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Declining subscriptions to the *Maliando* Mutual Health Organisation in Guinea-Conakry (West Africa): what is going wrong?

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Abstract

Mutual Health Organisations (MHOs) are a type of community health insurance scheme that are being developed and promoted in sub-Saharan Africa. In 1998, an MHO was organised in a rural district of Guinea to improve access to quality health care. Households paid an annual insurance fee of about US$2 per individual. Contributions were voluntary. The benefit package included free access to all first line health care services (except for a small co-payment), free paediatric care, free emergency surgical care and free obstetric care at the district hospital. Also included were part of the cost of emergency transport to the hospital. In 1998, the MHO covered 8% of the target population, but, by 1999, the subscription rate had dropped to about 6%. In March 2000, focus groups were held with members and non-members of the scheme to find out why subscription rates were so low.

The research indicated that a failure to understand the scheme does not explain these low rates. On the contrary, the great majority of research subjects, members and non-members alike, acquired a very accurate understanding of the concepts and principles underlying health insurance. They value the system's re-distributive effects, which goes beyond household, next of kin or village. The participants accurately point out the sharp differences that exist between traditional financial mechanisms and the principle of health insurance, as well as the advantages and disadvantages of both. The ease with which risk-pooling is accepted as a financial mechanism which addresses specific needs demonstrates that it is not, per se, necessary to build health insurance schemes on existing or traditional systems of mutual aid. The majority of the participants consider the individual premium of US$2 to be fair. There is, however, a problem of affordability for many poor and/or large families who cannot raise enough money to pay the subscription for all household members in one go. However, the main reason for the lack of interest in the scheme, is the poor quality of care offered to members of the MHO at the health centre.

Keywords: Community health insurance; Mutual Health Organisations; Social perception; Health services accessibility; District health systems; Guinea-Conakry

Introduction

Mutual Health Organisations (MHOs) have been defined as autonomous, not-for-profit, member-based organisations whose aim is to improve access to health care. They are voluntary associations based on solidarity between members (Atim, 1998). Insurance is the financial mechanism most commonly employed, but members sometimes opt for pre-payment, credit or savings arrangements. A movement of MHOs is emerging in Africa—especially in French speaking countries[1] (Brouillet, Wade, Kambé, & Ndao, 1997;

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[1] The MHO is the most common type of community health insurance or micro-insurance as some label these innovative

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Bennett, Creese, & Monasch, 1998; Atim, 1998; Criel & Van Dormael, 1998).

In 1996–2000, a research project to study the feasibility of MHOs (PRIMA—*Projet de Recherche sur le Partage de Risque Maladie*)[2] was carried out in the Kissidougou district, within the province of *Guineé Forestière*, part of rural Guinea-Conakry.

Health policy environment of the PRIMA project

The health care system of Guinea-Conakry has made significant advances since the mid-eighties. With the support of the international community, the entire public health care delivery system was revitalised, especially in the rural parts of the country. Cost sharing was introduced for first line services through the creation of revolving funds; clinical decision-making was rationalised; health committees were created with the object of encouraging community participation in the management of the health services. In a second phase, district hospitals were rehabilitated to provide the necessary support for the health centre network. All this was done in a well-planned, nation-wide effort, which was sustained for many years. Increasing utilisation rates observed at all levels of the health system in the late eighties and early nineties were an unequivocal endorsement of this policy. The renaissance of the Guinea health system was considered to be one of the success stories of UNICEF's Bamako Initiative strategy in West Africa (Levy-Bruhl et al., 1997).

But the limitations of this centrally planned policy gradually became apparent. The top-down management and decision-making processes that may have been justified during the mid-eighties and early nineties went together with standardisation and uniformity, leading, eventually, to rigidity. There was little room left for local creativity and genuine community participation. Increasingly, patients expressed their dissatisfaction about the quality of care in public health facilities. Complaints were voiced against the standardisation of clinical decision-making which was perceived as excessive and not appropriate to patients' needs, and about attitudes that were regarded as unpleasant and disrespectful amongst health workers (Haddad, Fournier, Machouf, & Yatara, 1998). Eventually, more and more people began to look to the private sector for alternatives. It is against this background that the PRIMA research project was designed and launched.

Local context

The Kissidougou district has about 180,000 inhabitants. Government health services are organised into a two-tier system: a network of health centres and a district hospital. With the exception of informal and traditional practitioners, there are few private health care providers. The government hospital has a virtual monopoly.

Payment for health services provided by the government is a compromise between a flat fee and fee-per-item. The fee charged for a hospital admission varies between US$10 and US$30; the fee charged for an episode of care at a health centre varies between US$1 and US$5. The rates are different for adults and children, for curative and preventive care, and depend on the nature of the problem and the type of drugs or laboratory investigations required. It is a complex system frequently abused by health workers who levy illicit payments on top of the official fee. Communities are not sufficiently organised to challenge this behaviour at present and attempts to curb overcharging have failed.

The principal source of revenue for rural households in the *Région Forestière* is arable farming. Rice, coffee and cola are harvested towards the end of the year. Part of the harvest is sold at the beginning of the dry season in December/January. Most of the traditional celebrations take place during the months of February, March and April, considerably depleting household resources. The bulk of the rice harvest is stored, either for use later or as a source of cash income when required. Reserves are at their lowest during the third quarter of the year. Hence, part of the population faces financial deprivation and encounters great difficulty in purchasing health care in the second half of the year. This often coincides with the rainy season.

PRIMA project: development of a Mutual Health Organisation

The PRIMA research project was set up to study whether, and under what conditions, the development of MHOs could: (i) improve financial access to health care for its members; and (ii) strengthen the position of members in seeking to improve the quality of care

(*footnote continued*)
models of financing health care (Dror & Jacquier, 1999). Attempts to translate the French term 'mutuelle de santé' have always been dogged by the lack of any clear recognisable equivalent, perhaps illustrating the fact the mutuals' reality is different in English speaking countries. The term MHO, however, has since a few years come to be used in the discourse to describe organisations of this kind. Another important type of community health insurance is the provider-driven model of community health insurance where the management of the insurance plan is in the hands of the health care provider (see Criel, 2000 for a more detailed typology).

[2] PRIMA was a joint research project between the Ministry of Health of Guinea-Conakry, the German bilateral co-operation (GTZ), the non-governmental organisation Medicus Mundi Belgium (MMB) and the Institute of Tropical Medicine (ITM) in Antwerp.

available to them from health care providers. The underlying hypothesis of the project was that if people organise themselves into autonomous self-managed member associations that negotiate and establish contracts with health services, this structure then becomes an effective lever for demanding and obtaining better services. PRIMA attempted to test this hypothesis in the field in an action research frame.

After an intensive period of preparation lasting more than a year (for more details see Criel, Sylla, de Béthune, Lamine Yansané, Camara & Condé, 1998), a first MHO called Maliando—meaning 'mutual aid'—was set up in 1998 in the target area of the government health centre of Yende under the supervision of a Malinese sociologist.[3] Yende is a village in the southern part of Kissidougou district, about 50 km from the district hospital. The target population of Yende health centre consists of approximately 17,000 people scattered over two dozen small villages and hamlets within a 15 km radius. In the hamlet of *Mano* (about 1 km from Yende health centre), a male nurse, retired from public service, runs a legal private health care facility.

Instead of the textbook 'Minimal Package of Activities' usually defined by health professionals, the research team promoted the negotiation of a 'Consensual Package of Activities' in which community preferences were taken into account. The reasons for choosing this alternative were to ensure effective participation from the start and to link improved financial access to an improvement in perceived quality of care. This approach resulted in two important adjustments to the design. First, the range of drugs available at the health centre was significantly increased after extended debate amongst health workers. Second, although the original idea was to provide hospital care only, first line health care was included in the benefits package from the start, in response to the explicit wishes of the population. It was agreed that the insurance would cover all first line health care at the Yende government health centre, as well as emergency obstetric and surgical care for all adults along with health care for children under fifteen, at the government district hospital. A local private company provides emergency transportation to the hospital, for which Maliando pays a fixed amount. All agreements are prepared in the form of written contracts. Membership gives free access to the benefit package, except for a small co-payment per episode of illness. The annual subscription fee per individual was about US$2 in 1998, rising to about US$2.5 in 1999 and 2000. The household is the unit of subscription, which means that all members of the household have to subscribe simultaneously.

The management of the system is in the hands of local people—albeit with important technical support from the PRIMA team. The management structures that were created comprise: (i) a General Assembly, composed of delegates of the different constituent villages; (ii) an Executive Bureau which implements decisions taken by the General Assembly (within which, one person is charged with overseeing relationships with the contracted health services); and (iii) a Control Commission supervising the management of the Executive Bureau.

In 1998, the Maliando MHO covered only 8% of the target population, i.e. 1398 out of 17,275 people. In 1999, the subscription rate dropped slightly, to about 6% (1029 people). Moreover, a significant proportion of the households that had joined during the first year did not renew in the second year. In 2000, the subscription rate remained at 6–7% (1082 people) but the political turmoil, insecurity and violence in the region of *Guinée Forestière* which began in July 2000 jeopardised all further research activity in the area. The PRIMA project was halted at the end of 2000 but the Maliando MHO is still active.

Activity reports from 1998 and 1999 clearly indicate that the utilisation of health services by members of the insurance scheme increased dramatically. The rate of curative consultations at the Yende health centre, for example, had more than tripled, from about 0.5 new cases per inhabitant per year to more than 1.5.

Research questions and methodology

We anticipated few applications for subscriptions during the first year of Maliando: the research team considered a low subscription rate an expression of a rational 'wait-and-see' attitude. The even lower rate during the second year, however, was a clear sign that something was wrong.

The research team formulated six hypotheses, which might explain why the insurance scheme failed to attract more subscribers:

(i) Perception of poor quality of care in the public health services contracted by Maliando, despite efforts to offer a Consensual Package of Activities.
(ii) Poor understanding and/or acceptance of the concepts and principles underlying health care insurance (pre-payment of an insurance premium, risk-pooling, redistribution of financial resources beyond family or clan).
(iii) Lack of confidence in the management of the system.
(iv) Hostility towards institutionalised associative movements (because of previous negative experiences with other, similar projects).

[3] This expert, the late Mr. Sylla Moussa Bokar, headed a multidisciplinary team of 5 Guinean researchers (a medical doctor, a rural engineer and three community animators). Together they constituted the local research team.

(v) Failure of Maliando to adapt to or integrate with existing systems of mutual aid.
(vi) Inability to pay the subscription fee.

To validate these hypotheses, a qualitative study was commissioned and carried out in March 2000. Focus group discussions were held with people selected from four different patient sub-groups:

1. Sub-group 1: the 555 people who subscribed during two consecutive years (1998 and 1999).
2. Sub-group 2: the 843 people who cancelled their subscription after the first year.
3. Sub-group 3: the 474 people who only subscribed during the second year.
4. Sub-group 4: people who did not subscribe at any time during the period 1998–1999.

Three focus groups were organised for each sub-group, with a different set of questions for each specific sub-group (the topic guide for sub-group 1 is given in Appendix A). Twelve participants were selected per group and contacted by the facilitators in the week before the discussions took place. Updated household lists and the members' lists of the MHO were used as the basis for selection of both villages and respondents.

Four additional focus group discussions—one for each sub-group—were organised to validate the findings of the first 12 focus groups. Specific questions for these discussions evolved from an intermediate analysis of the initial findings.

Six researchers, five men and one women, were hired locally to lead the discussions. Two pre-tests were organised following 2 days of initial training. A moderator, accompanied by two secretaries, led each focus group. The discussions took place in the following languages: Kissi, Malinke and Manika. The local research team was advised not to tape the sessions because many inhabitants endured painful experiences when information was collected by the former political regime. The records were translated into French on the same day and the three facilitators compared both sets of notes.

The transcripts were initially analysed one at a time in order to identify key messages, and also to detect possible problems with group dynamics that could have altered the validity of the observations. Coding was carried out in line with the six hypotheses and from themes suggested by the first readings. Coding and analysis was completed along three lines: (1) cross-analysis with the six hypotheses plus the additional subject of access to health care; (2) a classification of reasons for joining and not joining the scheme; and (3) a classification of the range of comparisons made by participants to clarify their arguments (e.g. comparison of treatment of members with non-members, of health centre with hospital, of expectations with outcomes). Thus, most responses have been classified more than once. The four sub-groups have been compared across each of the three lines of analysis. The findings of the three approaches have been crosschecked.

The interpretation and reliability of the coding was verified by a second researcher and, for a sample of responses, compared to the interpretations given by two external experts. Classification was carried out through the use of the various functions available with 'MS Word'.

The benefits of quantifying some issues emerged during the course of the analysis. Particular expressions (e.g. 'discouragement' or 'everybody would subscribe if') were so often repeated that it seemed appropriate to quantify those subjects, which appeared to upset people the most. Quantify remarks on the themes 'reasons for joining', 'reasons for not joining' and 'quality of care' also appeared to contribute to a fuller understanding of respondents' attitudes. In addition, enumeration helped to quantify opinions expressed by people in different groups.

The four supplementary discussions were only examined after the analysis of the 12 initial focus group discussions was completed. The same methods were applied to the process of analysis, but no quantification of responses was carried out. In addition, the analysis focussed on revealing any discontinuity with the initial interviews, and also on uncovering new information.

Results

Of the initial 12 focus groups, 5 took place in the central village of Yende, 7 were held in other villages. Selected respondents who were absent on the day of the discussion were not substituted. Each group consisted of 8–12 respondents. In total, 137 villagers participated. Because women were more difficult to recruit, each sub-population consisted of 2 male groups and 1 female. Of the 4 supplementary discussions, 3 took place in Yende and 1 in a smaller village. There were 3 groups of men and 1 of women (in total 47 participants) who played no part in the initial discussions. Each discussion took between 85 and 140 min.

The 4 supplementary discussions entirely confirmed the findings of the 12 initial ones. For the purpose of this paper, the results of all 16 focus groups have been consolidated, except for enumeration, which was carried out for the 12 initial groups only. For responses that were quantified, the figure given in brackets relates to the number of quotes that were collected. Citations added to the text are followed by a code in brackets, which indicates the discussion from where they were extracted.[4] Details of the sub-population and gender to

[4] For instance, the code (Pop 2.3) stands for a quotation from the third focus group discussion held with members of the first year only, i.e. sub-population 2.

which respondents belong can be checked against the list of groups in Appendix B.

The data showed that almost all positive comments refer to the philosophy which underlies the MHO model, i.e. the principles of health insurance and the objectives and design of an MHO. Negative remarks almost all relate to the practical realisation of these principles. The presentation of our results is based on a clear distinction made by participants between the concept on the one hand, and its implementation, on the other. The target populations' understanding of the concept is discussed in part one; their appreciation of the practical outcome in part two.

Part 1: Understanding the principles, objectives and design of an MHO

Insurance is about prevention

When explaining why they did subscribe to Maliando, participants frequently used expressions such as "in anticipation of future illness (Pop 2.3)", to "preserve our health (Pop 2.1)", "guarantee our health (Pop 3.3)", to have "the guarantee to benefit from health care during the whole year (Pop 1.1)", or "it's for when times are hard (Pop 2.3)". The concept of prevention, i.e. to contribute today in order to avoid financial difficulties tomorrow, appears to be well understood. Non-members also refer to this concept: "…if we are convinced that by paying only 3400 FG (*Francs Guinéens*) per year you have the assurance that you will get cured within the year in case of illness, then what is going to stop us from joining (Pop 4.2)".

Redistribution effects of insurance are well accepted

The transfer of funds from those who have remained healthy to those who have used the service is recognised as the fundamental principle of Maliando. This financial redistribution, according to need rather than to contribution, is considered to be the main strength of Maliando. "It is mutual assistance. It is not said that when someone becomes ill, his own contribution will treat him, no! This is exactly the idea underlying Maliando, to treat every member who is ill (Pop 2.1)". "If I had no illness during a whole year, that cannot be bad for me, so in this case I have taken care of someone else, who is my brother. It is you who have supported the other. (Pop 2.3)". "That is exactly the Mutual Health Organisation (Pop 2.3 (next intervention))".

The fact that any redistribution system must recruit large numbers of people in order to function properly is also well understood: "what 100 people can do together, can 2 people do it? (Pop 4.1)". It is equally well understood that if a premium of 3400 FG is required to meet the sometimes high costs of health care, then there is need for a financial mechanism that goes beyond family or village borders in order to generate the necessary reserves to meet these costs. "Maliando covers many villages,… Our great number increases our budget, which helps for the treatment of ill people (Pop 2.1)". "If there are many members, we can cover the health care needs (Pop 1.1)". "We have to be numerous to have more power. That is the real idea behind Maliando (2.3)".

People approve of solidarity beyond traditional boundaries

Only two women showed a reluctance to participate in the MHO and went on to express a preference for village-based savings systems or individual pre-payment. One other person seemed to hesitate between individual pre-payment and risk sharing. All other comments were in favour of extended solidarity. Respondents' reasons for approving this principle fell into three categories: (i) it is good to help each other; (ii) others will support me when I need health care; (iii) I have rendered a service before God for which I shall receive his benediction. One *verbatim* brings together the three arguments: "We are in Maliando to assist each other in the matter of health. When my money has been used to treat a member that I do not know, this rejoices me. Before God I have rendered a great service. I will have his blessing. Me in turn, I can become ill. The cost of my treatment may exceed my subscription fee. (Pop. 1.1)"

Objectives that are clear to all

At least one participant in each focus groups—including those in sub-groups that were not members at the time of the investigation—was able to explain Maliando's objectives, i.e. better financial access to health care and improvements in the quality of the care offered by the contracted services.

Improved financial access is often the reason why people join an MHO (see Table 1). Access to expensive hospital care is especially appreciated: "by paying 3000 FG, you can deliver by operation, which costs more than 30,000 FG (Pop 4.2)"; "with 3000 FG you could get treatment for an illness of 50,000 to 100,000 FG, or even more (Pop 3.3)".

Both subscribers and non-subscribers alike recognise the role of an MHO as a body that represents its members' interest in their dealings with health care providers at health centres and hospitals. "We know that Maliando is there to defend us by enabling us to have a good treatment when we show our membership card… (Pop 3.1)".

Table 1
Why adhere?[a]

	Pop 1	Pop 2	Pop 3	Pop 4	Total
Insure health/ preserve health	3	1	5	2	11
Financial accessibility	15	4	18	5	42
Help each other	2		1		3
Convincing information campaign	1	4	4		9

[a] Only when directly mentioned as reason for adhering to the MHO.

Two concepts that respondents do not take into account: adverse selection and moral hazard

All respondents seem to be aware that "you should subscribe everybody in the family, and not for instance 4 out of 6 and leave the others (Pop 1.2)"—i.e. the household and not the individual is the subscription unit. But this requirement is only perceived as a restriction of membership Not a single respondent referred to the link between mandatory subscription of the entire household and the need to avoid adverse selection, the underlying reason for this requirement. The risk of offering preferential subscriptions to people with a high likelihood if becoming ill never came up in the discussions. In fact, several women explain that they joined Maliando precisely because they are "frequently ill (Pop 3.1)", or they urged others who are "always sickly (Pop 3.1)" to subscribe to the scheme.

The discussions also showed that the concept of 'household',[5] as set out by Maliando, seems too vague in a cultural context of polygamy and changing household composition: "The first year, I paid for 9 people, but among them some were not living with me in the family (Pop 1.1)"; "Fela adhered by the channel of his mother in law (Pop 4.2)". Several responses also suggested that the father does not always subscribe with the rest of his 'family': "My husband told me…you will subscribe with your child (Pop 4.2)".

Nowhere in the discussions, 'over-consumption' of health care services is seen as a threat to Maliando's financial equilibrium. The very notion of over-consumption is simply not recognised, or is even rejected. Many respondents report that "we go to the health centre when we are ill (Pop 2.2)". Two participants are very puzzled about the warnings given by the management of Maliando not to abuse the system. "The health centre of Yende should be happy when many people come. They are there to take care of the ill. (Pop 2.2)".

The small co-payment fee per new episode of care is not challenged, as such. But the reason for its introduction—i.e. to discourage and reduce 'unnecessary' utilisation of health care services—does not appear to be understood. In fact, the amount is perceived as too small to present a significant barrier to utilisation. Rather, people see this payment as a price reduction in the cost of their medicines: "with only 500 FG you obtain drugs for which previously we paid 5000 or 8000 (Pop 3.2)".

Existing systems of mutual aid and the MHO: different arrangements meet different needs

Respondents made a clear distinction between Maliando, as an MHO, and existing mutual aid associations. When comparing both, they invariable refer to the specificity of the MHO—"Maliando has a clear and precise objective: health (Pop 1.1)", "Maliando is for illnesses only (Pop 3.2)", whereas traditional associations cover a variety of social and family situations such as "marriage, baptism, death, celebrations (Pop 3.2)". Many participants state that their prime interest is in a system that takes care of health problems. "The mutual…is essential for us because it preserves our health (Pop 2.1)". Health care is a crucial matter—"you need good health before thinking of anything else (Pop 2.2)"—that is not tackled in a satisfactory way by existing organisations. "You cannot be member of the village associations when you are ill… Maliando specialises in health problems, something our local associations do not take care of (Val. 1)."

Gatherings, celebrations and a variety of ceremonies are an intrinsic part of the *raison d'être* for traditional organisations. The people who have contributed financially to the organisation anticipate an opportunity to meet and socialise on these occasions. This social dimension is not expected from Maliando. "Maliando is there for health care and not for celebrations. We want to be treated, that is our concern (Pop 3.1)".

In their discussion about the differences between Maliando and the traditional organisations, respondents mentioned a number of local associations which tackle a range of needs, including collective saving arrangements, pooled labour with profit sharing, credit unions, family and neighbourhood solidarity systems, and solidarity mechanisms between rich and poor. They understand very well the differences between traditional systems and Maliando. In particular, they mentioned the following differences in ways in which the two systems function.

- Subscriptions to traditional saving schemes are paid at regular intervals. In case of 'significant life events' (births, deaths, etc.) or in case of individual requests for help, the money is raised when the need arises.

[5] In the focus group discussions, the term 'family' was systematically used instead of 'household' in both the questions addressed to people as in their answers.

The purpose, in both instances, is to create a fund able to defray sometime substantial expenses, from several small contributions. The system of Maliando is described as quite the opposite: households pre-pay a single sum annually which insures against a range of possible health care costs for a period of 1 year.

- Maliando provides its members with access to health care as soon as the problem occurs, unlike traditional systems, where access to financial assistance is delayed until the group agrees to release the funds, or until the necessary funds are collected.
- The unique nature of the benefit provided by Maliando sets it apart from the collective nature of benefits offered by traditional associations: "Maliando helps us individually whereas our associations target an entire group and defend its interest. In our associations, when you fall sick but did not participate to the collective labour you will have nothing (Pop 1.3)." The benefits of traditional saving schemes and pooled labour arrangements are either distributed in equal parts amongst those who contribute, or are dedicated to a specific project, such as the purchase of a specific tool that can be used by each of the contributors in turn. The community makes sure that benefits are shared in accordance with the contributions made by each member. A clear distinction is made between this notion of reciprocity and the notion of solidarity inherent in the Maliando structure. The distribution of funds according to individual need, independent of the size of the contribution, is considered and valued as a new concept with no equivalent in existing systems. This different approach is perceived as the main advantage of an MHO.
- Certain local organisations can meet the cost of health care expenses, albeit within certain financial limits. Requests for help, however, need to be submitted to, and approved by, other members of the group. "Maliando is to be saluted if it respects what is said concerning help for our health. Despite the union in our organisations, they cannot ensure or guarantee our treatment. We may have money in our fund but we may disagree on its utilisation in case of illnesses (Pop 4.3)." Social control of this sort does not feature in the Maliando scheme so guaranteeing greater discretion to patients. "Maliando takes care of illness and all kind of diseases (Pop 4.1)".
- In addition to reciprocal aid schemes, other mutual aid structures lend substantial funds to individuals, but only at very high rates of interest: "with 3000 FG Maliando can treat a disease that costs 50,000 FG, whereas in our associations you borrow a bag of rice and next year you have to give back the double (Pop 1.3)". The health care expenses of non-subscribers necessarily need to be borne by their next of kin who, if they do not sell assets or livestock, have to borrow money at high interest rates. Participants contrast this with yet another advantage of Maliando: financial help can be substantial, yet the premium is universally considered to be reasonable.

People understand and embrace the new concepts

The straightforward responses of survey participants allow us to reject two of the initial research hypotheses outright. Poor understanding of and/or acceptance of the concept (hypothesis 2) and insufficient adjustment on the part of the Maliando scheme to existing alternatives (hypothesis 5) cannot continue to be considered as reasons for the low renewal rates. Non-subscribers express equal understanding of the functioning, advantages and disadvantages of Maliando as subscribers. The underlying concept of a formal insurance scheme, together with aspects which are specific to Maliando are clearly perceived as both new, and different to what existed previously. But the participants never expressed a desire to merge or combine the best aspects of both systems. They perceive Maliando as a well-designed model to treat episodes of ill health. We conclude that participants consider Maliando as an arrangement of mutual aid that is *complementary* to existing schemes.

One comparison between the traditional organisations and Maliando reflects poorly on the Maliando scheme and this may help clarify why the target population's interest remains marginal. Traditional associations seem, on the whole, to fulfil the 'mission' they have set themselves. This is not the way the research sample perceived Maliando, as we shall discuss at some length in the second part of this paper. "… Our associations succeed to fulfil the objectives of their creation (help in the case of marriage, baptism, and death) when compared to Maliando that is taking care of diseases. Maliando does not succeed in satisfying the objective of treatment of disease for which it was created (Pop 3.1)."

Part 2: A reality at odds with the vision…

Four of our six hypotheses are related to operational aspects of the MHO scheme: suspicion about the motives of mutual organisations; lack of confidence in the management; inability to pay the subscription fee; and whether there existed a perception of poor quality of care in contracted health facilities.

In this section we review the evidence we used to test these hypotheses.

Suspicion towards institutionalised associative movements

The only person who mentioned that Government is not involved with Maliando referred to information

given during the public-awareness campaign and not to something he noticed himself: "We were told that…the Government officials will not have any influence on Maliando (Pop 1.1)". Most responses suggest that the participants did not link Maliando with the Ministry of Health but differentiate the MHO from public health services: "The people in charge of the Mutual Health Organisation have to be between us and the people of the health centre in Yende, in order to obtain that the doctors respect our demand (Val. 1)."

There were some negative references to micro-finance initiatives that had been tried previously in Kissidougou. However, participants did not express disapproval of these arrangements per se, but were concerned with problems of dishonest management: "We had the bad experience with the *Crédit Mutuel*, we paid the money and the people in charge used it all for their personal benefit (Pop 1.2)". Still, according to the majority of respondents, these incidents with other organisations do not seem to have a lasting impact on the credibility of Maliando: "The bitter memories of *Soguicaf* or the *Crédit Mutuel* cannot be the real causes (Val. 3)".

Participants seem convinced that Maliando has an independent management structure with no links to Government institutions. They did not express any objection to the formal status of the MHO. Suspicion towards institutionalised mutual associations does not seem to be an issue.

Lack of confidence in the management of the system

"The first year, I wanted first to observe whether what had been said would be done (Pop 3.1)."

Respondents in all sub-groups mention the common practice of first observing and then subscribing. Some participants mention this prudent attitude in relation to their own experiences with dishonest management. In the minds of respondents, embezzlement is not only linked to formal structures, "The first year, I hesitated because of the experience with *Soguicaf* that has taken our money and until now, they have not been seen again (Pop 3.2)", but also to informal initiatives: "I have the experience of our local associations 'Bendas'. Each time we contribute, our leaders embezzle our accumulated sums (Pop 3.2)". However, a fear that there might be a conspiracy to defraud the members was only expressed by respondents who have been subscribers for two consecutive years or who had not joined until the second year. For the latter, the suspicion of dishonesty was one reason for their delay. However, in the end, it was not a sufficiently strong reason to stay out.

Two participants could not accept the remarks about 'over-consumption' made by representatives of Maliando. Others gave examples of financial conflicts for which no satisfactory solution could be found. These controversies "have discouraged me (Pop 2.1)" or "discouraged the inhabitants of my village to adhere to Maliando (Pop 2.2)". One participant pointed to the absence of a system to settle such disputes: "In the local associations, when I have a problem after having paid the contribution and do not benefit of assistance, I can lodge a complaint with the authorities. This is not the case with Maliando (Pop 1.1)."

Notwithstanding this isolated problems, the management skills of the scheme organisers, that is their administrative or organisational competence, was not challenged in any of the focus group discussions, and also the organisers' honesty in handling the scheme finances appears to have been accepted without question. Several respondents express their appreciation of the "representatives, who by the way I congratulate (Val. 3)"; "The people in charge take well care of us (Pop 1.2)" and "are very dedicated (Val. 1)".

Yet this positive opinion of the management could not hide a real feeling of disappointment in the manner in which the MHO was run. Many participants reproach Maliando because, in their view, it promised more than it could deliver. "In the beginning, the people in charge told us good things about Maliando, but we have not seen anything (Pop 4.3)". "You have to admit that the Mutual Health Organisation does not manage to satisfy our expectations (Pop 3.1)."

We can conclude that, rather than any lack of confidence in the integrity and management skills of the Maliando directorate, respondents criticised the Organisation for failing to reach its objectives, failing to defend its members and failing to keep its promises.

Poor families and large families: inability to pay

Members identify the physically disabled, blind and the chronically ill as population categories that are too poor to pay the insurance premium. Men also point at "the lazy ones (Pop 1.1)", those who "drink more in a day than the annual premium (Pop 3.3)", those who "do not realise the importance of safeguarding their health (Pop 3.3)". Women do not share either these moralising views or men's restricted definition of the destitute. They claim that "there are many people who do not have the means to subscribe to the Mutual Health Organisation (Pop 3.1)".

Participants who have never been subscribers or who have not renewed their subscription for the second year tend to confirm this last observation. Within this category, "lack of resources (Pop 2.3)" is often given as the main reason for not joining. "Maliando is a very important matter, it has come to help us with our health. I have seen this personally. It is a very good idea but we are poor (Pop 4.1)". Collecting the premium at harvest time is no guarantee that people will be able to raise cash needed. Two participants even said

that they had "nothing at all at the moment of subscription (Pop 2.3)".

Three remarks demonstrate how an illness episode which affects the breadwinner may prevent the household from joining the MHO: "Last year some people were late with their payment, we knew and it was because they had financial problems or were ill (Pop 1.3)"; "…, because of illness I could not become a member last year (Pop 2.1)"; "The first year, I was weak, I did not have the means.… (Pop 3.2)". These examples suggest that those who are in the greatest need of health care are sometimes excluded. This possibility was actually suggested by a non-subscribing female respondent: "We, the sick, the ones that loose a lot of children, we are the ones who could benefit more from Maliando than those who are less sick than we are. The other women deliver children quickly and are in good health without problems. They will get fewer benefits from Maliando than we would. We, the sick who consult also the traditional healers, we go to whatever witchdoctor to get help, and in spite of all that, the illness remains… (Pop 4.2)."

It is not only the poor who experience difficulties in meeting the subscription fee. Because each subscriber must include every member of the household, the total amount deters large families: "…if you have 10 family members at 3400 FG per person, it's a bit difficult (Pop 2.1)". All respondents who mention "large families (Pop 4.1)" say that the household subscription is too large a burden for big families to bear.

Participants made different suggestions to help the very poor. Some suggested that traditional solidarity mechanisms should be called upon. Membership for the poorest could be paid "from a village fund (Pop 3.2)", other villagers could pay "part (Pop 3.1)" or even "half of the premium ((Pop 3.1)", "the rich could pay for their poor neighbours (Pop 1.1)", or the poor could pay in kind. The majority, however, suggest that Maliando should "take on the poor free-of-charge (Pop 3.1)" or at least "at a lower membership fee (Pop 1.1)", though without acknowledging that such generosity would mean the premium would need to be higher for other subscribers. One person, nevertheless, mentioned that "if there is a large number of subscribers, it would be possible to offer free membership to the very poor (Pop 1.1)".

In order to make subscriptions more affordable for large families, several respondents proposed that these families should be allowed to "pay in instalments (Pop 2.1)", that "the fee per person be lower (Pop 2.1)" or that only part of the family would have to pay the subscription charge. The way in which certain participants describe the apparently frequent practice of registering only part of their family suggests that registering the whole household is felt as being unreasonable—"The second year, I only paid for 6 persons, and they asked me to explain why. I answered that I had paid according to my means (Pop 1.1)".

We can say with some confidence that a lack of financial resources is an important reason on the part of a number of respondents for not joining. This is the case not only for the limited number of the real destitute but also for those who say they are too poor to pay the premium and for large families who nobody considers as poor.

Quality of care

Respondents in each sub-group recognise that subscribers to an MHO have faster access to health care and can use health centre services "more quickly, more often and without delaying at home (Pop 4.1)". This could lead to an erroneous belief that the subscribers are satisfied with the care they receive. On the contrary, the majority of subscribers say that they are dissatisfied with the quality of care offered at the public health centre. Although fast access to care is seen as an advantage, both members and non-members conclude that this is hardly a benefit since the care on offer is inferior. "I know, they have more facilities but to resolve what? Often when they come back they tell us about their disappointment (Pop 4.3)".

What people understand by quality of care is expressed in terms of disappointment with the outcomes and through a series of comparisons which they make between their original expectations and the reality, between the care given to subscribers and to non-subscribers, between the care on offer before and after they decide to subscribe, between the care available to the rich and poor and between the 'good care' in the private sector and the hospital, and the 'bad care' in the health centre.

Criticism and disappointment of the Yende health centre is often expressed in general terms: members do not receive good care (32), the treatment is unsatisfactory (14), and members are disappointed by the quality of care in the health centre (5). Several participants give a concise definition of quality of care: fast recovery, good medicines and a friendly reception. "…if we would receive good care, that is a friendly welcome, good products and a fast recovery, I would be ready to join in the year 2000. If that does not happen, then I am sorry but I am not going to join (Pop 3.1)."

The fact that no cure or fast recovery is to be found at the health centre is mentioned no less than 22 times. "We go more quickly to the health centre than non-members, but very often, they do not cure our illness (Pop 1.1)". The absence of recovery is often linked to ineffective drugs dispensed at the centre.

The lack of "good products" is the main criticism directed against the health centre, and this complaint is formulated in different ways. The quality of the

products is not good (24); patients receive drugs that do not make them better (18); patients always receive the same drugs even for different illnesses or when they return more than once for the same episode of illness (16). The participants did not understand the fact that subscribers may receive just pills (4), or that these drugs are the same as those available in the marketplace (9). They prefer to buy drugs in the private sector, because with these, at least, "you get better (Pop 2.1)". Finally, they suggest that good products should be made available to Maliando's subscribers (18). The initiative taken by the PRIMA research team to expand the range of essential drugs available at the health centre was never mentioned. Respondents believed that non-subscribers have access to a variety of drugs perceived as more effective, but that they pay a higher price. These are drugs sold through a parallel circuit run by the nurses. Subscribers to Maliando are not welcome "because the staff of the Yende health centre does not have any financial benefits with us, they feel that they are losing out (Pop 1.1)".

Obviously, focus group participants do not think highly of the staff who work at the health centre. "I have subscribed to Maliando in order to be able to treat our many illnesses. But since the staff at the Yende health centre does exactly the opposite (are not welcoming towards the patients, are not skilled, do not have good medicine, do not even talk with the patients…) this has really discouraged me (Pop 2.3)". The poor reception (24), the lack of consideration, respect and attention for patients (6) generated heated criticism from several respondents: "the doctors did not even look at me (Pop 2.3)"; "in the health centre they give you a few pills but not in a friendly manner (Pop 3.1)"; "They don't listen to us and don't respect us (Val. 2)"; "They think they are superior to us (Val. 2)".

Several participants claim that they prefer to seek care in the private sector (10) despite much higher charges, or to go directly to the hospital at their own expense (5). Others find themselves obliged to seek alternatives when treatment at the health centre has not helped their condition (9). In the hospital, patients receive good quality care and treatment (3). The indices which they use to define quality are: we get well again (10), fast recovery (1), we receive good medicines (4), the diagnosis is well made (3), the reception is good (5), the doctors are good (2) and take well care of the patients (3).

Participants greatly appreciate the easy access to care that the MHO secures at the hospital (17). The hospital, in turn, receives such a high score on perceived quality of care that there is not a single negative response.

The ideal solution for problems encountered by patients at the health centre can be summarised in three sentences: we need a warm reception, we must have good quality medicines and we want a fast recovery. Detailed improvements frequently requested included competent doctors (20) (although it is not clear from the discussions what participants mean by 'competent') and good products (18). A popular suggestion was to set up a health centre for the Maliando subscribers only. This suggestion was made 7 times across 4 different focus groups.

For those able to pay the premium, the poor quality of care which patients received at the health centre undoubtedly explains the low membership figures. The conflict that arose between the anticipated advantages of better access to care and the actual experience of disappointing quality of care in the health centre is what strikes most. Participants simply felt that, in practice, better access is not worth the effort of joining Maliando. Improved financial access to the hospital, on the other hand, is seen as a distinct benefit of Maliando because the care they receive there is considered to be of good quality.

The two issues that seem to matter most to respondents are quality of care and financial accessibility. Response quantification helps to clarify which of

Table 2
What should be done to increase the membership rate

	Pop 1	Pop 2	Pop 3	Pop 4	Total
Improve the quality of care					*70*
Improve the quality of care	4	6	3	3	16
Send good medicines	6	1	6	5	18
Ensure a good reception			4	1	5
Increase the number of doctors	1				1
Sent competent doctors	8		6	6	20
Improve the staff's attitude	1	1	1		3
Build a hospital for the Mutual Health Organisation			4	3	7
Improve the payment modalities					*17*
Lower the premium	1	4		3	8
Accept premium payment in instalments		1		4	5
Suppress obligation to subscribe all household members		2	1	1	4
Others					
Make subscription mandatory	2				2

these two issues can best explain the low subscription rates. When asked what needs to be done in order to make membership more attractive, most of the answers can be classified (see Table 2) under the heading improved quality of care (70), A long way behind was 'improve payment modalities' (17).

Enumerating forceful expressions that convey patients' fundamental thoughts about the MHO shows that poor quality of care deters participants the most. Some claim to be "discouraged" by the high premium (3), many more claim to be "discouraged" by the poor quality of care (32). Two participants observed that everyone *could* subscribe if the subscription fee was not such a financial obstacle. Fourteen mentioned that everyone *would* subscribe if Maliando were to provide access to quality care—or, conversely, eight participants expressed the opinion that "when the first members do not receive good care at the health centre, the others will not subscribe (Pop 3.1)".

Methodological limitations

The focus group discussions were not taped because it was feared that, given the socio-political context, this would greatly embarrass participants and inhibit their freedom of expression. After translation, the two stenographers compared their notes. On each occasion, it was found that the notes were consistent. Any disparities were about translation of some specific idioms into French.

More male than female participants were included because women had a tighter work schedule and men were more accessible during the day. This may be a source of bias in view of the fact that health care often is seen as much more an issue for women than for men—"We, the women know better (Pop 2.3)".

In one of the all-women groups only negative comments were voiced regarding the quality of care in the health centre. In two all-male groups of, only positive comments were made. It was evident that, at least in one of these groups, some participants had been involved in the promotion of Maliando. In one validation group, one single woman (who undoubtedly enjoyed a position of power in her village) dominated the debate. Such situations could, in principle, be avoided through the selection of participants who did not know each other. This was not always possible due to the small population size, and this was a particular problem in the smaller villages. Not all of the focus groups were asked all of the questions, because of assumptions that later proved to be wrong. For example, non-members were not asked their opinion about extended solidarity because it was assumed they had not understood the system properly. However, these shortcomings have been largely overcome by the wealth of information given by almost all participants.

Discussion: what did we learn and what remains for us to investigate?

In this study we have found evidence that challenges some commonplace assumptions that hold sway in the current debate on the development of community-based health insurance arrangements in sub-Saharan Africa. In this section we focus on the particular situation as it exists in Maliando, and invite the reader to compare our findings and observations with other situations that he or she may be acquainted with.

The limited attraction that MHOs hold for sub-Saharan Africans is real indeed (see Letourmy, 1998; Carrin, Desmet, & Basaza, 2001). Enthusiasts for the MHO model sometimes tend to attribute this meagre interest to differences in attitude that households in the industrialised world and African households hold in relation to the notion of risk. It is assumed that Africans are less risk-averse, not interested in investing today in order to avoid future health care expenditure, and are reluctant to become involved with risk-pooling arrangements that go beyond the traditional boundaries of family, clan or ethnic group.

A significant finding of the present research is the data that suggests that a lack of understanding or acceptance is definitely *not* the reason for the low subscription rate to the Maliando scheme. Indeed, the great majority of participants, men and women, subscribers and non-subscribers alike, prove to have a very complete understanding of the concepts and principles underlying health insurance. They do not challenge—in fact, they even appreciate the system's re-distributive effects which operate on a scale that goes beyond village or next of kin. People also value the improvement in financial access to health care that the insurance scheme has provided.

The considerable time and effort taken to discuss these concepts with community members partly explains their almost complete comprehension. The preparatory phase of the PRIMA project took more than a year. The following comment illustrates the importance of sustained communication and dialogue: "…, when they came to explain the methodology of the functioning, the information has been extensively commented for the sake of the population… On that day, I did not want to join, thinking that if it is something important, these people will come back to the village a second time. (Pop 3.2)".

It is striking to note that distrust of the Maliando management is barely mentioned despite negative experiences with previous micro-finance initiatives that some participants referred to. The intense period of

preparation and the genuine sense of community participation that was incorporated from the start have substantially contributed to this impression of trust. It has also helped to develop confidence in the capacities of local managers.

Another important finding was that the working assumption that formal social security systems should build upon, or be integrated with traditional solidarity systems (Midley, 1994) appears to be invalid. The participants were able to point out the differences, advantages and disadvantages, of both traditional financial mechanisms and the new techniques of formal insurance, in clear relief. The ease with which the novel notion of risk-pooling was accepted as a financial mechanism to address specific needs, demonstrates that it is not essential to base new health insurance schemes on existing systems. On the contrary, many respondents explained that their traditional mutual support schemes and financial arrangements were not competent to finance health care, and that the new system, based on principles that were novel to them, met a previously unmet need.

This does not, however, preclude the necessity of integrating some existing elements of local systems within the management of a formal health insurance scheme. For example, a preliminary study of a traditional financial system might have indicated that paying a large sum 'upfront' is rather exceptional. In order to ease the financial burden of paying a substantial premium for a large family, MHO promoters could consider relying instead upon existing savings and/or credit facilities. Participants also mentioned the opportunities for appealing against a negative decision or event that are included in constitution of their associations. Members of Maliando can voice their complaints to the General Assembly, but this measure does not seem sufficiently specific to redress their complaints about the poor quality of care. A formal appeal system to settle disagreements would give more power to subscribers and could avoid the problem of frustrated members leaving the organisation.

Although respondents showed an understanding of the fundamental MHO concept that is, without doubt, more comprehensive than the majority of people in Western countries (where social health insurance systems are firmly established), some technical aspects of insurance are not fully understood. The financial limits within which an insurance scheme has to operate are rarely mentioned. The risks of adverse selection are not mentioned at all. When asked how to help the 'really poor', most participants suggest that Maliando should offer them free membership, but only one observed that this would required a large number of subscribers. If health insurance is to be organised as a sustainable, community-based institution, members should be better informed about all financial aspects.

Technical aspects may not be assimilated because they are perhaps not relevant. The focus groups suggest that over-consumption appears to be more a subject for concern raised by the organisers of Maliando than a preoccupation amongst beneficiaries. The concept of over-consumption, indeed, is one that respondents do not accept easily. In their view, people only seek health care when it is necessary. A divergence of opinion between health professionals and patients as to what constitutes illness could help explain why certain needs are not recognised or are considered as trivial complaints. Health workers' attitudes could also stop patients from presenting with their real ailment. Consistent with the fact that participants do not think unnecessary utilisation of health services is an issue, the focus groups clearly demonstrated that the rationale for co-payments is not entirely understood. This finding brings into question the frequent use of co-payment arrangements in health insurance systems.

To avoid the risk of adverse selection, the PRIMA project proposed that the household is used as the subscription unit. Although most participants considered a personal premium of about US$2 as fair and affordable, many large families found it difficult to raise the cash to pay for all household members. This finding suggests that more flexibility and creativity in the design of scheme financing will reduce the incidence of adverse selection. Avoiding adverse selection is a technical requirement of health insurance programmes if the financial equilibrium of the scheme is to be maintained. When the requirement to register the whole family becomes an obstacle to membership, the objective of the insurance—to increase access to health care—is jeopardised.

The findings also demonstrate the necessity of clearly defining the unit of subscription—'the household'—in every social and cultural context. The unit of subscription that is most convenient, and the decision on who should or should not be considered as members of a household should be discussed with the target population. This would also create an opportunity to raise the concept of adverse selection.

Not only large families are unable to afford the premium. The significant number of people who classified themselves as too poor to pay raises some doubts about the feasibility of organising an MHO in an impoverished area. It would be useful to determine the poverty threshold, above which an autonomous health insurance system could attract sufficient members, and below which partial, external funding of the organisation is required in order to ensure access to health care. An assessment of the financial status of members and non-members would give more reliable information on the real financial capacity of the target population.

Poor quality of care at the health centre is, far and away, the main criticism that people have of Maliando.

It is a fact that, when quality of care is perceived as unsatisfactory, people will not be motivated to join the scheme. The research team was aware of this possible flaw at the beginning of the project. Two lessons, nevertheless, can still be learned. First, the research team underestimated the degree to which people disapproved of the care offered at the health centre. Second, the assumption that the creation of an MHO would, almost by definition, be a sufficient lever to improve the quality of care has proven wrong. This has important implications for the overall design of future projects studying the development of MHOs. The creation and development of MHOs should be situated in the broader perspective of local health systems and be embedded in a set of strategies and interventions that aim to improve the quality of health care delivery. Regular supportive supervisory visits, conceived as a means of continuing education of the nurse-practitioners working at health centre level, is one of the activities that can play an important role in improving the capacity of health personnel to offer patient-centred care.

Finally, there remains the issue of the health professionals' perception of the creation of MHOs. What is in it for them? And do the gains outweigh any losses that they may incur? For the health workers, there may be good reasons *not to support* the development of MHOs. Indeed, it is understandable that health workers, trained and active in a cultural environment where accountability as a professional practice is virtually non-existent, are reluctant to engage in a process where they are forced to discuss 'professional decisions' with their clients. Hence, the need to reflect on MHOs designs that lead to a win–win situation. Certainly life should improve for patients and their communities, but also health workers should eventually fare well under this novel arrangement for financing health care.

Conclusion

We believe that this study contributes to our understanding of community health insurance in Africa. It generates new and hopefully useful ideas for the successful design and development of future MHOs.

The study demonstrates that, in the case of Maliando (Guinea-Conakry, West Africa), the concept of health insurance is understood and appreciated by the population. The MHO is welcomed as a model that is better able to deliver access to health care than traditional support systems. The causes of the low subscription uptake rates should not be sought in people's lack of understanding or acceptance, but in the operational difficulties that arose during implementation of the model. The study indicates that lack of financial resources is an obstacle that prevented many people from joining the MHO. However, the main problem that discouraged most people from joining was the poor quality of care in the contracted health services. Beyond doubt, an MHO will always fail to attract a significant number of subscribers until the quality of care offered is acceptable.

Both these barriers to expansion and success are difficult for individuals to overcome alone. The government and development organisations could, in dialogue with community members, reflect on how best to assist MHOs with subsidies; and health professionals, specialised in quality management methodologies, could assist the health workers in improving the quality of the care they offer.

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Appendix A. Topic guide for the focus groups of people who subscribed for year 1 and year 2

1. Times are difficult at the moment. Health care is but one of your many preoccupations (e.g. find food, pay school fees for your children, pay for clothing, find water and wood, etc.). Also, sickness is only something which might happen but on the other hand may not happen, it is no certainty. However, you have been a subscriber to the *Maliando* MHO for 2 years in succession (1998 and 1999) and you have done this on a voluntary basis. Could you explain this a bit more? Can you help us to understand the reasons behind your membership?
2. One of the objectives of the creation of an MHO is to contribute to improve the quality of health care in general (e.g. access to a larger range of medicines), and the quality of human relationship between health worker and patient in particular (e.g. a better reception at the health centre and the hospital, no over-billing). What do you think about this? Do you feel that *Maliando* contributes to this? Please tell us.
3. Another objective of the MHO is to improve the financial access to health care at health centre and

hospital level. What do you think about that? Do you go more often now and more quickly (i.e. without waiting too long at home) to health centre and/or the hospital? Please tell us.

4. Are there families in your community, which do not have enough money to pay the subscription fee for all members of the family? According to you, what should be *Maliando*'s attitude towards these people?
5. Many mutual aid associations or clubs exist in your community at a family, group or clan level. They also intervene in case of, for example, 'disasters' (death or an accident). In what way do these associations differ from the MHO *Maliando*? And do you still need an MHO if these associations are able to adequately cover the cost of an illness?
6. In these associations everybody knows everybody else and the social life of these 'clubs' often offers members the possibility to meet each other to have a talk, tell jokes and have celebrations. Is this also the case in the mutual health association? What do you think?
7. If a person who subscribed to the MHO did not become ill, but someone else who is also a member becomes ill, the contribution of the first person will be used to pay the health care of the second one. This person can be a family member but can equally be someone he does not know (e.g. someone from another village). What do you think about this?
8. The contribution campaign for the third year of *Maliando* (2000) is in full swing at the moment. What are your intentions? Are you going to renew your membership for a third time? If yes, why? And if no, why not?
9. Why have the majority of people in your village not subscribed to *Maliando*? What do you think? And why have some people who subscribed the first year not renewed their membership?

Appendix B

See Table 3

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Table 3
Description of the focus groups

Group	Membership	Location	Number of respondents	Gender	Language	Duration (min)
Pop 1.1	2 years	Yende	12	Men	Kissi, Malinke	94
Pop 1.2	2 years	Yende	12	Women	Kissi, Malinke	88
Pop 1.3	2 years	Touffoudou	12	Men	Kissi	104
Pop 2.1	1st year	Yende	12	Men	Malinke	107
Pop 2.2	1st year	Gbekadou	8	Men	Kissi	103
Pop 2.3	1st year	Mano	12	Women	Kissi	100
Pop 3.1	2nd year	Yende	12	Women	Manika	100
Pop 3.2	2nd year	Gbandou	10	Men	Kissi	110
Pop 3.3	2nd year	Bagbedaye	12	Men	Kissi	120
Pop 4.1	Non-members	Yende	11	Men	Kissi, Malinke	95
Pop 4.2	Non-members	Toly	12	Women	Kissi	90
Pop 4.3	Non-members	Soumtou	12	Men	Kissi	100
Val. 1	2 years	Yende	11	Men	Kissi, Malinke	113
Val. 2	1st year	Bailan	12	Women	Kissi	140
Val. 3	2nd year	Yende	12	Men	Kissi, Malinke	105
Val. 4	Non-members	Yende	12	Men	Kissi, Manika	85

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