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The challenges of health reform in Senegal: qualitative analysis of the departmentalization of community-based health insurance

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ABSTRACT

Introduction: In Senegal, community-based health insurance (CBHI) schemes have long been favoured as the main instrument for achieving universal health coverage (UHC). Historically managed by community volunteers, these schemes have struggled with financial sustainability and coverage effectiveness. In response, Senegal launched a reform in 2022, transitioning from communal to departmental CBHI schemes to enhance management and service delivery. This study aims to explore the challenges associated with implementing this reform in the country.

Methods: The qualitative study was conducted from 2020 to 2023, utilizing 27 in-depth interviews with stakeholders from four regions to explore the roles of social actors, ideas, power dynamics, and context in the reform. The interviews specifically aimed to capture the dynamics of support and resistance to the transition from communal to departmental CBHI. Data were analyzed using a thematic analysis approach.

Results: Findings reveal significant resistance among existing communal CBHI managers who fear loss of autonomy and financial control. Stakeholders expressed concerns over the rapid and top-down approach of the reform process, which many felt was forced upon them without adequate consultation. Despite these challenges, some stakeholders recognized the potential benefits of professional management and streamlined operations to enhance healthcare accessibility and efficiency.

Conclusion: The study shows that despite encountering resistance stemming from entrenched ideas, values, and power dynamics, the reform has been accepted and is currently being implemented. The role that departmental CBHI will play in the ongoing reform process remains to be seen.

Keywords: Reform, community-based health insurance, universal health coverage, Senegal, policy analysis

Abstract in Español at the end of the article

INTRODUCTION

For many years, research on health financing reforms in several African countries has shown that relying on local community-based health insurance (CBHI) for universal health coverage (UHC) is ineffective. In French-speaking West Africa, CBHIs are often called *"mutuelles de santé"*. They are local micro-insurance schemes based on solidarity, autonomy and participatory democracy. Membership is voluntary and governance is community-based [1]. Reforms focusing primarily on this financial mechanism have failed, despite strong support from some international organisations [2]. While these local

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CBHI have helped their very limited number of members access better care and reduce expenses, their geographical coverage remains inadequate [3,4]. In Senegal, for example, current penetration rates have never exceeded 10%, even though a national policy has promoted this instrument since 2013 [5]. However, CBHI have existed in the country since 1915, and numerous projects have supported these local CBHI since the 1980s [6,7].

Many studies have investigated the factors behind the low adherence of African populations to these CBHI. These factors are multiple and complex—including individual considerations (knowledge, ability to pay), organisational challenges (linked to health and insurance services), and social aspects (trust, politics) [8–11]. Several studies, notably in West Africa and Senegal, have demonstrated how the professionalisation of managers, trust deficits between the management and the population, power relations between the population, the health professional and the CBHI management team, social capital of local community, and community organisation dynamics contribute to the effectiveness challenges (i.e : membership) of these local CBHI managed by community voluntary members [2,6,10,12–15].

A recent debate in Social Science & Medicine explored the role of social capital—defined as "altruism, trust, norms of reciprocity, and a shared commitment to the common good" [16]—in CBHI. The relationship between people, community managers of CBHI, and State institutions remains central to the factors influencing their success [10,11].

Thirty years ago, analyses of health reforms had already highlighted the challenges related to community representation in CBHI [17]. In Mauritania, community leaders of CBHI resisted recent reforms and used arguments based on their authority. As a result, *"reluctance to implement needed changes was the main obstacle towards the expansion of the MHO [CBHI]"* [15].

In Senegal, following an experiment conducted in two departments (Foundiougne and Koungheul) since 2014 [18] and after a national evaluation in 2021—which produced twelve reports and included public consultations [4]—the state launched a major reform aimed at significantly improving the performance of the healthcare system [19]. The National Agency for Universal Health Coverage (ANACMU) is implementing the reform. As a result, all communal CBHI (more than 600) previously run by community volunteers have been replaced by a single CBHI in each of the 47 departments beginning in 2022. Inspired by Ghana's earlier experience, the primary objective is to reduce fragmentation by merging systems—one of the four reform options for achieving UHC (i.e. shifting, merging, cross-subsidising, harmonising) [4,20].

By April 2023, 22 out of 47 departments had started the process of departmentalisation. These new departmental CBHI are no longer managed by community members but by professionals with expertise in management, finance, and community mobilisation. These professionals are employed by the departmental CBHI and recruited through a call for applications overseen by the Management Board (MB) and the decentralised regional services of ANACMU. Community governance is maintained through a president and a board composed of members elected by the general assembly, which consists of the communal board members and delegates representing villages and neighbourhoods.

The reform does not alter the service package (departmental/regional portability) and the process for joining the CBHI. The service package was offered under the same terms and conditions in all the former communal CBHI at the national level, following the harmonization instructions requested by ANACMU. Contributing members must pay an annual membership of 3,500 CFA francs, which is matched by a state subsidy of an additional 3,500 CFA francs. Non-contributory members who are exempt from payment receive a subsidy (managed by the CBHI) of 10,500 CFA francs per person. These individuals are identified as indigent and are selected under the National Family Security Scholarship (cash transfer) program.

Only a few countries in sub-Saharan Africa have implemented this type of reform. As a result, there remains a lack of empirical knowledge about the challenges of organising such reforms in West Africa. In Mali, a similar reform was implemented in 2015, but only as part of a project heavily supported by international aid (from 2017 to 2021) and within the context of a complex security crisis. While local stakeholders welcomed this innovation, the study highlights the challenges and resistance associated with introducing the reform [21].

The objective of this study in Senegal is to understand the challenges of implementing the reform, which phases out communal CBHI to establish departmental CBHI. The results may be valuable for other countries in the region seeking to pursue this greater level of risk sharing as an intermediate step toward UHC.

METHODS

The method and article presentation are part of the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist. [22]

Research team and reflexivity

The data was collected by BK, a sociologist (PhD student) research assistant of Senegalese nationality and VR, a researcher (PhD) with expertise in health systems. VR is of French and Canadian nationality and has been living in Senegal from 2019 to 2023. The study was conducted by three male researchers in Senegal who have been collaboratively studying CBHI schemes for four years with national and regional stakeholders. The two senior researchers, VR and AF, (both PhDs) have been analysing health system reforms in West Africa for 20 years. All study participants were informed about the study's objectives and the status of the three authors.

The article was initially written in French to facilitate

collaboration. Although the study was funded by an international project supporting the reform discussed in this article, the funding did not influence data collection and analysis. The research team maintained independence throughout the study by ensuring the absence of influence, verifying all data sources, triangulating information, and specifying the nature of the independent investigation with the people interviewed. In addition, the author's detailed knowledge of the context and subject enables them to check the quality of the data they receive through this qualitative approach.

Study design

The theoretical approach for this analysis aligns with the research on health systems in Africa, where the issues of power and trust are essential for understanding reforms [23–25]. The aim is not only to focus on the hard/tangible components of health systems—such as services, medicines, and hospitals—but also on the soft/intangible elements, including trust, ideas, power dynamics, and interests [26]. These aspects emerge from the interactions among social actors shaped within a specific historical socio-political context [27,28]. There are numerous approaches and frameworks to understanding change within health organisations (e.g. policy triangle, streams, network, coalition, etc.) and the factors influencing strategies to transform situations (e.g. context, actors, ideas, process, evidence, power, etc). However, the role of donors—through their ideas, financial tools, and projects—has long been recognized as a key influence in reform analysis [17] , as it has already been shown on a national scale for CBHIs policy options in Senegal [29,30].

We used qualitative research methods to complete this study. We collected data after over three years of immersion in Senegal at the national and local levels with several studies on CBHI. We conducted individual interviews with 27 participants with relevant knowledge of the subject as key CBHI players (members of boards of directors, representatives of ANACMU regional offices, etc.) [31], including 21 men and six women participants from four of the country's 14 regions (Saint Louis, Kaolack, Fatick, Thies).

The sampling strategy followed the principle of diversification—considering regions, hierarchies, and opinions about the reform—and the ability to collect data relevant to the study [31]. Diversification occurred at the CBHI level (by length of involvement to reform; region) and among the individuals interviewed (by length of involvement and resistance to reform, gender, power position, knowledge, region, etc.). The people were chosen because they represent a diversity of views on the reform, but above all, because they have sufficient knowledge of the proposed changes to give an informed opinion for the research [31]. The four regions selected for the study were those most affected by the reform at the time of data collection. Of the 27 people interviewed, 23 came from the community, and four were from ANACMU's regional (public) services based in the four regions covered by the study. Among the 23 community members (including six women), participants included employees of departmental CBHI (n=3) and communal CBHI (n=2); chairman of the board of directors of departmental CBHI (n=2) and communal CBHI (n=14); and representatives of the National Union of Community CBHI (n=2). Of these 23 participants, 19 opposed departmentalisation, while four supported it. None refused to participate.

Following a few test interviews in one of the regions concerned, the content of the interviews was refined based on prior empirical knowledge about resistance factors to reform and conceptual dimensions drawn from scientific literature on similar reforms. We aimed to capture participants' perceptions of the objectives of the reform, justifications, raised issues, the organisational process and context, the capacities of communal CBHI to participate in change, and the reform's potential consequences. We conducted the interviews either in the offices of the CBHI or at people's homes, depending on their preferred time (sometimes on weekends) and location, ensuring privacy and confidentiality. The interviews lasted between 45 and 75 minutes.

Analysis

All interviews were transcribed into French, and BK carried out a first-level manual thematic analysis. Then, based on the overall report and multiple exchanges between the three authors, VR synthesized the thematic analysis, aligning it with the conceptual dimensions of the study of the reforms. AF validated the final synthesis. Where empirical evidence allows, the results compare the perceptions of actors who supported the reform with those who opposed it; otherwise, the findings are presented comprehensively.

RESULTS

Objectives and rationale for the reform

Supporters of departmentalization argue that the reform's objectives aim to reduce the fragmentation of CBHI and improve their professionalization. The goal is to provide better services to members and increase membership penetration. The strength of collective action is highlighted:

> "*What one individual can do will be better done by a group of individuals*" (CBHI President)

Communal CBHI were considered too fragile financially, with concerns about their viability. They struggled to pay their debts to health facilities while reducing insurance portability. The introduction of individual cards (replacing the old letters of guarantee) is expected to enhance accessibility:

> "*treat yourself in the department wherever you are with this card*" (CBHI employee)

Improving access to care remains central to the reform.

For historical reasons, particularly long-standing commitments to the mutualist movement, resistance to

the reform was strongest in the regions of Kaolack and Thiès. Thiès, in particular, has a long tradition of community engagement with communal CBHI, as evidenced by several studies [32]. In contrast, residents of the St. Louis and Fatick regions were more receptive to the reform. Its rollout in these areas was supported by an international project that promised them both material (buildings, vehicles, offices, recruitment) and technical assistance (including study tours, training, archiving and management) to support change. Indeed,

> "*we had someone to support us financially, to allow still us to do the job as we should. This motivated us*" (CBHI President)

Although similar support was offered in Kaolack, the mutualists there did not accept it. They feared the delegation of power to technicians while their CBHI were, according to them, effective. The mutualists of Saint-Louis however, recognized the significant debts of some communal CBHI and supported the reform's rationale for merging into departmental CBHI, where

> "*the strongest will reach out to the weakest*" (Director of Departmental CBHI)

This approach emphasizes mutual assistance to strengthen the collective ability to pay for healthcare services. Ultimately, the reform is also a technical solution for communal CBHI experiencing great operational difficulties (low members, debts to pay health facilities, dependence on state subsidies, etc.). Thus, the reform proposal, although late, may come at the right time.

In addition, those interviewed cited the 2021 national assessment and the experience since 2014 in both departments as sources of reference (evidence) justifying the reform.

Resistance to change

Empirical results show divergent perceptions between people in favour and against change. Mutualists in favour of the reform believe that personal reasons and conflicts of interest linked to power dynamics explain the refusal of others (see below). Opponents argue that those in favour just are trying to save their failing CBHI, the one that have lost the confidence of the population. According to the opponents, the former have nothing to lose, which makes them more likely to support the reform. One CBHI president commented:

> "*Did you go to xx? They are for departmentalization because nothing works there*" (CBHI president)

On the other hand, CBHI with strong financial standing do not benefit from being associated with loss-making CBHI:

> "*They prefer to stay with their money*" (CBHI manager)

Not only do they lose their resources and the benefits of their long-term community involvement, but their leaders risk losing power and social status. The title of "*president*" is highly valued.

Thus, opponents argue that they have served their communities for many years voluntarily and that replacing them with professionals should be reconsidered. Some fear being excluded from positions of responsibility because of the recruitment of professionals. They also expressed concerns about the 'one voice, one vote' principle when electing the new departmental CBHI community leaders. For example, the three communal CBHI performing well in one department will face the votes of eight loss-making CBHI that risk removing them from power. As a result, the election of the governance of new departmental CBHI has often given rise to attempts at influence and co-optation by former presidents of communal CBHI. One president referred to this as "*malignance*" and a "*refusal posture.*" Some meetings between community leaders and ANACMU regional leaders were very tense. The community's location concerns the managers and others involved in the communal CBHI (manager, facilitator, fundraiser, etc.). There are concerns about job loss or the loss of financial benefits. Some are also alarmed by the difficulty new employees will face in gaining the community's trust because "*to get money out to the population, it will be a difficult thing because they will not trust*" says an opposing president. Thus, many question the impact of professionalization on the connection with local communities and the geographical and social distance it may create, particularly regarding communal CBHI perceived as performing well and fostering a strong sense of regional belonging.

However, the challenge is not only statuary for those responsible, but also financial, as it is for this communal CBHI, of which the President's daughter is the manager. She receives a salary, the amount of which is not negligible. The issue of power is therefore added to the financial interests to resist the reform because

> "*the problem is the management of resources, they wanted to continue to manage resources, and they know that if the CBHI has become departmental, they will no longer manage these resources*" (Director, CBHI)

In addition, some point out that state subsidies are sometimes significant.

> "*There were power structures that, through mutualist movements, were resisting because the stakes were enormous. President of CBHI, you are given grants and receive 30, 40 million twice, three times a year. But you are manipulating $90 million. For someone who was a teacher or does not even have a profession in rural areas, who does not even have a job and who heads a structure where he can manipulate 90 million people are not ready to let go. It was above all these issues*

that made sure that there was resistance and a war underneath; it was cheese that should not be left behind" (CBHI Manager)

Echoing one of the elements justifying the reform, some opponents argue that there is no evidence to support the proposed changes. A mutualist leader who is still engaged in the reform process still wonders today:

> *"We have never been presented with a document that assures us of the success of departmentalisation, i.e. a feasibility study or a study on the technical and financial viability of departmental CBHI that takes account of specificities. It was not done"* (President, CBHI)

In addition, some question the quality of the 2021 national assessment, which is said to have excluded well-functioning communal CBHI from its sample to generalize failure based on non-performing CBHI. It has even been suggested that *"the agency evaluation was somewhat biased"*(President, CBHI).

The recent communal CBHI assessed have yet to receive the necessary support, unlike the first departmental CBHI, which have been mainly supported by international aid since 2014. Opponents argue that the comparison is therefore neither fair nor reasonable. They explain that the challenges these communal CBHI face are also due to delayed payments from the State, meaning the source of their difficulties is also exogenous.

Context

Indeed, the context of constrained public funding explains part of the resistance to change. For many CBHI, these public subsidies are essential to their budget. However, negotiations are undertaken with the heads of the communal CBHI for the reform, and ANACMU announces its wish to stop these subsidies. For non-contributors, ANACMU wishes instead to reimburse health facilities directly based on the actual healthcare consumption of the indigent. Although this decision may seem technically justified in the name of public finance efficiency, its timing appears to be aimed at something other than the community leaders.

> *"It is since this circular [on the cessation of subsidies] that we began to talk about departmentalisation"* (President, CBHI)

This has led to multiple exchanges and complaints from the National Association of Community CBHI. The President recalls that a meeting with the Minister was organised, and he 'said there was a misunderstanding'. But this moment of the reform is also part of an older context of very significant late payment by the State concerning these subsidies (and those of the payment exemption policies). Some CBHI report delays of more than two years. A president even suggested a strategic intention and links between late payment of subsidies and biases in the national evaluation which were used to justify the reform on the grounds of the underperformance of communal CBHI:

> *"You ask me to take the money from the [contributory] classics to treat [non-contributory indigents] throughout the year, and at the end of the year, you select a few [indigents during the evaluation] who say they have not been treated to say that you are not going to pay me. But it was they who brought us to our knees."*

Process

In addition to financial and technical support from a development partner for specific regions, the dissemination of ideas on the reform was organised by study visits to the two departmental CBHI that have been in place since 2014. Numerous field visits were organised to community leaders. Beyond what they had heard, they could see the relevance of departmentalisation and professionalisation. However, despite these visits, some remained skeptical about the proposed changes, particularly questioning their ability to take root in other contexts. A president opposed to the reform explains,

> *"We must not imitate by saying that it is Rwanda, etc.; these countries have their specificity, but what is the specificity here in Senegal? These realities must be taken into account. If we don't consider them, it will catch up with us"*

Some reluctant indivuduals found the process to be very vertical and even *"cynical"*:

The reforms were presented to us very cynically; there was not a whole time of sharing, of exchange, especially with the community actors. We are something that fell on us one day. There were no prior consultations to gather our expectations, guidelines, etc. These were guidelines that had already been laid down.

Others note that the process has also been rushed, including how to achieve change. In one region, one person referred to the fact that they *"burned steps,"* not leaving enough time for discussions between stakeholders at the local level, and another person referred to a *"slightly hasty"* way. It was also essential to be cautious before embarking on the proposed reform. The change was new, and specific areas of uncertainty and possible '*unsaid*' (CBHI president) reinforced the need for circumspection.

But the people who were more in favour of the reform thought the opposite and said that "the process is good," explains the president. But he quickly mentioned that nothing would have been possible without the support of the already-mentioned international project. Others highlight the many consultations and discussions that have occurred since the beginning. Some even note participation in decisions or co-construction in the process, even if the information does not necessarily circulate to the bottom. They claim that nothing was imposed and that it was possible to refuse the reform: *"It was not an obligation, and everyone had the right to say yes or no if they adhere to this new policy that the State has presented to us,"* says a president in favour of change.

Moreover, some (Fatick and Gossas) had already requested the support of an international project to departmentalise their CBHI in 2021. In addition, ANACMU has also undertaken activities to promote and prepare this reform, such as a meeting at the departmental council of Saint-Louis, with the presence of the Prefect:

> *"We gave a presentation with a video, showed the characteristics, the advantages, etc. We gave the experiences everything, and I saw that many people started shaking their heads, saying it was interesting"* (Employed, CBHI)

Have room for manoeuvre?

Some explained that, in the end, the administration gave them little room for manoeuvre or even that they had no choice. A president of a communal CBHI explains:

> *"I think we are the last to agree to enter the stage because we also have our vision; even if all CBHI agree to join, then we too are obliged to do so. I think that was their goal"*

Another president explained that the level of indebtedness of his communal CBHI meant that he was forced to accept the reform; he lamented the situation but had no solution other than taking it. An unfavourable president even recalls receiving threats from ANACMU to accept the reform. In the absence of the roadmap, he recalled a letter:

> *"There is a letter the Director-General sent based on that letter. I read the letter myself, but there were threats. The agency's DG threatened us; we are big people, and nobody is threatening us. We know what we are doing and what they want to do. If he threatens us, we leave him with these things"* (President, CBHI)

In another region, an unfavourable president considers that he was excluded from the process and not summoned to the constituent assembly of the departmental CBHI. Elsewhere, a president claims to have also been dismissed because he had clearly announced his refusal to reform.

Although the people we met did not mention the use of coercion, the feeling was instead that of a state steamroller. Indeed, *"as it is a reform that the Health Insurance Agency and we are obliged to go and try since it is a programme. I think that as it is a state policy, with reforms, all the departments are gone, so why is the department not going to leave?"* Others explain, however, that the evolution of their position is also due, on the one hand, to better information received as the process progresses and, on the other hand, to greater trust between regional state actors carrying out the reform and local community leaders. ANACMU has also strengthened its communication and strategies to inform and convince local actors or their national representatives.

Lessons learned

We have systematically asked the people we met what lessons they have learned from this ongoing reform. We summarise the recommendations in Box 1, but as all the presidents remind us, the prerequisite is that ANACMU's subsidy debts be repaid.

Box 1. Lessons learned by participants for reform.

1. Involve all stakeholders, including local and regional authorities, at an early stage of the reform
2. Take time for collective discussions about the content and the process of the reform
3. Provide evidence to support proposals based on a rigorous and transparent evaluation of the current policy
4. Share in advance a document specifying the details of the content of the reform, its expected objectives, its operation and implementation plan, etc.
5. Organise on-the-spot consultation sessions and collective and open exchange processes about the content and the process of the reform
6. Striking a compromise between professionalization of CBHI management and the community involvement in governance and mobilisation
7. Organize advocacy at the level of local territorial authorities regarding the reform's content
8. Possess suitable communication equipment to dissemination information about the reform
9. Accompanying the reform process to support it's implementation

DISCUSSION

This qualitative study first analyses an original reform in French-speaking West Africa. In the context of Senegal, this is a significant departure from national policy, which has always focused on supporting communal CBHI with management organised by volunteers. The study shows that despite some resistance due to the persistence of ideas, values, and power issues, the reform has been accepted and is being implemented. The presence of these resistances is logical and understandable. In 2022, more than 30 departments are being engaged in this reform and by the end of 2023, all the country's departments had held the general assemblies required to set up the CBHI departments, according to ANACMU. This is an interesting first step in favour of pooling [20], reducing the fragmentation of the system [33–35] and

"the imperative for scale and professionalisation in terms of management" [36].

As elsewhere in Africa [4,35,37], the fragmentation continues to pose a significant risk in the Senegalese health system. The interactions and power dynamics between actors have been key factors in maintaining this fragmentation. The national strategy based on communal CBHI from 2013 onwards contributed to *"the 'break-up of CBHI organisations"* with the strong involvement of ANACMU [38]. Disagreement between the various CBHI organisations on the relevance of the reform has led to conflict and major distancing, undermining the CBHI movement's coherence. In 2023, the National Commission for the Evaluation of Public Policies acknowledged (as did ANACMU officials at their hearing in June 2022) this error and the lack of national ownership of this communal approach, influenced by US cooperation (USAID) and its ideas [39]. In 2018, while ANACMU was promoting communal CBHI and initiating its reflections on departmentalisation, it also supported a CBHI intended solely for actors in the cultural sector [40]. Since then, there have been many CBHI of this type (for artisans, sportsmen, etc.) supported by ANACMU, which nevertheless planned the reform studied in this article. Senegal is, therefore, starting to draw inspiration from Ethiopia, Ghana, Rwanda and Sudan, which have made exciting progress in reducing the fragmentation of their insurance systems [4,41,42]. The challenges of coherence in the content of public policies [43] are not, however, the prerogative of the Senegalese State but also of its international partners (Belgian and German Cooperation, International Mutual Insurance Association, International Labor Organization, etc.), which may have supported both the departmentalisation of CBHI and CBHI intended for certain groups of professions. The congruence between CBHI organised on a territorial basis and those on a professional basis is one of the challenges of UHC in Senegal.

Adapting to the context is undoubtedly the other challenge in finding suitable financial instruments for UHC in Senegal. Ethiopia's experience confirms that *"the success of Coop Health is context-specific"* [41]. Research and state services have shown how the promotion of an inadequate instrument by development partners and their ANACMU colleagues, which did not have a partner coordination strategy, caused a significant delay in UHC reforms [29,38,39]. Ghana and Rwanda, which have experienced defragmentation of their insurance system, were visited by ANACMU officials and took time to influence decision-making in Senegal. In Rwanda, CBHI have not been managed by the communities since 2015, and membership is compulsory, which is still far from the case in Senegal, even if a feasibility study has been proposed since 2017. Transferring policies and the journey of models and social policy ideas in Africa is not always as easy [44,45]. The same applies to the influence of the pilot projects in Senegal since the reform principles were in place in 2014 in two departments but did not inform decisions before 2022 despite tests of some form of departmentalisation from 2019 onwards [29,38,39,46]. However, if these challenges had been known for a long time, it would have taken time for the reform analyzed in this article to be formulated and started. In Ethiopia (the context has changed since), while the CBHI pilot project began in 2011 in 13 rural districts, the studies influenced the scaling-up from 2013 onwards. In 2021, 79% of districts will have a membership rate of 63% to these CBHI, which remain voluntary [41].

If the technical aspects are to be considered in these delays in Senegal, we must pay attention to the political stakes and power games that certainly play a dominant role. For example, the report of the Court of Auditors analysing the failure of the national programme of communal CBHI was known to ANACMU officials. Still, it was only made public at the value of the political regime change in early 2024 [38]. The 2022 report of the National Commission for the Evaluation of Public Policies, which was not public, reports on the influence strategies of US cooperation by recruiting the 'key decision-makers' of the Ministry of Health to promote their model of local CBHI [39]. Thus, governance is central to transforming CBHI [36,41,42], and community social capital will not do everything [16]. The state, through ANACMU, has several years of debt to CBHI and health facilities concerning membership subsidies or exemption from payment of care for children under five. These subsidies and exemptions comprise 85% of the resources the ANCMU manages. Solutions to these debts are urgently needed to ensure the current reform's effectiveness and foster buy-in among stakeholders. In addition, the lack of state funding for ANACMU is another issue since, during its hearing before the National Evaluation Commission in June 2022, its director showed that between 2017 and 2021, the gap between the Agency's funding needs and what it obtained varies between 34 and 59 billion CFA francs per year.

The study confirms the role of stakeholders' perceptions of the proposed change in the challenges of its implementation, specifically the role of ideas in Africa and beyond [45]. A previous review has highlighted how implementers' ideas regarding user fee exemption policies in West Africa influenced their implementation [47]. In neighbouring Mali, certain groups of civil servants vehemently resisted the imposition of a health insurance reform, only accepting it several years later once they understood that they, too, could benefit from it [48]. Reform analysts often stress the importance of understanding the ideas of the people concerned and their positions about the proposed changes to anticipate the implementation challenges [28]. Stakeholder analysis is a crucial step in planning a reform, as shown by Mladovsky and colleagues [12], when they analysed CBHI in Senegal. However, this preliminary analysis of the forces involved was not necessarily conducted for the 2022 reform in Senegal. The state seems to have thought that it had the monopoly of decision-making, the sovereign power, that

the debates had been launched (at least since 2019) and that resistance would be weak or defeated. This perception was already present within ANACMU in 2019 when the first attempt to reflect on such reform was launched [38]. The reform's approach to change, far from being one of organisational development (participatory and decentralised), can be described as a hybrid of a (minor) political model that takes organisational power games into account and a (primary) hierarchical and classic model [49]. The state also used the latter approach during measures to combat the COVID-19 pandemic [50]. If the state is determined to proceed, we must welcome a return to the rule of law in the governance of the social protection system, akin to the construction of social security in France and CBHI in 1945 [51]. A comparative historical analysis of resistance to changes around mutuality and the state's role in Europe and Africa remains to be carried out [52]. In Ghana, local CBHI did not publicly express their disagreement with establishing district CBHI when the law was passed. However, strong opposition had been organised by a coalition of actors before the law. This reform, being an electoral promise, did not generate challenges once the law was passed by a democratically elected government [53,54].

Our study shows there has been relatively little resistance to change for several reasons. First, the change targeted CBHI whose poor performance could have given them the means to resist. However, this reform may have presented a window of opportunity for these CBHI (Kingdon, 1995) either for them to seize it or to realize they had no choice but to accept it. There was very little room for manoeuvre. An evaluation confirms that stakeholders *"quickly understood that merging CBHI into departmental professional insurance units is the most viable and attractive solution for the population"* [55]. Secondly, the communal CBHI remain fragmented, and their national association does not have sufficient weight to counteract the desires of the State and the National Agency. At times, the State sidelined this association, and when it tried to react—for example, by urging its members to stop caring for non-contributors in response to ANACMU's subsidy cessation announcements (a tactic already used in 2018)—its influence was too weak to impact negotiations.

Moreover, this national association had significant links of interest with ANACMU, particularly its Director General. They received substantial grants (CFAF 760 million from 2019 to 2020) from ANACMU as part of the project to support the professionalisation of communal CBHI. The leaders of the association received significant salaries during this project. The Court of Auditors has raised concerns about this project's relevance, consistency and management [38]. As Bonoli explains [56], no actor had the opportunity to act as a veto of the proposed policy changes, especially in the context of development aid where such links of interest tend to overshadow problems [57]. It cannot be said that the reform was imposed—given that it took many years to decide [29] and wait for a national assessment in 2021 to trigger it—the national association, described as a litigating coalition [58] used by the Court of Auditors [38], lacked the necessary power to influence reform implementation. However, *"the absence of veto points does concentrate power, but by the same token is also concentrates accountability, and thus makes electoral punishment for unpopular measures more likely"* [56]. This analysis helps us understand the political rupture at the beginning of 2024, which saw the loss of the political camp that had supported the communal CBHI program promised during the 2012 election campaign [59]. The ineffectiveness of the program, confirmed by the Court of Auditors in a 2021 report, was made public in May 2024 [38] and the National Commission for the Evaluation of Public Policies in 2023 [39].

Conclusion

At the end of March 2024, just before the President of the Republic handed over power to the newly elected leader, a decree was issued, transforming ANACMU into the Senegalese Agency for UHC. The government at that time seemed to want to convert this agency into an insurance fund, although the details of this reform still need to be clarified. It was only in May 2024 that the 2021 Court of Auditors' report, which questioned the Agency's performance, was made public. What role will departmental CBHI play in the ongoing reform process? Will there be a paradigm shift in public policy in the coming years?. Only time will tell whether the transformation of communal CBHI into professional CBHI at the departmental level has been able to fit into this decreed change. Ultimately, the coherence of this policy for UHC will be the critical issue.

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Publication Consent

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Competing interests

The authors report no conflict of interest.

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Author contributions

VR and AF proposed this study and obtained funding. The three authors drafted the study protocol. BK and VR interviewed the stakeholders and carried out the first level of analysis. The three authors finalised the analysis together, and VR wrote the first version of the article, which was improved and validated by BK and AF.

Data availability

The raw data generated and/or analysed during the current study are not publicly available.

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Los desafíos de la reforma de la política sanitaria en Senegal: análisis cualitativo de la departamentalización de las mutuas de salud

RESUMEN

Introducción: En Senegal, los planes de seguro médico comunitario (SMC) han sido durante mucho tiempo el principal instrumento para lograr la cobertura sanitaria universal (CSU). Históricamente gestionados por voluntarios comunitarios, estos planes han enfrentado dificultades relacionadas con la sostenibilidad financiera y la eficacia de su cobertura. En respuesta, Senegal inició una reforma en 2022, transformando los planes comunitarios en departamentales para mejorar la gestión y la prestación de servicios. Este estudio tiene como objetivo explorar los desafíos asociados con la implementación de esta reforma en el país.
Métodos: El estudio cualitativo se llevó a cabo entre 2020 y 2023, utilizando 27 entrevistas en profundidad con partes interesadas de cuatro regiones para explorar los roles de los actores sociales, las ideas, las dinámicas de poder y el contexto en la reforma. Las entrevistas se enfocaron específicamente en captar la dinámica de apoyo y resistencia a la transición de SMC comunal a departamental. Los datos se analizaron mediante un enfoque de análisis temático.
Resultados: Los hallazgos revelan una resistencia significativa entre los gerentes de los SMC comunales existentes, quienes temen perder autonomía y control financiero. Las partes interesadas expresaron preocupación por el enfoque apresurado y vertical del proceso de reforma, que muchos sintieron que se les impuso sin la consulta adecuada. A pesar de estos desafíos, algunas participantes reconocieron los beneficios potenciales de una gestión profesional y operaciones optimizadas para mejorar la accesibilidad y eficiencia de la atención médica.
Conclusión: La investigación muestra que, a pesar de la resistencia debido a ideas, valores y dinámicas de poder arraigados, la reforma ha sido aceptada y se está implementando actualmente. El papel que desempeñarán los seguros médicos departamentales en el proceso de reforma en curso aún está por determinarse.

Palabras clave: Reforma, seguro médico comunitario, cobertura sanitaria universal, Senegal, análisis de políticas

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