ESS **Extension of Social Security**

Extending health insurance in Senegal:

Options for statutory schemes and mutual organisations

Couty Fall

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Acronyms

ACOPAM	Associative and Cooperative Support to Grassroots Development Initiatives (Appui Associatif et Coopératif aux Initiatives de Développement à la Base)
ANMC	National Alliance of Belgian Christian Mutual Benefit Societies (Alliance Nationale des Mutualités Chrétiennes de Belgique)
CAMICS	Support Units of Health Mutual Benefit Societies (Cellule d'Appui aux Mutuelles de Santé)
CSS	Social Security Fund (Caisse de Sécurité Sociale)
DAS	Directorate for Social Action (Direction de l'Action Sociale)
DPS	Directorate for Forecasting and Statistics (Direction de la Prévision et des Statistiques)
ENDA	Environment and Development for the Third World (Environnement et developpement du tiers monde)
ESC	Economic and Social Council
FAGGU	Complementary Health Mutual Benefit Societies of Retirees of IPRES (Mutuelle de santé complémentaire des retraités de l'IPRES)
FNR	National Pension Fund (Fonds National de Retraite)
GDP	Gross Domestic Product
GNP	Gross National Product
GTZ	German Agency for Technical Cooperation
ILO	International Labour Organization
IPM	Health Insurance Institution (Institution de Prévoyance Maladie)
IPRES	Old-Age Pension Institution of Senegal (Institution de Prévoyance Retraite du Sénégal)
ISEP	Institute for Health and Development in Senegal
MHO	Mutual Health Organisations
OECD	Organisation for Economic Cooperation and Development
PAMS	Governmental Programme for the Support of Mutual Health Organisations
PHR	Partnership for Health Reform
PNDSS	Strategy for Fighting Poverty of the National Plan for health and Social Development
PNLCP	National Plan to Combat Poverty (Plan National de Lutte Contre la Pauvreté)
PROFEMU	Urban Women's Programme (Le Programme des Femmes en Milieu Urbain (Oxfam international funded programme))

PROMUSAF	Programme of Christian Mutual Benefit Societies and World Solidarity in Africa (Programme des Mutualités Chrétiennes et de Solidarité Mondiale en Afrique)
PSS	Health Planning in Senegal (Programmation Sanitaire du Senegal)
SMIG	Guaranteed Inter-Occupational Minimum Wage (Salaire Minimum Interprofessionnel Garanti)
SOCOCIM	West African Cement Societies (Société Ouest Africaine des Ciments)
STEP	Strategies and Tools against social Exclusion and Poverty (Stratégies et Techniques contre l'Exclusion sociale et la Pauvreté)
USAID	United States Agency for International Development
WHO	World Health Organisation
WSM	World Solidarity/Solidarité Mondiale
ZEF	Centre de Development et Recherche (Zentrum für Entwicklungsforschung)

Summary

Social security in Senegal covers less than 20 per cent of the population in terms of both personal and derived rights. The list of persons excluded also includes temporary workers and day labourers as well as workers in the informal sector.

Furthermore, it has transpired from studies conducted that the absence of protection is caused by problems of equity between protected workers and those who are not protected, which are related to the yield management strategies of undertakings related to international competition. A consequent challenge is that of finding relevant solutions that are balanced and that take account of the interests of all of the parties involved in labour relations.

Initiatives have been taken in Senegal, both at State level and in civil society, which have been designed to extend social security beyond the "formal" sector. These have included community initiatives developed since 1990 within the mutual health organisations (MHOs), offering separate coverage to essentially non-wage-earning population groups.

A survey conducted in May 2000 provided a better understanding of the socio-demographic characteristics of the persons concerned by social security in one way or another. The survey data reveal the needs in the social security field. The absence of contact with the social security institutions is to be explained by the lack of promotion and by the general lack of interest of the persons concerned. The overwhelming majority of the survey group wanted protection against short-term social risks—health, maternity, unemployment, employment injury—and some opt for coverage against long-term social risks—old age, disability and death.

The problem is that the income of those desiring coverage gained from seasonal activities, and therefore cyclical in nature. The irregular income pattern and the relatively high contributions can prevent people from joining mutual organisations; on the other hand, when contributions are too low the mutual organisations do not ensure effective coverage of hospital care, which is costly for members. Furthermore, the mutual organisations generally lack negotiating power and do not have the management capacities for adopting the most efficient mechanisms for paying the service providers; 55 per cent offer only services relating to hospital care.

In the period from 1994 to 1998 the mutual organisations were extended throughout the various regions of the country. Their schemes, most of which are recent, are generally small or moderate in size in terms of membership. The mutual insurance activities concern only a small proportion of the population of the country. The likelihood of access to hospital services is greater when one is a member of a mutual insurance scheme than when one is not. Although very costly to cover, it is considered more advisable to focus efforts on financing life-threatening illnesses.

In conclusion, it is suggested that the State work together more effectively with the various institutions to create support services in order to complement statutory social security and voluntary insurance. The overall objective would be to involve the various trades, and then to focus efforts on developing a mutual-benefit savings and credit system (as a fundamental basis) and ultimately to incorporate social coverage (social services) into this system. Furthermore, a solution would have to be found to the problem of financial barriers within the mutual organisations and the support structures.

Introduction

As a country of the Sahel situated in the Western extremity of Africa, Senegal has an extensive coastal zone and a total area of 197,000 km². It had an estimated population of 9,000,000 in 1997 with an annual population growth rate of 2.5 per cent (World Development Report 1998/1999, World Bank). The population density is relatively high in urban zones; 55 per cent of the population of the country live in rural areas.

The informal sector is far from being a transitory phenomenon; the increase in population is concentrated mainly in that sector. All in all, present-day economic realities are such that social security in the informal sector can no longer be provided by traditional or family solidarity, which has become uncertain. The future lies in research for original and adaptable solutions.

At present, the statutory social security system only includes wage and salary earners in the private, public and semi-public sectors and their dependants. This provides coverage to only 20 per cent of the population in terms of both personal and derived rights. It excludes temporary workers, day labourers, farmers and workers in the informal sector (the petty trades, the traditional crafts and trades, and the competitive informal sector).

Social security has evolved as the result of common tripartite action from the Government, employer organisations and trade unions, the present aim being to try to include not only workers in the informal sector but also those in the formal sector who are not yet covered.

This paper begins with a description of the statutory social security system and the labour market in Senegal, concentrating in particular on the informal sector. Chapter 2 describes and analyses the test programme put in place by the formal system, that was designed to include the groups of the population that are as yet excluded and specifically persons working in the crafts and trades. Chapter 3 provides an analysis of the extension of social security by community initiatives through MHOs, and Chapter 4 summarises the main conclusions and policy recommendations.

1. Context and approach

1.1 The working population and social security

The working population in Senegal—estimated at 4,000,000 in 1997, or 44 per cent of the total population—is absorbed mainly by the agricultural sector—77 per cent. The tertiary sector remains the second job provider with 15 per cent, followed by the industrial sector with 8 per cent.

In view of the low absorption capacity of the modern public and private sectors, the working population is evolving mainly in the informal sector, which thus plays an essential role of job provider; jobs which are insecure but which generate income.

Countries of Africa are characterised by rapid population growth (around 3 per cent per annum in Senegal), low employment levels and insecure employment. Presently though, only a very small portion of the African population, the wage and salary earners, have organised social coverage. In

Senegal, for example, social security is limited to less than 20 per cent of the population in terms of both personal and derived rights.

The categories of persons excluded from coverage include temporary workers and day labourers, who perform a large volume of work in undertakings but who do not have coverage because their employers do not pay the social contributions that are due.

Farmers, who account for 79 per cent of the population in Senegal and a share of 25 per cent of the formation of national wealth, also have no social security. Nor does the social security system cover workers in the informal sector in the following three categories:

- the subsistence informal sector covering all of the petty trades, which require little or no capital (shoe-shiners, stall-keepers, etc.);
- the traditional trades (blacksmiths, cobblers, builders, carpenters);
- the competitive informal sector, which can be subdivided into at least five activities—building, services, manufacturing, transport and shop-keeping—and these five activities can again be divided into two homogeneous groups—one-person enterprises, or those employing labour.
- Workers leave the social security system when they lose their jobs, for example; there is thus economic insecurity, which contributes to exclusion, marginalisation and poverty. It also makes social security discriminatory, since it becomes an instrument of social differentiation between working and non-working townspeople on the one hand and between townspeople and rural populations, who form the majority, on the other.

1.2 The broader issue of the extension of social security

1.2.1 A limited institutional basis

In Senegal, and in the countries formerly under French administration, social security emerged towards the end of the colonial period. Initially, the idea was to create minimal financial security which could compensate for the security hitherto provided by the institutions of traditional society—the family, the clan, the village, etc. Industrialisation and urbanisation often left workers totally destitute when faced with the new types of social risks. The social security system that was to be set up pursued an economic and political objective.

- **At the economic level,** the aim was to stabilise the wage and salary-earning category, it being the most likely to develop through modern production methods and the increase in economic activity. Employers thus took initiatives - prior to the adoption of official measures - to set up private provident funds and company health services. Statutory social security in Senegal was set up on the basis of these schemes and this explains the virtually exclusive precedence given to wage and salary earners.

- **At the political level,** the protection of so-called "indigenous" workers is the result of the unrelenting struggle of the trade unions to obtain rights equal to those enjoyed by workers in the towns and cities, who until then were the only workers enjoying any social security measures.

1.2.2 Scope of the scheme

The four branches of the Senegalese social security scheme offer a variety of benefits both in cash and in kind.

i) The family benefits branch, run by the Social Security Fund, offers both cash benefits and benefits in kind;

- **benefits in kind** are provided for the spouses and children of workers in the form of curative and preventive medical care and gifts of food supplements and pharmaceuticals within the framework of the health, social and family action plan;
- **cash benefits** cover the antenatal and maternity benefits which are paid to women wage/salary earners or to the spouse of a worker, the family allowances that are granted to workers and the daily allowances which are paid to employed women on maternity leave.

ii) The branch covering the compensation and prevention of employment injury and occupational disease, run also by the Social Security Fund, provides:

- **benefits in kind** in the form of the coverage or refund of medical, pharmaceutical and surgical expenses; the cost of vocational and functional rehabilitation in, and relocation to, a new job; and—in the event of accident or death—the costs incurred in moving the victim, the cost of prosthetic/ orthopaedic appliances and the funeral expenses.
- **cash benefits**, which are designed to compensate the worker's loss of earning capacity and which comprise daily allowances in the event of temporary incapacity for work, annuities in the event of permanent incapacity for work and annuities for beneficiaries in the event of the death of the victim.

iii) The old-age branch, which is run by the IPRES (Old-Age Pension Institution of Senegal), also provides:

- **benefits in kind** in the form of outpatient medical care, provided by the medical welfare centres, and partial coverage of the cost of hospital treatment of retired workers;
- **cash benefits** in the form of retirement benefits for former wage/salary earners who have contributed to the scheme for at least one year and benefits for widowers, widows and dependent orphans in the event of the death of a wage/salary earner or retired worker. These allowances also comprise solidarity benefits for former wage/salary earners who have contributed for at least one year or who have never contributed as well as special assistance for employed or retired workers or for their dependants.

iv) The health branch is run by the company or inter-company health insurance institutions (IPMs). Those employing over 100 workers are required to set themselves up as IPMs. Firms with smaller workforces are required either to become affiliated to an existing IPM or to group together in order to form one. The management and financing of these institutions is organised on the basis of joint representation.

- These institutions provide only **benefits in kind** in the form of coverage or partial refund of medical, pharmaceutical and surgical costs, the cost of hospital treatment, confinement costs and the cost of medical analyses.
- **Cash benefits** are provided by the employer in the form of daily allowances during a period which varies according to the worker's years of service in the firm.

1.2.3 Beneficiaries

The main beneficiaries of the Senegalese system are wage and salary earners in the private, public and semi-public sectors, and their dependents. Civil servants are covered by a special scheme, which is more favourable in certain respects. At the outset the scope of the scheme was geared to wage and salary earners but it was subsequently extended to a very limited number of other categories.

The other categories of workers include persons who do not have the status of wage or salary earner and who are covered by the protection of the Occupational Accidents Branch. These are namely:

- Apprentices, and prisoners who are performing correctional labour;
- trainees in public or private institutions of technical education, apprenticeship and vocational training centres and miners who have been placed in rehabilitation centres;
- members, managers and non-wage officers of workers' cooperative societies and production cooperatives;
- under certain conditions, presidents, directors and managing directors of incorporated and limited liability companies.

The other persons included are dependents of the workers, their spouses and children who are effectively dependent on the workers;

- older relatives of workers, provided that they are effectively their dependents, elderly or disabled.

1.2.4 Constraints and challenges of financing

The extension schemes which are currently being implemented in Senegal are self-financed through flat-rate contributions of participants, in the absence of any specific remuneration factor such as wages, the classical basis for the assessment of contributions. In the Social Security Fund (Caisse de Sécurité Sociale CSS) the flat-rate contribution has been calculated on the basis of the ceiling in effect for the general scheme, the rates being the same as in the general scheme. The possibility of day-by-day collection has been offered to those interested. The contribution rates selected are as follows:

- 7 per cent for the Family Allowances Branch, including maternity insurance, subject to a ceiling fixed at a base of 60,000 CFA of monthly salary;
- 3 per cent, 5 per cent or 7 per cent for the Employment Injury Branch (depending on the sector of activity), which is also subject to a ceiling of a flat-rate basis of 60,000 CFA;
- a flat-rate monthly contribution of 1,805 CFA francs, or 60 francs per day, for *apprentices, who are only allowed to join the scheme covering employment injuries.*

Unless regulations with regard to contributions and collection are adapted to informal sector enterprises, a permanent shortfall of revenue is feared, and this poses the problem of the role and responsibilities of public authorities in the financing or accompanying of extension projects. Certain theories maintain that consumers as a group participate indirectly in the financial burden, since the employers' contributions are partially covered in cost prices and thus in sales prices. This could justify direct or indirect State participation in the financing of the schemes intended for non-wage earners.

The voluntary schemes in Senegal are not as yet connected to the tax collection departments. The utilisation of the tax administration for the purpose of recovering social contributions is more understandable for the compulsory schemes. In the case of the voluntary schemes this method can only be resorted to as an exception and when agreement has been reached.

The social security of wage and salary earners in the private sector and of State employees without civil servant status is financed exclusively through the contributions of the employers and/or workers.

Table 1: Contributions in the Statutory System

Branch	Rate %)	Ceiling	Contribution
Family allowances	7	60,000 F/month	Employer
Occupational accidents	3, 5 or 7	60,000 F/month	Employer
Old age/death/survivor			
• General scheme	14	200,000 F/month	Employer = 2/3
• Scheme for management staff	6	600,000 F/month	Worker = 1/3
Sickness	6	60,000 F/month	Employer =1/2
			Worker = 1/2

In the case of civil servants the old-age branch is financed at the level of the National Pension Fund (FNR): the State in its capacity as employer pays 2/3 of the contribution and the worker pays 1/3.

Family allowances and health benefits are financed from the State budget, whereas benefits in kind related to health do not include the refund of pharmaceutical expenses incurred in outpatient services.

A 1996 financial profile of the Statutory System shows that the resources of the welfare institutions (CSS-IPRES-IPM) accounted for 65 per cent of the total of its budget. The share of the State in the formation of these resources was 25 per cent, which was equivalent to 4.2 per cent of the national budget and 3 per cent of GDP for the year.

1.2.5 Social security coverage rates

In 1996 total social security expenditure amounted to 3.5 per cent of GDP, whereas in the countries of the OECD it is 30 per cent on average. Calculated as per capita expenditure - still for 1996 - social security expenditure amounted to 6,257 CFA francs per inhabitant per year, which was equivalent to 17.3 per cent of the SMIG. According to experts, the social effort of the Senegalese nation is low compared to the standards of OECD countries, where per capita social expenditure amounts on average to 5 times the SMIG.

According to the simulations contained in the report of the Economic and Social Council, taking the private and public sector together, the official social security system provides protection for 175,667 people (120,274 + 55,393). This group of protected workers accounts for 5.1 per cent of the working population (3,439,737 workers), and 12.2 per cent of the working population in urban areas (1,441,750 workers). Taking the average number of children per beneficiary calculated by the Social Security Fund (CSS) as a basis (4.5 children), there are 790,501 dependant children covered by the system.

In total, after estimating the number of spouses of the workers affiliated to the scheme, there are 1,200,000 persons covered by the Senegalese social security system, or 13.3 per cent of the total population the country's 9,037,906 inhabitants. It can be seen that a very low number of persons is covered, notably on two scores:

- *It is low compared to the population which is actually (carrying out an occupation?) working***:** the coverage offered by the system is limited to only 5.8 per cent of the persons actually (carrying out an occupation) working, a fact which denotes a two-tier system in which there is a distinction between protected persons and non-protected persons within the same homogeneous unit of workers. Protection should cover not only the persons in occupations in the rural and informal sectors but first and foremost the important fringe of the working population which is effectively in employment but is excluded by the system in its present form of organisation and operation.

- *It is low compared to the total population of Senegal,* since it only concerns 13.3 per cent of total population. The Senegalese social security system cannot presently be regarded as an ideal instrument for combating social inequalities at the national level, and the disparity is liable to lead to a social rift if long-term complementary measures are not effective.

1.2.6 Preliminary observations

In the social security field the status of wage/salary earner is defined in the broad sense of the term and is applied whenever a contractual link establishing a relationship of subordination is established. The concept of dependent employment is thus independent of the nature and form of the contract, and of the amount and method of remuneration. Any wage-earning activity, even on a casual basis, is subject to compulsory coverage under the social security scheme. A large fringe of workers who are excluded on the basis of this definition alone ought to be offered social security by the official system. Currently, a very large number of workers who would normally be subject to coverage are not in fact covered at all.

As regards the branch of insurance covering occupational accidents and occupational diseases, the legislation only makes provision for voluntary insurance for workers who do not have the status of wage or salary earners or who have lost that status. These workers have to pay contributions amounting to only the employer's share.

The existing scheme was originally imported from a foreign country without any particular adaptation to the socio-economic context in Senegal. To what extent it is suited to the realities of the informal sector in Senegal, given the effects of globalisation and macro-economic adjustment, remains questionable.

In terms of the legitimacy and profitability of the schemes, the number of persons covered is less than 20 per cent of the population in terms of both personal and derived rights, and less than 4 per cent of GDP in the case of the income distributed. The gap between the population groups that are covered and those that are not is growing steadily.

1.3 The statutory social security scheme and the informal sector

As a result of the factors described, many firms have increasingly diversified their activities and now rely on a labour force flexible in function:

- by means of short-term contracts, depending on the immediate objectives;
- by externalising activities, sub-contracting labour, or using self-employed workers who are sometimes recruited through temporary employment agencies;
- more generally, by pursuing strategies at the macro-economic level:

  - flexible organisation of the labour market, in response to legislative reforms which were supposed to increase the impact of the supply and demand mechanisms, promote self-employed work and encourage job creation;

  - As a result of the decreasing number of wage and salary earners, the negotiating power of workers in industrial relations with employers has suffered, as has their capacity to defend precarious workers' interests.

The effect of the reduction of labour costs and of the level of worker protection has given rise to a very insignificant increase in employment in medium-sized and large enterprises, greater job insecurity in the informal sector, and low gains in competitive capacity.

The erosion of wage-earning employment in Senegal is evidenced, for example, by the figures published by the Old-age Pension Institution (IPRES) relating to:

- the general basic scheme, through the development in the ratio of the working population to the number of retired persons, which dropped from 5:7 to 2:3 in the period from 1984 to 1998;
- the supplementary scheme, in which the same ratio dropped from 10:8 to 3:9 in the same period;
- the consequent decrease in the number of declared workers subscribing to the scheme from over 170,000 in 1987 to 120,274 in 1999.

Overall, the change in the composition of labour in enterprises has resulted in:

- a decrease in the number of workers holding contracts without limit of time;
- an increase in the number of workers recruited on fixed-term contracts or in other atypical forms of employment devoid of social security;
- a decrease in the average cost of all labour due to the lower remuneration of temporary workers compared to workers holding stable employment contracts;
- the non-payment of social contributions by firms in difficulty, which thus deprive their wage/salary earners of proper social security.

To increase productivity, therefore, it would seem necessary to adopt alternative strategies such as stabilisation and protective measures and incentives.

McKenzie (1989) claims that in Senegal the difference between the formal sector which is described as the modern westernised sector, and the informal sector which is associated with the traditional sector, is not a difference in legality but a difference in culture. Approaches and definitions, although many and varied, are complementary, despite the fact that employers refer to the latter sector as the "illegal" sector.

The informal sector is in reality a conglomeration of small-scale economic activities involved in the production and distribution of goods and services. These activities are carried out, to varying degrees, on the fringe of the State regulations (the Tax Code, the Labour Code, the Code of Civil and Commercial Obligations, etc.) with the full knowledge of the administration, a fact which differentiates them from fraudulent activities in the illegal sector denounced by employers. Although labour legislation regulates the functioning of "formal" modern enterprises in principle, there is no social security for vast groups of workers due to the fact that employment situations can be so different and that economic activities and employment are becoming more informal.

The growing insecurity of employment and the absence of protection must also be borne in mind; these are factors that both in Senegal and in many other African countries are to be explained by:

- the economic difficulties which have been amplified by the globalisation phenomenon;
- a certain tendency of legislation and the available social security schemes to fail to work or to cover the new forms of atypical activity properly;
- the aggravation of the situation of the most vulnerable workers and their dependants; children, elderly workers, women, migrants and workers in the informal sector.

The informal sector is characterised mainly by the fact that it impacts both workers' organisations - as the result of the non-application of the national and international labour standards concerning freedom of association, minimum wages, child labour and social coverage - and employers' organisations, due to what is considered unfair competition.

1.3.1 The urgent need for State and community initiatives

Initiatives have been taken in Senegal at both the State level and community level to extend social security beyond modern enterprises in the "formal" sector, and efforts are also underway to expand the formal scheme.

The work carried out in 1995 within the project for capacity-building in the labour administration highlighted the consequences of the absence of social protection and security, not only for workers in the informal sector and their families but also for certain other population groups:

- the growing number of occupational accidents and their consequences in the absence of any monitoring system provided by social legislation, particularly the Labour Inspectorate;
- the effects of the absence of protection for workers and for society as a whole against diseases, accidents and environmental damage;

- the risks for the function of reproduction in the event that no maternity protection is provided;
- the gradual weakening of the application of social standards to the detriment of the community;

These shortcomings eventually led to positive initiatives to extend social protection.

Despite the inadequacies of the official system, the benefit of protection was reaffirmed, since it is a means of improving workers' circumstances and guaranteeing labour productivity. After long observation and an explicit request by workers in the crafts and trades, a voluntary insurance initiative was launched in 1996 through the impetus of the official social security system. The long-term objective was to provide basic protection for all workers who provide services for third persons, irrespective of the legal category of those services.

The classical basic protection is based on the binary system of labour regulation and the distinction made within that system between dependent employees and the self-employed. The initiative aims to bring about equality amongst workers and to respond to the imperative of taking ambiguous situations into account in the employment relationship. Furthermore, the basic protection guaranteed to workers would also serve the interests of both society and enterprise.

As far back as 1990, community initiatives thus started within the MHOs, offering separate coverage to several types of population groups, which were essentially non-wage-earning. Community systems designed to provide health protection to various segments of the population that did not enjoy social security were set up in the Thiès region from 1996 onwards within the context of difficult access to care. Three experiments were launched there, in Mont Rolland, Fandene and Sainte Anne.

This experiment brought about the creation of several MHOs, some of which are modelled on the first functional mutual insurance that was set up in Fandene, others being organised on differently. To some extent these experiments inspired the extension programmes launched by the formal sector that are described below.

2. Evaluation of the extension initiatives in the formal sector

2.1 The extension programmes launched by the formal sector

The legislative framework in Senegal comprises restrictions connected with its development. Social security applies more often than not to the families of workers and to certain categories of wage/salary earners. It is difficult to reconcile the characteristics of the informal sector with those of the social security systems as they were not designed for that sector to start with.

Until quite recently the social security system and the informal sector in Senegal had nothing to do with each other. Despite this factor, the statistics on the population groups covered compared to the total population revealed a situation that was worrying, as only 14 per cent of the working population was protected. This situation was due to factors such as mentalities, distrust of any administrative system on the part of the actors in the informal sector, and the inflexibility of the

panoply of legal instruments, which made it difficult to integrate that sector into the social security system. Yet, as an experiment, initiatives were nevertheless taken by the formal system.

2.1.1 Concerted measures - a basic principle

There was emphasis placed on extending the traditional social security partnerships, efforts being made by the parties concerned to find solutions to the various questions that arose: the choice of benefits; the system of flat-rate financing taking account of the fact that it was impossible to know what people's incomes were in order to determine the contribution base; and the occupational dimension as opposed to the geographical dimension. The effect of the participatory approach supported by a policy of communication was to engender better as an experiment, if not initial, knowledge of the statutory insurance system, giving rise to what was termed "switching" —a number of people in the crafts and trades and/or micro entrepreneurs using labour preferred to "switch" to the compulsory scheme during the first few months of membership in the voluntary scheme proposed by the Social Security Fund.

The participation of insured persons and their representatives through the various trade guilds throughout the process from the designing to the actual implementation of the schemes helped to guarantee that the test scheme reflected their needs and interests. It was a means of empowering the population groups excluded from the scope of social security to demonstrate their support for the system by being willing to pay what is considered an affordable cost.

Initially, a brainstorming session on extending protection to the informal sector was held in 1996 under the auspices of the Ministry of Labour and Employment. Thought was devoted to the target population, the reference wage, the services to be provided, the contribution rate and periodicity of payment as well as the types of services that could be adapted to the informal sector. It was attended by 146 participants from the crafts and trades sector, and the discussions led to the signing with the artisan trade associations of an Extension Agreement specifying free choice of affiliation to one or two branches of social security run by the Social Security Fund and certain technical issues such as the system of flat-rate financing and administrative procedures.

The actors involved played major a role, particularly those working in the crafts and trades, whose associations are organized on three levels: grassroots associations, regional associations and national associations.

A recent census of the Directorate of the Artisans, had shown that there were some 78,000 one-person businesses in the crafts and trades sector with a total of 400,000 persons, the permanent workforce thereby being estimated at 158,000 persons. It was because of this clear organisation of the manual trades that this sector was selected for the opening of consultations that were to lead to the launching of the test programme.

However, the pension system, which seems to interest people in the crafts and trades in particular, came up against a technical problem—the difficulty of obtaining reliable statistics on the population in that sector including a breakdown by age in order to conduct preliminary actuarial studies.

However, the CSS managed to launch the project more rapidly by taking Article 36 of the Social Security Code as a basis, in which it is stipulated that “persons taking out voluntary insurance” must enjoy the benefits of insurance against occupational accidents and occupational diseases.

The Social Security Fund has also opened up to the informal sector the branch of insurance covering family allowances and comprising maternity insurance.

2.1.2 Characteristics of the test programme

The main characteristics of the special social scheme for workers in the informal sector are as follows:

- the target group is comprised of non-wage-earners;
- the latter are defined traditionally on the basis of the following factors: they exercise the activity concerned in person; there is no subordination relationship; and they work for themselves, whether or not they employ labour.

The main target group at the outset was the group of persons working in the crafts and trades for the organisational reasons mentioned above, but the programme was rapidly extended to all non-wage-earners.

The benefits offered concern family allowances including antenatal and maternity benefits, family benefits, maternity leave, benefits in kind for the mother and child in the mother and child protection centres.

The scheme for compensating employment accidents and occupational diseases includes the same benefits in kind as those provided for wage/salary earners, namely, benefits in kind in the event of permanent incapacity for work and the benefits which are paid to the dependents of victims in the event of fatal accidents. Daily allowances in the event of temporary incapacity for work are the only allowances that are not provided.

Furthermore, the formalities for joining the scheme have been defined and organised around the submission of an application for voluntary insurance accompanied by a national identity card. As regards the option concerning the risks covered, persons taking out voluntary insurance are free to choose to take out insurance against one or several of the risks covered by the CSS.

The other rules that apply concern the following factors:

- the periodicity of the payment of contributions, which are paid on a monthly basis and must be paid no later than 8 days after the date on which they are due; systems of day-by-day or weekly collection are also proposed, in particular at the level of craft and trade associations;
- suspension and withdrawal of rights: rights are suspended when the monthly contributions have not been paid at the end of two successive payment periods, and affiliation ceases definitively at the end of six months' suspension;
- persons subscribing to the voluntary insurance scheme pay only the equivalent of the employer contribution; there is thus no double contribution.

Table 2: Flat-rate contributions in the test programme

Contribution rate (based on 60,000 CFA francs)	Monthly contribution CFA francs	Daily contribution CFA francs
Family benefit 7%	4,200	140
Work-related accident 5%	3,000	100
Work-related accident 3%	1,800	60
Family benefit 7% + work-related accident 5%	7,200	240
Family benefit 7% + work-related accident 3%	6,000	200

As shall be seen, contributions to the MHOs are also calculated as flat-rate contributions except for affiliation fees; they vary from one scheme to another depending on the region and the types of benefits provided. As indicated, the simplified flat-rate system is even more effective at the level of taxes on micro enterprises.

2.1.3 Implementation

The National Union of Trade Chambers (artisan trade association) has been involved in the project, all of the member guilds thereby taking part in the action to raise awareness in the informal sector and to interest people in social security and encourage them to join schemes individually and in the various seminars which were organised jointly for workers in the informal sector.

The project was considered to be an integral part of the activities of the CSS, which already had skilled staff at its disposal. It furthermore constituted a complementary activity, since there were several products similar in nature. Special training for the staff proved to be unnecessary.

The CSS had already opted to decentralise and establish regional units in order to iron out certain difficulties of access encountered by beneficiaries, who could thus obtain access more easily, understand the system better and pay their contributions normally. A computer programme was designed for managing the scheme, and the heads of the various regional agencies and establishments set up across the country were entrusted with the task of running it.

2.2 Evaluation of people's needs and willingness to participate in the extension programme

The project was evaluated at the national seminar held in 1998. The seminar participants were aware of the low membership rate amongst workers in the informal sector throughout the country —the total around 1,000 in the year 2000—and the Social Security Fund was thus invited to extend the project activities for a further period with emphasis on the communication component. It must be noted that the priority objective was not so much to measure the number of members but rather to raise awareness and cultivate the social security "culture" and "reflex" in that environment.

In May 2000 a more extensive survey conducted by the Economic and Social Council provided a means of making a general inventory of the needs of the various population groups, the extent to which they wanted to enjoy social security and were willing to join a contributory scheme, and the appropriate type of organisation.

2.2.1 Willingness of informal sector workers to join a social security scheme

A survey commissioned by the Economic and Social Council was conducted in May 2000 and provided a better understanding of the socio-demographic characteristics of the persons interested in social security in any way. It covered 119 persons distributed over the rural and informal sectors. Of the persons interviewed 63, or 53 per cent of the total number included in the survey, were carrying out an activity in the rural sector, and 56, or 47 per cent of the total, were working in the informal sector.

The women who were interviewed accounted for 13 per cent of the sample population (15 in absolute figures) as against 87 per cent for the men. Most of those women (12 out of the 15) had an activity in the informal sector. The 63 persons from the rural sector who were interviewed were crop farmers (45 per cent), animal farmers (19 per cent), fishermen (19 per cent), and market gardeners (14 per cent). The remaining 3 per cent were wholesale fish merchants and collecting agents. The 56 persons from the informal sector came from various occupations: shopkeepers (25 per cent), drivers (11 per cent), electricians (9 per cent), mechanics (9 per cent), labourers (9 per cent), persons with a craft or trade (5 per cent), etc.

The breakdown according to the number of dependant children showed that 27 per cent of the persons interviewed had no children as against 73 per cent who did. Persons with 10 or more children accounted for 13 per cent of the sample population. Eight-seven persons (73 per cent) were carrying out their activities on a permanent basis, 24 of them (20 per cent) were seasonal workers, and 7 (7 per cent) were day labourers.

The reasons explaining the absence of contact with the institutions are to do with the persons interviewed but also with the CSS and the IPRES. Lack of information was the reason given by 85 of the 119 persons interviewed - 71 per cent. According to 27 of those 119 persons, lack of interest was a further reason for this lack of contact.

The survey revealed the need for social security, practically all of the persons interviewed wanting to enjoy such security (117 out of 119, or over 98 per cent). The overwhelming majority (91 out of 117, or 78 per cent), would like to be protected against short-term social risks - health, maternity, unemployment - and some (18 out of 119, or 15 per cent) opt for coverage against long-term social risks - old age, disability, death; the remainder (8 out of 117, or 7 per cent) preferred to be protected against occupational accidents and occupational diseases.

A clear majority (79 out of 117, or 67.5 per cent) opted for social security organised in the form of partial or full coverage of the costs incurred by the occurrence of a social risk, and 38 out of 117 persons, or 32.5 per cent, were in favour of social security in the form of the payment of cash benefits.

For the management of social security, 32 per cent of the 117 persons opted for *statutory social insurance institutions*; the majority, or 52 per cent, preferred the *mutual insurance system*, which they considered to be more flexible and more transparent.

With regard to incomes, 113 of the 119 persons interviewed (95 per cent), said that they had a source of income, as against only six who had none. The source of income of the 113 persons mentioned was cyclical in nature in the case of 85 persons (75 per cent); it was income drawn from seasonal activities.

And as for their willingness to participate in the financing of any measures to extend social security, most of the persons who said that they had a source of income (95 out of 113), or 84 per cent, said that they were willing to join a contributory social security scheme as against 18 (16 per cent) who were not. They said that they were in favour of paying a financial contribution on a monthly basis (55 per cent) or each season (35 per cent).

Table 3: Desired periodicity of contributions

	Regions								
	Dakar		Kaolack		Fatick		Thiès		Total
	Informal	Rural	Informal	Rural	Informal	Rural	Informal	Rural	
Daily	0	0	1	0	1	0	0	0	2
Fortnightly	0	2	3	0	0	0	0	0	5
Seasonal	2	9	0	4	0	5	1	12	33
Weekly	1	0	0	0	0	0	0	0	1
Monthly	8	17	18	0	1	2	4	3	53
Other	0	0	1	0	0	0	0	0	1
Total	11	28	23	4	2	7	5	15	95

Source: May 2000 Survey by the Economic and Social Council

And finally, the persons who are willing to take part in a contributory social security system were prepared to pay an average monthly amount of between 965 and 1,438 francs. The average monthly amount of this contribution is higher for persons living in Dakar (between 1,142 and 2,123 francs) than for those living in the other regions. On the whole, this survey seems to reveal difficulties in contributing at the rates fixed by the Social Security Fund, at least in certain rural zones.

2.2.2 Analysis of the results of the survey

Although the survey carried out in May 2000 concerned a majority of persons in the rural sector, the results show that the persons interviewed were not well informed of social security mechanisms and consequently of the benefits provided. An information campaign organised at the community level will thus be essential to the success of the extension project launched by the

Social Security Fund. Social and traditional structures can serve as relays for spreading information in this context. It must be pointed out that health worries are the predominant concern, despite the solutions that are beginning to be introduced in this field.

The survey also provided information on occupational backgrounds. The likelihood of suffering a social risk is very high in the selection of persons studied: 98 of the 119 persons interviewed stated that they had been the victim of a social risk in the course of the 12 months preceding the survey. The risk occurring most frequently was illness (57 out of 98 persons), a fact which illustrates the precarious health situation of an important number of people in the rural and informal sectors and confirms the need to include the risk of health in the package of benefits provided by any scheme for these persons. Short-term risks (health, maternity, etc.) seem to be the primary social risks incurred - 74.5 per cent of the sample population. It is thus logical that 78 per cent of the persons interviewed wanted to subscribe to a system of protection that includes them. Consequently, long-term risks (old-age, disability, death) interested only 18 of the 117 persons, or 15.5 per cent.

Overall, the social security to be established for the rural populations should lay special emphasis on access to health care for children and women, who live in difficult conditions, since they have to take part in production in the fields as well as running the household.

The ten persons who were victims of an occupational accident—all working in the informal sector—were drivers (six of the persons interviewed) or were working as labourers or mechanics. This highlights the importance of *occupational risks* in this sector. The above data do not give reason to conclude that there are no employment injurys in the rural sector. On the contrary, this sector comprises a number of risks that are detrimental to people's health (chemical risks connected with the use of pesticides, lumber lesions caused by bad posture at work, etc.), but the people working in that sector know little or nothing about them.

According to the results of the survey, 75.6 per cent of the persons interviewed were not members of an association with an objective of financial or practical solidarity. Yet African countries are seen as highly associative societies with structural solidarity. “Tontines”, for instance, are renowned for their success in Africa. Perhaps the success of these systems should be placed more in perspective. In the sample population only 19 of the 119 persons interviewed, or 16 per cent, were members of tontines. At all events, tontines cannot provide an alternative to a social security system, since the objective of tontines is to build up savings and not to provide insurance against social risks.

With regard to *social security needs*, 98 of the 119 persons interviewed, or 82 per cent, had suffered damages in the 12 months preceding the survey. This percentage varied depending on the branch of activities - 86 per cent in the informal sector and 79 per cent in the rural sector.

With regard to *incomes*, the average monthly income of the persons interviewed ranged from 27,647 CFA francs to 48,780 CFA francs. However, this income structure is complemented by transfers received and by income from property. The average incomes of the persons from the rural and informal sectors included in the survey are low compared to the average annual per capita income registered in urban centres (416,423 CFA francs, or 34,700 francs per month). The mean income (ranging from 27,647 CFA francs to 46,780 CFA francs) means that it is not possible to adopt high contribution rates. It must be borne in mind that the SMIG is 36,245.3 CFA francs per month, and its must also be underlined that the incomes of the target groups are

not steady incomes: 71 per cent have cyclical or random incomes. Yet the cost of extending social security to the populations in the rural and informal sectors would involve a significant volume of funding.

The great majority of the persons interviewed considered that the costs incurred in covering the occurrence of social risks (health, accident, birth, etc.) are high. The question thus arises of the accessibility of health care (in monetary terms) for the target populations in general and for those in the rural and informal sectors in particular. The fact that there is no appropriate protection mechanism means that even though they are high all of these costs are covered by the persons involved or by means of family solidarity.

With regard to people's willingness to participate in the financing of any measures to extend social security, the propensity to join a social security scheme is very high (95 out of 113 persons interviewed - 84 per cent - stated that they were in favour of joining a contributory system). This denotes a remarkable development in mentalities in the rural zones, where, for socio-cultural and religious reasons, populations have always been reluctant to commit themselves voluntarily to a social insurance scheme in order to protect themselves against a number of risks.

The possibility of access to social security financing has often been raised - hence the need to design social security policies in harmony with programmes for access to credit. A simplified taxation system is also a requirement.

The study conducted by the Directorate for Forecasting and Statistics (DPS) shows the complexity of the Senegalese taxation system, which does not make life easier for businesses in the informal sector given the information that they are required to produce. In comparison, the taxes and levies paid by micro firms on the various marketplaces is a more efficient system. The collection of the levies on a day-to-day basis calculated on the basis of the floor space or area occupied is carried out without any great difficulty by supervisors and representatives at the various markets. In fact it is this type of collection on a daily or weekly basis that is practised by certain members of occupational associations that subscribe voluntarily to the insurance scheme offered by the Social Security Fund and by the MHOs.

And finally, the growth in resources of saving and credit mutual funds (achieved by strengthening deposits), which increased from F.CFA 13,469 billion in 1986 to F.CFA 17,332 billion in 1998, confirms that the securing of savings that have been built up, the obtaining of credit, and rejection by the classical banking system are the three main causes for the growth in the volume of the savings of the members of the micro finance systems.

It has transpired that various population groups in Senegal are generally prepared to contribute if they are given the guarantee that their money is well invested, if the benefits correspond to their priority needs, and if the administration of the system is reliable and sound—the priority social security needs of workers in the informal sector being health care costs, survivors' benefits, maternity and schooling for children.

3. Community initiatives and access to health care

3.1 Experience gained in extending the mutual insurance sector

3.1.1 Development of micro health insurance schemes

Analysis-by-risk reveals that currently there are two branches that are being extended by the formal system—on the one hand, family allowances including maternity benefit and employment injury risks, and on the other, by the mutual-benefit voluntary insurance system. If these modes of extension are applied throughout the country they can compensate for the limits of the classical system. These insurance systems share a number of features with the former ones such as being financed by the members, their representatives participate in the choice of risks to be covered and they are based on insurance and are technically and financially viable.

The micro insurance systems could in the long-term constitute new components of the social safety net situated between the contributory schemes and the usual social assistance. They are intended for people with lower incomes who, in the name of equity and solidarity, ought legitimately to enjoy the financial support of the public services. Furthermore, they could eventually constitute one of the channels for distributing social assistance.

3.1.2 Health situation

It is appropriate to take stock of the risk of health, the safety net available and the situation in the health sector, as well as the situation regarding the incidence of disease. An ill-health incidence rate of 38.4 per cent was registered for Senegal as a whole in 1999. The rate is higher, however, in rural areas than it is in urban zones (43.1 per cent and 31.2 per cent, respectively). Malaria remains the primary cause of ill health irrespective of region, accounting for almost 1/3 of the cases of disease (33 per cent).

The "Survey on priorities" conducted by the Directorate for Forecasting and Statistics (DPS) gives an indication of the prevalence of disease in the population. Of a population of 7,306,400 at the time of the survey, 1,313,500, or 18 per cent, of the total population stated that they had been ill during the 30 days preceding the interview. This rate reflects the prevalence of chronic, and the incidence of certain diseases during the post-winter period, which is characterised by new outbreaks of malaria, "flu" and skin disease. The ill-health prevalence rate, which is high, could be explained in part by the period during which the survey was conducted. There was an epidemic of skin disease between September and October in many districts in the suburbs of Dakar and in towns in the interior.

In the same period, 839,700 persons requested a consultation at least once for reasons of health, 391,000 of them consulting only once, 260,200 consulting twice and 188,500 consulting three times and more. Health posts are the type of facility which the majority of the population (415,200 cases) uses on the first visit. These are followed by hospitals and health centres (201,700 cases) and then private services and NGOs (64,400 cases) and, finally, traditional health practitioners. Doctors in private practice attend to only 39,500 of the visits requested for reasons of health.

Studies have also revealed that women fall ill more often and use the health services more frequently than men, and the survey results confirm this hypothesis.

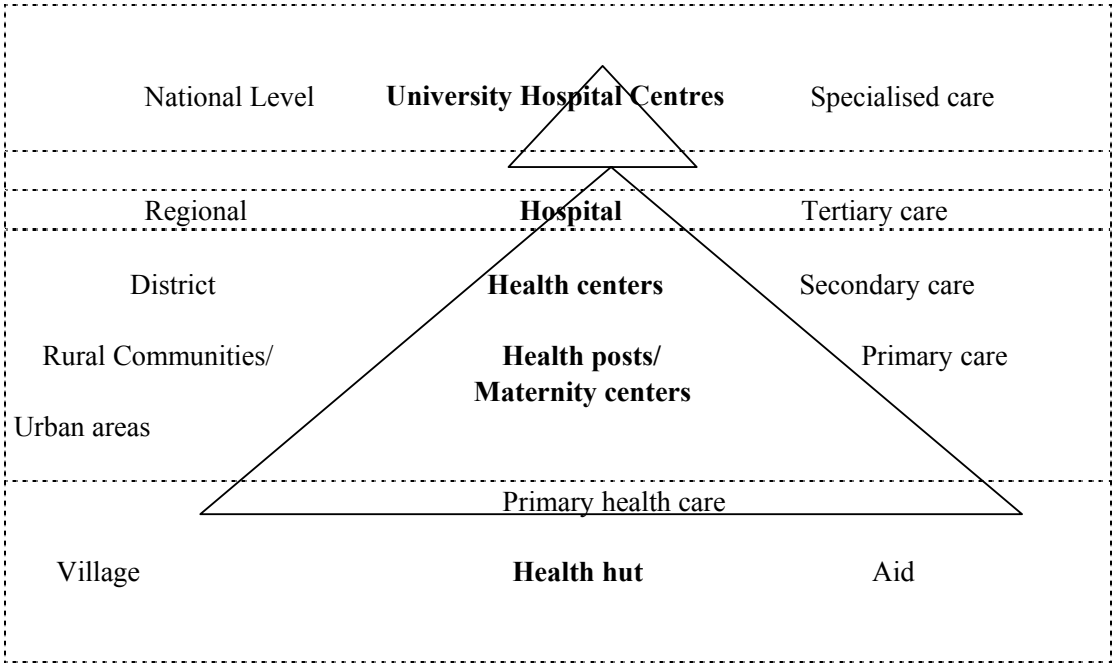
The death rate remains high despite the decrease that has been registered over the past few years. The crude death rate is around 18 per thousand, and life expectancy at birth is 54 years. The infantile mortality rate has decreased to some extent, dropping from 86.4 per thousand in 1986 to 68 per thousand in 2000. The maternal mortality rate is also high, estimated at 510 for 100,000 live births.

In order to study mutual health insurance systems and evaluate their impact in terms of efficiency, one needs to examine the care that is provided.

3.1.3 Health pyramid

The organisation of the health care system in Senegal and the definition of the types of health facilities come under the "Health Planning in Senegal" programme (*Programmation Sanitaire du Sénégal* - PSS) under which the national territory has been divided into a four-level hierarchy of territorial units with a view to coordinating action more efficiently. Each level has its own administrative entity, which is in charge of coordinating and monitoring all health activities and care structures.

Figure 1: Health care pyramid



Source: Author

The basic unit in the health pyramid is the health hut, where the village pharmacies are located. There are 1,384 such health huts in Senegal, which are often run by "community health agents" or by women, who often come from the local village.

The next level of the pyramid comprises health posts and maternity centres. It is at this level that primary health care is provided. There are 768 such health posts, which play an extremely important role, since they constitute the infrastructure that is most widespread and thus most accessible to the various population groups.

The intermediate level is the level where secondary health care is provided, the care unit being the Health Centre, which is run by a general practitioner with the assistance of a qualified midwife. The activities of the Health Centres range from consultations to in-patient hospital care.

Senegal is thus divided into 58 health districts, each of which has a Health Centre. Each region of the country has a hospital, which is under the authority of the administrative unit known as the "Medical Region", which constitutes the second referral level for the public and private health facilities in the region. The University Hospital Centres form the top of the pyramid and constitute the third referral level of the health infrastructures in Senegal.

In general, the five levels of the health pyramid are not often respected, since the population groups that can afford to consult a doctor directly prefer to do so. This situation results in an excessive workload for the hospital facilities, whereas certain complaints could be treated at the health post or health centre level, which would also be more cost-effective.

The above is the organisational context in which the mutual health insurance sector is evolving. The advantages obtained through these MHOs are many and varied and have been documented in studies and by surveys conducted in the target groups, some of which are noted below:

- easy, rapid and fair access plus the quality care which the mutual insurance scheme offers beneficiaries;
- the guarantee that the majority of the resource-poor population will have access to care on an equal footing with the "well-off" and that care will be more open to the public;
- the reduction of health problems as the result of health care, and the mobilisation of resources with which the operation of the care structures can be strengthened;
- varied and flexible responses to the concerns of society through the involvement of the main actors in the development of community health facilities.

3.1.4 Contribution of the health committees

The disintegration of the traditional social structures such as clans, groups or extended families, which formed the arena for coping with individual difficulties - particularly financial ones and access to costly care - has aggravated the health situation.

In actual fact the existing systems of resource-poor African States have never been able to provide universal or effective medical coverage for all of their populations, particularly the poorest groups, because they have lacked the means of doing so.

It is thus necessary to find other modern mechanisms that are transparent and incur the responsibility of all parties. The initiative to launch a strategy for primary health care in 1978 has meanwhile provided a means of identifying the fundamental role which individuals and communities must play in order to resolve their own health problems. This role cannot be limited to only one or several aspects; the only limiting factor that could be accepted would be the persons' ability to pay and their level of commitment. Individuals and communities have thus

been, or are in the process of being, involved in the overall process of resolving the health problems of the populations and in mobilising resources so as to implement the solutions. Throughout Africa, user fees charged by public health services have been an important contribution in certain zones since it has provided a means of financing up to 80 per cent of the cost of medicines and over one-third of the salaries of the care staff.

3.2 Development of associations and mutual health organisations (MHOs)

The development of MHOs has involved not only communities but also several national and international institutions. Programmes geared specifically to developing MHOs have been started by cooperation agencies such as the ILO, USAID, the GTZ (German Agency for Technical Cooperation), and the ANMC/WSM (Alliance Nationale des Mutualités Chrétiennes de Belgique/Solidarité Mondiale). The State has also taken a number of measures to create a legal and institutional framework that would define, organise and regulate the MHOs in order to guard against adverse developments. The involvement of cooperation agencies, research structures and the State in the community has been a key factor in the development of mutual insurance in Senegal.

Senegal has a long experience of community solidarity, which facilitates the adaptation of such schemes. The MHOs in Senegal have evolved in three phases.

- During the first phase, from 1990 to 1993, only 10 per cent of the MHOs came into being. The process then spread in the Thiès region, where several communities that were convinced by the experience of the Fandene mutual insurance scheme set up their own schemes. It was thus during this period that most of the MHOs were set up.

- The second phase, from 1994 to 1998, was the period when the mutual organisations were extended to other regions of the country. The system was codified and former community-type systems that had operated on the principles of mutual aid and solidarity were transformed into mutual organisations. This phase was marked by the ILO/ACOPAM programme, which focused efforts on improving knowledge and disseminating information on the mutual insurance experience more widely. As well, there were several initiatives taken by the Ministry of Health through its programme of support for MHOs (PAMS).

- The current phase, which has been underway since 1998, is marked by the tremendous popularity of MHOs:

    - both with the general public and with the State, which has set up a mutual health insurance support unit (CAMICS),
    - and with national and international development organisations - reflected in particular in the ILO programme Strategies and Tools against Social Exclusion and Poverty (ILO/STEP), Partnership for Health Reform (PHR), PROMUSAF (Programme des Mutualités Chrétiennes et de Solidarité Mondiale en Afrique) and ENDA-GRAFF programmes.

These programmes have contributed greatly to the dissemination of knowledge through the publication of information brochures, manuals and the organisation of training workshops and awareness days.

A distinction must be made furthermore between what are known as supplementary mutual health organisations and those that are known as *"au premier franc"* schemes (schemes providing full reimbursement).

- The supplementary MHOs are set up to cover the benefits that are not provided by the compulsory scheme. This is the case with the following mutual organisations—the FAGGU of the retired persons in the IPRES, the schemes of the Senegalese armed forces, the national police force, the Senegalese customs administration, the employees of the SOCOTIM - INDUSTRIE, teachers in higher education, etc.

- The MHOs providing full reimbursement are generally organised on a regional basis. This is the case with the mutual organisations which cover almost all in-patient care costs and which have been launched by village communities (Fissel, Fandene, Gandiol Sante), district communities (Dimbeuli Yoff, Thialy, Goxu Mbath) or associations of workers in the informal sector (Dyers' Mutual Health Scheme, the mutual organisation of the PROFEMU network, etc.).

It should be noted that the "Jeunesse-action" ("youth-action") team of the NGO ENDA (Environmental Development Action in the Third World) has managed to organise five associations for domestic employees in Dakar, one in Thiès and one in Kaolack. This system is open to over 1,800 persons and enables them to receive outpatient consultations and generic medicines in return for a flat-rate contribution of 100 to 250 francs a month.

In 1998, 29 MHOs were operational, 26 were in the pipeline and 3 were in difficulty. The inventory also identified 31 mutual insurance projects. Annex 1, Table 1, gives a detailed breakdown of the MHOs by type, sector, date of establishment, number of members and number of beneficiaries.

The survey conducted in 2001 revealed the following information:
number:
- number of operational mutual organisations: 102, 95 of which provide full reimbursement and seven are supplementary;
- number of mutual organisations in difficulty: 34, two of which are bankrupt;
- number of mutual organisations in the funding period: 16;

coverage:
- number of persons covered by the supplementary mutual organisations: 298,700;
- number of persons covered by the mutual organisations providing full reimbursement: 122,970;
- for a total number of 421,670 persons covered.

Health insurance institutions (IPMs) cover at least 700,000 wage/salary earners and members of their families. They constitute one of the primary sources of alternative financing of health care

in Senegal, because they are a compulsory model of health insurance that is decentralised despite certain management shortcomings.

3.2.1 Impact of the MHOs

It is important to evaluate the impact of the mutual organisations, the crucial question being to decide whether they provide the solution or whether they represent merely an alternative.

A study on access to health care in Western and Central Africa highlights the rapid development of mutual organisations as community or occupational organisations over the past few years. This rapid expansion will have aroused the interest of the populations, governments, NGOs and international organisations, particularly with a view to finding innovative answers to the question of how health care can be financed and how social security can be extended in the region.

The results of this study demonstrate firmly both the emergence and strong dynamism of mutual organisations in West Africa, and they have the following characteristics:

- they are generally small or medium-sized in terms of membership, over 60 per cent of the schemes studied having less than 100 members;
- most are very recent—at the time of the survey, two-thirds of the 50 mutual organisations listed had been in operation for less than three years;
- their activities concern only a small proportion of the population of the countries in question, although they have vast possibilities for development.

These evaluations have been confirmed to some extent by the community-level survey in the Thiès region in May 2000, a pilot zone in the creation and expansion of MHOs which enjoy a special relationship with the private Saint Jean de Dieu Hospital in that area. The survey, which was carried out by a team from the Institute for Health and Development in Senegal (ISED) and by an expert from the Centre for Development and Research (ZEF) in Bonn, provided a means of measuring the real impact of the MHOs in that region.

3.2.2 Samples for the 2000 Thiès survey

A total of 346 persons in the villages of Fandene, Mont-Rolland, Ngaye-Ngaye and Lalane-Diassap plus 300 patients in Saint Jean de Dieu Hospital were interviewed in the survey. The majority of the interviewees were Sérères (80.6 per cent), followed by Wolofs (13 per cent), Peulhs (4 per cent), and others (2.3 per cent); 63.3 per cent were Christians, and 36.7 per cent were Muslims.

The socio-economic level of the populations of these villages was taken into account. The proportion of persons who considered themselves poor was very large (37.9 per cent). This is perhaps reflected in the type of housing observed in the zone: 70 per cent of the persons interviewed were living in houses built of durable material (cement). Although the overall economic level of the populations concerned was satisfactory in terms of diversity and quantity of products, there were nevertheless disparities, the wealth seeming to be concentrated in the hands of a minority. Only 93 of the 346 persons interviewed grew groundnuts, the cash crop par excellence in the country; 79 of them kept cows, each owning an average of 6.7 heads of cattle.

Apart from the wealth factor, which is assessed by the existence of a house built of durable materials, radio was the only other factor that could be linked statistically with the probability of belonging to an MHO. Radio broadcasts obviously contribute to a great extent to informing the population and raising awareness in the various fields of development including that of mutual health insurance.

At all events, the overall economic level of the populations is not in keeping with the level of membership in MHOs. There ought to be more members. As several of the interviewees remarked, this phenomenon could be connected with a lack of information on MHOs, the poverty of some of the people concerned who cannot pay the contributions, but also with the types of pathology encountered most frequently in the zone. The medical complaints in the area are predominantly bacterial infections and parasitosis such as malaria in particular. Most of them do not require in-patient hospital care, particularly when they are treated in the early stages. As a result of primary health care, which is strengthened by the strategy of the Bamako initiative, most of the inhabitants of these four villages can afford to pay for the necessary treatment. They are also particularly sensitive to preventive measures applied locally within the means available. However, membership in a mutual insurance scheme is influenced by social factors such as ethnic group and religion. The Wolofs and Christians join such schemes more frequently than is the case with the other ethnic groups and religions. This difference is to be explained essentially by the higher level of information and awareness observed in these two population groups.

3.2.3 Results of the Thiès region

The following was observed in the opinion poll carried out amongst the members of mutual organisations (cf. Annex II for the relevant tables):

- The likelihood of access to the services of Saint Jean de Dieu Hospital is greater when one is a member of an MHO than when one is not.

- Given the limited means of the members of mutual organisations in rural zones, the frequency of common pathologies and the existence of procedures for reducing the cost of primary health care within the framework of the Bamako initiative, it is considered more advisable for the schemes to finance life-threatening illnesses although they are costly to treat.

- The majority of the persons interviewed (43.3 per cent) joined an MHO because they were convinced of the advantages the scheme would bring them, although 22 per cent stated that solidarity was the main reason for joining. The interviewees recognised that solidarity was a second important factor regarding membership in an MHO, solidarity that seems to be the alpha and omega of any mutual insurance process. For example, 82.1 per cent of the persons covered in our study confirmed that there was effective solidarity amongst the inhabitants of the four villages concerned. The third decisive factor in the forming of MHOs is the extent to which the target populations accept modern medicine. In certain zones of rural Senegal it has been shown that the local populations have much more confidence in traditional medicine than in modern medicine. The modern health structures that are set up in those areas are thus only used to a very limited extent despite the efforts to decentralise and to reduce the cost of services to a minimum. It is thus

difficult to promote MHOs in such circumstances, since the existing mutual organisations are geared to financing the health services provided in the field of modern medicine. The extent to which the health facilities in the zone studied are used clearly demonstrates that the populations concerned have completely adopted that form of medicine.

- The populations seem to have realised and understood the many different benefits of MHOs;

- Regular payment of contributions determines membership status and confers all of the rights offered by the mutual insurance scheme.

- Irregular payment of contributions, which prevents members from receiving the benefits provided by the mutual insurance scheme and deprives them of membership status, is one of the factors restricting the efficiency of the MHOs with regard to guaranteeing access to quality hospital care for those in greatest need.

- 10.4 per cent of the persons interviewed in the study found that contributions that are too high can make it difficult for people to join mutual organisations or indeed prevent them from doing so.

- On the other hand, when contributions are too low, the mutual organisations do not provide effective coverage of hospital care, which is costly for the members.

Furthermore, one of the indirect beneficial effects of the MHOs is that they help to raise awareness and contribute to the health education of their members. Through the discussion of health topics the very fact of belonging to a mutual organisation helps to educate people on health problems and the measures to be taken. The schemes can thus contribute effectively to promoting health and have a positive influence on the application of measures to prevent common diseases in the zone.

The influence of the MHOs on the number of people who frequent primary health care structures must also be included in this context. Where illnesses are essentially infectious diseases and diseases due to deficiencies, the mutual organisations can play a major role in the prevention of disease and in health promotion by guaranteeing that proper care is provided. The general environment is obviously one of the principal determinants in these pathologies, but behaviour, attitudes and practices that are harmful to health are also major factors. Preventive measures in this field are the State's responsibility as part of its action to resolve public health problems, but they require the participation of all other sectors, including that of the MHOs. They are at all events an opportunity for those schemes, since they provide a means of reducing their expenditure and increasing the productivity of their members.

Moreover, 45 per cent of the persons interviewed in the study were of the opinion that membership in an MHO had had a positive impact on their production activities (Annex II, Table 2). The guaranteed financing of care that is offered by mutual organisations means that the members and their families are spared the difficulties and constraints of mobilising funds when they fall ill. They thus gain time for attending to their economic and social activities. The MHOs thus have a favourable effect on the socio-economic circumstances of their members, as was indeed confirmed by the members of such schemes interviewed in the survey (Annex II, Table 3).

The following can be established from the results of the study:

1. It is actually possible to organise MHOs at the village level; that is on a geographic basis or on the basis of geographic affinity.

2. It is necessary to inform populations and to promote awareness of the various advantages offered by these schemes, and in particular the socio-economic advantages related to the prevention of disease.

3. The most decisive factors inducing people to join mutual organisations are economic in nature but also socio-cultural, depending on ethnic group and religion.

4. MHOs influence the productivity of their members by saving them the time and effort they would otherwise have to spend on to find funds to finance treatment.

5. MHOs play an effective part in the efforts to make costly hospital care accessible to the general population.

In this respect MHOs offer a number of considerable advantages, namely:

- The combination of insurance and solidarity, the insurance aspect of which is necessary in that when a risk occurs the member's health care is covered after payment of a contribution. There is also the solidarity aspect in that, although everyone contributes, only those for whom a risk occurs are indemnified. Many different forms of solidarity are created between those who are ill and those who are in good health, between the poor and the rich, between the generations, and amongst the various communities belonging to the scheme.

- Respect of the principle of equity amongst individuals: this equity means that people with the same needs would receive the same benefits and services.

- By virtue of equity, mutual organisations take account of social inequalities by setting the contribution rates of the various populations and by defining the scenarios for which services are provided. They generally use fixed contributions for that purpose. They do not make provision for payment in kind, even in rural zones. Although this is not to be criticised per se, in organisations that are run democratically the members ought to be given the option of paying in kind.

- Improvement of the care provided could be achieved by becoming veritable negotiating partners and making care financially accessible, and the MHOs can press for improvement in the quality of the care provided in the health structures.

- The mutual organisations could achieve greater efficiency in the allocation of resources within the health sector by encouraging better use of preventive care and health promotion services, particularly by using a compulsory reference mechanism.

- Apprenticeship in democracy, the principle behind mutual benefit schemes, demonstrates to people the values of transparent management and participation.

Furthermore, mutual organisations generally lack the bargaining power–and management skills necessary for adopting the most effective mechanisms for paying the care providers. In many cases the choice of care providers is too limited for any negotiation to be possible. The relative weakness of some mutual organisations in this field is due in part to the fact that they are young schemes, that they are also small schemes and that they lack management skills. This limits their bargaining power since it prevents them from exercising their function of representation as organised users in order to negotiate the quality of care and the rates to be charged for it. Schemes are generally viable when they have a high membership density, i.e. when membership is compulsory, the target group is reduced, and there is a high penetration rate (between 50 per cent and 100 per cent).

The MHO for voluntary teachers is an excellent example in this respect. The status of voluntary worker makes membership compulsory, and contributions are collected in advance for the entire duration of membership, which corresponds to the four-year period for which the worker is engaged, or 40,000 CFA francs. Families are not covered, but in-patient care is covered in full. According to the assessment indicators as a whole, the situation is satisfactory and indeed exemplary for the expansion of mutual insurance throughout the country.

3.2.4 Mobilisation of resources

Mutual organisations play a fundamental role in the mobilisation of resources, but they have tremendous potential in extending this role. Their contribution is currently limited by factors such as low penetration rate of the target groups, low levels of contributions, inadequate marketing, or the fact that the dates for payment of contributions are not synchronised with the periods when incomes are available. The possibility of paying the contributions in totality or in kind in the zones dominated by agro-pastoral activities would have permitted an extension of the community initiatives.

As regards efficiency in the allocation of resources, 20 per cent of the mutual organisations included in the study offer only services connected with primary health care, whereas 55 per cent offer only services connected with hospital care; only 25 per cent of the schemes offer services relating to both types of care.

Furthermore, most of the mutual organisations do not use a referral system.

With regard to equity, it was observed that contributions were established according to incomes (wages/salaries) in only one of the schemes studied. Almost all of the other schemes applied the same contribution levels to all of their members. Very few of the schemes have a membership composed exclusively of wage or salary earners. In the case of the other members it is very difficult to assess incomes, particularly in rural areas and in the informal sector. It is thus very complicated and indeed impossible to relate contributions to income levels.

MHOs play an important role in access to health care and extension of social security to deprived segments of the population, by targeting essentially people in the informal sector and in rural

areas (73 per cent of the schemes). They contribute actively to equity in access to care in the regions where they operate.

4. Conclusions and prospects

4.1 Strengthening the extension of social security

On the basis of the data obtained in the study, guidelines can be summarised for strengthening the social security system for non-wage-earners.

First, with regard to the general trend of extending the protection of target groups, coverage has been strengthened:

- in the formal system through the efforts of the Social Security Fund with a view to insuring all wage and salary earners; this is evidenced by the appreciable increase in the number of employers affiliated to the scheme despite the employment crisis;
- through opening the formal schemes to persons wishing to join voluntarily and moving away from the exclusive coverage of wage and salary earners;
- by taking the example of the first categories of urban and rural populations, which are henceforth included in the group of protected citizens, at least for the risk of health - a factor which is an incentive to respond to the requests of the sectors that have hitherto been excluded from any form of protection.

Furthermore, the experiences of micro voluntary insurance schemes seem to correspond to the spirit of independence of the informal sector despite the widespread opinion that compulsory insurance is the only means of ideal coverage from the point of view of personal and substantive scope and of providing services which are not yet covered either by the formal system or by the mutual insurance system.

The priority should be to guarantee both retirement pensions and general forms of health insurance. This priority should also concern the coverage of the occupational accidents and diseases typical of activities in the informal sector and possibly services and/or benefits for families in order to promote education and, more generally, the productivity of human resources at the national level.

The crucial issue is thus that of policies for promoting insurance schemes. In economies such as that of Senegal, it would be unrealistic to expand contributory social security without tackling the causes of poverty and without establishing a system for generating incomes, namely by developing micro finance and then integrating micro insurance into micro finance.

The most effective approach to extending social security is to take action both within and outside the framework of institutional social security thereby distributing roles between the latter, the State and civil society through community initiatives.

The statutory social security system has set up voluntary insurance schemes for the benefit of those employing labour in the informal sector. Appreciable results can be obtained through consolidation of the existing system by considering both those who have been evading their

social obligations and also new categories of persons to be insurable simply through the presumption of dependent employment.

One question that is as yet unanswered is how to extend social security as far as possible without pretending to provide universal coverage in the short term. The answer presupposes that the plan of action drafted by the CSS be continued first of all and that the public authorities commit themselves to policies for promoting insurance, and in particular for promoting a structured mutual benefit approach.

4.2 The extension of social security and income-generating programmes

The sustainability of the systems that are established cannot be ensured unless policies are implemented to promote employment and/or the incomes that are essential in view of the low ability of the populations that are not yet covered to pay contributions. This interlinking of extension "policy" and income-generating programmes can be achieved in Senegal through the programmes that are already running:

- The "Action to raise incomes" component of the Strategy for Fighting Poverty of the National Plan for Health and Social Development (PNDSS), which aims to transform the policy of dependence on welfare implemented in the Social Action sphere into action to step up income-generating activities for deprived population groups.

- The Programme for Supporting Mutual Savings and Credit Funds, which aims to promote access to decentralised financial services for a segment of the population hitherto excluded from the banking system through the network of mutual savings and credit funds, which promote job creation and generate incomes and thus make it possible for non-wage-earners to pay contributions to the social security schemes, and to combat exclusion phenomena.

The joint action of the State - through the PNDSS - and the local communities, which participate to a very great extent in the financing of the public health system and of the structures for access to primary health care, would make it possible to establish a minimum of social protection as a strategy for reducing poverty. Two sectors have proved to be of primary importance for achieving this:

- the health sector, where measures to strengthen the means of the Directorate for Social Action for the benefit of the vulnerable classes are essential, as are measures to facilitate access to health care, which is still difficult despite the constant efforts of the State to provide primary health care and the effectiveness of the policy to promote the participation of the various population groups;

- the old-age pension sector, where it is urgent to ensure a minimum old-age pension both for retired wage and salary earners and for non-wage earners in order to alleviate the phenomenon of impoverishment and the anxiety caused by financial insecurity. Although the State budget necessarily has to be used for State employees and for the vulnerable

classes, certain persons who have an income say that they are prepared to participate in a voluntary pension scheme.

In view of the systems that have already been set up, the sharing of responsibilities is now well established. This is in keeping with the Bamako Initiative, in support of which the State and the population have already joined forces. The actions launched by various groups or communities to provide social insurance must now be promoted. The aim being to find a solution to the double challenge of improving the health of the populations and finding a sustainable means of financing care for those who are deprived of health insurance).

4.3 The institutional environment for the MHOs

As regards the promotion of MHOs, the example of a successful experiment is a strong incentive for setting up such schemes, as has been demonstrated by the scheme launched in the Thiès region, where the network of mutual organisations is the densest in the entire subregion. Several factors have thus helped to make the institutional environment more conducive to the development of MHOs over the past few years. The Government should thus devote more attention to the role played by these structures in terms of mobilising resources and improving access to care.

The fact is that a legal framework is keenly awaited in Senegal with a view to clarifying, regulating and guaranteeing action to redefine the relationship of such schemes with the support structures, which have played a leading role in the efforts to build up their organisational capacities and to continue the synergism amongst the various actors through the framework provided by the "Consensus-building" initiative of the ILO/STEP programme.

Senegal has taken original initiatives in this context such as the special scheme for MHOs within the formal system—the Bamako Initiative—that concerns the financing of basic health care. The mutual organisations can thus serve as examples for developing the mutual benefit movements in Senegal and can be tried out in other sectors of economic and social life for the benefit of other segments of the population.

4.4 Constraints and prospects

In view of the necessary links between any mechanism aiming to extend social protection and the formal social security system, the main question is how to promote new forms of coverage when the existing forms have not yet fully met the needs of their beneficiaries.

Furthermore, the problems of financial barriers within the mutual organisations and the support structures will have to be resolved. The financial constraints in the MHOs are widely denounced as being one of the factors restricting their development. As seen, the fact that households do not have sufficient resources at their disposal is a factor preventing people from joining a mutual organisation or, in the case of those who are already members of such a scheme, from paying their contributions regularly.

The insurance scheme for voluntary *teachers* is intended for an educated group of persons whose incomes are moderate but who are due to become civil servants or salary earners in the modern sector and whose status is thus temporary. The situation of voluntary workers could be approximated to that of students, for example, and the establishment of a university MHO could

thus be considered. And the voluntary workers covered by such a scheme could then become resource persons who could promote awareness of the mutual benefit movement throughout Senegal.

The mutual organisation for *retired persons* can serve as a model for creating supplementary mutual organisations for all categories of persons who already have health insurance coverage - generally wage and salary earners in the modern sector and civil servants.

And finally, mutual organisations established at the *village level* prove that such a scheme can work despite the low level and irregularity of the incomes of its members. These experiments can be useful in rural zones but also for the informal sector in urban areas.

The operating method of these three types of mutual organisations can be adapted to other contexts in order to extend health coverage to the majority of the Senegalese population. This development can only be achieved with strong institutional support and regular accompanying measures. It is absolutely essential to circulate information widely on the experience gained with the schemes in order to promote and explain the principles of mutual benefit insurance.

4.5 Measures for supporting the extension project

In the defining of new institutions, other forms of social security and new lines of action for State representatives, trade unions and employers, the creation of a support service could be planned in order to help small producers and the managers of micro enterprises, the objective being first of all to get the trades properly involved (self-organisation) and then to develop a mutual savings and credit system (as an anchor) with a view to subsequently incorporating social coverage (social services) into that system.

The application of appropriate solutions to specific target groups (custom-tailored social insurance scheme) will have to be founded on the existence of a dynamic association based on confidence on the one hand (agricultural cooperative, federation of associations, for example) and, on the other hand, on an administration that is able to collect contributions and to pay benefits. Collective membership will have to be promoted in order to rely on social pressure and the discipline essential to the efficient functioning of the group; individuals could be entitled to a limited number of services in a given period in order to avoid abuse of the system. And action must be taken to involve further NGOs and religious organisations, which play an important role with regard to sensitisation.

And finally, measures will need to be taken to promote:

- an experimental approach,
- an efficient participatory approach focusing on communication,
- an information and management system that is suited to needs as well as monitoring performance indicators,
- a strategy for containing expenditure and recovering contributions.

4.6 Towards a viable strategy

It has transpired that the populations that have hitherto been excluded are prepared to contribute to a social insurance scheme when they can gauge its effectiveness and when the services

provided correspond to their priority needs. It has also been clearly demonstrated that the ability to pay contributions is not the essential factor for the success of mutual organisations. What is essential is that the level of benefits be in keeping with the means that are available and that this principle be stringently respected. Calculations must allow for a marked increase in the consumption of medical services in the first few years. The establishment of health insurance coverage considerably changes behaviour, and it takes several years for the frequency with which the services are used to stabilise. These results have been observed in the mutual organisations included in the study, and they are significant with regard to the role played by mutual organisations in access to health care.

There are other factors that are vital for the viability of a mutual insurance scheme. Transparent management, the dedication of the persons in charge, and the confidence that is placed in them are essential, since the slightest doubt as to the integrity of the administrators can cause the collapse of the entire scheme. Social control and close contact between the administrators and the members of the scheme also play an important role, limiting arrears in contributions and reducing the number of cases of abuse and fraud - and this monitoring must of course be accompanied by rigorous management. And finally, a high penetration rate can be achieved through measures to raise awareness.

The mutual organisations must collaborate as closely as possible with care providers. This will enable them to obtain reductions in charges, to introduce the system of direct payment by the insurance schemes, and to control the consumption of medical services and the quality of the care provided. Unless agreements are reached on these issues, mutual organisations with very limited financial resources, such as the Lalane Diassap scheme, would never come into being. The reductions in rates granted to that scheme enable it to provide important guarantees for a population that is unable to pay high contributions.

The Senegalese government is well aware of the fact that initiatives are dispersed. Although the impact of action on MHOs is visible, it is less evident when it comes to the health committees, not to mention the IPMs. Restructuring projects have therefore been launched, aiming primarily to create regional coordinating units and technical associations in order to expand and, in particular, to rationalise all of the initiatives taken.

It can thus be stated in conclusion that society can act collectively to strengthen income security by providing other means of compensation in view of the implacability of market forces. Social security will thus help to stabilise demand in periods of crisis and, above all, to limit social tensions. It will provide a means of improving the welfare of the populations that have been the victims of exclusion and of creating a climate of confidence, which will promote economic development.

Annex 1: Situation of mutual health organisations and projects in Senegal

Table 1

N°	Name	Operation status	Type	Sector	Established	No. of members	Beneficiaries
01	Fandène	Operational	Com	Rural	1989	287	2,096
02	St Jean Baptiste	In difficulty	Com	Urban	1992	350	1,752
03	Koudiadiène	Operational	Com	Rural	1993	400	2,227
04	Lalane/Diassap	Operational	Com	Rural	1994	250	1,196
05	Sanghé	Operational	Com	Rural	1994	87	461
06	Ngaye ngaye	Operational	Com	Mixed	1994	225	1,210
07	Mt Rolland	Operational	Com	Rural	1994	456	5,400
08	Faggu	Operational	Corpo	Urban	1994	1,175	
09	Pandhiénou	Operational	Com	Rural	1994	207	1,283
10	Thially	Operational	Com	Urban	1995	142	339
11	Mboro	Operational	Com	Urban	1996	242	1,116
12	Sopenté	Operational	Com	Rural	1997	355	2,500
13	Wer werlé	Operational	Com	Mixed	1998	196	1,000
14	Diappo	Operational	Com	Mixed	1998	293	1,800
15	And Faggru	Operational	Com	Urban	1999	135	455
16	Médina Gonass	Operational	Com	Urban	1998	310	
17	Wer werlé	Operational	Com	Urban	1998	335	886
18	Santé Yalla	Operational	Com	Urban	1998	243	1,500
19	Tazawudus shubaan	Operational	Com	Urban	1998	15	200
20	Enseignants du Supérieur *(Teachers in higher educ*	Operational	Com	Urban			
21	*Gendarmerie Nationale (national police force)*	Operational	Corpo	Urban	1984		
22	Volontaire de l'éducation *(volunteer teachers)*	Operational	Corpo	Urban	1995	7,000	28,000
23	M.Assistance Education	Operational	Corpo	Urban	1987	1,100	4,400

24	Dimbali Yoff	In difficulty (has stopped operating)	Com	Urban	1993	150	750
25	Douane Sglaise	Operational	Corpo	Urban	1997	388	1,000
26	Forces Armées	Operational	Corpo	Urban			
27	Goxu Mbaadj	Operational	Com	Urban	1999	135	675
28	Gandiol santé	Operational	Com	Rural	1997	388	1,000
29	Gouloumbou	Operational	Com	Rural	1996	475	1,075
30	Unacois/Mbour	In the process of establishment	Corpo	Urban	2000	450	2,250
31	Fissel	Operational	Com	Rural			
32	MUTEM/UDEN	In the process of establishment	Corpo	Urban	1997	1,308	
33	Tivaouane	In the process of establishment	Com	Urban	2000		
34	Baback	In the process of establishment	Com	Rural	1999		
35	Château d'eau	In the process of establishment	Com	Urban	2000		
36	Bargny (Farlu)	In the process of establishment	Com	Urban	1999	52	
37	FENAGIE-Thiaroye	In the process of establishment	Com	Urban	2000	554	
38	FENAGIE-Bargny	In the process of establishment	Com	Urban	1999	381	
39	Suture	In the process of establishment	Com	Urban			
40	Thieurigne	In the process of establishment	Com	Urban			
41	Administration pénitentiaire *(prison administration)*	In the process of establishment	Corpo	Urban	1997		
42	Malika	In the process of establishment	Com	Urban	2000		
43	Guinaw Rail	In the process of establishment	Com	Urban	2000		
44	Khar Yalla	In the process of establishment	Com	Urban			
45	Ouakam/PAFEO	In the process of establishment	Com	Urban	2000		
46	Teinturières	In the process of establishment	Com	Urban	1996	32	160
47	Koungheul Maly	In the process of establishment	Com	Urban	1999		
48	Koungheul Ville	In the process of establishment	Com	Urban	1999		
49	Koungheul Escale	In the process of establishment	Com	Urban	1999		
50	Koungheul Santhie	In the process of establishment	Com	Urban	1999		
51	Koungheul B M Coura	In the process of establishment	Com	Urban	1999		

52	Koungheul Campement	In the process of establishment	Com	Urban	1999
53	Koungheul Diameguène	In the process of establishment	Com	Urban	1999
54	Keur Malum	In the process of establishment	Com	Urban	1997
55	Bokk Jeff	In the process of establishment	Com	Urban	1996
56	Koundam	In the process of establishment	Com	Urban	1996
57	Enfant de la rue	In the process of establishment	Com	Urban	1996
58	Alwar/kandialan	In the process of establishment	Com	Urban	1997
59	Peyrissac	In the process of establishment	Com	Urban	1997
60	Lyndiane	In the process of establishment	Com	Urban	1997
61	JROK	In the process of establishment	Com	Urban	1997
62	Bambylore	In the process of establishment	Com	Rural	2000
63	Book Yénné	Project	Com	Urban	2000
64	N. Dame Fatima	Project	Com	Urban	
65	Thiès none	Project	Com	Urban	
66	Ressortissant Galoya	Project	Com	Urban	
67	Guédiawaye	Project	Com	Urban	
68	Book Yénné	Project	Com	Urban	
69	Notto Gouye Diama	Project	Com	Rural	
70	Réseau FENEGIE (Fenegie network)	7 Projects			
71	Réseau Caisses GRAFF (network of GRAFF funds)	17 Projects			

Annex 2: Results of the survey on the impact of the mutual health organisations in the Thiès region

Table 2.1 Opinions of the persons interviewed on whether there was solidarity amongst the inhabitants of the villages concerned

Existence of solidarity	Absolute no.	Percentage of the total	Percentage of the respondents
No	59	17.2	17.6
Yes	276	79.8	82.1
Don't know	1	0.3	0.3
No reply	10	2.9	-
Total	346	100.0	100.0

Table 2.2: Number of replies to the question: "Why has your membership in the mutual insurance scheme influenced your production activities?"

N°	Replies obtained	Absolute number	Percentage of the total	Percentage of the respondents
1	More time for work because less problems of sickness	19	17.8	17.9
2	More time because it is no longer necessary to hunt around to find the money to pay for treatment when ill	21	19.6	19.8
3	More time because complications in the illness requiring hospital care are no longer expected and the treatment is thus quicker	10	9.3	9.4
4	Peace of mind with regard to illness; one can attend to one's work properly, because any member of the family who falls ill can obtain proper care without delay	54	50.5	50.9
5	Other reasons	2	1.9	1.9
6	No reply	1	0.9	
7	Total	107	100.0	100.0

Table 2.3: Number of affirmative or negative replies to the question: "Does your membership have a favourable impact on your production activities?"

Replies obtained	Absolute number	Percentage of the total	Percentage of the respondents
No	78	32.8	34.5
Yes	130	54.6	57.5
Don't know	18	7.6	8.0
No reply	12	5.0	-
Total	238	100	100.0

Table 2.4: Economic level and membership in village mutual insurance scheme

Replies	Member of the village scheme		Non-member		Total	
	No.	%	No.	%	No.	%
Rich	18	7.6	7	6.5	25	7.2
Average	152	64.1	37	34.3	189	54.8
Poor	67	28.3	64	59.3	131	38.0
Total	237	100.0	108	100.0	345	100.0

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