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

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

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SENEGAL

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HEALTH SYSTEM

Until 1970, Senegal, like other African countries, experienced economic growth. A health system financed exclusively with public funds was considered a positive legacy of the French colonial period. Then, in the early 1970s, economic decline set in, to which several factors contributed: the oil crises, poor rainfall, low industrialization, and a peanut monoculture. In 1990, foreign debt service reached 66.5% of GDP. The budget for health went in the opposite direction. In 1970 nearly 10% of the national budget was allocated to health, against 5.2% in 1992.

Along with this economic crisis, structural adjustment programmes increased the constraints on the country. The health sector has been hit hard by "political donations." To this must be added a health system that was highly centralized and poorly distributed geographically. All these factors lead to an alienation of health facilities from the population.

It was in 1987 that African health ministers met in Bamako, Mali to adopt a strategy of health system reform. The Bamako Initiative aimed to strengthen community-based primary health care in order to increase access to health for all. It also sought to promote greater resource mobilization, including the adoption of cost recovery (for both consultations and drugs), in order to improve the management of health facilities and to decentralize the public health system.

Population (in thousands): 13,726

Population median age (years): 18.01

Population under 15 (%): 43.54

Population over 60 (%): 4.57

Total expenditure on health as a % of Gross Domestic Product: 5.0

General government expenditure on health as a % of total government expenditure: 9.6

Private expenditure on health as a % of total expenditure: 44.1

In Senegal, the Initiative was accompanied by a drug policy reform that reorganized and decentralized the National Medical Stores. Promoting essential drugs in their "generic" forms became generalized across the country. Alongside these structural reforms to the public health sector, the private sector has been mobilized and has contributed significantly to the improvement of health care delivery, especially in urban areas. The private sector falls into two categories – religious institutions and non-profit – and benefits greatly from external grants and from the for-profit sector.

MUTUAL HEALTH ORGANIZATIONS

Senegalese MHOs have had to carry on despite great legal uncertainty.[1] Since 2011, they have been governed by West African Economic and Monetary Union (WAEMU) Community Regulation.

A recent survey of Senegal's MHOs[2] identified 149 community MHOs and 15 professional MHOs. Nearly half (48%) are located in the regions of Dakar and Thiès, and most of their members (57%) are women. Reportedly, 122 MHOs (74% of the total) benefit from the support of a structure or organization, and 39% have no office. In addition, only 5% offer their members a local health care unit and/or a pharmacy.[3]

Senegal's MHOs are highly flexible organizations which can be readily adapted to the experience, needs, and abilities of their members. MHO contribution systems are generally suitable and affordable in communities. Indeed, microhealth insurance is important to extending health coverage to the maximum number of people. (Lalane Diassap MHO covers more than 80% of the village. See "Case Study.")

Studies show that the ability to pay is not the key factor for success of MHOs. Some manage to offer significant benefits with very low fees. The adjustment of the level of benefits to available resources must be rigorous, however. Other factors essential to MHO performance are the dedication and proximity of managers, so that their integrity and their rigor with respect to mutual principles encourage a like commitment on the part of the population. Again, the Lalane Diassap MHO is a good example of success in this area.

That said, MHOs in Senegal must contend with many operational and institutional weaknesses, quite apart from the aforementioned regulatory transition between Senegalese law and the WAEMU Community Regulation.

Member retention is a serious issue. Losses occur as a result of resignation, suspension, cancellation, or self-exclusion. Other causes are automatic suspension of members for failure to pay their contributions on time, mismanagement, lapses in care in case of illness, and a lack of flexibility, understanding, and real solidarity.

The basic package of services is often inadequate, but so is the collection of contributions: At best, 60% of members are up to date with their contributions. (Aggravating the situation is distrust regarding the use and practical impact of contributions. Popular belief has it that payment of contribution actually invites disease.)

Daily operations suffer for lack of management infrastructure (office, vehicle, records, computers, training, etc.). Essentially, accounting and record keeping are manual. This does not jeopardize MHO viability, but it does hinder their development and efficiency.[4]

Case Study

In Senegal, MHOs are numerous. In Thiès alone, 42 MHOs cover 18,500 families (100,000 beneficiaries) or 10% of the region's total population of 1 million. The GRAIM (Groupe de Recherche et d'Appui aux Initiatives Mutualistes/Research and Support Group for Mutual Initiatives/Enda Graf Sahel) supports the coordination of 40 of these organizations and 25 in the rest of Senegal (as well as six district unions).

Like many village MHOs in Thiès, the **Lalane Diassap MHO** was established in 1994 at the initiative of a village association, the association of young Lalane.[5] It is the current performance benchmark for rural MHOs in Senegal.

Lalane Diassap MHO started its health insurance operations in February 1996. The MHO has 568 members, and covers 2,809 beneficiaries or 82% of the vicinity's total population (1,200). This attests to the credibility, effectiveness, and awareness of the campaigns which the MHO has conducted. In the village of Lalane only two families are not affiliated.

The membership fee is $2.00 USD (1000 FCFA). The contribution, originally set at $.31 USD (150 FCFA), is now double that due to the MHO's extensive service package. The rate of collection of contributions (60% of participants) needs to improve but it is quite high for a rural MHO. The proximity of members is essential to the collection of contributions. Beneficiary documentation, including contribution payments, is in order.

The financial condition of the MHO is satisfactory. The contribution/expenditure ratio is 1.8 in 96 and 1.45 in 974, if one excludes advances on hospital bills which are not MHO expenses. (Taking these advances into account – in which case no refund is payable – the ratio is slightly greater than 1.) Even in the worst case scenario, the MHO can still meet its expenses.

Data on operating costs was not available but they must be close to zero: the MHO has no office, no phone, and managers receive no compensation. However, Lalane Diassap MHO must improve its rate of contribution collection and quickly set up regular evaluation and monitoring procedures. The negotiation of preferential rates with health care providers is also critical, for it allows the MHO to offer significant benefits while taking an acceptable fee.

SOURCES

[1] MHOs in Senegal were to be governed by a law adopted in 2003 (Law n° 2003-14 of June 4, 2003), followed six years later by an implementing decree (Decree n° 2009-423 of April 27, 2009). According to the Law of 2003, an MHO is a non-profit group which proposes (mainly through membership fees) "to exercise foresight, action, solidarity, and of mutual assistance in the interest of the members and their families." A few years later, a draft modification of this legal framework was introduced in 2009, then, in 2011, the entire framework was repealed when Senegal adopted the WAEMU Community Regulation.

[2] The survey was carried out by Hygea consulting firm, at the initiative of the Senegalese Ministry of Health and Medical Prevention in partnership with the University of Montreal. For more details, see: Mané, Jean-Pierre. 2010. "Étude sur les Mutuelles de santé au Sénégal : 43% des membres quittent les structures pour radiation ou suspension." *Senetoile.info*, July 2. Retrieved September 2, 2014 (http://senetoile.info/component/content/article/61-sante/7285-etude-sur-les-mutuelles-de-sante-au-senegal-43-des-membres-quittent-les-structures-pour-radiation-ou-suspension.html).

[3] The survey also indicates that growth in the MHO network has long been slow. The first MHO was created in 1989. The period 1993-1999 saw the creation of 23 new MHOs, and during the years 2000-2008, another 140. Mané 2010.

[4] Institutionally, MHOs are often hampered by isolation from other health authorities. They may lack a contractual relationship with health care providers. Low involvement of MHOs in the definition of health policies, with public health institutions and health committees, or with supporting development organizations are other serious disadvantages. For more information about the strengths and weaknesses of MHOs in Senegal, see: IWPAR. 2014. "Le projet IWPAR." Enda Tiers-Monde. (http://www.iwpar.org/accueil.html).

[5] IWPAR 2014.