not up-to-date. The women wanted, at all costs, to avoid [having their name read] so they did everything possible to be up-to-date. When the MHO started to grow, this job became difficult and even the president joined the effort. In addition, the Education and Promotion Committee play a very important role; before going to a group we asked them to come and see us so that we could give them a rundown of the situation and we realized that this visits revitalized the groups. Unfortunately, we don't always have the money to do this." Management, MHO E

The delegates or extension workers form an important mechanism for ensuring participation in MHO functioning, both by representing the village or sub-community and by being the spokesperson for the management committee. In many instances these individuals were to relay any information or decisions taken by the management organs back to their communities or women's groups. They were also to transmit concerns, problems, and issues that members have back up to the management organs.

> "We hold a meeting with a village and afterwards the people elect someone. It is that person who will represent them and collaborate with the MHO. We then bring these representatives together for a meeting and they are instructed to return to the village to be the delegate." Manager, MHO A

However, in MHO C, it appeared that this decentralized system may have impeded resolution of problems members experienced with the provider. Members seemed not to be aware that they had direct recourse in the MHO president or secretary. They preferred to go back to their village and discuss with their delegate who would only communicate the problem at the next monthly meeting.

> "We want the zones to be autonomous, for them to hold their own meetings and assemblies, for them to solve their problems. Of course we can go to the zones but this doesn't take away their independence. We have organized ourselves in such a way that the zones pay their basic health costs. We do not want to centralize everything. In addition we want their members to see that they are responsible." Manager, MHO A

In addition to adding personnel to help in the tasks, some MHOs went beyond the notion of "delegates" to create a truly decentralized structure with zones or sectors. Several of the MHOs in the study were considering adding this element, and two MHOs (A and G) had already implemented strategies.

MHO A, with over 900 members in 60 villages, developed a system of eight zones, each having its own management committee and being represented in the overall board of directors (with five members per zone). The zones are responsible for paying their primary care providers directly with the money they receive in premiums. The central cashier then tops off these payments with revenues from other zones if the money was not sufficient, and they also pay hospitalizations. When policy issues arise that need full agreement of all zones, the central executive committee attends all the zonal GAs to explain the situation.

> "We decided to organize sectoral assemblies to explain to them that, if we continued in this manner, the MHO would fail. It was very difficult; it was a very passionate debate in certain localities, but there was only one alternative: increase [the premiums] or decrease the benefits. They accepted because they knew they did not have a choice." President, MHO A

In MHO G, finding that attendance at GA meetings held in the central village was not adequate, they developed a system of "sectoral" GAs held annually in each of the four participating villages. The management committee goes to each of the GA to make proposals, discuss, and hold elections for the management committee and delegates, and to make decisions.

> "In the beginning, meetings were held [in the central village] but we realized at one point that few members were coming. We decided to make up a schedule and hold the meetings in several localities so that the members would attend." Founding member, MHO G

6.3 Community Factors Influencing Social Participation

The extent and effectiveness of social participation in MHOs appears related to certain pre-existing factors in the community. Two factors explored in this study include existing leadership capacity and experience with other associations and/or solidarity mechanisms.

6.3.1 Leadership Capacity

> "The essential thing is to invest yourself in the development of your locality, to do it without expecting something in return, to be credible and not to touch the money that does not belong to you… the majority of members had made it known that they would only be members of the MHO if I was managing it." President, MHO B
>
> "[The president] is the one that convinced everyone to join and she invested so much that we are doing everything to assist her." SG, MHO B

Creating an MHO requires individuals who can inspire others in their communities and associations to take the risks of becoming part of an MHO. The eight MHOs studied were able to tap into individuals with leadership capacity and the trust of the community to manage this enterprise. In community-based MHOs (A, B, C, G, H), although not a specific question in the focus group guides, the quality of their leadership was mentioned again and again, including honesty, dedication, commitment to community, and hard work.[4] Many mentioned that the MHO would not be working if it were not for the individual (or individuals) who were managing it. As one founding member of MHO B said: "A leader should be someone that brings people together; he must be able to have good relations with everyone, while keeping in mind each one's character. [Our president] has those qualities."

> "It is because I reside here, I am constantly here, the people can see me or my collaborators all the time, I am attentive to them. One must also say that we have a board of directors that works well together… I have never seen them quarrel; all the decisions are debated and sincerely discussed. The opinions can be contradictory but we always opt for the best solution. Again it is not the fact that I am school director but because I am from here and I love my country." President, MHO G

> "As for [the manger], I believe that if everyone was like him the MHO would have passed this stage: he does not do it for himself but for the community." New member. MHO A

In FGDs with two MHOs (B, F), MHO members or even leaders mentioned that when women managed the activity, things went more smoothly. Examples were given, not only of MHO activities but also health committees and other community activities. However, the study showed no evidence of specific problems in those MHOs in which men were presidents, managers, or treasurers.

> "When the men were leading, [the facility health committee] did not work. The women mobilized themselves so that it would not fail and picked a woman as the treasurer." President, MHO B

[4] For MHOs emanating from and embedded in existing organizations (D, E, F), leadership issues were not raised spontaneously in any focus group discussion. However, in several cases, the MHO president was already in a key leadership position in the association.

6.3.2 Community Organizational Capacity and Experience

The MHOs embedded in women's organizations (D, E, F) capitalized on structures and competences that were already in place and could build on the experiences of working together for other association goals. The other MHOs took advantage of existing associations in the community to help build the MHO. In some communities, these associations were strong: "There is an extraordinary associative dynamic that we can not find anywhere else in Saint Louis… Independent of the creation of this MHO, there is an extraordinary associative life: everyday that God creates, there are meetings." President MHO H

> "It is not a project that comes from the women's groups but it is the good intentions that were regrouped. What interests me most is that the MHO works: maybe it would have had problems if it depended on the women's groups." Executive committee member, MHO B
>
> "We used the help of a [local federation] to create the MHO, but if we had followed them maybe the MHO would not work. They wanted us to integrate them in the board of directors. Then their organization went bankrupt and we thought that if they had been part of the MHO board of directors, the MHO would have gone bankrupt too because the people would not have confidence in it." Manager, MHO A
>
> All the associations and groups were represented: the ASC, the women's groups. If only one association had done all the work, [the MHO] would have been an associative affair, but we wanted everyone involved. [Here] everyone has their own association, but if there is something of general interest, everyone puts aside their differences for the communal effort, even if the next day we might fight between ourselves." Management, MHO H

Yet, many MHOs felt that the associations, even though they could contribute, should not dominate the process. They mentioned the dangers of these other community associations' own problems spilling over to the MHO, and that the people chosen to run the MHO should be chosen on merit, not on membership of some other association.

Willingness to participate in an MHO is also determined by knowledge and experience of other MHOs or financial collaborative enterprises. If these experiences were successful, the community might be ready to take on another enterprise. If it were negative, they would be more likely to be suspicious and cautious. MHOs A and G were able to build from the successful experience of the pioneer MHO in Senegal – their communities were already aware of the benefits of MHO membership.

Several MHOs built on their organizations' earlier efforts with collective funds for drug costs (D, E, F), and had little difficulty gaining membership initially. However, particularly in the community-based MHOs, one heard echoes of previous negative experiences with associations and mutual aide activities, and individuals talked of a general mistrust to buy into something without first being sure it was viable.

> "In the beginning there were women's groups of 20 or 25 members. The women paid dues every month and this money was lent to members who used it for various economic activities, mostly small business." New member, MHO H

"[Someone had diverted funds in another project.] This explains the lack of enthusiasm from the women for the projects that came afterwards – they no longer have confidence or trust. If this kind of misadventure had not happened to us, this MHO would have reached another stage of its development. Despite all this, the mentalities started to change and the people began to join progressively." President MHO B

"I was member of a MHO started in the company that I worked for but we know what caused its failure: the way it was managed left much to be desired. In addition, certain sick persons, in cahoots with the physicians, charged things to the MHO that were not to be included. The fact of arranging for a friend to be covered under the name of one of your beneficiaries with the doctor as accomplice was an abuse of the system that eventually placed the MHO in difficulty. We think this will not happen in this MHO. I am a member and all the directors are my friends, we often talk things over together." Member MHO C

7. Results of Social Participation

A number of "results" of social participation are proposed in the Conceptual Framework (Figure 1). The research methodology used in this study did not allow for assessment of changes over time, and many of these intermediate results were not explicitly targeted in the focus group guide design. However, numerous spontaneous remarks during the focus group discussions in many MHOs indicate that these "effects" or results are related to social participation.

7.1 Member Kowledge

Member knowledge of what the MHO does and how it works is important for continuing support of the MHO goals. Comparison of the kinds of responses made by founding members to those made by newer members showed that new members were consistently less well informed than founding members. In MHOs A and G, which served tight-knit communities and had developed effectively decentralized systems for delegates, zones, and general assemblies, newer members were generally better informed than in the other MHOs. The major gap in information that newer members demonstrated was related to specific aspects of the benefits packages (what services were covered, how much was covered). Information was particularly problematic for MHOs that had not held a general assembly recently (D) or where the general assembly was attended by representatives and not the entire membership (F).

7.2 Trust in the MHO

The viability of the MHO depends on the existence of trust in the institution itself, its leaders, and other members. Mechanisms for transparency ensure that the resources mobilized by the community to support the costs of health care are used for that purpose and promote confidence and trust. Promoters provided training and tools to support transparency and accountability. Although transparency was not a specific topic in the FGD guide, several mechanisms were mentioned spontaneously, including having an MHO charter which outlines everyone's responsibilities, taking minutes of meetings that can be viewed by others, having a stamp held by the manager to ensure that no one is allowing those who have not paid to receive care, only allowing premiums to be paid to the delegates or managers, using letters of guarantee to receive services, and holding general assemblies where the budget and revenues are openly discussed. These mechanisms were mentioned by management or founding members almost exclusively. While founding members of MHOs were well aware of these mechanisms, their trust in MHO leaders appeared to be of greater importance to them, than the existence of such mechanisms.

> "Because this is a project where we ask people to give their money, you have to work with people that know you, who have trust in you." Founding member, MHO B
>
> "The leaders do a good job, they are honest… they do all the work even though they are not paid, it is volunteerism." New member, MHO H

Many individuals were skeptical and waited to see whether the institution itself was trustworthy. Yet, the focus group discussions produced plenty of evidence that members have trust in their leaders and that this trust positively affected the legitimacy of the MHOs. Trust and confidence was mentioned frequently in the community-based MHOs where the management positions are all voluntary, as if reflecting the sacrifice these individuals were making. Although most of the MHOs studied held elections on a regular basis, there was a tendency for the communities to stick with those people elected in the beginning, with relatively little turnover (see section 6.2.2), reflecting the personalized nature of trust within the MHO. The issue of having found individuals who deserve trust and confidence appeared to play a large role in how members perceive the need for management structure renewal or "alternance." Knowledge that they have the *right* to replace MHO managers if they do not do their job properly was, for many, sufficient.

> "I am a member of the MHO. I was informed since the beginning about the creation of the MHO, but I did not join earlier because I did not think it would last." New member, MHO H
>
> "I am someone who is very cautious. There are so many associations in Senegal that one has a hard time keeping track. So I observed for a while and I realized that it was advantageous, and so I joined." New member, MHO B

> "No [the executive committee has not changed.] They stay because their work is appreciated by the MHO members… We have realized that at no moment have they put the MHO in danger, and I think that if the executive committee needs to be up for election, we need to show our trust by re-electing the leaders who have done such a good job." Founding member, MHO H
>
> "The executive committee [has been here] forever, at every general assembly [the members of the executive committee] want us to elect new people but it is the MHO members that refuse because they do a good job and have clean hands." Founding member, MHO G
>
> "No we would not let the MHO fall apart if [the president] were to leave some day. We would elect someone honest because she is not the only one. For example if she did not merit the trust of the people who elected her, she would be replaced." New member, MHO B
>
> "[The executive committee] has already said that the members can replace them if they thought that things were not going well. But I think that it would not serve us well to replace them, just to elect someone who may cause us problems. Given that I have done five [years] with this [president] and I do not know what is in store with the one that will follow, I prefer to stay with the person I know in the mean time." New member, MHO G

7.3 Responsiveness of MHO to Community Needs

Social participation of members in MHO functioning should result in policies and procedures that reflect the needs and aspirations of the members themselves. The first evidence of responsiveness takes place in setting the premiums at a level that the community feels comfortable with. All but one MHO (MHO B) made this decision during the initial general assembly and any increases were debated at subsequent general assemblies.

> "We cannot increase the premiums because the people do not have the means; we are not in a rich neighborhood. In the beginning we thought long and hard about the amount and I can tell you that it was a well-thought through decision." Founding member, MHO H
>
> "[Increasing the premium to 150 FCFA and 200 FCFA did not cause MHO members to leave the MHO] because they knew it was in their interest to have this increase so that they could for example be hospitalized. We explained the situation and the "why" of this increase and they understood. It was discussed during the sectoral assembly and they approved of the idea." Treasurer, MHO G

However, in several MHOs, members and potential members appeared somewhat dissatisfied with

the benefits package, particularly in the urban MHOs when hospitalization was not covered. This reflects an unmet aspiration, but could also reflect inadequate communication about reasons why hospitalization is not currently included in the benefits package (trade-offs in premiums and need for adequate membership size).

7.4 Sense of Ownership of MHO

At least among the leadership of the community-based MHOs, there is a real sense of ownership and responsibility – that what they have created (and succeeded in) belongs to them and their community. Analogous expressions were not heard in the MHOs associated with women's associations.

> "It is giving of yourself, it is a humanitarian gesture. Even if the donors give us billions, we have our intelligence, our *savoir faire*, our strength, and our willingness to do well and that is worth more than a billion. If we have the money, but not the willingness, honesty, and commitment, the termites will benefit from the billions. Of course, what I am saying for the leaders and the delegates is also valid for the other members of the MHO who sometimes are enlisted to pass on the word. The majority is committed – I cannot say everyone because this would be lying – but the majority believes in the MHO and they invest their energy so that the message is passed easily from mouth to ear during the meetings. I would like the MHO members to like their MHO, not because it covers the cost of their health care, but because it is their future." President, MHO G
>
> "Of course, there was a raising of consciousness among MHO members who know the importance of the MHO; they come themselves to pay their premiums. In addition it is evident that everything is clear in this MHO, transparency exists, the sector heads have all the financial information, we can tell you how many millions there are in the cash box." New member, MHO G

In MHO F, one saw an example of someone who took the MHO to heart:

> I was a member of the executive committee, but I want to explain to you that, thanks to my work as a tailor, I was able to sensitize many people. In good humor, I would ask them to buy membership booklets by giving them a reduced price or a credit on what I was sewing for them. In this manner, I was able to sell lots of membership booklets."

From the focus group discussions in most MHOs, there was also a sense of ownership among the founding members who made sacrifices to build a functional MHO. Generally, little evidence of such ownership was seen in new members, and many new members were more likely to perceive the MHO as a means to access care for themselves, than as a system of solidarity.

7.5 Social Solidarity

Social solidarity is a major principle and basis of the MHO movement. Expressions of social solidarity were witnessed in the FGDs in every MHO and included the structural aspects of solidarity that are built into the MHO (risk sharing), but also solidarity in terms of extension beyond a limited social group or towards poorer or less fortunate members of the community.

Although no one in any focus group used the term "risk sharing," the terms "solidarity" and "helping others to get treated" were cited in all MHOs (see box below for examples). However, it

should be noted that these expressions of solidarity were more frequent in the FGDs with management and founding members than with newer members.

> "Besides, everyone who joins a MHO would not want to become sick so they could use their benefits from the MHO. One should consider that an MHO is a way of helping one another, of solidarity. We do not join a MHO to receive care but to help those who are in need." New member, MHO B
>
> "The MHO is a question of solidarity. A member can have a prescription for 5,000 FCFA that he would not have been able to pay for. It is the premiums of the other members that will help him and he will only pay 600 FCFA." Secretary General, MHO C
>
> "If you are in good health but your family is not, you do not need to worry. Besides, the MHO is a question of solidarity. If, by good luck you do not become sick, your money will help provide care for someone else. Being Muslims, our religion encourages this solidarity and this will only bring us benefits." Member, MHO E
>
> "I think it is more interesting to ensure health care for someone so that he stays among us, instead of leaving him to fend for himself and to bury him after his death and arrange the funeral. The goal of a MHO is to organize solidarity between people. I think for some people to understand this, you must give them concrete examples." New member, MHO A

> "…the MHO took the decisions to no longer admit people who are not members of a women's group…it is difficult to make members of the women's group pay their premiums, not to mention a person who is not affiliated with a group. Despite all this I can take them on as beneficiaries on my membership and they pay me regularly." Member, MHO E

Several MHOs (A, G) showed evidence of successfully extending MHO coverage to social groups that had not been covered before, particularly from other ethnic and religious groups that had previously been excluded. These expansions sometimes created tensions. In MHO G, expansion to other ethnic and religious groups had to overcome some strong resistance in the then current membership. In addition, current members were concerned that new members would not be making the sacrifices that the original members did, in enduring a long initial waiting period in which original members built up the capital needed to start the MHO; newer members would be able to jump right in and take advantage of benefits offered. This tension was resolved over time, but created some difficulty at the time of expansion.

> "In the beginning, we had to discuss with the original members of the MHO. They thought that the new members would profit from the money [these orginal members had invested]. We had to explain that an expanded MHO is in the interest of everyone… At this moment in time, a MHO cannot be the affair business of a single locality, if we want it to be viable. There needs to be enough members to take on a certain number of services and to respond to the aspirations of the people." President, MHO G
>
> "I asked them during a meeting to expand the MHO (first within the Christian communities in the other villages); some accepted and others refused. I did not stop battling; I continued to nag them until they accepted. We started with four people but now we have more than 80 adherents and all the ethnic groups and religions are part of it." Founding member, MHO G

Other aspects of solidarity relate to helping those less fortunate. Evidence of such solidarity, although not necessarily part of an MHO, was seen in several of the MHOs studied, often in the form of individual members helping out others who did not have sufficient money to pay their premiums. Most MHO leadership recognized that, although the premium levels were determined by the community, this did not mean that they were affordable for everyone. There were examples of members paying for their relatives who were without money or even paying the premiums for non-family members. In addition, MHOs D and E

> "[We], pay her premiums each month with our own money because she clearly told us that she could neither pay the premium regularly [nor] buy the prescriptions. She does not even know where the money comes from. We do it because we do not want her to leave the MHO." Member, MHO C

created a mechanism to cover the costs of premiums for a certain number of *talibés*[5] who did not have someone to ensure their access to health care. This system, like being a godparent, enabled individuals with money to pay the premiums and drug costs for these children.

> "When we have a sick person hospitalized, the manager or I go to visit and inquire after their situation. This touches people enormously… If a woman gives birth, we pay them a visit: the baby and her. We have a very sociable relationship with our beneficiaries. If by some misfortune a beneficiary dies due to a sickness – there are not very many but this does happen – we take some money from our solidarity fund and we present our condolences to the family." Management, MHO D

A final example of solidarity was the role that some MHO management played in providing moral support to their members, during times of illness and possibly bereavement.

In several MHOs, members and management felt they should be doing more for those less fortunate. Some discussions led to possible suggestions for strengthening the ability to help those who cannot pay some or all of the premiums.

> "I want to talk about people who would like to pay the premiums but who do not have the resources. We had to take money from a Spanish priest to help some people join or catch up in their payments. [The priest] sent me 100,000 FCFA in the beginning in the name of the MHO and I divided this among the people who wanted to join but I know that others wanted to join but they do not have the resources. If we could help them, that would be good. I think we should help them so that they only have to pay 50% of the premium." Founding member, MHO G
>
> "Besides, I think that the rich ones in the region should help the poor that do not have the resources to join the MHO. I am talking about the emigrants and the cadres that are here and in Dakar. They can form a group and give 100,000 FCFA, 200,000 FCFA and we would divide this money among specifically targeted individuals so that they can receive care." President, MHO B
>
> "[This woman whose husband just died] is obligated today to take care of everything. If, for a certain period, she cannot honor her commitments, this will cause a problem and the MHO funds will feel the effect. We need to sit down and talk about all this." Founding member, MHO A

[5] These are students of Koranic schools who must beg for money for food.

8. Determinants, Participation, and Intermediate Results

The qualitative and exploratory nature of this study does not permit statistical analysis of association between determinants, levels of participation, and intermediate results, as depicted in Figure 1. However, the data do reveal where determinants appear to coincide with higher levels of various dimensions of participation, and indications of intermediate results. Presentation of data (Table 7) in this format is not intended to assert association but rather to provide some initial indications of these links, worthy of further exploration in future research.

Table 7: Possible Associations between Determinants, Dimensions, and Intermediate Results of Social Participation

	Dimensions of Social Participation		
	Social Basis	**Set-up/Design**	**Governance**
Determinants			
Promoter approach		√	
MHO structures: Mgmt organs, decentralization	√		√
Community factors: Leaderships, prior experiences	√	√	√
Provider relations	√		√
Intermediate results			
Member knowledge			
Trust in management			√
Responsiveness	√		√
Ownership	√	√	√
Social Solidarity	√		√

From Table 7, one can see that the social basis appears to coincide with most determinants, with the exception of the promoter approach, and appears most linked with leadership and decentralization. Higher levels of participation in set-up/design of the MHO appear in MHOs with explicit promoter interventions to structure this phase (e.g., constitution of initial working groups) and with MHOs where the base has experiences in working together on other activities (e.g., decision making in early general assemblies). Strong governance aspects of participation seem to occur where leadership and decentralized structures are also strong. The availability of honest and competent leaders appears to affect how willing the communities are to participate, and how long it might take for the necessary social legitimacy to develop.

For links between types and levels of social participation and the various intermediate results, there are indications that trust appears in concert with governance, but does not seem to be linked with the social basis or set-up/design. Responsiveness, trust, ownership, and social solidarity appeared stronger in MHOs with greater participation in governance: in those MHOs that had developed effective mechanisms for engaging a larger number of people in the operational

management (decentralizing many of the functions) and for engaging a larger proportion of the members in general assemblies.

Limited participation of external stakeholders (reflecting the institutional and regulatory environment) appeared to discourage those in MHO management structures, and poor relations or unfavorable behavior of providers discouraged members. This discouragement was evident in most of the study MHOs at some level.

This qualitative study cannot conclude that the associations seen in Table 7 reflect causal links, but they do indicate that the conceptual framework warrants further study and verification.

9. Discussion

The MHO movement has gained in momentum over the last decade. Social participation is an integral component of the MHO, embedded in its very definition. Its importance has been frequently mentioned, but rarely studied. This qualitative research sought to elucidate how much social participation is occurring in the MHOs studied; what determinants affected these levels of participation; and what kinds of results emerged from those MHOs with significant social participation.

> ***How does an MHO define itself?***
> "It is a question of democracy, solidarity, helping each other. Members must pay their premiums regularly so that the MHO can pay the providers… The MHO is not a *tontine*; it is non-profit. It is an issue of democracy because one is free to join or not, no one is forced. The president and a regular member have the same power of decision-making. We always discuss together before taking a decision." Management, MHO F
>
> ***Why create an MHO?***
> "Creating MHOs ensures that poverty does not block access to health care." President, MHO C

What are the forms and intensity of social participation with internal stakeholders? The criteria presented in Table 2 provide a first attempt to articulate the specific processes of social participation expected in a well-functioning MHO. The older MHOs (A, G) had higher overall levels of participation in terms of both the strength of their original links with the community and in terms of ongoing governance. What is now considered standard practice in terms of social participation during the set-up and design stages does not appear to substitute for a broad and organic local desire to develop the MHO or for ongoing participatory governance of the MHO. It appears that the intensity of participation and the range of individuals participating in MHO governance diminished over time in many MHOs.

> "Social participation is the indicator of the sustainability of the MHO. It translates into sharing and ownership of the MHO." ASADEP
>
> "Social participation is the best guarantee of regular payment of premiums and acceptance of policy changes in the MHO." Matar Camara, USAID/Senegal

What are the forms and intensity of social participation of external stakeholders? Participation of external stakeholders in those facets where they are expected to contribute has been quite limited. Providers only participated passively in the promotion of most MHOs[6] and local governments rarely played any role. Two of the schemes in the sample appear to have benefited from a greater involvement and commitment of providers to the promotion of MHOs, but even so it is not clear that the MHOs have been able to translate that systematically into continued collaboration in areas of mutual benefit or interest outside of negotiating prices and contracts.

Local and central governments have vital roles to play in promoting the MHO movement and providing continuing technical, political, and material support. Local government was seen to have a significant role in MHO promotion mainly in one region but not much elsewhere. The central government, through the Ministry of Health, was seen as playing a vital role so far, mainly in extending the MHO experience beyond Thiès to other regions through its *Cellule d'appui aux*

[6] A possible exception here is the promotional role played by St Jean de Dieu Hospital, including the Catholic Diocese of Thiès, especially during the emergence of the MHO movement, and some health facilities outside the zone of MHO A who asked specifically for the MHO to expand to their areas.

mutuelles de santé, aux IPM et aux comités de santé (CAMICS) public education program. The central government has also passed a law on MHOs but perhaps because the legislative instrument (*décret d'application*) for its implementation had not yet been passed, its effect is yet to be seen or appreciated at the grassroots level.

How are MHO management and governance structures related to social participation? The key structures that are supposed to facilitate social participation in the study MHOs are the working group in the initial pre-set-up phase, and then the general assembly, the board of directors, management, and control committee once the MHO is functioning. Most MHOs studied appeared to have strong and trusted leadership and possessed most of these management structures although the control committees were frequently non-functional. However, simply having the structures in place does not mean that they necessarily foster broad participation. Most MHOs continued to be managed by the same small group of individuals, and many were not able to engage fully their general membership. Several MHOs had developed innovative schemes to decentralize the management and policy-making bodies to zonal and village levels. MHO leaders who had understood the special problems involved in ensuring that newer members participate to the same extent as older or founding members had made conscious efforts to bridge this divide by targeted sensitization to upgrade the knowledge, skills, and confidence of newer members.

How do pre-existing community factors facilitate or inhibit social participation? Though the study has not unearthed direct evidence of how pre-existing factors contributed to MHO social participation, the data available suggest that factors such as strong leadership and previous experience in similar social organizations are associated with greater social participation. MHOs A, E, and G, which exhibited high degrees of social participation and strong solidarity and trust, also had relevant previous experience in similar organizations.

What are the results of social participation in MHOs? Spontaneous comments from FGD participants provided evidence that knowledge, trust, responsiveness, ownership, and solidarity are more present in the more participatory MHOs. MHOs with stronger social basis and governance appeared to also perform better in terms of member knowledge, trust, responsiveness, sense of ownership, and social solidarity. The effects of MHO set-up and design were not as clearly linked with these intermediate results, implying that, although participatory processes may be used during start-up, they do not necessarily secure participatory governance in the future.

Occasionally, as in MHO G, trust was found to be limited to those within the same ethnic or religious group. This exclusiveness could likely inhibit the scope for expansion of the MHO.

Another important dimension of social solidarity was found in the caring behavior exhibited between MHO members at times of sickness. This behavior was based on reciprocity rather than charity and indicated a sense of social solidarity among MHO members. This concept appeared fairly well understood (and accepted) by founding members of the MHOs, but less so by newer members.

Cautionary notes about social participation: Da Chunha and Pena (1997) observe that "Participation can make development assistance more effective, but it works best for groups that are already participatory … Discussions of participation cannot ignore issues of political power, local power, populism, and representation ... They cannot avoid the pressure that a dominant group may exert to forge solutions that are morally unacceptable." This issue was highlighted in the discussions of the role for existing social structures or associations in social participation in MHOs. Large strong associations have many advantages that can prove especially crucial to the process of MHO set-up: a pool of skills and experienced managers/leaders, a captive base for recruiting members as well as channels for reaching those members, resources for initial mobilization work, solid mechanisms for

organizing and information sharing, and providing parallel solidarity structures such as credit and saving clubs, etc.[7] However, many associations operating at community level had somewhat dubious reputations and this generated a deserved cautiousness among the MHOs in their involvement. Furthermore, although not in the eight MHOs studied, leaders of the parent association in some other MHOs have been reluctant to support the functioning of democratic bodies of the MHO members because they fear these bodies may come to pose a threat to their leadership and control. This can lead to tensions and in the worst cases outright conflicts that may prove disastrous for the MHO.

The separate structural mechanisms for participatory management that have been consistently promoted for MHOs – management committees, board of directors, control committees -- appear difficult to operationalize at community levels. Many MHOs were not able to maintain regular meetings of the several organs proposed and, in the end, many of the MHOs studied operated with an expanded management committee or a merged board of directors and management committee, and often it was a handful of dynamic individuals that participated rather than the full board/committees. This poses a question of whether what is being proposed is really well suited for voluntary community management.[8]

[7] The dispersion of their membership can, however, create problems for managing and continuing sensitization.
[8] These same practices have also been noted for other types of community associations, and not only for the MHOs.

10. Future Directions

Social participation is key to the functioning of an MHO – it facilitates ownership and engagement necessary for continuous payment of premiums and for management decisions to reflect the needs and aspirations of the membership. The results of this study indicate some areas where MHOs, their promoters, and other external stakeholders need to focus more of their attention if this movement is going to be able to provide a continuously functional mechanism for ensuring access to health care services for parts of the population who currently find it difficult to pay for health services. Although this study cannot answer definitively the question of whether rapid expansion and roll-out of MHOs can create viable and sustainable organizations, it does indicate that attention to social participation throughout the life of the MHO is critical and currently not well thought-out.

Examining the eight MHOs studied, one can see that efforts of the MHO movement in Senegal, led by many promoters, have successfully created mechanisms and strategies for engaging founding members in the process of designing the MHOs. However, the viability and institutional sustainability of the MHOs formed may be doubtful, as the broad initial social participation appears generally to wane over time, and new members do not display the same engagement and understanding as founding members. This raises the question of how to ensure ongoing high levels of social participation in MHO functioning. Social participation arising from the organic process of MHO development is not easily maintained without explicit efforts. Some possible strategies for reaching this goal are outlined below.

10.1 Implications for the MHOs

MHOs should undertake explicit discussions about how to maintain and increase social participation, among both founding and new members. Experience shows that one cannot assume that early levels of social participation of internal stakeholders will continue unabated, or that newer members will be as engaged as the founding members were.

Experiences highlighted in this research indicate some possible mechanisms that can be used (and should be promoted) to overcome the decline in social participation occurring after the creation process. The decentralization of management operations (premium collection, letters of guarantee, payment of local providers) appears to be effective in increasing the number of competent individuals operating in the MHO and in bringing information and communication closer to the membership (GRAIM, 2002). The decentralization of the general assembly (either through zonal operations or through sectoral assemblies) also appears successful in increasing participation. These kinds of initiatives appear to both promote social participation and lead to better overall performance in terms of member recruitment /growth and rate of dues' recovery.

10.2 Implications for Promoters and the State

Increasing social participation also requires the attention of promoters. Both through research and technical assistance, MHO promoters, in collaboration with government, can make a significant

contribution to the exploration and promotion of strategies and tools that facilitate ongoing internal stakeholder social participation. For the external stakeholders, clear roles and frameworks for collaboration with both providers/health committees and local authorities would assist in arriving at productive relationships that support the MHO movement in a constructive manner. This is important for building trust relations among the various stakeholders (Schneider, 2004). The definition of an MHO is that it is an autonomous organization; autonomy here refers to its self-governance, not necessarily to its ability to be completely self-sufficient. While the need for some technical assistance is widely accepted for the development and expansion of MHOs, there is also a need for political and some financial assistance (such as office space, subsidies to poorer families) to ensure their viability and their ability to serve their whole communities (and not just those who are better off).

It is clear that the role of promoters and technical assistance may need to extend beyond the first general assembly. Promoters need to explore how their resources can best be used to promote ongoing social participation, internally and externally, by providing training for providers and local authorities, and assisting the MHOs to effectively decentralize once they reach a certain size.

The MHO movement appears to provide a mechanism capable of reducing the financial risk of accessing health care to many living in both urban and rural areas of Senegal. However, the results of this study indicate that rapid roll-out of this movement risks falling short of its objectives of sustainable and viable community-based health insurance organizations, if all concerned do not recognize the critical role of social participation and focus attention on promoting mechanisms for maintaining social participation.

Annex A: Focus Group Discussion Guides Used in the Study

a) Guide d'entretien destiné aux dirigeants des mutuelles

1. D'où est venue l'idée de création de la mutuelle et comment la mutuelle a t-elle été créée ?

- Si la mutuelle a été créée à partir d'autres associations, comment ces associations fonctionnaient-elles ?
- Approfondir la question du rôle que les initiateurs de la mutuelle ont au sein de la communauté (relations avec les leaders de la communauté et avec les autorités politiques

2. Quelles ont été les étapes de création de la mutuelle ? (Approfondir cette question jusque dans les détails). A chaque étape quels sont les membres qui ont été impliqués et quel a été leur type d'implication ?

3. Comment la mutuelle est-elle gérée? Comment le bureau et les autres organes sont élus ? combien de fois y a t-il eu élection des organes ? Comparer la composition des organes d'une élection à l'autre ; S'informer sur les raisons des permanences ou des changements éventuels.

4. Comment les différents membres participent-ils à la prise de décision et aux activités quotidiennes (dirigeants/membres simples) ? Prendre assez de temps pour les réponses et pour la clarification de cette question avant de continuer. Approfondir la question en évoquant la participation aux réunions, aux sessions de formation, aux activités de sensitization et autres. Chaque fois, s'intéresser au pourcentage de membres impliqués.

5. A votre avis, une plus grande participation des membres a t-elle des incidences sur le fonctionnement de la mutuelle, Lesquelles ? Donnez des exemples.

b) Guide d'entretien destiné aux membres des mutuelles

1. D'où est venue l'idée de création de la mutuelle et comment la mutuelle a t-elle été créée ? Si la mutuelle a été créée à partir d'autres associations, comment ces associations fonctionnaient-elles ? Approfondir la question du rôle que les initiateurs de la mutuelle ont au sein de la communauté (relations avec les leaders de la communauté et avec les autorités politiques.

2. Quelles ont été les étapes de création de la mutuelle ? A chaque étape quels sont les membres qui ont été impliqués et quel a été leur type d'implication ?

3. Comment la mutuelle est-elle gérée ? Comment le bureau et les autres organes sont élus ? combien de fois y a t-il eu élection des organes ? Comparer la composition des organes d'une élection à l'autre ; S'informer sur les raisons des permanences ou des changements éventuels.

Approfondir en demandant si on peut en savoir plus sur les dirigeants de la mutuelle (noter que dans un focus group, certains peuvent avoir peur d'apparaître comme des délateurs).

4. Comment les différents membres participent-ils à la prise de décision et aux activités quotidiennes (dirigeants/membres simples) ? Prendre assez de temps pour les réponses et pour la clarification de cette question avant de continuer. Approfondir la question en évoquant la participation aux réunions, aux sessions de formation, aux activités de sensitization etc. Chaque fois, s'intéresser au pourcentage de membres impliqués. Voir s'il n'y a pas d'autres formes par lesquelles les membres participent à la vie et au développement de la mutuelle.

5. Comment êtes vous informés sur la marche de la mutuelle (pour voir s'ils sont réellement informés)? A la prise de quelles décisions participez-vous ? Avez vous le moyen d'influer sur les décisions majeures relatives à la mutuelle ? Comment ?

6. A votre avis, une plus grande participation des membres a t-elle des incidences sur le fonctionnement de la mutuelle, Lesquelles ? Donnez des exemples.

c) Guide d'entretien destiné aux prestataires de service

- De quand datent vos relations avec la mutuelle ?
- Quelles sont les relations que vous entretenez avec la mutuelle?
- Que savez-vous du processus de conception et de développement de la mutuelle ?
- Avez-vous été impliqué à certaines étapes de la conception et du développement de la mutuelle ? Comment ?
- Pour ce que vous en savez, qu'en a t-il été de la participation sociale aux différentes étapes du développement de la mutuelle ?

  a. Peut-on dire que les membres sont réellement impliqués dans les activités de la mutuelle ?

  b. Comment les dirigeants ont-ils été choisis ?

  c. Comment se prennent les décisions ?

  d. Quel est le rôle des femmes dans la mutuelle ? Participent-elles à la prise des décisions ? Comment ?

  e. A votre avis, une plus grande participation des membres a t-elle des incidences sur le fonctionnement de la mutuelle, Lesquelles ? Donnez des exemples.

- Quels sont les résultats produits par les activités des mutuelles,

  a. en termes de réduction de la fraude et des détournements

  b. en termes d'amélioration de l'offre et de la couverture sanitaire

  c. en termes d'amélioration de la qualité de service

d. en termes d'accroissement de l'utilisation des services

e. en termes d'accès des pauvres et des populations mal desservies aux services

Annex B: Characteristics of the Eight MHOs Studies

MHO	A	B
Promoting organization	PHR*plus*: assistance came long after start-up, support for decentralization process already underway	PHR*plus*: assisted with design, feasibility study, training and ongoing support
Start date	No feasibility study 1997 contributions collected (18 months) 1998 meeting of members 9/1998 General Assembly 10/1998 Services start Annual GAs	GA 1/2002
Working group composition	Informal working group, originally formed by ex-members of the management committee of an existing MHO, but gradually enlarged with delegates from participating neighborhoods	Representatives from the various associations and women's groups in the area
Type of MHO	Rural community-based MHO (male and female)	Urban community-based MHO (male and female)
Nb. members	998 members	304 members
Nb. beneficiaries	6300)	913 beneficiaries
% members up to date	50%	27%
Membership (cost of membership booklet)	1650 FCFA + 1500 F for photos	200 F/beneficiary
Regular contributions per beneficiary (monthly)	200 FCFA	200 FCFA
Services covered	60% of primary care, 50% hospital costs (up to 10 days) and including Cesarean sections, surgery, curettage MHO pays everything and members reimburse the 50%	At health post, MHO members pay 625 FCFA covering ticket, consultation, and drugs. This is based on a fixed price of 1250 FCFA (MHO pays the other 50%). At health center, hospital – 50% hospitalization, laboratory, generic drugs (no limit on length of stay)
Waiting time	18 months	
Source of care	12-13 health posts and a mission hospital that gives a reduction of 45% of hospitalization and 25% of surgery costs	Health post, health center, and regional hospital
Population in catchment area	60 villages in four rural communes	
Executive office/committee	Eight zones, each with manager and board of directors who receive a small motivation payment Most positions in management organs are held by men	Voluntary President is female, while rest of management organs are mixed

MHO	C	D
Promoting organization	PHR*plus*: assisted with design, feasibility study, training and ongoing support	BIT-STEP: training and sensitization activities, plus some start up funds
Start date	General Assembly 2002	GA 10/1998
Working group composition	Representation of the various neighborhoods	Representation of the various women's groups that make up the women's association
Type of MHO	Rural community-based MHO (male and female)	Urban MHO for members of association of women's groups, but now includes women participating in their savings club
Nb. members	486 members	101 women members
Nb. beneficiaries	1029 beneficiaries	2275 (men, children, women) – up to 15 beneficiaries per member
% members up to date*	42%	48%
Membership (cost of membership booklet)	500 FCFA	1200 FCFA
Regular contributions per beneficiary (month)	160 FCFA	200 FCFA
Services covered	600 FCFA for prenatal care, deliveries, vaccinations or curative services using drugs available at the health post. This is based on fixed price of 2,040 FCFA, of which MHO pays 70%.	MD consults M/Th at association office (for 500F), 100% of basic curative care, pre-/post-natal care, x-ray, sonogram, laboratory, hospitalization (7-10 days) at health center, 50% (non-generic) prescription costs, generic drugs sold at MHO office
Waiting period	3 months	
Source of care	One health post	4 health centers; 1 family health clinic
Population in catchment area	13 villages	2800 association members at the time of MHO start-up
Executive office/committee	Voluntary President is female, rest of management organs are mixed	MHO manager and assistants (for drug sales) paid by association; association animators help with sensitization All members of management organs are women

* Data on membership (number of members and beneficiaries, and premium recovery rate) collected by PHR*plus* independent of FGDs in 2004.

MHO	E	F
Promoting organization	BIT-STEP: training, sensitization activities, brochures	BIT-STEP: training for feasibility study and other trainings
State date	1998 General Assembly 1999 GA extraordinaire 2002 Second GA	12/2000 GA 6/2001 services started GAevery year
Working group composition	Representation of the various women's groups that make up the women's association	Representation of the various women's groups that make up the women's association
Type of MHO	Urban and rural MHO for members of association of women's groups, but now includes women participating in their savings club	Urban MHO for women's groups
Nb. members	954 members	196 women members
Nb. beneficiaries	3030 (men, children, women) – up to 15 beneficiaries per member	337 (men, children, women), up to 18 beneficiaries per member
% members up to date*	70%	11%
Membership (cost of membership booklet)	1200 FCFA	1000 FCFA
Regular contributions per beneficiary (month)	200 FCFA	200 FCFA
Services covered	100% of hospitalization up to 12 days, 50% of drug costs (both generic and brand name) that are purchased by MHO, 40% of delivery costs, 50% sonograms, and 100% of prenatal care	100% for consultation, 50% for laboratory analysis and generic drugs, 100% for normal deliveries, and up to 50,000F for complicated delivery.
Waiting period	3 months	3 months
Source of care	Mission hospital (which provides discount on services), 3 health centers, 3 health posts, 2 pharmacies (regional hospital will be added soon)	Health center
Population in catchment area	Approximately 3000 association members at the time of MHO start-up	40,000 inhabitants; 14 neighborhoods
Executive office/committee	MHO manager and assistants (for drug sales) paid by association; association animators help with sensitization (some transportation, however, paid by association up to 2004) All members of the management organs are women	All voluntary All members of management organs are women

* Data on membership (number of members and beneficiaries, and premium recovery rate) collected by PHR*plus* independent of FGDs in 2004.

MHO	G	H
Promoting organization	PROMUSAF: assistance came long after start-up – provided funds for an office	PROMUSAF : training, sensitization, carnets (had assistance from local NGO before)
Start date	No feasibility study 1/1994 2/1996 services started General Assembly every year	2/1999 GA 7/1999 second GA 11/1999 – services start Other GAs for re-elections of the management committee, for sensitization, and for re-launching MHO
Working group composition	Informal working group including the Young Men's association and other interested parties	Representatives of the various associations and women's groups in neighborhood; current president was *not* part of working group
Type of MHO	Rural community-based MHO (male and female)	Urban community-based MHO (male and female)
Nb. members	372 members	206 members (101 men and 104 women)
Nb. beneficiaries	1732 beneficiaries	1030 beneficiaries (up to 5 beneficiaries)
% members up to date	71%	27%
Membership (cost of membership booklet)	1000 FCFA	1000 FCFA
Regular contributions per beneficiary (monthly)	200 FCFA	500 FCFA (for 5 beneficiaries or 100 FCFA per beneficiary)
Services covered	50% of cost of care (45% at hospital up to 15 days, surgery and lab 40%) MHO pays and members reimburse their part, even for services not covered by the MHO	All services up to 2,000 FCFA (including drugs). Above this, the MHO pays and the member reimburses. Members do not pay for the ticket.
Waiting time	1 year	5 months
Source of care	Mission hospital (which provides discount); 3 dispensaries	Health post and military garrison health post
Population in catchment area	Everyone is covered in the first two villages – covers 4 villages	20,000
Executive office/committee	Voluntary All members of management organs are men, with one exception	Voluntary Management organ positions are held by both men and women

Annex C: Dimensions of Social Participation in MHOs

a) Criteria related to social basis of MHO

Social basis of MHO – origins embedded in target community: that the origins of the MHO were embedded in the target community, such that they had a sense of ownership of the idea and start-up processs.

Social basis of MHO: inclusiveness of current membership: that MHO membership is open to all within the catchment area of the scheme who wish to join, such that membership is not constrained and the notions of social solidarity can take hold.

b) Criteria related to involvement in design and set-up of the MHO

Feasibility study: that a large group of individuals are provided with skills, experience, and awareness of information collected about the community.

Definition of scenarios: that a large group of individuals works with community and provider data, interpreting them, and thinking through a range of options such that this large group understands the tradeoffs in premiums and benefits package contents.

Initial policy decisions: that a large proportion of the general membership hears about multiple scenarios such that they also understand the tradeoffs.

Sensitization: that the general membership feels engaged enough in the MHO to participate in gaining new members and retaining current members and see it as their responsibility.

c) Criteria related to governance of the MHO

Autonomy of MHO: that members make decisions about the scheme (benefits, dues, structure, management positions, providers, etc.), without external control, such that it is the members only who make the decisions about the MHO and not non-members of the scheme (e.g., those of a wider body to which the MHO is related but who are not members).

Operational management decision making: that the number of people making operational decisions is as great as possible – that the management organs are fully operational and meet regularly to be able to share information (executive committee and board of directors).

Frequency of elections: that members are offered frequent/regular opportunity to change or confirm their leaders, and to demand accountability of existing or outgoing ones.

Frequency of general assemblies: that ordinary members have the opportunity to have a direct say over how the affairs of the MHO are run.

Frequency of activity reports to members: that members have information about the activities and performance of the MHO, such that there is accountability and that members can effectively participate in the affairs of the scheme.

Report presentation to members: that members can "access" the information in reports on activities and performance such that they can absorb and interpret it (that it is presented in a form they can understand.

Resolving members' problems and issues: that the general membership communicates their issues to management and that their concerns and suggestions are heard and discussed.

Ongoing policy decisions: that ongoing policy decisions (changes in premiums, benefits packages, and/or providers, or expanding membership beyond original target community) are discussed and decided on fully with the general membership.

Annex D: Bibliography

Arhin-Tenkorang, Dyna. 2001. *Health Insurance for the informal Sector in Africa: Design Features, Risk Protection, and Resource Mobilization*. World Bank, HNP Discussion Paper September 2001.

Atim, C. 1998. *Contribution of Mutual Health Organizations to Financing, Delivery, and Access to Health Care: Synthesis of Research in Nine West and Central African Countries*. Technical Report. Bethesda, MD: Partners for Health Reform.

CAS/PNDS/Partenariat, Ministère de la Santé, République du Sénégal. July 2004. *Plan Stratégique de Développement des Mutuelles de Santé au Sénégal*.

Criel,B. and Waelkens M. 2003. "Declining subscriptions to the Maliando Mutual Health Organization in Guinea-Conakry (West Africa): What is going wrong?" *Social Science and Medicine* 57: pp. 1205-1219

Da Cunha P. V. and Pena M.V.J. 1997. *The limits and merits of participation*. Policy Research Working Paper. Washington, DC: World Bank.

Eyre R. and Gauld R. 2003. "Community participation in a rural community health trust: the case of Lawrence, New Zealand." *Health Promotion International* 18(30 Sept 2003): pp 189-197.

GRAIM*:* Coordination Régional des Mutuelles de Santé de la Région de Thiés et de Diourbel. 2002. *Décentralisation et gestion démocratique: Compte Rendu d'atleier*. Sénégal, 26-27 février 2002.

Massiot, N. 1997. *Contribution actuelle et potentielle des Mutuelles de santé au financement, à la fourniture et à l'accès aux soins de santé*. Dakar: Cas du Sénégal.

Rifkin, S, Muller F, and Bichmann W. 1988. "Primary Health Care: On Measuring Participation." *Social Science and Medicine* 26(9): pp 931-940.

Sachs, Jeffrey D. 2001. *Macroeconomics and Health: Investing in Health for Economic Development*. Report of the Commission on Macroeconomics and Health. Geneva: World Health Organization.

Schneider, P. 2004. "Trust in Micro Health Insurance: An exploratory study in Rwanda." Draft submitted for publication.

Tikare, S, Youssef, P, Donnelly-Roark, and Shah, P. 2001. "Organizing Participatory Processes in the PRSP" In PRSP Sourcebook. Washington DC: World Bank.