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RESEARCH ARTICLE

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Acceptability of innovative department community-based health insurance in central Mali: A mixed methods study

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Abstract

As the Universal Health Insurance Plan (RAMU) is gradually being implemented in Mali, community-based health insurance (CBHI) —considered one of the pillars of this programme— must innovate to meet the challenge of universal health coverage. An experimental CBHI was tested in central Mali between 2017 and 2021. This innovative CBHI professionalizes and organizes risk sharing on a larger scale than before, moving from municipalities to circles (departments). A mixed-method study was carried out in the Mopti region to assess the acceptability of this innovation among CBHI elected representatives. In April 2021, 118 questionnaires were administered to CBHI elected representatives, followed by 43 qualitative interviews from the same sample in October 2021. Sekhon et al. (2017) developed an approach outlining seven dimensions of acceptability (attitude, burden, values, coherence, opportunity costs, perceived efficiency, and personal effectiveness), which was used as a conceptual model for data analysis. The results obtained by factor analysis indicate that more than half of individuals (58%) reported above-average acceptability. Elected representatives feel

well supported in their activities by the Technical Union of Malian Mutuality (TUM), the umbrella organisation of CBHI. They show some confidence in their ability to perform their duties effectively despite varying levels of commitment that often fall short of expectations and needs, which they justify by their volunteer status. Elected representatives note that the system is very effective despite the nonoptimal conditions linked to the prevailing insecurity. The new CBHI is highly advantageous for the population in terms of content, financial, and geographical access. Professionalisation is an unavoidable condition for the performance of the innovation, as well as the new community assembly. However, elected representatives are concerned about the sustainability of this CBHI and rely on the State and its partners to assume responsibility. The TUM will play an essential role in continuing its support and fulfiling its functions as a delegated management organisation within the framework of the RAMU.

KEYWORDS
acceptability, CBHI, innovation, Mali, UHC

Highlights

- Mali has innovated by testing two community-based health insurance (CBHI) managed by professionals and organised at the level of departments.
- Elected representatives of CBHI have well accepted this innovation.
- Elected representatives feel well-supported in their activities by the Technical Union of Malian Mutuality, the national umbrella organisation of CBHI.
- Professionalisation appears to be an unavoidable condition for the performance of this innovation.
- Elected representatives are concerned about the long-term sustainability.

1 | INTRODUCTION

Community-based health insurance (CBHIs), implemented for over 30 years with the support of international partners, face the challenge of improving their low performance. Global health actors and governments in the countries concerned are aware of the limitations of these volunteer-run organisations in moving towards universal health coverage (UHC).[1,2] Even if these CBHIs protect their few members financially,[3] their population coverage

rate remains so low that it requires searching for new solutions and innovations.[4] CBHI movements, both international and African, are calling for such changes. The Lomé Plat-form (a group of organisations promoting the development of CBHIs, supported by the International Association for CBHI) proposes a shift towards mandatory membership and the professionalisation of CBHI staff.[5]

Moreover, the history of mutuality in Europe and the development of CBHI in Asia show the need for competent and trained staff.[1,6] Research demonstrates the limits of CBHI organised on a scale that is too small, such as a village or communal scale, as is common in most West African countries. Over 20 years ago, Bart Criel explained the value of risk sharing on a larger scale, proposing that of a health district whose size varies from country to country.[7] However, this call has not received significant attention in the region. Apart from Mali, Niger, and Chad, which have recently tried this approach in pilot projects, only Senegal in French-speaking West Africa has been implementing department-level CBHI led by professionals since 2014. Although these Departmental Health Insurance Units (DHIU = UDAM) are now a success and extend nationally, their establishment has not been without challenges or resistance[8] on the part of the government, which has long been focused on its national policy of communal CBHI, international organisations[9] and members of national CBHI bodies. Transitioning to a CBHI managed by professionals and operating on a departmental/district scale requires dissolving each local CBHI, often governed by notable locals.[10] The stakes of power are immense because local elected representatives, often drawn from the local elite (village chiefs, teachers, retired civil servants, etc.), will lose their positions, their symbolic and financial powers, and their associated privileges.

Mali piloted an innovative CBHI, similar to the Senegal DHIU model, as part of an experimental programme in two administrative subdivisions (circles: department) of the Mopti region, Mopti and Bandiagara.[11] It is this innovative programme that is the subject of this analysis. The National Universal Health Insurance Scheme (UHIS = RAMU) was enacted in 2018. Under the umbrella of a single body, the National Health Insurance Fund (NHIF = CANAM) brings together three schemes: (1) compulsory health insurance (CHI = AMO), intended to cover civil servants, employees, and their dependants; (2) medical assistance scheme (MAS = RAMED), intended to cover the worst-off; and (3) CBHI for the agricultural and informal sector at the municipal level, consisting of 78% of the population. Since 2010, the government has subsidised 50% of the contribution cost. Since this CBHI covers less than 2% of the population,[12] it seems necessary to reform the system and the CBHI offer further.

From 2017 to 2021, a project funded by the French Development Agency (FDA = AFD) tested an innovative CBHI scheme in the Mopti and Bandiagara circles. This innovation is based on various instruments, such as an additional 30% subsidy for the contribution, a more attractive care package, the professionalisation of human and material resources, and structuring at the circle level (department). The Technical Union of Mutuality (TUM = UTM) is the national umbrella organisation of CBHI. As a management platform, with its technical capabilities and professionalism, it was responsible for implementing this system. The TUM was decentralised to operate at the scale of the two circles in the Mopti region, which is the first essential characteristic of innovation. Before the project, only seven municipalities had a CBHI (Mopti, Socoura, Konna, Sio, Bandiagara, Dourou, and Sangha). With the project, the two circle-based CBHI extended coverage to all 36 municipalities, representing significant added value for the community. The elected CBHI members (the population of this study) are volunteers who have seen their role, and their missions restructured with this new system. This major restructuring implies significant changes for these people (power, money, influence, etc.) and justifies the relevance of our study. Elected at constituent meetings by the village and municipal authorities, they must partner with salaried staff recruited and remunerated by the TUM. We chose to study the acceptability of three instruments of the CBHI innovations: (i) the professionalisation with the recruitment of employees (coordinator, accountant, medical adviser, development assistants, and managers), (ii) computerised management tools, and (iii) structuring at the level of a circle with branches in the municipalities (15 in Mopti and 21 in Bandiagara). Regarding recruiting professionals (employees), the manager contacts the population, informs them about the CBHI, manages enrolment and collects contributions. They are supervised by the development assistant, who collects data on the CBHI and liaises with the coordinator.

This article defines innovation using Rogers' classical sense as '*an idea, practice or object which is perceived as new by an individual or another adoption unit*'.[13] Following Rogers' work, research on health innovations confirms the central role of social actors in their adoption.[14] The studies also show how centrally these people, their acceptance of innovations and the social context play a central role in enabling them to evolve on a larger scale.[15]

In Francophone West Africa, where decision-makers are looking for solutions to improve UHC, it is essential to understand the acceptability of this type of innovation on the part of people at the heart of CBHI, the elected officials who lead them. In public health, the work of Proctor et al.[16] has made it possible to include acceptability in the criteria for evaluating interventions. Acceptability is '*the perception by the actors of the implementation that a given treatment, service, practice or innovation is pleasant, palpable or satisfactory*'.[16] The study and application of acceptability are increasing in public health.[17] However, research in Africa remains scarce,[18,19] beyond studies in clinical research and new technologies.[20] Even more scarce is research on the acceptability of innovations in Africa using conceptual frameworks and mixed methods to take advantage of the complementarity of quantitative and qualitative data.[21]

This research aims to study the acceptability of this innovative insurance in Mali among elected CBHI leaders.

2 | METHODS

2.1 | Design

This research used an explanatory sequential mixed methods approach. We began collecting quantitative data in April 2021 and qualitative data in October 2021. The quantitative and qualitative data are of equal analytical importance.[21]

2.2 | Conceptual framework

Several conceptual frameworks are available for studying the acceptability of social or technical innovations.[15,22] In this article, we chose the approach of Sekhon and her colleagues[17] proposed because it seemed best suited to our subject and most relevant. The approach has been fruitful in our previous work in West Africa.[23] Acceptability is understood from seven dimensions: attitude, burden, values, coherence, opportunity costs, perceived efficiency, and personal efficiency.[17] This CBHI innovation had been in place for 4 years at the time of this survey.

2.3 | Quantitative approach

2.3.1 | Population and sample

For security reasons, only seven municipalities of these two circles were targeted (Mopti: municipalities of Mopti, Sio, Socoura; Bandiagara: municipalities of Bandiagara, Dourou, Sangha, Soroly). Of the 118 elected members of the CBHI, 58 were from the circle of Mopti and 60 from the Bandiagara circle. The population under consideration concerns all elected representatives of the CBHI sections of these seven municipalities and the circle boards of directors (CAs) elected representatives, for a total of 118 persons (Table 1). We chose these people for the sample because their acceptability is central to the success of the changes proposed for the CBHIs. The challenges of this restructuring are central to these people, whose role is changing with the arrival of professionals. They work for CBHI voluntarily. Their role is to raise awareness and inform the community about health insurance, support CBHO professionals in their activities and defend the rights of CBHI members in health centres.

TABLE 1 Description of the quantitative sample (n = 118 elected officials).

	Number of staff	Percentage in %
Gender		
Man	85	72.0
Woman	33	28.0
Total	118	100.0
Age		
Under 40 years of age	43	36.5
From 40 to 49 years	17	14.4
50–59 years old	31	26.3
60 years and older	27	22.8
Level of instruction		
No level of education	5	4.2
Koranic teaching only	6	5.1
Only literate	10	8.5
Fundamental 1st cycle/2nd cycle	51	43.2
Medersa 1st cycle/2nd cycle	4	3.4
Secondary Medersa	2	1.7
Classical secondary	10	8.5
Technical and professional secondary	19	16.1
Superior	11	9.3
Total	118	100.0
Officially designated village delegate		
No	6	5.1
Yes	112	94.9
Total	118	100.0
Members of the communal section		
No	18	15.3
Yes	100	84.7
Total	118	100.0
Member of the board of directors of the circle CBHI		
No	85	72.0
Yes	33	28.0
Total	118	100.0
Member of the former CBHI of the municipality		
No CBHI in the municipality	66	55.9
Not a member of the communal CBHI	30	25.4

(Continues)

TABLE 1 (Continued)

	Number of staff	Percentage in %
Yes	22	18.7
Total	118	100.0
Occupation of other functions and responsibilities in the village, the municipality		
No	6	5.1
Yes	112	94.9
Total	118	100.0
Village customary authority		
No	74	66.1
Yes	38	33.9
Total	112	100.0
Elected communal		
No	91	81.3
Yes	21	18.8
Total	112	100.0
Head of a professional/cooperative organisation		
No	35	31.3
Yes	77	68.8
Total	112	100.0
Member community health association (ASACO)		
No	70	62.5
Yes	42	37.5
Total	112	100.0
Other associations, school committee, twinning		
No	20	17.9
Yes	92	82.1
Total	112	100.0

Note: *Some elected representatives of the Council of the CBHI Circle are also elected from the CBHI sections of communes other than the seven deductions.

2.3.2 | Data collection tools

The questions to explore acceptability were organised according to the seven dimensions of Sekhon et al.[17,24] All questions were formulated using a Likert scale giving the choice to five possible answers (1. Strongly agree, 2. Agree, 3. Neither disagree or agree, 4. Disagree, 5. Strongly disagree). The data collection was carried out with ODK (an electronic platform for data collection) based on the KoBoToolbox platform. The questionnaire was created on XLSForm and deployed via a server. The collection was performed on the KoBoCollect app.

2.3.3 | Data analysis

The methods used allow us to study the internal consistency, inter-item coherence, and acceptability dimensions measured by the items.

2.3.4 | Internal consistency

The Cronbach coefficient α is used to verify whether the items are sufficiently homogeneous to measure acceptability at the surveyed level. A value greater than or equal to 0.7 is needed to indicate good internal consistency.[25]

2.3.5 | Interitem coherence

Loevinger's H coefficient checks to what extent a given item is compatible with all the items chosen to measure a dimension. A value greater than or equal to 0.3 is needed to indicate good interitem consistency.[26]

2.3.6 | Dimensionality

Confirmatory factor analysis is used to fit seven dimensions based on Sekhon's theoretical framework of acceptability and to identify the issues associated with these dimensions. The comparative fit index (CFI) is used to verify the validity of the confirmatory factor analysis and the measured dimensions. A value greater than 0.8 is needed to indicate a good measurement of the dimensions.[27]

2.4 | Qualitative approach

2.4.1 | Population

The population under consideration is elected officials who responded to the quantitative questionnaire, that is, 118 people.

2.4.2 | Sample

We proceeded by reasoned sampling. Of the 118 elected officials, we selected those available during the survey, accessible due to insecurity problems and who had shown some involvement in the CBHI service. A survey was carried out in October 2021 by two research assistants among 43 elected representatives from both circles. Of these 43 elected officials, 20 are part of the Mopti Circle and 23 of the Bandiagara Circle. This sample comprises 35 men and eight women, mostly 50 and older, with different responsibilities in their village or at the standard level or circle.

2.4.3 | Data collection and analysis tools

Semidirected interviews were conducted face-to-face using a guide following the seven acceptability dimensions.[17] The interviews were conducted in French or Dogon in Dourou. They were all recorded with the participant's

consent, translated into French if necessary and then transcribed. All transcripts were analysed with QDA© Miner software following the seven dimensions.

2.5 | Mixed methods approach

Data integration was carried out during the analysis and draughting of the results.[28] Quantitative factor analyses did not guide the qualitative data collection, which was based on the seven dimensions of acceptability[17] but influenced the organisation of their analysis. Thus, we compare and contextualise the results of the quantitative factor analysis with the qualitative results to draw up an exemplary description of the acceptability of the innovation.

2.6 | Ethics

The Mali Ethics Committee authorised the research (No. 34/2018/CE-INRSP on 26 December 2018).

3 | RESULTS

3.1 | Overall acceptability score

The quantitative analysis of interitem coherence indicates that the questions used in the measurement of each of the dimensions of acceptability may be related to other dimensions ($H = 0.30$) except questions concerning 'personal effectiveness' ($H = 0.37$). The internal consistency analysis shows that the questions relating to 'perceived effectiveness' ($\alpha = 0.74$) are remarkably consistent in exploring this dimension. The factor analysis model adjustment criterion (CFI) values indicate that the acceptability dimensions were well measured, with the perceived efficiency (CFI = 0.760) being the most difficult to assess. The overall score obtained from all the questions has good internal consistency ($\alpha = 0.81$).

Analysis of the score (Table 2) shows that more than half of the individuals in the sample (58%) report above-average acceptability. It shows that the scores obtained are generally high (74.2%) on all the questions used. The dimensions of 'consistency' and 'ethics' are those for which individuals are less in agreement.

The results follow each acceptability dimension according to the constructions retained by the quantitative analysis and then relate the perception of these built by the actors encountered in the qualitative approach.

3.2 | Attitude: Affective attitude towards the intervention

The quantitative results show that the questions asked to study this dimension have low interitem ($H = 0.25$) and internal ($\alpha = 0.55$) coherence despite excellent dimensionality (CFI = 0.973); see detail in the appendices for all constructs (Tables A1–A7) and a summary Table A8. The standardized average score in the sample shows a positive attitude towards the device overall.

The elected CBHI members feel comfortable with this new insurance programme, primarily as they operate autonomously at the municipal level. They see little point in the board of directors at the circle level, but they appreciate that the TUM provides them with adequate support in implementing their activities.

TABLE 2 Summary of scores by dimensions and overall acceptability score in the sample (118 persons).

Acceptability dimension	[Minimum-maximum]	Average score in the sample	Standardized average score (in %) in the sample	% of people with a higher than average score
Attitude	[16–28]	21.2	63.6	53%
Burden	[6–15]	13.0	83.5	55%
Perceived efficiency	[32–59]	48.1	75.2	51%
Personal efficiency	[9–25]	21.6	83.0	59%
Coherence	[21–34]	27.4	72.8	46%
Ethics/Values	[2–10]	6.0	50.3	17%
Opportunity cost	[4–10]	9.4	92.9	62%
Overall score	[**107–161**]	**146.8**	**74.2**	**58%**

Note: Bold values indicate the over all scores.

> One of the advantages [of this new organisation] is the presence of the team of employees who work and respect us, the elected representatives. If there is a meeting, they show the level of insurance in the commune. They tell us the truth. That is very good. If you've worked well, you'll know. You'll get the desired result if you haven't worked too hard. (Section treasurer, board member)
> It's like a chain. Everyone knows and does what they have to do at their level. (Section treasurer)

Finally, although they are concerned about the sustainability of this insurance system, they very largely present it as a model to be promoted for the future, and the best informed are counting on the advent of the UHIS to achieve this result.

3.3 | Burden: Perceived efforts to participate in the intervention

The quantitative results show that the questions asked to study this dimension have low interitem coherence ($H = 0.10$) and overall coherence ($\alpha = 0.22$) but good dimensionality (CFI = 1.000). The standardized average score in the sample assumes that the effort to participate in the intervention is not a brake.

Elected representatives identify volunteering, isolation, and insecurity as the three burdens they face, which the programme has only partially alleviated.

Volunteer work, a fundamental principle of insurance operation, is a heavy burden for elected insurance members. It is an obvious source of demotivation. They discuss their difficulties reconciling their voluntary work with their professional lives. However, they are aware that professionalisation has lightened this burden by limiting the involvement of elected representatives in the day-to-day running of the insurance.

Insecurity was a significant obstacle to implementing the programme and carrying out the activities (e.g. prohibition or difficulty in moving around and gathering in certain areas).

> What has harmed the work of elected representatives in my local authority is the upsurge in insecurity. Insecurity has meant that almost all the elected representatives in my community are afraid and have given up as if they were doing nothing. The fear of jihadists is at the root of all this. I am one of them. (Social action secretary, board member)

In the end, elected representatives feel very alone in defending CBHI and cannot count on the commitment of other local players, such as local councillors or health workers.

> If the health workers are not in favour of the CBHI, the association is a stillborn child, it will go nowhere. (Section vice-president, board member)

3.4 | Perceived efficiency: Perceived as likely to achieve its objectives

The quantitative results show that the questions asked are relevant for studying this dimension by presenting low interitem coherence ($H = 0.22$) and good overall coherence ($\alpha = 0.74$) as well as an acceptable dimensionality (CFI = 0.760). The results remain in favour of good acceptability vis-à-vis the system, even if users seem less in agreement with the perceived effectiveness of the intervention.

Although this pilot programme could not be rolled out under optimum conditions due to the prevailing insecurity in the region, the elected representatives note that the scheme is highly effective. The new insurance benefits the population regarding content, financial, and geographical access.

According to the elected representatives, a wide-ranging information campaign was organised on CBHI when the new scheme was introduced. The awareness-raising activities carried out by elected representatives and employees produced tangible results, to the extent that the elected representatives claim that the population is now well-informed and that the insurance members have taken over, sharing their experience very effectively.

Professionalisation is seen as essential for the scheme's performance, as is the new community structure. Inevitably, the question arises as to whether the scheme will be sustainable once the programme subsidised by a funder ends. To this, the elected representatives object not to a reduction in the quality of the services on offer but rather to the State and its partners assuming their responsibilities in the face of an enormous challenge—accessible healthcare at lower cost—which they have just experimented with in a completely unprecedented way for a few years.

> I'm 60 years old now, and I haven't seen anything in Mali that's more interesting than the CBHI scheme. The state is to be congratulated on this; we must not be ungrateful. During the malaria season, some people have three or four sick children. Still, with the health insurance scheme, they are no longer afraid to take their children to the health centre, as the cost is meagre compared to the cost without health insurance. I'd say that the results of the health insurance scheme are good, but I'm worried about continuity. (Section president, board member)

3.5 | Personal efficiency: Adopt the behaviours needed to participate in/benefit from the intervention

The quantitative results confirm that the questions asked are relevant for studying this dimension by presenting excellent and overall acceptable interitem coherence ($H = 0.37$) ($\alpha = 0.67$) and good dimensionality (CFI = 0.881). The standardized average score in the sample testifies to the innovation's ease of use.

Elected representatives clearly know their responsibilities and tasks and show confidence in their ability to carry out their duties to the fullest. Their primary mission is to raise public awareness. They defend the rights of insurance members in their access to care; they can report problems encountered by insurance members in health centres.

> We know what we have to do. It's clear. We must raise people's awareness so that they join the insurance. We must support the manager and the assistant in the commune to facilitate the insurance's activities (Section general secretary)

Most of them, therefore, feel that they are indispensable and essential to running the CBHI. The presence of employees also strengthens their credibility. But many, especially at the end of the programme, say they are discouraged and not very involved. Their commitment varies significantly, often falling short of expectations and needs, which they recognise and justify almost exclusively in voluntary work.

> We say every time that we're going to hold a meeting, but we can't do it now. We need to renew the executive because some members are not here. The president hasn't been here for over a year, so we will choose a new president (...) The section office is discouraged. (Section social action secretary)

3.6 | Coherence: Understanding the intervention and how it works

The quantitative results show that the questions asked have good interitem consistency ($H = 0.02$) and acceptable overall consistency ($\alpha = 0.51$), as well as good dimensionality (CFI = 0.961). The standardized average score in the sample favours a good understanding of the device overall.

Efforts have been made to ensure that elected representatives understand the programme and how it works (for example, the involvement of the State and the external partner, as well as the various instruments proposed). The TMU is a recognised information and training centre for the day-to-day support of elected representatives and capacity building.

> The idea behind the arrival of the health insurance scheme is to enable the poor to have the same easy access to health care as the rich, because for years it has been the service sector, i.e. civil servants paid monthly, who have been able to access health support from the CHI. So farmers, stockbreeders and fishermen were omitted. However, the CBHI was set up to give people in rural areas access to quality healthcare. The CBHI came in to fill the gap that CHI had created.
> (Section vice-president)

However, section representatives have little or no knowledge of the CA (board members), how its members are appointed, or the link that is supposed to exist between the two levels. The elected representatives regret insufficient communication between the sections and the board and between the sections and the TUM, which would enable them to improve their understanding of the programme during the programme.

> The problem today is communication. Even now, we haven't had any exchanges between the circle committee and the communal committee since they were set up. Our whole problem is the lack of communication.
> (Section secretary for training, leadership, and health education)

3.7 | Ethics/values: Aligns with individuals' values

The quantitative results show that the questions asked to study this dimension have low interitem ($H = 0.01$) and internal consistency ($\alpha = 0.01$) but good dimensionality (CFI = 1.000). The standardised mean score in the sample

implies that, based on the dimensions studied, the compatibility of the intervention with personal values is less accepted.

Community participation is considered essential to the success of CBHI for an overwhelming majority of elected representatives. It facilitates people's adherence to the programme and builds their confidence. The new insurance setup preserves or even strengthens this community ethic through a longer, more costly, but more effective implementation process for communication and representativeness.

The selection criteria for elected officials and their method of appointment adhere to the social principles and values of appointing representatives, albeit sometimes to the detriment of their effectiveness. The elected representatives acknowledge that the long process of setting up the CBHI has allowed all villages, even hamlets, to have representatives in the CBHI bodies.

During the establishment of the CAs and sections, the TUM proposed some criteria, including the involvement of women and educated people. The renewal of experienced formerly elected officials they were not imposed. The notion of inter-knowledge was very prevalent in this choice of elected officials. Thus, the designated persons are often elderly and therefore not very mobile, low, or out of school, and women remain very minority. In addition to another concession to local culture, elected officials were not appointed after a classically democratic process but rather by appointment by local officials (mayor or village authority) and often by consensus more than by vote.

However, these values concerning the appointment of representatives are no longer unanimous. Some elected officials reported some adverse reactions from young people, denouncing the lack of representativeness of these offices, from which they consider themselves primarily excluded. Some elected officials have also criticised the imposition of the method of appointment by consensus, which is regarded as undemocratic.

3.8 | Opportunity cost: Give up benefits, profits, or values to engage in innovation

The quantitative results show that the questions asked to study this dimension have low interitem coherence ($H = 0.09$) and overall coherence ($\alpha = 0.12$) despite excellent dimensionality (CFI = 1.000). The standardised average score in the sample implies that insurance members perceive real advantages in using the device. At the same time, the qualitative results below provide nuances to the reading of this result.

Participating as an elected representative in a CBHI is not lucrative and even forces some elected representatives to finance their participation and lose income opportunities to make themselves available. The fact that insurance bodies are not very functional shows that elected representatives often weigh up their participation to avoid penalising them too much.

The change of institutional scale will likely give rise to a sense of loss of autonomy at the communal level in favour of a circle board with absolute power. The frustration of former elected officials at the obligation to dissolve communal insurance societies is rarely mentioned.

> The renewal did not give rise to any frustrations or even fears on the part of the former members of the local insurance society because the local insurance society was on the verge of disappearing. The elected member had already seen the importance of insurance. When he saw that it was going adrift, he was delighted if new insurance appeared alongside it and if it had the same resources and the same strength as the local insurance. (Section treasurer)

The professionalisation of the system is managed in such a way as to avoid any conflict of power between elected officials and employees. Some elected officials consider themselves 'employers' of their section, with control over the employee who intervenes in their commune. However, they are aware of the limits of their absolute power. More than power, elected officials demand respect and a climate of good collaboration. Paradoxically, for

elected officials, the presence of the UTM and employees strengthens their local power and makes their involvement more rewarding.

4 | DISCUSSION

This research shows elected officials' good acceptability of this new CBHI, which was evaluated retrospectively. This acceptance of both the principle and the functioning has not been without raising challenges and questions but is seen in the light of the benefits they derive, personally as elected officials and the population as beneficiaries. Relying on the professionalisation of managers and risk sharing on a larger scale than those of municipalities, which have long been called for, seem promising and uncommon in terms of performance,[7] with the prior approaches whose effectiveness is weak for UHC.[1,4]

The elected representatives acclaimed the professionalisation of the management of the two CBHI that met during this study. Like the history of amateurism and volunteerism challenges in managing CBHI[1,4,29] and participating in inefficiencies and collusion challenges in the region,[30–32] the elected representatives confirm the importance of using professionals. Interestingly, these elected officials still have a certain degree of knowledge of the functioning of CBHI and prove the importance of entrusting their management to trained and competent people. Moreover, it is not a question of mentioning the management skills alone, as has been highlighted in Mauritania,[32] but the skills in social marketing and the sharing of risks, which are also essential for the functioning of this CBHI and the enlistment of beneficiaries.[33] Thus, the role of the umbrella organisation, the TUM and its professionals has been central to the efficiency and acceptability even if the time allocated to its implementation has been reduced[11] and the reflection on optimisation of professionalisation is absent.[34] In addition, elected officials stress the importance of trust between professionals and elected officials, similar to the state of knowledge about CBHI in West Africa.[35] Other research has shown in Mali how much confidence is central to the functioning of health centres,[36] similar to all studies on CBHI in the region.[33] In Senegal, a national survey showed that professional managers strengthened municipal CBHI's performance,[37] and the two departmental insurance units in place since 2014 confirm this importance.[8] At the same time, while Mali's elected officials are aware of the technical limitations of volunteering, they also say that the lack of financial compensation for their involvement reduces their motivation to engage in the process. We are at the heart of an international dilemma in the field of social economy, which is very prevalent in the context of scarcity of resources and the vast presence of global public aid.[29,38] The people who manage these CBHI need to be paid decently, and the current low coverage in many countries means that some are demanding that the state or their international partners be able to participate in these salaries.[32]

The place of citizens, elected officials and, therefore, communities has been widely addressed as an essential element of the acceptability of innovation and these challenges. The analysis of CBHI in the Democratic Republic of the Congo shows that this dimension is critical, particularly in the relationship with health professionals.[39] As in Rwanda, where CBHI are no longer managed by communities but by the state,[40] Mali's elected officials question their place. The coordination of all stakeholders involved in CBHI in West Africa has been debated in Senegal[41] and Mali.[11] In Tanzania, the failure of CBHI has prompted the State to centralise them, to organise risk-sharing at the regional level and their management at the national health insurance fund.[42] Giving more space and, therefore, power to professionals is a dilemma for solidarity economy organisations in Mali, where the health system's history has given communities an essential place in managing primary health centres. Community health associations whose members are elected from villages have been running these health centres for a very long time.

The effectiveness of community governance has long been questioned in Mali.[43] However, it is also a dilemma for the development of CBHI since the feeling of belonging and the social bond within these insurance participate in their attraction.[44] Will professional management reduce this feeling? The study shows that elected officials are much more ambivalent now about community management, whose limits they see, appreciate respectful

management by employees and want the involvement of the state and other local actors. However, this does not mean, as in the case of departmental insurance in Senegal, which seems to succeed in this alchemy,[45] that the communities cannot have power in governance bodies or do not wish to join CBHI managed by professionals.[46] The balance is difficult to find, and the elected representatives understand it perfectly. In Mauritania, the power stakes forced the professional manager to no longer be innovative and confine herself to the routine to avoid conflicts. The community's power structures and decision-making processes have been reproduced in the management of the CBHI.[32] The elected representatives of Mali also stress the role that local and regional authorities should be able to play. However, local and regional authorities face significant challenges due to a lack of financial and human resources to support national social protection policies.[47]

This dimension is crucial if Greenhalgh and her colleagues[48] need to draw attention to the sustainability of innovations beyond their adoption. Indeed, in the development field, particularly in Mali, dependence on development assistance makes any innovation of exogenous origin challenging to sustain. The elected CBHI members did not hesitate to say that while they generally accepted the proposal, they were aware of the challenges posed to its sustainability even though an international partner largely financed it. In addition, the new CBHI was tested in an area susceptible to the security plan, which quickly became, as the project progressed, dangerous for both health professionals and populations and their use of care.[49] While responsiveness and anticipation are two fundamental principles of innovation implementation processes,[50] they have not been quickly mobilised in this project. Moreover, contrary to what evidence advocates,[51] sustainability planning was late thought by the programme's initiators and a strategy for exiting the external partner. However, TUM has drawn up a sustainability plan to anticipate the cessation of support for the project, given that the government does not have the resources to sustain the support in the context of the security crisis. The government appointed the TUM as the operator for developing health insurance in Mali. Therefore, it continued to pay the professionals' salaries and operating costs at the two CBHIs. However, the project's 30% subsidy of members' contributions has ended, and the community now have to pay 50%, with the government trying, with difficulty, to maintain its 50% subsidy.

This research has faced some methodological limitations inherent in its organisation in a complex Malian context, particularly in the study area. Several authors of this article were not allowed to go into the field, but they are familiar with the subject and the region. In addition, multiple methodological exchanges were carried out remotely during data collection. The comparison of quantitative and qualitative analyses within the framework of the mixed-method research makes it possible to nuance the results. The results were also presented and discussed with stakeholders. Finally, in addition to analysing its implementation challenges,[11] this study of the acceptability of elected CBHI members must also be understood as a piece of the performance puzzle. Indeed, this CBHI has ensured 9% of the region's population in less than 4 years, a rate certainly low but well beyond all attempts for 30 years in Mali. If this result is modest, it remains present, and the model's acceptability certainly contributes to this explanation.

5 | CONCLUSION

Mali's contemporary challenges are immense, and those to enable it to strengthen access to quality care for its equally essential populations.[49] Faced with the previous failures of CBHI at the municipal level and its system of user fees, Mali has been engaged in experimentation in the centre of its territory over the past 5 years and primarily funded by an external partner, the project aimed to test the organisation of CBHI on a circle scale whose management is left in the hands of professionals. The present study shows that the elected representatives of CBHI have accepted this insurance innovation well. However, they are concerned about its sustainability and see the added value for their community and the performance. The end of the project in 2021 and its funding in support of the project do not bode well for its continuation. However, the Malian Institution (TUM) accompanying this CBHI process is a national organisation that will not disappear. It is called upon to act as a delegated management body

within the framework of the UHIS as part of a global movement of delegation of insurance functions.[52] The future will tell us whether it has been able to have the means to continue its support and, eventually, scale it up as the needs for social protection are essential in Mali.

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DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

ETHICS STATEMENT

The Mali Ethics Committee authorised the research (No. 34/2018/CE-INRSP on 26 December 2018).

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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