


Innovations in mutuality: challenges and learnings for the Universal Health Insurance Plan in Mali

Laurence Touré,¹ Pauline Boivin,¹ Yacouba Diarra,¹ Seydou Diabaté,¹ Valéry Ridde ^{2,3}

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¹Miseli, Bamako, Mali
²Ceped, Université Paris Cité, IRD, Paris, France
³Institut de Santé et Développement, Université Cheikh Anta Diop, Dakar, Senegal

Correspondence to
Professor Valéry Ridde;
valery.ridde@ird.fr

ABSTRACT

Background Many Sahel countries in Africa are looking for solutions for universal health coverage (UHC). Mali is in the process of adopting the Universal Health Insurance Plan, which allows for the mutualisation of existing schemes. Its operationalisation requires numerous adjustments to the current mutualist proposal and innovations in the system. The study focuses on innovations experienced in mutuality and their conditions of scale for UHC in Mali.

Methods This is qualitative research by multiple case studies. It is based on the collection of data by interviews (n=136), at a national and local level, on the analysis of documents (n=42) and a long field observation (7 months). The analytical framework concerns the dissemination and maintenance of health innovations (Greenhalgh *et al*, 2004).

Result The analysis of this innovation shows an interest in the technical and institutional viability that determines its performance and scale-up. The procrastination and scepticism displayed at the highest level of the state and the international level, the reluctance, both financial and ideological, to renew the old mutualist proposal, penalise this Malian experiment.

Conclusion This innovation is a decisive step in ensuring the health coverage of Mali's agricultural and informal sectors. The reform will need to be amplified and supported in the future to expect the scale-up of a cheaper, technically and institutionally more efficient system. Without a political intention to mobilise national resources and accept a fundamental paradigm shift in health financing, the search for the financial viability of mutuality may, again, be at the expense of the performance.

INTRODUCTION

In addition to the security challenges, Mali has faced over the past decade and which have had a significant impact on its health system,¹ it faces many obstacles in finding solutions to strengthen its health system and universal health coverage (UHC).

However, various sociohealth reforms have been driven and encouraged by international technical and financial partners.^{2,3} In the 1970s, Mali introduced primary healthcare. In the

WHAT IS ALREADY KNOWN ON THIS TOPIC

- ⇒ Community-based health insurance (CBHI) has failed to protect populations in the Sahel's agricultural and informal sectors.
- ⇒ The Sahel countries are reforming their mutualist proposal from the perspective of UHC.

WHAT THIS STUDY ADDS

- ⇒ The experimental conditions of the pilot CBHI reform programme are the main obstacles to the system's innovation.
- ⇒ The financial viability of an attractive CBHI scheme for the target population requires optimising the technical reform, organisation and institutional commitment.
- ⇒ The non-systemic approach and the lack of communication, collaboration, and involvement between national and local actors hamper the development of a performative mutualist system.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

- ⇒ The pilot project, freed from CBHI principles and in a region disturbed by insecurity, could lay the foundations for an effective and sustainable system for health coverage in the informal and agricultural sectors.
- ⇒ The national Universal Health Insurance Plan must provide a framework to initiate a reflection on the reform of mutuality and the health system.

1980s, the country generalised direct payment in community-run health centres,⁴ such as Benin, Guinea or Niger.⁵ While this policy has ensured better geographical availability of essential generic medicines, it has yet to be able to improve access to care.⁶ In the 2000s, Mali embarked on reforms focused on the demand for care by organising payment exemption policies.^{6,7} The effectiveness of these policies in West Africa varied greatly⁶ with notable successes in Burkina Faso,⁸ failures in Niger⁹ and challenges in Mali.⁷

The Universal Health Insurance Plan (UHIP, RAMU in french) is the latest and

arguably the most ambitious social reform proposed. It requires the merging of the various social protection systems against sickness (Compulsory Medical Insurance: AMO), Mutuality (community-based health insurance: CBHI), Medical Assistance Scheme (for the poorest: RAMED), User-fees exemption policies) under the aegis of a single par-public body, CANAM (National Health Insurance Fund). The aim is to pool resources and risks through concerted intervention management and a reduction in transaction costs.

Given the low coverage of public health insurance in Africa, international partners began testing the organisation of community-based health insurance (CBHI) as early as the 1990s. Despite some relative successes for their (rare) beneficiaries in Benin,¹⁰ for example, they remained on a small scale, protecting only a tiny proportion of the population.¹¹ Today, 9% of the people in Kenya and 5% in Senegal are members of a CBHI,^{12 13} despite an ambitious policy of UHC for the past 10 years.^{14 15} Thus, in their initial form of voluntary membership and community management, CBHI failed to deliver on their promises.¹¹

Several countries are currently trying to innovate and change how they operate. Research has shown that the presence of professional managers is a factor in the performance of CBHI.¹⁴ Work in the Democratic Republic of Congo in the 1990s prompted the creation of larger-scale CBHI, particularly that of the health district.¹⁶ However, only some countries have embarked on this dissemination. Senegal has transformed from communal CBHI to departmental CBHI. This transformation has proven to be effective in increasing coverage.¹⁷ In Rwanda, local CBHI moved to a national network in 2006 with a complete operation change. Membership in CBHI is not compulsory. However, it is mandatory to be insured by one of the existing schemes, which represents a solid constraint for membership. The professional management of CBHI is under centralised governance.¹⁸ But they still face equity challenges, especially in protecting the poorest despite membership subsidies.¹⁹

While research on CBHI and insurance systems in Africa has focused heavily on the determinants of membership or how they operate,^{20–22} more work needs to be taken to understand current innovations (larger-scale structuring, professionalisation, incentive/obligation to membership, etc). Although since Rogers' proposals,²³ there have been numerous analyses of health innovations, such as Greenhalgh *et al's* famous meta-analysis,²⁴ studies in West Africa on social²⁵ innovations in health systems remain rare^{26–28} unlike technological innovations.²⁹

This study aims to understand the conditions for experimentation and possible scale-up of innovations in the field of a CBHI proposal in Mali in the context of UHIP.

METHODS

Study setting

The Malian state has renewed its trust in CBHI to cover 78% of the population, despite a low performance and lack of alternatives deemed acceptable. Meeting this challenge,

Table 1 Presentation of the experienced mutualist system and offer in Mali (*in italics the innovations*)

Cofinancing of contributions (subsidies)	State: 50% co-financing <i>AFD/PADSS2: additional co-financing of 30%</i>
Membership	Voluntary membership 1000 FCFA (€1=FCFA655 957) membership per 15-person membership unit Annual individual membership fee: FCFA1730 or 20% of the total contribution of FCFA8650.
Package of treatments	All generic, <i>antimalarial drugs: generics and specialties</i> , <i>All public and community health facilities</i> Third-party payer: 70% of outpatient fees and 80% in hospitalisation <i>Third-party payer: for 100% of obstetric and neonatal emergencies</i>
Professionalisation	<i>Team: coordinator, accountant, manager, development assistant, medical adviser</i> <i>Management software, computerisation</i>
Structuring	<i>Mutual Circle/District and Communal Antennas</i> <i>Mutual offices at the municipal level</i> <i>Board of Trustees of the Circle-wide Mutual</i>
Partnerships	Agreement with health facilities
AFD, French Development Agency; PADSS2, Programme of Support for Socio-Health Development, Phase 2.	

therefore, required tackling both the problems of operationalising this policy and the low attractiveness of the mutualist package proposed since the 1990s. The national strategy for extending health coverage to agricultural and informal sectors by CBHI laid³⁰ down the principles of this reform in 2010. The Health Financing Strategy for UHC will be developed in 2013³¹ and the RAMU law in 2018.

In the context of the slow maturation of RAMU, in 2015, a pilot experiment was initiated as part of the Programme of Support for Socio-Health Development, Phase 2 (PADSS2), funded by the French Development Agency. It incorporates a large number of proposals from the Strategy. It provides attractive membership conditions and offers, professionalisation of the service and deployment of CBHI on a broader scale (table 1).

Study design

This study is qualitative research by multiple case studies with several levels of analysis. The cases are the CBHI, MICBA (Interprofessional CBHI of the Bandiagara district) and MICMO (Interprofessional CBHI of the Mopti district), which implement the innovations. They are implemented in two circles in the same region of Mopti: Bandiagara and Mopti. The analysis levels correspond to the conceptual framework's geographical scales and dimensions. Mali is organised administratively into regions, cercles and communes.

Conceptual approach

We used the conceptual framework of Greenhalgh *et al*²⁴ for disseminating and maintaining health innovations

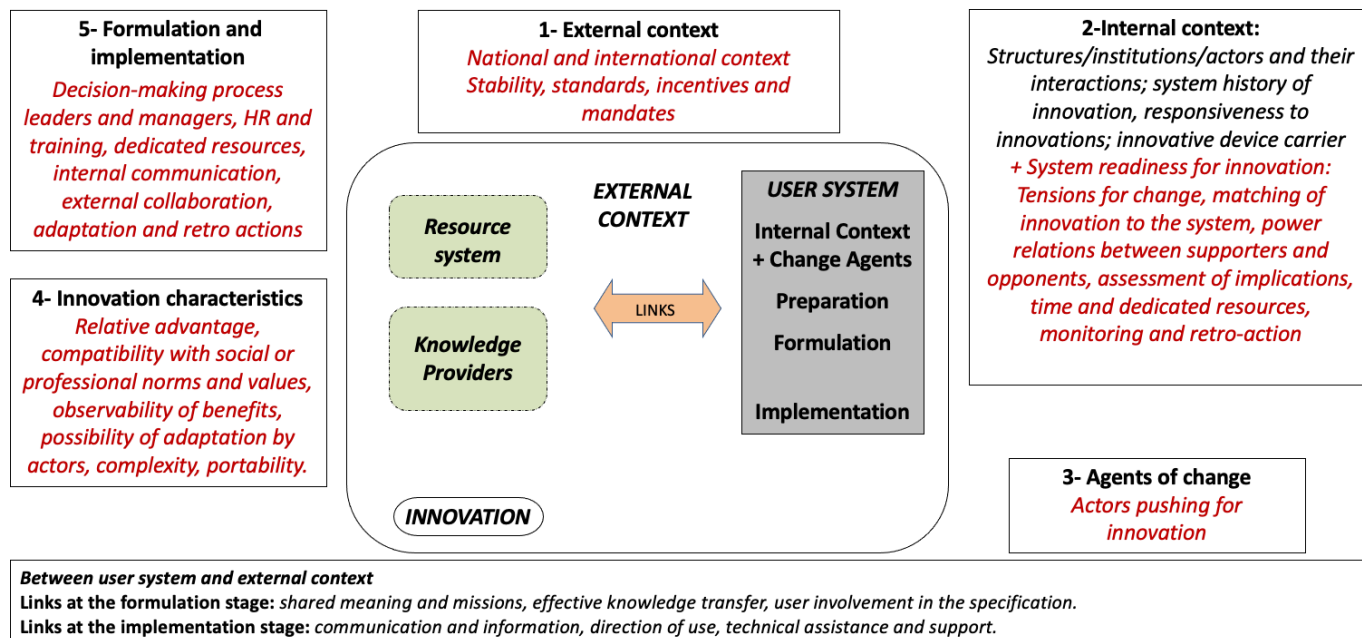


Figure 1 Analytical framework.

adapted to the purpose of our research (figure 1). The authors point to the fact that many promising innovations in the field of health have resulted in unsuccessful attempts to scale up. They produced a framework for analysing the dissemination and maintenance of inventions, helping to predict and evaluate their success, taking into account different dimensions to be studied (box 1).

Sampling and data sources

The surveys were conducted from October 2019 to December 2021, and several data collection methods were used (table 2).

Interview sampling strategy

At the national level, we interviewed the leading executives involved in mutuality, the RAMU and the PADSS2 programme. At the level of the circle, we met with the actors involved in the reference health centre (district

hospitals), the boards of administration of CBHI, and the Technical Union of Mutuality (UTM) regional coordinators.

Box 1 Adaptation of the conceptual framework to the context of the study

The external context is the international, national or local influences exerted on the experiment and may impact its scale-up. The internal context is the sociohealth sector. It includes the history of the mutualist system in terms of innovation, the institutions that constitute it, the interactions between actors/institutions, their responsiveness to change and the state of preparation of the sociohealth system for innovations. The actors of change are the two actors that have pushed for innovation and enabled it to materialise: (1) a group of experts responsible for the operationalisation of RAMU and (2) Programme of Support for Socio-Health Development, Phase 2 (PADSS2). The characteristics of the innovations are those of the innovative mutualist system experienced in the PADSS2 and able to influence its adoption. Formulation and implementation are the actions undertaken during the stages and activities of this mutualist programme.

Table 2 Data collection methods

136 in-depth and semistructured individual interviews (10 with women)	Technical Union of mutuality (UTM): national Directorate: 23 and Mopti Regional coordination: 6 State: 7; Expert Group: 8 Civil society and partners: 5 PADSS2: 5 Elected mutualists: 43 Local partners (mayors): 6 Mutualist members: 30
Documentation (42 documents) (See online supplemental appendix 1)	Legislative and regulatory texts, national policies and strategies, strategic plans, study reports, articles
National workshops observations	Finalisation of the UTM Strategic Plan in November 2019 Validation of the national strategy for extending health coverage to agricultural and informal sectors by CBHI, Koulikoro, December 2020 Consultation on CBHI experience in Mopti, January 2019, PADSS2 steering committees
In situ observations and informal interviews	7 months, 6 missions, 2–4 research assistants, in 6 communes of the 2 circles.
CBHI, community-based health insurance; PADSS2, Programme of Support for Socio-Health Development, Phase 2; UTM, Technical Union of Mutuality.	

At the local level, we selected six municipalities, three per circle. These are the municipalities of Mopti, Sio and Socoura in the circle of Mopti and the municipalities of Bandiagara, Dourou and Soroly in the circle of Bandiagara. These municipalities were chosen to vary the contexts: performance of the communal section of the CBHI (membership rate), the performance of the Community Health Centre (CSCoM, primary health centre) (frequency) and the urban or rural character of the municipality. The insecurity factor forced us to exclude some of the municipalities initially retained. In these six municipalities, our interlocutors were the mayors, the elected representatives of the six communal CBHI sections, effectively involved in the activities of the CBHI society, the health professionals of the CSCoM and the mutualist members. The sample of mutualists was randomly selected from the membership base of CBHI by telephone.

The observation phases were organised in the same municipalities and at the level of the regional coordination of the UTM. We have chosen to follow in their activities the main professional actors recruited by the UTM at the rate of one whole week per observation post: six managers, three development assistants, two medical advisers, the coordinator and the central manager. We also observed 1 week in each of the six health centres in the selected municipalities. Finally, at the end of 2019, two assistants followed the week of intensifying awareness-raising activities and enlisting CBHI to observe the interactions between elected mutualists and CBHI professionals. Systematic and daily notetaking of all these observations was made.

Analysis

We fully transcribed all the interviews in French and entered observation notes. Those data were analysed manually in light of the dimensions of the conceptual framework.³² The authors' reflexivity statement has been added as online supplemental appendix 2.

RESULTS

We will present the results for each dimension of the conceptual framework. Table 3 gives the overall summary of the analysis.

External context

UN organisations have long resisted implementing social policies.³³ As part of the promotion of UHC, from 2010 onwards, they declared themselves in favour of social protection and promoting health insurance in the countries of the South.

However, there are divergent views within the international community on the policies to be prioritised to achieve UHC.³⁴ International partners encourage health and social policies that often compete.³⁵ Sceptical about the capacity of CBHI to cover the informal and agricultural sectors, external support tends to focus

Table 3 Summary of empirical results

External context	The international and national contexts are a barrier to the scale-up : (1) ambiguous positioning on the strategy to be prioritised in order to achieve UHC, (2) insufficient technical and financial support for reforming dynamics.
Sector context and system preparation for innovations	After a long period of ideological and technical immobilism, the mutualist system begins a prudent reform. The recurrent underfunding of the sector is fueling tensions and a brake on accompanying UHC reforms.
Agents of change	The group of experts responsible for the operationalisation of RAMU is the first agent of change, imposing certain innovations in mutuality. The second player, PADSS2, implemented this reform with an innovative pilot programme. But these two actors fail to evolve in a synergy of reflection and action.
Features of the innovative scheme	Most of the features of the experienced mutualist system are in favour of national adoption in the perspective of UHC. The transferability of the model and its financial viability are compromised by a lack of ambition of the content of the innovations and their articulation.
Formulation and implementation process	The low-system, reflexive and iterative intervention strategy limits the pilot's scope and compromises his chances of scaling. The potential remains partly unexplored.
PADSS2, Programme of Support for Socio-Health Development, Phase 2; RAMU, Universal Health Insurance Plan; UHC, universal health coverage.	

on strengthening health supply rather than organising demand for care.

International mutualist networks, including that of UEMOA (West African Economic and Monetary Union), have contributed to adopting regulations and social legislation. They are essential meeting and advocacy frameworks (Abidjan, Lomé, etc). They now place 'the development of CBHI from an 'ecosystem' perspective and seek to promote the mutualist model as a lever for UHC.³⁶

Our documentation review and interviews with various national stakeholders and partners showed that the Malian state reproduces its partners' ambiguous and ambivalent positioning on achieving UHC. In recent years, the inconsistency of policy directives has resulted in a stack of policies that need to be revised. The government's position on the direction to be prioritised to achieve UHC remains somewhat disconcerting and unilinear. The absence of arbitration at the highest level of the state, even though health funding from the state

budget does not reach 6%,³⁷ fuels scepticism about the state's ability to achieve its commitments:

We have a governance problem related to people's issues too. The RAMU depends on three departments without a level above, which is a problem. A minister cannot hold another minister accountable at the same level as the minister. The one in charge of the file must inform and involve others. What he doesn't always want to do to keep his hand on the file. However, for a long time, no one has followed this issue in primacy. — Civil Society and Partners, 2

Finally, the political security context is worrying. The Mopti region, where innovation is taking place, is symptomatic of this climate of insecurity and the resulting consequences in terms of the growing vulnerability of populations and the health system breakdown.

Sector context and system preparation for innovations

Institutions and their interactions

The social sector was built in Mali in the budget shadow and the indifference of health actors. This lack of synergy translates into weak intersectionality in the debates and favours partisan positions at the expense of the system. Inconsistencies within the state encourage and reinforce historically constituted intrasectoral divisions and tensions. Beyond consensus on the need to move towards UHC, the divergence of approach between health and social development is recurrent.^{35 38 39}

There are few actors involved in mutuality. They are essentially the regulatory and supervisory structures and a flagship structure belonging to civil society, the UTM (Union technique de la Mutualité), which provides authentic leadership, thanks to its experience and technical expertise, unparalleled in Mali (figure 2).

History of change and receptivity to innovations

The UTM developed a fairly reformative view of the coverage of the informal and agricultural sectors. However, it needs help to express it since it derives its legitimacy from the mutualist movement and suffers from the recurring underfunding of the sector. The arrival of a new player in 2019, the AMAMUS (Malian agency for social Mutuality), shakes the institutional head-to-head between the Malian state and the UTM without stimulating a real reform dynamic despite the substantial autonomy conferred on it by its status.

Other national actors concerned with social protection remain on the margins of decisions on mutuality, in particular the Directorate General of Health, the National Health Insurance Fund and the National Medical Assistance Agency. Local actors need to be stronger involved due to reduced decentralisation of decisions and inefficient management of partnerships.

Competition to access scarce social resources fuels institutional tensions that weaken it. Professional and bureaucratic culture (respect for hierarchy, vertical communication) generates weak collaborative dynamics and encourages routine behaviour:

This lack of synergy, this notorious lack of collaboration between actors on the ground, is as if everyone is trying to draw the cover towards him by forgetting that, individually, no one will be able to have good results. With the momentum we are currently in the mutualist movement, I am not very optimistic for RAMU. State/expert group, 4

In terms of ideas, a significant community ideology considers appropriate to the African context. Its use by the State has been reflected since the 1990s in creating multiple community entities, including community health associations (ASACO) that manage primary health

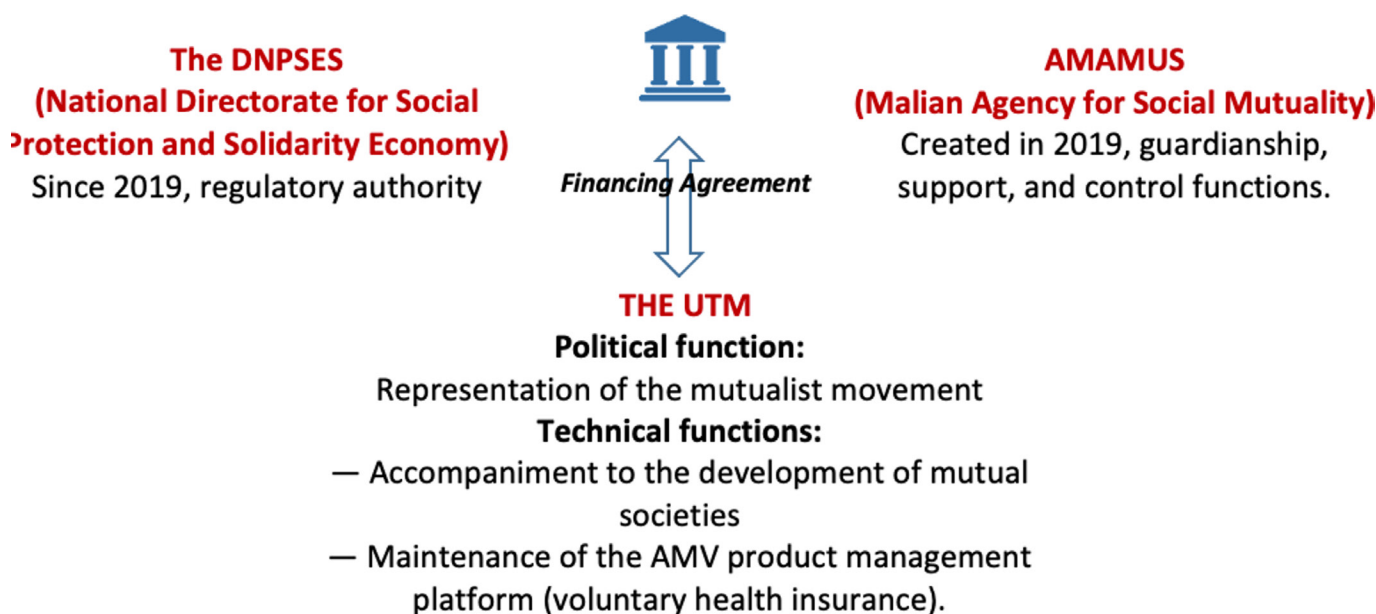


Figure 2 Actors involved in mutuality. UTM, Technical Union of Mutuality.

centres and CBHI despite their ‘poor result’ (civil society and partners, 5).

Voluntary lay management is often considered preferable to the risky dependence on state funding, which would compromise the autonomy of CBHI. Resistance to change is manifested by a weak consideration of the recommendations of studies which, for a long time, show structural weaknesses and propose solutions, including the professionalisation of management and broader portability of a more attractive product.¹⁶

System readiness for change

In 2015, we noted the beginning of a dynamic of change. It is a question of reducing the system for rapid national coverage and of carefully engaging in reflection on the limits of the original model of CBHI and the possibility of overcoming it:

It is said at home that we must not see the clouds and empty the jar, so it is essential that we continue but keep the existing one. For the time being, it is the community mutuals but on a circle scale rather than a communal one. UTM, 8

Agents of change

Since 2015, the group of experts in charge of the operationalisation of the UHIP has given new impetus and the opportunity to make the reform a reality. This multidisciplinary group of experts, composed for the most of national executives, constitutes a unique framework for consultation and multisectoral reflection.

By putting CBHI into perspective for the first time with the two other existing social protection systems (AMO and RAMED), it proposes a law that constitutes a reforming framework for mutuality. Many CBHI principles are thus called into question. The prescription of compulsory membership of the UHIP calls into question the principle of voluntary membership of CBHI, the management of risk by the CANAM and the significant involvement of the State (subsidisation of 50% of the amount of contributions), marking the end of the autonomy of CBHI. This perspective requires the professionalisation of the CBHI system. Finally, it suggests a streamlined structure at the level of the circle, offering national portability of an insurance product equivalent to other existing schemes.

‘Many questions remain to be solved because there are different mutualist principles incompatible with UHIP: voluntary membership, different contribution levels, harmonisation to be planned and probably difficult to do.’ State/Expert Group, 4

Since the end of 2018, this group has been struggling to give actual content to the various decrees implementing the law to bring this mutuality reforming logic to fruition. In addition to the problems of political instability in recent years, the progress of the work has been hampered by its very inclusive operation. The National Committee for Reflection and Follow-up for the Operationalisation of the UHIP, whose function is precisely to validate and monitor the proposals of the group of

experts and to open debates, has only met twice since its creation in 2015. The Civil Society Platform for UHIP is no longer held due to a lack of external funding. Finally, the expert group deplores the lack of quality studies to support the reflection, especially around the thorny issues of financing the scheme, while national technical expertise in the actuary field is still limited:

Many questions remain to be resolved because there are different mutualist principles incompatible with RAMU: voluntary membership, different contribution levels, harmonisation to be foreseen and probably difficult to do. State/expert group, 4

The PADSS2 occurs in this context. This programme presents the originality of a comprehensive approach (supply and demand) with the parallel implementation of three components. Component 1 focuses on strengthening the provision of maternal and child healthcare. Component 2 provides ‘the establishment of an innovative financing mechanism aimed at the accessibility of care and the sustainability of health facilities’.⁴⁰ Ultimately, the development of CBHI is retained by the National Strategy. Component 3 aims to strengthen the capacity of ministries involved at a central level and deconcentrated in their planning and oversight missions.

Experienced in the only two circles of Mopti and Bandiagara (Mopti region) between 2017 and 2021, this programme is presented as a pilot from the perspective of RAMU. It considers the proposals for reforms contained in the strategic and planning documents for CBHI actors of the UHC.

These two actors of change need to pursue the synergy of action and reflection envisaged in the formulation of the programme over the long term. The two processes, the pilot programme and the operationalisation of RAMU are evolving in parallel. The PADSS2 coordinator needs to participate in the expert group meetings as initially planned. The PADSS2 Steering Committee rarely meets. The progress of the pilot programme needs to be presented to the specialist group. The latter endorses certain decisions in the context of the implementing decrees of the RAMU Act without worrying about the results of the pilot experiment underway.

Mopti’s experimentation was also very poorly known to the group of experts when this program was set up to experiment. We are moving forward without referring to what is being done in this experiment. State/expert group,⁶

Features of the innovative scheme

We note the compatibility of the experienced scheme with the new international creed and the national recommendations. It is also the expression of a largely endogenous dynamic. Both the actors of change and the drivers of the initiative are part of the sociohealth sector. Only funding is mainly external.

This mutualist proposal has visible and observable advantages compared with community CBHI. There is a clear interest in the model from target populations and

local partners. Professionalisation improved access to the CBHI service, the reliability of the management, thus the credibility and performance of the scheme:

The role of salaried agents in the establishment of the section is enormous; they are like the engine of the CBHI; they are the ones who train us, they inform us, they show us the paths to follow, and they help us to sensitise people to join the mutual insurance company. (H, section social action secretary, Mopti circle)

With the MICBA CBHI, the quality of the remedies is better with a technical and medical team that controls and monitors the products prescribed to patients. Whereas with the communal CBHI, there was no control over the quality of the products prescribed. (H, section secretary for external relations, Bandiagara circle)

The attractiveness of the CBHI offer translates into a faster rate of penetration than that of previous schemes. In 2021, about 9% of the population of both circles were members of CBHI, while this rate was less than 1% in 2016, before the project.

The experimental proposal is consistent in its innovative approach since it provides for complementary, organisational (professionalisation), technical (digitalisation), institutional (mutualist structuring on a circle scale) and financial innovations.

However, the lack of formalisation of procedures makes the portability of the proposed model easier. Furthermore, modelling seems premature, as poor performance requires optimisation of the proposed institutional and technical framework.

The validity of this innovative scheme is not optimal and could not be improved during implementation:

As regards the institutional setup, implementation shows a practical simplification of the administrative procedure compared with the previous model. But the establishment of the various mutual bodies (mutuals and communal offices) takes time and requires a vital budget for the often-limited involvement of elected officials. Mutual authorities, aware of their limitations, are well accommodated from a management delegation to a team of professionals.

Professionalisation has a certain degree of completeness, with that of human resources, material resources (provision of IT and logistics equipment) and activities (management activity in particular). On an unprecedented scale in Mali, it nevertheless shows some limitations:

- ▶ Recruitment of qualified personnel in the absence of an actuary training structure.
- ▶ The anticipation of the evolution of the workload defines the employee team profile.
- ▶ Computerisation and automation of administrative and financial procedures.
- ▶ The formalisation of team management tools, governance and internal management documents (modelling of the scheme).

- ▶ Professionalisation of certain core activities: communication and management of partnerships. Health facilities need to be more involved in promoting mutuality or helping discourage mutualists.

The risk of lack of financial viability of the experimented model is real since, at the end of the programme, the funds available can only cover expenditure up to 1 year, according to the regional coordinator of the UTM.

Formulation and implementation process

The programme's ambitions are supported by substantial funding, and its 6-year duration, exceptional in support of mutuality, is a very positive factor.

On the other hand, the choice of a region exposed to different hazards (one of the poorest, weak health indicators, context of insecurity) could be more conducive to a pilot programme. Thus, nearly half of the 57 communes of the two circles were under total jihadist occupation during the programme period, with most other municipalities being partially occupied.

In addition, component 1 is neither in the context of innovation nor in the interests of the sustainability of the acquis. The contribution to establishing the accreditation process at a national and regional level is envisaged but without linking with component 2, and ultimately abandoned.

The experienced mutualist system is separate from the systemic approach initially planned. From the moment of formulation, the activities are envisaged without consultation or coordination between the actors of components 1 and 2 of the PADSS2. Their implementation is done without synchronisation due to various administrative and bureaucratic constraints, both on the part of the state and the lessor. Scepticism, manifested openly against mutuality by the two successive PADSS2 coordinators, does not facilitate the understanding of the stakes of this pilot programme or the articulation of the two components. The two schemes coexist without actually collaborating.

Finally, the UTM is selected as the lead operator, foreshadowing the delegated managing body (OGD) role it is called on to play in the context of the RAMU. This is a significant asset. Despite its strong expertise, it remains pretty new to the scale of innovations to be tested and articulated. It should be able to position itself as a learning structure, with technical support and continuous capitalisation, which is not foreseen in the programme. Indeed, the reflexive approach inherent in any pilot is limited during implementation. The technical management of the UTM is almost the only accountant of the outcome of this innovative experiment. Anxious to show its capacity to deal with rather than its doubts or the inevitable limits of the initial institutional and technical arrangements, and with little room for manoeuvring to make changes, it is limited to exciting adjustments but to the margin. The state is associated with the framework of a steering committee, but it remains in poor capacity for proposals and support for this local experience.

DISCUSSION

For the first time in Mali, given the challenges of RAMU, a scheme with many innovations has been tested over a long period. It has characteristics that make it attractive to the population, more reliable and efficient, with a professionalised management allowing to consider the integration of mutuality in the RAMU to cover the informal and agricultural sectors. The penetration rate of 7% of the two CBHI in 2021 in a few years of implementation⁴¹ exceed the results achieved by CBHI over the past 30 years. However, they still need to be improved to ensure their viability and sustainability.

The analysis of the contexts and the implementation process, usually overlooked,²⁷ makes it possible to show that the conditions for implementing this experiment have reproduced, at the programme level, the main obstacles to innovation that have always been exerted against the mutualist project. Thus, strategic thinking and reforming ambition have been constrained by the actors' ineffective communication and consultation capacity and a certain ideological conservatism. This has played a negative role in communication around this pilot project and on the operator's ability to convince in a local context of experimentation characterised by a strong scepticism of the partners and heavily impacted by insecurity. The deficit in the financial viability of CBHI is the result. However, it risks fuelling the very consensual chilliness of its designers and even more of its critics for fear of the consequences of adopting these innovations for RAMU. Finally, with some repercussions on a technical 'design' of CBHI possibly reduced, and an institutional status quo, even though innovations remain to be found to reduce costs and to build a new way of thinking about the health coverage of the agricultural and informal sectors.

Senegal, which launched 2014 similar innovations through two departmental health insurance units (UDAM), is in this perspective. The context is relatively identical: the same international and national ambiguity for UHC, even a long history of an inefficient community mutuality and even the need to renew this proposal. In addition, the technical proposals come together: structuring at the level of the circle/department, professionalisation and subsidising of the state. But the Senegalese model has specificities. It renews the community approach by replacing it with decentralised citizenship. It also demonstrates the benefits of a systemic approach because, in parallel with the organisation of demand, the programme has intervened to reform supply.⁴² Several studies have presented the sustainability and resilience of these UDAMs⁴³ and confirmed the fundamental role of professionalisation for the performance of CBHI in Senegal.¹⁴ In September 2022, the National Agency of the CMU of Senegal decided to transform all communal community CBHI into 46 departmental CBHI. The experienced schemes, therefore, seems to have borne fruit and influenced this decision-making of a scale-up.

The paralleling of these two programmes, in perspective with other experiences in Rwanda, Ghana, Ethiopia^{44 45} and soon in Benin, to better integrate mutuality into a broader national health financing mechanism, shows that technical and institutional solutions exist and are proven. In Ghana, the NHIS (National Health Insurance Scheme) programme 'was the subject of a presidential review in 2017. The recommendations made increasingly distance the system from any Community responsibility for the governance of health insurance'.⁴⁵ In Rwanda, the success of mutuals in terms of membership rate was achieved at the expense of the initial commitment to community participation and management. The CBHI deployment has been accompanied by a significant involvement of the government and its donors in funding health.^{18 45}

Mali could build on these initiatives and continue its efforts to achieve sufficient institutional, organisational and technical sustainability conditions to consider its scale-up without diminishing its scope.

Establishing a social protection system against the disease has a political significance that justifies the substantial financial effort it entails. Some sub-Saharan countries have understood this and have been able to find ways to finance it.^{18 45} The Malian State could unambiguously embark on this path and admit the full potential of this mutualist reform, previously perceived as an outsized expenditure item. Especially since Mali, notwithstanding the current crisis, can find the means of its policy. Many international reports or studies have shown this.^{38 42 46} The mining sector represents a unique opportunity for national and sustainable UHC funding to limit healthcare reliance on external funding sources. It is, therefore, essential 'to articulate the objective of maximising mining revenues, as defined in the National Policy for the Development of the Mining and Petroleum Sectors and the 2019 Mining Code, with the financing needs of key utilities'.⁴⁷

Limitations of the study

The number of interviews conducted and the inclusion of a wide range of actors, from the national to the very local level, the cross-referencing of these interview data with each other and with the extensive documentation used (data triangulation), reinforces the credibility and reliability of the results presented. In addition, colleagues from the relevant organisations have validated the analyses in this article. The fact that the context of the experiment studied is very specific in terms of security, limits the scope of the innovations implemented, but does not influence the transferability of the results presented here.

CONCLUSION

Like most countries, Mali has long stumbled against the idea that social protection is a luxury that African states cannot offer their people. Acceptance of this finding was facilitated by the solidarity and community organisation

of their populations. It is in this context that mutuality has developed, on a very local scale and with autonomous and community functioning. The lack of state involvement and the low contribution capacity of the informal and agricultural sectors have limited the ambitions of this scheme. After more than thirty years of experimentation, it is still unattractive and underperforming. The idea that universal health insurance is possible in low-income countries, particularly for informal and agricultural groups, has come a long way. With the promotion of UHC, some countries have demonstrated that it is technically and socially feasible to meet the challenge. One of the conditions is to stand out from the original CBHI model whose principles are a barrier to its success. The study of the experimentation of an innovative CBHI programme in the Mopti region shows that Mali has committed itself timidly to this path. Successful experiences in a growing number of sub-Saharan countries must be a source of inspiration and lead to push this reform momentum further.

The operationalisation of RAMU in Mali and the synergy of its various regimes should facilitate this awareness. This could materialise the scaling up of innovations to disseminate a successful insurance product for the informal and agricultural sectors. Otherwise, the risk of a scale-up from a model to a discount in the name of cultural and social realism or of a financial inability of the state is not to be ruled out. In the absence of a strong will on the part of the state to impose a recast of mutuality from a global perspective, including supply and demand, to finance it, and to think of technical, institutional, and financial viability without opposing them, it is to be feared that the measures adopted will not allow the scheme to gain credibility. It will not be able to make the difference with competing travelling models, promoted with the force of international technical and financial support.

Twitter Valéry Ridde @ValeryRidde

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Competing interests None

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Patient consent for publication Not applicable.

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ORCID iD

Valéry Ridde <http://orcid.org/0000-0001-9299-8266>

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Appendix 1: list of documents consulted

	Titles	Authors	Date
Legislative and regulatory texts; national policy documents or strategy			
1	Law n°2018-074/of 31 December 2018 establishing the universal health insurance scheme	Presidency of the Republic, Mali	Dec 2018
2	Decision No 0236 MSHRN-SG, amending Decision No 0165/MSAHRN-SG of 08 June 2015, listing the members of the Group of Experts for the establishment in 2018 of Universal Health Coverage in Mali	MSAHRN	July-15
3	Decree N°2019-0661 laying down the organization and operating procedures of the Malian Agency for Social Mutuality (AMAMUS)		August 2019
4	Decree No. 2022-0018 laying down the procedures for implementing certain provisions of Law n°2018-074 of 31 December 2018 on the institution of RAMU		January 2022
5	Logical framework of the National Strategy for Expansion of Sickness Coverage to the Agricultural and Informal Sectors by Health Mutuels and its Action Plan (2021-2025)	MSDS General Secretariat, Mali	Nov 2020
6	Pilot phase of the implementation of the National Strategy for Expansion of Sickness Coverage by Mutuels in the regions of Sikasso, Ségou and Mopti 2011-2013	MDSSPA	April 2011
7	National Health Funding Policy for Universal Coverage 2014-2023	MSHP; MSAH; MPFFE	
8	National Strategy for Expansion of Sickness Coverage to the Agricultural and Informal Sectors by Health Mutuels and its Action Plan (2021-2025)	MSDS General Secretariat	Nov 2020
9	Towards the Health Reform in Mali. A presidential initiative for the progressive reform of the Malian health sector. 2019-2022	General Secretariat, MSHP	March 2019
10	Strategic Plan for the Development of the Universal Health Coverage Agency, 2017/2021	ACMU Senegal	Dec 2016
Study, evaluation, programme documents			
11	Situational analysis of community-based mutual organizations within the framework of the Universal Health Coverage from January 2017 to September 2019	MDCEST, Senegal	Jan 2020
12	Universal health coverage and informal sector in Francophone West Africa. Current status, prospects and proposed strategic guidelines	World Bank Group	June 2018
13	Health Innovations: conceptual and methodological renewal to sustainably transform the field of health, Editorial	Corinne Grenier, Hervé Hudebine, Bertrand Pauget	2021

14	Networking of health mutuals in West Africa	IMT, M.P Waelkens, B Criel	April 2007
15	Health sector reform in Mali 1989-1996	Zakaria Maiga, Fatoumata Traoré Nafó and Abdelwahed El Abassi. Studies in Health Services Organization & Policy	Dec 1999
16	Mobilization of resources and financing of national strategies to extend risk coverage Mali: state of play, challenges, and perspectives	MSAHRN	Nov 2015
17	NCO CML 13 11 PADSS Mopti II	Summary	
18	Organisation chart UTM PADSS2 Mopti	UTM Mopti	
19	Potential of health mutuals for the implementation of Universal Health Coverage in Mali and Senegal	Oumar Ouattara; Pascal N'diaye. Research Gate	June-17
20	For a common vision between mutuals, social movements, public authorities — Dakar Declaration — Final.	AIM	
21	Strategic Plan and Annexes 2019-2023	UTM	
25	UTM Annual Activity Report 2018	UTM	
23	Capitalization report on the implementation of UDAM VF		May 2017
24	Final Report: Health funding in Mali through innovative sources of funding.	Mariame TRAORE and Nouria Brikci	July-16
25	Reports of missions 1, 2 of the technical assistants pearled support mutuality		Jan 18, April 18, 18,
26	PADSS2 Annual Activity Reports Component 2, Year 2016, Year 2018 Year 2020	UTM	
27	Annual Report, Foundiougne Department: Region of Fatick: 2019	UDAM FOUNDIIOUGNE	
28	Report of rapid investigations in health facilities in Mopti and Bandiagara, PADSS2	Health South	June 2016
29	Interim report of the external evaluation mission of the Health and Social Development Programme	Etc Crystal — HERA — <i>Alter</i>	November-02
30	Final report. Development of Mutual Sickness Insurance contributing to the CMU within the framework of the PADSS2 Mopti	UTM, regional representation of Mopti	July 2022
31	Capitalization ratio. The implementation and results of these UDAMs in Senegal,	MSAS, CTB	May 2017
32	Mission report to Bamako (revised version based on items received since the first version). Study I3S PADSS2	Alain ETOURMY, Economist, Honorary Researcher at the CNRS	July 2015
33	Interim report of the external evaluation mission of the Health and Social Development Programme	Etc Crystal — HERA — <i>Alter</i>	November-02

34	Grant of EUR 13 million for the financing of Phase II of the Support Programme for Social and Health Development (PADSS) in the Mopti region	DDH/SAN, Roman ANDRE AFD	
35	“SOLIDARITE SANTE SAHEL” INITIATIVE Serving Universal Health Coverage. Progress report	AFD, Human Development Department Health and Social Protection Division	APRIL 2017
36	Evaluation of the implementation of the pilot phase of the national strategy for extending health coverage by health mutuals 2012-2014	Diakity	2015
37	Strategic intentions	Ouattara O., Sissouma I., Masson G., UTM	Doc. undated
Articles, books			
38	Extension of Health Insurance and the Role of Health Mutuals in Africa: lessons from Senegalese experience, Public Economy/Public economics, 28-29 2012/1-2Varia	Bruno Boidin	2012
39	The extension of health insurance in Senegal: progress and obstacles; <i>Medicine and Tropical Health</i> 2012; 22: 364-369	Alenda J., Boidin B.	2012
40	Factors contributing to innovation readiness in health care organizations: a scoping review, <i>BMC Health Services Research</i> (2022) 22:997	Monique W. van den Hoed, Ramona Backhaus, Erica de Vries, Jan P. H. Hamers and Ramon Daniëls	2022
41	Is health innovation perceived as technological or social? Conceptual reflection in the field of public health, <i>Review Organizations & Territories</i> • Volume 30 • No. 1 • 2021	Marietou Niang, Sophie Dupéré, Marie-Pierre Gagnon	2021
42	the regulation of health mutuals in Benin; <i>The State actor of development</i> , Karthala, Paris	M.C Vermer, Marthe Nyssens, Pascal Wele, in Leloup F, Brot J, Gérardin H	2012

Authors' Statement of Reflexivity

This research, financed by the AFD, was developed following a series of interviews with the actors of this programme to define their leading questions and expectations concerning research on the PADSS2 programme. This research corresponds to the expectations of Mali's social protection actors, particularly the group of experts in charge of drawing up the RAMU. The AFD also expects this study to contribute to the capitalisation of this PADSS2 pilot programme. A Malian research association carried it out, Miseli. They worked in a good partnership with the UTM, the holder of the innovative mutualist programme within the framework of PADSS2, and the other stakeholders. In the context of insecurity, data collection in the field was primarily carried out by the two Malian research assistants. All means were used to ensure the security of these two colleagues who took no risk to their physical integrity and could leave the areas at any time. They write the observation notes in order and transcribed the interviews conducted in the national language. Pauline Boivin and Laurence Touré performed the interviews at the national level. The results were interpreted by the two researchers and submitted for discussion to the head of the UTM in Mopti and other researchers. The article was written by Laurence Touré, with Valéry Ridde contributing to the introduction. The paper was proofread and amended by UTM and all co-authors. The article was written in French to allow all French-speaking authors to participate in writing and then translated into English for this special issue. All ethical issues were considered, and the interview participants' anonymity was respected.

