Community-based mutual health organisations in Senegal: a specific form of social and solidarity economy?

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A heterodox health economics perspective

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Abstract

Community-based mutual health organisations (MHOs) are today regarded as an essential element in the establishment of universal health coverage in sub-Saharan Africa. Nevertheless, their development has been impeded by numerous technical and institutional difficulties. While these obstacles are indeed important, our purpose in the present article is to investigate a paradox that has not yet been examined as such. In their underlying principles, community-based MHOs fall within the scope of the social and solidarity economy (SSE). However, these principles come up against a range of different values and representations within the organisations themselves. This phenomenon is illustrated by a case study of Senegal. A qualitative methodology is adopted in order to compare representations and practices with the criteria of the social and solidarity economy. Our survey shows that, although community-based MHOs are indeed part of the SSE, local constraints and specificities make it difficult to unify the mutualist movement.

Keywords: mutual health organisations; social and solidarity economy; universal health coverage; mutualist values; Senegal

JEL codes: I, I13, B5, O

1. Introduction

Africa is currently experiencing a drive to promote universal health coverage, in which the WHO is one of the prime movers [WHO, 2010]. Given the impossibility of applying the models of social protection found in rich countries, this drive is relying to a large extent on the expansion of community-based mutual health organisations (MHOs). However, MHOs are beset by a number of technical and institutional limitations, as the literature shows. These include a lack of household resources for paying premiums, inadequate management, organisational limitations etc. (Jütting 2003; CAS/PNDS 2004; Waelkens and Criel 2004; De Allegri *et al.* 2006; Jehu-Appiah *et al.* 2011). While acknowledging the scale of the obstacles highlighted in the literature, we are concerned in the present article with another difficulty that has not been investigated as such in the literature and which to a large extent adds to those listed above. This difficulty arises out of a paradox: although MHOs in Africa are indeed part of the social and solidarity economy (SSE) in terms of their founding principles, they nevertheless vary considerably in the ways in which their managers and members perceive their underlying values and priority objectives. These differences in perception may be compared with the principles underlying the ideal types in the SSE. This sector's apparent homogeneity actually conceals a certain degree of heterogeneity that makes it difficult to bring the mutualist initiatives together in order to extend health coverage.

This article takes the example of Senegal, where the promotion of universal health coverage has been regarded as a major national issue by governments since the mid-2000s. We draw on a field survey carried out between 2013 and 2015 (Alenda 2016) among MHOs and institutional actors. Although the term 'social and solidarity economy' is itself little used in Africa by public and socio-economic actors, it is our view that the various initiatives launched to promote MHOs are certainly consistent with such an approach. After all, in their attempt to find new ways of meeting economic and social needs, they rely on the reciprocity principle in Polanyi's sense of the term (Polanyi 2001 [1944]).[1] Thus in contrast to the so-called third and non-profit sectors, which are conceived as specific sectors that complement the market and the state, the SSE, broadly defined, falls within a more encompassing framework within which the blueprint for an alternative economics has been developed (Defalvard 2013; RIPESS and Kawano 2012; Satgar 2014; Utting 2015; Loh and Shear 2015; Miller 2010). It is this last approach that is adopted in this article, with the organisations in question being considered through the prism of their relationship with the wider society and with politics, in the tradition of heterodox health and development economics.

In the first section, the characteristics common to organisations in the SSE are identified. They then serve as an ideal type for MHOs. In the second section, the survey methodology is outlined. In the third section, we present the results, drawing on the analytical framework of the SSE.

2. A framework for analysing mutualist values and characteristics

The forms of the SSE can be found in any activity as long as it puts certain particular characteristics into practice. Before outlining these characteristics, it is necessary to explain the particular place the various concepts of the SSE occupy in the countries of the South.

2.1. The various concepts of the SSE and the countries of the South

[1] This principle makes reference to the symmetry of the relationships between the members of society, in the sense that each one needs the others' activities in order to fulfil his or her needs. However, in contrast to the market and redistribution principles, reciprocity is motivated not by private interests or public constraint but rather by the realisation that others are in a state of symmetric dependence vis-à-vis oneself. Competition and constraint are here replaced by complementarity. Now as Servet (2012) notes, this Polanyian framework can be used to show that it is only when the reciprocity principle plays a dominant role compared with the market and redistribution principles that an organisation can be described as belonging to the social and solidarity economy. After all, only the primacy of the reciprocity principle limits the scale of the exploitation and domination that can result from market competition or the extent of the protection without participation that results from the redistribution principle.

The social and solidarity economy encompasses a number of different realities depending on its location. Thus in the countries of the South, Castel (2015) regards the popular economy as a branch of the SSE, since the intentions behind it are similar, with a collective project to establish an alternative to the capitalist economy and a common identity among the workers. Some of these popular organisations combine market, non-market and non-monetary resources, in the same way as the SSE (Castel 2007). In this respect, MHOs in Africa certainly fall within the scope of the SSE. They are putting into practice a collective plan to establish an alternative economy in order to fill the gap between the right to healthcare for all and the actual implementation of that right. This alternative economy is based on solidarity and reciprocity in Polanyi's sense of the terms (Polanyi 2001 [1944]) and is far removed from the process of marketising health favoured in the neoliberal policies that have been implemented since the 1980s. This is also a political project, since it aims to create autonomous spaces for debate on health matters within these MHOs in which civil society is being encouraged to contribute to collective decision-making. In this way, MHOs are facilitating interaction between the domestic sphere, external partners, the public authorities and the private sector.

Polanyi's insights provide a basis for defining MHOs in greater detail within a popular economy framework specific to the countries of the South. The primary locus for healthcare in Africa is the domestic sphere. In the event of illness, the first source of assistance is the immediate family and close relations. Thus reciprocity operates at various levels. Weddings, births, funerals and illnesses are all situations in everyday life that provide opportunities for gifts and counter-gifts (Ballet *et al.* 2014). In the sphere of reciprocity, analysed by Polanyi in the context of the capitalist countries that he investigated (Polanyi 2001 [1944]), a failure to display 'generosity' can lead to exclusion from this system. MHOs combine reciprocity and redistribution as alternatives to the 'quasi-market' in healthcare that has become the dominant norm (McCaster *et al.* 2015). The health care they provide extends interpersonal reciprocity to encompass members of the same MHO. This combination of reciprocity, self-interest and redistribution runs counter to the standard theory of MHOs (Dror and Jacquier 1999; WHO 2010; Wang *et al.* 2010), in which contractualisation is seen as a means of combating supposedly purely opportunistic behaviour. In contrast to the instrumental rationality hypothesis, individuals are concerned not only that their personal wants should be satisfied but also that they should be satisfied indirectly, which in turn links up with their social identity (Caillé 2006). Membership of the community enables individuals to receive assistance from the group without any distinction being made between members. Such membership simultaneously brings into play self-interest, reciprocity and the significance attached to group affiliation.

2.2. The ideal-typical characteristics of MHOs as components of the SSE

Three main characteristics of the SSE can be identified from the literature. The first is democratic plurality (Laville 2010), which arises out of both an internal mode of operation and an activity external to the organisation in question. Internally, the SSE is based on member participation in deliberations and decision-making. The favoured form of deliberation involves the construction of rules by comparing various points of view placed on an equal footing with each other. Collective deliberation is an economic principle, just as market or state regulation are (Dacheux and Goujon 2015). Externally, SSE organisations are forums for debate that bridge the gap between the community level and the higher levels (local authorities, state, international actors).

The second characteristic is common identity: it is the collective deliberation specific to the particular organisation in question that makes it possible to forge a group identity that is shared by members. This identity is forged by establishing social links between the members as well as through the legitimation of the organisation, its purpose and its values. As far as MHOs are concerned, the project must make sense to potential members so that they can share a common interest and decide to operate collectively. The values the organisation adopts function as a coordination mechanism, since they enable individuals to evaluate its activities and to forge membership of a community (Batifoulier 2012).

The third and final characteristic is economic plurality and the position occupied by the reciprocity principle.[2] The aim is to seek alternative ways of managing goods and services and to create and share wealth. These alternative experiments lay the foundations for economic plurality, their purpose being to humanise the economy, to democratise it (Lewis and Swinney 2008) and to move beyond market hegemony in order to incorporate different economic principles (Laville 2003). Resources are pooled in order to provide health care in a context of interdependence between members within a 'social whole' constituted by the MHO. [3]

[2] The distinction between solidarity and reciprocity is an important one. The two are undoubtedly linked: reciprocity is put into practice within a solidary framework, while solidarity is a social tie based on reciprocal commitment and dependence. However, reciprocity is wider in its scope than solidarity; it is a principle of economic integration that contributes to family production and subsistence (Polanyi 2001 [1944]). While solidarity is positive, reciprocity can be negative (vengeance may, for example, underpin the maintenance of a social order). Thus in SSE organisations, reciprocity is organised within a framework of solidarity between members, all of whom share a common identity. However, these organisations have to coexist with forms of reciprocity that already exist in the contexts from which they emerged. West African society is characterised by several modes of social interaction. It may be ritualised and hierarchically organised (contribution to family ceremonies), codified in such a way as to extend the boundaries of the community in question and its day-to-day activities (collective productive activities, civic and cultural training) or voluntary, manifesting itself in local development associations or the advocacy of certain causes regarded as being in the general interest (Vuarin 2000). While these three forms give rise to different forms of social protection, they share values specific to those societies. The SSE falls within the scope of the day-to-day and voluntary forms since it codifies relations and reciprocity and has to seek an accommodation with the ritualised forms.

[3] The 'social whole' is defined by Servet (2007) as the formation of a totality within which individuals are united and that is conceived of as such by those individuals, in contrast to the interdependence of individuals in the

3. Methodology

3.1. Material and method

Some of the results are based on a qualitative survey conducted in Senegal between 2013 and 2015 on the place of MHOs in the extension of health coverage (Alenda 2016). The survey has three main sections. The first is a review of the academic and institutional literature on MHOs in Senegal and other developing countries. The second comprises the exploratory interviews conducted among a diverse range of actors (institutions, development cooperation agencies, researchers, experts and promoters of MHOs), which served to refine our analytical framework and to gather the documentation and information required in order to understand the issues at stake and the institutional framework. The third and final section comprises the case studies based on the documentation gathered and the interviews conducted with members of the MHOs and elected representatives within the organisations.

A total of 66 semi-structured interviews were conducted (with groups and individuals); they were supplemented by informal interviews and visits to organisations.

The case studies were carried out in the organisations listed in Table 1. The *Groupe de Recherche et d'Appui aux Initiatives Mutualistes* (The Mutualist Research and Support Group/GRAIM) manages the oldest community-based MHOs in the country, in the Thiès region. The *Partenariat pour la Mobilisation de l'Épargne et le Crédit au Sénégal* (Partnership for the Mobilisation of Savings and Credit in Senegal/PAMECAS), a mutualist organisation active throughout the country, is an innovative experiment that seeks to link micro-credit and micro-insurance. Rémusac (*Réseau de Mutuelles Communautaires*/Network of Community-Based Mutual Health Organisations) is the umbrella organisation for MHOs in Guédiawaye. TransVie, finally, is the national MHO for Senegal's truck drivers.

[Table 1 here]

3.2. Topics addressed

As far as the exploratory interviews are concerned, the first topic to be addressed was the potential contribution of MHOs in the eyes of the interviewees. The aim here was to reveal the interviewees'

market, in which the totality is reduced to the sum of individual interests. *"Reciprocity is part of a totality conceived of as such."*

perceptions of their strengths and weaknesses and the values and motivations of the various actors, and in particular the importance of being community-based. The second topic was the place of mutuals in the transition towards universal health coverage. Finally, the question of the evolution of health coverage as a whole was addressed in order to ascertain how our interviewees perceived developments in this area.

In the case studies, the interviews conducted with members addressed five topics in each organisation: a) socio-economic profile; b) reasons for joining the mutual; c) awareness of what mutuals stand for and the values being sought in joining (with the aim of gathering opinions on the purpose of a mutual and to ascertain interviewees' degree of involvement); d) views on mutuality and e) member satisfaction. These five topics were discussed with both members and elected representatives in order to provide a basis for comparisons and cross-checking.

3.3. Classification of the four organisations investigated

The case studies have the advantage of representing a range of different types of mutual organisation, above and beyond their shared initial objective. We have constructed a typology of MHOs in Senegal [Alenda 2016:300] based on two differentiating criteria. Firstly, each mutual varies in the extent to which the reciprocity principle, which lies at the heart of the mutualist movement, is central to its activities. Secondly, the homogeneity of the target population, which is of course fundamental to the constitution of a common identity, varies in degree from organisation to organisation. On the basis of this typology, each of the four organisations can be positioned in relation to the criteria.

[Figure 1 here]

Figure 1. Typology of Senegalese mutuals in relation to reciprocity and heterogeneity (authors).

Thus the typology also reflects the links between the mutuals' three ideal-typical characteristics. After all, the (ethnic, religious and socioeconomic) homogeneity of the target population plays a not insignificant role in each organisation's operations, since it facilitates the trust and feeling of solidarity that support a deliberative process. Similarly, homogeneity facilitates the development of a common identity. Lastly, reciprocity is both the third ideal-typical characteristic and a characteristic encouraged by homogeneity.

4. Results

We show the difficulties mutuals encounter in adopting the three criteria outlined in Section 1 while at the same time setting them alongside the results of the literature review. However, in contrast to what is generally found in the literature, our approach involves examining not just one but all three criteria, since they are interconnected. Thus reciprocity contributes to the objective of humanising the economy, with that objective being achieved by the members sharing a common identity based on reciprocal relations and a 'concern for the other' (Servet 2007). Each member is valued the same as the others and each can contribute to the deliberation. In their turn, democracy and regular exchanges underpin the members' unity and shared identity, which are crucial to the organisation's durability (Wallimann 2014). However, our results reveal gaps between the ideal-typical framework and the reality experienced by the mutuals' members and managers.

4.1. An internal democracy to be constructed

The literature on what motivates people to become members of MHOs has highlighted the important part played by transparency in governance, by trust in management and by social control of decision-making. Numerous studies carried out in Sénégal (Devignes 2014) and other African countries (Waelkens and Criel, 2004; Schneider 2005; De Allegri *et al.* 2006; Basaza *et al.* 2008) have shown that having consideration for these characteristics leads to higher penetration and membership rates. Our study confirms this tendency. In the course of our interviews, several actors emphasised the need for appropriation by members and for internal democracy as a means of achieving the social objectives shared by members. The following extracts illustrate this notion from the point of view of the mutuals' managers:

> The chairman of the Goxu-Mbathie mutual (exploratory interview) noted: *"Of the 9 mutuals that used to operate in the Saint Louis region, only two survive, namely ours and the one for caretakers. […]. The organisation has to function properly, there has to be permanent awareness, periodic meetings with the healthcare providers to ensure quality and diversity in the provision of care […], there has to be joint decision-making, not an authoritarian system. Decisions have to be democratic. Everything that contributes to cohesion is a good thing".*
>
> The executive director of Intermondes (Rémusac's support organisation), differentiating himself, so he said, from the public authorities, who take the view that participation involves "*contributing to the measures put in place by the state",* defined participation "*as a broader, more active, more creative process, which takes place round a table. We have to contribute and assess things together*". The aim is to "*promote dialogue between the economic, social and political actors, with a view to strengthening citizens' participation […]. In order to reach*

as many Senegalese as possible, the community-based HMOs are there to serve their localities, to benefit their communities, to promote the values that exist within society. It is important to meet users in order to ask them their opinions."

The coordinator of GRAIM explained: "*We at GRAIM were at pains to avoid developing mutuals just so we could tell people to look after themselves. They do enable people to access healthcare but they also enable a community to ask questions about its situation and to consider its future and its relations with the various actors, including the authorities. To take a position vis-à-vis authority. […] The mutual will not survive long unless communities appropriate mutuality and the internal resources they put in place in order for them to become real communities, real societies*."

Certain examples are emblematic of the search for a form of internal democracy that makes it possible to adapt the rules to the mutual's specific needs. Thus as some studies have already noted (Atim *et al.* 2005), the key parameters are almost always fixed at the founding general meeting. This procedure means that collective decisions can be taken that differ from those recommended in the feasibility studies. This was the case with the Thiès mutual, whose coordinator highlighted the fact that premiums and services are fixed on the basis of a debate among members:

"*We continue talking for as long as the amount has not been agreed. And you make the connection between premiums and service. And so each mutual made its decision on that basis, the level of premium accepted by the whole membership*."

However, studies of HMOs in sub-Saharan Africa have generally found that, despite the enthusiasm these organisations arouse among the target population and development partners, the reality is often disappointing, with lower membership and coverage rates than anticipated (Fonteneau 2003; Waelkens and Criel, 2004; De Allegri *et al.* 2006). Moreover, the legitimacy of the actors in mutuals to intervene in the democratic process at national level should be linked to the legitimacy of the mutual's internal democracy (Laville 2014). However, our survey shows that, above and beyond the convictions of the mutuals' managers, there are significant gaps between members' visions and those of the elected representatives and managers. Several problems are revealed. Mutual managers' heavy workloads encourage a concentration of decision making for lack of time for deliberation. Democratic practices are an aspiration when mutuals are set up, but they tend to get forgotten over the long term because of the pressures of day-to-day management. When outside consultants are called in, they favour 'turnkey' solutions that tend to ignore real needs. Low levels of education mean that not all

members have the ability to participate effectively in debates and decision-making. Some of these problems are illustrated in the following extracts:

> The director of the Hygea research company regretted: *"The representative democracy in the mutuals doesn't really represent the members. The chairmen are always consulted but never the members, their needs are not taken into account. When a guy wants to set up a mutual, he always brings in the same experts who do the same feasibility studies and then set up the same mutuals that are not suited to the situation." [Director of the Hygea research company]*
> The coordinator of the Saint Louis Regional Union of Mutual Insurers mentioned a case of embezzlement in a mutual: "*This is an example of failure at a mutual. The original intentions were good, but the money went into the hands of the managers, the people could always be made to wait. There's a problem with transparency, there's no real democracy".*

PAMECAS is a striking example of a mutual with significant flaws in its internal democracy. The annual general meetings cover the savings and loans mutual but not the MHO. However, the members we met during our survey informed us of their desire to express their needs and complaints. We also noted that the burden of their administrative duties restricts the time management teams can devote to member involvement. It was clear from the interviews we conducted in the community-based mutuals that there are difficulties in recruiting trustworthy and competent people to manage mutuals. Consequently, the senior executives are frequently reappointed many years in succession, which further concentrates decision-making. Our observations also echo those studies (Letourmy and Pavy-Letourmy, 2005; Miller Franco *et al.* 2004) that indicate that member involvement takes place mainly when a mutual is being set up, at a time when executives and managers are keen to establish a relationship of trust and to reach a consensus on premium levels and the content of service packages.

4.2. The difficulties of creating a collective identity

Attempts to construct a collective identity for community-based MHOs come up against some significant difficulties, for two reasons. Firstly, merely being a member of a mutual does not mean that the individual in question necessarily shares a common vision with his or her fellow members. Secondly, those community-based mutuals that prove to be durable are often based in tightly knit communities, which may conflict with the creation of an identity specific to the mutual rather than to the community. These two aspects, noted in certain studies conducted in Senegal and other African countries, were also encountered in our survey.

A study carried out in the Senegalese mutuals in Fatick, Kaolack, Diourbel and Kaffrine (CAFSP *et al.* 2011) shows that members regard mutuals above all as organisations based on collective solidarity that facilitate access to healthcare for their members and their families. The 'togetherness' principle is emphasised, which further consolidates social cohesion. Thus in a general context characterised by the expansion of individualist insurance systems, the mutuals are ploughing a different, collective furrow based on reciprocity and the forging of social ties. Consequently, a pre-existing degree of social cohesion is likely to be an important factor in determining the viability of MHOs. Some community-based mutuals have succeeded not because of the nature of their activity but because of the ties forged and the socialisation mechanisms set in motion by that activity (Letourmy and Pavy-Letourmy 2005; Mladovsky and Mossialos 2008).

So if one of the SSE's characteristics is to seek to create an identity around a project, such a collective identity does not appear to gain a foothold in MHOs unless it can draw on pre-existing common identities. In this respect, the literature shows that mutuals are more durable when members are united by a strong common identity (Daff 2000). "Word of mouth" is very important (Toucas-Truyen 2001), as it reinforces the role of networks in encouraging membership. This common identity is generally weaker in urban areas where, in the absence of an initial collective identity, it seems very difficult to escape from a form of solidarity that simply functions mechanically. Solidarity seen by the international financial institutions in a purely mechanical and functional way leads to the imposition of technical recommendations on populations whose primary motivation is in reality trust in their communities. This significant difference between urban and rural areas in the target population's heterogeneity and homogeneity was observed in our survey.

> By way of example, the director of the Hygea research company noted: "*there's strong solidarity against sickness but not inside the mutuals […] The problem here [in urban neighbourhoods] is that community mutuals are based on the neighbourhoods. People know each other to a greater or lesser extent, there aren't any horizontal relationships, just individualism."* In contrast, the members of rural mutuals stress the importance of belonging to a community, as a PAMECAS member observed: "*It's a community here, everybody's practically one big family. It's a community of characters. Who act together. So if they accept something, they do so together.*"

Our direct observations also brought such differences to light. Thus the high level of solidarity already present in the Serer[4] culture in Thiès or among the women in the Rémusac mutual illustrates the

[4] The third ethnic group in Senegal.

importance of such ties in ensuring that community MHOs achieve higher penetration rates. Fandène and Lalane Diassap, mutuals in the Thiès region, are two examples of MHOs in rural areas that have strong social foundations and high penetration rates (90% and 82% respectively) (Devignes 2014). Our interviews and observations suggest that this durability is linked to a large extent to the following factors: the close links with the Saint Jean de Dieu hospital, the practice in Serer communities of getting organised and paying subscriptions in order to obtain services and of giving (e.g. church collections) and the high level of social cohesion in the villages.

Paradoxically, it also seems that the high degree of community cohesion constitutes an obstacle to the extension to the country as a whole of health cover based on the mutualist movement. After all, the mutuals in question do not accept members from outside these communities, as the following extracts show:

> The chairman of the Diourbel Regional Union of Mutual Health Organisations observed: "*At national level, mutuals are established on the basis of 'belonging to a brotherhood'. This has advantages and disadvantages. Because those outside the brotherhood will not be able to join. The religious leader has a stranglehold. If the population was concerned only with health, then we could focus more on health, nothing more, nothing less"*.
>
> The GRAIM coordinator analysed this question as it applied to Thiès: "*Fandène is a social reality, same ethnic and religious community. And when you want to move outside those circles, that's when you encounter difficulties. When you want to include others, they may come initially but numbers soon begin to dwindle*."

Thus in contrast to the common identity regarded as the ideal type in the SSE, analysis of the MHOs in Senegal reveals a mixed reality. On the one hand, the presence of tightly knit communities facilitates the creation of durable mutuals. The other side of the coin, however, is that it leads to their fragmentation and the exclusion of those populations that do not belong to the founding communities.

4.3. The top-down approach vs. reciprocity?

A study conducted in 1997 in traditional rural communities (Platteau 1997) showed that members were guided by the "balanced reciprocity" principle and did not regard insurance as a game with winners and losers. Risk pooling was not regarded as a transfer but as a debt contracted with the other members. Nevertheless, the literature also shows that, while most of the actors initiating the mutualist movements share the vision of solidarity and reciprocity, this approach is not regarded as sufficient by members (Mladovsky *et al.* 2014). Mutuals are often perceived as a support for families rather than as

a means of implementing reciprocity (authors' survey and LARTES 2010). In this case, members' motivation is limited to their own individual interests.

Our study confirms that different visions coexist within MHOs; sometimes it is individual interests that predominate, at other times reciprocity. The lack of real participation in mutuals' day-to-day activities often reduces the relationship between members to its financial dimension, to the payment of premiums rather than collective involvement or the sharing of values. We observed a gap between the vision of managers, who are often very involved and committed and espouse mutualist values, and members, who put self-interest before reciprocity. The following extracts illustrate this finding.

> The director of the Hygea research company confided that: "*For 20 years, the whole question of the mutuals has been mouldering away, lots of little mutuals that are not really viable. There's too much emphasis on problems of management and training and on the fact that the mutuals are modelled too closely on Western organisations. Nobody really talks about solidarity other than the financial aspect*."
>
> The manager of the MHOs and accountant at the Saint Jean de Dieu hospital pointed to the gap between declarations of solidarity and the decisions taken by members, which are determined more by self-interest: "*I've got a friend who paid premiums for 5 years but didn't get sick so he stopped paying. […] The guy got sick immediately afterwards and had to pay. When I showed him the different costs, […] the guy took the point and started paying in again. There's a problem with solidarity, that's what's lacking. Just as with car insurance*."

Another interesting finding from the case studies concerns the connections that have emerged between the three characteristics of the SSE (internal democracy, common identity and reciprocity), as was assumed in Section 2. Thus the lack of participative democracy and information sharing hampers the construction of a collective identity around common values. Similarly, the limits of democracy may lead to the adoption of a form of reciprocity that does not meet everyone's needs and aspirations. If the reciprocity principle as defined by Polanyi is applied, everyone should pay according to their ability (Servet 2007). According to Mladovski *et al.* (2014) and our interviews with the members of PAMECAS, some mutual members would like to move towards this form of reciprocity rather than retaining the system of equal premiums as currently practised. If such rules were applied, there would be little change in premiums in the relatively homogeneous communities. The differences would be much greater in heterogeneous communities, particularly in urban areas. Our survey shows that many people declare themselves willing to increase their premiums but that many of them are unable to pay

them as things stand at present. Members often acknowledge that there is a lack of vertical redistribution between richer and poorer members.

A third and final result concerns the links between, on the one hand, the difficulty of establishing a reciprocity principle that would satisfy all members and, on the other hand, the relatively exogenous nature of certain initiatives. After all, the community dynamic in Senegal is strongly supported by the public authorities and development partners. However, in a context in which health cover is presented as a national priority, the actors in the mutuals deplore the escalating institutional pressures being brought to bear on their organisations and the consequences that ensue from the insufficiently endogenous or 'bottom-up' nature of the initiatives, which tend to favour a 'top-down' approach ill-suited to mutualist values.

Of all the 'top-down' approaches, DECAM (a project to mutualise health risk as part of the decentralisation programme) is the programme most frequently criticised by the mutual managers we interviewed. Launched in 2010 at the instigation of the United States Agency for International Development (USAID), DECAM establishes a partnership between community-based MHOs, local authorities and the state. Its aim is for each municipality or rural community to have an MHO. The state subsidises part of the premiums and an equity fund is put in place, supported by USAID and the Belgian cooperation partner. While the actors in the mutual are unanimous in recognising this new scheme as an opportunity, they deplore the fact that those mutuals that have joined the programme did so in order to take advantage of the financial manna associated with it rather than from any commitment to the programme in itself. The following extracts illustrate this scepticism and anxiety:

> The GRAIM coordinator deplored the fact that initiatives are now decreed rather than discussed. "*There has to be a real debate in order to get changes accepted. But today everything is decreed. Now it's no longer you who decide the premiums to be charged by your mutual, it's the state that decides […] Crazy, crazy, crazy these targets set by the state. It's all very ambitious, but also very mechanical. […] That's it actually, the procedures, the sense of due process, that's all been forgotten."*
>
> The chairman of the Fandène mutual was critical of the direction in which the drive to extend health cover is heading: "*It's bad: people are having to adapt to the organisation, and that's not good. It's not just support and subsidies that are required, you have to do things yourself. It's the organisations that should be adapting to the population. Each different environment, its possibilities, its financial resources, has to be researched. We need ideas on participation, that's how you get results."*

Ultimately, the ambitions of the public actors are regarded as both an opportunity and a threat. The threat arises in particular out of the fact that the corollary of the aid provided as part of the extension programme is the restriction of member participation to an economic dimension that has to be dealt with as a matter of urgency. This restrictive approach disregards efforts to develop a pluralist vision of the economy and to construct reciprocity between members over the long term.

5. Conclusion

This article has sought to compare the SSE ideal types with the actual practices and perceptions of the actors in MHOs in Senegal. These organisations are often described by international institutions and aid donors as appropriate vehicles for extending health coverage in Africa. Our field survey has shown that, despite the fact that the MHOs do indeed form part of the social and solidarity economy, there are constraints on their implementation as well as specific and heterogeneous practices that call into question their ability to unify the system of health cover.

It might then be wondered what changes the MHOs might undergo as they are integrated into the system of health cover on the initiative or order of aid donors. Will we see the gradual disappearance of the reciprocity principle, despite the fact that it is the foundation of these initiatives, even though in reality it is applied to varying degrees? This question arises out of the observation that international standards occupy a central position in all programmes implemented in poor countries. The health sector lays bare this standardisation of objectives and mechanisms. The contractualisation of relations between the actors is an imported mechanism that the local authorities are obliged to incorporate into their objectives. Prepayment is another mechanism that has been in fashion for a decade or so. These various mechanisms are all part of a drive towards the quasi-marketisation of healthcare. However, according to the international organisations that have adopted 'good governance' models as levers to improve healthcare systems, the community-based MHOs are supposed to be the favoured vehicles for the implementation of such mechanisms.

As mechanisms imported from outside are continually being assimilated, questions might well be asked about the ability of the public authorities at local level to develop their own original programmes. They generally have limited room for manoeuvre. Thus the standardisation, or even the marketization, of community-based MHOs is a major risk that might well harm their contribution to health coverage. This risk should be taken seriously by national and international decision-makers.

Disclosure statement

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Table 1. Organisations investigated.

Structure	GRAIM	MS-PAMECAS	Rémusac	Transvie
Type of organisation	Network of community-based MHOs	National mutual, combined with a micro-credit mutual	Network of community-based MHOs	National mutual for truck drivers
Location	Thiès	National (neighbourhood offices)	Guédiawaye (Dakar)	National
Type of area	Rural	Urban and rural	Urban	Urban and rural
Target membership	Homogenous	Heterogeneous	Heterogeneous	Homogenous
Management	Voluntary	Professional	Voluntary	Professional

Figure 1. Typology of Senegalese mutuals in relation to reciprocity and heterogeneity (authors).