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Social and Solidarity Economy as Main Actor of the Extension of Social Protection in Health in Africa?

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Abstract

From the 90s, many mutual health organizations have been set up to provide social protection mechanisms to populations uncovered by their national social protection systems. In various African countries, these organizations are expected to play a major role in the upcoming policies related to social protection. Mutual health organizations are expected to cover de facto about 80% of the population. The inclusion of such organizations in public policies can be interpreted as recognition in terms of capacity of the Social and Solidarity Economy in providing service, governance and representation of the interests of the members. But the low number of mutual health organizations and their weak capacity to scale-up raise questions about the feasibility of such policies. In this paper, we propose an analysis of this paradoxical situation from both the perspective of public policies and the perspective of the social and solidarity economy.

Introduction

In most African countries, social security systems originated in the 50-60s. The design of these systems was based on the assumption that developmental processes in Africa would certainly follow the Western model. This explains why existing social security systems in Africa are somehow a copy/paste of the Western social security systems, mostly strongly linked to the labour market. As we know, development processes in Africa have taken another turn and the majority of the population is (still) working in the informal sector or in the rural sector without any kind of formal social protection in health. Existing State-run social security systems are offering limited benefits for a small part of the population, namely the civil servants and workers employed by formal enterprises. In addition, administrations in charge of social security issues are in many African countries, rather inefficient and sometimes ineffective in their duty (ISSA, 2008).

From the late 80s, many community- or NGO-based initiatives have been taken to somehow offer health insurance packages to people not covered by their national state-run social security systems and neither able to buy insurance package from private for profit companies. Many of these initiatives led to the creation social and solidarity organizations, namely, mutual health organizations.

This situation has been left as such for years, with African governments and the international community paying no attention to social security and social protection issues. But since 2000, social protection has been (re)appearing on public policy agendas under the influence of major international organizations (ILO and the World Bank in particular) (see. e.g. Social Security : a new consensus", 2001; de Haan, 2000; Barrientos & Hulme, 2009). Over the years, various tools have been developed by these international organizations to operationalize the extension of social protection, especially in developing countries: specific analytical framework in the second-generation of PRSP, the Social Protection Floor initiative launched by the ILO in 2009 in collaboration with other UN agencies, adoption in June 2012 of a new ILO recommendation (202) of social protection that marks the recognition of social security as an economic and social right and a social necessity for the development and progress.

In many developing countries, social protection systems have entered in deep reform process. In the health sector, these processes are closely linked with the ones about financing health systems and the "path to universal health coverage" since a more equitable, effective and efficient health systems financing is considered as a part of the solution to a better social protection in health (WHO, 2010).

In several francophone African countries (i.e. Mali, Burkina Faso, Benin, Senegal) social protection strategies being developed or under discussion classify the overall population classified according to their activity (formal - public or private economy, rural/urban informal economy - incl. agriculture -) and/or individual characteristics (vulnerable groups: women, people with disability, children under 5, absence of revenue). To each group correspond specific (private, public or community-based) mechanisms (insurance, assistance) and financing sources (government revenue, contribution of the population, international aid). Social and Solidarity Economy

organizations are expected to play a major role in this new social protection model systems since mutual health organizations should, according to the model elaborated in these countries cover about 80% population, namely all those working in the informal economy or in the rural sector.

In this paper, we will propose to critically look at such social protection policies mainly based on social and solidarity economy initiatives. We will start from an empirical description of the development of mutual health organisations in Africa and of their relations with the State. Based on this situation, we will try to analyse the challenges associated with such policies from both the perspective of public policies and the perspective of the social and solidarity economy. This paper will focus on several Francophone West Africa countries (Mali, Senegal, Burkina Faso, and Benin) where the development of mutual health organizations has been more significant than in other regions. We will more in particular make reference to the cases of Senegal and Burkina Faso (based on our own research and studies; see bibliography) where the development of mutual health organizations and the proposed reforms related to social protection in health also present important common characteristics.

1. Development of Mutual Health Organizations in Africa

1.1. Mutual health organisations as Social and Solidarity Economy organizations

The existence and implementation of MHOs in Africa did not occur by chance. African MHOs first appeared in the late 1980s and early 1990s, coinciding with two developments (Fonteneau & Galland, 2006): 1) beginnings of democratization processes and 2) the implementation of the Bamako Initiative. In many African countries, the late 1980s represented the beginning of democratization and the emergence of a civil society. As a result, many initiatives were undertaken by the population to respond to urgent needs and political issues. These initiatives were encouraged by development cooperation agencies that wanted to support the democratization process. In this context, the associational affiliation of MHOs, as non-profit, autonomous, mutual-interest organizations was an easy and flexible way to launch a collective initiative. During the 1990s, the Bamako Initiative (launched in 1987 by the World Health Organization and UNICEF) was also progressively implemented. Designed to secure access to quality primary healthcare, the Bamako Initiative rested on three principles. First, primary healthcare services must attain a sufficient level of self-financing, which requires patients to contribute through user fees. The second was the principle of better access to medicines, particularly generic pharmaceuticals. The third principle was community participation to enhance the quality of care. The principle lies on the idea that if representatives from the local community sat on the boards of the healthcare centres, this would make the providers more transparent and responsive. More broadly, this last principle recognized that a range of actors should be involved in the healthcare system, including community-based organizations.

Standard features of mutual health organisations reflect the "classical" criteria of social and solidarity economy organizations (Defourny & Develtere, 1999, Fonteneau & Galland, 2006, Fonteneau et al., 2010):

- Improve access to healthcare through risk-sharing and resource-pooling
- Not-for-profit
- Members are owners and beneficiaries at the same time
- Autonomy
- Participatory decision-making
- Voluntary membership

Like other insurance systems, mutual heath organizations are based on a mechanism of risk-sharing and resource-pooling. But as social and solidarity economy organizations, these organizations are non-profit and do not select their members based on their individual risk profiles. Access to healthcare through solidarity is thus the main objective of these organizations. The members of mutual health organizations are the owners, the decision-makers and the policyholders. This feature requires strong participation and control mechanisms to make collective decision-making effective. Annual general meetings decide on issues such as budgets, accounts, what to do with surpluses, and operational matters as well as overall strategy. Membership is voluntary. This principle clearly distinguishes MHOs from compulsory insurance schemes such as most national and often state-run social security systems. As in any non-profit organization, a person may choose to become a member but is never forced to join. In most MHOs, members share some common characteristics, such as being members of the same organizations, inhabitants of the same village or workers in the same trade, often because they are built from or on an existing organization. Bearing in mind that membership is voluntary, a MHO has to find a way of ensuring that it can gather a "sufficient" number of members to run the risk-sharing mechanisms in an efficient and attractive way: the larger the group, the greater are the benefits for the members.

But MHOs cannot be reduced to their insurance function. As participatory mutual interest organizations, MHOs fulfil functions beyond insurance, like health education. They also act in a sector (healthcare) where the interests of users have only recently been represented. By organizing potential users of health services, they become an interlocutor that represents members' interests vis-à-vis e.g. healthcare providers. In the same way, we observe MHOs representing (individually or collectively) the population in policy discussions an lobby on different issues: health financing, quality of care, etc.

1.2. Development of mutual health organisations in West Africa: where do we stand?

In this section we will briefly give an overview of the main features that characterised the development of MHOs in West Africa (Jakab & Krishnan, 2004; Churchill, 2006; Fonteneau & Galland, 2006; Matul, Mc Cord et al., 2010; Lievens & Witter, 2011).

As for many other social and solidarity economy initiatives in Africa, there is a serious lack of comparative and reliable data on mutual health organizations. Yet, there have been some attempts to carry out multi-country inventories (La Concertation, 2004 and 2007). The 2004 inventory of 'La Concertation' identified 622 schemes in 11 countries. From these 622 organisations, 366 were functional (delivering insurance service), 142 being set up, 77 projected to be set up and 33 in difficulties. The last inventory carried out by La Concertation in 2007 in 15 countries described 188 functional MHOs. The difference between the 2004 Inventory does not imply that the 2007 inventory was incomplete as some schemes may have stopped operating, or have remained too small to partake in further rounds of the inventory. But if some methodological factors (e.g. geographical scope, typology of MHOs taken into consideration in the surveys) can explain this difference, it reveals above all the lack of lack of monitoring at both the project-level (when MHOs are supported by international or national development organisations) and at the national level (by the State or other national programme).

In order to give a better idea of some current dynamics, we present hereunder some recent primary data extracted from surveys or monitoring reports of support organisations. With the exception of Burkina Faso, the mentioned initiatives do not reflect the entire existing dynamics at the national level. These data illustrate the relative sober outcomes of MHOs in West-Africa despite the number of existing entities and the continuous creation of new MHOs initiated by diverse local or international initiatives.

	Network or Support organisation	**Number of MHOs**	**Number of beneficiaries (insured person)**	**Sources**
Benin	Réseau Alliance Santé (Borgou District)	27 MHOs	26 000	French NGO CIDR, 2009
	Réseau des mutuelles de Bembérèké (Borgou District)	8 MHOs	6880	Belgan NGO WSM, 2009
Senegal	Oyofal Paj (Region of Kaolack)	11 MHOs	22 000	Solidarité Socialiste Monitoring Report 2012
Burkina Faso	National Survey	165 MHOs	100 479	NGO Solidarité Socialiste, 2011
Mali	(National) Union Technique de la Mutualité	81 MHOs	NA	UTM Monitoring Report 2013

Table 1. Overview of recent data on MHOs (source: own compilation ; Sources mentioned in the table are detailed in the bibliography).

Apart from a few exceptions, the size of MHOs remains relatively small, namely between 300 en 1000 beneficiaries (beneficiaries being defined as a person covered by the insurance (namely a registered person whose the financial contribution has been paid). From an insurance point of view, this limited size restricts the resource pooling and in consequences the services packages that can be provided. The majority of MHOs only cover smaller risk (primary health care). Packages including larger risk like in-patient care remain the exception.

In theory, mutual health organisations are open to all types of members, whatever their socio-economic profile. In the practice, and moreover due to the community-

based character, members often share the same characteristics, namely households with limited and/or irregular revenue from their activity in the agriculture or the informal economy. MHOs are for those populations the only way to get a health insurance. Especially in the beginning, the membership of an MHO is often homogenous, which can have negative effects in terms of risk diversification. Such a situation also has a limited ability to achieve vertical solidarity through cross-subsidization between richer and poorer people.

Most MHOS are still run by elected members, sometimes supported by "managers" whose salaries are funded by temporary programs of development agencies). Despite some signs toward a more professional management, this kind of management has broadly demonstrates his weaknesses. In terms of governance, a recent survey carried out in Burkina Faso (Zett & Bationo, 2011) showed that MHO general assemblies (gathering all members) are mostly held according to MHO constitution but that board meetings are much more difficult to organise on a regular basis.

The reasons behind these findings are of different orders. MHOs are obviously very dependent on the health sector and in particular the provision of care. However, the quality of care is generally low in health facilities in West Africa. In that sense, it may not be attractive to become member of a MHO (and buy insurance product) that facilitate the access to health facilities providing bad quality of care. Especially in rural areas, MHOs often do not have other options than contracting with public health facilities. In urban areas, health facilities providing better level of quality of care exist but they are often not affordable for MHOs.

The low contributory capacity of populations is often used to explain the small mutual and low contribution collection argument. Whereas the amounts of the contributions are relatively low (between 1800 and 3600 FCFA / year / person, so between 10,800 and 21,600 FCFA (per year for a household of six persons), it is difficult to argue that the ability to pay is itself the cause of the weak development of mutual health organisations in all parts of the population. This incapacity/unwillingness to pay should be put in perspective with the level of insurance package offered by most mutual health organisations (mainly limited to small risks), the poor quality of care some and some management and trust related issues.

The development of mutual health organizations in West Africa has been supported (or initiated) by many national and international stakeholders (national support organisations, NGOs, development agencies, etc.). Different support models have been tested: long term and hands-on approach in specific areas (the French NGO CIDR in Benin and Guinea Conakry, for example), very focused approaches community aspects (the Belgian NGO World Solidarity and Socialist Solidarity), support and / or creation of health micro-insurance combined with a national policy support program (STEP / ILO, USAID, World Bank) to support joint supply and demand for care (Belgian Development Agency in Benin and Senegal), etc. Some approaches have encountered more success than others but all have faced the problems mentioned above and the fact that such processes (education, information, training, operational support, monitoring and evaluation) require magnitudes human, technical resources and financial. The consequence of this diversity of support has also led to a considerable dispersion of mutual health organizations), making it difficult to gather them in unions or federations at both local and national level.

2. Brief look at relation between public authorities and mutual health organisations

In most west-African countries, authorities have positively observed the development of MHOs. In 1998 already, the Malian Ministry of Health designed and supported the creation of an organism called *Union Technique de la Mutualité* (UTM) (Fischer et al., 2006), in cooperation with the French Cooperation. The UTM still fulfils both functions of being a technical office providing services to MHOs and a union representing the interests of MHOs. In other countries like in Senegal or Benin, national authorities took initiatives to create from MHOs (at the local or national levels). But globally very few of these attempts were successful. In many cases, a too interventionist and top-down approach entered into contradiction with the member-based and autonomous dynamics that characterise mutual health organisations and that are necessary to set-up and sustain such social and solidarity economy organisations.

National authorities have quite soon recognised the potential role MHOs could play in the extension of social protection in health. From the mid-2000, several National Health Strategies mentioned MHOs as one of the policy options to improve the access of health care, especially for the category of population considered as (working) poor. At the same time, there have been some “disputes” to decide which ministries should be in charge of this new kind of organisations. Several administrations manifested their interest: Ministry of Health because MHOs are acting in their sector, Ministry of Social Affairs because MHOs are dealing with exclusion of health care and poverty issues, Ministry in charge of social protection because of MHOs’ insurance function or Ministry of Domestic Affairs because MHOs are considered as civil society organisations. From the one hand, one can suspect that part of these disputes was driven by quests in terms of influence or resources. But on the other hand, these disputes reveals the (typical) multiple functions (political, economical, social) played by these social and solidarity economy organisations.

MHOs (still) encounter lots of obstacles in their environment, especially in the day-to-day relations with the health sector and the health care providers at the local level. Health providers seem to be reluctant to contractualize with this kind of insurance schemes. These contractual relations are complexified by the role played by MHOs in terms of patients' rights, and in particular by the voices they represent on the issues related to quality of care. Despite some evolutions, classical health systems remain very few open to recognize MHOs as being a legitimate part of the health sector. These difficult relations between MHOS and health providers can certainly be explained by the closed nature of health systems (in Africa or elsewhere) and their reluctance to include organizations representing patients in their logic.

For a long time, MHOs have mainly functioned informally, without any legal status. Only Mali (in 1996) and Senegal (in 2003[1]) voted laws regulating MHOs. Niger (Fonteneau, 2005) expressed the will to pass some laws in order to control the development of MHOs but the process did not go further probably because of the too weak and unpredictable development of MHOs. From 2004, the West African Economic and Monetary Union (UEMOA) took the initiative to elaborate a specific

[1] The law was adopted by the Assembly but the operational decrees have never been enacted.

regulation on what they have called "*Mutuelles Sociales*[2]". This process has been supported by the French Cooperation and implemented by the ILO through a very participatory process involving ministries, MHOs (and unions when existing), support organisations. This regulation has been adopted by all UEMOA members in 2009 and each country is since2010/2011 in the process to translate this supra-national regulation into their own national legal framework.

3. Towards a new model to extend social protection in health

In parallel to this regulation process at the supra-national level, almost all west-African countries are designing new social protection regimes in order to achieve universal health coverage. In French-Speaking West-Africa, these strategies are still under discussion but about to be adopted in several countries. From a formal point of view, and in comparison with a few years ago, we clearly observe higher-level political commitment regarding social protection issues. In Burkina Faso, a Permanent Secretariat dedicated to the follow-up and implementation of the Universal Health Coverage project has been set-up since 2009. Several feasibility reports have been produced and recently (March 2013) adopted by the Council of Ministers. After his election, the new Senegalese President set-up a "Cellule d'Appui à la Couverture Maladie Universelle" within the Ministry of Health and more broadly a *Délégation Générale à la Protection Sociale et à la solidarité nationale* has been established under the Prime Ministry.

In several West-African countries, the social protection model under discussion is made of a mix of mechanisms targeting to different groups of population. We will use the scheme currently under discussion in Burkina Faso to present the model because it gathers the main components that are to be found in the other national projects. Countries like Ghana and Rwanda have already implemented similar regimes to ensure universal health coverage to the population.

[2] This terminology has been chosen to cover mutual organisations providing health insurance without excluding the addition of other social risks.

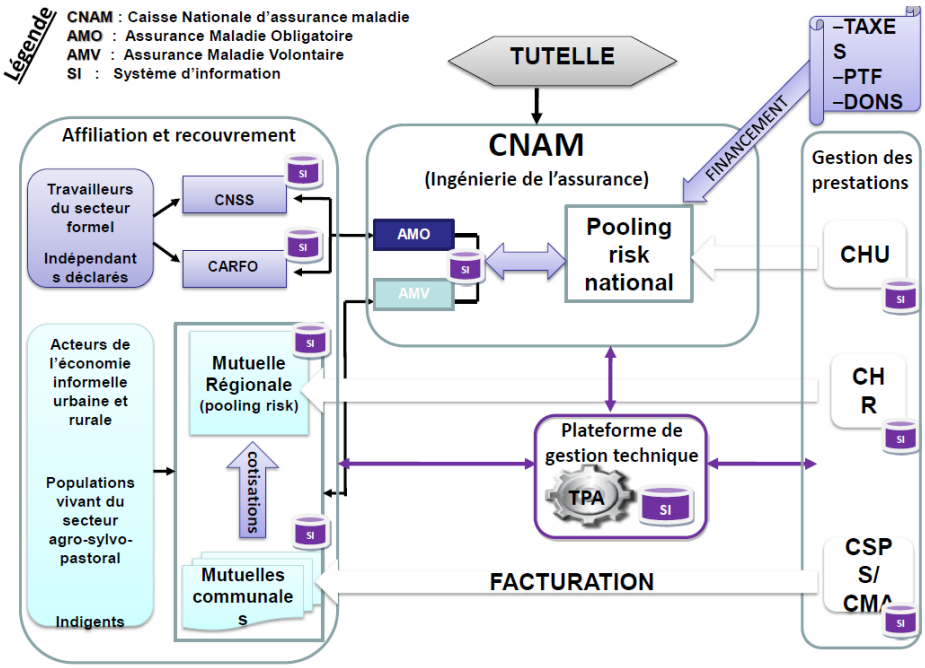

Figure 1: Social Protection Model Burkina Faso (July 2012)

Workers of the formal private and public sector would be still covered through compulsory contributory mechanisms managed by national social security institutions (*Caisse Nationale de Sécurité Sociale*). The main innovation of these projects involves the 80% left of the population, namely those who are active – at various levels of development - in the agricultural sector or in the informal economy. For these populations, universal health coverage will be reached through primary local mutual health organisations that would collect the premiums and manage the small risk pooling. Part of these financial contributions would flow to secondary (at regional or departmental level according to the country) MHO's that would manage the risk pooling at a secondary level. For the poorest part of the population, namely those that are not able to financially contribute, assistance mechanisms ensuring free access to health care would be foreseen. In some countries (as indicated in the scheme above for Burkina) these assistance mechanisms would transit through MHOs. A technical platform (Third Party Administrator) would assist the risk pooling management and ensure the links with the administration in charge of the insurance engineering (*Caisse Nationale d'Assurance Maladie* or CNAM).

4. Social and solidarity economy organisations as main actor of the extension of social protection in health in West Africa ?

According to the social protection model described above, mutual health organisations would become one of the main actors of the extension of social protection in health in West-Africa. This model and more broadly the extension of social protection strategies discussion constitute a huge opportunity to improve access to health care of the majority of the population. In addition, the model is quite innovative in that sense that it would embed a public-private partnership with social and solidarity economy

organisations as central pivot of a public policy. However, we face a paradoxical situation. On the one hand, we observe many community-based mutual health organisations existing but most of them are still facing difficulties in terms of governance, management, membership and insurance package scaling-up and institutional and operational relationships with health practitioners and authorities. On the other hand, we have governments expressing their will to extent social protection to the majority of the inhabitants through these same mutual health organisations. But is also raises some questions about the roles assigned to these mutual health organisations and about the extent it could affect their objectives and functioning principles.

Before analysing this model from a social and solidarity economy perspective we would like to point out some of the challenges of this model from a public policy perspective.

4.1. Challenges from a public policy perspective

As Hickey (2008, p.249) suggests it, one of the dimensions to understand the politics of social protection in Africa are the political institutions. The political institutions refer to the formal (elections and political party systems) and informal (patron-client relationships) political institutions that define the "rules of the games" within a given society (North, 1990 ; cited by Hickey, 2008). Social protection has long not been an explicit issue addressed by the West African political parties. More recently (from 2005), many social assistance programmes targeting pregnant women, destitute or oldest people have been the launched under Presidential initiative and funded by domestic resources (Plan Sésame in Senegal for instance launched under the Wade Presidency to provide free health services for elderly). Hickey analyses such initiatives as typical patron-client politics. According to some authors, the weak performance of the Plan Sesame in Senegal is linked with e.g. a bad design and a high level of improvisation among the administration to implement it. Only recently, social protection (in the broad sense) became one of the main topics during the electoral campaign of the new elected President (2012) in Senegal or in Benin for instance. In both of these countries, steps have been undertaken after the elections to address the issue of social protection but in both cases, one cannot observe yet the sign of real political debates regarding the design and establishment of these policies.

The implementation of this social protection model will require a high level of design, regulation and monitoring capacity at the State level. Because the policy domain of social protection has been left behind for so many years, the level of knowledge and technicality on these issues is often weak (Fonteneau et al., 2004) among the administration. This observation is not surprising in countries where social-sector ministries have always been marginalised and marked by a lack of appropriate staff (Mathauer, 2004 cited by Hickey, 2008). The administration does not always have the capacity to critically inform and discuss different policy options proposed by e.g. donors. In addition, the regulation of such model presents many challenges due e.g. to the involvement of diverse (public and private) actors and ministries. Monitoring and evaluation of this social protection model will also require strong mechanisms to inform on the achieved outcomes in terms of coverage of population as well as on the

satisfaction of the population and the effectiveness of the model to increase the access to quality health care. As we mentioned above, West African countries like Burkina Faso or Senegal have set-up specific bodies to design and implement the social protection reforms. However, the lack of human and financial resources and the lack of capacities within these bodies do not allow them to fulfil their function as they should.

At a more operational level, some countries like Senegal (through the DECAM project) or Burkina Faso are exploring the idea to involve local authorities (communes or "*collectivités locales*") at the local level to fulfil some functions (i.e. collection of premiums). In theory, this involvement would make sense in the framework of the decentralisation process that confers some responsibilities related to health to local authorities (Boidin, 2012). To be effective, their involvement would imply transfer of financial and human resources from the central level but so far, these transfers remain slow or problematic (Touré, 2011).

The lack of capacity on social protection related issues and the weakness or absence of political discussions on social protection scenarios does not foster a "national ownership" around social protection issues. Looking at this from a donor perspective, Niño-Zarazúa et al. (2008) noted that : "to date, donors have not engaged productively with the politics of social protection in sub-Saharan Africa where they have more often proposed new initiatives rather than built on existing ones, worked through NGOs and parallel project structures rather than the state, failed to develop good enough baselines on which arguments for scaling-up could be based, couched their ideas in terms of welfare rather than growth, and failed to identify powerful political actors to work with".

The planning related to these social protection projects based on the discussed model is ambitious. Senegal plans that this system would cover 50% of the population by 2015 (Boidin, 2012). Burkina Faso also committed to develop by 2016 an "effective system to protect people against risks and shocks through adequate mechanisms and sustainable" (Action Plan 2012-2014 National Plan Social protection, 2012-2014). There is a discrepancy between the ambitions announced and the current level of development of MHOs. The current number of existing MHOs is of course not sufficient to cover 80% of the population. In order to cover them, new MHOs should be created at the local level. However, mutual health organisations are not only risk-sharing mechanisms. After almost 25 years, lots of lessons have been learned about the complex social engineering process that is required in the creation of MHO. This complex process is made of a mix of "technical" factors (quality of health care, etc.), financial factors (willingness and capacity to pay premiums) and socio-political factors (social cohesion, trust, leadership, collective choice, etc.) that cannot be mechanically and top-down created. Even if the MHO to be created will not be as community-based as the currently existing ones, the question is under which conditions public authorities can initiate the creation of such social and solidarity economy organizations. For the countries we focus on in this paper, policy documents do not contain explicit strategies to address this issue or, as mentioned above, public policies supporting the development of such SSE organisations.

A broad range of health financing options is currently under discussion at both the domestic and the international (global) levels (innovative financing, development

assistance). Some ILO simulations (Berhendt, 2008) suggest that, although well-designed programs could be affordable in some African countries, current fiscal space and/or capacity for tax collection are too limited to support the financing of national social protection strategies and even of new social protection initiatives. Indeed, all African governments are concerned about the financial implications of introducing social protection programs in a context of high poverty incidence and fiscal constraints (Niño-Zarazua et al., 2012). As illustrated in the figure above, existing national social protection strategies, the financing issue remains often vague, foreseeing the theoretical financing mix scenario (made of revenue of national governments, aid from international donors, private, community and NGO financing, household saving and out-of-pocket expenditure; Barrientos, 2008) but without perspectives related to the certainty, the predictability and the sustainability of these financial plans. In the short term, we still observe that implementation of specific social protection mechanisms mainly relies on external temporary resources made available by donors or NGOs or revenues of national governments (for ad hoc presidential initiatives). With a few exceptions, donor interventions regarding social protection often remain donor-driven in their approach and fragmented in their financing and implementation.

4.2. Challenges from a social and solidarity economy perspective

As this model is not implemented yet in the countries we focus on in this paper, conclusions based on empirical observations cannot be drawn. But from a theoretical point of view, what are the challenges and opportunities presented by this model from a social and solidarity economy perspective?

The role assigned to MHOs by this new social protection model has been very positively welcomed by MHOs and their technical and financial partners. In some countries (e.g. Burkina Faso), MHOs even claimed and obtained that this role would be uniquely assigned to them and not open to any civil society organisations or other kind of intermediary organisations. For such organisations, this social protection model is an important sign of recognition of the efforts and innovations that have been undertaken by the social and solidarity economy. For MHO involved actors, this model also involves the prospect of being able to continue to exist and provide services while being technically and financially supported to do so in the context of a national strategy for the extension of social protection. So far in West Africa, many individual MHOs have demonstrated capacities to offer health insurance to groups of population. But so far no MHOs, even organised in networks have succeed to cover a significant large group of population with insurance package covering larger risks. International recent experiences (i.e. Rwanda, Ghana) have clearly demonstrated that better results could be achieve by MHOs when they are articulated with national social protection policies. From that perspective, MHOs could become more effective in achieving their ultimate goal that is increasing access to (quality) health care of their members. Scaling-up and professionalism will be essential steps for these social economy organizations to be more performant. This shift entails strong power issues because it requires human and technical resources that may not have current MHO elected leaders. In addition, beyond their main function related to insurance, these social and

solidarity economy organisations represent for their leaders “spaces” allowing voices, actions and power at the local level.

Mutual health organizations present indeed many advantages in terms of proximity with the members and the population. Considering the weakness of the public administration, this proximity could be used not only to collect the insurance premiums but also as communication channel between the administration and the insured people. Without such intermediary organisations, the implementation of a social protection mechanism for population working in the informal economy or in the rural sector would be almost impossible. In Latin America, this choice has been explicitly made by several governments to promote a plural economy by incorporating social and solidarity economy to the public policy design (Caruana & Srnec, 2012). But in West Africa, despite the positive interest of the State in regard to MHOs, no genuine policies have been implemented so far to support their development and sustainability as social and solidarity economy organisations. From that perspective, this new model of social protection policy does not seem to reflect an explicit political choice made by governments but rather a pragmatic choice.

Social and Solidarity Economy Organisations are autonomous organizations. As Defourny & Develtere) put it, their autonomy in management distinguishes the social economy from the production of goods and services by governments. They enjoy the independence that informs the basic motivation behind every associative relationship (Defourny & Develtere, 2008). This “autonomy and Independence” feature has also been recognized by the West African regional UEMOA legal framework (Règlement n°7/2009/CM/UEMOA, art. 12). Indeed, MHOs operate so far in a rather autonomous way from the State (see previous section) deciding in theory on their own design, internal governance principles, financial contributions, insurance package, and relationships with health care centres. The new social protection model will lead to a certain standardization of the mutual health organisations, in terms of functioning and structures and in terms of insurance package offered to the population. This standardization can have positive effects if it contributes to a more equitable access to health care. But it could also hinder the autonomy of MHOs as social and solidarity economy organisations, especially because of the limited functions MHOs should fulfil in the new social protection model (i.e. namely, collecting financial contributions).

As SSEO, mutual health organisations are based on participatory decision making processes. In the practice, the level of participation among existing MHOs should not be romanticised: if the members have formally the right to decide in general assembly, the influence of informed elites, leaders or external support organisations remain high. But participatory decision making processes also allow members to get informed about their own rights as patient (e.g. in terms of quality of care, access to information, etc.) and to control the good functioning of their organisation. In the new social protection model, these both functions will have to be ensured vis-à-vis the State but also vis-à-vis the other actors managing the risk pooling at all levels.

From the perspective of the social economy, inclusion in this public policy commit to mutual health necessary scalability and more professional management. The scaling has the benefits of insurance-point view because it allows sharing the risk over a larger number of people. Moreover, the presence of member-based organizations in a social

protection system potentially ensures representation of its members. By integrating the mutual welfare system, we can say that the State undertakes that its governance is based on a multi-stakeholder participatory process. However, this is an essential element if you want to operate an element of the transformative dimension of social protection, namely, the capacity to address concerns to address concerns of social justice and exclusion. This social transformation dimension of social protection also means that specific actors, in particular from the civil society, have to play a political role that goes beyond the provision of social protection services or the intermediation between e.g. the State and the population. As Michielsen et al. (2010, pp.655-656) put it regarding social protection in health, the transformative dimension is about "transforming the social and institutional context of the health system to counteract exclusion and deprivation of the right to health and quality care".

Although mutual health organisation are not a recent phenomenon in West Africa, we can say that their articulation with a formal public policy start relatively early compared to the level of structuring of mutual health, both locally / regional and national levels. The landscape structure of the mutual «movement» remains very fragmented in West Africa. There is so far only one national union in West Africa, namely in Mali. In other countries, unions or federations exist but they mostly gather only a part of the existing mutual health organisations, namely those set up or supported by the intervention of a technical or financial partner or even a parent organization (example of the Union of Kaolack in Senegal). In this process, technical and financial partners bear a great responsibility. The way they design their intervention and support to the MHO movement in a country or a geographical areas can have direct influence on how the way MHOs can set-up collective representative structures. Such structures are of crucial interest not only to discuss the role of MHOs in the new social protection model but also the recognition of the nature of social and solidarity economy organisations.

Conclusion

In this paper we have tried to describe the paradoxical situation that is taking place in West Africa related to the development of new social protection model and policies. These policies aim to extent social protection in health to the majority of the population through already existing – and to be created - social and solidarity economy organisations, namely mutual health organisations. This articulation between social and solidarity economy organisations and this public policy presents huge potential. But considering the design of this policy and the weaknesses existing mutual health organisations are still facing, many questions can be raised not only about the realism and ownership of such policies but also about the challenges at stake for MHO as social and solidarity economy organisations. (conclusion to be completed).

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