



# Guide to COOPERATIVE APPROACHES *to* COMMUNITY HEALTH

Tools, Tips & Lessons for Greater Participation and Sustainability of West African Health Mutuels



## ABOUT THIS GUIDE

This guide was made possible by the generous support of the American people through the United States Agency for International Development (USAID) and its Cooperative Development Program. The contents are the responsibility of the National Cooperative Business Association and do not necessarily reflect the views of USAID or the United States Government.

This guide was produced by the staff and consultants of the National Cooperative Business Association and its CLUSA International Program, including Papa Sene, Director for West Africa; Beth Melby, Community Health Project Manager; Ted Meinhover, Assistant Project Manager; E.G. Nadeau, Technical Consultant; and Marcia Yudkin, Editor. The guide was designed by Andrea Klores of Klores Design.

Free downloadable copies of this guide are available in English and French at [http://www.ncba.coop/clusa\\_news.cfm](http://www.ncba.coop/clusa_news.cfm).

## ABOUT NCBA'S CLUSA INTERNATIONAL PROGRAM

Founded in 1916 as the Cooperative League of the USA, the National Cooperative Business Association is the oldest national cooperative development and trade association in the USA. Working worldwide under the name CLUSA, NCBA has delivered quality technical assistance to cooperatives, civil society organizations (CSOs), nongovernmental organizations (NGOs), local governments, member-owned businesses, and village-level associations in 79 countries. CLUSA works at the grassroots level to build individuals' and organizations' capacity to organize and manage cooperatives in a number of sectors including agriculture, production, and community health. The CLUSA Approach is founded on the belief that our clients are the decision-makers when it comes to confronting their communities' most pressing development problems and can be empowered through customized training and assistance to articulate and design sustainable, locally-generated solutions.

Guide to  
**COOPERATIVE  
APPROACHES** *to*  
**COMMUNITY HEALTH**

Tools, Tips & Lessons for Greater Participation and  
Sustainability of West African Health Mutuals



1401 New York Ave. NW, Suite 1100 • Washington, DC 20005 • USA  
Phone: 202-638-6222 • Fax: 202-638-1374 • E-mail: [international@ncba.coop](mailto:international@ncba.coop)

[www.ncba.coop](http://www.ncba.coop)

# CONTENTS:

---

HOW TO USE THIS GUIDE .....	1
INTRODUCTION .....	2
THE RESEARCH FINDINGS.....	3
ORIGIN OF THE COOPERATIVE PRINCIPLES .....	4
<b>COOPERATIVE PRINCIPLE #1:</b> VOLUNTARY AND OPEN MEMBERSHIP.....	5
<b>COOPERATIVE PRINCIPLE #2:</b> DEMOCRATIC MEMBER CONTROL .....	8
<b>COOPERATIVE PRINCIPLE #3:</b> MEMBER ECONOMIC PARTICIPATION.....	11
<b>COOPERATIVE PRINCIPLE #4:</b> AUTONOMY AND INDEPENDENCE .....	15
<b>COOPERATIVE PRINCIPLE #5:</b> EDUCATION, TRAINING AND INFORMATION .....	18
<b>COOPERATIVE PRINCIPLE #6:</b> COOPERATION AMONG COOPERATIVES .....	21
<b>COOPERATIVE PRINCIPLE #7:</b> CONCERN FOR COMMUNITY .....	25
CONCLUSION .....	28

---

# HOW TO USE THIS GUIDE

This guide leads the reader through the major lessons learned from recent research and analysis on West African health mutuals. It also introduces and utilizes the Cooperative Principles as a framework for improving the economic performance of existing health mutuals as well as health outcomes; for mobilizing greater and more meaningful community participation in their formation; and enhancing their operation and deepening their impact in promoting health-seeking behavior.

Rather than a comprehensive, “how-to” manual, this guide highlights key issues related to the success and failure of the health mutuals in the study and presents approaches to community health that are rooted in the seven Cooperative Principles. By combining the lessons learned and recommendations from the research project with the National Cooperative Business Association’s (NCBA) over fifty years of experience promoting community-based development in Africa, the guide suggests more holistic ways for mutuals and other community-based health organizations to make a measurable impact on the lives of their intended beneficiaries.

This guide is designed to serve as a resource for local communities, mutuals, non-governmental organizations (NGOs), other development organizations, primary and secondary health care personnel, public and private donors and anyone else interested in strengthening the role of mutuals in improving community health or in increasing local leadership of and participation in community health strategies.

Mutuals and cooperatives both exist today and are promising means by which people can organize themselves to access health-related services. Though some mutuals may be suited for full transformation into a cooperative to provide services, some mutuals may be better suited for the adoption of more cooperative

strategies and organizational structures to enhance their sustainability, delivery of services and community participation. This guide does not prescribe one entity over the other but rather believes that community members should be empowered to make the choice based on their needs and the local context.

NCBA, through its CLUSA International Program, will draw from this guide when implementing a series of workshops in Benin, Burkina Faso and Mali for interested organizations and individuals in 2009. These workshops will serve as “Trainings of Trainers” for participants from health mutuals, NGOs, and others who want to improve their methodology and make a greater, more sustainable impact on community health in West Africa.



# INTRODUCTION

Beginning in the summer of 2007, CLUSA embarked on a research endeavor to apply its expertise and experience in cooperative development to a type of organization that is highly visible in West Africa, mutual health organizations, also known as mutuals or *mutuelles*. Mutuals are health-related, risk-sharing associations operating at the local community level. Health cooperatives are similar to mutuals but emphasize democratic control by members and other cooperative principles.

of these factors with the spread of deadly diseases such as HIV/AIDS has resulted in generally poor health outcomes across sub-Saharan Africa, with only slight improvements over time.

CLUSA's interest in health mutuals stems from our full commitment to the communities we have served in the past 50 years of international development activities. Traditionally recognized for our work to promote cooperative entities and producer organizations as a



Since the late 1990s, mutuals have received significant attention and support from international development practitioners, researchers and donors with respect to their potential as a means for financing health care at the local community level in sub-Saharan Africa, particularly in West and Central Africa.

Centrally funded health care in sub-Saharan Africa is inadequate. Budget cutbacks since the 1970s have reduced the financial resources available within the entire system of care – from Tier One (local community health depots) all the way to Tier Four (national hospitals). Consequently, comprehensive services do not reach deep into communities, making accessible services and quality care scarce. With financial and human resources stretched thin, emphasis is often on basic curative care for those who present with an illness. Though prevention also ranks high in importance for Ministries of Health, most families have a mindset of curing what is ailing, rather than taking preventive measures. The convergence

means to improve livelihoods and productivity, we extended our work to tackle community health concerns, which were frequently voiced by agricultural clients and their families. Without good health, productivity, profits, and community unity all diminish. Because we could not ignore this fact, CLUSA has looked beyond our traditional scope of work to search for solutions to the health problems identified by community clients.

Accordingly, CLUSA undertook a study to determine an effective method of contributing to health service delivery. We noted that the typical mutual has some cooperative aspects but falls short of being a true cooperative when evaluated against the yardstick of the seven internationally accepted Cooperative Principles. The research study provided a factual basis for recommendations on specific ways that the cooperative model might help improve the sustainability of mutuals in West Africa.

# THE RESEARCH FINDINGS

In May 2008, the West African Health Cooperative Project released a research report that used fieldwork, a literature review and interviews to assess the performance and potential of 30 health mutual organizations in the West African countries of Benin, Burkina Faso and Mali. The mutuals – health-related, risk-sharing associations operating at the local level with some characteristics of rudimentary cooperatives – help make health care available at low cost. The study’s findings included the following:

- The majority of mutuals seemed to be doing a good job of delivering health insurance services and improving members’ health. Interview and focus group participants reported that members more frequently sought out health services than non-members.
- Mutual membership made health care services and information more accessible for members, resulting in improved health and a reduction in risky behaviors.
- Minimal community participation took place during the initial design and establishment of the mutuals. Indeed, in all but three of the communities visited, the goal of forming a mutual came from outside the community, and in almost all cases, recommendations in the outsiders’ feasibility studies were adopted without changes.
- None of the communities carried out research prior to establishing the mutual to determine the health needs and priorities deemed most important by community residents and whether a mutual would meet those needs.
- Few mutuals had undertaken long-term strategic and financial planning.
- A majority of the mutuals provided insurance services to less than 5% of their communities.
- In more than half of the mutuals, 50% or more of beneficiaries were not current in their payments.
- In 25 of the 30 mutuals, the role of paid staff was filled by often temporary and less trained volunteers.



This guide provides specific recommendations for improving the long-term prospects of the mutuals by bringing together the seven fundamental principles of cooperative associations with observations from the research study. Whenever possible, successes from the mutuals studied illustrate specific ways of applying approaches grounded in the Cooperative Principles so as to bring about scaled-up improvements in the health of West African communities.

# ORIGINS OF THE COOPERATIVE PRINCIPLES

The modern seven Cooperative Principles are the core of the **Statement on the Co-operative Identity** adopted at the 1995 Congress and General Assembly of the International Co-operative Alliance (ICA). These principles have their historical roots in the Rochdale Principles which were first articulated in 1844 as a set of ideals for the operation of cooperatives. These ideals have been revised on three occasions, most recently in 1995 by the ICA, in an effort to capture the state and needs of the cooperative movement at the end of the twentieth century. The ICA sets forth the values of self-help, self-responsibility, democracy, equality, equity and solidarity as fundamental values for all cooperatives. Furthermore, in the tradition of the founders of the modern cooperative movement, co-operative members believe in the ethical values of honesty, openness, social responsibility and caring for others. The seven Cooperative Principles are the guidelines by which co-operatives put their values into practice.



# COOPERATIVE PRINCIPLE #1: VOLUNTARY AND OPEN MEMBERSHIP

**C**ooperatives are voluntary organizations, open to all persons able to use their services and willing to accept the responsibilities of membership, without gender, social, racial, political or religious discrimination.

Here “voluntary” implies not only freely chosen but also chosen with a full understanding of the rights, responsibilities and procedures of membership. Accordingly, prior to the formation of a mutual, there must be an extensive participatory process involving as many sectors of the community as possible. In addition, instead of coming into the community with the purpose of forming a mutual, organizers should facilitate good decision-making on whether or not a health mutual or some other structure best fits local needs.

As a business, a health mutual has to attract an optimum number of paying members to sufficiently bear the financial risk of paying for the health care of members who become ill. Only through a proactive and genuine process of engagement that provides venues and opportunities for local residents to voice questions, concerns and opinions can the true demand for a mutual be ascertained. High demand increases the chances of long-term financial viability.

## ELEMENTS OF A COOPERATIVE ENGAGEMENT PROCESS

- Enter into a genuine engagement process with local residents to educate them about health organization options and the process. This should include formation of a local health task force through which delegates from neighborhoods can come together to formulate ideas, ideas can be taken back to communities for discussion, and community interest and concerns can be reported back.
- Encourage participation by all segments of society, including women, indigents, and other traditionally marginalized groups. The task force can get wide input through household interviews, discussion groups, surveys of health providers and reviews of community members.
- Work with local leaders and organized women, youth, faith-based and producer groups as well as established business associations, which can each provide a structure through which information can be shared

and disseminated. Build on the local leadership and community organizations, which have much to offer in the way of existing social networks, human capital and expertise on the local environment.

Preparatory work by women’s associations in Tanguin Dassouri, Burkina Faso and Zegoua, Mali helped get the mutuels there off to a good start. In Doumanzana, a neighborhood on the edge of Bamako, Mali, a local doctor, a community based NGO and the *chef de village* took the lead in initiating a feasibility study and developing an innovative mutual that operates a clinic as well as providing health insurance. The mutual in Bobo Dioulasso in western Burkina Faso also launched successfully with members primarily from 20 associations of self employed people and small businesses. In most cases, however, the mutual design did not adequately take into account the local environment and organizations already active within the community. In Mopti and Bara, Mali, NGOs working with successful women’s organizations to develop health mutuels have recommended implementations contrary to the preferences or circumstances of the women’s associations.

- Support a participatory feasibility study whereby community residents take part in evaluating proposed activities. Instead of rubber-stamping outsiders’ proposals, community meetings should be geared toward identifying high-priority health-related issues and strategies that address those issues appropriately given the local context. This process helps generate more realistic planning, creates a sense of ownership among residents and indicates whether a mutual, or another community-based health financing scheme, will receive sufficient community support.
- Invite continuing community engagement. Besides holding meetings, post documents such as feasibility study results and the community health plan in communal locations in the local language. Have dialogue sessions with district health staff, community health committees and other government or community stakeholders to discuss the findings and the way forward.





# COOPERATIVE PRINCIPLE #2: DEMOCRATIC MEMBER CONTROL

**C**ooperatives are democratic organizations controlled by their members, who actively participate in setting their policies and making decisions. Men and women serving as elected representatives are accountable to the membership. In primary cooperatives members have equal voting rights (one member, one vote) and cooperatives at other levels are also organized in a democratic manner.

A democratic process for forming a health mutual begins with a community-led health assessment that provides a basis for determining whether or not forming a mutual is a community priority. If it is, the next step is a community health action plan, with input from community members on reviewing, amending, approving or disapproving the plan. Methods of member input must continue to be built into the planning and management process if the mutuals are to succeed.

## GUIDELINES FOR DEMOCRATIC MEMBER CONTROL

- Community members always retain the power to decide whether or not to form a mutual and continue its operation.
- Members decide on rules and regulations for the mutual's operation.
- Members must control the process of designing the mutual to respond to local needs and the local situation. Besides increasing member commitment to the ultimate program, such participation often leads to innovative solutions well-suited to a particular community.
- Elect and train a committed, representative board of directors. Develop and maintain a healthy relationship between the board of directors and management.
- Hire a part-time or full-time paid manager or accountant. The feasibility study or improvement plan should always include a clear plan and timetable for hiring and training paid staff. Otherwise, the mutual risks overly

relying on a few volunteers, who tend to “burn out.”

In some communities, it might be appropriate to create an in-kind compensation package for staff generated from donated communal labor on staff members' farms or payment in crops or local artisan products.

- Monitor and evaluate the mutual's performance in a manner that is accountable to the community. The research study rated 13 of the 30 mutuals as having a low or very low potential for sustainability. A cycle of planning, implementation and evaluation raises the odds for success. That is, revise the plan using the results of the evaluation, implement the revised plan, evaluate its results and repeat the cycle again and again. A part of the evaluation should be tracking of the mutual's financial performance and evaluating financial indicators (e.g., premiums paid, co-pay collected, treatment costs incurred) with stakeholders, including the board of directors, members, community leaders, and service providers. This is an important way to keep them involved and motivate continued participation in and improvements to the program. Consistent tracking of performance can also help ensure that the entity is economically viable, is efficiently providing services and is fulfilling its original purpose.
- Facilitate community feedback by maintaining open records in both the official and the local languages, involving mutual members in setting and reviewing annual performance goals and objectives, holding open board meetings and actively seeking out questions and comments on the mutuals' operations.
- In already established mutuals, especially those facing financial or operational problems, carry out a mutual improvement planning process that assesses the problems of the mutual and makes recommendations for its future. With democratic involvement, residents decide either to dissolve the mutual or continue its operation in a manner that has an increased likelihood of success.

In about one third of the mutuals in the study, it was apparent that the organization was in good hands. The board members and general members who participated in the interviews were enthusiastic about the mutual, kept careful books and had plans for the future. This kind of knowledge and commitment results from good preparation for the startup of the mutual, involvement of established and potential leaders during the development phase and effective training so they have the skills to direct and manage the association once it is up and running.





# COOPERATIVE PRINCIPLE #3: MEMBER ECONOMIC PARTICIPATION

**M**embers contribute equitably to, and democratically control, the capital of their cooperative. At least part of that capital is usually the common property of the cooperative. Members usually receive limited compensation, if any, on capital subscribed as a condition of membership. Members allocate surpluses for any or all of the following purposes: developing their cooperative, possibly by setting up reserves, part of which at least would be indivisible; benefiting members in proportion to their transactions with the cooperative; and supporting other activities approved by the membership.

The cooperative approach points the way toward entrepreneurial solutions that overcome the limitation of relying solely on mutual members' dues and fees – a problem affecting all the mutuals visited in the research study. Equally crucial is developing a feasible system for collecting premium payments from mutual members. This pays huge dividends later in financial health, high morale of volunteers and commitment of members and beneficiaries. Several mutuals in the study collect membership fees and premium payments in a way that fits local conditions.

## IDEAS FOR MEMBER ECONOMIC PARTICIPATION

- Conduct a participatory viability study and draw up an operating and financing plan. In contrast to the feasibility study, the viability study looks at the economic and business environment for long-term financial viability of the mutual.
- Develop realistic membership and beneficiary goals and objectives for a potential geographical catchment area and track progress toward those goals on a regular basis.
- Include a sustainability plan in the original feasibility study, including a strategy for expanding members and beneficiaries to increase the economic base for operations support.

- Involve established community groups in collecting fees and premiums from their members.

The women's groups in the area around Tanguin Dassouri, Burkina Faso and over 40 subgroups in the Kemon area of Benin handle premium collections for their mutuals. Respondents told researchers that only 4% of the premium payments for the former mutual and 1% for the latter are delinquent.

- Consider hiring a paid collection agent.

The mutual in Honhoue, Benin pays a local agent a 3% commission to collect premiums. This approach may work in areas where strong local solidarity groups do not exist. Such commissions could also become an incentive for community groups, which could use the commissions to carry out community improvement projects or subsidize premiums for poor residents.

- Develop systems for accepting crops as in-kind payments or guarantees.

Kemon, Benin has a successful in kind guarantee scheme that assists members to store crops during the period of low prices immediately after the harvest and to sell them later when prices recover. This gives members a good return on their crops and also makes it easier for them to pay their premiums. An approach along these lines might play a critical role elsewhere in recruiting or retaining members who would otherwise find it difficult to pay premiums on time

*(Continued on the next page)*

## COOPERATIVE PRINCIPLE #3: MEMBER ECONOMIC PARTICIPATION *(continued)*

- Create loan programs to pay for premiums.

In Guilmaro, Benin, the cotton co op uses a loan from the local credit union to pay members' mutual fees and then deducts those payments from members' cotton checks. This approach may work well in other communities where there is a convenient means to deduct the loan repayment from the borrower's future income. Individual loans are riskier and could result in increased member debt and default on the loans.

- Develop a business approach that includes diversified sources of income. Two of the mutuals visited by researchers are starting to explore gardening and farming projects as sources of revenue. Other options are health-related economic activities, such as selling over-the-counter medication, mosquito nets, and drinkable water, or organizing health markets that bring health services direct to the community. Small business options may suit some communities, including chairs and canopies rental, a small village shop, or some sort of joint venture with a local entrepreneur.

Twenty women's groups in Zegoua, Mali cultivate communal gardens and use the proceeds to pay for members' health care costs. In Gamia, Benin some members set aside individual plots to grow fruits and vegetables for the local market to pay family insurance premiums; the mutual has developed a system for storing members' produce as a guarantee for their premium payments. In communities that depend on cotton for cash earnings, these gardens can provide an important hedge against the uncertain price of cotton on the international market.

- Establish a reserve fund for emergencies. The easiest way to do this is to deposit membership fees in the emergency reserve account and use beneficiary payments for health services, drugs and the ongoing operation of the mutual.

Two of the mutuals in the study averted financial disaster by maintaining an emergency reserve fund. The mutual in Lena, Burkina Faso dipped into its reserve fund to stem an outbreak of meningitis. The mutual in Guilla, Burkina Faso used its reserves to offset a very bad farming season that prevented many members from paying their premiums on time. In both cases, the mutuals built their reserves back up after the crisis passed.







# COOPERATIVE PRINCIPLE #4: AUTONOMY AND INDEPENDENCE

**C**ooperatives are autonomous, self-help organizations controlled by their members. If they enter into agreements with other organizations, including governments, or raise capital from external sources, they do so on terms that ensure democratic control by their members and maintain their cooperative autonomy.

To thrive, mutuals should pursue partnerships with health providers, NGOs and government entities as long as such relationships are consistent with the autonomy of the mutuals. Strategic planning with the aid of partners helps keep the organization on track with healthy autonomy.

## STEPS FOR ENSURING AUTONOMY AND INDEPENDENCE

- Guard autonomy by shielding mutuals from outside influence or attempts to control the organizations, which could come from NGOs, politicians, health personnel, etc. Autonomous decision-making is crucial even if the direction from outside forces appears beneficent.

Researchers concluded that the mutual in Klouekanme, Benin had formed due to national and local politics rather than serious local interest in having a mutual. It appeared that community leaders had pressured people into joining the mutual. Although 465 people paid membership fees of \$2.15, when it came time to pay premiums, the vast majority of members balked.

- Develop a clear agreement with health providers on the role and responsibilities of the community and providers vis-à-vis each other. Besides a good written agreement covering the relationship, create a process for solving problems that arise between the mutual and health care providers.

Most of the mutuals in the study had clear written agreements with the primary health centers and hospitals used by their beneficiaries. Sometimes,

monthly meetings bringing all the parties together sufficed to prevent misunderstandings and service problems. In other cases, mutuals collaborated with NGOs, health committees or associations and district health staff to replace health personnel who were not working well with the mutual or not providing good quality services to the community at large. A very good relationship between the mutual, health providers and the health committee or association was a strong indicator of a mutual's overall success.

- Develop plans that keep the organization focused, organized and autonomous. Utilize strategic planning that includes vision, mission and identity statements and core principles and values as well as medium- and long-term operational plans. Plans should include health objectives, financial objectives, organizational development objectives, and measurable steps toward autonomy and sustainability.

Most of the mutuals in Mali possessed a copy of their feasibility study, but most did not know what was in the document. Almost none of the mutuals in Burkina Faso or Benin were able to present researchers with documentation of the mutual's mission, objectives and business feasibility. In addition, the researchers were surprised to learn that not one mutual had a medium to long term strategic plan, looking ahead three to five years. Just a two or three page document readily available in the local language would serve this purpose.

- With members, NGOs and other stakeholders, review and revise the strategic plan annually or more frequently to ensure that the mutual fits properly within community priorities as determined by the community health plan, that the previously defined identity, vision and mission are still relevant, and that the membership growth plan is on track.





# COOPERATIVE PRINCIPLE #5: EDUCATION, TRAINING AND INFORMATION

**C**ooperatives provide education and training for their members, elected representatives, managers, and employees so they can contribute effectively to the development of their cooperatives. They inform the general public – particularly young people and opinion leaders – about the nature and benefits of cooperation.

This principle points to a promising yet untapped means for achieving better community health. By providing health education, training and information to the public as well as to members, a mutual would serve not only as a vehicle for providing access to health services for those people who are sick or exposed to sickness but also truly help healthy people to stay healthy. Mutuals should therefore create health education programs for their members and the community.

Based on the literature review section of the research study, educational efforts might focus on reducing child and maternal mortality, halting the spread of HIV and AIDS, and spreading the word about low cost interventions that can help prevent deaths from respiratory infections, malaria, diarrhea and tuberculosis. According to several studies cited in the report, mutual health organizations tend to have success in promoting community participation in tackling public health issues. Many reports emphasized mutuals as a ready conduit for health education about preventive and primary health care services.

CLUSA's fieldwork noted this resource is not being tapped. In Kemon, Benin, for example, Ministry of Health officials were engaged in a mass education activity for over seventy women's group leaders. Yet, no leaders of the local mutual were informed of the activity despite their good rapport with health officials and the potential of the mutual to disseminate the information to its members.

Educational programs also help persuade non-joiners to become members. Preventative health education provided to members is indeed a key motivator in encouraging participation. Community-nominated health task forces and health educators, recruited during the process of health care planning, are valuable channels for sharing educational materials with mutual members and non-joiners alike. And sharing information with non-joiners is a good motivator for their eventual membership in the mutual. The health messages shared about how to reduce out-of-pocket health care costs and prevent illnesses often relate to individuals' financial sensibilities and desire to keep their families healthy.

## HOW EDUCATION BECOMES A PASSPORT TO HEALTH

- Make health education a key service to members and community. Create and implement a health education plan to disseminate information and promote health awareness among members.
- Use volunteer facilitators to organize and lead dialogue groups and outreach activities within the community. Developing a regular schedule and location for these education sessions has proven to build attendance.
- Foster collaboration between volunteers and Ministry of Health representatives and other in-country programs to increase volunteers' access to information, education and communication materials. Good collaboration makes available up-to-date information and educational aids at generally no cost to the mutual and can result in better health outcomes for mutual members.
- Encourage relationships and frequent interaction between mutual members and their health care providers to ensure that opportunities such as immunization days are well advertised and attended. This helps to spread the word about initiatives aimed at protecting community health.
- Ensure adequate ongoing organizational and management training for managers and members of the board of directors, so that they can make wise decisions that safeguard the future of the mutual.





# COOPERATIVE PRINCIPLE #6: COOPERATION AMONG COOPERATIVES

**C**ooperatives serve their members most effectively and strengthen the cooperative movement by working together through local, national, regional and international structures.

A number of the sites in the study illustrate variations on the mutual model that have the potential to increase community participation and improve health service delivery and community health. As already noted, existing local organizations have proven very helpful in recruiting members for mutuals and collecting premium fees. Additionally, working together with other local cooperatives can produce financial efficiencies and provide a channel for health education. The literature review conducted by the researchers noted that mutuals have the potential to build upon the principle of solidarity, which is widely valued across much of sub-Saharan Africa.

## STRATEGIES FOR WORKING TOGETHER WITH OTHER GROUPS

- Consider hybrid mutual/co-op/health care center models, particularly where there is already a close working relationship between the mutual, the community health committee or association, and the local health facility.

In Kafana, Mali, the mutual pays part of the salary of a nurse who was hired to help alleviate the pressure on the overloaded clinic staff. Researchers were also told about a community health management association elsewhere in Mali that raised local funds to increase the staff at the local health facility. In Burkina Faso, the mutual in Sourgou plans to merge its operations with the community health committee. This would be a unique model that consolidates the health planning functions of the community health committee with the financial risk sharing operations of the mutual. The

Doumanzana mutual not only pools members' premiums to provide health insurance but also supports a private clinic to deliver health services to members - a model that might have the most value in rural areas where health services are not available or readily accessible. The first community health association in Mali, in the Bamako neighborhood of Bankoni (ASACOB), similarly worked with a local doctor to improve health services through a community owned clinic.

- Consider mutual federations and networks, which marshal economies of scale that enhance each organization's ability to provide services, with increased bargaining and political power, reduced costs, better marketing and greater opportunities for ongoing training.

In Benin, mutuals are beginning to form regional federations and networks so they can offer hospital coverage, promote themselves and improve their operations. Researchers also encountered pseudo federations, where the name implied a federation linking groups but in reality the network was merely a technical assistance provider or was led by independent professionals rather than being controlled by member mutuals. True federations and networks should also be guided by the cooperative principles of autonomy and independence desired for the mutuals themselves.

*(Continued on the next page)*

## COOPERATIVE PRINCIPLE #6: COOPERATION AMONG COOPERATIVES *(continued)*

- Promote financial cooperation among local organizations.

Low prices for cotton in recent years have resulted in cotton farmers dropping out of mutuals or being delinquent in their premium payments. In Guilmaro, Benin, the mutual, the cotton cooperative and the credit union came up with a way to prevent this problem. The cotton co op takes out a loan from the credit union and pays the annual premiums owed by its members to the mutual. When the co op gets paid for the sale of cotton, it deducts the amount of each member's share of the loan before paying them for their cotton. This approach may work well in other communities where there is a convenient means to deduct the loan repayment from the borrower's future income. Individual loans are riskier and could result in increased member debt and default on the loans.

- Work with cooperative businesses and other cooperative community groups such as women's groups or youth groups as channels for health education.







# COOPERATIVE PRINCIPLE #7: CONCERN FOR COMMUNITY

**C**ooperatives work for the sustainable development of their communities through policies approved by their members.

Mutual health organizations enhance the well being of their members by increasing their access to health services. Using the cooperative model, they also work for the betterment of the community at large.

## HOW MUTUALS CAN PAY ATTENTION TO COMMUNITY HEALTH NEEDS

- Develop a sustainable scheme for encouraging indigents' participation in the mutual. This includes making a distinction between the able-bodied poor and indigents when people cite poverty as a reason for not joining the mutual.

Board members of the mutual in Kemon, Benin saw the potential for the use of government run "indigent funds" administered at the local level and tried to contact their local government to discuss this as a way of paying the cost of premiums for very poor families and individuals. Often government funds for the indigent are available, but with an overly bureaucratic procedure for accessing them. Providing coverage for indigents through mutuals is both practical and cost effective for governments.

- Strive for continual community participation and engagement so that any planning for the mutual reflects the concerns being voiced by the community.



- Use issues identified in the health planning process to create plans for partnerships to take action on a multitude of health-related problems, especially water and sanitation, environmental issues and the economic well being of the community.

In Pouytenga, Burkina Faso, members of the mutual showed their community spirit by organizing a tree planting campaign for the local area.

- Provide leadership for health advocacy at all levels – local, district, regional, national. For instance, mutuals joined in networks or federations could advocate for community-based health mutuals to become part of national health care systems as a way to make health services more responsive to community residents, reach more communities and reduce public health care costs.





# CONCLUSION

Even though mutuals exist in a small fraction of communities in West Africa and serve only a small number of residents in those communities, the CLUSA researchers found that many of the mutuals make a distinct difference in the lives of members. Members of those mutuals, particularly children and pregnant women, make more frequent health care center visits than non-members and enjoy improved health. While mutuals now play only a minor role in community health in West Africa, this guide has suggested specific ways to strengthen that role, using lessons, techniques and tools drawn from experience with the seven Cooperative Principles.

By using the tools and tips in this guide, mutuals can improve their sustainability and performance in serving their members and their communities. Cooperative approaches to community health are one vital way to increase community participation, generate sufficient financial capital for sustainable operations and make

lasting improvements in community health outcomes. This guide also presents numerous ways in which processes for planning health interventions and mobilizing communities to use health services could be made more effective with the application of cooperative approaches.

Mutuals and cooperatives are by no means mutually exclusive. Health cooperatives and mutuals both exist to provide important and relevant health-related services to their members. Mutuals may be good candidates for full conversion to cooperative entities, but they could also simply adopt more cooperative approaches to enhance both the benefits and services they provide as well as their long-term sustainability. Cooperative approaches have the ability to generate valuable information from the target beneficiaries about their needs and the local environment which are the foundation of highly relevant, far-reaching and economically viable community-based health interventions.

