East, Central and Southern Africa Health Community

Report of Study Tour Mutual Health Organisations Senegal

18-28 March 2003

Health Systems Development

1. BACKGROUND

Health Systems in Africa still suffer from chronic under financing. This situation is worse among HPIC countries for which Poverty Reduction Strategy Papers to qualify for debt relief are currently implemented. There is strong political will at international level as evidenced by Millennium Development Goals that take into account better health, particularly maternal and child health. In Africa, heads of states meeting in Abuja in 2001 declared a commitment to health services by announcing the Abuja Declaration which states that governments in Africa should commit 15% of public budget to health services.

Senegal, an African country at the westernmost tip of the continent is, like most other Sub-Saharan Africa, currently addressing the issues of increase in resources for health services. Two significant steps taken to meet this objective are as follows: first, increase the public health budget to 10% (9% is the WHO recommended health sector allocation of budget for health); second, the current president of the country M. Abdoulaye Wade in support of better health for his people, sanctioned the creation of a division of Prevention of Diseases in the Ministry of Health.

2. OBJECTIVES OF THE STUDY TOUR

The main objectives of the study tour were to learn from better practices in Mutual Health Orgainisations in Senegal and to orient managers in ECSA in the West African approach to Community Health Financing**.**

3. METHODOLOGY

Apart from the methodology proposed in the concept paper the group had a briefing in Nairobi with USAID/REDSO Health Financing Advisor, Gilbert Cripps and CRHCS Health Systems Development Coordinator, Dr. Mark Bura. Available tools and literature on Community Health Funds such as those developed by Chris Atim of PHRplus, Mark Bura and Gilbert Cripps were distributed to the participants. Participants had an opportunity to compare these tools with tools introduced during the Study tour.

4. HEALTH SYSTEM IN SENEGAL

Financing the Health System in Senegal

In 2002 Senegal had a per capita GDP of 1,207 international dollars and a total expenditure on health of 4.6 % of GDP. Of the total government expenditure in 2000, 13% was spent on health; equivalent to US$ 12 per capita. The total per capita expenditure on health was US$ 22.

In Senegal in general, alternative Health Financing initiatives include new models of financing health services through risk sharing activities such as MHOs, social health insurances, user fees and financing drug supplies through the Bamako initiative.

The sources of funding for health services in Senegal have little difference from those of East, Central and Southern Africa. Generally, social security contribution is negligible, while external sources contribute 14.3%, private expenditure 43.4%, out-of-pocket expenditure 39.6% and a significant proportion of 8.7% in form of prepayment plans mostly Mutual Health Insurance. No ECSA country has such a prepayment level of contribution to public health expenditure.

Ministry of Health partnerships division oversees alternative financing initiatives in particular Mutual Health Organizations. A special unit under this division know nas CAMICS was created to oversee and support Mutual Health Organisations in this country.

The Senegalese Health System is decentralized within the self-governing units since 1972. Local government units cater for communes of 20,000 inhabitants. These are further sub-divided

into 10,000 collectivities of rural communities. In total there are: 48 communes, 360 rural communities and 11 Regions.

The Capital City, Dakar has 2 million people. The population of the country is about 7 million.

Map 1. Republique du Senegal

Governance, Democracy and the Health System

Each Region has a Regional Assembly with its own President (chairman) and the National Assembly is chaired by the Speaker (referred to as the *le president* in French)

Governance at Village level: Like the higher levels, decision making at this level pivots on the Local General Assembly whose members are elected every 5 years. The communes and rural communities form the basis of local governments. The following are the functions of the local government.

- Land allocation through community assembly
- Environment and Natural resources

- Health and Social Action
- Youth, Sport and Culture
- Education and Literacy
- Planning

- Organizing territory e.g roads
- Urbanisation and habitat

Allocation and mobilisation of resources at local level: Local collectivities have financial problems always. In 1993 some local government were financed by the National government. It is a normal practice for a commune to build a health center through locally mobilised resources and the government to provide personnel

There are local taxes and fund raising activities of some kind at local level. In addition, decentralized cooperation - through donors can bring financial support directly to the communities. However there seem not to be a strong balancing system for resource allocation between regions since donor decisions impact on where support is given.

It is under the above governance structure that HMOs operate in Senegal.

Structure of the Health System

The health system is built on the same government structure

LEVEL	TYPE OF GOVERNANCE / ORGANISATION		
	ADMINISTRATION	COMMUNITY	HEALTH FACILITY
NATIONAL	President of the Republic	Speaker /National Assembly	National hospital
REGION	Governor	Chairman/ Regional Assembly	Regional hospital
DISTRICT/ MUNICIPALITY	Prefect	Mayor / Council	Hospital Health Centre (with a

			medical doctor)
RURAL COMMUNITY	Sous-Prefect	Chairman /Rural Assembly	Health post (with a registered nurse)
VILLAGE		Village Chief	Health Hut

Health Committees are present at all levels of health care since 1996. They oversee cost sharing money at the provider level.

A User fee is universal in Senegal. This makes access difficult and therefore people are willing to resort to new alternative financing models such as MHOs that could improve access to health services.

Protective mechanisms to help the poor to access health care are still not successful in Senegal according to the opinion of local inhabitants.

As an example of how a health committee operates, the group visited one of the district level health centers in order to meet members of the Health Committee that oversees the management of user fees. (See notes on visit to Health Centre page 24)

The Origins of MHOs in Senegal

A mutal health organisation is a voluntary prepayment scheme based on solidarity where financing of health services is pooled by a natural[1] group of community members and services provided through a contractual agreement with a provider of health services.

In Senegal, Mutual Health Organisations, as an alternative health financing initiative started in the late 1980s and early 1990s. The first of these, Fandene, was created at the initiative

[1] A natural group of a community is one that did not form a group in order to profit from a health prepayment scheme.

of a Catholic Mission Hospital – Saint Jean De Deu in 1989. This first MHO effectively started to provide benefits to its members in January 1990 after a waiting period of 12 months. The objective of this pioneer MHO was to increase access for costly hospitalization for the rural communities close to the Town of Theis in Senegal who could not access these services.

It was the provider of services, the Saint Jean De Deu Hospital, that recognized this need and initiated this first MHO.

At the time of the study tour there were 25 functioning MHO out of 30 in the pioneer Region which includes Dakar and Thies.

5. PRINCIPLES OF SETTING UP MHOs IN SENEGAL

The following are basic principles of setting up MHOs in Senegal. All MHO initiators follow these principles carefully:

- Expressed need by community i.e. potential members
- Feasibility study – not always possible but PHRplus experience shows that generic study results can be applied to a small community
- Solidarity links among members
- Confidence of the people in initiators of MHO-leadership
- Social Economic factors
- Good fund management-charisma of initiators (it is important to fully support his attribute)
- Democracy
- Government policy
- Quality of services-currently addressed in Senegal by Abt Associates/PHRplus and STEPS.

Steps in Setting up MHOs.

Setting up MHOs is fully documented in the ILO/STEPS manual and other publications in West Africa.

The major steps are as follows.

- Set up working group. This is the time to create leadership from the community

- Marketing by working group
- Convene General Assembly
- Constitution to be worked up by the working group and legal requirements for registration that need to be addressed.
- Financial hypothesis - costing and financial plan – to establish various scenarios of benefits.
- Executive committee created
- Control committee to check funds and call a general assembly when there is an urgent need.
- Staff training – no provider choice in most cases in Senegal. Usually first connection is with health center/health post then later higher levels.
- Sign contracts with health providers

6. SUPPORT STRUCTURES TO MHO IN SENEGAL AND WEST AFRICA

A special feature of MHOs in West Africa is the partnership developed between them and the support organizations and institutions.
Several organisations are supporting MHOs in Senegal. These organizations support networks and some of them provide technical support for on-going MHOs and initiation or setting up of new ones when a community requests them.

Cellule d'Appui aux Mutuelle de Sante, IPM, et comites de Sante, CAMICS is a unit of the Ministry of Health in Senegal

that oversees alternative Health Financing initiatives. CAMICS has an important role in relation to MHOs and Social Health Insurance. Although the government of Senegal spends 10% (9% by WHO standards) of the public budget on health services, there is still a gap to fill. Alternative health financing such as MHO through which communities are directly involved is one initiative supported by the MoH in Senegal to fill the gap.

We met the coordinator of Alternative Health Financing, Dr. Mme Mariama Diop. Mme. Diop coordinates the following initiatives:

- Mutual Health Organisations
- Social Health Insurance
- Bamako Initiative pharmacies

CAMICS was formed in 1998 but by then health committees were already started and functional. CAMICS has been working to support MHO in the following areas:

- Training – working with Health Committee at community level on how to manage training.
- Technical support
- MHO documentation.
- CAMICS is also working on Social Health Insurance for Civil Servants -there are about 800,000 civil servants whose insurance cover could generate 130 billion CFA per annum.
- Work with LA CONCERTATION *(an MHO network in West Africa)* and have joint meetings to share information per quarter).

Legal Framework for MHOs: A Legal framework is being created and the bill was with the cabinet at the time of the study tour.

PROMUSAF AND ANMC

PROMUSAF is a Christian Organisation that supports MHOs in the three West African countries of Senegal, Burkina Faso and Benin. PROMUSAF is a member of the LA CONCERTATION. This organization works in collaboration with GRAIM in strategic areas of LA CONCERTATION:

- Training
- Sensitization
- Technical Support to MHOs

One can see that this is an intermediate organisation. PROMUSAL contracts consultants in the region to carry forward the above objectives. The organization supports in addition, associations of women groups, small and medium size industries and schemes officially set up by employers.

PROMUSA, like PHRplus conducts feasibility studies on MHOs. These are usually generic studies whose lessons can be applied to a whole region or a country.

Tool Harmonization:
All tools on sensitization, mobilization, management etc are being harmonized through meetings between PROMUSAF, LA CONCERTATION, CAMICS and PHRplus. These organisations are all members of the West African MHO network, the LA CONCERTATION.

Main Training areas:
Using three modules (by STEPS/ILO) for target groups
PROMUSAF trains in the following subjects:

- How to set up MHOs
- Financing and Administration of MHOs
- Monitoring and Evaluation.

During the discussions at PROMUSA, some questions were raised by the team:

Q. *The team leader*: Do you think government is strongly supporting the MHO*?*
A. Yes, government is working on sensitisation and gives funds to support media. There is one broadcast on MHO per month. There is also a National Day on MHO (as stated by CAMICS coordinator earlier). The president of Senegal supports MHO. However MHOs do not like to be controlled by Government (-refer to Lalan-Diassop meeting)-*by the PROMUSAF coordinator.*

Q. *Study team member:* How are the poor who cannot afford services supported?
A. There is a difficulty in deciding who are the poor though some procedures through mayors, etc exist is Senegal.- *by the PROMUSAF coordinator*

Q. *Study team member:* How is quality of services addressed by your organisation? -
A. *PROMUSAF coordinator*: PROMUSAF is supporting the government to support the quality of services. -

According to the HMO support organisations the role of the government is:

- Support sensitization
- Support Training – by giving a financial support

The support organisations also stated that some governments in the region are trying to give technical support - though their capacity is questionable.

GRAIM

Groupe de recherché et d'appui aux initiatives mutualitte is one of the oldest organizations which in turn is supported by

ENDA-GRAF and PHRplus. Other support organizations[2] include AIM, ILO/STEPS, GTZ, Reseau d,appui aux mutelles de sante (RAMUS), UNMS and WSM.

7. CONTRACTS BETWEEN MHO AND HEALTH PROVIDERS

Assane Gueye " le Doyen" a retired Civil Servant has committed his time to the development of Mutual Health Organisations in the Region we visited. He is the Secretary General of La CONCERTATION (network) of MHO and support organization in the Regional and is highly respected.

"le Doyen" had a couple of points to stress on agreements between the MHOs and the providers of services, hospitals, health centers and health posts.

Deposit: A deposit is made at the provider level at the following proportions:

a. Hospital - 500,000 CFA per quartier
b. Health Centre -100,000 CFA
c. Health Post - 15,000 CFA.

This deposit covers the cost of a MHO person at the Hospital. This deposit can also be used by the Hospital to buy drugs when the provider has little cash in circulation on the understanding that it will be replaced and remain intact. This deposit is a guarantee to the hospital against failure of by MHO to cover the bills as may happen if an epidemic takes place.

Arbitration: In cases of conflict between the MHO and the provider, a case is solved by mutual negotiations without going to court. It was not however clear as to what action is to be taken by the MHO if the provider fails to provide services according to the contract.

[2] See Currier de la Concertation Numero 9 Janvier 2003, Special Forum

THE STRUCTURE OF MHO IN SENEGAL

The General Assembly is the highest decision making body of an MHO. It has a President and a Secretary General.

The network of MHOs in this Region conducts a bi-ennial General Assembly where currently two representatives represent an MHO. Soon the representation will be in proportion to the number of members of the MHOs.

Assani Gueye, referred to above, is the President of And Fagu MHO and Secretary General of the Regional General Assembly.

8. PROFILES OF MUTUAL HEALTH ORGANISATIONS IN SENEGAL

Up until recently the Senegalese MHOs executives – president, secretary, and treasurer were responsible for activities such as sensitization and collection of membership fees in their areas. This approached proved inefficient and currently the target potential member communes or villages have been divided into zones. Each zone or *quartier* has three volunteers to be trained.

MHO -Tiwaoune is one of the new MHOs based on micro-financing for women in informal sector. Tiwaoune has 6 *quartiers* and since November 2002, members of five *quartiers* have been trained. After training the volunteers from all six zones, the collection of member fees will be speeded up. The details of procedures for collection and accounting were not discussed.

In the company of Hussein Guyye, Mounir and Ngone we attended a training session for this mutuelle. A facilitator from GRAIM was conducting sessions. The duration of such training is one week. The training is based on training of trainers manual for Mutual Health Organisations in Ghana[3]

[3] Chris Atim, 2000: Training of Trainers Manual for Mutual Health Organisations in Ghana.

Profile of Tivaoune MHO

a. Membership-334 and 430 beneficiaries,
b. Type: Women MHO supported by GRAIM and PHRplus.
c. Inhabitants: 40,000
d. Fees:1,000 CFA for membership and 200 CFA monthly subscription.
e. Waiting period: 6 months[4].

f. Membership card covers up to 12 people in a family.
g. Date started: March 2001
h. First General Assembly 2000.

Questions and answers on Tivaoune HMO.

Q. Who determines fees?
A. The General Assembly; democratically.

Q. What is the grace period for beneficiaries who have not paid their monthly subscription?
A. While most mutuelles pass a financial year with a small surplus, the grace period for a person who does not pay his monthly fee is 10 days but 30 days for a retirees mutuelles of And Fagu.

Q. How do members understand the risk pooling?
A. This particular MHO is said to appreciate the concept of risk pooling and defaulters do not expect to be rebated. Generally 70-80% of members at any one time have their membership fees current.

[4] A waiting period is a period during which a new member of an MHO cannot access benefits yet. It varies from 6 to 24 months in West Africa. This rule excludes adverse selection and for a new MHO it helps build up the reserves before benefits can be accessed.

Benefits:

1. Hospitalization
2. Malaria
3. Vaccinations
4. Delivery
5. Pre and Postnatal care

MHO-Lalane-Diassop one of the first MHO.

Lalane-Diassop is one of the first MHOs. A school head teacher (*directeur de lecole*) of the village primary school is the chairman of this MHO. Two villages, Lalane and Diassop, comprise this MHO. There are two other smaller villages who

have recently joined this MHO. A main feature is that initially for 5-6 years this MHO like Fandene covered only hospitalization services. Now they cover primary care as well. It is organized like other MHOs, the general assembly meets every two years.

Profile of Lalane-Diassop

- Membership: 347 and 1589 beneficiaries,
- Type: For potential members of the two main villages and other smaller villages
- Inhabitants: 2,000
- Fees: 1,000 CFA for membership and 200 CFA monthly subscription.
- Waiting period: Started in 1994, but benefits accessed in 1996. There was a two-year waiting period. The waiting period is now 8 months. Some of the older members feel that the new members should have received the same treatment in terms of the waiting period.
- Membership card covers up to 12 people per family.
- Date started: 1996
- First General Assembly 1996

Services covered:
Although initially members of this MHO paid for major risk only, they now cover PHC costs as well. The benefits are:

- Hospitalisation is covered up to 15 days, after which the beneficiary pays the costs. However, if at discharge convalescing people cannot immediately find the cash to pay hospital bills, the MHO pays and the members reimburse the MHO before they can further benefit from the MHO services.
- Surgery: 40% cost is covered by MHO, while client covers 30% and the Saint Jean De Deu gives a discount of 30%.
- OPD 40% is covered by MHO.

- Emergency consultation -100% cover by MHO.
- According to the agreement, ordinary consultation and hospitilization receives a 50% discount for MHO by the hospital but the discount is reduced to 45% for MHO in 3rd year and further reduced to 35% in the 5th year. The provider assumes that by the 5th year of the MHO operations, the organisation should have become more sustainable and mature financially.
- Health Centre care: 50% cover by MHO.
- Health Post: 50% cover by MHO.

The MHO bureau receives invoices from the provider and pays the provider on a monthly basis. There is no control of referral system by the MHO but rather the health system. It is the health provider who decides when to refer a patient to a higher level care. Delays of complicated cases for referrals from lover level are said to increase costs at the higher levels. In this situation some MHOs such as Fandane have suffered huge costs when clients go for hospital care because they are usually sicker and require more costly care at a higher level. This facility is said to be run by low cadre health personnel. It is

perceived by the MHO that the quality of services is therefore generally poor.

Revenues are said to just cover the cost of health services. The waiting period is 8 months but this may change and will depend on the decision of the general assembly of the mutuelle.

Monitoring:

There is no formal monitoring system in place. Neither the providers nor the members of the MHO are surveyed to study the quality of services and member satisfaction. The executive and the general assembly usually gets some indication of the quality from the feeling of the clients.

Motivation of executive staff

The executive provide their services on voluntary basis. As the MHO mature, there is a hope of paying the executive some regular salary. However the treasurer is provided with some limited transport costs.

Support from Government:

Mutuelles value their independence of controlling their health costs to the extent that they see government support as a threat to that independence. However, CAMICS is a MoH unit that support MHOs. Documentation, legal frame and information sharing is the role of the government. Indirectly the MHOs get equipment, drugs and support for the Health Centres including those which have contracts with mutuelles.

MHO-Fandane-The first MHO in Senegal.

As stated earlier Fandane is the first MHO in Senegal. It is located in a small rural poor village 7 kilometers from Theis. The MHO was started in 1989 and after a waiting period of 1 year started to provide services in Jan 1990. Talking about Fandene is talking about the history of MHO in Senegal. Saint Jean De Deu Hospital in Theis noticed that only the rich people

benefited from services but not the poor. The hospital started the MHO for this poor village. Initially only hospitalization was covered but soon primary care was also covered. The president of the MHO was happy by our visit. The village community is of one culture and religion and felt united in solidarity to support each other. Their children who live outside the village or country also support their relatives financially.

Although initially members of this MHO paid only for major risk, an ideal situation in insurance practices, they now cover PHC costs as well. The benefits are:

- Hospitalization was covered for up to 15 days but was reduced to 10 days when they opted for primary care services as well.
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- Surgery: 40% of the cost is covered by MHO, while the client covers 30% and the Saint Jean De Deu gives a discount of 30%.
- OPD 40% is covered by MHO.
- Emergency consultation-100% cover by MHO.
- According to the agreement, ordinary consultation and hospitilization is discounted at 50% by the hospital and the discount is decreased to 45% in the 3rd year and to 35% from the 5th year onwards.
- Health Centre Care: 50% cover by MHO.
- Health Post 50% covered by MHO.

Membership and enrolment fees

An enrolment fee is 1,000 CFA initially with 200 CFA as a monthly subscription. When benefits were expanded, and 50% of members could not pay, the monthly subscription fee was reduced to 100 CFA until every one was able to pay then they increased it to 200CFA per person till now.

In 1990 there were 400 members, in 2001 there were 200 members and 2,000 beneficiaries but in 2003 there were 450 members and 3,025 beneficiaries. The current target is 5,000 members.

Seventy five percent (75%) of members have now completed their monthly subscription.

There are 200 beneficiaries with bills of 25,000 to 500,000 CFA who had to pay their dues. This has posed a great financial difficulty though the scheme has 1 million CFA reserve. Since 1990 the mutuelle has paid benefits worth 68 million CFA for 10,000 people. The mutuelle celebrated its 10^{th} anniversary in 2000. The debt will increase the premium per member. Whether the increase is going to be substantial and lead to poor members opting out, will be clear with time.

Premium adjustment to offset losses: there is a plan to adjust premium by dividing total bills by total beneficiaries to add to

the monthly subscription in order to offset the costs of members who are not able to reimburse the MHOs for hospitalization.

And Fagaru-Second Generation MoH in Senegal

And Fagaru is one of the second generation MHOs in Theis. This MHO was initiated by a group of women in informal business who needed pre and post natal care. The target area is divided into 52 *quartiers* (zones) of which 32 are covered currently.

It was stated that the major problems facing this MHO are:

- Sensitization of the communities in the commune – 52 quartiers
- Collection of fees.

Decentralization is the process used to address these problems, particulary fees and revenue collection. In this process

associations, chiefs,andleaders at *quartier* level were involved. Fees are now collected by *quartier* level committees.

Decentralization has increased fees.

Objectives:

- To promote health insurance for everybody
- Facilitate access to health care for all
- Develop solidarity for solving health problems
- Improve quality of health care within the health system.

Organisation:

The general assembly is the highest decision making body of And Fagaru MHO. The target area is divided into *quartiers*. Every year there is one *quartier* general assembly followed by one And Fagaru General Assembly.

Representation at general assembly is 3 officers – president, accountant and secretary. These three officers attend the MHO general assembly.

Each *quartier* has a executive council of 21 people 3 ex-officials and 19 delegates. These 19 delegates help with collection of funds.

- At MHO level executive council meets monthly
- Administration committee meets monthly
- General Assembly meets annually.

Frequency of Meetings:

This MHO was created because 90% people in the area are informal sector workers. They are poor. Many participate in micro-credit financing. The MHO was initiated by setting up a starting committee. It was supported by GRAIM who trained the committee. The first GA was held in Sept 99.

In 2000 the MHO started the decentralization process that resulted into a five fold increase in membership (Doyen). This process involved contacting *quartier* leaders to open doors for the MOH.

Profile:

- Membership -1646 and 5071 beneficiaries,
- Type: Informal workers MHO
- Inhabitants: 250,000
- *Quartier* 52 with 32 covered -each quartier has 15-40,000 inhabitants
-

- Fees: 1,000 CFA for membership and 200 CFA monthly subscriptions.
- Waiting period: 3 months
- Membership card covers up to 12 people.
- Date started: Sept 1999
- First General Assembly 1999.

Agreements and Services:

Agreements: Agreements are in place with 14 providers, Saint Jean De Deu
Hospital, one health center and 12 health posts.

Referral: The referral system is respected and members receive services
at hospital upon referral from a lower center. In emergency cases referral procedures are not demanded.

- Hospitalization is for 10 days upon deposit of CFA 10,500 in case one stays longer. There are 100% coverage for 10 days.
- Consultation, pre and post natal care, immunization, deliveries, surgery is covered.
- Surgery, blood test, x-ray, for non-hospitalization only 50% is covered.

Revenues:

Total revenues in 2002 **2,763,000 CFA**

Membership fee: **839,000 CFA**

Spent:

Spent at St JDD Hospital **602,200 CFA**

Spent on Primary Care **2,092,000 CFA**

Subsidy: **1,200,000 CFA** by GRAIM to support training for the committees and set up of the MHO.

The following issues were discussed.

Do Mutuelles increase equity? First generation MHOs were created to address equity as created by the church hospital. These covered only hospitalization costs. Communities did not feel the impact of these. It was found that primary Health Care should be covered by MHOs so that everybody benefits rather than waiting for years before a family received a benefit. In this respect prevention of diseases is also important.

Motivation: This MHO was housed temporarily within the in GRAIM organisation. They cover telephone costs, transport and fax. For training GRAIM provided them with 1,200,000 CFA. The group is aware of the importance of financial autonomy and would not like external support to weaken this.

Sapante Mutuelle.

Sopante MHO, also a second generation MHO, was initiated in 1997 and started to operate in 1998. It has 886 members and 6000 beneficiaries. Like other MHOs membership fees is still CFA 1,000 and monthly subscription has been increased gradually from 100 to 200 CFA. It has contracted ST JDD Hospital, 12 health posts of these 5 are private and 7 public. The private facilitates are said to be expensive. The MHO

covers 60% of primary care level services and 100% for St. JDD hospital.

Organisation:
Organisation is like And Fagaru above.
Fee collection: Fees are collected from the 1st to the 10th of each month and collectors surrender the revenues the next day after collection to the principal accountant who sends the list of the beneficiaries to the hospital and health posts. The MHO faces the same problems as And Fagaru and others. It was set up in the same way as these others.

Union Nationale des Femmes Commercantes du Senegal

This is an urban based informal sector business women in Thies. Membership is open to other organizations and geographic areas. The MHO has only been operational for 3 months. The principal members are women only and girls are said to inherit the principal membership. This MHO has already made 4 contracts with various providers of services.

Members: 292 and 1507 beneficiaries. Fees and subscription are same as other MHOS.

Membership rate on a monthly basis is 65%. The women can choose a hospital of their choice or private doctor on the grounds that they can withdraw an equivalent of 8 days hospitalization charge. For delivery there is a flat rate refund of CFA 10,000 if a woman goes to a private hospital or a hospital of her choice rather than St.JDD hospital. The waiting period for this MHO is 6 months.

And Faggu-Mutuelle de Sante Complementaire de Retraites de l, IPRES

This is a mutuelle that is complementary to a scheme for private sector retirees, the health insurance scheme l'IPRES. This scheme was created because the retirees scheme did not

cover all services. While the hospitalization cost for 15 days was 10,000 CFA their other scheme could provide only 2000 CFA. Started in 1994, when the scheme could provide services for 15 days only, today the complementary MHO is able to provide unlimited hospital days for its members and the hospitalization rate has increase from less than 5% to about 25% three years later. The charismatic elder "Le Doyen", Assane Gueye, the General Secretary of this MHO, who is a retired cooperatives General Secretary in the past has the credit for the development of this MHO.

Contract and Services:

The MHO has contract with St Jean de Deu hospital which was already their provider of services with l'IPRES. The hospital therefore has two contracts to which the services are charged.

- And Faggu and l'IPRES.
- A feasibility study was done before a premium was worked out.

In addition through negotiations with St Jean de Deu hospital which receives philanthropic donor support, agreed to give members of the mutuelle a discount of 50% of the difference in price of hospitalization (7000/2-2000=1500 CFA per day)

Three scenarios of expected initial membership were considered (financial hypothesis) as follows:

- High 1500 members
- Low 500 members
- Medium 1000 members.

The basic family size for the scheme is 4 members.

The low scenario of 500 members was started with. The details are given in their report: *"Evolution des Indicateurs de l,Assemblee (24-10-94 au 31-12-99*)"

Services

There are two categories of services:

- The first category has a patient room with 2 hospital beds a TV, a telephone and other amenities
- The third category has 7 beds.

The health services are the same for both categories for an unlimited duration of hospitalisation. Other than hospitalisation there is reimbursement of 50% for minor surgery, investigations, consultations etc.

Subscription: Membership is 1000 CFA and quarterly (3 monthly) subscription of 500 CFA for a family of 4.

Organization and important features of this MHO is

- Good governance
- Transparency
- Control Committee for administration and finance, – this is not an external audit.

Mechanism for viability: The most important, mechanism was the waiting period before the benefits were available.

The General Assembly report in 1994 had 397 members *(not 500 as predicted)*

At that assembly they had a reserve of	765,000 CFA
They deposited	600,000 CFA
Kept in safe – petty cash	65,000 CFA

Social Policy of Exemption-the case of L,IPRES

Currently, through their records with l,IPRES the MHO has identified 30 indigent people whose treatment costs are covered by the mutuelle.

For further details see the beneficiary booklet; *Livret d'adherent* with contract details and the summary report of 4 general assemblies between 1994 and 1999.

A Health Centre in Thies-Dixieme

This health centre in Theis is an example of HC within the health system pyramid in Senegal. The health Committee comprising of chairman, treasurer and District medical officer was met by the Study Group. The committee is elected every 2 years but a member can have a tenure of 3 terms only.

The health committee is part of the Ministry of Health structure under decentralization that oversees the use of the user fees at the health center. The functions of the Health Committee are to represent the community and collect and administer user fees. There is a budget by MoH for health committees.

User fees, either direct payments or through the MHO, can be used for the following activities:

1. Community Based Health Care activities – 40%
2. Incentive for staff-20%
3. Maintenance - not more than 10%.
4. Others 30%

Expenditures and Controls

Staff salaries are paid by the government. A Bamako initiative drug store is in place and operates well here. The district health committee supervises the Health Committee and only generic drugs are bought through this system from the National Pharmacy.

Beds: 18.

Daily Attendance: Not available

Indigents: Assistance can be obtained through the social worker.

9. MUTUAL HEALTH ORGANISATIONS' NETWORK IN WEST AFRICA

ILO/STEPS AND LA CONCERTATION

Two visits were made to these MHO facilitating organisations. The first visit was made on the first visit day of the tour and the final one on the day before the last day of the study tour.

ILO/STEPS is one of the active international organizations that has been supporting the creation of the MHO network La CONCERTATION[5] in West Africa. The group had the opportunity to meet the Africa Coordinator (ILO), the West African Technical Coordinator (ILO) and the Coordinator of La CONCERTATION

La Concertation is a network of private organizations whose objective is to share experiences in alternative health financing in West Africa. La Concertation is composed of religious and bilateral organisations and eleven French speaking countries in West Africa. These are Côte d'Ivor, Chad, Niger, Togo, Benin, Mali, Burkina Faso, Cameroon, Cape Verde, Senegal, Guinea Bissau.

[5] **Mr. Paskal Njae- Coordinator of the La *Concertation* (West African MHO network)**
Ms Christine Bockstal- African coordinator (ILO)
Mr. Oliver- W-Africa technical coordinator (ILO).

Map 2. West Africa

The activities of this network started in 1999. A strategic meeting was held in Côte d'Ivor where Strategy to Support Mutual Health Organizations .The Abidjan Platform, was developed. Thereafter the West African MHO network. *La Concertation* was formed with its head office in Dakar, Senegal. Four strategic areas of this network have been identified:

- Facilitation of access to health care
- Resource mobilization
- Dissemination
- Drugs

The website for this network is www.concertation.org

Currier de la concertation is quarterly that focuses mostly on technical issues and news of MHOs. It is distributed to all member countries and 2,000 copies are printed per *quartier*.

Thematic workshops: Every two years there is a La Concertation forum bfor all 11 member countries. The first such workshop was held in 2000 attended by 18 countries and 2002 by 28 countries. Among other supports of this foundation is the Rockefeller Foundation.

Monitoring and Evaluation of MHOs.
The network makes 3 yearly evaluations of MHOs in the region.

In 2000 one evaluation was made and for 2003 one is planned for later in the year. (ECSA network would benefit from this experience) –The report can be found in the website cited above. The first evaluation instrument is shown in the report of the 2002 workshop[6].

Partners supporting la Concertation: La Concertation is supported by GTZ, STEPS/ILO, CAMUS, PHR, WSM-World Solidarity, UNMS –from Belgium - the Federation of Belgian mutuelles, AIM, ANMC Christian Associations supporting mutuelles in Belgium. The above organizations support *the network* financially as well.

Technical Secretariat for MHO Network in West Africa

STEPS, PHRplus, ANNC technically support the network and form the secretariat of la CONCERTATION.

Focal Person: In each of the 11 countries there is a *la concertation* focal person.

[6] Currier de la Concertation Numero 9 Janvier 2003 Special Forum

ILO STEPS in other parts of Africa and HIV/AIDS HMO Members

STEPS/ILO is supporting Ethiopia, Tanzania etc but would like to support the whole of Africa. ILO has been trying to link MHOs with HIV/AIDS and governments are considering subsidies to support people living with HIV/AIDS. A poster to this effect was put up in Barcelona by the ILO.

According to ILO/STEPS affordability of ARVs is the issue and ARVS should be included in the MHO packages - Direct subsidy of the membership fees at the mutulle level is not *feasible.*

Areas in which the ECSA network could collaborate with ILO were discussed.

The following areas were identified.

- Monitoring and Evaluation – see sample of their tools in appendix.
- Feasibility studies
- Premium Determinations

10. COLLABORATION BETWEEN LA CONCERTATION AND ECSA-CHF ASSOCIATIONS' NETWORK.

During the discussion with ILO/STEPS in Dakar it was observed that collaboration with ECSA-Health Community can be initiated. It is conceivable that that STEPS/ILO, LA CONCERTATION AND GRAM OR PROMUSAF could be invited to participate in forums such as the DJCC and Conference of Health Ministers to share their experience on the above areas.

11. CONCLUSION OF THE MHO STUDY TOUR IN SENEGAL AND REVIEW OF THE OBJECTIVES

On the last day of the tour the facilitators and the group sat together to evaluate the study tour outcome. In particular, the facilitators wanted to hear to what extent the objectives,

learning the basics of setting up MHOs in West Africa had been fulfilled.

The main objectives were to learn from better practices and orient managers in ECSA.

In general the team felt well orientated in the setting and management of MHOs in West Africa, in particular Senegal.

The group came up with an ABC of setting up MHO, based on the Senegalese experience as follows: (For further information refer to the ILO/STEPS Manual).

- Feasibility studies now have a generic application. PHR and other organisaiton have technical expertise in doing generic studies. Though these studies are expensive, one needs to know the costs and priorities of communities. (Refer to Doyens presentation)

- Starting group to open doors for the community. The starting group is formed to bring to gather those interested in initiating an MHO in the locality.

- Training the starter groups: The group is introduced to the MHO concepts, how to sensitize communities and organize MHO.

- Starter group does sensitization which takes 6-12 months-depending on the target group. There should be enough potential members for the General Assembly. The group drafts Constitution, approximates membership fees, strategy for fees collection etc. In other words the starter group develops a proposal for the inaugural General Assembly of the potential MHO.

- General Assembly: (a) The GA will enable Government approval to establish MHO in the locality. The GA approves the constitution, membership fees, administrative council (15-20 members) which elects the executive bureau of about 6 composed of the chairman, treasurer, vice chairman or treasurer for all and the control committee of 2-3 people. (b) The control committee must have power to call a GA. At inauguration of the MHO, anybody interested becomes the member of the assembly. The results of the feasibility study (usually a generic one adopted for the region/country) are disseminated at the General Assembly.

- Further preparations are necessary before services are accessed: The waiting period depends on level of membership and the reserve. The period varies from 3 months to 2 years.

- Train the executive bureau in MHO management.

  It should be noted that there is a need to sponsor the starting of an MHO, eg GRAIM sponsoring CHF And Fagaru.

- Call a second general assembly to harmonize the process of setting up MHO[7].

- Contract signing: Now the *MHO management systems is set in motion: The MHO executive bureau will* sign Contracts with the Providers and then the service provision starts.

- Monitoring and evaluation

Lesson for ECSA-CHFs from West African Mutual Health Organisatons

- Learn from failed MHOs what to avoid.
- Too low premiums could not support services in one of the MHOs. The lesson is "Right premium for right package of services".
- Agree with the community

Challenges of setting up CHFs and how they were addressed in Senegal

To convince communities through small Community based groups, NGOs or partners or supporters eg. PHRplus, CIDR, PROMuSAF, ILO/STEPS, seems to be the better strategy currently in use in Senegal.

[7] Chris Atim, 2000, Training of Trainers Manual for Mutual Health Organisations in Ghana.

11. WAY FORWARD OF THE STUDY TOUR

The visiting group representing their countries came up with the following ideas that they would suggest to their constituencies in their countries.

Ethiopia: The two Ethiopian delegates from Essential Services for Health in Ethiopia, supported by USAID plan to disseminate the study tour report to the Government leadership at the Ministry of Health in Addis Ababa.

Uganda: The Secretary of the Uganda Community Based Health Financing Association comprising 11 schemes that are institution based, plans to convince his association to change those schemes into community based initiatives. He plans to advocate for longer waiting periods to give time for communities to accrue enough starting capital for Community Health Funds.

Tanzania The two delegates from Tanzania, the District Medical Officer of Hanang representing the Government scheme of Community Health Fund in Hanang District and the secretary of an institution based Community Health Funds of a faith based organization, the Evangelical Lutheran Church in Tanzania, had the following comments: "We started as provider based schemes, but it should now be possible to turn these into community based initiatives. We need an NGO to facilitate this process of having the communities own these schemes"

Kenya: No comment as the delegate had left a day earlier.

Senegalese Tour leaders: The leader of the tour in Senegal, Dr. Mounir Toure advocated the creation of a network between MOH in West Africa and The ECSA Community Health Funds Associations Network. It was further observed that the CRHCS

is suitably placed to coordinate such a network in collaboration with PHRplus in Dakar.

"Le Doyen" Mr. Assani Guye the leader of MHOs in Senegal: As his last word of wisdom this charismatic leader of the MHOs in Senegal stated that though the premiums are similar among the MHOs in Senegal, these premiums were still far from the real cost of services. This is a point that most MHOs and CHF members do not realize.

Appendix A

Study Tour of Mutual Health Organisations Senegal 18-28 March 2003

List of Participants

	Name	Title, Organization & Country
1.	Mr. Lucas Wadenya	Chairman, ECSA-CHF Network, Western Kenya
2.	Mr. Gideon Mbalakai	Chairman, Tanzania Network, ECSA/ELCT Partnership Network Tanzania
3.	Dr. Festo Massay	District Medical Officer /Tanzania CHF-Hanang District Pilot (USAID/PHR.CRHCS supported) Ministry of Health, Tanzania
4.	Mr. A. Mastiko	Secretary, ECSA-CHF Network, Uganda
5.	Dr. Yohannes Kebede	Focal Person, CHF Initiative for Ethiopia, Ministry of Health Ethiopia
6.	Mr. Abebe Albachaw	Health Care Finance Specialist / Abt Associates, Ethiopia
7.	Dr. Mark W. T. Bura	Health Care Financing Coordinator, CRHCS – Health Systems Development Programme, CRHCS / ECSA Network

Appendix B.

Study Tour of Mutual Health Organisations
Senegal 18-28 March 2003

STUDY TOUR SCHEDULE

Date	Activities	Location	Comments	People in charge
Tuesday /March 18,	**Arrival / Lodging**	Dakar	NOVOTEL & Ndiambour Hotel	**Mounir /Ngoné**
Wednesday/ March 19,	1.Plan validation 2.Presentation MHO/Senegal 3. Presentation of East /West /Central Africa experiences**	Dakar	To create a contrast by highlighting differences between experiences	Mounir /Ngoné/ Doyen Dr Bura –CRHCS Kenya Lucas Wadenya Uganda-Augustine Mastiko Ethiopia-Yohanes Kebede. Tanzania-Mr. Dendoro /Dr. Massay
Thursday /March 20,	1. Meeting with Senegalese Ministry of Health and Prevention (MHP) authorities	Dakar	Ministry of Pubic Health, Director of Prevention / Bureau Chief PARTENARIAT	Mounir /Ngoné
Friday .March 21,	1. Visit STEP/ CONCERTATION / CAMICS 2. VISIT PROMUSAF	Dakar		A. Cissé / Mounir / Ngoné /
Saturday /March 22,	Recap Activities of the Week	Dakar		Mounir/Ngoné/Chris
Sunday/ March 23	BREAK	Dakar	Bus tour + GOREE island tour	Ngoné
Monday March 24	1.Tivaouone /2. Lalane Diassap /3. Fandène	Thies	Small MHO's, first MHO's in Senegal /22km from Thies	Mounir /Ngoné /Doyen
Tuesday/	1. Sopanté /	Thies	MHO set up by	Mounir/ Ngoné /

March 25,	2.And-Fagaru / 3. Mutuelle de santé des femmes de l'informel		merchant women working in the informal sector /7km from Thies	Doyen
Wednesday/ March 26,	And Faggu / GRAIM Visit STEP	Thies	Complementary MHO / Support Group and Coordination Unit To meet C. Bokstal	Mounir/Ngoné/Doyen
Thursday / March 27,	SUMMING -UP	Dakar	Dakar	Chris / Mounir / Ngoné
Friday March 28,	Departure	Dakar	Airport at 9h00	

Appendix C

Study Tour of Mutual Health Organisations Senegal 18-28 March 2003

PEOPLE MET DURING THE TOUR

1. Dr. Aboubakry Fall, Bureau Chief, Senegalese Ministry of Health and Promotion
2. Dr. Cheikh Fall, Partnership Bureau / Direction of Prevention /Senegalese MHP
3. Pascal Ndiaye, Coordinator / La CONCERTATION
4. Christine Bockstal, Coordinator / STEP
5. Olivier Louis dit Guerin, in-charge for monitoring /STEP
6. Mrs. Diop, Directoir of CAMICS / Senegalese Ministry of Health and Promotion
7. Aminata Sow Sall, Coordinator /PROMUSAF
8. Sarr (PROMUSAF)
9. Andre Wade, Coordinator (GRAIM)
10. Pascal Ndione, Chairman of the Fandene scheme
11. Jonas Tine, General Secretary Fandene scheme
12. Rigobert Tine, Treasurer Fandene scheme
13. Thomas Diop, President (Lalane Diassap Scheme)
14. Pierre Diop , Treasurer (Lalane Diassap Scheme)
15. Pascal Mbaye, Vice president (Lalane Diassap Scheme)
16. Mame Diarra Mbaye , Chairwoman (And Fagaru Scheme)
17. Ramatoulaye Sarr Manager/Treasurer (And Fagaru Scheme)
18. Amidou Cissoko, Secretary General (And Fagaru Scheme)
19. Adele Mbaye , Member of the Sopante Scheme

20. Guèye Aïda Fall, Chairwoman (UFCT Scheme)
21. Suzuka Furtado Sarr, Manager/ treasurer (UFCT Scheme)
22. Pauline Fall, Member of the UFCT Scheme, Chairwoman of the UFCT micro-credit mutuelle
23. Coumba Ba, Treasurer (UFCT scheme)
24. Julie Cisse, Member (UFCT scheme)
25. Khady Cisse, General Secretary (UFCT scheme)
26. Baïla Bass, President of the Health Committee. Thies X^{e} Health Center
27. Papa S. Diop, Treasurer/ Health Committee, Thies X^{e} Health Center
28. Mrs Ba, PHC Supervisor/ Health Committee, Thies X^{e} Health Center
29. Assane Guèye , Chairman of the Faggu MHO
30. Abdou Diene, Manager of the Faggu MHO
31. Abdoulaye Diop, Treasurer of the Faggu MHO

Mbissine Diop, General Secretary of the Faggu