



Exploratory study of the impacts of Mutual Health Organizations on social dynamics in Benin

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ABSTRACT

The primary aim of Mutual Health Organizations (MHOs) is the financial protection of their members. However, given their community-based, participative and voluntary nature, it is conceivable that MHOs, as social organizations, would affect social dynamics. In an exploratory study in Benin, we studied social dynamics related to mutual aid, relationships of trust, and empowerment. Four MHOs, as contrasted cases, were selected from among the 11 in the region. Focus groups ($n = 20$) and individual interviews ($n = 29$) were conducted with members, non-members, and elected leaders of the four MHOs, and with professionals from the health facilities concerned. We carried out a qualitative thematic analysis of the content.

Mutual aid practices, which pre-date MHOs, can be mobilized to promote MHO membership. Mutual aid practices are based on relationships of trust. The primary reason for joining an MHO is to improve financial accessibility to health services. Non-members see that members have a strong sense of empowerment in this regard, based on a high level of trust in MHOs and their elected leaders, even if their trust in health professionals is not as strong. Non-members share these feelings of confidence in MHOs and their leadership, although they trust health professionals somewhat less than do the members.

The MHOs' low penetration rate therefore cannot be explained by lack of trust, as this study shows that, even with some distrust of the professionals, the overall level of trust in MHOs is high and MHOs and their leaders function as intermediaries with health professionals. Other explanatory factors are the lack of information available to villagers and, most especially, the problems they face in being able to pay the MHO premiums.

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Introduction

Mutual Health Organizations (MHOs) are non-profit community organizations whose aim is to improve their members' access to health care systems. Membership is voluntary; members come together under the principle of solidarity (Criel & Waelkens, 2003). MHO development in West Africa since the 1990s has been significant. In 1997, there were 76 MHOs in 11 West African countries; by 2003, that number had reached 366, and the 2006 estimate was 626 (Ndiaye, Soors, & Criel, 2007).

MHOs' primary objectives are to ensure their members are financially protected when using health care services and to mobilize supplementary resources (Ekman, 2004). Their impacts are thus generally assessed against these criteria, somewhat simplistically. However, MHOs are also social organizations that interact with and act upon their environments. Because they are community-based and their participative, voluntary activities support exchange and solidarity, MHOs may positively influence social dynamics in settings where they are implemented (Mladovsky & Mossialos, 2006). By acting upon these social dynamics, particularly in the distribution of power and the empowerment of their members, MHOs can promote greater health equity (WHO, 2008a). This influence includes all effects MHOs can have on the social organization of the whole community, not just on their members. This comprehensive definition is

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operationalized in the Methods section, particularly as it applies to the intervention implemented in the specific context of Benin. To date, these potential effects have been very little studied (Schneider, 2005; Waelkens & Criel, 2004). This article presents the results of a qualitative study that explored the effects on social dynamics of MHOs in Benin.

MHOs and social dynamics

Evaluability assessment and concepts related to social dynamics

We carried out an evaluability assessment to identify the intervention theory and to focus our research objectives on the outcomes intended by the implementers. We analyzed project documents, conducted individual interviews, and met with those in charge of the intervention. The stakeholders clarified the theoretical links they perceived between the MHOs' organization and the social dynamics. The potential effects of MHOs on social dynamics were seen primarily to be in: i) *mutual aid* activities, not only among members but also in the community at large; ii) members' relationships of *trust* with MHO leaders and health professionals; and iii) members' sense of *empowerment*. We explored these theoretical links in our study.

- i) Mutual aid practices are carried out by a group of persons who decide to share expenses, duties and risks, whether for health expenses, social expenses (weddings, funerals), or work projects (home or harvest) (Arhinful, 2003; Atim, 1999; Habtom & Ruys, 2007).
- ii) Trust is a relational concept in which a person who is vulnerable or at risk (the truster) believes optimistically that another person, group, or organization (trustees) will look after his interests (Calnan & Rowe, 2006; Goudge & Gilson, 2005). Trust can be interpersonal (horizontal) or institutional (vertical). Interactions among the actors involved in MHOs (e.g. health providers, MHO leaders, members) are at the heart of the relational dimension of social dynamics. A health system based on relationships of trust helps to set societal values (Gilson, 2006) and also exemplifies them (Gilson, 2003; Ridde, 2008a). Conversely, "erosion of trust in health care constitutes a threat to social stability" (WHO, 2008b).
- iii) Empowerment is an active, participative process that supports the development of individuals', organizations' or communities' capacity to exercise control over the changes that concern them (WHO, 2006). The result of this process is also an objective in itself, making empowerment as much a process as an outcome (Ridde, Delormier, & Gaudreau, 2007). Ninacs (2008) presents empowerment as a succession of interlocking steps, like four threads making one rope (Fig. 1), representing these four dimensions: a) participation (from manipulation to participation in decision-making); b) technical competencies (knowledge to act and participate); c) self-esteem (self-recognition and recognition from others); and d) critical conscience (collective, social and political consciousness). This analytic framework has been used to evaluate or develop public health programs in Haiti and in West Africa (Bernier, Arteau, & Trudelle, 2006; Ridde & Queuille, 2006).

Previous studies

Studies exploring these three dimensions of social dynamics in the context of MHOs in Africa are relatively rare.

- i) In Eritrea, Habtom and Ruys (2007) inventoried several categories of solidarity groupings. Mutual aid for health

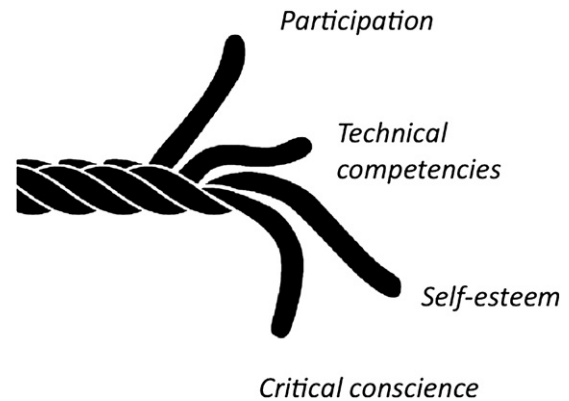


Fig. 1. Empowerment dimension. Source: Ninacs, 2008

- expenses remains largely provided by the extended family and religious associations. The socio-economic homogeneity of MHOs' members may hinder their capacity to create solidarity, redistribute resources equitably, and organize exemptions for the worst-off (Bennett, 2004; Ekman, 2004). Mladovsky and Mossialos (2006) call this the "negative" effect of social capital. When MHOs are connected with pre-existing mutual aid networks, households are more likely to join (Fonteneau, 2000; Habtom & Ruys, 2007; Jowett, 2000), although not always (Criel & Waelkens, 2003).
- ii) Studies in Rwanda, Uganda, and Burkina Faso have shown that trust in the MHO managers is essential to securing membership (Basaza, Criel, & Van der Stuyft, 2007; De Allegri, Sanon, & Sauerborn, 2006; Schneider, 2005). The risks covered and the terms of premium collection also affect members' confidence in MHOs (Chankova, Sulzbach, & Diop, 2008). We found no study in Africa on the development of trust relationships among MHO members.
 - iii) There seem to be no studies on MHOs relating to empowerment. However, some authors (Molyneux, Hutchison, Chuma, & Gilson, 2007) suggest that members of community organizations or of MHOs are becoming aware of their power with respect to the quality of care (Waelkens & Criel, 2004). For example, Schneider (2005) reports that members of a Rwandan MHO said they have the right to good-quality services, suggesting they are more demanding as patients. Conversely, we also know MHO managers often have little room to negotiate adequately with care providers (Schneider, 2005; Waelkens & Criel, 2004). Comparing two MHOs in Ghana and Cameroon, Atim (1999) showed that the sense of ownership toward MHOs is associated with the intensity of members' participation.

Context

This study was undertaken in collaboration with an international NGO (Centre for International Development and Research – CIDR) that supports the development of MHOs in a northern region of Benin. After MHOs began emerging under the impetus of NGOs and international agencies in the 1990s, Benin adopted a national policy beginning in 2003 that demonstrated the country's political commitment to MHO development, as well as its willingness to follow WHO recommendations favouring prepayment systems (WHO, 2008b). Our study took place in Parakou, a rural region in the centre of the country, whose economy is based on agriculture (corn, cassava, cashew nuts) and where the dominant religion is Christianity. Since 1993, CIDR has supported the creation of MHOs, whose development has been strengthened by the existence of three district hospitals. In 2007, there were 29 MHOs with a total of

27,000 members—a 4.5% penetration rate. The MHOs are grouped into a federation, the Health Alliance Network (*Réseau Alliance Santé* – RAS). All MHOs in a district hospital's catchment area are grouped into an “inter-MHO” to coordinate negotiations with health facilities. Our study was concentrated in the Papane inter-MHO, which comprises 11 MHOs.

The regional health system has three levels. First, there is the Papane hospital, which is denominational and offers first- and second-line services (100 beds). Its funding comes from a State grant, development partners, and user fees. Next, there are commune (CSC) or *arrondissement* (CSA) health centres, with nurses and midwives. Finally, the village health units (UVS) are managed by community health workers; recently these have become the first contact with the health system, staffed by nurses. Everywhere, patients pay for services; the money is managed by a village management committee. Unofficial payment is a known fact in the region.

The basic MHO organizations are the village mutual aid associations (GMV). The GMV secretaries collect the annual premiums, which they transmit to the MHOs. Each MHO in Papane includes on average 33 GMVs. Membership is thus on a village basis, but the risks are shared at the level of the rural commune, where the MHO management is located. MHOs are managed by a committee of three persons chosen by delegates of the GMVs. The annual premium is between 1500 F (2.3 €) and 2000 F (3 €) per person, depending on the MHOs. From these fees, 2.5% is transmitted to the RAS. The services covered are the high risks (heavy financial burden): childbirth, caesareans, hospitalizations, and urgent surgeries. For visits, members must pay a deductible of between 1000 F and 2000 F (1.5–3 €) and a co-payment of 25%–30% of the actual cost or of the fee. The system is “cashless”, with health facilities being reimbursed by the MHOs, except for the co-payments paid by users at the point and time of use.

Methods and data

Case studies and selection of participants

The methodological approach is that of multiple contrasted case studies with embedded levels of analysis (Yin, 1994) corresponding

to the three dimensions studied: mutual aid, trust, and empowerment. Considering the limited resources available, four contrasted cases were selected according to six criteria (Table 1), with the aim of selecting cases that would represent the diversity of the scenarios that could be encountered.

MHOs involve many types of actors, and obtaining their perspectives is essential to strengthen the internal validity of the analyses through triangulation of data and methods (Yin, 1994). To this end, we carried out in March and April 2007 individual and group interviews with: 1) villagers who were MHO members; ii) villagers who had never been members; iii) elected leaders of GMVs; iv) coordinators of the NGO project; and v) health professionals. Because MHO membership is at the village level through the GMVs, the first three types of interviews were carried out in the villages, where participants were most often recruited with the help of MHO leaders and GMV secretaries. In some villages, the researchers did the recruitment themselves.

Data collection tools

We carried out focus groups ($n = 20$) and individual interviews ($n = 29$) (Table 2).

Interview guides were developed based on the three dimensions to be studied. They were translated into the two main languages of the region (Nagot, Mahi) and pretested. Interviews were carried out either in French or in the local language and were recorded. The themes addressed are presented in Fig. 2.

Data analysis and ethics

The discussions were retranscribed into French with the help of an experienced local translator. The data were analyzed using thematic content analysis. The principal investigator (VR) and an anthropologist assistant from Benin (MY) read all the interviews several times to identify the main themes corresponding to the three dimensions of social dynamics. Then all the statements were coded with QSR NUD*IST software according to these themes, while allowing for the emergence of additional themes. Using matrices, the material was organized by dimensions and by cases studied, for better content analysis (Miles & Huberman, 1994). The translator in

Table 1
Some characteristics of the selected cases (2007).

	MHO1	MHO2	MHO3	MHO4
Penetration rate	5.88%	2.96%	6.62%	2.07%
Implementation date	2001	1998	1998	2001
Village socio-economic situation	V1	V2	V3	V4
Majority social group	Nagot	Nagot	Nagot	Mahi
Rurality	Near a city	Rural	Rural	Near a city
Schools	1 primary school	1 primary school	4 primary schools, 1 secondary school	2 primary schools, 1 secondary school
Immigration	Migrant farm workers and herders	Migrant farm workers and herders	Migrant farm workers and herders	
Selection criteria for cases				
A Length of presence of CSC personnel	>2 years	< 2 years	>2 years	>2 years
B Number of members	87	42	155	28
C Rate of re-enrolment	11%	53%	9%	75%
D Rate of CSC utilization	1%	3%	28%	30%
E Governance level score	0	0	1	–2
F Social dynamics	–	+	+	–

Notes: Rate of re-enrolment = number of members enrolled in 2007/number of members enrolled in 2006; rate of CSC utilization = number of members having used a CSC/total number of members. MHO governance = judgments made by two members of CIDR who have been present for more than 10 years, on a scale of –2 to +2. Social dynamics = judgments made by two members of CIDR on a three-level scale of – to +. Source: RAS, CIDR.

Table 2
Number of persons interviewed.

	V1	V2	V3	V4	Region	Total
Male members (MM)	18	14	25	20		77
Female members (FM)	14	10	08	12		44
Male non-members (MNM)	17	17	07	09		50
Female non-members (FNM)	12	14	08	13		47
MHO elected leaders	03	02	02	02		9
Health workers	06	02	03	03		14
Project coordinators					6	6
Total persons encountered						247
Women (F)	29	25	17	27	3	101
Men (M)	41	34	36	32	3	146

Source: Authors

Benin was consulted as necessary during the analysis to ensure there were no errors of interpretation. The preliminary results were presented for review in Benin in April and October 2008 to most of the stakeholders, with the four authors of this article present. The study was approved by the ethics committee of the Research Centre of the *Centre hospitalier de l'Université de Montréal* and an ad hoc ethics committee of the *Université de Parakou* in Benin.

Results

The results are presented according to the three areas of social dynamics studied. When the data allow, we specify differences between members (women FM, men MM) and non-members (women FNM, men MNM). These differences relate primarily to ideas of trust and empowerment; we did not observe any particular differences among the four cases.

Mutual aid practices

First, we should say that we did not encounter any mutual aid practices that emerged as a result of MHOs. These practices existed

Mutual aid:

- Organization of mutual aid systems specifically for health care
- Organization of mutual aid mechanisms that include non-members
- Envisioning a system that would look after the indigent

Trust

- What it means to trust someone
- Trust in other members, in the elected officers, in the mutualist organization, in the health care workers

Empowerment

- Joining a mutual to be able to act on something important
- Participating in actions, discussions and decisions
- Competencies/skills/abilities acquired to be able to take action
- Personal satisfaction derived from membership status
- Identification of causes and of detailed actions needed for change

Fig. 2. Themes addressed in the interviews.

beforehand. We describe them later, but sometimes they may support MHO membership, which we explain here.

The first type of community group we encountered in the villages focuses on financial and material aspects without actually being related to MHOs. Such groups operate along the lines of a “community credit cooperative”, where each member pays a subscription to increase the collective capital and can benefit from a grant or loan. The purpose is essentially economic (farming, gari manufacture, etc.) and sometimes social (death, marriage). Members share common social or professional characteristics: young people, people from the same village, etc. However, mutual aid is not always the focus of these cooperatives, their economic nature being more important: “*The different groups that we just mentioned are not mutual aid groups. When you have a health problem, you deal with it on your own*” (FNM V1; see Table 2 for interview acronyms). These cooperatives pre-date MHOs: “*We help each other, but it didn't happen because of the MHOs*” (MM V1), and members are not the only ones who can participate.

However, it happens that some associations are approached to support the enrolment of their members in MHOs. In V3, for example, some males started an association of about 30 people that can sometimes help members when it is time to collect premiums. To join, “*We pay 5,000 F plus a litre of sodabi (local whisky)*” and weekly premiums of 500 F (.75 €). Occasionally someone from outside the association will request a loan, in which case, “*The rate of interest to belong to the MHO is 10%*.” Thus, sometimes MHO promoters rely on existing associations to encourage the creation of the MHO: “*This is what I did at V2, these are traditional cooperatives that are already operating and that I make aware.*”

In none of the four cases did mechanisms emerge to facilitate membership for the poor. Many reasons, not mutually exclusive, are mentioned to justify this omission: i) this is not the MHOs' target public and these people do not have sufficient means to subscribe; ii) MHO members do not have the means to subsidize the poor (“*We can't ask the blind to lead the blind*” (MM V2)); iii) there are no indigents in the community; iv) it's a family responsibility; and v) MHO regulations do not support it: “*According to the MHO's principles, people are not allowed to enrol another person on their list who is not part of their family*” (MM V2).

Trust

Feelings of trust were studied at four different levels involved in the MHOs.

Trust among members

Being together and knowing each other encourages trust among members, “*because we're a unit*” (FM V1). Members provided us with evidence of this trust. In V3, the MHO accepted payment in kind (cashew nuts) from some members for their premiums. However, in some MHOs the idealistic vision is easily swept aside. In V4, for example, certain members were reimbursed for services provided to people who were not on the list of beneficiaries. After this, the MHO installed a photo system, and “*now there is a little more confidence*,” the director told us. A coordinator in V1 explained that some members who mistrust GMV secretaries give their premiums directly to MHO office staff, and thus, “*This means that trust doesn't exist at all levels.*”

Trust in the elected leaders of the MHOs

All the members fully trust the elected leaders of the MHOs—first, because there has never been any “*embezzlement*” (FM V1), and second, because these leaders often intervene with health workers for better services to members. This trust is reinforced by the villagers' knowledge of each other and the leaders' close relationships

with the members and the GMVs. Often, the leaders' longevity in the MHOs is a testament to this trust: *"The leaders in this place have been there for years"* (health worker CSC V4). The accounts reporting practices organized by the elected leaders help build and consolidate the trust expressed by members: *"When you help a blind man to shell a peanut, you need to whistle to show that you're not eating his peanut... That's what the elected leaders do there"* (MM V2).

Trust in MHOs

Members who received services and were reimbursed have absolute trust in MHOs, which in turn encourages membership. *"People see that it's for real, you pay your premiums and you will receive care"* (former MHO president V3). This trust is doubly advantageous for MHOs. First, it creates loyalty in their members, who then become effective ambassadors of MHOs in the villages. Like the members, health workers also have confidence, on the concrete basis of payments being reimbursed: *"We're sure that, if it's a member, we will get our money"* (health worker CS V3).

Many non-members we interviewed also trust the MHO because they believe it serves a noble function; they hear *"what goes on"* (FNM V2) in the village, and they think it helps with access to care. However, trust is not inducement enough to join: *"If they could lower the premiums, it would allow us all to belong to the MHO"* (FNM V1); *"We trust the MHO, but they tell us that you have to pay to join, and we have no money"* (FNM V3). Some non-members, however, say they are less confident in the MHO because they have heard (whether true or not) that the MHO does not fully cover their health costs: *"We don't trust the MHO that much because we see members taking money out of their own pocket to pay for services"* (MNM V4). Aside from unofficial payments, this observation may be related to the imposition of user co-payments, which certain members have neither understood nor appreciated.

Trust in the health workers

For many members, *"We don't trust the health workers because when a mutual aid member goes to the hospital, the services he receives are different"* (MM V4). Some complain that the health workers prescribe more medications than necessary, that are more expensive or not covered by the MHO. Others explain that the illegal practices of the workers persist, notably the overcharging of non-members. Not being a member can increase the likelihood that someone will be *"taxed"* (MM V3) or less well received: *"If you're a member, they take you right in, but if you're not, then first they park you like a bicycle"* (MNM V3). Certain minority subgroups seem to be victims more often, because of their social and geographic isolation: *"The Peuls are the ones that the health workers swindle the most"* (MM V3). Health workers do not have a monopoly on these behaviours; some people say the health centre cashiers are not always honest. Nevertheless, we also heard positive reports from both non-members and members who had been well treated.

Overall, the assessment of trust in health workers varies according to the type of health centre. The lower the centre is in the health system pyramid, the higher the level of trust seems to be. In villages, people's proximity to the health workers engenders trust, since *"The UVS workers are our children"* (MNM V2), the latter often being community health workers. Conversely, regarding the referral hospital, where this interconnectedness has disappeared, the vast majority of respondents said, *"We have no confidence in the health workers of the V1 hospital"* (GMV V3).

Empowerment

An individual's power to act (empowerment) cannot be increased by one single intervention that touches all aspects of life (Ninacs, 2008). So, we attempted to understand what part of this dimension,

which people considered especially important, they wanted to act on by becoming members. For the great majority, the first and foremost reason was to have power over financial accessibility to health care: *"It's really the easy access that got us to join the MHO"* (MM V1). A second reason—but very secondary and rarely mentioned—is solidarity. Being able to act on the quality of services was not mentioned. Below, we examine the four elements of empowerment.

Participation

Even if the members attend meetings, they do not always remember the decisions taken. These same people complain that meetings are held far from the village, such that *"It's our leaders who attend, not everyone"* (MM V1). Generally, *"Meetings are called, many don't come or arrive late, it doesn't work"* (MM V1), which was confirmed by the inter-MHO president. A former MHO president explained: *"The problem is, they join and then it's over"* (V3). Attendance at MHO meetings and participation in decision-making appears to reflect the social organization, which generally excludes women: *"We women, we have nothing to do with these meetings"* (FM V1).

Technical competencies

The higher we go in the mutual aid "hierarchy" (members, GMV, MHO elected leaders), the more improvement we see in people's technical competencies. Once such competency is public speaking, particularly among the GMV secretaries. This is also the case for some women: *"Today, thanks to the MHO, I can speak without being afraid of anything; I say what I think, even if it's not good"* (FM V4). One member likewise said, *"The MHO has loosened our tongues"* (MM V3). The elected leaders and GMV secretaries mentioned more technical aspects having to do with accounting, management, note-taking, and writing minutes. The elected leaders of V2 are pleased to have acquired group leadership skills. Knowing *"the list of diseases that will be treated"* (MM Papané) at the hospital is among the competencies acquired thanks to the MHO. Non-members also observe the differential advantage: *"The members are more aware than the non-members. They take more precautions against diseases, while the non-member is surprised by disease"* (MNM V4). On the other hand, the lack of information among non-members contributes to their reluctance to join. Women non-members of V4 are demanding other strategies than radio, and other people say, *"We have often heard talk of MHOs, but no one ever brought us together the way they do today"* (MNM V1). They don't always know what risks are covered, or they believe the elected leaders are remunerated by the MHOs, making premiums more expensive.

Self-esteem

Many of those in charge of MHOs are proud to be part of an enterprise that improves the health of people in their village. This feeling is shared by members: *"We are proud and satisfied with the MHO"* (FM V4). In some areas, not being a member is a source of shame. *"The Tchabè don't like us to say they are poor, that's why many of them do everything possible to belong to the MHO. If you're not a member, it's because you can't pay"* (MM V3). The pride of membership allows them to compare themselves with others: *"Before we were in the lead and now we've been surpassed by the neighbouring area"* (MM V3).

This pride is felt also in how they are regarded by others, which sometimes extends beyond the health care system. For example, *"Today, because of the MHO, we are welcomed into the mayor's office right away, while before we could be asked to wait,"* said the director of the MHO of V1. In the city or in the hospitals, they are recognized by residents as being people in charge. They say that, in managing *"the population's money"* and being leaders who work with people from international projects, they have acquired prestige and the confidence of others. *"Thanks to the MHO, I am a man of influence, we are respected,"* the president of the MHO said.

Critical awareness

Most members had become aware of their right to complain about how they were treated in health centres: “*They know that the health workers can no longer affect them; they know that they can no longer be sold embezzled drugs [unofficial payment]*” (Coordinator). The elected leaders of V2 had even managed to get identification numbers put on health workers’ shirts in the hospital, to make it possible to identify persons responsible in the case of a member’s complaint. Some non-members understood the benefit of member status: “*I know that, if I am a member, when health workers take too long to look after me, I can make a fuss*” (MNM V1). They recognize that only two statuses allow them to “*make a fuss*”—having money, or being an MHO member.

Health care workers have also observed this growing awareness, which obviously they do not always appreciate: “*When they come and they have their cards, they are quick to let you know they are members. They push you to review the bill*” (Nurse V1). A nurse adds, “*The MHO patient says, ‘I have my card, hurry up, take care of me quickly.’ They are a bit restless*” (Nurse V3).

The balance of power generated by the MHO has not always been readily accepted by the health workers. In certain cases (but not always), negotiations have had positive outcomes, testifying to the interrelationship between critical awareness and trust, since “*Now we have a little confidence*” (MHO president). The members are aware: “*Since our leaders started working with them, these practices no longer arise*” (MM V1). It is essential to preserve this positive relationship with the health workers because, as a former MHO president said, “*Where people have trust, you will see that the MHO moves forward.*”

Discussion

Methodological limitations

Carrying out a study associated with a development project can incur the risk of a social desirability bias among the participants. However, we made it clear to those we interviewed that this study was being carried out independently and that the results would have no effect on the NGO’s support for the MHOs.

Generally, the social dynamics appeared identical in the four cases studied. This convergence of results might prove, on one hand, the plausibility of our assertions based on a qualitative field study and, on the other, the internal validity of our research, since “*If the patterns coincide, the results can help a case study strengthen its internal validity*” (Yin, 1994). The convergence of results shows that the four cases have, overall, the same levels of trust and empowerment, but with different rates of penetration (Table 1). Thus, we could hypothesize that one explanation for this difference in penetration might be people’s ability to pay.

MHO enrolment: trust or ability to pay?

After 15 years of support to MHO development in this northern region of Benin, the rates of penetration, despite a few differences among the four cases, have stagnated at around 5% for the past several years. This low rate corresponds to the general situation of MHOs in Africa (De Allegri, Sauerborn, Kouyate, & Flessa, 2009). The results of this qualitative study confirm those obtained in Guinea-Conakry (Criel & Waelkens, 2003) and Cambodia (Ozawa & Walker, 2009) showing that MHOs’ poor success cannot be explained only by lack of trust. Members and non-members in Benin demonstrate a high level of trust in MHOs, their members, and their elected leaders. Several factors contribute to this sense of trust and ownership: the MHOs’ organization model, based on GMVs and on villagers’ knowledge of each other; the empowerment of the elected leaders; and positive experiences with MHOs or similar organizations. These results are in line with those observed in

Cameroon, Kenya, Guinea-Conakry, Ghana, and Burkina Faso (Arhinful, 2003; Atim, 1999; Criel & Waelkens, 2003; De Allegri, Sanon, Bridges, & Sauerborn, 2006; Molyneux et al., 2007).

The explanation for MHOs’ poor rate of success must therefore be sought elsewhere. Among the many factors, the data from this study lead us to believe the explanation lies primarily in two of them: villagers’ difficulty in paying the MHO premiums (and co-payments) and their lack of information about the risks covered and how MHOs are organized.

As we have seen, non-members trust the mutual aid system. Even though our study did not directly relate to enrolment, most of them spontaneously mentioned their inability to pay to explain why they were not members. The imposition of co-payments on members also appeared not to be viewed very positively. In addition, as in Guinea-Conakry and Uganda (Basaza et al., 2007; Criel & Waelkens, 2003), those who join MHOs are essentially motivated by the hope that their membership status will remove financial barriers to access to the health care system. Financial considerations are therefore just as central to those who join as to those who do not. In Kenya, “*Lack of money and low levels of trust often undermine the success of [local-level community-based organizations]*” (Molyneux et al., 2007).

Many non-members showed a relatively poor level of knowledge about MHO organization and the types of risks covered. This helps to explain why MHOs have hardly penetrated the villages. In fact, many studies have shown the importance of information and the need to adapt it to target publics to foster increased MHO membership (Basaza et al., 2007; Chankova et al., 2008; De Allegri, Sanon, Bridges, et al., 2006; De Allegri et al., 2009; Ozawa & Walker, 2009). However, this does not seem always to produce the desired result, since in Guinea-Conakry it was shown that the population was perfectly well informed, contrary to what the health professionals believed (Criel, Diallo, Van der Vennet, Waelkens, & Wiegandt, 2005).

MHOs and the relationship with health professionals

While we cannot speak about the quality of care, our study appears to confirm the existence of relationships of distrust between the populations and health professionals in West Africa (Jaffré & Olivier de Sardan, 2003), as well as of the illegal practices observed in Benin (Blundo & Olivier de Sardan, 2007). Members highlighted the role of MHOs and their elected leaders as intermediaries with health professionals to improve the quality of care. We also believe, however, that the role of supervision of the members in the district should be strengthened, to ensure the quality of services and the maintenance of a good-quality supply. Some authors hypothesize that quality of care, like financial accessibility, is a determinant of MHO membership. This does not seem to be the case in Uganda (Basaza et al., 2007)—where the system is based primarily on not-for-profit facilities—contrary to Burkina Faso, Ghana, or Guinea-Conakry (Arhinful, 2003; Criel & Waelkens, 2003; Dong, De Allegri, Gnawali, Soares, & Sauerborn, 2009). In a rural West African context, where MHOs do not have the option of dealing in a competitive environment, a relationship of trust with health professionals appears to be crucial for MHOs’ future development. Covering the small risks (lesser financial burden) at the level of the health centres, where there is more trust in health workers and greater attendance than in the hospital, could help MHO development. The increased involvement of MHOs and their members in health facilities management and in negotiations with health professionals could promote trust (Birungi, 1998) and empowerment. The implementation of MHOs can therefore also be justified by this role of intermediary between patients and health care workers. Obviously, this change in power

relationships is not without problems for health professionals, as was seen not only in Benin, but also in Guinea-Conakry (Criel et al., 2005). In fact, this is an additional, relatively recent point coming out of anthropological studies on the relationships between caregivers and care recipients, in which the latter are often at a disadvantage. In the present study, health care workers also complained about abuse from some patients. We observed this type of behaviour also in Niger, where the removal of financial barriers by abolishing user fees has transformed the power relationships and resulted in certain abuses by patients (Ridde & Diarra, 2009).

Mutual aid and limited solidarity

In this study, we were unable to uncover any verifiable impacts on the types of solidarity investigated. While certain pre-existing traditional mutual aid mechanisms might favour membership in these associations, a system of sharing health risks apparently does not lead to new mutual aid practices. Solidarity and principles of equity, both upstream and downstream from community-based health initiatives, are barely in evidence. On one hand, pre-existing community initiatives like credit unions are homogeneous and based on personal relationships or strong social connections, as is often the case in Africa (Lelart, 2001). Solidarity is “narrowly achieved [authors’ translation]” (Vuarin, 2000), and solidarity groups exclude those who do not resemble them—the previously mentioned “negative” effects of social capital. On the other hand, none of the four MHOs had organized a system to provide access to care for the worst-off, which is nothing new in Benin and neighbouring countries (Ouendo, Makoutode, Agueh, & Manko D’almeida, 2000; Ridde, 2008b). MHO promoters are primarily concerned with financial equilibrium and the viability of their organizations (Ouimet, Fournier, Diop, & Haddad, 2007). Thus, of course, it is the poorest who are not members, and those who are members get the best treatment. “Smaller-scale insurance can have a negative impact on health equity” (WHO, 2008a). In a context of poverty, our results also show the limits of social engagement for the benefit of the worst-off members of society: “Although community-based insurance is a step in the right direction, we cannot merely promote solidarity among poor people.” (Frenk, 2009).

Avenues of research

The objective of this study was not operational, but from the data collected, we are able to formulate some avenues of research that would support the development of MHOs. Specifically, it would be useful to determine the extent to which:

- relying on existing mutual aid groups helps to promote the emergence of health mutuals;
- membership in MHOs improves if people’s new needs and requests are considered when defining the risks covered, and if the mistaken information about MHOs is rapidly corrected;
- rapid reaction by MHOs to harmful practices makes it possible to correct them;
- the MHOs are effective in their negotiation and advocacy roles, being intermediaries between users and health care providers;
- the MHOs negotiation and advocacy activities need to increase as they move further up in the health pyramid.

There continues to be an important need for new knowledge development. There are several conceptual frameworks on trust in the field of health care, but more empirical research should be undertaken, particularly in Africa. An attempt was made in Cambodia to create an instrument to measure quantitatively people’s level of trust in MHOs (Ozawa & Walker, 2009); this could

be tested in Africa. It might also be advisable to use the new analytic framework for empowerment that we have proposed here (Ninacs, 2008), which merits other applications to reinforce its usefulness. As others have done in the fight against HIV in Africa (Bernier et al., 2006), the actors could also use this framework as a planning tool for promoting MHO development.

Conclusion

The results of this study show that the level of trust in MHOs is high, that MHOs can serve as brokers between members and health services, and that ability to pay continues to be a significant factor of enrolment. Abolishing user fees could have an impact on these three interrelated elements. In fact, in 2008 the president of the Republic of Benin announced the abolition of fees for children under the age of five years. This measure has not yet been applied but, as in Uganda, the promoters and managers of mutual aid associations are worried because many families join MHOs primarily to cover their children. Also, the current trend to eliminate payment for health care in Africa could, on one hand, weaken MHOs; on the other, this could be doubly positive for them. First, if payment for health care services were eliminated, people would eventually find their way back to the health centres and regain their confidence in the health care system and in a State that, finally, will protect its people. However, for this to be true, the State must obviously maintain and improve the quality of services, particularly by ensuring that there are sufficient health personnel and drugs to meet the growing demand. Second, the MHOs could negotiate with the State to manage the funds provided by the government for the exemption. This could energize the MHOs, strengthen people’s confidence in them, and increase their ability to establish effective partnerships with health professionals, in order to begin moving in the direction of universal access to health care (WHO, 2008a, 2008b).

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