Emmaus International health programmes

LESSONS LEARNED AND INSIGHTS GAINED

2010-2020 Report

emmaus INTERNATIONAL

ACTIVISTS FOR CHANGE

Contents

The Emmaus International mutual health experience: promoting access to health care rights by involving the most excluded

Almost twenty years ago, Emmaus International decided to set up mutual health access programmes in Burkina Faso and Benin in 2002, and in India and Bangladesh in 2011. Indeed, many elected members of the movement during the early 2000s, along with its founder, found it unacceptable to observe that even within the movement, depending on which country the member groups were based in, there were glaring inequalities in terms of access to health.

"While health has long been universally recognised as a precious good, the same cannot be said of the collective mechanisms that guarantee everyone a minimum level of prevention and protection in terms of health care. Access to health care for all remains a new and still poorly shared idea.

The Emmaus movement knows from experience that illness and premature deaths constitute factors which increase the vulnerability of the poorest people, keeping them in situations of exclusion. This is why where health protection systems exist, Emmaus advocates for common rights for all; and where public policies are lacking or unequal private profit-making systems prevail, Emmaus promotes the mutual health tradition, in line with its ideals and expertise. The construction of community-based social protection systems managed by individuals offers a powerful means of sustainably overcoming poverty. Moreover, it is an appropriate response to the demand for social justice. Based on the progress of the mutual health organisations launched by Emmaus in India, Bangladesh, Burkina Faso and Benin, Emmaus is acting as an advocate and instigator of universal health protection, but above all as an activist for social change."[1]

In order to guarantee access to health care for all, one must bear in mind that mutual programmes are based on three fundamental values:

> "Freedom", in the sense that mutual health organisations constitute groups of people independent of all political, financial or trade union power. The members are both beneficiaries and owners of their mutual health organisations;
> "Democracy": one person, one vote. The mutual boards are made up of members elected at the General Assembly, who perform their duties as volunteers. Decisions are made during the General Assembly, when each member, or representative appointed by the member, can vote;
> "Solidarity", to facilitate access to treatment for all. This solidarity is expressed in the mutual system in two ways: solidarity between mutual members in how they run the schemes, share health risks, and solidarity between the Emmaus groups around the world to launch, build, support and help implement these schemes.

Moreover, through these mutual organisations, the Emmaus movement set out to prove that it was possible for people living in extreme poverty to gain access to a fundamental right, or even to reclaim it.

[1] *Tam-Tam*, no. 52, November 2012.

Furthermore, by supporting the most excluded people and building their capacities, they could become stakeholders in the mutual organisation rather than simply beneficiaries.

The challenge was clearly immense and there were many constraints. It is of note that the state of health and social policies in the areas where the pilot programmes were set up was often appalling. The concepts of “the common good" and "fundamental rights", when they were mentioned, were only theoretical or used for election purposes. Literacy rates in the areas concerned, both in Africa and in Asia, were no higher than 20%. The vast majority of the population worked in the informal economy. The level of poverty was sometimes so severe that access to health care, even vital health care, was not a priority in daily life (it came after access to food, housing, drinking water, etc.).

In other words, the concept of a "mutual scheme" developed by Emmaus International would in practice be closer to a basic social security system, rather than a mutual health insurance scheme as we understand them in Europe.

In order to conduct a real assessment of the collective work initiated by the movement, we shall first of all describe the background to the introduction of mutual organisations up to 2010, as well as the challenges and actors involved (Part I). Then, in the second part, we will analyse and study the evolution of access to health care (Part II) and will present how the mutual health organisations have operated between 2010 and 2020 (Part III). Finally, after offering a snapshot of these mutual organisations at the end of 2020, explaining their role during the Covid-19 pandemic, and highlighting the strengths and weaknesses of the system as a whole (Part IV), we will endeavour to identify future prospects (Part V) for the next World Assembly.

Consultation at the medical centre of the Mutual Health Organisation, Tara Projects (India) ©Digital Rangrez (2021)

I. History of Emmaus International's mutual health programmes: from indignation to reality (2000-2010)

Health is a fundamental right recognised by many international treaties: the Universal Declaration of Human Rights, the Covenant on Economic, Social and Cultural Rights and the conventions of the International Labour Organisation (ILO) and the World Health Organisation (WHO).

Although this right is recognised by all states, access to quality health services remains an ongoing challenge for those subject to certain health care systems. In most developed countries, the existence of social security and mutual health schemes allows the population to benefit from fairly extensive health coverage. In developing countries, on the other hand, low incomes, the prevalence of the informal sector and the scarcity of public resources limit health coverage and access to quality health care.

After the devastating effects of structural adjustment programmes - which helped to reduce public spending on social sectors - the situation has worsened over the last twenty years due to the increased liberalisation of economies. This has transformed the health sector into a commodity and accentuated the existing inequalities in accessing health care between the poorest and the most affluent populations.

This has drastically eroded public infrastructure and led to a marked deterioration in health coverage. At the same time, we have witnessed a growing number of private health care facilities, some of which are of excellent quality. However, these are only accessible to a very small proportion of the population and leave behind the most disadvantaged in society.

It should also be noted that this trend is not unique to the so-called "poor" or "developing" countries: inequality in accessing quality care is also increasing today, for the same reasons, in the richest countries.

Against this background, which at times has resulted in drastic situations within our movement, the elected representatives and our founder decided to set up a joint solidarity initiative.

a. The origins of the initiative: responding to injustice (2000)

As a reminder, in 1999 the movement set up a health commission to study how it could assist, support and cover the financial costs of members of the movement without health coverage who fell seriously ill.

Furthermore, several events, such as the death of leading figures in the movement in the Africa region and the fact that members of these organisations had no access to health care, produced indignation within the movement, led by Abbé Pierre and the Emmaus International Board, and spurred them on to work towards more collective initiatives.

Emmaus International's suggestion to Emmaus Africa was to set up an international working group to reflect on and discuss this issue with the members of the Emmaus groups in Africa and to raise solidarity funds in order to deal with urgent situations, while waiting for a suitable programme to be put in place.

The CNAE[2] was tasked by Abbé Pierre to create and coordinate a working group in France, called the Africa health workshop, together with Emmaus International and the Africa region. Then, in September 2000, Abbé Pierre granted 150,000 francs (roughly €23,000) to the African health insurance fund (FAMA), which would go on to become the African mutual health organisation in 2001.

Laurent Desmard, a key figure in the creation of the mutual health organisations alongside Abbé Pierre, tells us about this experience (January 2021):

""This year, I noted - and I was very moved by this - that the "Les femmes de Zabré" organisation was to lay the keys to the houses it has allocated to families in difficulty on Abbé Pierre's grave on 22 January, the anniversary of his death. Yet there is a tragic history between Monique Kaboré, the founder of this organisation, and Abbé Pierre, which is partly at the origin of the mutual health programme in Africa. For this reason, I was very moved by this ceremony.

"I was at Limoges at the time for a meeting of leaders from the UCC federation. I was attending without great enthusiasm and I listened placidly to the debates on the 35-hour working week for community leaders. I was shaken out of my stupor by a phone call from Monique Kaboré: "I have breast cancer. They won't operate on me here in Burkina Faso. In any case, I can't afford it. Can you get me to France and find me a place in a hospital so I can be operated on as soon as possible?"

"As I hung up, I found myself still in this hall, with this sterile debate on the 35-hour working week which, clearly, was totally unfeasible for these leaders. This was such a middle-class problem, compared with the fact it was impossible for Monique to get vital treatment, simply because she lived in a different region of the world to Europe. Yet all of us did the same work, we were all Emmaus leaders, she worked there, we worked here. I found the injustice of this situation completely unacceptable. After speaking to Monique's doctor by telephone, who told me that I could bring her to France, but that it was already too late for her, I lamentably let things drag on and she died two weeks later.

"This tragedy upset me greatly. I spoke to the Executive Committee about it. Together with Franco Bettoli and Jean-Marie Viennet, we discussed this issue at length, without knowing what to do. Then Véronique, who was also an Executive Committee member, fell ill. This time, things were simpler. As she came over every month, she was able to be diagnosed earlier and she told us immediately about her problems. Very quickly, we got help from a clinic in Alfortville which gave Emmaus a special deal and Véronique was well looked after.

"But the problem persisted for all our African colleagues who had no social protection. We then thought, together with Véronique, that we needed to create a fund to help those who might fall ill one day and have need of it. So, we opened a clothing shop in the centre of Alfortville, selling the clothes that people left on our doorstep and with the help of the communities, particularly those in Orléans, Longjumeau and Charenton. This shop made some profit. At first, we intended to use the takings to treat health problems of members of the groups in the South. It became a solidarity thrift shop.

"But we could see that it was not enough and it would only last for a certain amount of time. So, we came up with the mutual fund system. This was not a foregone conclusion, as this system was not at all in keeping with African customs: "Why should I put money into a fund that I might not ever use and that will be used by others?"

[2]CNAE (National Emmaus Friends' Committee) is a federation which, at the time, included around thirty French associations.

"But we persevered and one day, when I was with Abbé Pierre, I told him of the worries I had about Monique and Véronique, of the forthcoming creation of a mutual health insurance scheme for African members and their hesitations. Without me asking him for anything, he said: "Check how much I have in my bank account and if there's any money in there, you can put it all into that mutual organisation, I want to be the first to contribute." So, with the 150,000 francs that Abbé Pierre gave us, we set up the mutual fund and asked the National Friends' Committee to pay a very substantial supplement.

"We set everything up with our African friends and the mutual programme began in Benin and Burkina Faso.

"Personally, I felt that to start with Europeans needed to participate in this mutual. In France, all companies have to pay at least half of their employees' contributions and it was only natural that Emmaus International should be involved. But the latter could not afford it. So, I thought I would appeal for donations from our activists. Personally, I'm a volunteer today. If Emmaus International asked for a monthly payment of 30 euros for the mutual health programme, I'm sure that many friends from the community would be ready to do the same. Whether it is for the benefit of Africans or Asians, it seems to me that we should show solidarity. This is the principle of the movement. I don't have Abbé Pierre's courage, but he set an example for me to follow."

b. Challenges facing the mutual health organisations

With the creation of mutual health funds - a project that is in keeping with the spirit that the Emmaus groups defend every day - the movement began to wage a battle that is unfortunately all too common in contemporary societies in Africa, the Americas and Asia: tackling inequalities in accessing health care.

However, as the projects progressed, a number of challenges had to be addressed, which, admittedly, are still relevant today.

Socio-economic context of poverty

One of the cornerstones of mutualist systems is that beneficiaries make regular and compulsory financial contributions. However, the people with whom the Emmaus groups work are poor and some are even extremely poor.

In Benin and Burkina Faso, the socio-economic backgrounds are varied. A few paid mutual members, as well as a few managers, have average or high salaries, but for the majority of people, their monthly salary remains low (between 30,000 and 50,000 CFA francs, i.e., between 45 euros and 76 euros), or even very low, while family expenses can be high, with sometimes up to six family members to support. This situation means that it is not possible for them to meet all their basic needs, let alone cope with any health problems, no matter how serious.

In Bangladesh, in the Thanapara group, the situation is similar, with a significantly lower average income.

Furthermore, in India, in the district where the mutual has been developed, the population lives in extreme poverty and derives a meagre daily income from the highly precarious informal economy.

Getting everyone to pool their financial resources to share health risks through a collective tool that will not be used right away, or may never be used, while other vital daily needs (such as food) are not always guaranteed, has been - and remains - a real challenge.

Self-sufficiency, financial independence, taking on responsibilities, building capacities and governance

In such a context, it is easy to see that although the financial autonomy of mutualist systems remains an essential objective, it comes up against many obstacles, including the financial capacity of contributors, which varies according to the area and the dynamism of local stakeholders. For several years, experiments have been carried out in this respect. They have led to significant developments, but there is still room for improvement.

The empowerment of mutualist actors is another essential aspect of these programmes: how can we implement a mutualist system in the form of a collective tool that enables mutual members themselves to manage and sustain access to the right to health? Indeed, this long-term challenge is made all the more difficult by the fact that the populations involved have very limited access to education and very low literacy rates.

Trust and commitment

Although the movement launched these mutual health access programmes without knowing exactly where they would lead and without a precise strategy, the support provided and the trust placed in actors from different backgrounds, and those working on the ground, have undoubtedly enabled these programmes to take shape, grow and develop.

It is well known that local actors involved in the management and development of mutual organisations play an essential role in carrying out the work. They are on the ground working with the population and the scheme. Their commitment remains fundamental. Indeed, it is precisely because the groups have been rooted in the local area for many years, because they work every day with people in great difficulty, that it has been possible to implement these projects. The local population placed their trust in them.

Influence on public policies

Through these successful alternatives, mutual members also aim to influence public policy. This is an area where progress can be made, but the efforts made in terms of access to health care for the most excluded and the mutualist approach itself can be highlighted. Some have already decided to get in touch with other organisations in their area to share their practices. In Burkina Faso, the public authorities, who have been working for several years to set up a universal health insurance scheme, regularly invite Emmaus and others running civil society mutual schemes to participate in consultations.

c. Involving the most excluded right from the beginning (2000-2002)

At the end of 2000, the Emmaus Africa representatives rallied the members of their organisations in Benin and Burkina Faso (countries that are better organised and have more local support capacities) and organised regular meetings to explain and raise awareness, along with determining the operating methods, contribution rates, allocation criteria, needs in terms of access to health, etc.

Nearly a dozen meetings were held within each group during this period. In parallel, the international working group held twelve meetings to discuss, define and study the proposals and choices made by

the members of the African groups (future mutual members), based on information from the field on the health context.

The mutual system was the obvious choice.

Over a two-year period, the members of the Emmaus groups in Tohoué and Pahou in Benin and SEMUS, ESO, Benebnooma and Pag-la-Yiri in Burkina Faso focused on the following issues: health needs, the ability to raise funds, the ability to work together and set up a working method, the proximity of health services to their association, and the right to health.

The health care fund, which was designed to reimburse health care costs, was to be financed by a monthly contribution from members and a financial contribution from Emmaus International (partly supplemented by the French Friends' Committees and some communities).

d. The development of mutual membership schemes in Africa (2002)

On 1 July 2002, the first membership registrations and contributions began and the main features of these mutual organisations were established:

> **Beneficiaries** are companions, employees and their family members from the Emmaus groups in Benin (2 groups) and Burkina Faso (4 groups). Signing up is voluntary;

> **The contribution amount** is set at 1,000 CFA francs (1.52 euros) per month for adults and 500 CFA francs (0.76 euros) per month for children;

> **The health benefits** defined at the time were: medical consultations, coverage of the costs of medicines and vaccines up to 75% (with a cap of 20,000 CFA francs (30.49 euros) per prescription), prescribed by a certified doctor;

> There is a six-month **waiting period**, which means that reimbursements only start after six months of contributions.

A mode of operation was established:

> **Mutual contributors** (beneficiaries) are members who pre-finance their treatment costs;

> **A local representative** collects and keeps a record of memberships. S/he fills in the monthly information collection form set up by the region and collects the claims for reimbursement upon receipt of prescriptions and invoices, which are submitted to the national management committee once a month;

> **A National Management Committee (NMC),** composed of three to four people, manages the registration of local memberships, the collection and management of local contributions, the authorisation of local reimbursements, monthly reporting, the management of a health account in each country and general monitoring;

> **A regional representative (Africa)** draws up progress reports and annual reviews, and participates in the international steering committee. S/he is also responsible for coordinating and monitoring meetings between the national organisations in Benin and Burkina Faso.

> **Emmaus International Board members** are responsible for managing the funds received, authorising the transfer of funds to national organisations. They should also coordinate and guide Emmaus Africa's health policies and report to the regional boards and assemblies;

> **Finally, a monitoring and evaluation committee** is responsible for monitoring and assessing the performance of the African health mutual. It is made up of regional representatives from Emmaus Africa, Emmaus International representatives and CNAE trustees.

e. Initial experiments and difficulties (2003-2007)

Initial reimbursements for health care began in January 2003 (i.e., after the six-month waiting period following registration).

Although the number of members grew gradually between 2003 and 2007 (particularly with the addition of two new Emmaus groups in Benin at the beginning of 2006 - the AFA [Association des femmes amies] and Metokan), the roll-out of the mutual came up against an obstacle that has already been mentioned: the population's purchasing power. Given the demands of day-to-day survival, it is indeed difficult - and very time-consuming - to convince people to spend money each month on a scheme that they themselves may not need and that will be used by another mutual member.

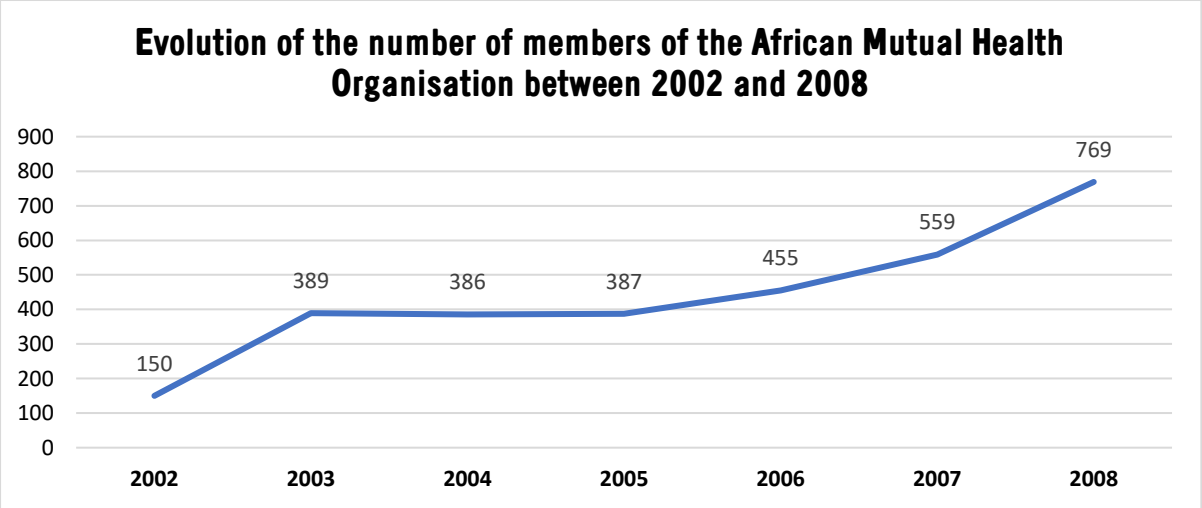
At the end of 2006, constant information-sharing on the mutual fund was necessary, particularly on how it worked and its principles of solidarity and sharing (sharing of health risks).

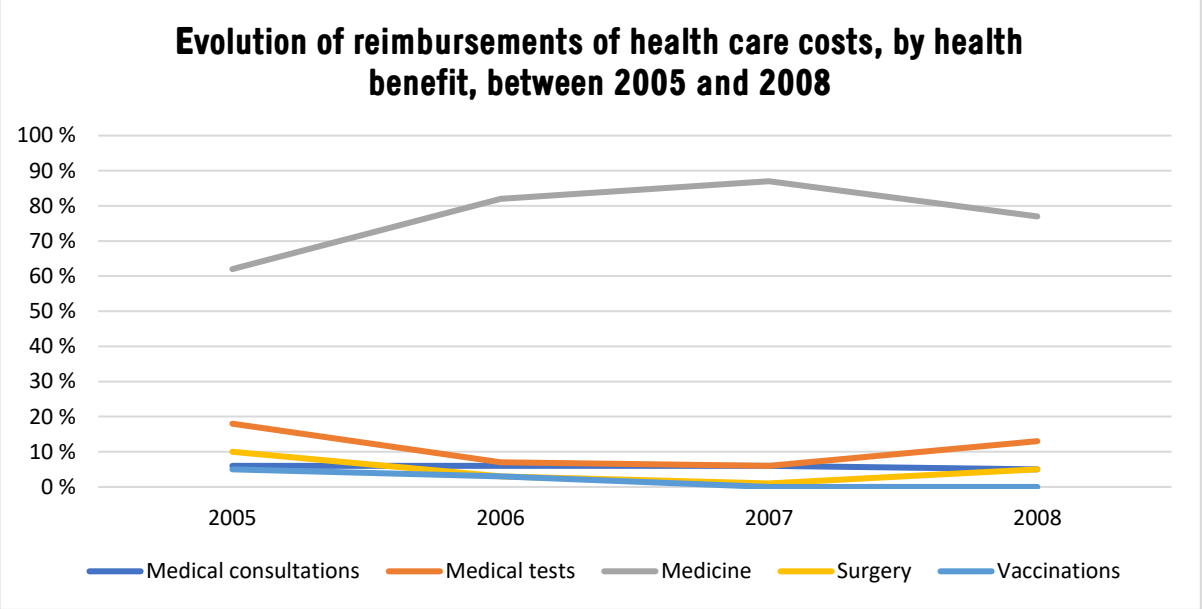
This awareness-raising work has been carried out by the local contact persons since 2007. Combined with the increase in health care services offered by the mutual from 2005 onwards (evolution of services towards a 75% coverage of medicines, consultations, medical tests, surgical interventions and vaccinations), this has resulted in an increase in the number of members (559 at the end of 2007 and 769 in 2008, including both Benin and Burkina Faso).

The feedback from members to non-members within the groups also contributes to this growth in membership.

For its part, during this period, the international health group met twice a year to evaluate the status of contributions, expenditure, health care needs, the number of members, and the funds required to keep the programme running smoothly.

A full report is produced every year by Emmaus Africa.





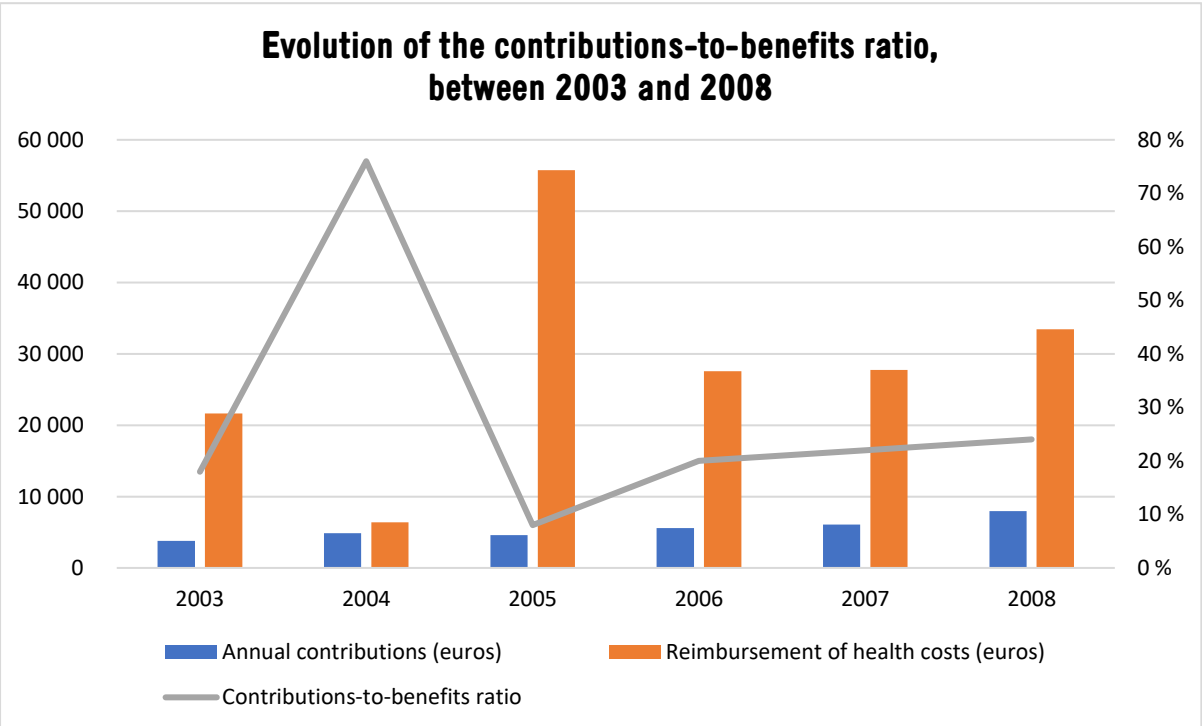
Note: Figures for 2003 and 2004 are not available.

Overall, in terms of benefits, the most significant reimbursements were for medicines and medical tests, followed by surgical procedures, medical consultations and vaccinations.

In terms of financial balance, between 2003 and 2008, contributions covered more and more health costs each year. Although health reimbursements may have been uneven among Emmaus group members before 2006, since then the "contributions-to-benefits" ratio has stabilised.

However, mutuals were far from being autonomous, especially since management costs (operating costs), albeit low, were not yet included at this stage.

After five years of operation, a preliminary assessment was carried out.



Several positive aspects were noted:

> The increasing membership numbers, which show that the programme is becoming stronger and more trusted than it was at the beginning;

> An improvement in the health status of members, due to effective access to quality care;

> Changes in members' behaviour, as they now seek treatment in health facilities, abandoning the practice of self-medication and consulting traditional healers;

> Establishment and operation of all the mutual's bodies (management committees, group contact persons, etc.);

> Financial support and long-term commitment in 2007 from more than forty Emmaus groups (mainly the Friends' Committees in France, but also French and Italian communities).

But there were also **some persistent difficulties**:

> The often-late submission of claims for reimbursement leads to disruptions in how they are managed;

> The lack of third-party payment remains an obstacle to health care access, as some beneficiaries are unable to pay in advance or are forced to go into debt;

> The continued purchase of expensive specialty drugs instead of generic medication.

f. 2007 World Assembly

The World Assembly in Sarajevo marked a major turning point in the development of the mutual organisations. It defined the right and access to health as one of Emmaus International's priority areas of work, along with the right and access to water and education, and the rights of migrants.

A work plan was then set in motion, focused on **structuring mutual organisations in Africa and the launch of new programmes in the Asia region**.

Of course, these pilot initiatives, such as the mutual organisations, demonstrate the ability of the most excluded to reclaim their right to health and the movement's ability to implement alternatives to the privatisation of health care access.

Emmaus International then formalised a partnership with Mutualité Française, which agreed to provide technical support to the movement for the mutual organisations in Africa and to study opportunities for development. An expert supported the movement for more than two years (2008-2010).

Similarly, an independent expert (employed by the NGO Inter Aide, which develops health programmes around the world) also assisted the movement in setting up and launching pilot projects in Asia for almost four years (2009-2014).

The structuring of mutual health organisations in Africa

The work carried out between 2008 and 2010 allowed Benin and Burkina Faso to **transform a health care support initiative based on a solidarity fund into real mutual health care programmes.** This development involved several stages:

> Two field trips were made to each country to assess the mutual health organisation in Africa (2008);

> Health and social surveys were carried out by medical consultants in Benin and Burkina Faso (in early 2010);

> Finally, further field visits and a final report including an assessment of the mutual fund activities, along with the health and social situation in the two countries, were conducted and recommendations were made (at the end of 2010).

These recommendations outlined two main objectives relating to financial autonomy and governance. To a very large extent, they provided a new starting point for mutual programmes in Africa (hereinafter referred to as the 'reform').

Although some of the recommendations were implemented as early as 2011-2012, it was nevertheless the holding of the Constitutive General Assemblies in Benin and Burkina Faso in November 2013 that established a new way of functioning, new objectives and the actual creation of mutual health organisations.

The launch of pilot experiments in Asia

The introduction of pilot programmes in Asia was carried out in two main phases from 2007 onwards:

> The first involved the selection of two Asian groups capable of taking on these pilot programmes for the movement (2008-2009);

> The second phase focussed on information, awareness-raising and support for the members of the groups potentially involved in setting up a mutual health organisation, in order to help them reflect on and participate in the project.

To begin with, the movement considered that it was wiser to set up experiments with only two groups, because although there were many groups that wanted to run this initiative, not all of them had the local capacity and availability to take on the process at the start and continue it over time.

A survey-study was therefore conducted by the Emmaus International Secretariat and an elected representative from the Asia region to verify all the essential parameters. This study, including interviews, questionnaires and a field visit, lasted more than a year and resulted in the selection of two groups: Tara Projects Association in India and Thanapara Swallows Development Society in Bangladesh. Emmaus International then signed a contract with a health expert to support the process of creating these two new health mutuals.[3]

The work began by preparing actors on the ground with support from a delegation from Emmaus International. Work meetings were organised and working groups created with future mutual members in both groups.

Then, at the end of November 2009, a meeting was held at Emmaus International headquarters with the leaders of the African and Asian groups so that the African representatives could share the experience they had gained over the previous years.

A few months later (during the first half of 2010), two rounds of training sessions were held in Tara and Thanapara to train the members of the groups who would be responsible for monitoring, creating the necessary tools and planning the work leading up to the launch of the mutual organisation. As in

[3] For the remainder of this document, we will generally use the shortened names of these Emmaus groups, i.e. Tara and Thanapara.

Africa, emphasis was placed on the involvement of mutual members from the outset. Therefore, a long process of information sharing and awareness-raising was carried out among the members of the groups (and future mutual members) on the principles of a mutual organisation and on the solidarity system it represents.

Finally, the mutual organisation entitlements were officially introduced on 1 July 2011 in the case of Thanapara and on 1 September 2011 for Tara, i.e., after more than three years of research, studies, support, consultation, information sharing and awareness-raising among local stakeholders. In this respect, these programmes clearly differ from the mutual programmes in Africa.

Since then, precise reporting tools have been created, making it possible to monitor the development of the mutuals on a regular basis, in addition to regular field assessments, as well as time for discussions and consultation with the various local stakeholders.

g. Support from the movement

At this juncture, it is important to note that in addition to the Emmaus groups on the ground, other actors in the movement have helped Emmaus International to achieve its objectives. These include the elected members of the movement (Board and Executive Committee), the Emmaus groups around the world, particularly in Europe, and the Emmaus International Secretariat.

Launch and organisation

Between 2000 and 2007, these stakeholders were greatly involved in the launch and organisation phase of the programmes in Africa, brought together by Abbé Pierre and the elected members of Emmaus International.

From the early 2000s, three to four meetings were held each year at Emmaus International's head office in Alfortville to discuss and organise the grassroots initiatives (information, awareness-raising, access to health, etc.). They brought together the movement's elected representatives, representatives of the African Emmaus groups involved, representatives of the CNAE federation (National Emmaus Friends' Committee) and Emmaus International Secretariat.

The first actions set up by the groups in Benin and Burkina Faso were supported by a co-ordinating body, which encouraged the movement's groups to support the programmes. In fact, some groups (mostly Friends' Committees) have supported mutual organisations from the beginning: Saumur, Saint-Claude, Lillebonne, Saint-Laurent-Nouan, Marvejol, Eu, Carmaux, Pontarlier, Roanne, Ruffec, Armentières, etc.

Then, in 2003, the health workshops at the Ouagadougou World Assembly led to a major development. The mutual organisations evolved from being solidarity actions to become the pilot experiment for one of Emmaus International's six priority areas of work: the right to health. The elected representatives, the Emmaus International Secretariat and the stakeholder groups continued to mobilise, meet, communicate and monitor the activity on site with the local groups. A progress report was presented at the 2007 World Assembly. Some forty groups supported the activities.

The decisions adopted by this Assembly - to consider access to health a priority, develop two new mutual organisations in Asia, structure the mutual organisations in Africa so that they become truly autonomous legal entities, backed by external, technical support - spurred the elected representatives and the Emmaus International Secretariat to garner support.

Rising momentum

This new impetus resulted in the need for better monitoring and increased support: an inventory, a report with recommendations produced by Mutualité Française on the programmes in Africa, steering and monitoring of the 'reform' with the African groups, preparation and launch of mutual organisations in Asia with the support of external expertise.

In 2009, the movement set up international coordination, with:

> An international steering committee, which would meet twice a year and work on implementing the objectives set by the Board and the Executive Committee, and would be made up of representatives from the mutual programmes in Benin, Burkina Faso, Tara and Thanapara. It also involved representatives from Emmaus groups to garner support from the movement in Europe, elected members of the Board and external experts (as a reminder, a member of the Executive Committee would go on to become the reference person for the elected members on the steering committee from 2011);

> The Emmaus International Secretariat, whose role is to support the mutual programmes on a regular basis (regular working meetings, development and monitoring of reporting tools, mobilisation of the movement's stakeholders - communication and facilitation within the groups -, liaison with the elected representatives for progress reports at Board and Executive Committee meetings, etc.);

> A technical advisor, from the movement, to assist the Emmaus International Secretariat in regularly monitoring the work with local groups and external experts;

> Field visits to the four areas at least once a year to review the situation, meet with local stakeholders, decide on objectives, etc.

Despite the scale of the task, the movement endeavoured to provide support by continually adapting throughout the process.

h. The actors involved

As with other human rights programmes, the movement did not work alone, especially given it is not a health specialist. From the beginning of the project to the present day, it has endeavoured to bring together actors from different backgrounds around a common goal.

Thus, within the movement, it brought together actors at different levels:

> Firstly, at local level, the first of these being of course the mutual members themselves, members of the local Emmaus groups or members from outside the groups, some of whom are involved in the day-to-day management and execution of the work (local contact persons, social workers, employees, leaders within the groups);

> Secondly, at national level: in Benin and Burkina Faso, the national organisation (which brings together the groups based in the same country) has been increasingly involved in terms of monitoring, support, information, discussions and making employees available;

> Finally, at the international level: the elected members of the movement (EC and Board) have monitored these international collective programmes. They discussed, guided, advanced issues and tried to resolve difficulties. The Emmaus International Secretariat also supported the four programmes. In addition to these actors, there are the groups in the movement that

supported the project: Emmaus Friends' Committees in France, communities in Europe (France and Italy mainly), in Africa and Asia, as well as collectives of groups.

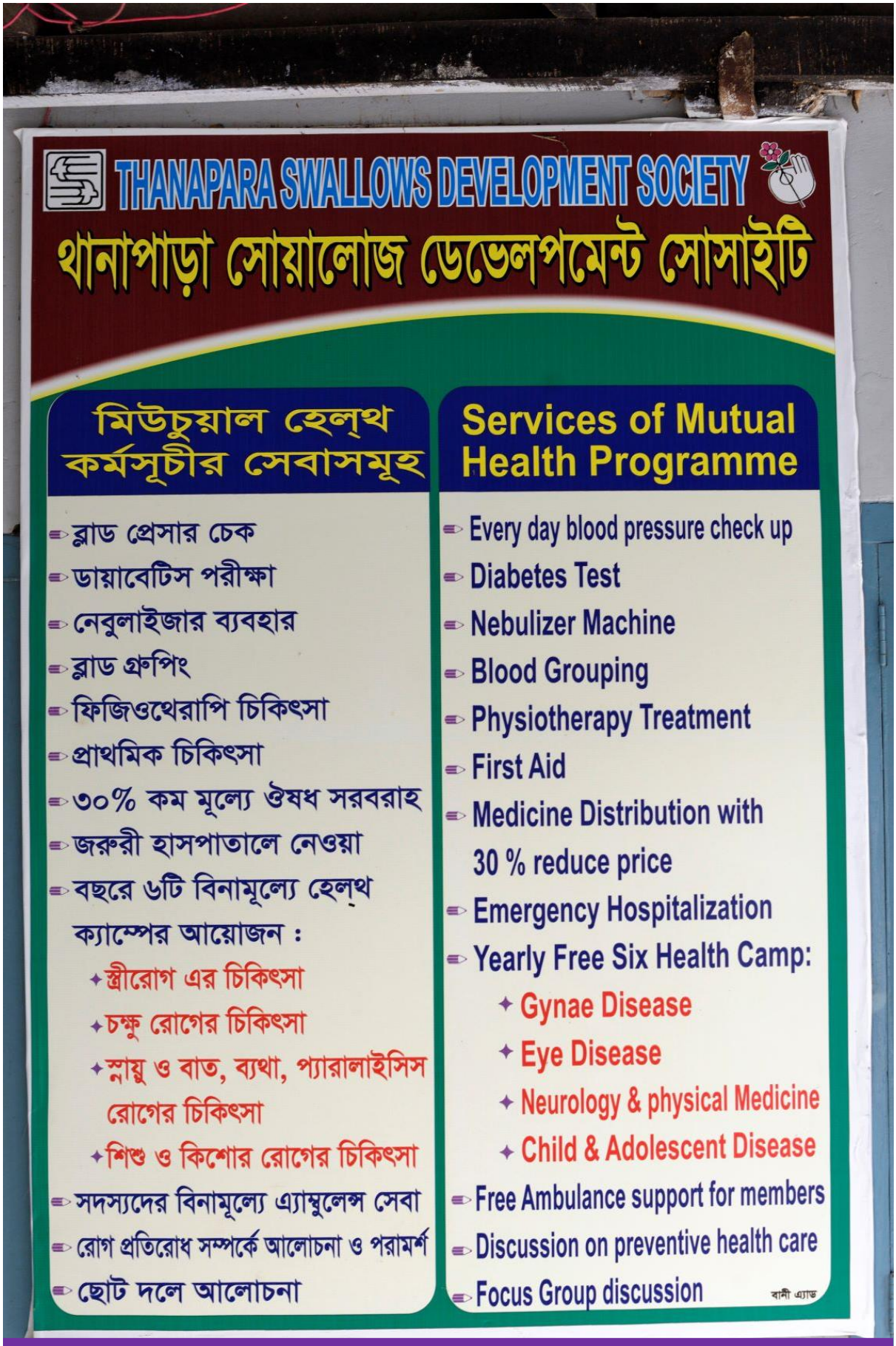
External players also took part in this work:

> Health stakeholders in the local areas where the programmes have been developed, i.e., the health structures that are the mutuals' partners (hospitals, clinics, testing laboratories, health centres, pharmacies, etc.);

> Medical consultants, who provided support during the development and changes to these programmes, by advising and, on occasions, training the local actors, etc.;

> The international experts who, through their involvement in Africa or Asia, helped the movement to analyse, refocus and consolidate some of the fundamental aspects of mutual systems, when necessary.

All in all, a wide range of stakeholders have contributed to Emmaus International's health programmes over the years, enabling different points of view to be heard in order to improve the development and sustainability of the initiatives that have been set up and, above all, to benefit the mutual members.



Care provided by the Mutual Health Organisation run by the Thanapara group (Bangladesh) ©Didier Gentilhomme

II. Analysis and evolution of access to health care between 2010 and 2020

It was clearly not a question of the Emmaus movement reproducing the same model in the different countries. This would have made no sense in terms of its values and philosophy, as for Emmaus, diversity is a source of enrichment for sharing practices. The movement has simply ensured that in the mutual health programmes the fundamental commonalities are respected:

> **Solidarity and mutual aid systems**, supported by the movement, to enable people living in poverty, and even extreme poverty, to have access to quality health care and to reclaim and manage their right to health;

> **Solidarity-based financial mechanisms** at the movement level, because it is the solidarity of the movement and of the groups worldwide that makes these experiences and their long-term support possible. This solidarity is also effective at the local and national level, because it is the mutual members who, on the basis of regular contributions, share health risks;

> **Involvement of the most vulnerable**, because the movement makes it a point of honour for all stakeholders to be involved in the initiative. Of course, not all mutual members can be involved with the same regularity and at the same level, but they all take part in the discussions and debates in dedicated spaces which allow their tool to develop. For example, the choices regarding operations, health benefits, contribution levels, etc. were defined and implemented in consultation with the future beneficiaries. And at each stage of the creation or development of the mutual health organisations, the stakeholders – and first and foremost the mutual members – were consulted, expressed their opinion and made proposals. For Emmaus, this is the indispensable condition for collective success.

This being said, each mutual organisation has its own history, its difficulties, its periods of progress, its moments of doubt or its “mishaps”, related to adapting to the countries, to practices and working methods, to cultures, to levels of management (local or national), to the state of the public and private health sector and even to the population concerned.

In this second chapter, we will therefore analyse membership and contributions, as well as the benefits and health care provided, to be able to answer a number of questions:

> Who are the contributing members of the mutual organisations, and how many of them are there?

> How much are monthly contributions and how do mutual members pay them?

> Are different types of membership available?

> What are the criteria for membership?

> What health services and benefits are mutual members entitled to?

> What is the cost of this?

> How does the reimbursement work for health care (arrangements and processes)?

> What were the developments on each of these points between 2010 and 2020?

a. Types of membership within the four mutual organisations between 2010 and 2020

THE MUTUAL HEALTH ORGANISATIONS IN AFRICA

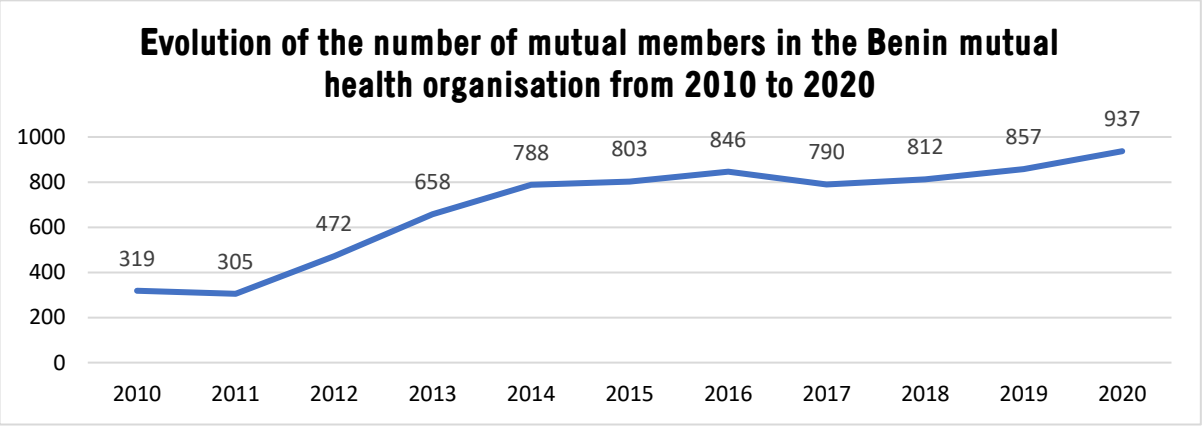
Until the Constitutive General Assemblies of late 2013/early 2014 in each country, the development of the mutual health schemes in Benin and Burkina Faso was similar.

The mutual members were employees of the Emmaus groups and their families. Membership was individual and voluntary and contributions were the same in both countries: 1,000 CFA francs for adults and 500 CFA francs for children and low wage earners. Health care was covered in the same way (75% reimbursement of medical consultations, medicines, medical tests, surgical operations and vaccinations). Members paid health care costs up front and were reimbursed upon receipt of invoices and prescriptions, which were approved or refused via the established procedures (firstly a local representative, then a national management committee).

Between 2010 and 2013, the 2010 recommendations were widely shared during meetings between Emmaus International, the Emmaus groups, representatives, mutual members, and other stakeholders. Some of these recommendations were implemented before the Constitutive General Assemblies, others after.

One of the 2010 recommendations was to **increase the number of mutual members**. This was reflected in **the decision to make membership compulsory, family-based and automatic for all Emmaus group members** (particularly for the member's spouse and children), with family contributions by income bracket.

BENIN: MUTUAL MEMBERS AND MEMBERSHIP



Explanation of developments

A slight drop between 2010 and 2011

The announcement of the change, some of the recommended guidelines and the initial implementation difficulties discouraged some mutual members and impeded the registration of new members, which had been on the rise until then (complicated implementation of third-party payment, change in contribution levels, changes in the mutual organisation's health care provision, etc.). Actual and potential members wondered what would become of their mutual organisation, and the

transition from the old system to the new one was accompanied by a period of indecision. However, the main stakeholders continued their efforts to explain and raise awareness of the essential principles of the mutual organisation, of the restructuring necessary to ensure the long-term future of the system and of the appropriation of the mutual organisation by its mutual members. The vast majority of members and their families remained satisfied with the system.

A sharp increase from the end of 2012 to 2014

The switch from voluntary individual membership to compulsory family membership, with different contribution bands, proved to be beneficial. This measure, introduced in September 2012, allowed for more people and all members of a family to receive health coverage, and also for increased contributions and better sharing of health risks (more people with fewer health risks). The 64% increase in mutual members in the last quarter of 2012, mostly children or adults in the same family, demonstrated this.

A decrease in 2016

There was a further decline in 2016. This was directly linked to the exclusion of the Metokan group from Emmaus International. The organisation was no longer involved in any work linked to the movement, including participation in the Benin mutual health organisation. Initially made up of four groups, the mutual health organisation now had only three.

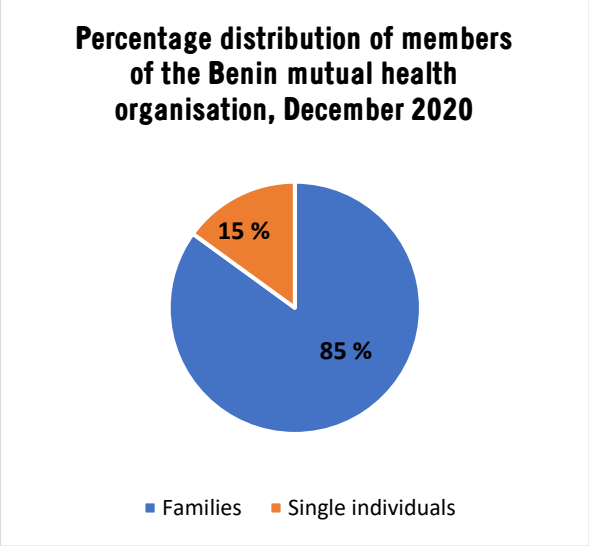
An upward curve continuing until 2020

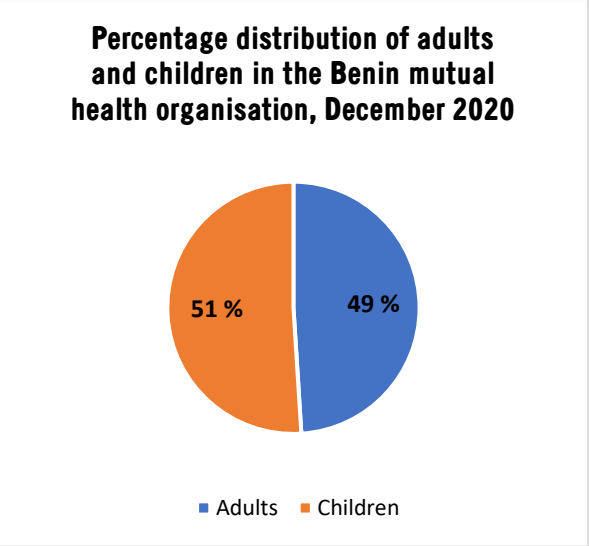
Emmaus International's field missions in late 2016 and mid-2017 redefined the main areas of work and improvement, and strengthened the initial momentum. The expansion strategy, which was a priority, targeted people who were not yet mutual members within the groups, with increased awareness-raising of the solidarity system represented by the mutual organisation, more frequent health education services and the “reintegration”, at their request and under specific conditions, of some of the former members of the ex-Metokan group, who were identified on a case-by-case basis and who did not have any links with the governance of the group.

In 2020, the mutual members of the Benin mutual health organisation were the employees and their families of the three Emmaus groups that are members of Emmaus International in Benin: Emmaus AFA, Emmaus Pahou and Emmaus Tohoué.

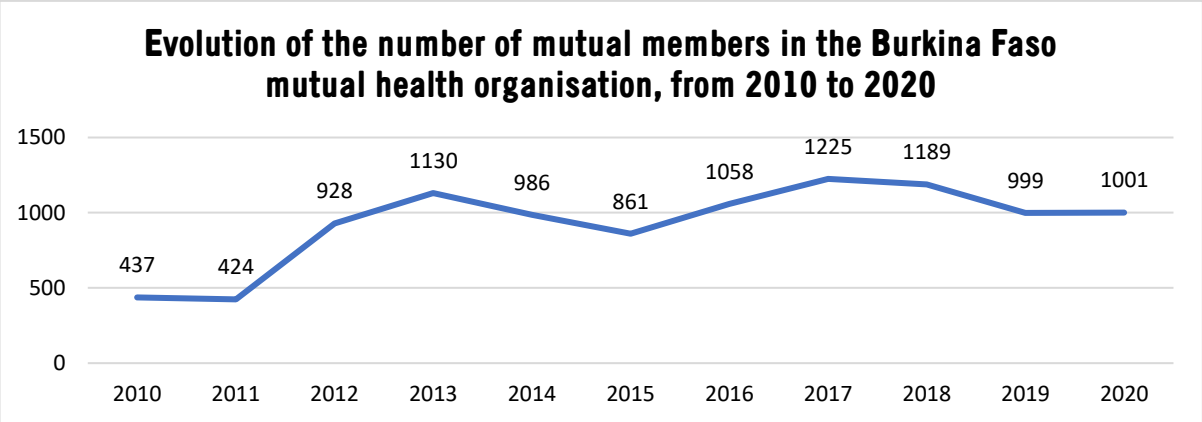
Types of members as of December 2020 (174 members/904 mutual members)

174 principal members including:	
Families	147
Single individuals	27
904 mutual members including:	
Adults	445
Children	459





BURKINA FASO: MUTUAL MEMBERS AND MEMBERSHIP



Explanation of developments

Burkina Faso's membership pattern differs from that of Benin, although similar reasons sometimes explain the phases of evolution.

A sharp increase in 2012

This very sharp increase (up 120%) was linked to the shift from voluntary individual membership to compulsory family membership, as well as to the constant effort made by the groups to welcome new mutual members. This growth lasted until 2013.

A drop between 2014 and 2015

This can be explained by the difficulty in implementing the guidelines adopted in 2010: late introduction of third-party payment, failure to expand the range of health services offered, failure of health care staff to comply with the agreements signed with health centres (high staff turnover resulted in a lack of knowledge of the agreements). Moreover, the groups experienced numerous departures at this time for various reasons (transfer, retirement, resignation, death): more than 100 departures from Pag-la-Yiri in 2014 and 77 departures from Benebnooma in 2015.

An upward curve between 2016 and 2018

As in Benin, Emmaus International's field missions in late 2016 and in mid-2017 gave new impetus to stakeholders and a review of the expansion strategy led to membership being offered to:

> Friends and relatives of mutual members microcredit beneficiaries, sponsored children in the organisations, health workers wishing to join the mutual organisation;

> Emmaus International trial groups and partner groups of Emmaus Burkina Faso (Zod Neere, Boyaba, Boblemeng Ne Wendé, Wend Yaam), whose inclusion was being considered (Boblemeng Ne Wendé and Wend Yaam joined the mutual organisation at the end of 2016).

However, the real increase in the number of mutual members during this period was not without its obstacles.

It was clear that for the Emmaus groups wishing to join the mutual organisation, there was insufficient local involvement and capacity to monitor, coordinate and support the work, particularly for Boblemeng Ne Wendé.

For other people, the mutual organisation provided that all new members should be sponsored by an employee of the group, with the contribution being deducted automatically from the sponsor's salary, and in the case of groups sponsoring children, that each group should deduct the amount of the contribution and pay it to the mutual organisation. In fact, the collection of contributions proved to be a complicated process and contributing member sponsors often found themselves in a difficult situation, as contributions paid for the sponsored persons were not always reimbursed.

A stabilised decline as of 2019

These problems would lead Boblemeng Ne Wendé to break away from the mutual organisation in 2018, as would some of the new members.

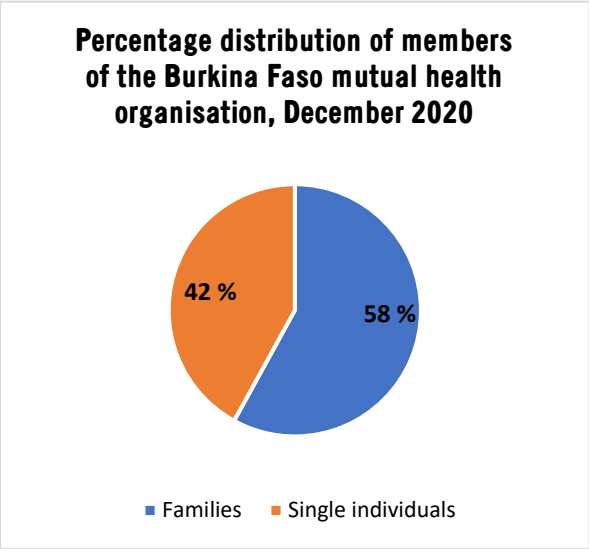
Moreover, it should be remembered that 2019 was a particularly complicated year in Burkina Faso, due to an unprecedented deterioration in the security situation. This led to the cancellation of most of the organisation's meetings, monthly meetings of the national management committee, awareness-raising activities, etc. The pandemic in 2020 also prevented the organisation from functioning properly.

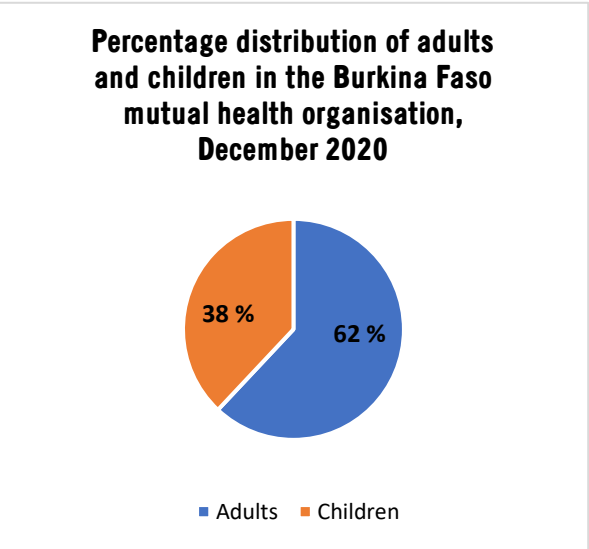
In 2020, the mutual members of the Burkina Faso mutual health organisation were mainly employees of Emmaus groups (four member groups of Emmaus International: Emmaus ESO, Benebnooma, SEMUS, Pag-la-Yiri; an Emmaus trial member: Wend Yaam), plus a few external people.

Types of members as of December 2020 (282 members/1,000 mutual members)

<u>282 principal members including:</u>	
Families	161
Single individuals	121
<u>1,000 mutual members including:</u>	
Adults	623

Children	377





THE MUTUAL HEALTH ORGANISATIONS IN ASIA

In Asia, implementing the creation, management and operation of the two mutual organisations, and the provision of access to health care for the population, required adaptation to a different context than that in Africa.

The members are therefore different and their financial link with the groups is not as close as it may be elsewhere.

If one looks at the standard of living of mutual members in India and Bangladesh, one thing is immediately obvious: it is much lower than that of mutual members in Africa.

In the case of Tara (India), mutual members are the inhabitants of a slum in the south-east of New Delhi (Tajpur Pahadi community, Badarpur). At the time the mutual organisation was launched in 2011, the Badarpur district was predominantly populated by migrants from agricultural regions of India in search of livelihoods and a better life. The district survives on the informal economy and has no public services for access to drinking water, energy or health.

The mutual members were identified by the group within which they had been carrying out several income-generating activities (craft workshop, activities financed by microcredit, savings groups) and community development activities (support classes, sewing and IT lessons, etc.) for over twenty years.

Thanapara is located in an isolated rural area in the north-west of Bangladesh, in the Rajshahi district. The poor health infrastructure is glaringly obvious and difficult living conditions are particularly acute. In this respect, Thanapara is an exception as a provider of local employment owing to its textile production. This work, although dependent on market activity and demand, provides opportunities for dozens of people, mostly women. As discussed further below, mutual members of the Thanapara mutual organisation are also diverse.

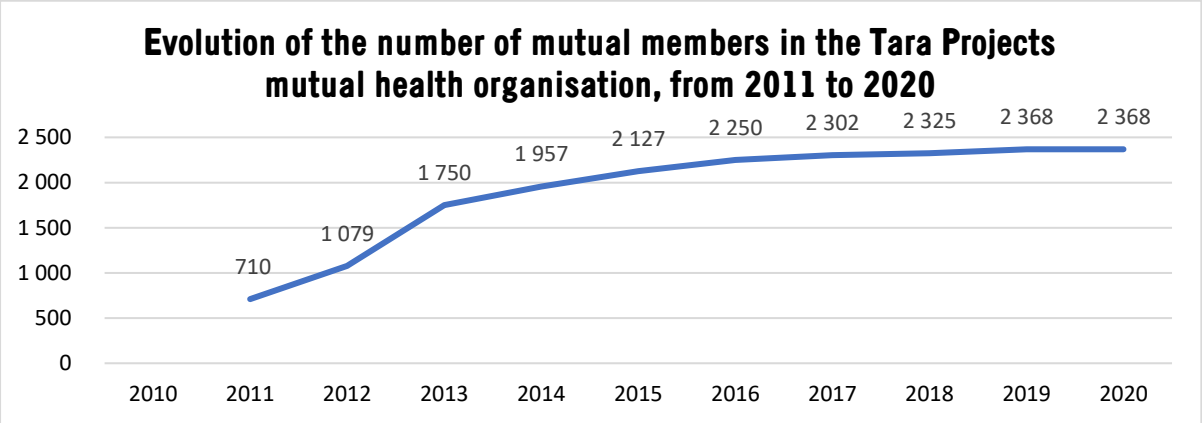
INDIA: MUTUAL MEMBERS AND MEMBERSHIP (TARA)

Some 5,000 families live in the Badarpur district (25,000 to 30,000 people). The health and social context, Tara's link with the population, and the considerations and choices of the mutual members led to the project being built on the following elements:

> Building a health centre in the district;
> Hiring a salaried doctor as part of the project, to provide general consultations, dispense basic medicines for the district's inhabitants, and seek partnerships with existing health facilities considered as priorities by the mutual members in terms of care (tests and hospitalisation, for example);
> A team of mutual member representatives in charge of studying hospitalisation reimbursement claims within a committee;
> Individual memberships for a period of one year (from 1 September to 31 August), for a fee of 250 Indian rupees (INR) – i.e., €4 in 2011 and €2.80 in 2020 – per person (this rate evolved towards preferential rates for families from 2012).

In order to join, the principal member and their family members must live in the Tajpur Pahadi area, Badarpur. An application form must be completed and approved. Wife, husband, children, dependent parents and parents-in-law, and dependent siblings, can join the programme and be entitled to the various health provisions covered by the scheme.

During the annual promotion and membership renewal period, from July to September each year, community representatives, the Tara team and volunteers carry out extensive awareness-raising work (group discussions, district meetings, membership "camps", door-to-door visits, street theatre, communication about the mutual organisation with "Information/Education/Communication" material, etc.).



Explanation of developments

A large number of mutual members from the start

From the outset, the mutual health organisation had 710 individual members, mainly people with an activity or work link with Tara, which had long been established in this densely populated area.

A sharp increase between 2012 and 2013

This 150% growth in membership in two years and 200% in four years is explained by:

- The increased awareness-raising work of the Tara team and word spreading quickly of the benefits of the mutual organisation in terms of access to health;
- The obligation for all microcredit borrowers from Tara who lived in the neighbourhood to join the mutual organisation, at least for the duration of the loan repayment period;
- The beginning of a change in the membership fees, as in 2011 a problem was quickly identified. The fact that membership is not based on a minimum of four members per family undermines the principle of solidarity between mutual members. Indeed, if membership is individual and voluntary, it is the adults, who are more likely to be ill ("anti-selection"), who join first, which leads to a higher number of claims and impacts on the self-sufficiency and sustainability of the system. In order to move towards family contributions, a first step was therefore designed and approved at the 2013 General Assembly. Two rates came into force: annual membership at INR 200 (€2.20) per person per year for members of families of four or more people, and annual membership at INR 250 (€2.80) per person for members of families of two or three people, and for single individuals.

Continued expansion

Although the number of members and mutual members continued to increase over the following years, it is difficult to analyse the evolution in detail, due to the lack of sufficiently precise reporting tools (e.g., number of departures or arrivals of contributors). Nevertheless, there has been a positive trend in the average number of members per family, which rose from 2.6 in 2011 to 3.8 in 2020. Moreover, it should not be forgotten that Tara devotes a lot of energy to the success of the annual renewal campaigns.

Types of members as of December 2020 (616 members/2,368 mutual members)

616 principal members including:

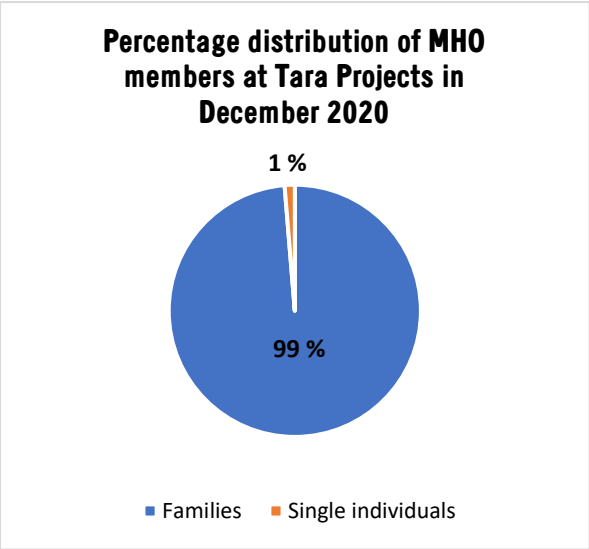
Families	608
Single individuals	8

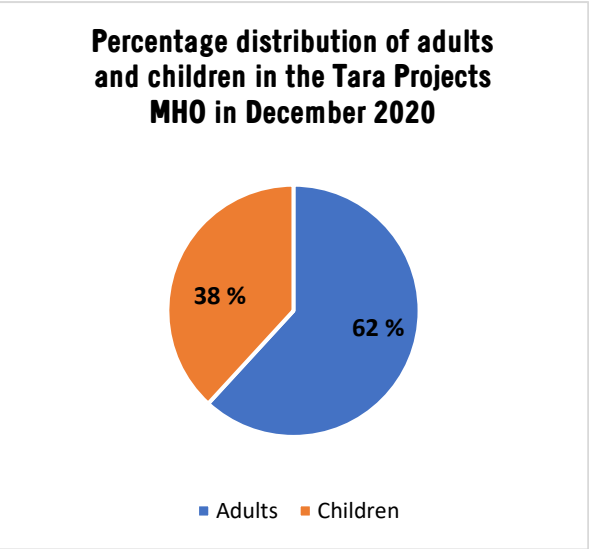
2,368 mutual members including:

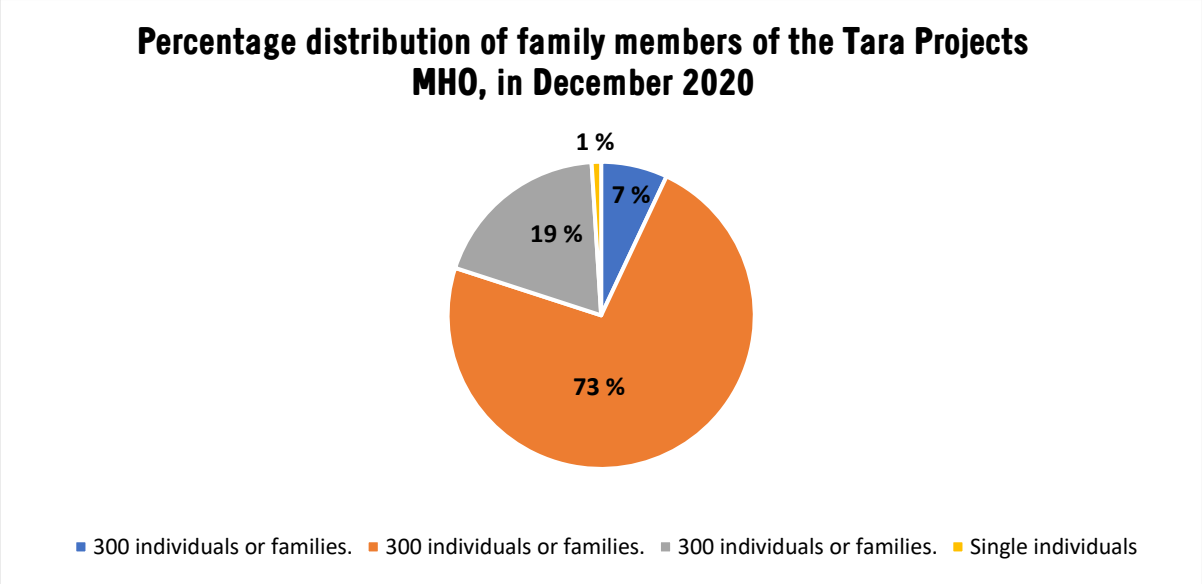
Adults	1,464
Children	904

Family composition:

5-person families	43
4-person families	450
3-person families	115
Single individuals	8







BANGLADESH: MUTUAL MEMBERS AND MEMBERSHIP IN THE MUTUAL HEALTH ORGANISATION (THANAPARA)

Based on the context of the group, the population it works with, the role of the Thanapara organisation in the area and the pre-existence of access to basic medicines, the programme started with:

> The existing health centre, which was to be improved as part of the mutual health programme;

> The presence of a salaried nurse as part of the programme, who carries out consultations, dispenses basic medicines and refers mutual members to the surrounding health facilities;

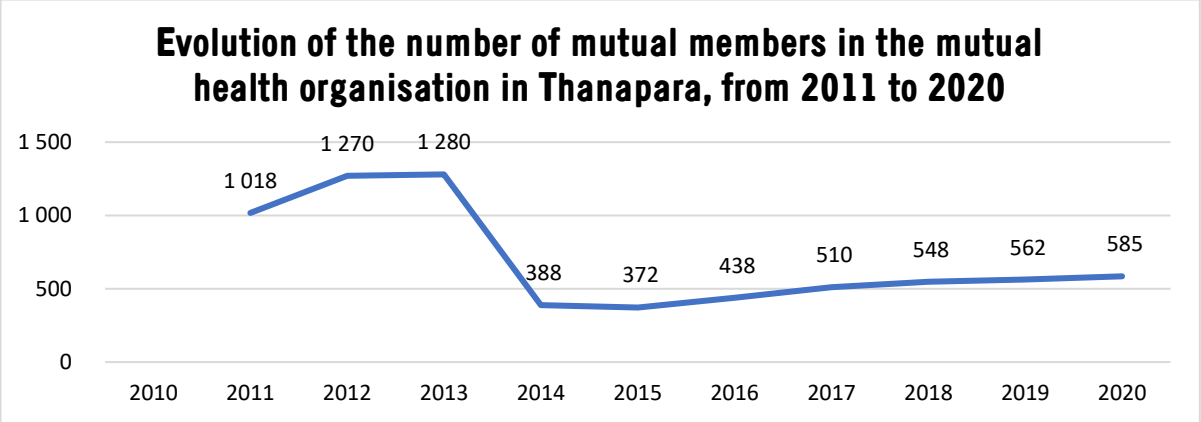
> A team of mutual member representatives in charge of studying hospitalisation reimbursement claims within a committee;

> An individual membership fee of 50 takas (€0.50) per person per year;

> Individual monthly membership contributions of 10 takas (€0.10) per person (this increased to 15 takas – €0.15 – in 2016).

During the study carried out in 2010, different "target" mutual members were identified: craft producers working in Thanapara's textile production unit (mainly women), members of the group's school (students and students' families), employees of the organisation's permanent team, microcredit borrowers, and the members of the various social action programmes developed by Thanapara.

Thanapara decided, initially, to progress step by step, giving priority to people with a strong link to the group (financial, geographical, work or activity link): craft producers, members of the school, and employees of the group.



Explanation of developments

Enthusiasm from the start

In 2011, when the mutual organisation started up, there were 1,018 initial mutual members.

A fall in the number of mutual members in 2013-2014

At the end of 2011, Thanapara's director experienced serious health issues. The initiatives he had put in place held up until 2013, then collapsed for several years: mobilisation ceased, there was no longer any coordination and the members of the group tried as best they could to ensure a minimum level of functioning.

A very slow recovery

Between 2014 and 2020, one problem followed another: mobilisation was still at a standstill, the formal school closed for two and a half years, the textile sector experienced economic difficulties in 2018 and 2019, and then the pandemic in 2020. All economic and social projects were impacted, in addition to the health programme.

In this context, it is particularly difficult for Thanapara to achieve the objectives defined collectively in terms of activities, involvement of mutual members, development of the membership policy, pricing of benefits, etc.

That said, the number of mutual members has nevertheless increased moderately in recent years, owing mainly to the inclusion of micro-borrowers.

b. Types of contributions, benefits and reimbursements for health care in the four mutual organisations between 2010 and 2020

To be viable, a mutual organisation must have a balanced “contributions-to-benefits” ratio.

In Africa, this is one of the main points of attention since the reform. To improve this ratio, many initiatives have been introduced concerning membership, contributions, benefits, agreements, control methods, etc. The results at the end of 2020 are convincing and there has been a clear improvement in the “contributions-to-benefits” ratios in Benin and Burkina Faso.

In Asia, the specificity of the contexts and populations joining the mutual organisations, the very form of these organisations and the organisation of access to health care, make it difficult to achieve a balance and greater overall financial self-sufficiency. As the operating costs of the health centres are very high, solutions are being examined to minimise them and to find new resources.

However, it should be borne in mind that no mutual social protection system is balanced, let alone in surplus, with the exception of private insurance, the very high costs of which are accessible only to a minority. For example, take the French social security system: it provides wide basic health coverage for the population, but has been in deficit for many years and, regularly, new financial mechanisms (taxes) are tried out to “bail out” the funds. Yet the French population has a greater financial capacity than the mutual members targeted by the movement in Africa and Asia.

THE MUTUAL HEALTH ORGANISATIONS IN AFRICA

Contributions

For the record, the amount of the contributions must take into account the members’ declaration of financial capacity, the desired health coverage, and the actual cost of the services.

The change in membership arrangements (from voluntary individual membership to compulsory family membership) and the transformation of contributions, which were now calculated by band to promote solidarity between families, was accompanied by an immediate overall increase in the volume of contributions.

The membership system agreed upon includes three contribution brackets for the two African mutual organisations. It came into effect in the last quarter of 2012.

Since 2002

Voluntary individual contributions

1,000 CFA francs/month (adults)

500 CFA francs/month (children and low wage earners)

From September 2012

Brackets	***Family membership rate***	***Single individual membership rate***
Income under 30,000 CFA francs/month	2,000 CFA francs/month	400 CFA francs/month
Income between 30,000 and 90,000 CFA francs/month	2,500 CFA francs/month	480 CFA francs/month
Income over 90,000 CFA francs/month	3,000 CFA francs/month	560 CFA francs/month

Health benefits

The level of benefits depends on the **frequency** of treatment and the **cost** of these procedures. Since 2002, the cost of health services has always been much higher than the volume of contributions collected and the contributory capacities of group members.

In 2010, a calculation was made which showed that a contribution of 7,250 CFA francs per person per month would be needed to cover the volume of health services spent at that time. It was therefore essential to find a way of reducing the overall cost of services and adjusting the contributory capacity of mutual members.

Here again, the recommendations of the 2010 report were implemented progressively, after discussions and approval by all mutual members, in order to reduce the number of services and to take action on both frequency and costs:

> Exclusion of the least used services: medical consultations and vaccinations (except those covered by national vaccination campaigns);

> Exclusion of health check-ups;

> Information provision and awareness-raising on the care pathway to be followed by mutual members (health pyramid, different levels of care, use of generic medicines, role of the GP, etc.);

> Negotiation and agreement with health facilities (public establishments, as a priority, with an acceptable quality of care, and private social or religious entities), annual monitoring of contracts.

As of 2013, health provisions in Benin and Burkina Faso have included:

> 70% coverage of medical tests, medicines and surgical operations;
> Health education sessions organised regularly in all groups (at least every quarter) on the most common health topics (diarrhoeal diseases, malaria, typhoid fever, food hygiene, etc.).

Methods of reimbursement

Today, two methods of reimbursement exist.

Since 2002, **direct reimbursement** to mutual members has been carried out – via the mutual organisation's local representatives – after presentation of invoices and prescriptions for health costs to these representatives, as well as their verification and approval each month by the national management committee.

Reimbursement from health facilities covered by an agreement is also possible. These agreements (research on which began in 2013) allow for **better control of health care expenditure** (only those services included in the mutual organisation's package of services are invoiced, guaranteed compliance with the care pathway, and facilities for which the quality of care and rates are verified) and the **development of third-party payment**, with mutual members only having to pay the co-payment, i.e., 30% of the cost of the service.

New rules and essential controls

To achieve financial autonomy, **rigorous controls** and good bookkeeping are essential. Moreover, in order to significantly reduce the overall cost of benefits and to curb, or even stop, the rare abuses that can weigh financially on the mutual organisations, several measures were decided upon after information and awareness-raising meetings with mutual members (conducted by the local representatives, medical consultants and elected representatives of the Burkina Faso board):

> Producing mutual member cards, with updated payment of contributions, photos of the principal member and beneficiaries from the same family;

> Stricter control at the national management committee level, with the stamp of the attending physician and the stamp of the health facility being required on health care invoices received;

> Non-reimbursement of invoices received three months after treatment;

> Distributing a regularly updated list of mutual members to all the health facilities covered by an agreement;

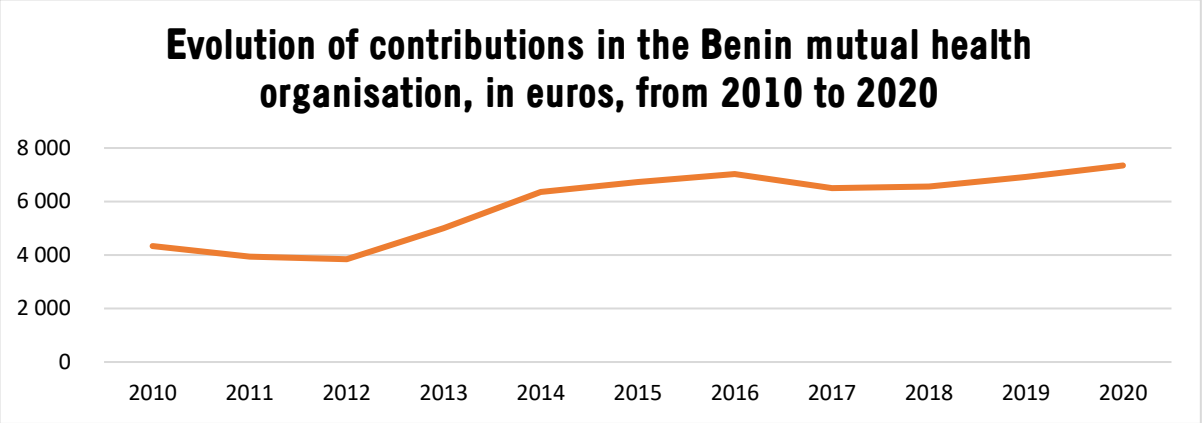
> Hiring a medical consultant to carry out the work of establishing agreements with health facilities, organising health education sessions, supporting the national management committee each month in checking the health care invoices for reimbursement and reporting to Emmaus International;

> Excluding mutual members in the event of non-payment of contributions for three months;

> Setting up an audit committee made up of mutual members with accounting skills to check the organisation's accounts and payments each year, as well as the mutual organisation's document filing system.

BENIN

Evolution of contributions



As can be seen, between 2010 and 2020, the evolution of contributions follows that of membership.

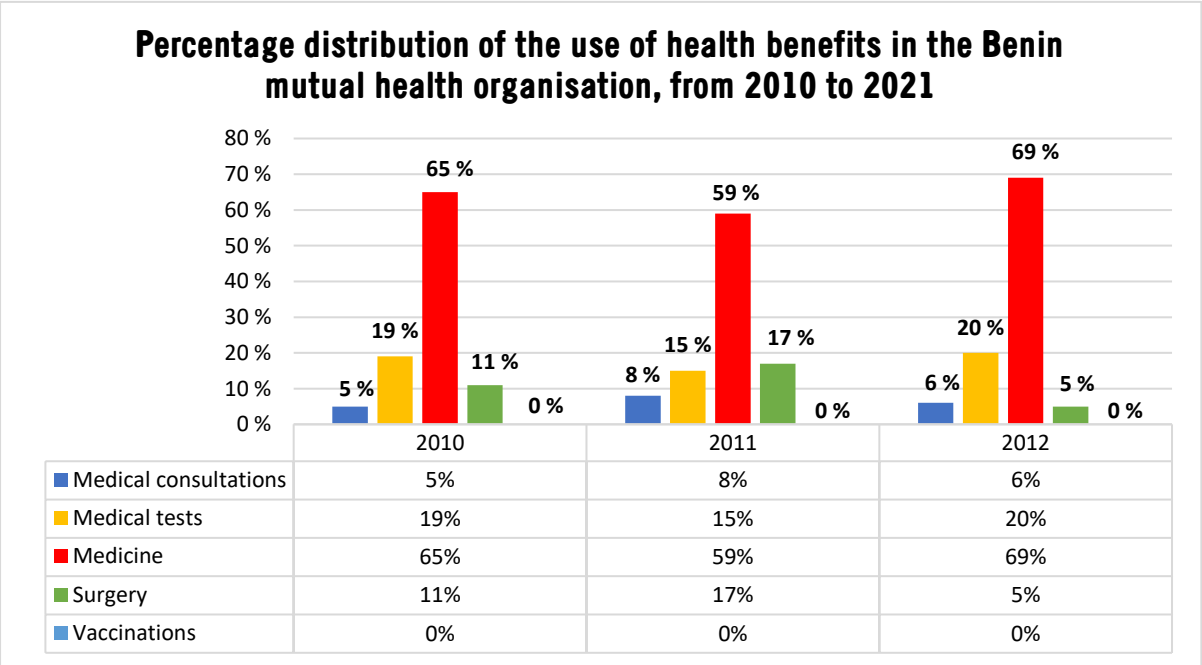
Contributions can be paid in several ways:

> Deduction at source for group employees. This is usually done on a monthly basis, but can be quarterly, half-yearly or annual, at the discretion of mutual members. Most opt for a monthly contribution, with a small minority choosing to contribute quarterly;

> For members from outside the groups, they are required to pay their membership fees directly every quarter or half-year to the local representatives of each local Emmaus group. There are frequent delays in the payment of external members' contributions and the local representatives in charge of collecting them encounter many difficulties in this respect.

Evolution of benefits

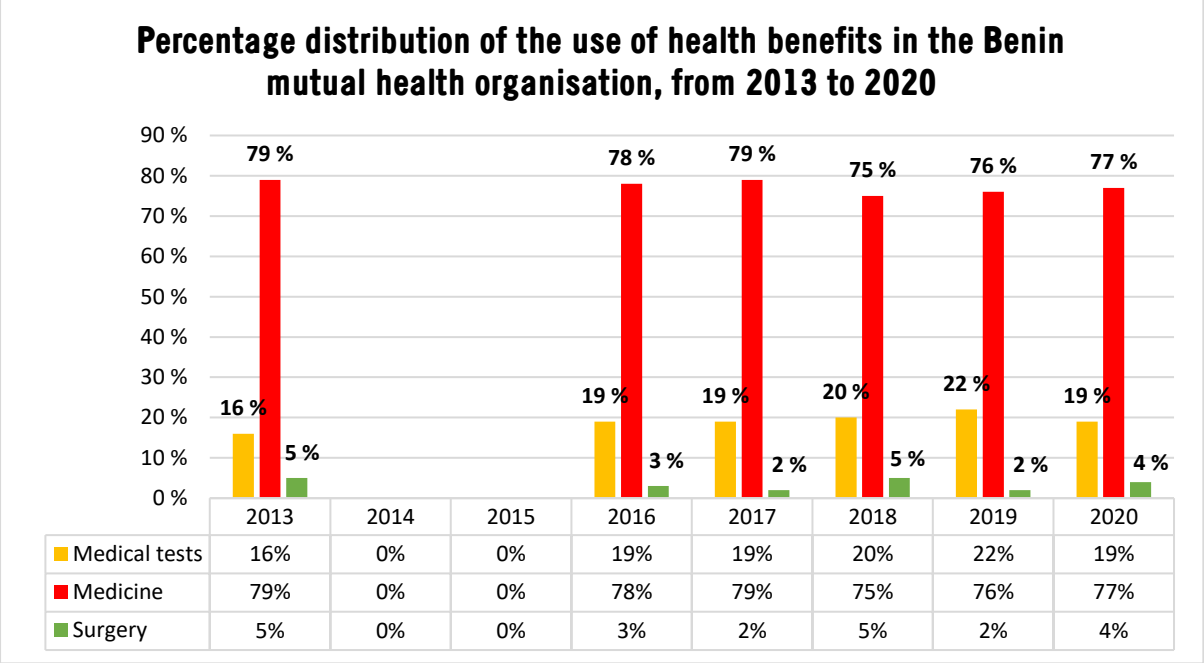
Pre-reform



	2010	2011	2012
Medical consultations	5%	8%	6%
Medical tests	19%	15%	20%
Medicine	65%	59%	69%
Surgery	11%	17%	5%
Vaccinations	0%	0%	0%

Prior to the reform, vaccinations and medical consultations were the least used benefits. Considering that they were not a big burden on families' budgets, it was decided to withdraw them. Conversely, although occurring much less frequently, surgical operations represented a significant cost for an individual or a family and sharing this financial risk among mutual members seemed an obvious decision.

Post-reform



	2013	2014	2015	2016	2017	2018	2019	2020
Medical tests	16%	0%	0%	19%	19%	20%	22%	19%
Medicine	79%	0%	0%	78%	79%	75%	76%	77%
Surgery	5%	0%	0%	3%	2%	5%	2%	4%

NB: Data for 2014 and 2015 not provided.

The largest item of health expenditure, close to 80% each month – with variations within the same year depending on the period (malaria in July and August, colds and coughs at the end of the year) – is medicines.

In terms of prescription and consumption of generic drugs, little progress has been made on the part of mutual members or health facilities. Generics are not used systematically and accessing them is not always easy, which leads to higher costs – sometimes three times higher (depending on the month).

From this point of view, Benin is still put at a disadvantage by the fact that the state unit responsible for quality control of imported medicines (many of them from India) has not been able to function for a long time, but also that some of these generics – because they are under-dosed – have proved to be less effective. This reality has left its mark on public mentality and still gives rise to many prejudices among consumers and prescribers alike, despite the enormous amount of awareness-raising work carried out in the field to explain that generics are the same as specialty drugs (same active ingredient, same dosage, same method of administration).

Evolution of methods of reimbursement

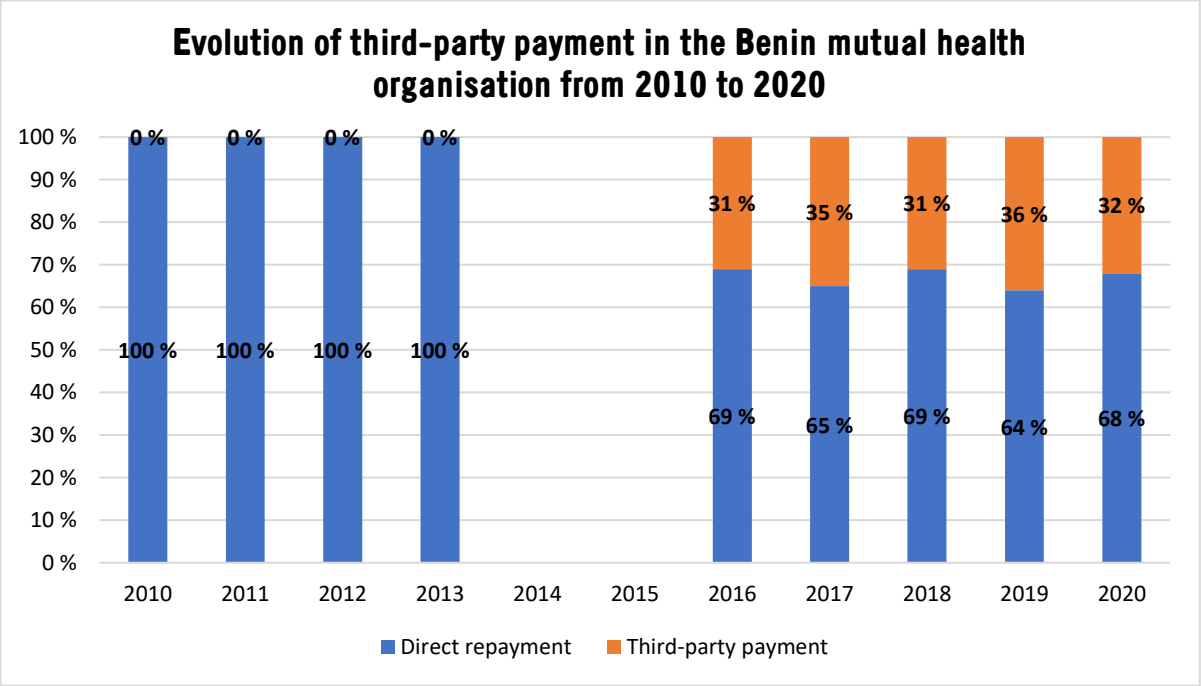
Although direct reimbursement to mutual members upon receipt of invoice has existed in Benin since the mutual organisation was created, the reimbursement of health facilities covered by an agreement via a third-party payment system is more recent. This process is a fundamental element of the mutual organisation, as it allows mutual members to take care of their health without having to worry about the cost of treatment. Previously, many of them were in debt to unscrupulous loan sharks, which worsened their financial situation and sometimes led them not to seek treatment.

In Benin, third-party payment has been in place since the first agreements were signed, in 2012. It allows mutual members to pay only the 30% of the remaining costs, while the 70% covered by the mutual organisation is invoiced directly by the health facility to the mutual organisation.

During the first two years (2012-2013), third-party payment was not used at all. The health facilities visited did not use this method of operation (lack of knowledge of the system within the facilities, mistrust of professionals with regard to the solvency of the mutual organisation) and the mutual members were either not in the habit of asserting their right to third-party payment, or else went to health facilities that are not yet covered by an agreement.

Work has been done in this respect since the reform, but it has taken a long time to bear fruit. It is only from 2016 onwards (no data are available for 2014 and 2015) that we start to see members using third-party payment, roughly equivalent to one third of total reimbursements.

Although awareness-raising sessions have been carried out by the medical consultant, the system suffers from irregular local coordination and follow-up by the group leaders and representatives.



NB: Data for 2014 and 2015 not provided.

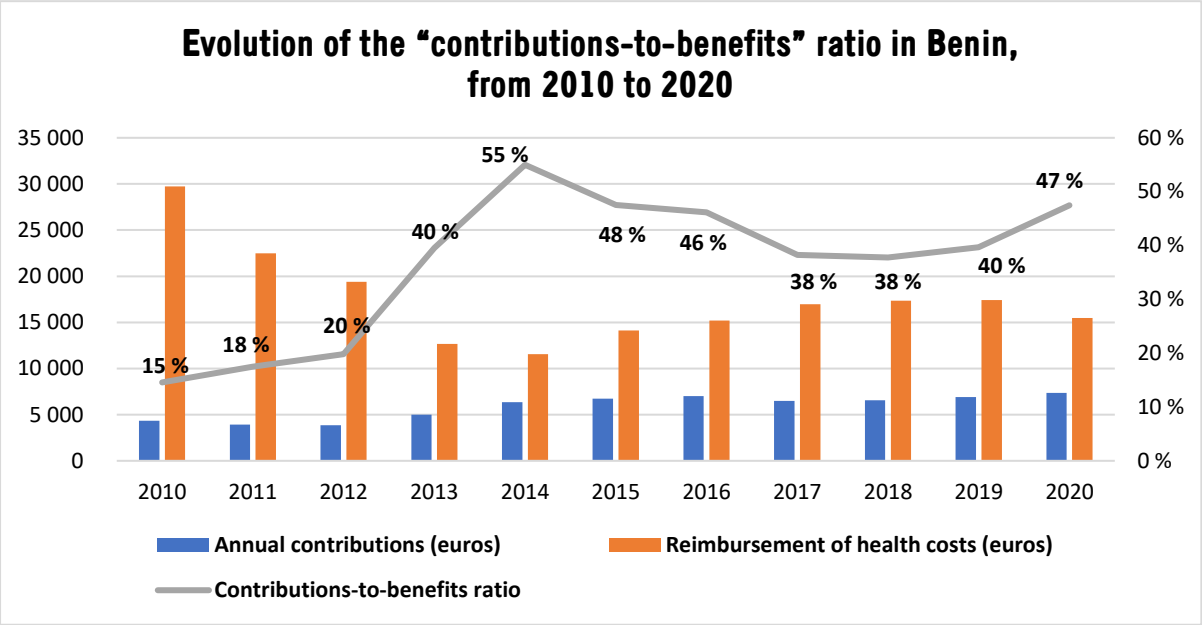
Evolution of agreements with health facilities

In Benin, ten health facilities are covered by an agreement. These are health centres, clinics and hospitals. No pharmacies are covered by an agreement, as they are not interested (additional management costs for too small a number of mutual members and too little financial gain).

New rules and essential controls

Today, strict controls have been established in Benin. Only one element has not been introduced: setting up an audit committee to check the organisation's accounts and payments each year, as well as the mutual organisation's document filing system.

Evolution of the "contributions-to-benefits" ratio

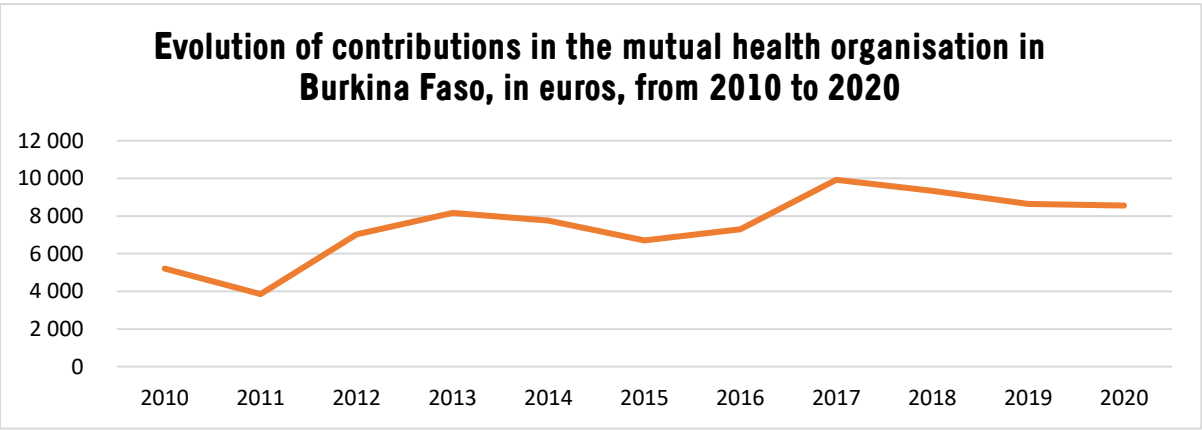


From the evidence provided, the positive evolution of the "contributions-to-benefits" ratio compared to the pre-reform period is evident: during the first ten years (2002-2012), this ratio was between 15% and 20% each year (for the Benin and Burkina Faso groups combined). Since the reform, it has fluctuated in Benin between 38% and 55%.

However, the overall level of benefit costs remains high and is hardly covered by the share of contributions, despite the increase in membership, the change to contribution categories and the development of more rigorous rules and control tools.

BURKINA FASO

Evolution of contributions



Between 2010 and 2020, the evolution of contributions follows that of membership in Burkina Faso too.

As in Benin, two processes exist:

> Deduction at source for group employees. In this case, there is in theory no delay in the payment of monthly contributions. The groups deduct the amount of the contribution defined each month directly and pay it to the mutual organisation via the local representative, who participates in the monthly national management committee meeting;

> For external members or members who have no financial link with the groups, a monthly or quarterly payment procedure has been put in place (people sponsored by employees or families of children attending schools or training centres).

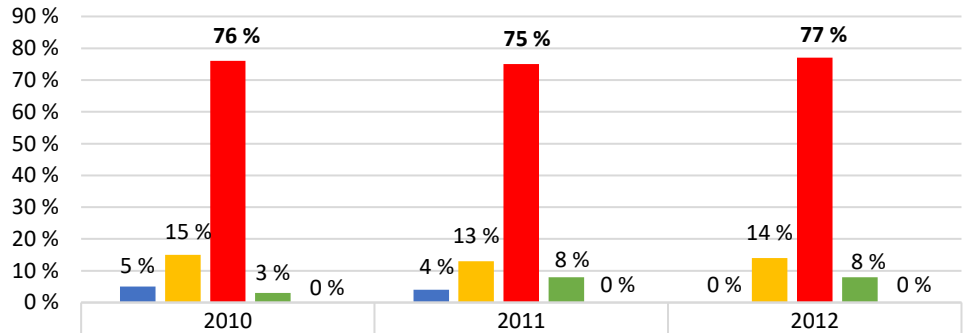
However, two problems have been identified. As mentioned above, late payment and non-recovery of contributions from external members is a regular occurrence, which puts the Emmaus sponsors in a difficult position, as they advance these contributions from their salaries. In addition, some groups in Burkina Faso frequently postponed or forgot to pay their monthly contributions to the mutual organisation, which has led to a change in the system. From now on, contributions are paid three months in advance, which ensures that there is no shortage of funds and that mutual members are reimbursed more quickly.

Notwithstanding this new system, late payments of contributions are regularly recorded each quarter (sometimes up to two quarters in arrears).

Evolution of benefits

Pre-reform

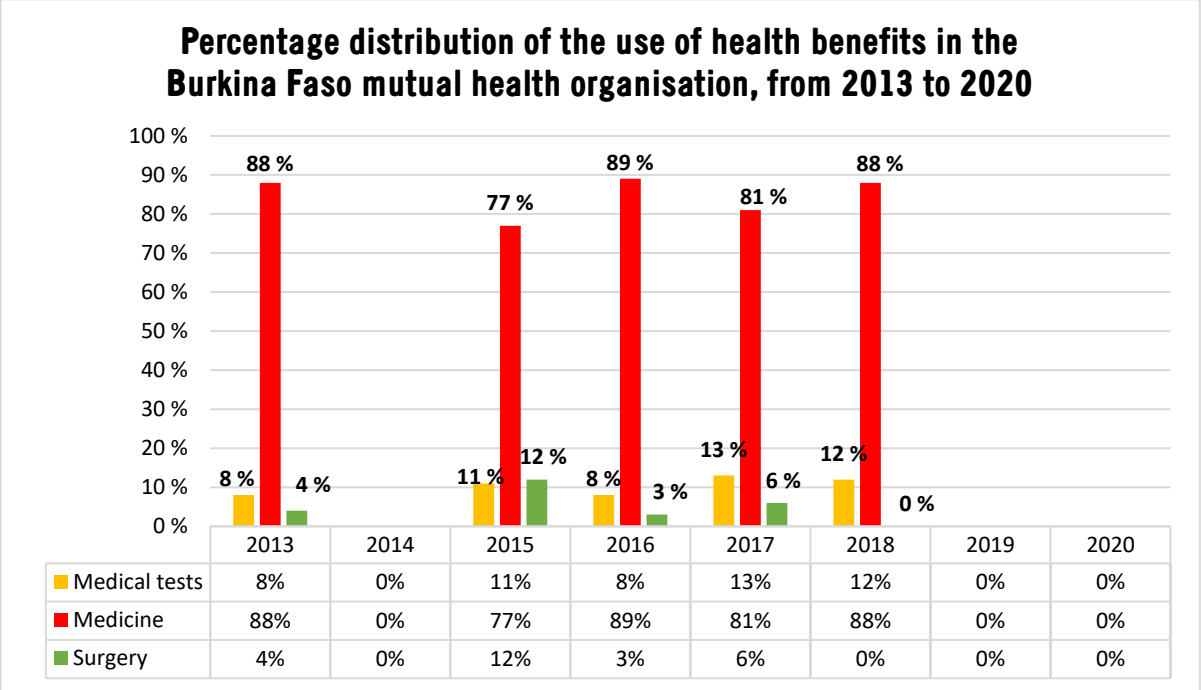
Percentage distribution of the use of health benefits in the Burkina Faso mutual health organisation, from 2010 to 2012



	2010	2011	2012
Medical consultations	5%	4%	0%
Medical tests	15%	13%	14%
Medicine	76%	75%	77%
Surgery	3%	8%	8%
Vaccinations	0%	0%	0%

The distribution of the use of health benefits in Burkina Faso is roughly the same as that in Benin. In 2013, mutual members also changed these benefits to focus only on access to medicines, surgical operations and medical tests.

Post-reform



	2013	2014	2015	2016	2017	2018	2019	2020
Medical tests	8%	0%	11%	8%	13%	12%	0%	0%
Medicine	88%	0%	77%	89%	81%	88%	0%	0%
Surgery	4%	0%	12%	3%	6%	0%	0%	0%

NB: Data for 2014, 2019 and 2020 not provided.

After the reform, the distribution of health benefits in Burkina Faso is almost identical to that in Benin. There are 10% more medicines in Burkina Faso (88% compared to 78% in Benin), 6% to 7% fewer medical tests (12% in Burkina Faso compared to 19% in Benin) and a roughly similar proportion of surgical operations.

As can be seen in the graph above, the overall distribution of health benefits is not available for 2019 and 2020. In fact, since 2019, the organisation has only collected invoices from health facilities covered by an agreement. This can be seen as a good thing in some respects: obligation for mutual members to comply with the care pathway, more patients for health facilities covered by an agreement, full use of third-party payment.

With regard to the consumption of generic medicines, unlike Benin, the Burkina Faso mutual organisation has, since 2015, identified and broken-down expenditure between generic and specialty drugs at the national management committee meetings. An enormous amount of awareness-raising work on the use of generics has been carried out among mutual members and health facilities covered by an agreement since 2016, leading to an increase in the consumption of generics and a decrease in that of specialty medicines between 2015 and 2017.

However, information in this area is lacking for the period 2018-2020.

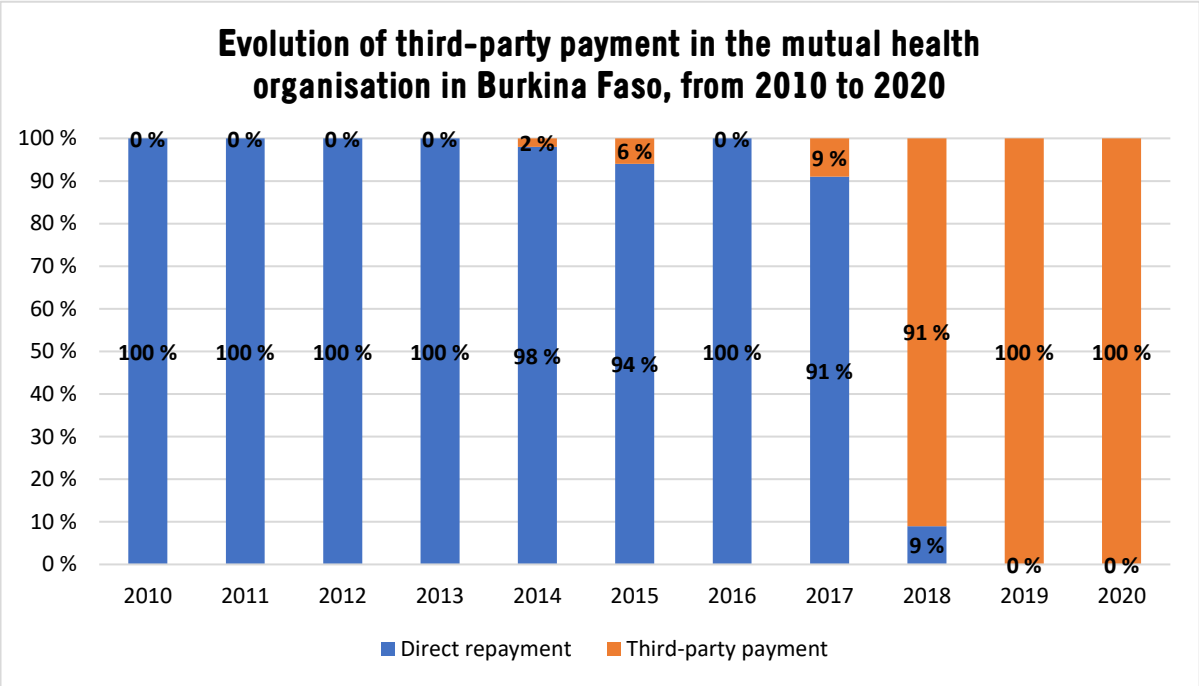
In order to be able to monitor and analyse changes in the consumption of health care and to specify the type of services and medicines provided, the liaison and communication documents between the health facilities and the mutual organisation will therefore have to be reviewed.

Evolution of methods of reimbursement

Direct reimbursement to mutual members upon receipt of invoice and reimbursement of health facilities covered by an agreement are also the two existing processes in Burkina Faso.

Until 2017, third-party payment was rarely used by mutual members, despite the awareness-raising carried out and the recommendations of the mutual organisation's board and local representatives, for the same reasons as those already mentioned for Benin (mistrust of health professionals with regard to the mutual organisation's solvency, lack of knowledge of the mechanism by a majority of professionals, attendance of non-health facilities covered by an agreement by mutual members).

A major development occurred at the end of 2018, which enabled third-party payment to become the norm: the mutual organisation decided in its board meeting to only reimburse invoices issued by establishments covered by an agreement moving forward. The mutual organisation considered that, with all the tools in place, mutual members could be treated fairly easily in the health structures covered by an agreement (which are more aware of the sale of generics), which limited the number of invoices containing products or treatment not covered by the system.



If mutual members submit claims for reimbursement of treatment or products that are not covered, the national management committee reimburses the amount of the benefits spent that are included in the mutual programme. It is explained to mutual members that treatment and products not included in the mutual health programme (consumables during hospitalisation, skin care creams, cosmetic products, etc.) are not reimbursed.

This said, despite the very positive development of the switch to 100% third-party payment, some health centres sometimes persist in invoicing for treatment or products not included in the mutual organisation's benefits.

Evolution of agreements with health facilities

Initially carried out by the medical consultant hired in 2011, the agreements with health facilities have since developed. The mutual organisation has sought to establish agreements with as many health facilities as possible that meet the criteria for each geographical area. It goes without saying that the health care provision is more extensive in Ouagadougou, the capital, than in rural areas such as Pag-la-Yiri (Zabré district). However, mutual members can receive treatment in any of the country's facilities covered by an agreement, regardless of the Emmaus group to which they belong.

Nevertheless, in reality, access to health facilities (covered by an agreement or otherwise) remains difficult for mutual members in rural areas. This situation is independent of the mutual organisation and is linked to Burkina Faso's public health policy.

This is why, depending on their needs, mutual members can now identify health facilities in their area that are not covered by an agreement and submit their proposals to members of the mutual organisation's board, who will then study them with a view to potentially establishing a new agreement.

With this in mind, but also in order to increase the number of centres with the same advantages accessible to mutual members, agreements have been drawn up with the higher levels of public health facilities – i.e., the districts. This is the case for the districts of Zabré (location of the Pag-la-Yiri group) and Koudougou (location of the Benebnooma group); the agreements signed allow mutual members to access all the district's health and social promotion centres (CSPS), with the same advantages. The CSPS are local health centres and the gateway to the health system of Burkina Faso.

The health centres that are currently covered by an agreement are either public establishments or private entities of a social or religious nature. In total, twenty-four health facilities (clinic, hospital, CSPS, dispensary, borough medical centre [CMA]) and eighteen pharmacies are covered by an agreement, which increases the possibilities of access to quality care, rapid treatment and the introduction of third-party payment.

While the frequent turnover of health care staff is sometimes accompanied by ignorance of past agreements and the rights of mutual members (particularly with regard to third-party payment), this is relatively quickly overcome once local coordination maintains a regular, substantial link with the health facilities.

In conclusion, it should be pointed out that each year the mutual organisation's board sends its comprehensive annual report, along with a letter of thanks, to all the health facilities that have signed an agreement.

New rules and essential controls

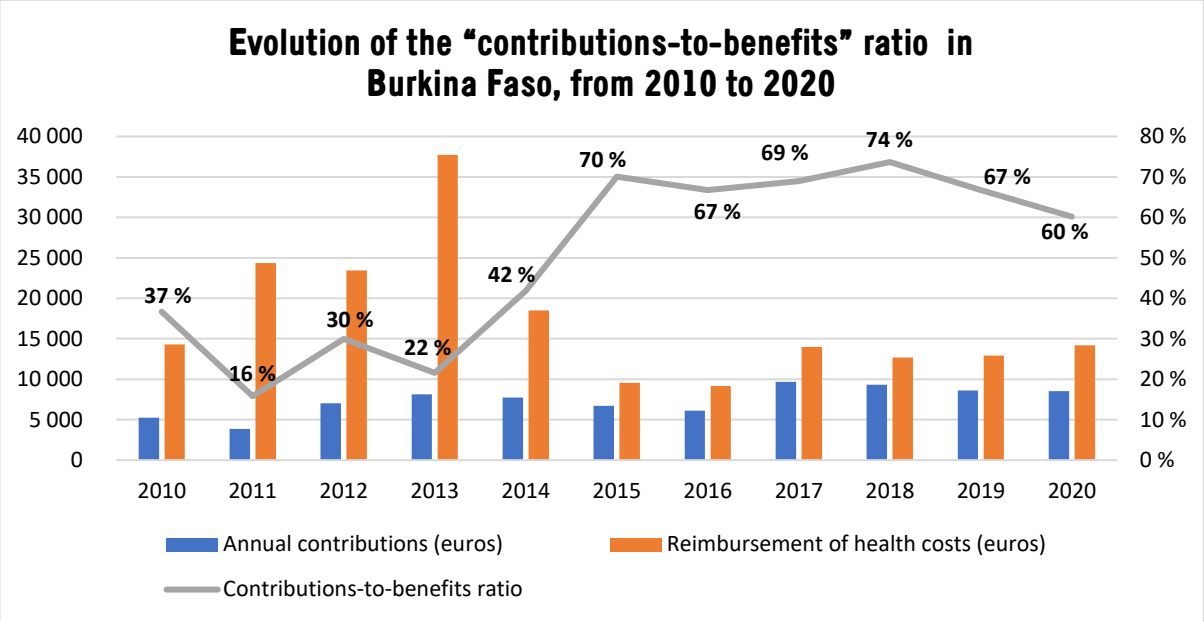
In Burkina Faso, too, rigorous checks have been put in place.

However, the audit committee, provided for at the 2013 General Assembly, has only carried out one audit. In 2016, the organisation went through an external company to validate its accounts and ask for recommendations on bookkeeping and the filing of the mutual organisation's documents.

In 2016, Emmaus International also stopped working with the medical consultant recruited in 2011 (due to unsatisfactory work and frequent absences from the national management committee).

However, the work continued, thanks in particular to a dedicated office that filled the gaps and took over the tasks of the medical consultant: establishing agreements with health facilities and supporting the national management committee each month to check the health care invoices to be reimbursed. Other alternatives have also provided support for certain tasks: a focal point for each Emmaus group area supports the local representatives in maintaining links with the health facilities. The focal point also raises awareness about generic medicines and provides health education sessions.

Evolution of the "contributions-to-benefits" ratio



There was a clear improvement in the "contributions-to-benefits" ratio as of 2015, two years after the official implementation of the reform.

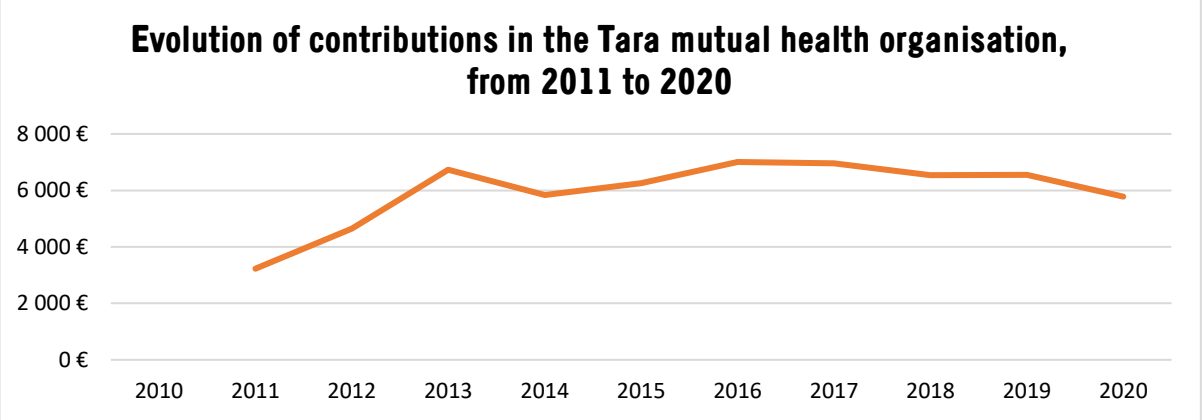
Some recommendations have largely contributed to this progress, in particular the change in membership and contribution methods, the development of health benefits, the proliferation of agreements and stricter procedures in terms of the verification of invoices and the consumption of benefits, etc. These good results are also due to the very good management of the organisation and the current board, as well as to its will to galvanise local actors.

As for 2019 and 2020, the ratio – although still high – was of course impacted by the various crises; firstly, the security crisis, and then the pandemic.

THE MUTUAL HEALTH ORGANISATIONS IN ASIA

TARA

Evolution of contributions



Here again, the evolution of contributions follows the overall evolution of membership between 2011 and 2020, with the exception of 2014 and 2015.

In Tara, the change in fees approved at the 2013 General Assembly became effective in 2014: families of at least four people saw their membership fee drop from 250 INR to 200 INR per person per year.

This intervention, which allowed more people within families to be covered (especially children), was accompanied by a decrease in revenue from contributions (stagnation in 2014, then a slight decrease in 2015, owing to the change in the profile of member families). The "anti-selection" that prevailed due to individual contributions fizzled out and the average family size rose from 2.6 people in 2013 to 4.2 people in 2015.

In other words, we end up with the same number of families, more mutual members and less income from contributions.

Evolution of benefits

The Tara mutual health organisation today offers a wide range of health care benefits, which is different from that of the African health organisations.

From the outset, Tara invested its own funds to build a health centre in the Badarpur district and to finance the purchase of medical equipment. Admittedly, this initiative transforms the principle of the mutual health organisation (putting mutual members in contact with existing health facilities).

In 2011, when the mutual organisation started up, the health benefits were as follows:

> Low-cost consultation with a GP hired at the health centre and dispensing of medicines; This health care provision meets the needs of families, who now have access to a health facility in the heart of the district. They have confidence in the quality of the treatment and medicines provided by the centre and the doctor;

> Potential referral to a laboratory for tests discounted by 50%;

> Reimbursement of 80% for hospitalisation up to a maximum of 10,000 INR;

> Free access to the themed "health camp" (specialised health care day held in the Badarpur centre, by means of paying relevant health care professionals: eye care, gynaecology, dental care, etc.).

In 2011, the system provided access to a consultation and medicines at a rate of 10 INR (€0.10). The rate was increased to 20 INR (€0.20) from March 2016, a development that was approved at the General Assembly in February 2016 following a process of reflection and discussion with mutual members.

Non-members of the mutual organisation can also attend a consultation at the centre, but at a higher rate (50 INR).

In addition to health care benefits, the mutual insurance company has been developing the following free of charge since 2013:

> Health prevention and education sessions: information and awareness-raising meetings, door-to-door visits to mutual members, and street theatre. These activities are carried out by Tara social workers;

> Health talks, which are held regularly in small groups at the Badarpur centre. In addition to the health and hygiene-related aspects, time is devoted to explaining the mutual organisation and the benefits it brings to mutual members.

In the system implemented by Tara, the operating costs are very high (particularly due to the wage bill).

Moreover, since 2014, the mutual organisation has developed new services at the Badarpur health centre, in order to have resources renewed and to be able to treat and monitor patients on-site, sometimes for several days, before referring them to hospitals for extensive tests:

> Day hospitalisation: 200 to 300 INR depending on the case (€2.25 to €3.40);

> Physiotherapy treatment (since 2015): 30 INR (€0.30) per thirty-minute session;

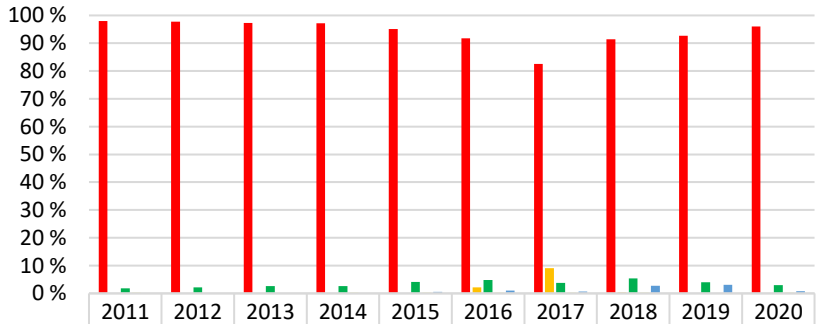
> Performing a blood glucose test: 20 INR (€0.20) per test;

> Hiring a female doctor. This recruitment of a female doctor, which many women in the district wanted, was made possible by Tara thanks to a grant obtained for this purpose (from October 2016 to January 2018).

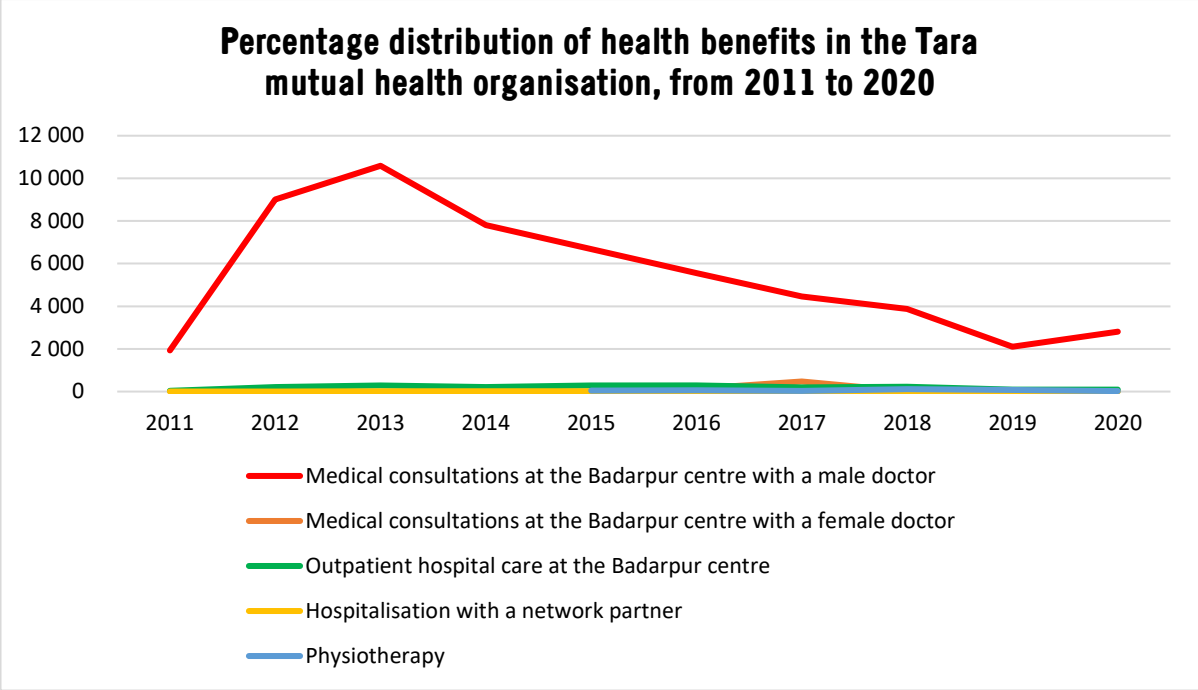
The organisation has also expanded the range of health benefits and established partnerships – which constitute the mutual organisation's network – with hospitals, as well as specialised health facilities (ophthalmology, dental care, radiography, etc.), and religious establishments. Some partnerships are verbal (public hospitals are not allowed to enter into formal agreements with external bodies without government approval), while others are formalised in a memorandum of understanding.

Finally, some services with partners are negotiated, while others are not. In all cases, mutual members pay costs up front before being reimbursed.

Percentage distribution of health benefits in the Tara mutual health organisation, from 2011 to 2020



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Medical consultations at the Badarpur centre with a male doctor	98%	97.7%	97.3%	97.2%	95.1%	91.8%	82.6%	91.4%	92.7%	96%
Medical consultations at the Badarpur centre with a female doctor						2.2%	9.1%	0.3%		
Outpatient hospital care at the Badarpur centre	1.8%	2.2%	2.6%	2.6%	4.1%	4.8%	3.8%	5.4%	4%	3%
Hospitalisations with a network partner	0.2%	0.1%	0.1%	0.2%	0.2%	0.2%	0.2%	0.2%	0.1%	0.2%
Physiotherapy					0.6%	1%	0.7%	2.7%	3.1%	0.8%



This graph shows the clear prominence of medical consultations, as well as the decrease in their volume as of 2013 (the year that health awareness and education sessions started to be held regularly).

Partnerships/Agreements

From the outset and until the end of 2020, Tara developed its network. In total, fifteen partnerships have been established. Five of them are with public facilities: these are hospitals designed to receive cases requiring hospitalisation or urgent treatment.

The ten other facilities include:

> Six radiography, testing and analysis centres;
> One general medical diagnostic centre;
> One private (religious) hospital;
> One dental care and treatment centre;
> One centre for eye care, treatment and surgery (mutual members receive free cataract surgery).

Reimbursement methods for health services

There is only one method of reimbursement within the Tara mutual health organisation (reimbursement upon receipt of invoice), the process of which, developed with the mutual members, is stated in mutual organisation's general policy document.

A care pathway to be followed has been defined. When a member of the mutual organisation falls ill, they consult the doctor at the Badarpur health centre, who refers them to a suitable hospital if necessary. When admitted to a hospital, the member must inform the mutual organisation's medical team.

The contributing member receives the necessary treatment, pays the hospital invoice, and then submits a claim for reimbursement to the mutual organisation with the hospital documents, invoices, etc.

At a meeting of the local steering committee, which is in charge of studying the claims, the Tara social worker on duty at the health centre, the contributing member representatives and the doctor check the invoices and documents submitted. The claim is then approved or rejected and a rate of reimbursement is decided according to the general policy rules of the mutual organisation.

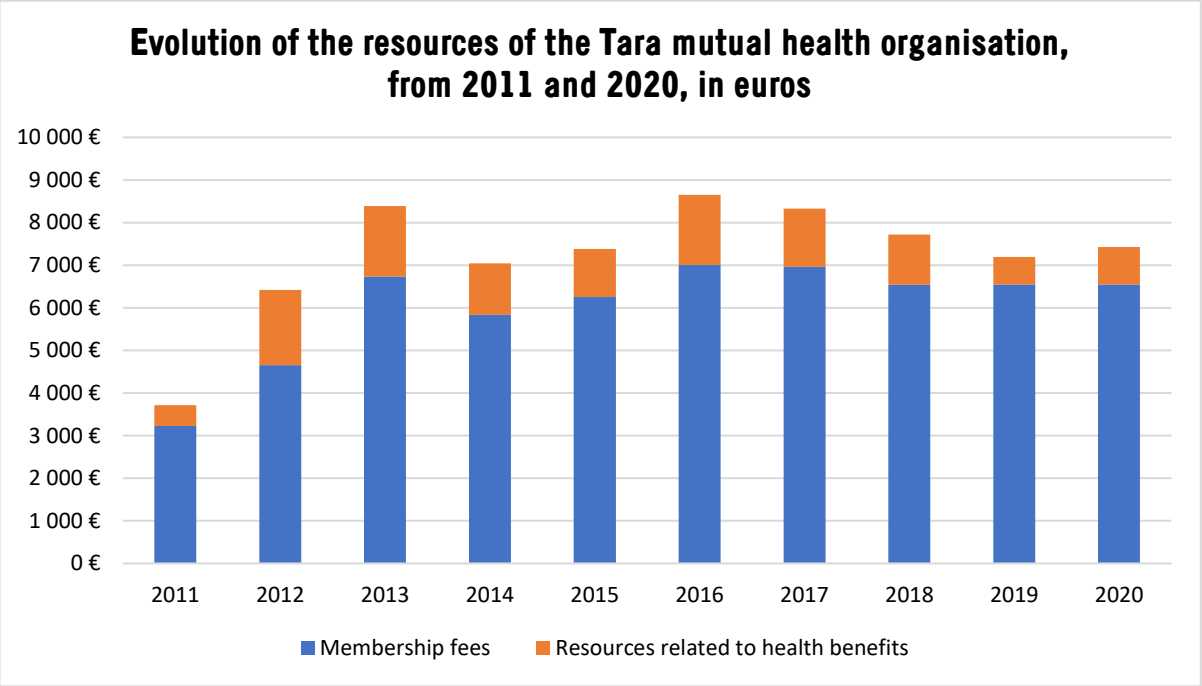
Regardless of the proportion of reimbursement approved, the contributing member is received by the steering committee and the rate of reimbursement applied is explained. Decisions are carefully recorded in the hospitalisation monitoring tool.

Evolution of the "contributions-to-benefits" ratio

As mentioned at the beginning of this chapter, access to health care has been developed differently in the Asian groups. It cannot therefore be analysed solely from the point of view of "contributions-to-benefits" since other factors are involved.

In these mutual health systems, it is more appropriate to take into consideration the resources linked to access to health (contributions and resources generated by the health benefits provided) and overall expenditure (hospitalisation costs, purchase of medicines for the Badarpur centre, cost of transport for transfers to facilities in the partner network, regular "health camps", wage bill of staff at the centre, etc.).

In terms of resources, the mutual organisation includes contributions and sources of income from the various services provided at the Badarpur health centre.

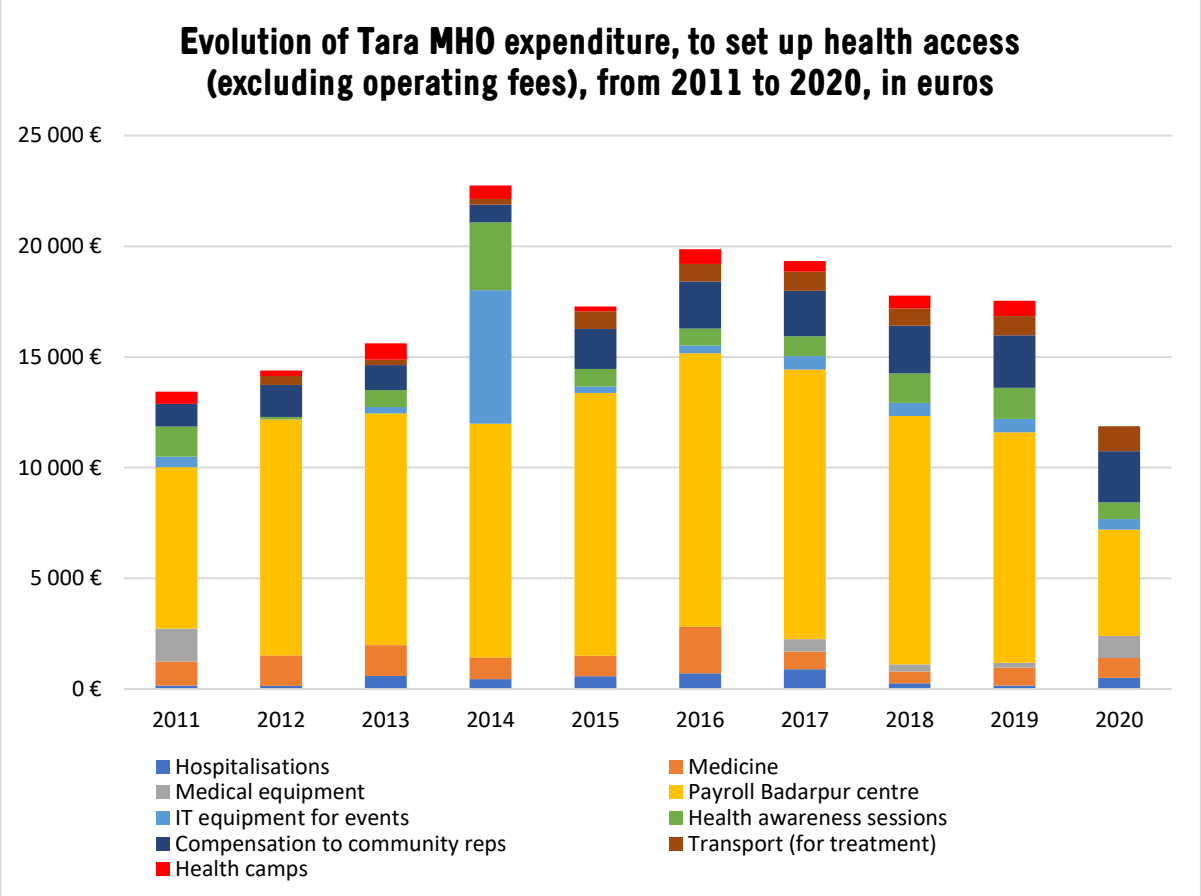


To a certain extent, the drop in consultations with the doctor at the Badarpur centre as of 2013 is compensated for by the increase in the number of other paid health services, which help to maintain the "contributions-to-benefits" ratio.

It is worth remembering here that while paid health services – even low-cost ones – are a significant source of funding for the mutual organisation, they also benefit mutual members who would not be able to access these services outside the mutual organisation, as the cost is too high.

In terms of health expenditure, costs include:

> Hospitalisations, which represent a maximum of 0.2% of the number of procedures each year since 2011;
> The purchase of a stock of medicines and consumables for the Badarpur health centre;
> Operating costs and medical equipment for the health centre and the day hospital;
> Transport costs to partner facilities;
> The wage bill for the health centre and day hospital (salaries of the GP and the social worker);
> Costs related to organising "health camps";
> The costs of facilitating health discussions (meetings, and Information, Education and Communication (IEC) materials);
> Allowances paid.



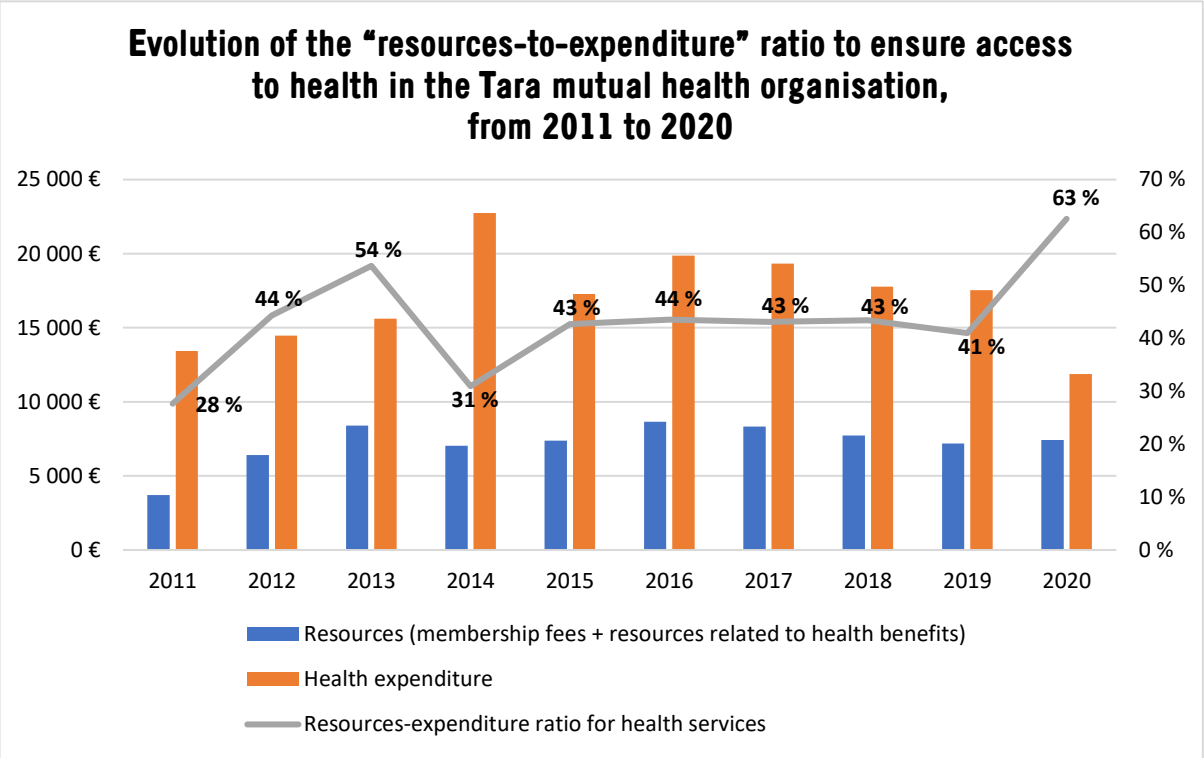
This graph calls for a number of comments.

First of all, that 2011 was a special year: there were only six months of operation, and it was marked by substantial investment in medical equipment.

Secondly, 2014 was the year the organisation invested in health education – a greater number of sessions were held, particularly with new mutual members, resulting in additional costs due to the production of resources (IEC material), and also of membership cards.

The third comment concerns the year 2020. This year was exceptional, as the centre suffered the consequences of the Covid-19 pandemic: several weeks of closure, additional medical equipment purchased (two oxygen cylinders), no "health camp", health education sessions carried out only between January and March, etc.

Finally, the preponderance of wage bill should be noted. This corresponds to the salaries of the GP and the social worker (present at the health centre every day). These salaries, as is customary in India, increase every year.



For this graph too, some comments are necessary.

Here again, 2011 is not representative. There are various reasons for this: only the doctor's salary was fully included, more medical equipment and materials were purchased, the services of the Badarpur health centre other than consultations had not yet been set up, and the "health camps" only started in 2012.

The year 2013 was marked by a sharp increase in the number of mutual members – and therefore in the financial income from contributions – while the year 2014 saw a greater number of health education sessions (due to an increase in the number of mutual members). This led to costs for the development of IEC materials, in addition to the usual operating costs.

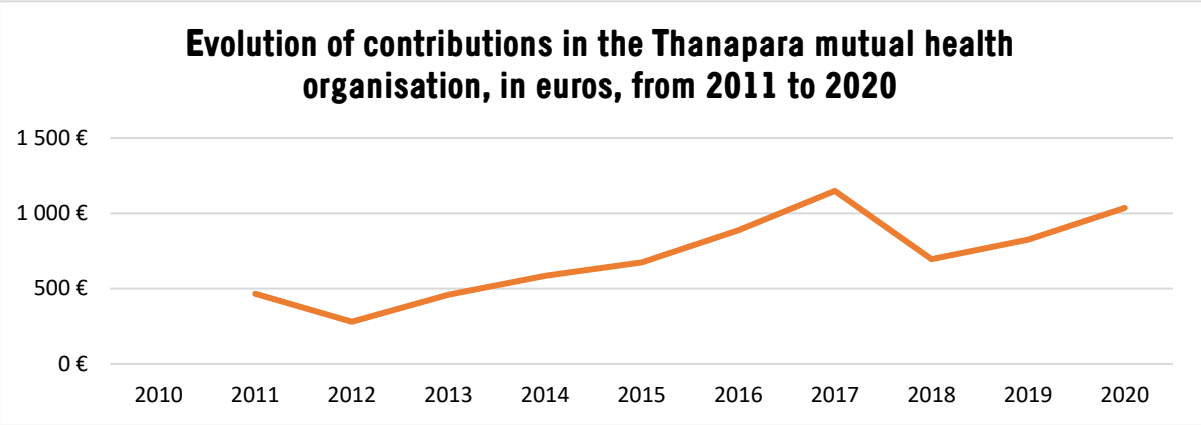
Between 2015 and 2019, the "resources-to-expenditure ratio" stabilised, before increasing in 2020. However, given the health crisis, which led to the closure of the centre for three months, with employees working part-time up until December and a decrease in operating costs, it does not reflect the mutual organisation's usual activity.

Finally, it is worth noting the interest shown in this mutual health programme by Tara, which shares the costs through an annual financial contribution of several thousand euros.

THANAPARA

Evolution of contributions

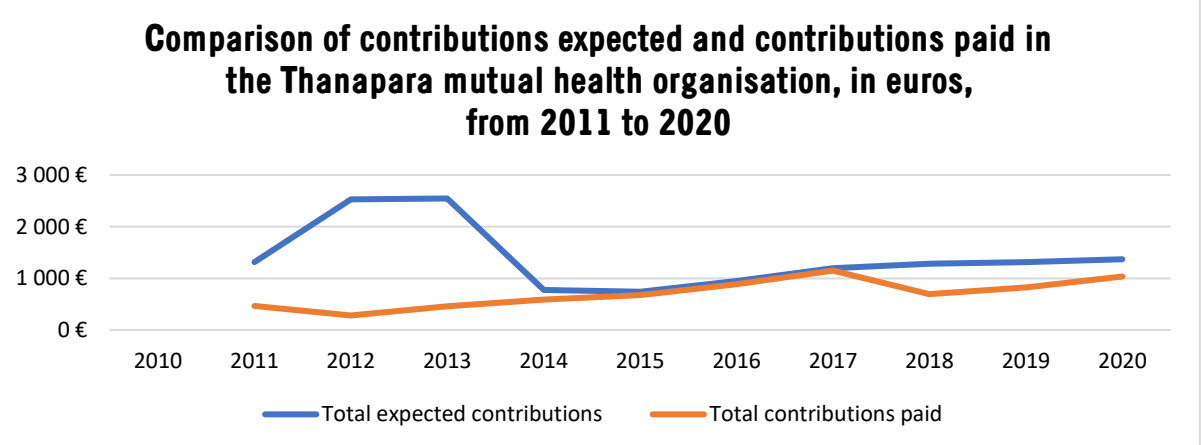
In Thanapara, mutual members make two types of payment: an annual membership fee of 50 takas (€0.50) and a monthly contribution of 10 takas per person (from 2011 to September 2016), which then became 15 takas (from October 2016 to 2020).



Contrary to what was observed for the mutual organisations studied previously, here the evolution of contributions does not follow that of membership, particularly for the years 2012, 2013, 2018 and 2019. These four years show the difficulty of collecting contributions, linked to mutual members' financial problems due to a persistently difficult economic context, but also to poor mobilisation by the mutual organisation in terms of explaining how it operates and the principle of solidarity.

The table below shows that the recovery rate is particularly low for the years 2011, 2012 and 2013, and very modest for the years 2018 and 2019. Only in 2015, 2016 and 2017 does it cross the 90% threshold. The increase in the recovery rate from 18% to 75% between 2013 and 2014 can be explained by the drop in the number of mutual members in 2014, those who remained members being those who had the most financial links (employees), work links or geographical proximity links (craft producers).

Year	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Recovery rate	35%	11%	18%	75%	91%	93%	96%	54%	62%	75%



Although the group clearly does not wish to penalise mutual members by depriving them of access to health, work on the collection of contributions must be put in place quickly.

That being said, two points should also be borne in mind: on the one hand, that the group has endeavoured, in years that were particularly difficult economically for the craft industry (2018 and 2019), to recover the missing contributions in the following year (even if some of the contributions remained due) and that the sums recovered have been included in the “Contributions and memberships paid” row of the table. Secondly, that Thanapara's salaried members regularly offer an extra day's pay to contribute to other members' fees (not included in the “Contributions and memberships paid” row).

Contributions are paid differently for different beneficiaries:

> For the craft producers and Thanapara's salaried staff, contributions are paid in cash each month to the project manager;
> For micro-borrowers, contributions are paid in one lump sum for the year when the loan is paid out;
> For members of the school, payment is made in two instalments, at the time of the two scheduled payments in the year to pay for school fees;
> For Thanapara employees, the amounts are deducted from their salaries each month.

Except for employees, the difficulties in collecting contributions also show the limits of a system where membership is not systematic.

Evolution of benefits

Thanapara is located in a very poor rural context, far from health facilities. The local public hospital is 5 km away, in Sardah. Although it provides basic health care and services, the medical equipment (technical platform, consumables, etc.) is lacking. Rajshahi Hospital, 30 km from Thanapara, offers many high-quality hospital services, but it is difficult to reach, especially in the event of an emergency.

It was this situation that prompted the group to set up a health centre many years ago. This gave the inhabitants of the village of Thanapara the opportunity to benefit from a free consultation with a nurse (part-time) and from low-cost medicines financed by the organisation.

With the implementation of the mutual health programme, progress has been made:

> The health centre has been moved within the group to more suitable and larger premises, allowing it to receive more people and equipment. The nurse is now a full-time employee. He examines patients and dispenses the medicines required at a low cost or refers patients to the appropriate existing health facilities (Chargat or Rajshahi Hospital);

> The consultation is free for mutual members. Medicines are sold at 70% of their purchase price. Blood sugar tests are charged at 5 takas and blood pressure checks are free;

> Rest beds have been installed and equipment for carrying out tests and physiotherapy treatments has been purchased;

> Reimbursement of hospitalisation fees has been implemented according to the following schedule (defined by Thanapara);

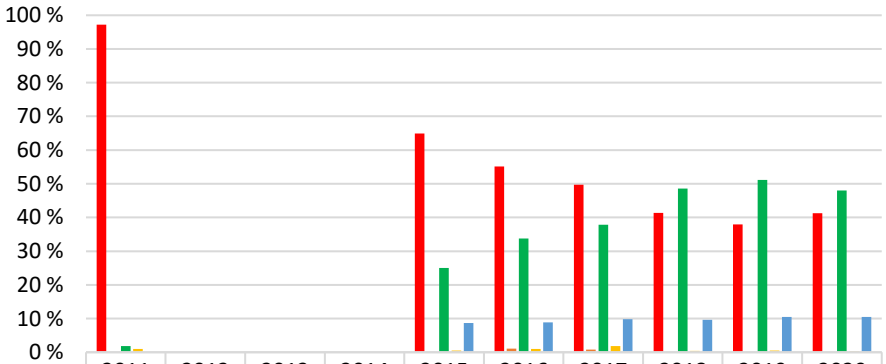
Amount of expenditure by the contributing member	Level of reimbursement
Up to 500 takas	80%
From 501 to 1,000 takas	70%
From 1,001 to 2,000 takas	60%
From 2,001 to 3,000 takas	50%
Over 3,000 takas	40%

> An ambulance service makes it possible to reach hospitals in the event of an emergency, with the mutual members concerned paying 50% of the petrol costs;

> Regular "health camps" (three to four per year) lasting half a day or a full day enable mutual members to benefit from more specialised care, free of charge: eye care, gynaecological care, etc.

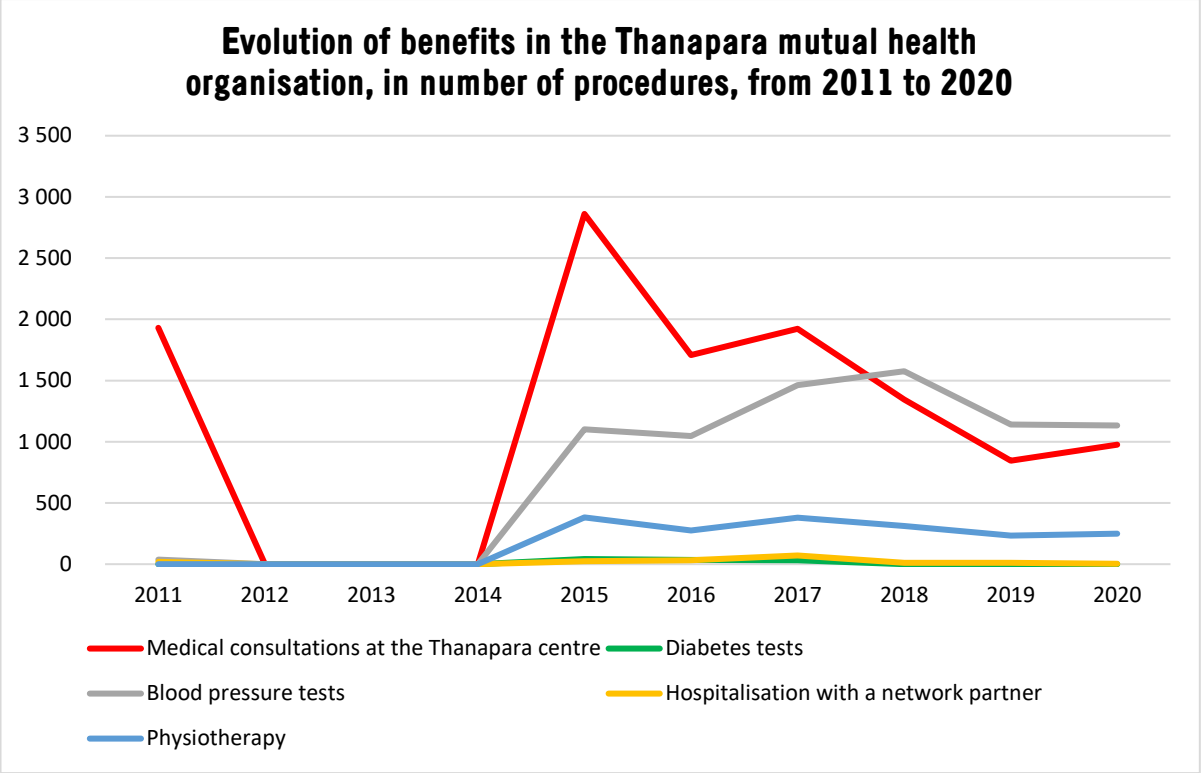
In addition to health care services, the mutual organisation has been developing free health prevention and education sessions since 2013. Information and awareness-raising sessions are regularly organised and offered to mutual members. They are usually given free of charge by doctors from Chargat or Rajshahi Hospital (travel costs are covered), and then taken on by the health centre nurse for subsequent sessions.

Percentage distribution of health benefits in the Thanapara mutual health organisation, from 2011 to 2020



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Medical consultations at the Thanapara centre	97.2%	0%	0%	0%	64.9%	55.1%	49.7%	41.4%	37.9%	41.3%
Diabetes tests						1.1%	0.8%	0%		
Blood pressure tests	1.8%	0%	0%	0%	25%	33.8%	37.8%	48.6%	51.1%	48%
Hospitalisation with a network partner	1%	0%	0%	0%	0.5%	1%	1.8%	0.4%	0.5%	0.2%
Physiotherapy					8.7%	8.9%	9.8%	9.6%	10.5%	10.5%

NB: Figures for 2012, 2013 and 2014 not provided.



NB: Figures for 2012, 2013 and 2014 not provided.

Although some figures are missing, we can see, as in India, a preponderance of medical consultations at the centre, which proves the importance of the existence of a first level of basic consultations in this context where health facilities are absent or inaccessible.

There has also been a decrease in medical consultations since 2014 (probably since 2013 in fact), even though the number of mutual members is tending to rise. One could deduce that this is the result of the many health education sessions that have been held since 2013, but this remains to be verified.

Partnerships/Agreements

Despite the very poor coverage of health facilities in the region, Thanapara has nevertheless managed to establish four formal partnerships:

> With two public hospitals, Chargat Hospital and Rajshahi Hospital: for each of them, memoranda of understanding have been drawn up, institutionalising the frequency of "health camps" (once a quarter) and allowing mutual members who turn up to these hospitals to be very easily received and treated (they skip the queue);

> With two local private clinics: here too, mutual members are received promptly and discounts of 40% are applied for various tests and diagnostic procedures.

Thanapara has a quarterly review meeting with each partner.

Reimbursement methods for health services

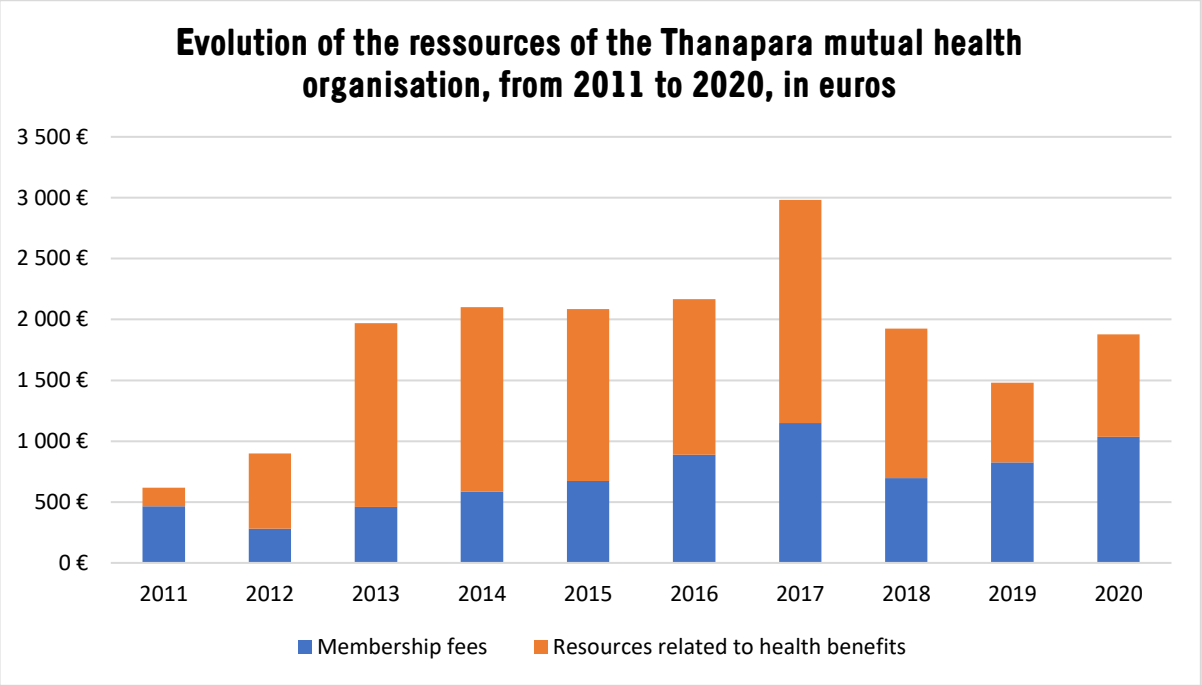
In Thanapara, there is only one method of reimbursement (reimbursement upon receipt of invoice), the process of which is enshrined in the operating rules of the mutual organisation.

Whether it is a referral from the mutual organisation's nurse or an emergency, the contributing member pays the hospital invoice and then submits a claim for reimbursement, providing hospital documents, invoices, etc. The mutual organisation's local steering committee then examines each case and makes a decision on each reimbursement. Here too, as with Tara, everything is carefully recorded in the hospital case tracking tool.

Evolution of the "contributions-to-benefits" ratio

In Bangladesh, too, the mutual organisation includes different resources and costs to those of the mutual organisations in Africa.

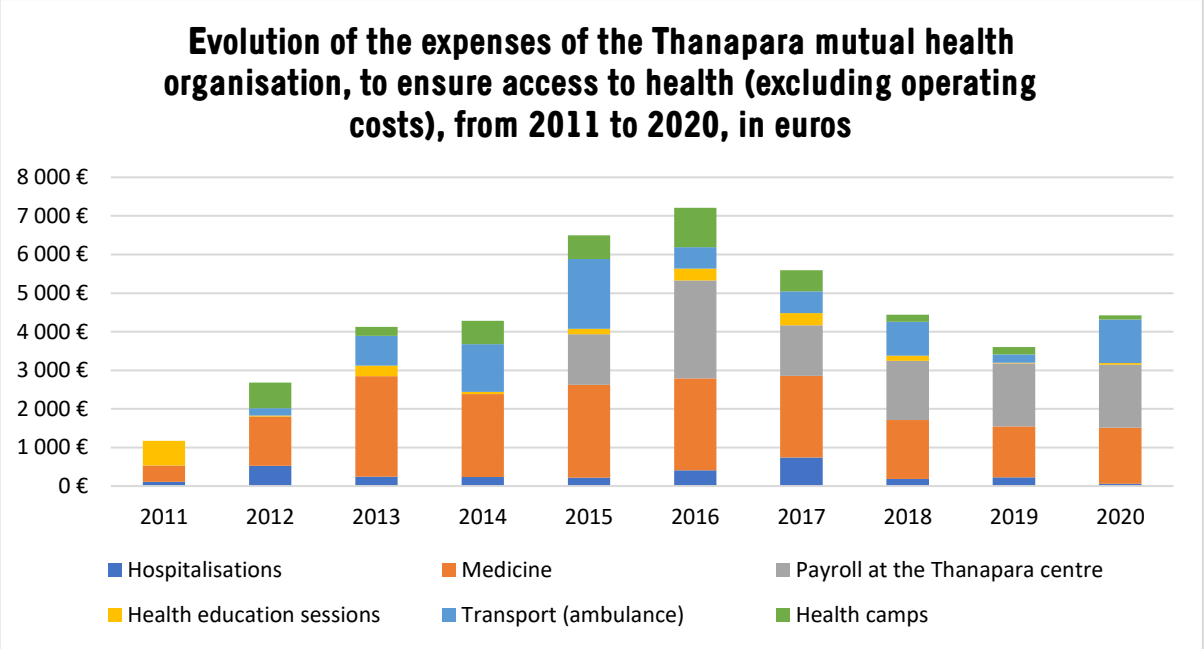
It takes into account the many expenses for access to health, excluding operating costs. The resources include contributions, as well as income from the services offered by the Thanapara health centre (mainly linked to the sale of medicines).



As in India, paid health services – even low-cost ones – are a significant source of funding for the mutual organisation. In the case of Thanapara this is even more apparent, since these resources are now greater than the annual income from contributions, which is conducive to a better "contributions-to-benefits" ratio.

These expenses include:

> The purchase of a stock of medicines and consumables for the health centre;
> Hospitalisations, which represent a maximum of 1.82% of the number of procedures each year since 2011;
> Transport costs to hospitals and clinics, as well as vehicle repair and maintenance costs;
> The wage bill for the health centre (nurse's salary);
> Costs related to organising "health camps";
> The costs of running health education sessions.

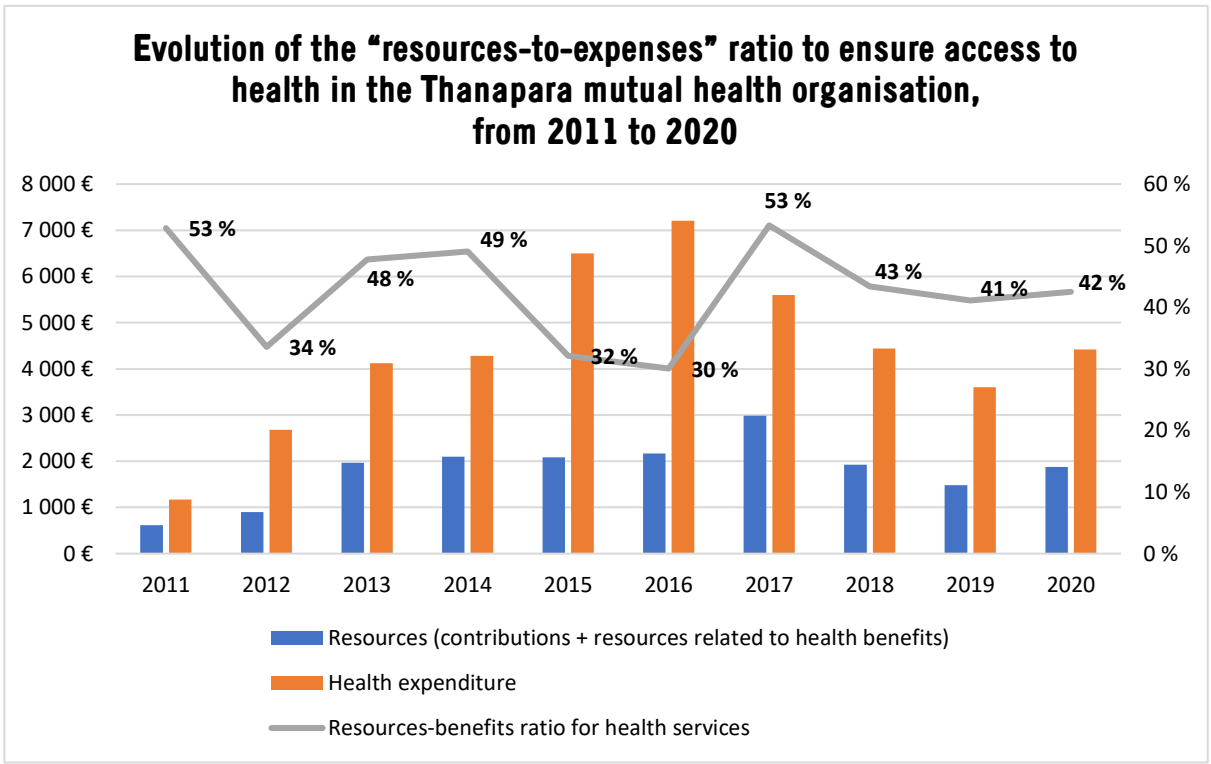


This graph tells us several things.

Again, 2011 is a special case, as the programme had only been running for six months. The years 2012, 2013 and 2014 were doubtless affected by the health issues of Thanapara's director and the consequences thereof in terms of coordination and monitoring.

Overall, we can also see that the purchase of medicines and the wage bill constitute the lion's share of expenses. As regards the wage bill, one might question its fluctuation, particularly in 2016.

Finally, it can be seen that the activities of the mutual organisation and their monitoring worked better in 2015, 2016 and 2017 and that the years 2018 and 2019 were clearly affected by the particularly difficult economic situation.



Once again, 2011 is not representative, as the programme only started in July of that year. For 2012, it can be seen that the low contribution recovery rate led to a very low “resources-to-expenditure” ratio.

As of 2014, resources linked to contributions has increased slightly, while the number of mutual members has fallen (with a better contribution recovery rate). From 2014-2015 onwards, there has also been a significant increase in ambulance-related expenditure (repairs, maintenance, taxes, etc.). In addition, the salary of the centre's nurse was only included in the budget from 2015 onwards.

The years 2018 and 2019 remain two problematic periods: Thanapara's main economic activity slowed down, even coming to a standstill at times, which was accompanied by the non-payment of contributions. While the school was closed, Thanapara could not deny people access to care. In other words, although use of the health programme by mutual members was reduced, the centre remained accessible: 1,000 consultations were recorded during these two years and four to five cases of emergency hospitalisation.

It is clear that despite the difficulties encountered, Thanapara has been doing its best for several years to maintain the programme.

Constitutive General Assembly of the Mutual Health Organisation in Benin ©Emmaüs International

III. Analyses and changes to how our mutual health organisations work

In this third chapter we aim to respond to a number of questions:

> How is the principle of democracy applied?
> How are the mutual members involved?
> How do they work on the ground?
> Which stakeholders and tools are available?
> How can we make mutual organisations work?

a. Governance

In this respect, there are different modes according to whether it involves Africa or Asia, firstly because of the legal rules, but also because of differences in culture and approach. In fact, in Benin and Burkina Faso, it is possible to set up a citizen association or an association of a group of persons, yet this is not the case in India or Bangladesh. In the two latter countries, in order for the mutual organisations to exist, they must be included in the Tara and Thanapara groups' activities.

This being the case, whether in the context of a legally recognised structure or an informal organisation, the work conducted within the mutual organisations must respect the objectives set by the movement and the principles it defends in terms of governance and democracy.

GOVERNANCE WITHIN THE AFRICAN MUTUAL HEALTH ORGANISATIONS

From the end of 2011 until the end of 2012, several work sessions took place within the Benin and Burkina Faso groups, as well as at the international monitoring committee, to draft the statutes and internal rules for ratification by the Constitutive General Assembly of both mutual health organisations.

The statutes and internal rules of the mutual organisations define and set forth the modes of governance, along with the missions, composition and terms of office of these bodies (General Assembly, board, steering committee and national management committee).

The first elections were organised on this basis, to set up a board and steering committee. However, establishing this governance system alone is not enough to make it work. In the case of the Benin and Burkina Faso mutual organisations, the national and regional organisations, along with the local groups and their leaders, have a significant role to play in this equation.

GOVERNANCE WITHIN THE MUTUAL ORGANISATION IN BENIN

In Benin, the experience of the first elected team during the General Assembly at the start of 2014 very quickly revealed its limits. Indeed, although the work of the national management committee continued with the support of the medical consultant to introduce certain important recommendations for reform, the elected representatives of the Benin MHO played only a very limited role. Moreover, although the organisation still existed, it was unable to boost the solidarity system (e.g., organisation and work meetings, sharing and involvement of stakeholders) since the elected representatives did not understand the meaning of the mutual project and did not fully share it.

Therefore, very quickly (in 2014-2015), Emmaus International produced written reminders and organised meetings with the Beninese stakeholders to remind them of the objectives, procedures and tasks to be performed.

Then, at the start of 2016, faced by the inertia of the organisation's elected representatives, Emmaus International decided to "wipe the slate clean" with regard to the existing governance team (executive and board members, national contact position). A field trip was organised in October 2016 to collaborate with the stakeholders on the objectives and tasks to be met and accomplished. A new team/group of volunteers was set up which, over six to eight months, supported this work in order to perform an evaluation.

This showed that a more serious approach to monitoring and implementing certain tasks had been initiated, but that the work was not complete. The Emmaus International Executive Committee then granted an additional six months to finalise the work and prepare a General Assembly to be held at the start of 2018.

However, in all honesty, the work needed to prepare this General Assembly never came to fruition and the volunteer members - whose role was meant to be temporary - did not wish to continue their work. For its part, since 2018, Emmaus International has not been in a position to undertake a new assignment to assess and revitalise the work.

To date, the organisational structure of the mutual in Benin is therefore non-existent. There is no leadership, no discussion, no proposals, no choice of guidelines, and this places the mutual organisation and its members at a disadvantage. Only the national management committee (local representatives) and the medical consultant, who monitor health issues (reimbursements, contributions, health education sessions, links with the approved health structures) are operational and the Emmaus Benin national secretary has taken on some tasks and functions (coordination of the national management committee, annual and financial reports), although this is not part of her role.

GOVERNANCE WITHIN THE MUTUAL ORGANISATION IN BURKINA FASO

In Burkina Faso, the Constitutive Assembly held in November 2013 formed a team of elected representatives from the groups, which quickly set to work:

- Regular executive committee meetings (monthly), the board (every three months at least), an enlarged board meeting if needed, at times with decentralisation in the groups;
- Support and monitoring of the local representatives' work, the work of the medical consultant (up until 2016), the national management committee;
- Monitoring of the agreements;
- Meetings with the group leaders, with the management of health structures, if necessary, with other mutual organisations in Burkina Faso;
- Meetings with contact persons in the contracted health structures, organisation of training days of contact persons;
- Participation in the government consultation group on mutual organisations in Burkina Faso, the annual activity and financial report, maintaining the activity schedule, collaboration with Emmaus International, etc.

The organisation here has fully taken ownership of its role. It has tried to involve stakeholders and has sought solutions and alternatives.

Although it was difficult for Emmaus International and the team of elected members of the mutual to meet easily due to security problems in Burkina Faso in 2014 and 2015, it was nevertheless possible. However, the subsequent General Assembly only took place in 2016 (18 February). It reappointed the existing board team.

Today, the governance bodies are as follows:

- **Board:** this body meets at least three times a year to review progress, the work of the executive and the various stakeholders, to discuss ongoing issues and their developments, and to make recommendations;
- **Enlarged board meeting:** the extended board consists of the board members plus the group leaders. It meets to try to seek solutions when difficulties are identified or to inform the group leaders of developments in the mutual (for example, the enlarged board took decisions concerning the quarterly payment of contributions, the commitment of an annual financial contribution of 200,000 CFA francs for each group). In Burkina Faso, the enlarged board has met twice a year since 2014;
- **The executive committee (Chair, Vice-Chair, Treasurer, Secretary):** the executive members keep abreast of the day-to-day business of the mutual. Specifically, they apply the General Assembly and board guidelines. The executive monitors the work of the different stakeholders, ensures the respect of missions and roles, makes proposals, if necessary, on each objective of the mutual health organisation. One to two members (including the Chair) participate in every national management committee (NMC) to address problems raised by the latter after each meeting and to analyse developments. The executive is in constant contact with the local representatives and the NMC, who is given strict working instructions to improve performance and increase visibility;
- **The monitoring committee** (three members elected every three years by the General Assembly from among the non-administrative members): the monitoring committee checks the regularity of accounting operations, bookkeeping, cash and bank accounts, as well as sound governance of the mutual. The results of its work must be set out in a written report submitted to the Chair of the board before the General Assembly. In reality, this monitoring committee has never been able to meet due to the lack of availability of its members. An external audit of the accounts was conducted in 2016, followed by a report with recommendations on bookkeeping implemented in 2017.

Finally, it should be added that although field visits and occasions to reorient the work were also required in Burkina Faso, they did not concern governance (see the sub-section on local coordination).

GOVERNANCE WITHIN THE ASIAN MUTUAL HEALTH ORGANISATIONS

In India and Bangladesh, the establishment of a formal independent association was very restrictive. The mutual organisations are legally attached to the Tara and Thanapara organisations in India and Bangladesh, respectively, as social grassroots initiatives.

Despite their different modes of operation, the Asian mutual organisations share some similarities with the African organisations, notably the desire to involve the most excluded and the creation of collective spaces for work and reflection.

GOVERNANCE WITHIN THE TARA MUTUAL ORGANISATION IN INDIA

Tara is a well-established Emmaus group, in which thousands of people work together in a range of different areas. It engages in many activities: microfinance, support for project leaders, craftwork. It

also works to promote access to fundamental rights such as education and health. Tara also organises information and discussion groups (on women's rights, on violence against women, for example) and offers training courses (IT, community leadership, etc.).

To manage and monitor all of its activities, Tara works holistically by area. The group is used to managing multiple projects. For forty years it has been working to find solutions to situations of hardship encountered on the ground.

In addition to management and administration staff, a large number of Tara's employees are social workers and project managers who coordinate and run the various activities and programmes.

Because of its mode of operation (in the form of project management, which does not support a process that should eventually be led by the people concerned), but also because the vast majority of the population does not have access to education, the goal of encouraging the involvement of mutual members in the management and coordination of the mutual organisation is a real challenge for Tara.

In other words, there is no governance per se. Having said this, and given it is legally complicated to create an association of persons, with the right support from the movement, Tara could try to involve mutual members in a more informal setting and give shape to another form of governance.

Nevertheless, some aspects are in place and others have been set up gradually, which could constitute a solid base for establishing governance by stakeholders:

- **An annual meeting of mutual members** has been organised since 2012, but not institutionally, as a General Assembly would be. Its role is more informative (annual activity and financial reports), although some points discussed in advance are endorsed. This annual gathering adopted the name “General Assembly” in 2017;
- Voluntary **community representatives** are elected for two years at the annual assemblies. These eight representatives (of which five to six actually take action) participate in monitoring and in the daily work of the health centre and are signatories for the local bank account. These representatives participate in organising and running “health camps” and can respond to emergencies when the mutual health centre is closed. They contribute to work on memberships, at the monthly reimbursement committee, health talks and focus group discussions, to training young volunteers and to the steering committee. Recently, four to five of the active community representatives have been women health workers. Tara provides training to the community representatives on the mutual health organisation, its values and objectives, as well as Emmaus International;
- **The involvement of mutual members:** For Tara, this means informing mutual members of changes and developments, explaining the procedures within the mutual, and getting them to participate and reflect on the various aspects and decisions relating to the mutual (rules and processes to be put in place, membership, contributions, reimbursement of hospitalisation costs, etc.). Involving 2,368 mutual members is a major challenge. Tara focuses its work on families, rather than individuals (there are 608 families and 8 individuals) and strives for the involvement of one person per family. Today, roughly 80% of families participate. Specifically, Tara’s work is conducted through a number of channels: focus group discussions (FGD), where the running of the mutual is discussed, along with the solidarity system, the rules, organisation, objectives and Emmaus International; through health talks on different health subjects; through outreach activities, where Tara's social workers, community representatives and involved young members (Badarpur volunteers) each follow a defined number of families in a neighbourhood area.

GOVERNANCE WITHIN THE THANAPARA MUTUAL (BANGLADESH)

Because of its history and location, Thanapara has a number of advantages: the reputation it has acquired over the years in the local area, its proximity to the surrounding population and the trust between the employees and the people with whom the group works.

Involving the mutual members in managing and coordinating the mutual organisation, according to Emmaus International's objectives, still remains a real challenge for Thanapara. The group seems to have encountered difficulties in setting up the different spaces planned, despite the fact that training, work and discussion forums were set up for mutual members at the outset: a local steering committee appears to have met in 2016, 2017 and 2018 and discussion times with mutual members have been almost exclusively focused on health education and awareness, as well as focus group discussions to address structural issues and the development of the mutual organisation.

The implementation of good governance was also made more difficult for reasons already mentioned (economic problems, health problems suffered by the director, shortage of people capable of managing the governance and coordination of the mutual).

However, spaces have been defined and roles identified. For the movement, it is now a case of supporting Thanapara towards bolstering procedures (organisation of the activities, definition of the roles, coordination, capacity building, etc.).

The existing aspects are as follows:

- **A General Assembly:** since 2014, a General Assembly is organised every year on 7th April, World Health Day. An overview of the activities implemented during the past year and financial data are provided; planned activities and the budget for the following year are proposed and approved. The assembly elects its representatives. It is also a social occasion where all the mutual members meet, which helps to strengthen the community and the sense of belonging to the mutual;
- **Elected representatives:** from the mutual members, six representatives are elected to participate in the local steering committee. They make the link between the groups of mutual members in terms of information needed (dates of the health camps and health awareness sessions) or points to be reflected on (on the mutual, its organisation, its perspectives);
- **Involvement of the mutual members:** in theory, the mutual members are involved in existing work and discussion spaces: annual General Assembly, focus group discussions (FGD). In reality, Thanapara does not have the means to set up and run these FGDs.

b. The coordination of the mutual organisation (role of the stakeholders)

Although governance is a fundamental aspect of the mutual organisations, their coordination is essential to keep these solidarity systems alive. Once again, it is organised differently according to the area, the contexts and capacities of the groups. The running of the mutual organisations requires monitoring and dynamism that is all the more important because of the large number of actors involved today.

The role of each stakeholder is essential. For this to work, everyone must do their part: mutual members, group leaders, local representatives, elected members of the executive committee or

board. The representatives and group leaders have a fundamental role in local management and must be fully committed.

RUNNING THE MUTUAL ORGANISATIONS IN AFRICA

COORDINATION OF THE BURKINA FASO MUTUAL HEALTH ORGANISATION

With the exception of 2019 and 2020, which were exceptional periods, the members and stakeholders of the mutual organisation met very regularly and many connections were made.

The stakeholders

The local representatives

Staff members from the groups who spend part of their time working on the missions and performing tasks within the framework of the mutual health organisation. In addition to their salary, they receive a monthly allowance and are a central link in the programme. These representatives provide the link at local level with the mutual members, the health structures covered by agreements, the group manager, the association and its bodies. They also participate each month in the national management committee.

Their work is key and they have many tasks, such as local management and coordination responsibilities. They are trained by the mutual organisation on an ongoing basis and supported by members of the executive committee (each elected member of the executive comes from a different group).

Emmaus International and the mutual organisation also count on the group leaders to support the representatives, ensure that spaces and the necessary work tools are placed at their disposal to perform the tasks and help them in procedures or in planning of their work. In practice, some local representatives do not receive this support from their group leader. In other cases, the work is carried out, planned and monitored perfectly. It is in these groups that we find informed and aware mutual members who are used to making proposals during the quarterly meetings.

The secretary of Emmaus Burkina Faso

The accounting secretary at Emmaus Burkina Faso dedicates 20% of her working hours to the mutual. 20% of her salary is covered by the mutual (operating costs). She participates every month in the national management committee, summarises the monthly membership review, contributions, health services, activities organised by the representatives and managers, annual contribution from groups, etc.

She also liaises between the executive committee and the representatives, as well as Emmaus International with regard to related documents.

An important problem lies in the lack of activity by the Emmaus Burkina Faso national organisation. For years, it has not organised meetings or drawn up common work topics or a budget, which has significant consequences for the mutual:

- Lack of support and coordination shortfalls;
- Need for the mutual to cover the additional running costs (photocopier, etc.);
- Direct impact on the working conditions for the secretary, with her workplace moved to a sheet metal house on the outskirts of Ouagadougou.

Group leaders

The group leaders are entrusted by Emmaus International with the proper development of the mutual. They require visibility on what needs to be done and what is being achieved within the group and its territory. This involves a number of tasks:

> Monitoring and supporting the work of the local representative;
> Encouraging the implementation of new agreements;
> Supporting the development of a local membership strategy;
> Participating in the collective discussions or resolving problems at a local and national level;
> Ensuring timely payment of quarterly dues;
> Checking the payment of the group's annual financial contribution;
> Participating in the mutual's extended board meetings.

However, for many years, the often weak or even minimal involvement of the various managers has not changed.

Medical consultant

In Burkina Faso, a medical consultant worked between 2011 and 2016, but his contract was terminated by Emmaus International due to unsatisfactory work. Steps have been taken to recruit another medical consultant, but so far, they have been unsuccessful. The executive therefore decided to rely on advisory support contact persons (ASCPs) identified in each locality to perform some of the tasks of the medical consultant. This process should have been formalised in 2020, but it had to be postponed due to last year's situation.

Advisory support contact persons (ASCPs)

The objective of the ASCPs is to provide local support to the representatives - who are not health workers - in checking invoices and other claims for reimbursement, in running awareness-raising or health education sessions, but also through their links with the various contracted health structures. They are responsible for completing an activity report every quarter and are paid (monthly allowances). For each locality, the ASCPs are a focal point of the contracted health structures.

The contact persons of the health structures under agreement

The contact persons are the people who act as a link, for each agreed health structure, with the local representative. These people are trained by the mutual health organisation on the processes (third-party payment, liaison documents) and services reimbursed or excluded from the mutual health organisation and are the internal reference points in their structure for other health workers who work there.

Spaces

The national management committee

Technical body responsible for the management of memberships, contributions, benefits and awareness/information from mutual members, the national management committee is made up of four local representatives. It meets twelve times per year, i.e., once at the start of each month. It benefits from support from the accounting secretary of Emmaus Burkina Faso and from one or two executive committee members.

Quarterly feedback sessions from representatives to mutual members

Originally, after each meeting of the NMC, the representatives were to provide mutual members with a systematic review of the previous month. In view of the low level of local activity in the majority of groups, the executive decided in 2016 to impose a minimum of one quarterly feedback session for mutual members. It must include precise information: figures from the previous month, national management committee decisions, decisions by the executive and board, dates of the next health talks, agenda for the next board meetings (so that opinions can be gathered and discussions held, or proposals made).

Training meetings of contact persons of the health structures under agreement

The setting up, on two occasions, of meeting/presentation/training days stemmed from remarks by mutual members about the fact that their rights were not always respected within the framework of the established agreements. The objective of these meetings was to rectify the lack of knowledge of the principles of the mutual, its functioning and the liaison tools by certain reference points.

COORDINATION WITHIN THE MUTUAL IN BENIN

The stakeholders

The local representatives

As in Burkina Faso, the local representatives are employees of the groups who dedicate part of their working time to the mutual. In Benin, the representatives are trying to make up for the many shortcomings of the other stakeholders: the lack of governance - and therefore of elected members of the mutual - the lack of local involvement of the group leaders, the shortcomings of the national Emmaus Benin structure and the limited support provided by Emmaus International. As a result of this lack of support, there is a growing lack of motivation among representatives.

The Emmaus Benin secretary

In the same way as in Burkina Faso, 20% of the Emmaus Benin secretary-accountant's working time is devoted to the mutual (20% of her salary is therefore also covered by the mutual). The secretary has the same tasks and duties to perform, but since 2016 she is also responsible for coordinating the work of the NMC with the representatives and the medical consultant.

Due to the failure of the volunteer group to prepare a General Assembly in 2016-2017 (see Governance in Benin), this secretary also acts as a link with Emmaus International for monthly reporting and the production of activity and financial reports.

Group leaders

The involvement of group leaders has also been lacking in Benin for several years, and even more so since 2018. Their role, which is essential to the mechanics of the mutual, is not being fulfilled and the related tasks are not being performed either locally or at Emmaus Benin level.

Medical consultant

In Benin, the medical consultant has a contract directly with Emmaus International. This contract is renewed annually after evaluation. The medical consultant has been monitoring the mutual since

2009, he has participated in all NMCs without exception and sends a progress report every six months. He is responsible for the following tasks:

> Participation in the national management committee once a month: checking invoices and prescriptions (examination of claims for reimbursement), support for the drafting of the NMC's monthly report and the accompanying rapid analyses, long-term "training" of the representatives (on the basic monitoring rules and simple health issues);
> Continuation of the agreement process and third-party payment;
> Organising health education activities for mutual members in Emmaus groups once a quarter;
> Supporting, encouraging and advising the various actors in their work.

In fact, while the governance and national coordination of the mutual in Benin have been non-existent for many years, the medical consultant is deeply involved and represents an important support for the representatives and the national secretary. According to this doctor, the mutual health organisation constitutes an alternative to the failure of public policy in the field of health.

Spaces

The national management committee

The organisation of the NMC and its tasks are the same as in Burkina Faso: management of activities related to membership, contributions, benefits and awareness-raising/information of mutual members. It also meets twelve times per year, i.e., once at the start of each month.

Communication with the contracted health structures

Contrary to the set up in Burkina Faso, in Benin the collaboration between the groups/local representatives and the contact persons within the contracted structures is not formalised. This often involves telephone calls during the review of reimbursement files by the national management committee, for example to explain the lack of coverage of certain services billed (on the basis of the documents provided and the list of excluded services and medicines).

Feedback by the representatives to the mutual members

In view of the need to involve mutual members more, so that they better understand the issues of the mutual, this activity clearly needs to be reviewed.

RUNNING THE MUTUAL ORGANISATIONS IN ASIA

In Asia, although the work required is identical to that in Africa, the coordination and operating methods are of course impacted by previously developed aspects in the mutual organisations in Asia.

COORDINATION WITHIN THE TARA MUTUAL

The stakeholders

> **Social workers:** they play a key role in the current running of the mutual and provide an essential link with the mutual members. One of them, a nurse and paramedic, is present full time at the health centre, while two to three others devote 50% of their time to the mutual health organisation (paid for by Tara). Their tasks are to organise and participate in the annual membership campaign (July-September), as well as to set up awareness-raising activities on mutual health for the inhabitants of the Badarpur district. They also take part in focus group

discussions (FGD), along with running the various health talks and health activities (such as health camps) organised at the centre. They also visit the homes of mutual members (as part of health monitoring or awareness-raising);

- **The health programme manager:** the manager plans and monitors the mutual's activities. He leads the local team in the field and organises the monthly reimbursement review meetings. He regularly monitors the activities of the centre and participates in various field actions. He draws up the training plan for community representatives and volunteers, and creates the necessary tools for this. He plans, organises and runs the annual meeting. The manager encourages the organisation and coordination of community meetings (FGD, health talks, etc.). He develops and consolidates partnerships with local health structures. Finally, he is in charge of a number of administrative tasks (monthly reports, financial monitoring, liaison with Emmaus International - meetings, exchange of information, sending of documents - and with the Tara management);
- **The doctor and nurse at the health centre:** the doctor and nurse are the health professionals at the Badarpur centre. The former provides medical consultations at the centre, delivers medication and refers patients to the network of health partners if necessary. For mutual members, he can be contacted by phone in case of emergency. He also coordinates day hospital treatment. The nurse, in addition to the tasks conducted with the social workers (see above), provides daily assistance to the doctor in the health centre, in the day hospital and during the "health camps": blood pressure checks, other measurements, assistance with physiotherapy, applying dressings, monitoring patients and their pathology, home visits;
- **Community Representatives (CRs):** these representatives are very involved, working closely with the social workers from Tara. They are local residents, mutual members, and most of them have jobs in the health sector;
- **Health workers:** from the Badarpur district, these young volunteers have been providing support since 2019. Most of them are children of mutual members who are looking for work, an activity or training. The mutual's team provides them with training three days a week for three months (two months for the theoretical aspect, one month for the practical training). Following this process, a final exam and a field assessment, they obtain a certificate issued by Tara. Each session includes eight young volunteers. In practical terms, these volunteers make a very concrete contribution to health-related activities, information and awareness-raising, and outreach work in the neighbourhood. Although they are not considered to be either trainees or employees, they are nevertheless compensated for their work.

Spaces

Spaces to involve members and build capacity and knowledge (FGDs and health talks)

Although these training sessions on the running of the mutual health organisation and awareness-raising on health issues do not yet allow for the practical involvement of mutual members in the management of the mutual health organisation, they do have the advantage of offering a time to organise and pass on information, in addition to understanding the mutual health organisation and its objectives.

They also strengthen the sense of belonging to a mutual community among members and beneficiaries. For each topic, the meetings take place in small groups (which requires constant planning) in a large, dedicated space on the second floor of the health centre. Another venue in the district will be renovated in the near future (2021) and will be used for training and awareness-raising activities.

Local steering committee

Established in 2017, it is composed of community representatives, a social worker, the doctor and the Tara team in charge of the project (director, programme manager and social worker). The committee's mission is to plan actions and operations in the field, to monitor the mutual's strategic performance and to improve networking with other organisations.

Reimbursement committee

It meets every month to review the reimbursements of health care costs for mutual members. Composed of community representatives, the doctor, the centre's social worker and the programme manager, it examines the claims based on the invoices and decides on the rate and amount to be reimbursed in accordance with the mutual's general policy document. Mutual members applying for reimbursement attend this committee and the rates applied and the amount reimbursed (or not) are explained to them.

Health centre

The health centre, built in early 2011, is now an institution in the neighbourhood. In addition to the health-related activities that are developed on a daily basis, other Tara activities take place there (training sessions, notably on the first floor of the building). Over time, it has become an essential social space within the Badarpur community.

RUNNING THE THANAPARA MUTUAL

The stakeholders

- **The director of Thanapara and the programme coordinator:** the programme director, who was very committed from the start, was hampered by his health problem and no one was able to take over the work of leading the governance during his absence and recovery. However, he has been assisted by the manager of the crafts team since 2018 in coordinating the programme;
- **Driver:** employed by Thanapara, this driver is made available by the group if necessary to drive the ambulance;
- **Thanapara accountant** is also made available at the end of each month, in order to take stock of expenditure and income. This person keeps track of contributions and resources related to health benefits, as well as expenditure in the programme;
- **Elected representative:** elected at the General Assembly, the six representatives collaborate closely with the members of the steering committee. They are in contact with the mutual members of their daily working group to provide information and awareness if needed, and are also responsible for collecting monthly contributions from mutual members;
- **Nurse:** provides consultations at the centre, delivers medicines and refers mutual members to hospitals or clinics if necessary. He can be contacted by phone in case of emergency by mutual members. He keeps records of the care provided in the centre and follows Emmaus International's health reporting tools. Together with the Thanapara director, he also runs the health education sessions and organises the 'health camps'.

Spaces

Spaces to involve members and build capacity and knowledge (FGDs and health talks)

If forums exist to keep in touch with mutual members, raise awareness and involve them, they have rarely been implemented. More clearly, the organisation of health talks is maintained, but the FGDs,

which are focused more on reflection and participation of mutual members in issues relating to the mutual as a tool, are not set up.

Local steering committee

Composed of elected representatives, the Thanapara director and programme managers (school, crafts, etc.), the local steering committee theoretically meets every month. It examines and evaluates the implementation of the activities validated by the General Assembly and monitors the income and expenditure. The first two to three meetings of the steering committee are devoted to the training of the newly elected representatives on the objectives and issues of service and governance within the mutual, provided by the director and the nurse.

The members of the steering committee from the General Assembly ensure the link with the distinct groups of mutual members in the territory and at least two members of this committee are present during the health education sessions.

Health centre

The health centre, which existed before the mutual health organisation was set up, was upgraded, relocated to another location within the group and opened in 2011. Consultations are held there along with health camps.

c. Management and monitoring tools

Today, although some tools are common, each mutual is organised with its own qualitative and quantitative tools, which are more or less advanced. Two types of tools can be distinguished: those used for management and those for monitoring.

MANAGEMENT AND REPORTING TOOLS IN AFRICA

In Africa, the mutuals started off on the same foot in terms of tools. The management tools, renewed in 2013, are identical in both countries. On the other hand, the reporting tools, which were the same at the outset, have evolved over time with practice and now exhibit some differences.

Management tools

Eight management tools are used:

- **Membership card:** each member has a mutual membership card, which also lists the various family members (with their photos) who receive benefits from the mutual health organisation. This tool facilitates external identification and strengthens the sense of belonging to the mutual. In Burkina Faso, new magnetic cars are being created;
- **Membership form:** the membership form is a management tool (paper format) which remains in the hands of the representative. It allows for individualised monitoring of each family;
- **Membership register:** this register (paper format) records all memberships. Updated on an ongoing basis by the local representative of each group, it allows the evolution of the membership to be tracked;
- **Information sheet:** the information sheet is a paper document distributed to all mutual members. It provides information on Emmaus International, the mutual health organisation, and the rights and duties of mutual members;

- **Benefits register:** this register (paper format) allows the local representative of each group to record the benefits in an exhaustive manner and to study the health benefits used by family and by health facility under agreement;
- **Agreements:** agreements have been created in each mutual (Benin and Burkina Faso) to establish the framework for partnerships. There is an agreement for each health facility that has an agreement, whether it is a health centre, a hospital, a clinic or a pharmacy. All agreements are recorded at the national secretariat;
- **Care certificate:** this document (several sheets of paper) is a tool for liaison and follow-up of care with the health structures that provide services to mutual members;
- **Register of contributions:** this register (paper format) is used by the local representatives of the groups to compile and monitor the payment of contributions;
- **Income and expenditure register:** this (computerised) register is kept by the secretariat of each national organisation, in conjunction with the elected representatives and the national management committee, to monitor income and expenditure.

Reporting tools

There are differences in the form and content of these tools. Certainly, work needs to be done to rethink the coherence of existing reporting tools:

- **Monthly summary:** the most useful tool for monitoring the evolution of the mutual's main indicators. After each national management committee, the two mutuals produce a monthly report with figures for each group and for the national mutual as a whole. Emmaus International conducts its annual quantitative data monitoring using information from these summaries:
    - In Benin, each specific summary, by group and at national level, of the number of members, contributions collected, health services reimbursed, use of third-party payment, management costs, and the monthly balance sheet. This data is only quantitative. There is almost no qualitative information or information about the local work undertaken by the representatives (which is linked, of course, to the lack of governance and local coordination);
    - In Burkina Faso, we find the same basic indicators, but also quantitative and qualitative information on local activities: changes in agreements, annual group contributions, activities carried out by the representatives and group leaders (meetings with mutual members, meetings with health structures, updates on the implementation of decisions by the board and the executive committee on the work of the representatives, etc.). Records of the representatives' interviews with local actors are also available.
- **Activity and financial reports:** produced every year, but the conditions for drafting them differ:
    - In Benin, because of the lack of associative life since 2016, the secretary-accountant produces a report on the activity of the mutual during the past year, together with a financial statement, without the support of mutual actors or group leaders;
    - In contrast, in Burkina Faso, the credit union sends its annual activity report each year, duly completed, with an overview of the indicators, an analysis of the progress made according to each objective, an account of the difficulties encountered and prospects for new objectives. The financial report contains all the information related to the expenditure and income of the mutual: state of income, type of expenditure, profit and loss account, bank statement and cash statement from 1 January to 31 December. This work is largely carried out by the president and the accounting secretary, but also shared and enriched by the members of the executive committee.

- **Activity planning:** since Emmaus International's field missions in 2016, precise work schedules have been established. In Burkina Faso, these schedules are used and updated annually by the office team, enabling regular monitoring of the work. In Benin, this task, performed for a few months by the national secretary with the support group, has now been discontinued;
- **Minutes of the association's meetings (executive committee, board)**: In Burkina Faso, minutes are taken after each meeting of the executive committee, board and extended board. In Benin, as mentioned earlier, this associative life does not exist;
- **Six-monthly reports of the medical consultant:** in Burkina Faso, as we have said, there has been no medical consultant since 2016. In Benin, however, the consultant sends a quality report at the end of each semester. He reports on his missions, provides his analysis regarding participation in the national management committee, monitoring of invoices for health care services, the introduction and use of third-party payment, health talks implemented in the groups and communicates his recommendations. These reports offer Emmaus International a different perspective.

MANAGEMENT AND REPORTING TOOLS IN ASIA

The management and reporting tools have been in place since 2011. As far as reporting is concerned, the systems have evolved to allow for a better assessment of the situation and developments.

Management tools

In Asia, for management at grassroots level, almost identical tools have been implemented by Tara and Thanapara:

- **A member card/membership booklet:** at Tara, a membership card per family (with photos) states the identity and relationships between the members of the family, membership information, mutual rules; at Thanapara, a booklet states the identity of the mutual member and provides information on the payment of contributions. It also acts as a health booklet (it states the benefits used by the mutual member);
- **Membership record:** at Tara, an Excel file includes all the individual data of each family member (name, age, address, relationship with the main member, link with Tara, membership fees, date of membership or renewal, expiry date of membership); at Thanapara, a register (paper format) is kept by the health centre nurse;
- **Record of contributions:** at Tara, this information is included in the membership record (Excel spreadsheet); at Thanapara, a record (Excel spreadsheet) states, under the member section, if each member's contribution is paid for each month and includes an overall summary;
- **Benefits record:** A paper record is kept at the Tara centre for all consultations that take place; at Thanapara, there are six meticulously completed paper records: consultations; diabetes examinations; weight monitoring; blood pressure checks; 'health camps'; and hospital claims;
- **Budget monitoring tools:** for the two mutuals, there is no format or tool dedicated to budget monitoring other than the Emmaus International reporting tool. Budgets are reviewed regularly at the local steering committee meetings in Tara and Thanapara. The accountants of each group monitor the budgets;
- **A written document for partnerships:** a Memorandum of Understanding (MOU) exists between each private partner and Tara and with the public hospitals and private clinics in the case of Thanapara;
- **A general policy document:** this essential document describes the framework for health access for mutual members, along with their rights and duties (internal rules). It stipulates the pricing of benefits and reimbursements for treatment. This document is available at Tara, but is not yet available at Thanapara.

Reporting tools

At the beginning of the mutuals, tools were developed with the expert in charge of monitoring and support. The reporting tools used by Tara and Thanapara are identical and computerised:

- **Monitoring memberships (Excel spreadsheet):** to keep track of memberships, a fairly comprehensive tool has been developed in both groups. At Tara, it is the same as the one used as a management tool. With some improvements, it could constitute a model for the three other mutual organisations;
- **Monitoring contributions (Excel spreadsheet):** at Tara, the information related to contributions is included in the monitoring of memberships (based on the annual fee); at Thanapara, an Excel spreadsheet of the membership rules per family and per individual has been created. It is kept by section (artisan-producer, formal school members, microcredit members, employees, etc.);
- **The monitoring and use of health benefits (Excel spreadsheet):** at both Tara and Thanapara, the tool takes into account information on the different benefits used by mutual members. A specific tab is dedicated to medical consultations at the health centres, another on hospitalisations, another on physiotherapy, and a separate tab on health talks. The budgetary elements are integrated into this tool: cost of procedures, cost for mutual members, etc. As it stands, the system provides a satisfactory and regular overview of the health activities and services developed. A summary tab summarises the elements by service. If reworked, this tool could be shared with the African mutuals;
- **The budget (Excel spreadsheet):** in the two groups, the tool is general and provides an annual picture of the mutual's expenditure and income. Some data is still missing or poorly broken down (often due to lack of support). It is therefore now essential to set up a more regular (monthly) monitoring tool based on mutual activities and accounting ledgers;
- **Annual activity reports:** Tara and Thanapara regularly send annual reports. Nevertheless, it would be interesting to develop a framework for an annual report that would be suitable for all four mutuals in order to obtain an overview of the programmes.

d. Financial statements and self-sufficiency of the mutuals

A health system or a mutual organisation are rarely financially self-sufficient. This is why it is worth examining the situation of the mutual organisations developed by the movement:

- What is their financial status?
- Have there been any developments since the beginning and if so, which ones?
- What resources and expenses are included in the overall budgets?

The mutuals' budget consists of several parts:

- The resources come mainly from contributions, but depending on the area and the context, the mutual organisations try to find other resources;
- Reimbursements for health care in mutual organisations in Africa, but also purchases of medicines in mutual organisations in Asia, constitute health expenditure;
- Operating expenses are essential to keep mutual systems alive: these include the costs of forums for meetings and exchanges, and the regular working time of the operational staff, etc. Salaries, partial salaries or allowances also fall under this part of the mutuals' budget.

In addition to the "contributions-to-benefits" ratio already seen above, the overall self-sufficiency rate takes into account other resource items, but especially expenses, in order to obtain a complete overview of the financial autonomy of the mutual.

IN AFRICA

Resources and expenditure in Benin are almost identical to those in Burkina Faso.

Resources

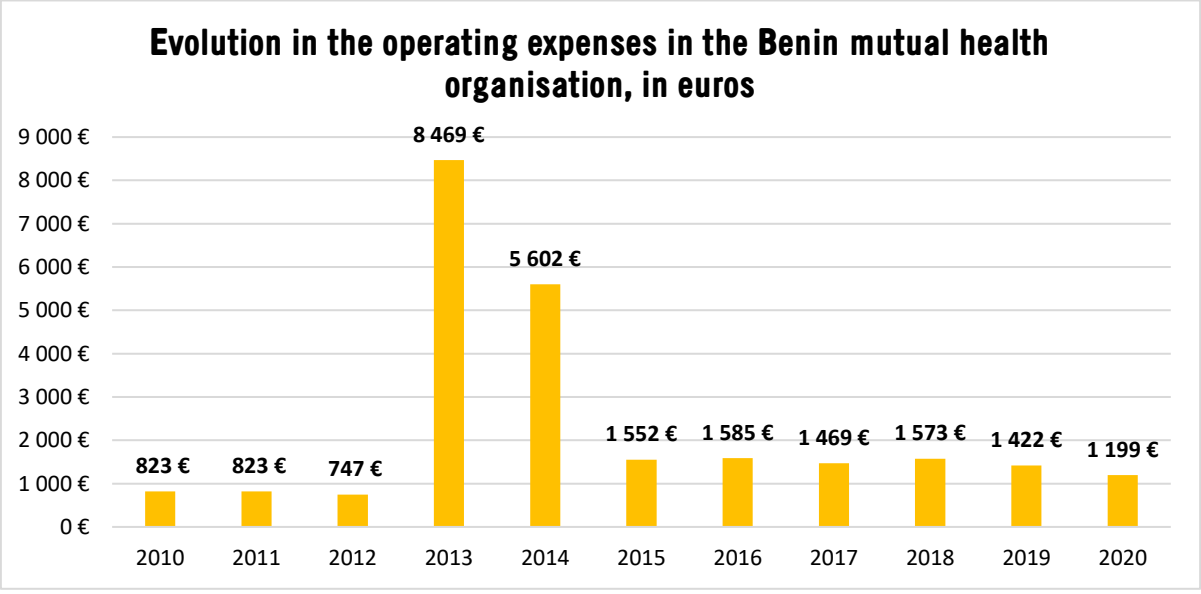
In addition to contributions, there are two types of resources in Africa:

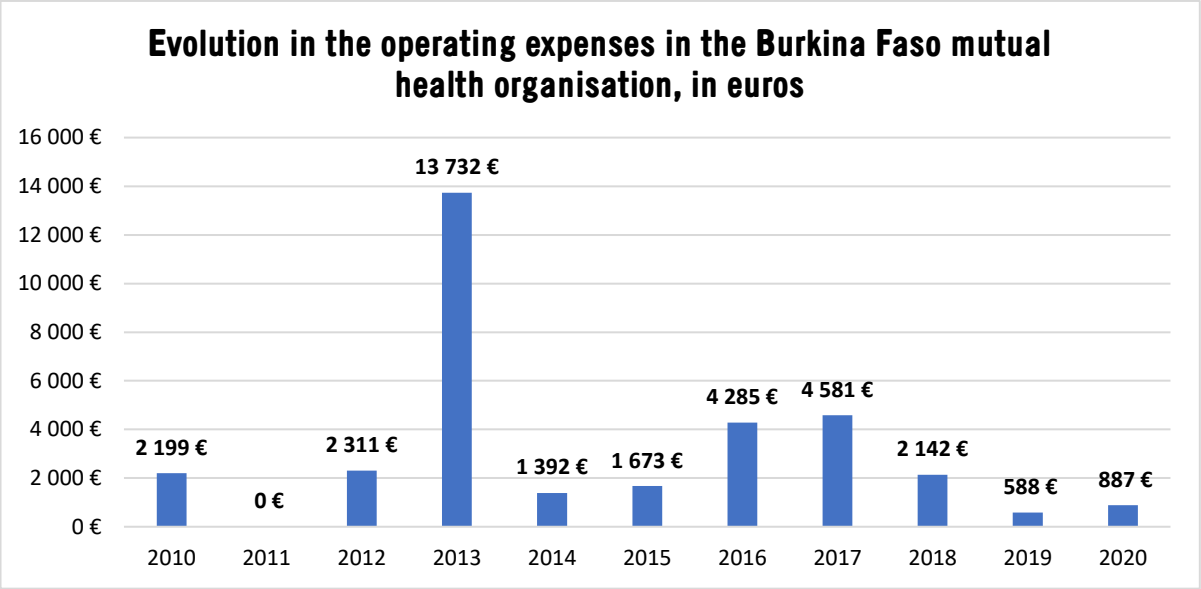
> Since 2016, an annual contribution from groups of 200,000 FCFA has been agreed in Benin and Burkina Faso to contribute to the running costs. However, in Benin, this commitment was only met for 2016, while in Burkina Faso, only one group fully met its commitment each year;
> Since 2018, in Benin two containers of medical items have provided supplies to the technical facilities of the health structures under agreement. In Burkina Faso, for its part, the sale of two containers of equipment was used to replenish the mutual's coffers and to meet exceptionally high health costs. It would be interesting to analyse and evaluate the impact of this initiative for a possible extension of the mechanism.

Expenditure

Operating expenses are also quite similar between Benin and Burkina Faso. The expenditure items are as follows:

> Fees related to the national management committee meetings;
> Expenses relating to meetings of the association (executive committee, board, enlarged board), that are sometimes decentralised;
> Costs related to contacting local stakeholders (agreed health structures), mutual members and groups if necessary;
> Secretariat costs (telephone, photocopies, supplies, etc.);
> Production costs for management tools (renewal or creation of membership cards, etc.);
> Allowances or salaries (allowances for local representatives, payment of 20% of the salary of the national organisation's secretary-accountant for the time spent working on the mutual).





Note: 2011 figures not reported.

While for the period 2010-2020, the overall evolution of operating costs is quite similar between the two countries, some years nevertheless warrant further comment.

As we have seen, 2013 and 2014 are the years when the Constitutive Assemblies of the mutuals were held. In addition to the usual operating costs described above, there were also the costs of organising and running these assemblies and of the lengthy prior awareness-raising and preparation work: meetings in the groups, with mutual members, production of new management tools, training of the staff of all the health structures in the changes to come, and the costs of meetings of the constituent General Assembly organising committees.

In Burkina Faso, the increase in costs in 2016 and 2017 can be attributed to relaunching the coordination process after the Emmaus International visits: the mutual association's office held more meetings, travelled to support the local representatives in their work, and visited other mutual association systems in Burkina Faso, etc. The decrease in costs in 2019 and 2020 is related to the security and health situation.

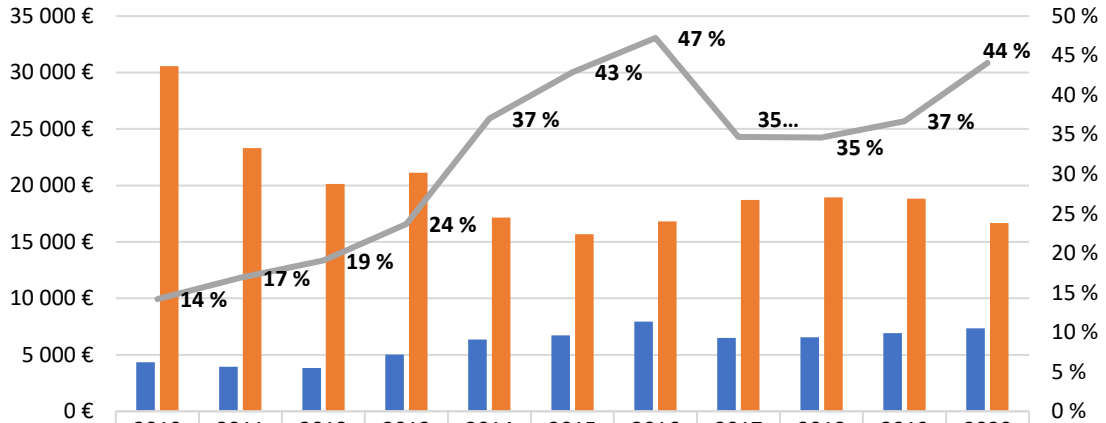
Financial self-sufficiency of African mutuals

From the operating and health expenses, it is possible to assess the evolution of the self-sufficiency of mutuals.

In Benin (see graph below), health expenditure in 2013 and 2014 is lower than in previous and subsequent years, which explains the lower impact of expenditure related to the preparation and running of the General Assembly.

2016 is, for its part, the only year when all the Beninese groups paid their annual contribution.

Evolution in the overall self-sufficiency rate of the MHO in Benin, from 2010 to 2020



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Resources	4 340 €	3 938 €	3 843 €	5 010 €	6 352 €	6 732 €	7 938 €	6 502 €	6 561 €	6 914 €	7 347 €
Expenditure (healthcare + operations)	30 576 €	23 314 €	20 132 €	21 131 €	17 151 €	15 692 €	16 805 €	18 726 €	18 935 €	18 835 €	16 674 €
Overall self-sufficiency rate	14%	17%	19%	24%	37%	43%	47%	35%	35%	37%	44%

With regard to Burkina Faso, several aspects help us to explain the following graph:

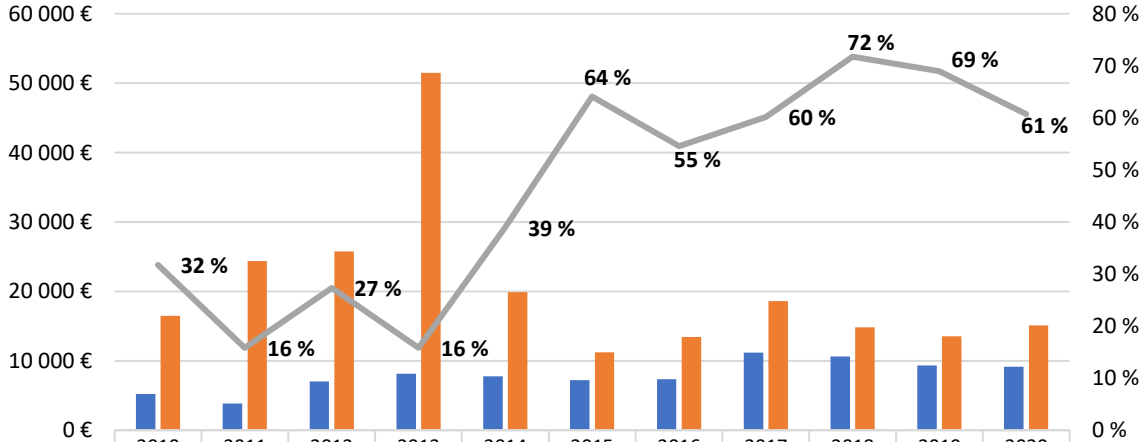
> In 2011 and 2012, the rules for strict monitoring of prescriptions and health invoices were not yet in force;

> 2013 and 2014 are visibly impacted by the very high operating expenditure related to preparing and running the General Assembly;

> The year 2015 was marked by a high level of insecurity in the country which, by limiting travel and meetings, reduced operating costs quite significantly;

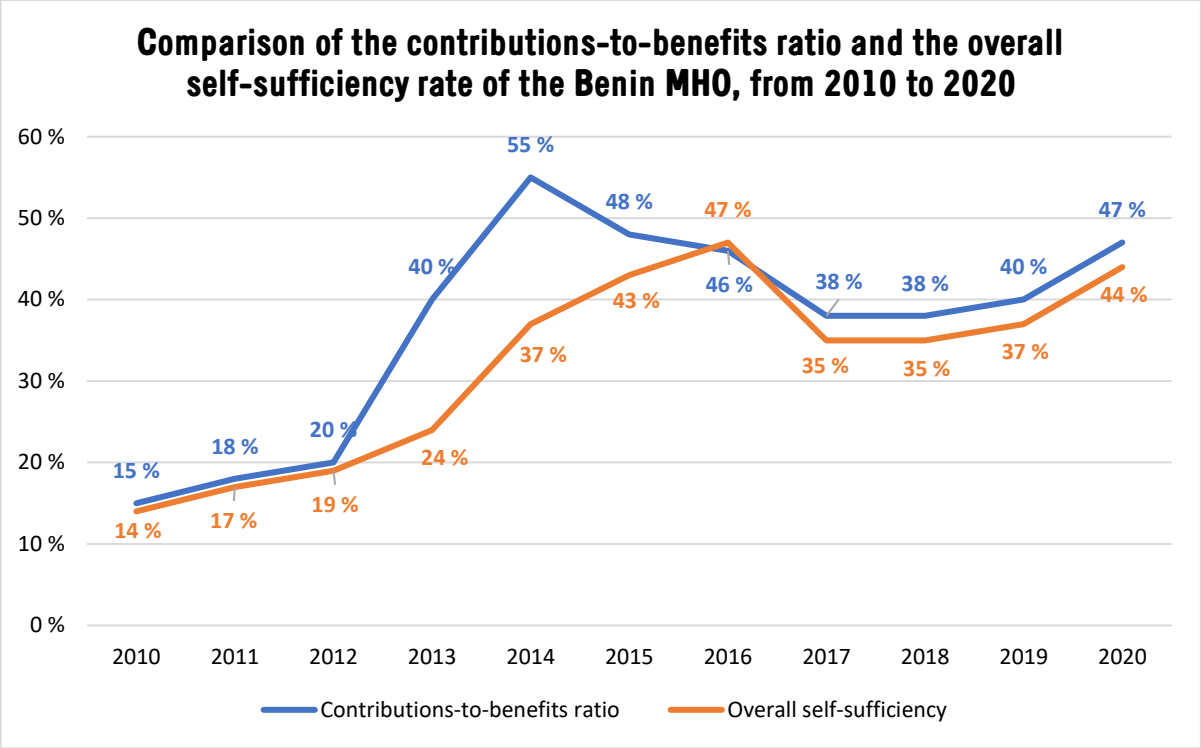
> In 2017, 2018 and 2019, the groups in Burkina Faso paid part of their annual contribution.

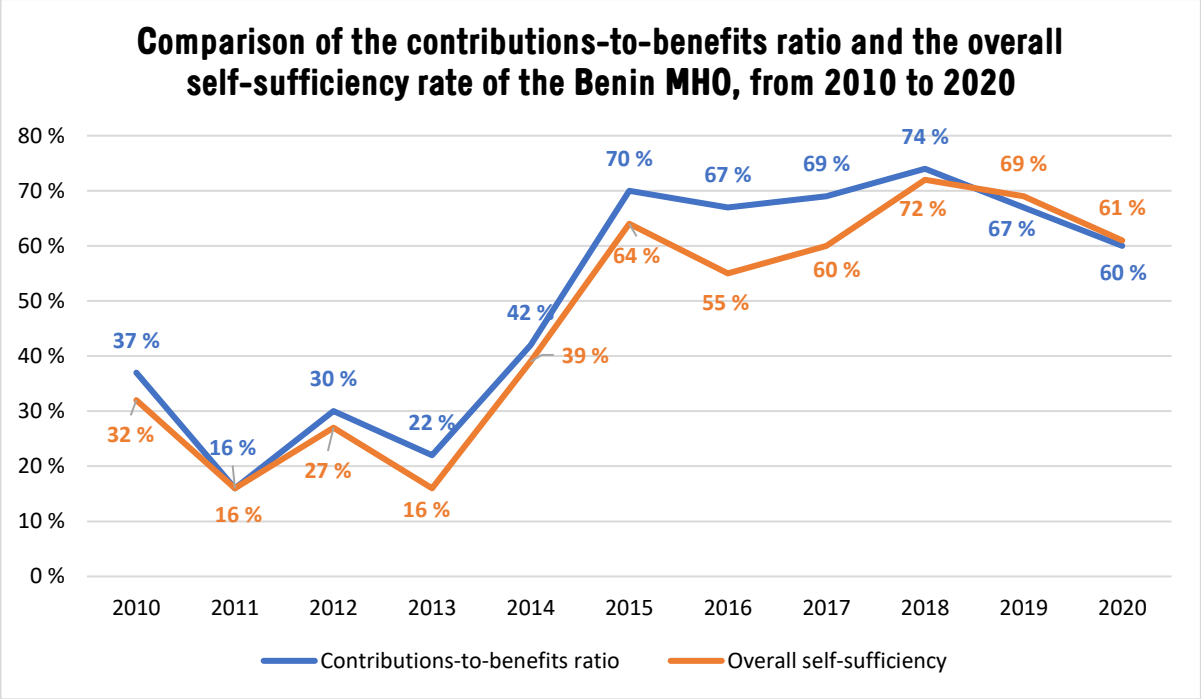
Evolution in the overall self-sufficiency rate of the MHO in Burkina Faso, from 2010 to 2020



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Resources	5 244 €	3 853 €	7 033 €	8 157 €	7 751 €	7 204 €	7 344 €	11 186 €	10 637 €	9 326 €	9 163 €
Expenditure (healthcare + operations)	16 503 €	24 349 €	25 764 €	51 482 €	19 885 €	11 243 €	13 459 €	18 590 €	14 825 €	13 521 €	15 094 €
Overall self-sufficiency rate	32%	16%	27%	16%	39%	64%	55%	60%	72%	69%	61%

Comparison of the evolution of the contributions-to-benefits ratio and the overall self-sufficiency rate





If we compare the two curves, several observations can be made.

It can be seen that the ratio of contributions-to-benefits and the overall self-sufficiency rate improved significantly from 2013 for Benin and Burkina Faso following the reform.

There is also the impact of operating costs related to the General Assembly for 2013 and 2014.

Moreover, the drop in the curve in 2016 in Benin seems to highlight the virtual absence of associative life and the minimal functioning of leadership since that date.

In contrast, the growth observed from 2016 to 2018 in Burkina Faso reflects a dynamic associative life, with the downturn in 2019-2020 being due to difficulties in getting together linked to the local context.

IN ASIA

As mentioned in the previous sections, resources and expenses in Asia differ from those of mutuals in Africa.

Resources

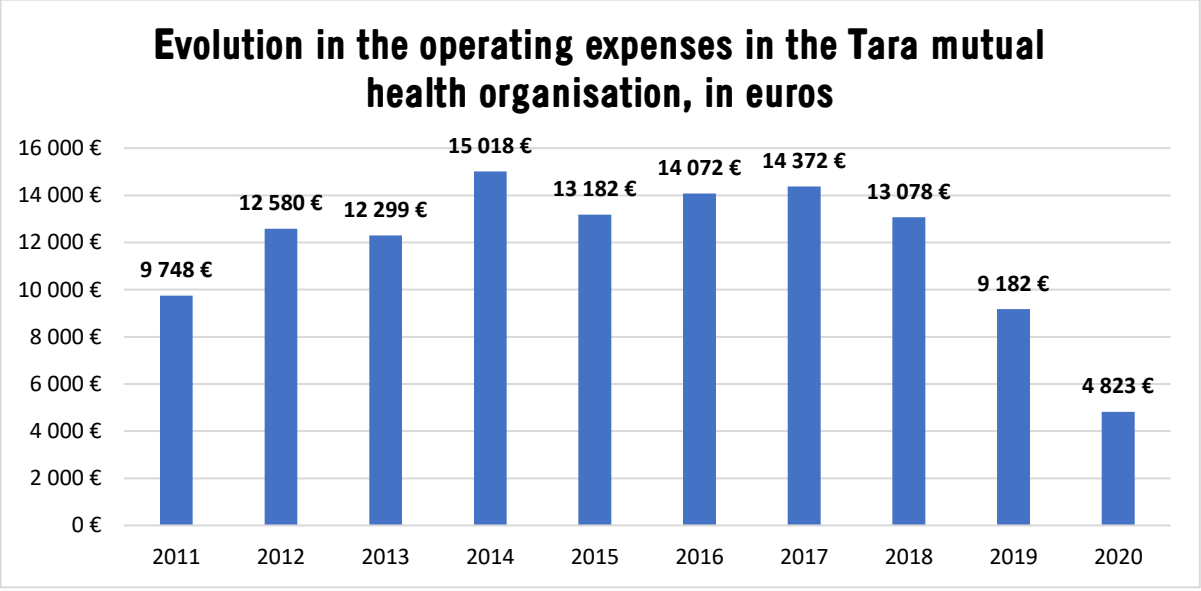
In Asia, the resources of mutuals include contributions, but also resources linked to the sale of health services within the health centres. For structural reasons, Asia cannot benefit from Emmaus sending containers.

The Asian mutuals also have an important specificity: in accordance with the advice given by the health expert who originally supported these mutuals, the contributions collected by the two mutuals are set aside and accumulated over the years in order to build up a contingency fund for possible exceptional health costs (emergency fund). In Tara, this fund amounted to €5,276 at the end of 2020; in Thanapara, this contribution reserve, increased by unspent annual funds from Emmaus International, totalled €13,241 at the end of 2020.

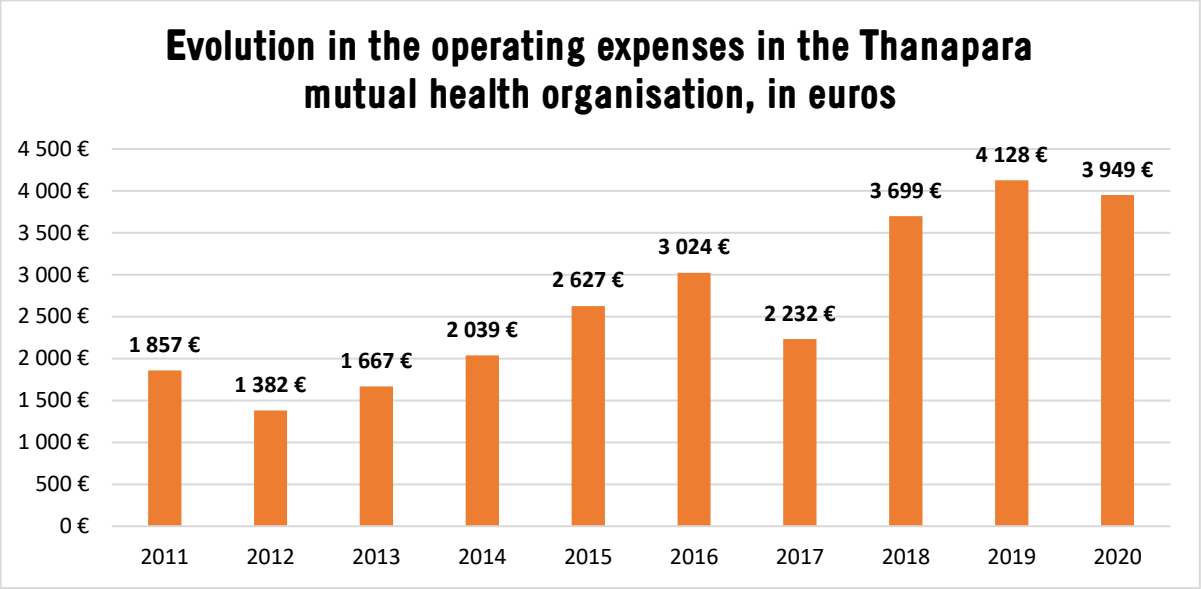
Expenditure

These are expenses related to meetings, the annual satisfaction survey, the costs of producing management tools (membership cards and photos), the holding of local steering committees and various administrative expenses.

The operating wage bill is separate from the wage bill dedicated to access to health: project manager and accountant for Tara; project coordinator, accountant and ambulance driver for Thanapara.



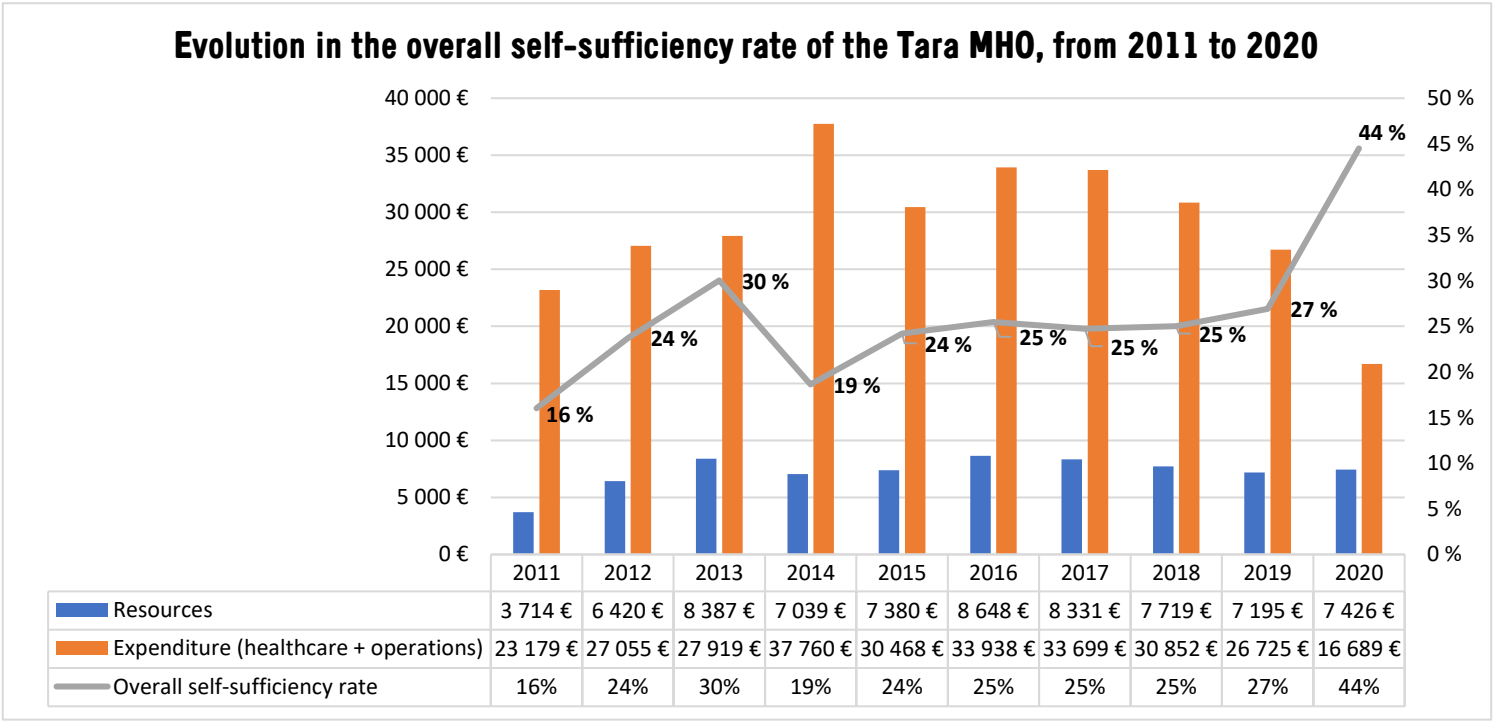
It has to be said that operating expenses are particularly high at Tara (except for 2020, which is an exceptional year due to the pandemic): the centre's operating costs (water and electricity bills, etc.) and the two salaries - accounted for in proportion to the time spent working on the mutual (project manager and accountant) - account for 80% to 90% of these expenses each year.



Again, the largest item of operating expenditure remains the wage bill (project coordinator, accountant and driver), with a clear increase over the last three years.

Financial self-sufficiency of Asian mutuals

From the operating and health expenses, it is possible to assess the evolution of the mutuals' self-sufficiency.



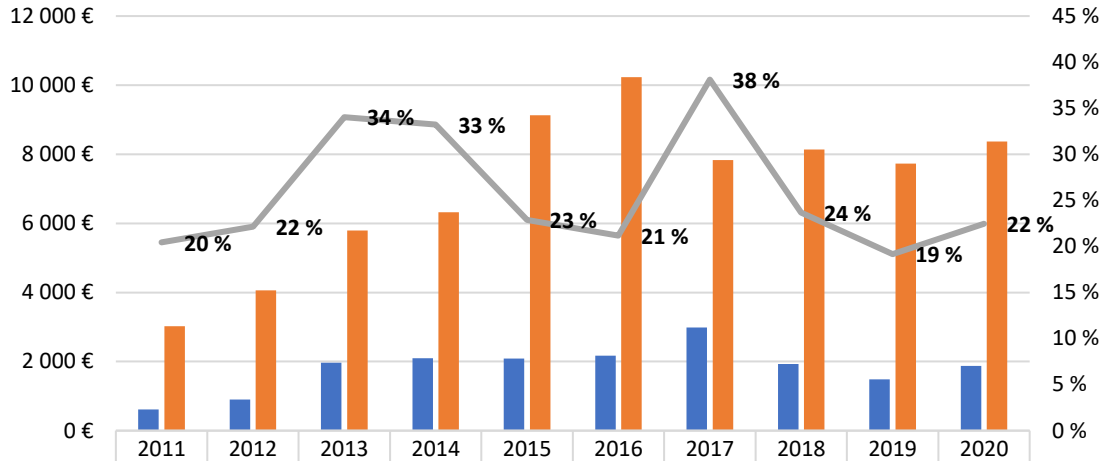
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Resources	3 714 €	6 420 €	8 387 €	7 039 €	7 380 €	8 648 €	8 331 €	7 719 €	7 195 €	7 426 €
Expenditure (healthcare + operations)	23 179 €	27 055 €	27 919 €	37 760 €	30 468 €	33 938 €	33 699 €	30 852 €	26 725 €	16 689 €
Overall self-sufficiency rate	16%	24%	30%	19%	24%	25%	25%	25%	27%	44%

.

Overall, for a "normal" year, total expenditure is between €27,000 and €35,000 for resources varying from €7,000 to €8,500, i.e., a self-sufficiency of about 30%.

It should be noted that the budget allocated by Emmaus International has remained the same since the beginning, namely €15,000 per year. The rest is covered by Tara each year, which shows a real investment by the association to maintain the functioning of the mutual.

Evolution in the overall self-sufficiency rate of the Thanapara MHO, from 2011 to 2020

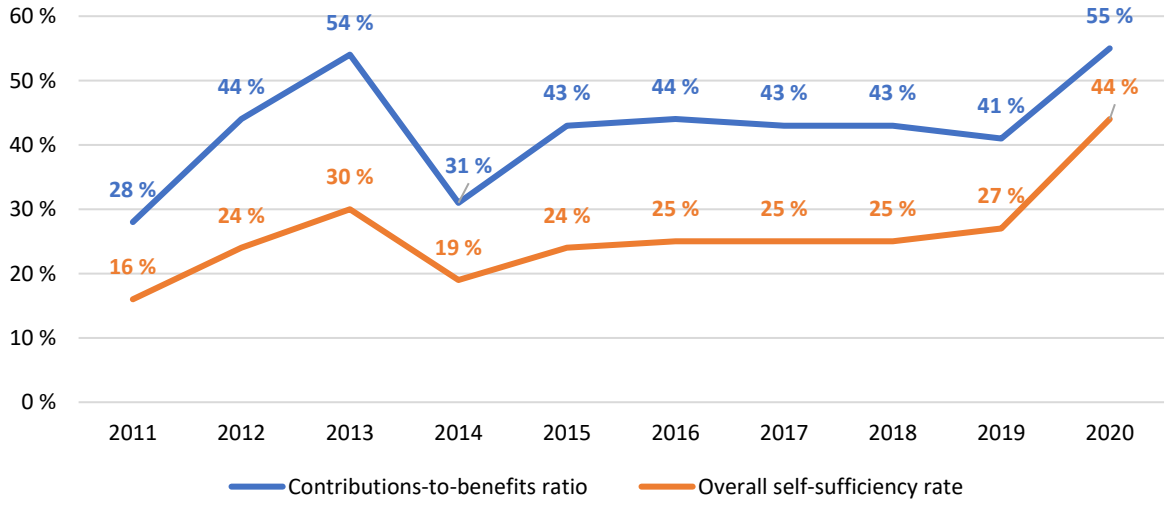


	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Resources	618 €	900 €	1 970 €	2 100 €	2 086 €	2 166 €	2 983 €	1 926 €	1 481 €	1 878 €
Expenditure (healthcare + operations)	3 026 €	4 065 €	5 791 €	6 320 €	9 125 €	10 232 €	7 829 €	8 140 €	7 730 €	8 369 €
Overall self-sufficiency rate	20%	22%	34%	33%	23%	21%	38%	24%	19%	22%

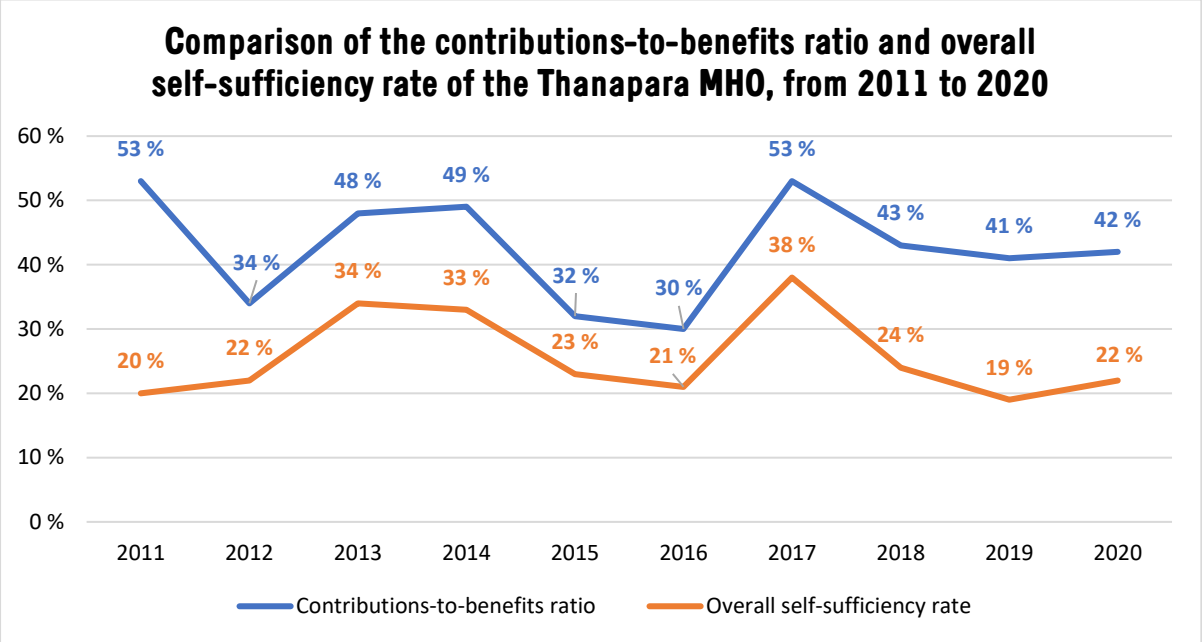
Once again, the irregularity of self-sufficiency rates can be seen. The increasing increase in some operating costs still needs to be analysed.

Comparison of the evolution of the contributions-to-benefits ratio and the overall self-sufficiency rate

Comparison of the contributions-to-benefits ratio and the overall self-sufficiency rate of the Tara MHO, from 2011 to 2020



Although there is no governance as such, Tara's mutual organisation is very dynamic in terms of actions: there are dozens of awareness-raising or discussion sessions every month, which generates significant operating costs. The operating wage bill represents between 30% and 35% depending on the year.



Within the Thanapara mutual, it is the operating wage bill (accountant, driver and coordinator) that accounts for the difference: it represents between 10% and 20% between 2013 and 2017, and between 35% and 45% in 2018, 2019 and 2020.

e. Networking

This is an important aspect of the deployment of mutuals. Today, only the Burkina Faso mutual has undertaken to develop it, focusing its work on three aspects.

Linking up with similar organisations

In 2017 and 2018, the executive committee took active steps to meet other mutuals in Burkina Faso and participate in exchanges of experience (discovering each other's operations, sharing of practices). Thanks to these contacts, the executive can consider new ideas for implementing certain practices or technical operational aspects.

Involvement within a national collective process

Since 2010, the Burkina Faso mutual has been participating in CAMUS-BF (Concertation des Acteurs de la Mutualité Sociale du Burkina Faso [Consultation of Social Mutual Insurance Actors of Burkina Faso]) which coordinates the work of the country's mutualist actors. A five-member board, of which the Emmaus mutual is a member, works with a representative of the ASMADE and RAMS NGOs, which support CAMUS and its members in the development of health mutuals in Burkina Faso and in their structuring and training, with the aim of setting up a national mutual movement and advocating for universal health insurance.

Unfortunately, the security situation in the country has not permitted any real progress on this issue. In 2019, however, a federation of social mutuals was created, integrating different types of mutuals. A survey is underway to map these mutuals (social, community, etc.) more precisely.

Working with public authorities

With the exception of CAMUS, the Burkina Faso mutual has no direct link with the public authorities.

However, it was approached by a consultancy commissioned by the Ministry of Labour and Social Promotion which organised interviews with resource persons from mutual organisations to determine needs and expectations in terms of indicators for monitoring the implementation of the national social protection policy.

An interview was therefore held with the mutual organisation in order to identify its beneficiaries, the local areas it works in, prospects for extension and the satisfaction or claims made by beneficiaries.

Today, pilot experiments have begun in the country for the introduction of universal health insurance.

Presentation of action taken by the Tara MHO during the Covid-19 crisis ©Digital Rangrez (2021)

IV. Overview and assessment of the mutual health access programmes in 2020

After presenting a snapshot of the mutual organisations at the end of 2020 and an analysis of the impact of the Covid-19 pandemic on their operations, this section will assess the strengths and weaknesses of the programmes and stakeholders, in order to identify the strategic choices to be made and the possible prospects.

a. Snapshot of the mutual organisations at the end of 2020

	Benin Mutual Health Organisation	*Burkina Faso Mutual Health Organisation*	*Tara, India*	*Thanapara, Bangladesh*
Start of the mutual health organisation	2002	2002	2011	2011
Place and context in these locations in 2020	National mutual organisation (three groups involved: Pahou, AFA Tohoué) Three geographically remote areas (rural and urban)	National mutual organisation (five groups involved, including one trial group: ESO, SEMUS, Pag-la-Yiri, Benebnooma, Wend Yaam) Four geographically remote areas (urban and rural zones)	Pilot project in Asia Urban area, Tajpur Pahadi, Badarpur area (South Delhi district)	Pilot project in Asia Rural area, Thanapara community, Sardah village
Targets for mutual health membership	Companions, employees and beneficiaries of the Emmaus groups Medium-term prospect of extending membership to people receiving microcredit from the Emmaus organisations	Companions, employees and beneficiaries of the Emmaus groups Medium-term prospect of extending membership to people receiving microcredit from the Emmaus organisations	Residents of the neighbourhood with links to Tara Other residents of the neighbourhood	Members of the Emmaus group (three categories): family members of the organisation's employees (255), family member of the craft producers (575), family members of children in school at Tara (450) Medium-term prospect of extending membership to families (3,500) already receiving microcredit (for productive purposes in the agricultural sector)

Number of members on 31/12/2020 **(total: 4,892 members)**	937 members	1,002 members	2,368 members	585 members
Health product	Establishment of an agreement with health facilities (hospital, clinic, health centre, analysis laboratory), in order to obtain preferential rates, automatic identification and treatment of mutual members and the implementation of third-party payment Prevention and health education sessions for all mutual members once a quarter	Establishment of an agreement with health facilities (hospital, clinic, health centre, analysis laboratory, pharmacy) in order to obtain preferential rates, automatic identification and coverage of mutual members and the implementation of third-party payment Prevention and health education sessions for all mutual members once a quarter	Construction of a health centre by Tara in the neighbourhood, providing access to generic and basic medicines, quality medical consultation with the doctor at the centre, outpatient admission to the centre, blood pressure check, blood sugar test and physiotherapy treatment, for a modest fee Free access to the "health camps" organised by Tara (eye care, etc.) Regular prevention and health education sessions on current topics Preferential rates in several medical analysis laboratories (50% discount) Referral to other hospitals (public or private) for quality, affordable treatment Free cataract surgery for mutual members at the Shroff Clinic	Establishment of a medical centre within the group, providing access to low-cost generic and basic medicines, consultation with a nurse, outpatient admission, blood pressure check, blood sugar test and physiotherapy treatment Free access to the "health camps" organised by Thanapara (eye care, gynaecological care, etc.) Referral to the local public hospital for more specific treatment Ambulance service for transfer to Rajshahi Hospital Partnership with the Medical School is being set up for more specific medical services

<table>
<tr><td rowspan="4">Membership fees</td><td>Brackets</td><td>Family membership rates</td><td>Individual membership rates</td><td rowspan="4">Individual and annual rates vary according to the number of people in the family

Single individual: 250 INR/person/year (€2.88)

Family up to 3 people: 250 INR/person/year (€2.88)

Family of 4 people plus: 200 INR/person/year (€ 2.30)</td><td rowspan="4">Individual and monthly payments: 15 takas (€0.15)/person/month, i.e., 180 takas/person/years (€1.78)

Each mutual member must also pay an annual membership fee of 50 takas/person (€0.50)</td></tr>
<tr><td>Income under 30,000 CFA francs/month</td><td>2,000 CFA francs/month</td><td>400 CFA francs/month</td></tr>
<tr><td>Income between 30,000 and 90,000 CFA francs/month</td><td>2,500 CFA francs/month</td><td>480 CFA francs/month</td></tr>
<tr><td>Income over 90,000 CFA francs/month</td><td>3,000 CFA francs/month</td><td>560 CFA francs/month</td></tr>
<tr><td>Governance</td><td>A (non-functional) association</td><td>An association with members elected at the General Assembly (executive committee and board)</td><td>No governance</td><td>No governance</td></tr>
<tr><td>Coordination</td><td>3 local representatives
+
Emmaus Benin secretary
+
medical consultant</td><td>Association (4 members)
+
5 local representatives
+
Emmaus Burkina Faso secretary
+
5 support contact persons</td><td>1 project manager
+
4 Tara social workers
+
1 doctor
+
8 community representatives
+
8 young volunteer health workers</td><td>2 Thanapara employees
+
1 nurse
+
6 elected representatives</td></tr>
<tr><td>EI annual budget</td><td>€20,000</td><td>€20,000</td><td>€15,000</td><td>€10,000</td></tr>
<tr><td>Latest field visits</td><td>2017</td><td>2017</td><td>2015</td><td>2016</td></tr>
</table>

Latest international steering committee	2014	2014	2014	2014
Own resources in 2019	€6,914	€9,326	€7,195	€1,481
2019 expenses *healthcare + operations*	€18,835	€13,521	€26,725	€7,730
Financial independence in 2019*	37%	69%	27%	19%

* Financial independence is calculated based on expenses related to the reimbursement of health care costs and operating costs, from revenue from contributions. The 2019 rate was chosen over the 2020 rate, which is higher but less representative due to the crisis.

b. Role of the mutual health organisations during the Covid-19 pandemic (2020)

In 2020, the global health context brought the objectives set for each mutual organisation to an abrupt halt. Although the mutual health activities were maintained, the local Emmaus teams supporting them shifted their focus to emergency actions.

To support beneficiaries during the crisis, the mutual organisations benefited from the Emmaus International emergency aid fund. This enabled the **individual and collective preventive measures** to be followed by helping to finance the following actions:

> Purchase and distribution of masks, hydro-alcoholic gel and hygiene kits;

> Organisation of hand-washing stations within the groups and in the places where mutual members gather (clean, drinkable water, and soap);

> Disinfection of potentially contaminated places and objects within the groups and in the areas where mutual members gather;

> Purchase of laser thermometers to regularly measure the temperature of group and mutual members).

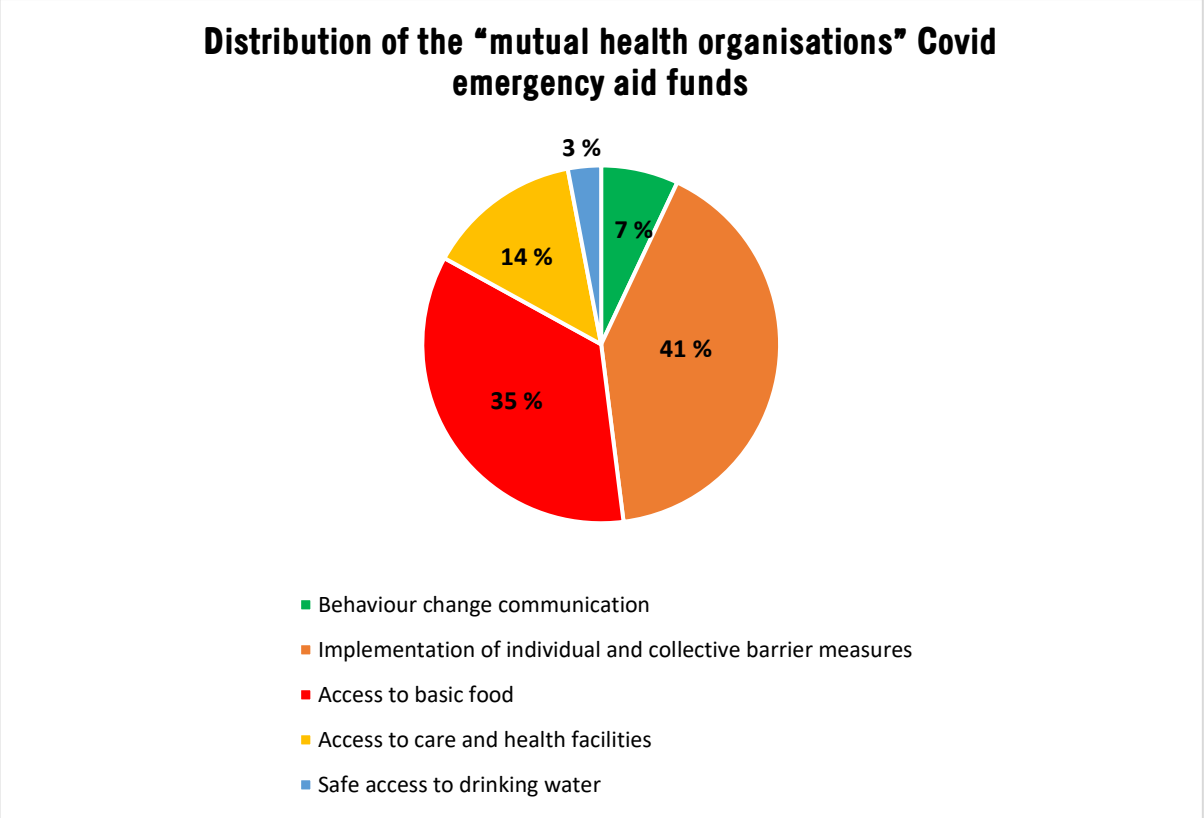
The mutual members also endeavoured to **mitigate, as far as possible, the socio-economic** impact of the pandemic for mutual members. Actions included:

> Organising the distribution of basic food items (to help strengthen people's immune system);

> Setting up (temporarily free) drinking water stations;

> Granting mutual members and their families permission to continue to use health treatment and facilities, by covering the membership fees (between three and six months).

The "mutual health organisations" Covid emergency aid funds were distributed as follows:



The emergency fund set up by Emmaus International also enabled mutual members and their families to take ownership of preventive measures by raising awareness of good practice in a way that was adapted to the different local contexts: awareness-raising in small groups in the living spaces of mutual members in Badarpur, messaging on local radio stations in Burkina Faso, dissemination via village "criers" in Bangladesh, and sending numerous messages on WhatsApp groups in Benin.

c. Strengths and weaknesses of the Emmaus International approach

Emmaus International maintains that it is possible to place the most excluded people at the centre of the design, development, implementation and management of programmes to access fundamental rights, given the right political choices and appropriate financial resources, despite the many constraints.

STRENGTHS

Taking the long view

Time is a prerequisite for working towards lasting change. This is fundamental in environments where there are multiple difficulties (extreme poverty, population surviving on an informal economy, high illiteracy rate, privatisation of basic public services, etc.). Convincing people living in these conditions that it is possible to move from being a victim to playing an active role cannot be done in just a few years.

Construction methods

In order to make the actions sustainable, it is also crucial that the people concerned do not perceive the tools developed as imposed mechanisms. It is essential to set up participatory spaces so that everyone feels involved and contributes to the development of tools.

Adapting to the context

The approach adopted by the Emmaus movement for its mutual health programmes requires constant questioning and adaptation. Existing models can be looked to for inspiration, but they cannot be reproduced identically. Mutual health systems must be adjusted to the different local health, economic and cultural contexts.

The will to change codes and mentalities

The daily lives of the people with whom the movement works are dictated by the urgency of survival, for themselves and those close to them. Solidarity is relegated to second place. It is an important choice to make these people aware of the usefulness of having a common objective and to make them understand the benefits of pooling individual resources to access a right.

It is also about strengthening collective organisation and the feeling of belonging to a community.

At the same time, the movement's approach encourages mutual members to take on responsibilities – local representatives in Africa, women in India or Bangladesh (they take initiatives, and some become leaders within their community).

WEAKNESSES

Maintaining commitment over time

Paradoxically, long-term commitment, which is one of the programme's strengths, is not so simple and can face several obstacles:

> Within the Emmaus groups supporting these mutual health programmes, other priorities can take precedence over the programmes. Furthermore, if it takes too long to achieve the desired result, momentum can falter and people may become discouraged.

> For the movement's elected representatives, long-term support and coordination are also a difficulty. The constraints of the contexts in which the mutual organisations are developed are so severe that implementation and concrete changes are very slow to happen. Here again, other priorities may arise, meaning that elected representatives are forced to put this issue to one side. Moreover, this issue does not directly concern the groups of many of these elected representatives (European elected representatives face different situations in terms of access to care, and Latin American elected representatives, who do not have a pilot health project, find it more difficult to comprehend the implications).

> Finally, engaging in mutual health programmes requires financial investment and substantial, regular budgets.

The "micro" dimension of the action

The movement has chosen to develop its mutual organisations in a context of poverty, or even extreme poverty, which inevitably places the actions within a limited perimeter. The weakness and

fragility of members' contributory capacity – which requires regular support (from the local group, from established reserves or from international solidarity) – as well as members' limited predisposition to implement advocacy at the local or national level, restrict the extension of the programme.

d. Strengths and weaknesses of the mutual models

After having taken stock of the four mutual organisations, it is appropriate to examine their strengths and weaknesses. They will be analysed by type of mutual organisation, as it is clear that they take two forms: in Africa, the programme is similar to a basic social security scheme, whilst in Asia it is based on health centres from which the right to health is organised.

STRENGTHS OF THE EMMAUS MUTUAL HEALTH ORGANISATIONS

IN AFRICA

Access to health

> The system of family membership works well. It has led to a steady increase in the number of mutual members over the last 10 years, covering all people within the same family and leading to better sharing of health risks.

> Contributions have been rising steadily for the past 10 years within the two African mutual organisations. Mutual members have a better understanding of mutual organisations as a solidarity system, with contribution brackets adapted to income, which appears to be socially fairer.

> The financial link between the groups and the majority of mutual members has made it possible to introduce a deduction at source system in Burkina Faso and Benin, via the income of employee members, facilitates and secures the payment of contributions.

> The overall "health product" now enables mutual members to cover their most common needs, with clear rules in terms of coverage or exclusion from benefits. Education sessions on health care take place regularly and present an opportunity to answer mutual members' questions and increase ownership of this collective tool.

> Finally, in Africa, the mutual health organisations have established agreements with health facilities, which is contributing to a progressive local network. The introduction of third-party payment is an important step forward and the links with health facilities are being consolidated over time.

Operations

> The legal frameworks of each of the two mutual organisations are defined by statutes and internal rules. The texts specify the rules, role of the elected members and democratic processes. However, the governing bodies are only effective in Burkina Faso, where the current elected representatives play a full role in a voluntary and dynamic organisation, which assumes its responsibilities to tackle the problems that arise.

> Many actors are involved in coordinating the mutual health organisations, which results in a large number of mutual members who are involved, or even very involved. They also have a good knowledge of the progress of the mutual organisation's work.

> Management and reporting tools are used to monitor developments and manage the framework for access to care. Every month, generally thorough and regular monitoring is carried out by the local representatives and the national management committee in each mutual health organisation. In Burkina Faso, qualitative reporting is systematically carried out for any meeting or workspace implemented, at either local or national level. Moreover, in Burkina Faso, a new trial for the local organisation of work is underway to compensate for the lack of involvement of group leaders and to support the local representatives in their action in the region.

> Finally, the accounts are in good shape in both Benin and Burkina Faso. The use of the funds from Emmaus International is transparent. The "contributions-to-benefits" ratio, along with the overall self-sufficiency rate, are progressing within the two mutual health organisations, owing to the levers put in place as part of the reform. Stakeholders are seeking to increase the mutual organisations' own financial capacities, such as from containers and annual contributions from groups.

IN ASIA

Access to health

> In both India and Bangladesh, the mutual organisations operate locally with a single group. The determination of these groups and their leaders is robust, and the human and/or financial resources dedicated to these programmes are significant.

> Membership potential is very high in the two Asian mutual organisations. At Tara, the shift from individual to family memberships is on track for success.

> The creation of the mutual organisations has considerably increased the sense of health security, as these people have no other quality alternatives for health care.

> It has also increased solidarity and cohesion within the neighbourhood and the group: the health centre set up by Tara in the middle of the eastern neighbourhood of Badarpur has become a meeting place and a social link; at Thanapara, the health centre plays the role of a basic rural health facility that can refer people to the nearest and best equipped medical facilities.

> The annual contribution rate is affordable for all mutual members, even the poorest. At Tara, the annual contribution system allows the mutual organisation to collect almost all the memberships during a single period; at Thanapara, the regular financial links with the mutual members (salaried staff, craft producers and micro-borrowers) and the community links (school members) facilitate the collection process.

> The increase in the network of partners as well as the growth of health services developed within the Badarpur centre mean that a wider range of quality care is now offered to mutual members at a low price. In short, the financial volume of the cost of the services has a minimal weight in the system.

> Finally, in general, the creation of these mutual organisations has an impact that goes far beyond access to health care. It encourages the emergence of leaders and the empowerment of women, who can thus overcome certain social barriers linked to patriarchal systems.

Operations

> Collective spaces exist, which encourage community participation, particularly of women, and democratic life. Community representatives are elected.

> In terms of coordination, the Tara and Thanapara groups quickly organised their own teams and/or meeting places. At Tara, leadership is a real asset for the mutual health organisation, with health care activities, a system, and procedures well established. Spaces are provided to increase the knowledge of mutual members about basic health practices, as well as on the operational functioning of the mutual health organisation; local actors are trained to carry out basic medical monitoring and tests (community representatives and young volunteers).

> Management and reporting tools are computerised, and generally well maintained and detailed, making it possible to monitor changes (in membership, contributions, benefits, etc.), as well as to carry out data analysis and cross-referencing.

> The ratio between health expenditure and resources is at an acceptable level for a first decade, despite the economic, health and structural pressures that exist in both India and Bangladesh. For the past 10 years, both mutuals have been seeking new resources. Finally, self-sufficiency rates have plateaued in recent years (with the exception of 2020) and levers are in place to improve them.

WEAKNESSES OF THE EMMAUS MUTUAL HEALTH ORGANISATIONS

IN AFRICA

Access to health

> There is no national overview of the members of the families, the make-up of each family, or the history of contributions and access to care, nor is this information computerised.

> In both Benin and Burkina Faso, work must be carried out on a regional basis, coordinated by the group leaders, to propose ways of expanding the programme to people close to the groups or to local partners. It is vital to collectively reflect on this process of opening up and to build it in the same way, as the attempts at expansion that have taken place so far, in an ad hoc and uncoordinated manner, have caused problems.

> The groups continue to pay the contributions deducted from the salaries of their employees irregularly (particularly in Burkina Faso) and there are persistent difficulties in collecting contributions from mutual members outside the groups. In addition, the contribution brackets should be reviewed, as they are more than 10 years old and are not adjusted to family income due to a lack of transparency in income declarations.

> Another weakness is the persistence of consumer-type behaviour: members of the mutual health organisation ask for an increase in the range of health services on a regular basis but are really not aware that this requires funding.

> The prescription and use of generic drugs remains lower than that of speciality drugs, which are much more expensive.

> Finally, the frequent turnover of health care staff makes it more difficult to ensure knowledge of the agreements within the health facilities. Regular reviews with these facilities are essential. In addition, in Benin, it would be useful to increase the number of agreements in order to facilitate the growth of third-party payment.

Operations

> While organisational management is well in established in Burkina Faso, it is non-existent in Benin, as there has not been an elected team since 2016. In other words, there is no impetus, no monitoring or control, which leads to a lack of involvement of mutual members.

> Statutory elements need to the situation on the ground, in particular to the difficulty of finding volunteers willing to commit. At present, the statutes provide for elective General Assemblies every year, which may not be appropriate given the time needed for elected representatives to understand their role.

> Some members do not play their role due to a lack of willingness and/or time, which does not allow the mutual organisations to develop as they should:

- The local representatives receive little, if any, support and guidance, even though they have a pivotal role in running the mutual organisations. Their work should be monitored and supervised by the group leaders, the elected representatives of the mutual organisation, the national Emmaus organisation and, from further away, Emmaus International and the Africa region.
- The fact that the group leaders are not sufficiently involved in the mutual health programmes undoubtedly hinders the progress of the mutual organisations. Some local representatives are demotivated due to a lack of advice or support. In addition, the failure or delay in paying contributions to the mutual organisation via the groups and the irregular or non-existent payment of the annual contribution weaken the financial balance of the mutual organisation.

> The links between mutual organisations and group leaders are at best very irregular and most of the time non-existent, as are the relations between the mutual organisations and the national Emmaus organisations. However, these links could facilitate exchanges of practices, coordination and reinforcement at the national level, and improve bargaining power with health partners, as well as the possibilities for challenging public policy in this area.

> Management and reporting tools should be computerised, both for better monitoring and analysis of developments and to secure the storage of information, which is currently handwritten.

> Financial monitoring tools are weak, making it difficult to anticipate changes, for example to operating costs.

> Old health costs – in principle excluded from the services offered by the mutual health organisations, but which were nevertheless exceptionally accepted for chronic illnesses or unexpected surgical operations – still weigh heavily on the finances, and the “consumption” of certain health services or speciality drugs remains high.

> Finally, the supervisory committees, although provided for in the operations, are non-existent in both Benin and Burkina Faso.

IN ASIA

Access to health

> The membership packages are not sufficiently geared towards family membership owing to members’ very low contribution capacity. Payment of the annual contribution also raises questions.

> Members' very low socio-economic level, which make the solidarity principle difficult. In this context of a very precarious informal economy, it is very difficult for Tara and Thanapara to track the actual income of members. This results in very low contributions compared to the operating costs.

> At Tara, there is not a systematic link between the mutual members and the group's activities. The vast majority of mutual members live in the neighbourhood where the group operates, but financial or work links are not systematic. The collection of contributions is therefore less secure. At Thanapara, the contribution recovery rate is low.

> The members of these two mutual organisations have such high health needs that they are first and foremost "consumers" of the services, relegating their role as stakeholders in the mutual schemes to the background. In addition, the irregular links with the mutual organisations do not facilitate the understanding of the system and the involvement of the members.

> The wide range of services offered at a very low price by the two mutual organisations leads mutual members to believe that receiving treatment is something they are "due". They regularly request additional health care services. However, the decision to build an equipped health centre, with a doctor or a nurse, represents a high operating cost in addition to the initial investment cost, unlike to the model implemented in Africa. Furthermore, reimbursement for hospitalisation is too low (budgetary prudence), even though they are one of the main reasons the mutual health system exists (collective sharing of health risks).

> Finally, although other mutual or community experiences exist on the ground, no work has been done to organise meetings and to share practices.

Operations

> The Tara and Thanapara staff lack experience in developing a mutual system involving those concerned (supporting mutual members in governance). At the same time, identifying and renewing local representatives is limited by the fact that the mutual members come from particularly disadvantaged backgrounds. Finally, the role of mutual members remains poorly defined in terms of managing the programmes.

> As the work of the mutual organisations is mainly carried out by the groups' salaried teams, it focused on health-related matters and not on the empowerment of mutual members.

> While the tools are generally well maintained, some of them do not include details that would improve visibility, as well as analyses and projections. Local monitoring and reporting are not regular enough, there are too few qualitative elements and the annual activity reports are not complete enough.

> Even today, it is clear that the mutual organisations could not survive without solidarity support from the movement. The groups face numerous restrictions: prohibitive health care costs in India, high operating costs (in 2019, the total wage bill within the mutuals in Asia – operating budget + health access budget – represented 65% of the total annual budget at Thanapara and 60% of the total annual budget at Tara).

> Financial monitoring needs to be improved in order to achieve greater visibility: keeping of budgets, analysis of expenditure, breakdown of resources related to health services, etc.

e. Strengths and weaknesses of the movement's support

STRENGTHS OF THE MOVEMENT'S SUPPORT

Collective support

In Africa as in Asia, the creation of mutual organisations has prompted the movement to initiate concerted support efforts: the elected members have closely monitored the programmes during Executive Committee and Board meetings and collective spaces have been created with mutual members (regional and international steering committee).

Spaces for mobilisation

To involve as many players as possible from within these programmes, collective work and discussion spaces have been created (workshops during the successive World Assemblies, annual meetings for health stakeholders, work camps). These events have been very motivational – the involvement of stakeholders has clearly increased following these sharing sessions.

Strong mobilisation of the movement

The momentum gathered for the implementation of the mutual organisations has widely involved and affected the different levels of the movement: support from the movement's groups at the international level; establishing links and boosting the work at the regional level; the development of these systems and their practical roll-out thanks to group leaders at the local level and their local knowledge and reputation.

The movement's ability to adapt and raise questions

Since 2008, following the first pilot projects in Africa, the movement has sought external and/or international mutual programme expertise. This expertise has shed light on the dysfunctions of the systems initially set up and contributed to discussions on the decisions to be taken to remedy them.

Moreover, starting in 2009-2010, some groups that had been supporting the mutual organisations in Africa for eight years began to lose steam. The movement then tried to further develop the transmission of information on the evolution of mutual health programmes:

> The issue came up quite regularly in Emmaus International's communication tools between 2010 and 2013 (see *Tam-Tam*, No. 52);

> Annual meetings with the stakeholder groups were organised in France in order to carry out progress reviews, contribute to drawing up the next action plans and listen to the testimonies of the stakeholders on the ground;

> An international "Health Asia" work camp was organised in 2013 at Tara and Thanapara, allowing representatives of the groups supporting these programmes to understand the reality of the contexts and to participate meaningfully in local actions.

This mobilisation has encouraged new groups, including communities in France and Italy, and collectives of communities (groups in the West of France, for example) to join together to contemplate communication activities and support initiatives (dedicated sales, "salons", etc.), and to get involved in activities on the ground.

Financial solidarity

This solidarity has been essential and remains necessary, despite improvements in self-sufficiency.

WEAKNESSES IN THE MOVEMENT'S SUPPORT

Since 2016, there has been a clear loss of momentum in the movement's support. There are several reasons for this.

A lack of political support from regional and international bodies

During this period, few meetings of the Board and the Executive Committee have addressed the issue of the mutual health programmes (2017 for the Executive Committee).

Several points were made in 2016, 2017 and early 2018 by Emmaus International Secretariat to alert to the worrying situation in Benin and Burkina Faso in terms of governance, local coordination and involvement of local groups. Four missions (two to Benin and two to Burkina Faso) helped to boost the local stakeholders, but it has to be said that there was hardly any follow-up, questioning or search for improvement.

This is not a deliberate choice of the elected representatives, but rather the indirect consequences of the World Assembly in Jesolo in 2016. This World Assembly opened a particularly busy period due to the demanding guidelines for relaunching international solidarity, formulating Emmaus' political voice, and also bringing the legacy of Abbé Pierre and the movement's founders alive (organising the World Forum of Alternatives in 2018, changing working method on solidarity projects in 2019 – solidarity guide and new process for requests for support, organising international work camps, celebrating 50 years of the Universal Manifesto). The programme was also hit hard by the health crisis in 2020. Moreover, the political contexts did not facilitate missions on the ground, particularly in Burkina Faso (security crisis) and Bangladesh (political and security crisis).

In addition, Emmaus International Secretariat, which is heavily involved in implementing the new guidelines and does not have the human resources to meet the needs, has not been able to regularly support local stakeholders in achieving the objectives. For the time being, it still does not have dedicated support within its team or external technical support (except for a few specific cases).

All this means that the coordination of the movement and the groups almost non-existent. With the exception of the annual activity reports to the Board, no communication to the groups has been carried out during this period and interventions to mobilise and inform the groups on this issue have become few and far between.

At the same time, the organisation of work via international or regional steering committees has not existed for several years (the international steering committee of the health programme last met in 2014). As a result, programme stakeholders can no longer meet to assess the situation on a regular basis, share practices, collectively consider how to overcome the difficulties encountered on the ground and, more generally, reflect on the impact of their work on the fight against poverty and on the political voice that should be developed to allow access to fundamental rights.

Finally, the annual meetings, where all the stakeholder groups used to get together and which enabled the strengthening of information, participation and engagement, have ceased (the last one was in 2015).

National organisations are missing from Emmaus International's health programmes

Despite their current difficulties, the national organisations in Benin and Burkina Faso have an important role to play in creating collective momentum, driving coordination at national level by supporting the mutual organisation's elected representatives, encouraging mobilisation and reflection, etc. However, they have never really been involved.

Very little involvement from regions

The regional levels of the movement (Africa and Asia regions) do not seem to have found the right formula to get involved in the monitoring and development of the health programmes taking place in their area. Information updates are sometimes organised, but most of the time they are very quick.

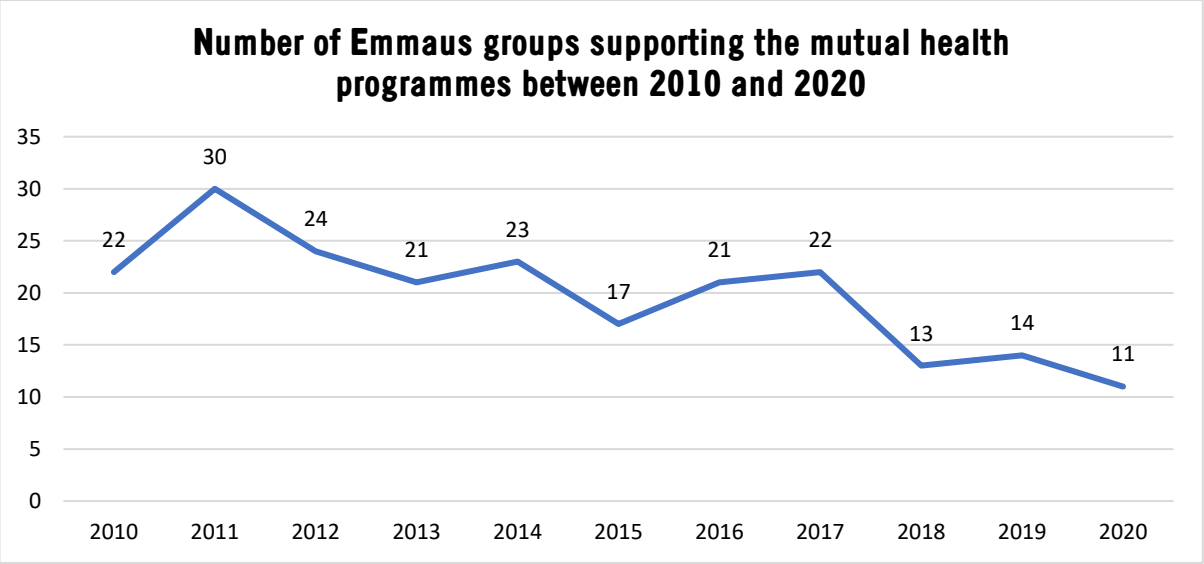
Collective discussions on the mutual health programmes are never suggested, either because the region's elected representatives do not feel politically responsible for this process, or because they are not directly involved in the mutual organisation (their group or their national organisation does not have one). However, even in the latter case, their participation would be useful, as these programmes have everything to gain from everyone contributing and giving their ideas.

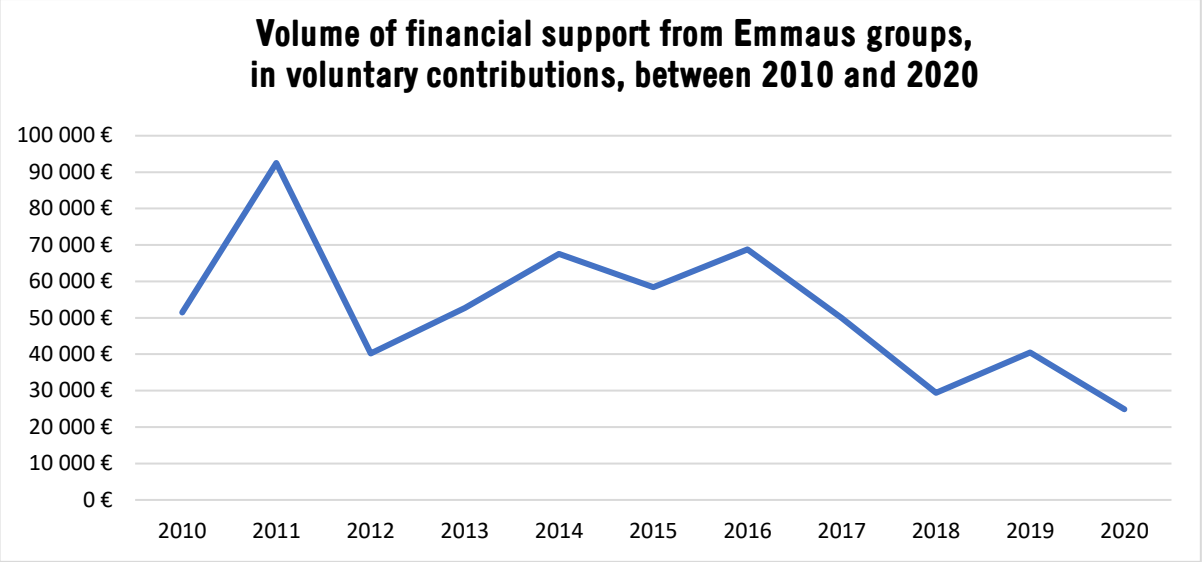
Finally, although the regional secretariats can sometimes act as a link, they do not seem to be in a position to support such programs currently.

Decreasing engagement of the movement's actors

Currently, there is a lack of information on the development on the mutual health programmes. The various initial communication channels are no longer used. The spaces for stakeholder involvement that used to be held regularly no longer exist (annual stakeholder meetings, work camps).

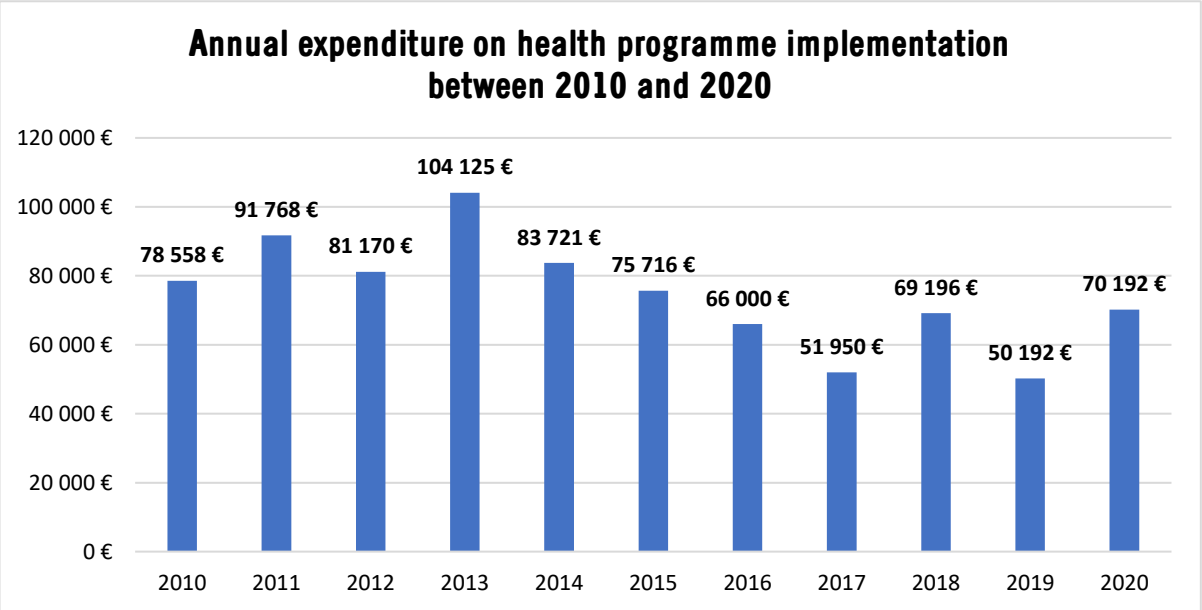
Overall, in the past few years there have clearly been fewer support initiatives, meetings, discussions, field visits, etc. This slowdown has been felt by all actors, from those working on the ground to the movement's groups that support this collective action. Due to the lack of information (which prevents them from following the development of the programmes), some have lost motivation, while others have suddenly withdrawn their support.





The graphs above show the decline in the number of groups supporting health programs and the volume of financial contributions between 2010 and 2020. Today, these voluntary financial contributions no longer cover the annual expenses of the health programmes, the difference being covered by a levy on the annual solidarity sales and sometimes by the contribution of a few regional salons in France.

It is also worth noting that there were occasional increases corresponding to meetings and discussions: in 2011, the World Assembly in Anglet; in 2013 and 2014, annual meetings, international steering committees, and a work camp on the mutual health organisations in Asia; in 2016, the World Assembly in Jesolo.



As a reminder, the annual expenditures for the mutual health programmes vary each year. The average over the period is €74,781 per year. Annual expenditures represent:

> Reimbursement of care to mutual members (€20,000 for Benin; €20,000 for Burkina Faso; €15,000 for Tara; €10,000 for Thanapara);

- External support costs (expertise and medical consultant);
- Expenses related to local (Asia) or national (Africa) coordination of the mutual organisations;
- Costs related to the international coordination of the programme: international steering committee, field missions, work camps.

Interpretation of the graph

- In 2010 and 2011, even before the opening of the programmes in Asia, the travel, implementation and expertise costs were high (Asian expertise, French mutual organisation expertise in Africa, medical consultant in Burkina Faso, medical consultant in Benin). In addition, the Asian mutuals operated for six months in 2011.

- In 2012, apart from support for health care, two missions took place in Africa (preparation of the Constitutive General Assemblies) and one in Asia, and the expertise budget plateaued.

- In 2013, two major events took place: the Constitutive General Assemblies in Benin and Burkina Faso, in which representatives of the international steering committee took part, and an Asia work camp at Tara and Thanapara, with the collaboration of representatives of groups from Europe.

- In 2014, an Asia mission and an Africa mission took place.

- From 2015, external experts were no longer involved in the programmes, with the exception of the medical consultants in Benin and Burkina Faso (2015 was the last year of the Burkina Faso medical consultant).

- It was not possible to organise additional work and reflection sessions in 2016, other than the World Assembly in Jesolo. A mission with a member of Emmaus International Secretariat and an elected representative was carried out in Burkina Faso and then in Benin to support the stakeholders in the governance and/or leadership crisis.

- The last four years correspond to were years with a minimal budget: support for the payment of health costs, interventions by the medical consultant in Benin. It should be noted that in 2017 and 2019, the funds paid to the mutual organisations in Africa were halved, due to their progress in terms of self-sufficiency and management. A complementary mission (to the one in 2016) is took place in Africa in 2017.

Meeting of members of the Thanapara Mutual Health Organisation (Bangladesh) ©Emmaus International (2017)

V. Outlook

Today, thanks to the four mutual health systems that have been set up, the movement has gained substantial field expertise. It is important that this expertise is enhanced and showcased. While the original choice of running this pilot scheme as a process (to avoid falling into a project management approach) is interesting, it could potentially be revisited to provide long-term support.

a. Improving access to care and the operation of the mutual organisations

Thanks to these mutual programmes, the movement has provided access to quality health care to more than 5,000 people, while involving those concerned in the development of their tool and pooling the skills and efforts of many stakeholders.

Nevertheless, areas of improvement have been identified to improve the models established in Africa and in Asia. These improvements must now be implemented so that the mutual organisations in both Asia and Africa can become increasingly self-sufficient.

THE MODELS IN AFRICA

ACCESS TO HEALTH

Changes need to be made to a number of aspects.

With regard to **membership**, it is now essential, within the framework of national management, to create more demanding tools in order to be able to supplement and update the data regularly, and also to better monitor developments and fine-tune the membership policy. Initially, this will also make it possible to check membership in the groups more accurately before potentially opening them up to external members.

The joint work in each area should also be relaunched, under the coordination of the group leaders, in order to redefine the strategy and ways of expanding outwards.

In terms of **contributions**, the African mutual organisations are faced with the task of updating the brackets defined over 10 years ago. The aim is to redesign the contribution brackets to make the system fairer and more inclusive. On a technical level, there is an urgent need to set up a direct debit system for the payment of membership fees from the group accounts to the mutual organisations' accounts.

With regard to **access to care**, it is necessary to take stock of more than 10 years of agreements with health facilities, to increase the number of agreements (in Benin), to renegotiate them and to set up a sustained effort of local coordination and training for health facilities covered by an agreement and for mutual members.

At the same time, in view of the weaknesses and wishes identified, a **review of the health services** is needed: capping of speciality drugs and certain medical procedures (in terms of frequency or financial volume per member), inclusion of new benefits, creation of a solidarity fund to cover uncovered, expensive or exceptional benefits (study their operation, criteria and resources).

Finally, it would be useful to compare the health coverage of the mutual health organisations with the health coverage that group employees are supposed to benefit from via the social charges paid by their employer.

OPERATIONS

Certain situations should be dealt with urgently.

In terms of **governance**, Ordinary and Extraordinary General Assemblies (end of 2021/start of 2022) should be planned quickly, with all that this implies in terms of prior statutory work and access to health. These assemblies should be followed by training for elected representatives and operating teams. It will then be a matter of organising and planning the work with the newly elected board members and executive committee members.

In terms of **coordination**, Emmaus International should initiate a meeting with the group leaders in Benin and Burkina Faso to discuss the involvement of groups and their leaders, the commitment of national organisations, their positioning and the resources and working tools of national secretariats.

Collective work with the stakeholders should also be done to reflect on how to organise and develop local coordination, and on how to share practices that work.

This requires **support** for the mutual organisation's stakeholders (elected representatives and field workers) in their missions and tasks (coordination and management) and capacity building (training on management and the use of tools, etc.).

Finally, joint discussions between the African mutual organisations should be held to redesign, improve or create the necessary management and financial monitoring tools, as well as the essential procedures and workspaces.

THE MODELS IN ASIA

ACCESS TO HEALTH

In Asia, the priority of the mutual organisations is to review **membership policies**: individual/family, fees, frequency of commitment and financial collection, study and analysis of the renewal rate (at Tara), monitoring of recovery rates (by thinking about a structure and a method [at Thanapara]). In order to do this, after 10 years of existence, it seems relevant to carry out a social study on the make-up of families.

At Thanapara, a strategy for the progressive inclusion of micro-borrowers should also be proposed, depending on the programme's coordination capacities.

Furthermore, even if it seems very difficult given the mutual members' socio-economic situation, it would be useful to study the possibility of **differentiated contribution rates** according to family income (at Tara) or categories of employees (at Thanapara).

In terms of **access to care**, several aspects need to be reviewed: rates charged in the mutual health organisations' health centres, particularly the difference in price between members and non-members; reimbursement scale for hospitalisation (particularly at Thanapara).

At the same time, raising mutual members' awareness of the fragile balance of the mutual organisation and the danger of over-consumption remains a constant challenge.

Finally, at Thanapara, the breakdown of costs related to the ambulance on the group's different programmes and projects needs to be reviewed quickly.

OPERATIONS

Today, it is essential to support the mutual health models in Asia in setting up a **governance** similar to that of an association, informal in legal terms, but with roles, missions, and spaces for reflection, proposal and decision-making that have a clear and defined framework.

In this respect, the Thanapara group in particular needs support in **coordinating** the mutual health programme (the role of the employees involved needs to be redefined).

Furthermore, in Asia too, the existing budgetary and financial management and monitoring tools need to be amended, adapted or created.

Finally, it seems important for Emmaus International to adopt a position on the payroll of the two mutual organisations.

b. Improving support from the movement

In order to implement the improvements envisaged, the mutual organisations' stakeholders urgently need renewed support from the movement.

In view of the needs identified, it is essential to decide on the **involvement of the movement's elected representatives**:

> At international level: creation of a new international coordination group, with elected representatives from Emmaus International, from each region concerned and from groups that support the programmes.

> At regional level: setting up a working and monitoring group for the mutual organisations, made up of group leaders, the regional secretariat and mutual member representatives, to bring the region's programmes to life and move them forward, and also to share analyses and proposals at the international level.

Dedicated human resources are also needed:

> At Emmaus International Secretariat: one single employee monitors the four programmes. However, this staff member devotes only a limited amount of time to this, as the role is not dedicated to this pilot project, but it is just one of many activities. The movement's decisions on the way forward will have to take into account the need to identify resources within Emmaus International Secretariat dedicated to the implementation of the new guidelines.

> Externally: by providing expertise.

It is also necessary to think about a **new communication strategy**, internally of course, but also externally depending on the decisions adopted, particularly in terms of political lobbying.

Finally, it would be appropriate to define the **financial support** that the movement wishes to give to these programmes. Based on the current annual budgets and the prospect of international coordination, the annual budget for the four existing mutual programmes could vary between €90,000 and €100,000, at the minimum:

- > €15,000 per programme (access to health and functioning of the programmes locally);
- > €5,000 to support each programme (field visits, regional meetings with those involved, etc.);
- > €20,000 for international coordination (coordination group and international meetings with stakeholders).

c. Setting up new projects

While nearly 5,000 people currently have access to quality health care, they only represent a minority of the entire movement.

Inequality in access to health care remains a reality.

On the one hand, there are the members of the movement who live in countries where the state plays its role, with mechanisms of solidarity and health and social protection that work, at least minimally (in Western Europe, notably in France). There are also the members of the movement who, because they are part of the groups involved in the Emmaus mutual health organisation project, can access quality care more easily.

And then there are the others... It is true that some groups are involved in individual initiatives and support individuals or families by assuming the more or less significant costs associated with care. However, such occasional assistance cannot replace real access to quality care.

Moreover, for years now, many groups have also wanted to benefit from a mutual health programme.

To go further, it seems that the movement has to choose one of the following options: set up new mutual projects in new areas or establish an Emmaus global health access scheme.

In order to choose the best option, it is essential to ask the right questions and to draw on the experience gained over the years.

SETTING UP NEW EMMAUS MUTUAL PROJECTS

There are several important elements to consider when implementing a pilot project.

The choice of a group (or several groups)

Certain criteria are decisive:

- > A community or semi-community setting which facilitates management and coordination;
- > Strong financial ties between the group developing the mutual health programme for Emmaus International and the potential mutual members;
- > Very good knowledge of the potential mutual members to activate levers if necessary;
- > The possibility of making family memberships compulsory for group members immediately;
- > The willingness and availability of group leaders to monitor and supervise the programme's development at each stage and to be involved in local coordination;
- > The organisation must be able to provide one or two employees for the local management of the mutual organisation (following up mutual members, local coordination, link with health and social facilities, etc.);

- The group's awareness that it needs to make a permanent financial contribution (although it does not own the programme) and that Emmaus International does not cover the programme's ancillary operating costs;
- The ability to work collectively to support the mutual members in managing their collective tool themselves in the long term (a mutual organisation is not the property of the supporting group or of Emmaus International, but of the mutual members);
- The ability to work closely with the movement or other external support.

The need for long-term work and human and financial investment

It is estimated that one or two years of preliminary study are needed a mutual health system is launched. Several stages are essential before a new pilot project is implemented:

- A period of on-site investigation and auditing, analysis of the health and social context, exploration of the capacities of the group(s), etc.;
- Preparing the group and the people concerned to understand how a mutual system works, its principles, values and responsibilities. This requires a lengthy awareness-raising and training process supported by Emmaus International (and now perhaps by experienced movement members), which can take six months.

It is also important to bear in mind the capital investment (human and financial) made by the group(s) concerned over a long period of time in order to start up, develop, monitor and carry out a mutual programme.

In other words, it is thought to take around 10 years to lay the foundations of the mutual system, to make it work properly and to establish partnerships with local or national health facilities, and about 15 years to see significant development (more self-sufficiency).

Human, financial and coordination resources for the movement

On the basis of current experiences, the necessary financial resources can be estimated at:

- €15,000 per programme and per year (access to health and functioning of the programmes locally);
- €5,000 per year to support each programme (field visits, initial support);
- €2,000 to €3,000 for the initial health care and social studies;
- €5,000 if a choice is made to use external technical support during the preparation and start-up phases.

Depending on the decision taken on how to monitor and coordinate existing programmes, the issue of human resources will also have to be adjusted. Supporting the stakeholders at the outset requires a great deal of time and effort, either by Emmaus International Secretariat and/or through external technical support.

ESTABLISHING AN EMMAUS HEALTH ACCESS SCHEME FOR EMMAUS MEMBERS

As there is still a great need for access to quality care in many of the countries where Emmaus groups are based, it might seem more appropriate to think about creating a global Emmaus health access instrument – a kind of “internal” Emmaus mutual organisation (for its members and the groups they work with) – rather than setting up a large number of mutual organisations.

The idea would – initially – be to develop an instrument that is accessible to members of Emmaus International groups. Careful consideration would of course have to be given in order to outline the scheme, identify the different possible scenarios and launch feasibility studies.

This global instrument, which would be part of an international ambition, would enable the movement to carry out an action on an unprecedented scale, to be more visible and to have a greater impact.

There are several possible forms:

> An Emmaus international mutual health scheme:
  - Who is it for?
  - What health coverage would be provided?
  - Minimum access to care for all?

> An Emmaus global mutual fund:
  - To enable those who have no access to health to be able to receive care?
  - What health coverage would be provided?

The movement will also need to address the issues of financing, management and monitoring:

> Can it set up this facility with the current funds? Should it make proposals for targeted support? Should it set up a global solidarity system between its members on access to health (for example, introduce specific support from the European member groups, from the European members themselves or increase the membership fee, etc.)?
> What type of monitoring could be carried out by the movement? With what organisation and what human resources? What type of management should be considered?

d. Using the experience of the mutual organisations to campaign for the right to health

The pilot programmes run by Emmaus International had three main objectives:

> To demonstrate by example the capacity of the most excluded to be actors of social change;

> To develop pilot projects (as part of a collective and international approach) to provide examples that could be replicated in other regions;

> To draw on large-scale actions to construct advocacy actions to change policies on access to rights (the pilot schemes legitimise the political voice of the movement).

THE EMMAUS MUTUAL ORGANISATIONS: INVOLVING THE MOST EXCLUDED AS DRIVERS OF SOCIAL CHANGE

Involvement of the most vulnerable

Within their region, the Emmaus groups work with people who, from a socio-economic standpoint, are all or almost all experiencing poverty, or even extreme poverty, and consequently exclusion.

From the outset, the movement has emphasised the involvement of mutual members, as one of the priority objectives of the mutual health organisations was to enable these excluded people to reflect, become organised and jointly construct a system to reclaim their right to health.

To a very large extent, it is not so much the concept of a mutual organisation that is important as the working method adopted by Emmaus International in this context: the fact that everyone, regardless of their social situation, can participate in the mutual system is an essential rule of the programme.

However, this statement alone is not enough: this participation must be encouraged and promoted, keys to understanding must be passed on, communication must take place, etc.

At the end of 2000, information, awareness-raising and preparation sessions were therefore organised with the members (potential mutual members) of the groups in Benin and Burkina Faso. The aim was to inform them about the principle of a mutual organisation and the solidarity system it implies, and also to get them to participate and think collectively about certain aspects of this instrument. In Asia, too, collective spaces were set up from the outset in order to create community participation (especially among women). The difficulty encountered by some mutual organisations is in maintaining this collaboration over the long term.

While involving those concerned from the outset in work, programmes or projects is a **working method, it is also a guiding principle**. The political choice to work with these groups within the framework of a mutual system – so that they can access rights and take action for their own future – is not without consequence. It represents a significant burden in terms of support, coordination, capacity building and international solidarity.

In *Emmaus: Our Voices*, *Emmaus' first Global Report on our struggles to combat the causes of poverty*, Emmaus International sets out three requirements for overcoming poverty, including **involving vulnerable people for them to assume their rightful place in society**. Certain sections of the population are more exposed to poverty. This is particularly the case for women, people who are ill or disabled, exiles, etc. From the outset, under the impetus of Abbé Pierre, the Emmaus movement was built on supporting, involving and including the people it welcomes. In its governance and management, the movement has created spaces for training, debate and decision-making at all levels. It is this involvement that gives the most vulnerable and excluded people the opportunity to rebuild their lives and gives them a sense of purpose, by becoming solidarity actors themselves.

Including women in the implementation of mutual programmes

In the countries where the mutual health organisations have been set up (Benin, Burkina Faso, Bangladesh, India), most women suffer from twofold exclusion: due to their economic situation – extreme poverty – but also due to their social situation – being a woman in a society rooted in patriarchal traditions. This exclusion hinders them and undermines their freedom, investment, social participation and exercise of citizenship.

However, as the Nobel Prize-winning economist Elinor Ostrom says, "*the people involved and confronted with the need to secure and preserve a commons vital to their survival have far more imagination and creativity than institutions can muster from a non-empirical, off-the-ground viewpoint*" [4]. Public policies, which are intended to defend the general interest, must effectively combat violence against women and the inequalities that affect them. This requires, among other things, the participation of women in the decisions that concern them.

[4] https://laviedesidees.fr/Elinor-Ostrom-par-dela-la-tragedie-des-communs.html (original quote in French)

The Emmaus mutual programme tries to work towards this, although the efforts made to involve women depend on each mutual organisation.

Let's take the example of India and the Tara mutual organisation. In this country, changes in the economic and social status of women are still very much hampered by legal barriers and the weight of religious traditions. Tara's mutual health organisation has not only enabled women to overcome their lack of access to the right to health but has also contributed to capacity building and behaviour change for these women. By being included in the design, monitoring and implementation of the project, some of them have developed considerable decision-making and leadership skills, etc. Many of Tara's female mutual members get involved, put forward ideas and take initiatives. And their skills go beyond the context of the mutual health organisation.

It is clear that real behaviour change occurs when individuals are given the freedom and opportunity to take action. This also leads to a break with the dominant patriarchal model.

One of the demands of *Emmaus: Our Voices* concerns women's access to political and economic life and the fight against the inequality they suffer.

Rejection of all privatisation strategies in order to guarantee access to health care for all

Health is a fundamental right recognised by many international treaties: the Universal Declaration of Human Rights, the Covenant on Economic, Social and Cultural Rights, and the conventions of the International Labour Organisation (ILO) and the World Health Organisation (WHO).

However, the disparity and inequality of health systems between countries is obvious.

In most countries with low or very low GDP, health and medicine needs are not being met. Low incomes, the prominence of the informal sector and the scarcity of public resources restrict health coverage and access to quality health care.

The situation in these countries has worsened over the last twenty years as a result of the reduction in public spending on social sectors and the fact that health care sector has increasingly become a commodity. Each day, inequality is further accentuated between the poorest and the most affluent populations.

Conversely, the so-called "developed" countries, which are over-equipped and "over-supplied" with products, implicitly participate in an inequitable distribution of the goods necessary for the health of their populations.

In addition to this global disparity, there is an unbridled race to privatise and commoditise health. In Badarpur, a district of south-east Delhi, the population is faced with exorbitant fees in the (majority) private health sector. As such, they are unable to access it. To get treatment, they have only two options: a failing public hospital service, with very limited resources and a precarious technical platform, or "quacks" (fake doctors selling fake or out-of-date medicines), who are very common in the slums.

Emmaus International's mutual health organisations aim to preserve the non-profit nature of health care. They are an alternative to an "ultraliberal" economic and financial management. Unlike private mechanisms, this is about pooling and combining strengths and resources and then sharing them with each other. If the level of contributions is adapted to the income of the member families, each family receives the same benefits, leading to solidarity and wealth sharing between the members This

pooling of resources therefore contributes to reducing inequalities while meeting a general interest objective.

Emmaus International has been denouncing the privatisation of the commons for many years. The *Emmaus: Our Voices* report reminds us that health is not a commodity. It is a right, a common good that benefits both individuals and the whole of society at the same time. As its second requirement for overcoming poverty, the movement reminds us that it is urgent to **place the general interest at the heart of public policy**. It calls for the protection of fundamental rights, including the right to health, by promoting the collective management of the commons. Access to the commons is a social practice of "being and acting together" to manage and ensure the sustainability of a resource in the general interest: the commons is not only made up of the resource, it also includes the community that manages it and the rules of governance that it sets for itself. There is an eminently political aspect to this.

The experience of the Emmaus mutual organisations shows that it is possible to guarantee access to health care for people who are excluded from existing private schemes that are too expensive. It proves that models other than those regularly proposed/imposed by the dominant neo-liberal economic system are possible and legitimises the political voice of the movement.

It sends out the message that it is the responsibility of public policy to include excluded people in the collective construction of public initiatives that affect their region and not to give in to the mantras of neo-liberalism by destroying any common good approach, particularly for health, which is a universal fundamental right.

Without waiting for this hoped-for change to finally take place, the movement and its members have set themselves the task of making their initiatives and their mutual method known and recognised at all levels and in all possible regions.

This idea is also developed at the end of *Emmaus: Our Voices* – the sixth demand concerns the recognition and prioritisation of the ethical and solidarity economy stakeholders in the face of a market economy that only benefits a few. The ethical and solidarity economy promotes a social vision of "living well" as opposed to profitability. Its actors strive to use work to promote dignity and emancipation, the participation of stakeholders, to share resources and knowledge, and to create inclusive and democratic governance. This is also the challenge that the mutual health access programmes developed by Emmaus try to address on a daily basis.

STRENGTHENING THE POLITICAL VOICE OF THE MOVEMENT ON THE RIGHT TO HEALTH

Political advocacy may seem secondary to the more concrete ways in which mutual programmes can be developed and improved.

However, the Emmaus movement has always sought to tackle the structural causes of poverty and destitution.

While the mutual programmes have made the right to health effective for several thousand people, if no advocacy work is carried out, neither mentalities, nor behaviour, nor public policy will change. In order to achieve this objective of social transformation, it is therefore essential to combine the mutual programme with collective political reflection and advocacy at different levels.

At the local level, it is important to firstly ensure that all those involved in mutual programmes understand the political implications of their involvement in these projects. To this end, this lesson-learning document could be an opportunity to organise an information and/or political training session within the groups that set up the mutual organisations and for all those involved in the mutual organisations. This would make it possible to politically convey the progress made by the mutual organisations for the most excluded populations and to share it with the people concerned.

In addition, the existing mutual organisations could start – or continue – networking in the areas where they operate:

> In India, Bangladesh and Benin, mutual or community-based initiatives exist nationally, but no work is done to reach out to them, exchange, share practices, create or get involved in a network. This connection of actors working for the right to health would allow us to understand the forces at work, to join together formally or informally in order to carry more weight with the public authorities and to make the progress facilitated by these mutual or community-based initiatives more visible.

> In Burkina Faso, the work described above has been underway for several years: at present, there are meetings and exchanges of practices with other civil society actors, networking within CAMUS and monitoring of the two regional pilot projects to set up UHI (currently on hold due to the security and health situations).

Another important point is that the member groups of Emmaus International, who are responsible for informing, communicating and being the intermediary in terms of what is happening elsewhere in their area, are indispensable for raising awareness advocating among citizens and decision-makers about what the movement is able to achieve. It is therefore essential to discuss the strategy and support processes to be put in place: awareness-raising, training, facilitation/intervention in groups, creation of tools, etc.

In addition, as this lesson-learning report points out, there is a real lack of political support from the movement's national, regional and international bodies. While the mutual organisations are an interesting example of the most excluded reclaiming their fundamental rights, their programmes and political aspects are only very rarely discussed within the various Emmaus bodies.

A collective political debate could therefore be proposed on the mutual projects in order to involve those concerned in a different way and to encourage the participation of stakeholders who, until now, have not felt involved (international elected representatives, regional and national organisations, etc.). The strengthening of political support at the various levels would make it possible to define a clear stance and defend it in governmental bodies.

Independently of this, bringing together other civil society actors committed to the defence of the right to health is vital to establish a balance of power. Whatever actions the movement uses, its legitimacy is based on field initiatives that work, and it would be appropriate for it to create – or join – alliances with actors with a similar orientation and demands to its own.

In June 2021, the UN Special Rapporteur on Extreme Poverty and Human Rights, Olivier De Schutter, proposed the creation of a global fund for social protection to help low-income countries establish and expand social protection systems in the form of legal entitlements. The effectiveness of this fund will depend on the process of designing and implementing national strategies, which should be guided by the principles of dignity, equal treatment, inclusion, solidarity and participation. A dialogue on the Emmaus mutual health programme could be opened with the UN bodies.

At the international level, it would also be important to strengthen the involvement of groups and the general public on certain issues through awareness-raising and advocacy campaigns run jointly by several organisations. An example of this is the European citizens' initiative on access to vaccines and anti-pandemic treatments for all, which has been supported by Emmaus International since 2020.

Finally, the development of new mutual initiatives, or even the creation of a global instrument (as presented in the previous sub-section), could be accompanied by a political advocacy component. Such an instrument would allow the movement to carry out a large-scale initiative, to be more visible and to have more impact with public decision-makers.

In view of the commitment and investment that the movement has made in launching the four mutuals, and in view of their relevance – which was proven during the recent pandemic, as they were the only health safety net for vulnerable populations – the time has come to choose a future. The question is whether we can go further.

Beneficiary of the Asia Mutual Health Organisation (India) ©Digital Rangrez (2021)

GLOSSARY

CGA: Constitutive General Assembly

WA: World Assembly

UHI: Universal health insurance

EC: Executive Committee

CAMUS-BF: Concertation des Acteurs de la Mutualité Sociale du Burkina Faso [Consultation of Social Mutual Insurance Actors of Burkina Faso]

EC: Executive Committee

CMA: *Centre médical d'arrondissement* (district medical centre)

CNAE: *Comité national des amis d'Emmaüs* (National Friends' Committee of Emmaus)

NMC: National management committee

CSPS: *Centre de santé et de promotion sociale* (health and social promotion centre)

EI: Emmaus International

FAMA: *Fonds d'assurance-maladie Afrique* (Africa health insurance fund)

FGD: Focus Groups Discussion

IEC (materials): Information, Education & Communication (materials)

MHO: Mutual Health Organisation

MOU: Memorandum of Understanding

MSA: Africa mutual health organisation

ASCP: Advisory Support Contact Persons

CR: Community representative

IR: Internal rules

EIS: Emmaus International Secretariat

APPENDIX

Workstreams identified for the mutual health programmes

The mutual health organisations in Africa

AVENUES TO BE EXPLORED TO IMPROVE ACCESS TO HEALTH CARE

Memberships

1. Purchasing a database tool or creating a computerised member management tool (Excel), indicating all the necessary characteristics and information on all members (family make-up, mutual member history, medical treatment, benefits used, status of contributions, etc.).

   The objectives of a tool like this would be to:

   > Gain greater visibility of the mutual members' profiles;
   > Set up and facilitate national management;
   > Achieve better overall monitoring of members;
   > Fine-tune the membership policy and enlargement strategy (individual versus family memberships).

2. Fill in the new tool in detail and on a regular basis (every quarter or six months) and thoroughly check the different information on all mutual members: family composition, contribution rates according to household income, history of mutual membership, treatment and benefits used, etc.

3. Reflect on an outward membership enlargement strategy and define it before its implementation.

   > Work on clear membership and contribution terms defined according to the external targets;
   > Work on reviewing benefits before opening up to external parties (benefits, caps, etc.);
   > Develop a strategy to inform and raise awareness of potential external members (about the mutual, its objectives, its functioning, its rules, its benefits, establishing the terms of collecting contribution fees, etc.);
   > Each group should be asked in advance to put forward a strategy for different target groups.

4. Implement social field studies (12 years after the previous one) to adjust the membership and contribution policy.

Membership fees

1. Deduction at source:

> Ensure it is fully and automatically applied within the groups;
> Study the options for automatic bank-to-bank transfers to pay the contributions of the groups' salaried members to the mutual (monthly in Benin, quarterly in Burkina Faso) for rapid payment.

2. Work on redesigning the contribution brackets to make the system more inclusive: draw up a new contribution table of contributions according to income brackets (the current table dates back to 2012), that takes greater account of wage differences.

> Propose and update the contribution rates for mutual members:
    - According to changes in the families' financial resources (social surveys?, close work with the group management team?, request pay slips?);
    - Include new, higher membership fees for those with higher salaries, increase individual membership fees, work on specific membership fees for groups' external members.

> Move from three contribution brackets to four, five or six.

3. Awareness-raising work to be carried out to explain the success of changes from 2012 in terms of membership fees, and ensure the upcoming changes are clear before the next General Assembly, which may endorse this work.

Benefits and agreements with health facilities

1. Restart sustained local coordination work, plan it, identify the actors (local representatives, group leaders, contact persons in Burkina Faso) and targets (health centres, mutual members):

> Continue/resume the awareness-raising and communication with mutual members regarding generic medicines, the interest in attending health centres, the mutual system in general;
> Continue awareness-raising-information-communication on the benefits covered and those excluded from the mutual health organisation (and reimburse only the benefits covered);
> To establish a much closer link with the health facilities that have signed an agreement (updating the list of members, payment of invoices, regular updates, etc.);

2. Institutionalise quarterly meetings with mutual members at group level.

> Organise discussions on the difficulties encountered by mutual members, participation in considerations and choices, information and awareness-raising sessions; to be coupled with health education sessions;
> Review who participates for the mutual (representative + elected member of the mutual / + medical consultant in Benin and contact person in Burkina Faso?

3. Regarding the agreements with the health facilities:

> Evaluate all the agreements that have been in place for several years, and study opportunities to propose new ones, with new liaison tools that are better adapted to the shortcomings identified;

> Set up an annual review with each health facility;

> Restart work on agreements in Benin, to increase the network of health facilities in the country. Study the particular case of Zabré in Burkina Faso;

> Organise national training in Benin on the MHO for the representatives of each health facility with an agreement (contact persons) in Cotonou or Porto Novo;

> Repeat a national training session in Ouagadougou on the mutual health organisation for the representatives of each health facility that has signed an agreement, like the one in 2016;

4. Analyse the distribution of use of the health services in the MHO's monthly and annual reports;

5. In preparation for the next General Assemblies in Benin and Burkina Faso (and in line with the new membership and contribution terms and rules to be put in place), work on redefining the health care benefits package (caps, exclusions or limitations of medicines or services). For example:

> Implement a different co-payment scheme (50%, 60%, etc.) for certain services: specialty medicines, X-rays, scans, etc.;
> Set a cap on the cost of laboratory tests: number of tests per year/per person and amount;
> Limit the coverage of specialty consultations by amount (3,000 CFA/consultation) with 50% co-payment;
> Only cover emergency surgery, not scheduled surgery (possible use of the solidarity fund);
> Study the possibilities of defining treatment packages per pathology with some health facilities.
> Examine if it is possible to extend these new rules to other health benefits claimed for a long time (general practitioner consultation, for example).

6. Compare this with the health coverage available to group employees.

7. Study the possible creation of a solidarity fund to cover some chronic illnesses and some scheduled surgical operations (after studying the file), and look at how these funds could be replenished and managed.

Reimbursement modes

1. Continue to provide information and raise awareness of third-party payment (local coordination work):

> With health care facilities (as part of the agreement with the mutual organisation);

> With mutual members (so that they benefit from their rights).

2. Only reimburse health facilities under agreement for services covered by the mutual health organisation (with a clear explanation of the reasons).

Rules and monitoring

1. Re-establish a monitoring committee in Benin as in Burkina Faso with elected or voluntary members from the next General Assemblies and train their members.

DETAILED FIELDS OF WORK TO IMPROVE THE MHO OPERATIONS

Governance

Prepare to set up General Assemblies in Benin and Burkina Faso by the end of 2021/start of 2022, with common and specific objectives.

1. Prepare the General Assemblies.

   This means:

   > Preparing proposals on the different topics to be submitted to the General Assemblies and Extraordinary General Assemblies;
   > Planning preparatory work for the general meetings as soon as possible in order to formulate proposals, raise awareness and organise a debate on possible changes with mutual members in the groups:
      - in terms of statutes and internal rules (work based on the existing document *Roles and responsibilities of the MHO stakeholders*);
      - with regard to proposals for new contribution rates, review of the health care package, etc.
      - for elections of new members from the mutual health organisations.
   > Information and awareness-raising on the role of elected members within the mutual health organisations prior to the General Assembly. Identify volunteers within the mutual organisations that could be stand for election to the executive committee/board and the steering committee. Reflect on methods of countering power and spaces involving mutual members (in Benin in particular);
   > Preparing the logistical organisation of the General Assemblies.

2. Hold the General Assemblies

   Shared objectives:

   > Discuss the changes put forward for each MHO that will have been worked on in advance by the stakeholders (mutual members, groups, national organisation, Emmaus International), in order to approve them or to suggest ways of thinking and working (care package, cap on certain care, policy of extending coverage to other countries, new income-based contribution scale, etc.);
   > Organise Extraordinary General Assemblies on the fringes of the General Assemblies, to endorse the preliminary work carried out to propose statutory changes (length of terms of office, regularity of the General Assembly, clarification of the role of elected representatives, etc.) and to the internal rules (inclusion of the precise functioning of the MHO, integration of a document on the *Role and responsibilities of the stakeholders*, clarification of the health care benefits, etc.)

Specific objectives:

> In Benin, the aim will be to re-establish democratic life and governance with elected members who take responsibility and contribute to making the mutual health organisation more dynamic and involving the members;
> In Burkina Faso, it will be a matter of electing some of the elected members to enable work to continue and continuous training of new elected members, run by the most experienced representatives, on their role and responsibilities during the term of office.

3. After the General Assemblies.

> Since the end of the General Assembly in Benin, an initial two-to-three-day training course could be organised for the newly elected members by a group made up of one or two long-standing members of the Benin MHO, one or two members of the current Burkina Faso MHO board, a member of the Emmaus International Secretariat or an elected member of Emmaus International. The stakeholders will have to discuss and consider the possibilities and opportunities for renewing this training for a second time during the course of the mandate;
> After the General Assembly in Burkina Faso, a half-day training by former elected members should be organised with the newly elected members, with other training sessions planned if required. The presence of Emmaus International Secretariat or one Emmaus International elected representative may be required.
> Organise the holding of a board and executive committee meeting within each mutual team to set priorities, distribute and plan the work.

Coordination

Keeping a mutual alive is more than just the task of the elected representatives who play a role in its coordination. Other actors should be involved: local representatives, group managers, Emmaus national organisation. And Emmaus International should support each of the actors in their own role.

We have already noted that the coordination within the mutual organisations in Africa has not been adapted to the change and transition of the mutual from local to national level.

To enable actors of the mutual health organisations to assume their role, Emmaus International must act and shoulder its responsibilities in providing support on the one hand, and by working with groups and national organisations on the other, so that their managers fully assume their role and representatives can, under the supervision of these leaders, perform their activities easily.

1. Urgent measures/levers to be set up:

Organise a meeting between Emmaus International and the group leaders only, in Benin and Burkina Faso;

> Ensure the stakeholders (Emmaus International, the national organisation, group leaders, representatives and elected members of the mutuals) work together on organising, reinvigorating, extending and implementing local activities;
> Reinvigorate the national bodies of Emmaus Benin and Emmaus Burkina Faso (which should be places for mobilisation, reflection, information sharing and analysis, etc.) and think about possible actions by Emmaus International and the Africa Region in this respect;
> Consider whether to further formalise the supply of local representatives with each group;
> Re-establish an international steering committee and set up a regional steering committee;
> Pool coordination practices between the mutual organisations.

2. Medium-term action:

> Ensure support for representatives and elected members of the mutual from different actors (Emmaus International, local groups, national organisation, mutual members, etc.);
> Build capacities of representatives and actors in some management areas and use of tools;
> Set up national training and refresher courses on the mutual, its operation, the roles and various missions for different stakeholders;
> Obtain exhaustive and qualitative feedback every month on the actions implemented locally in each territory;
> Institutionalise quarterly meetings with mutual members at group level;
> Formalise and institutionalise regular meetings with the health facilities under agreement.

3. Actions to be carried out in Burkina Faso:

> Explore, support and supervise the work and contracting of ASCPs (advisory support contact persons);
> Review the work process with Pag-la-Yiri: the uniqueness of this territory (extensive, rural zone, with families that are often isolated) makes the management and the coordination of the mutual organisation difficult for the representative;
> Find a decent workspace for the national secretary of Emmaus Burkina Faso.

4. Actions to be taken in Benin:

> Renew the medical consultant's contract after evaluating his or her work every year;
> Make the link with the identified contact persons official within the health facilities under agreement (to be added to the agreement documents/prior discussion with the management?)

Management

Management tools

1. Computerise the data (in the two mutual organisations)! This work has been an objective for several years, but it hasn't yet started, including in Benin where computers have been provided to the four local representatives. It's urgent to start this in the two mutual organisations with Excel spreadsheets, while reflecting on developing these tools for better use.

2. Review the agreements with the health facilities, insist on the assessments as soon as the work on revising the benefits has been completed.

Reporting tools

1. Work together to redesign or improve reporting tools.

> Review monthly reports (monthly summaries): redesign and standardise the summaries (inclusion of a progress report on the different tasks and objectives of the mutual organisation in Benin, the distribution and analysis of benefits in Burkina Faso, indicators on consumption of generic/speciality medication, etc.);
> Propose a template for the activity report and financial report for the mutual organisation in Benin (based on the reports from the mutual organisation in Burkina Faso);
> Arrange an accounting monitoring tool and create a new tool to be able to provide more regular updates (monthly or quarterly) on the mutual organisations' income and expenditure;

> Work on the monitoring tool/database of members or consider purchasing software to manage memberships (cf. point on memberships).

Work and tools used by the medical consultant

1. Actions to be taken in Benin:

> Continue the assignments and develop the contract into more focused support for the "analysis of NMC data and health indicators" and the production of annual reports for the health facilities under agreement;
> Set up more regular meetings with the medical consultant;
> Amend the contract period (from 1st January to 31 December)

2. Actions to be carried out in Burkina Faso:

> Assess the work of the ASCPs.

Budget, financial and self-sufficiency monitoring

Financial stability/visibility

> Define and set up procedures, better adapted and more regular monitoring meetings and tools (financial situation, expenditure ledgers, accounting monitoring tools) to develop greater visibility, a more in-depth analysis and to ensure better support from the movement in fostering financial autonomy.

Health expenditure

> Set up an emergency fund to cover exceptional benefit costs. Reflect collectively on the form, management, resources, accessibility criteria, spending caps, etc.

Operating expenditure and those related to running the mutual health organisation (coordination and governance)

> Adapt the tools to provide visibility, monitor the different operating expenses and those related to the life of the mutual organisations: divide the annual budgets (forecast, monitoring and financial) into four sections: resources, access to health, operations, life of the mutual organisation (governance and coordination).
> Set up a contribution from groups towards “small” monthly operating expenses.

Resources

> Draft financial reviews and impact reports on reception of both types of containers (items to sell and medical equipment) to work on a strategy for greater efficiency.
> Strengthen the local groups’ compliance with commitments concerning annual financial contribution to the mutual organisation, or even go further. The contributions agreed (by the groups themselves) representing 200,000 FCFA per year, or 16,600 FCFA per month (approx. €25). This contribution could be increased from 200,000 FCFA to 300,000 FCFA per year, or 25,000 FCFA per month (€38).
> The movement should assume its responsibilities in the event of non-respect of commitments by groups.

The mutual health organisations in Asia

AVENUES TO BE EXPLORED TO IMPROVE ACCESS TO HEALTH CARE

TARA

Memberships

1. Obtain more precise renewal rates, implement tools and membership periods that run from January to December, review monitoring and reporting tools.

2. Review the frequency of the membership commitment (annual, quarterly or monthly?): this entails a risk of members leaving, but the act of commitment is stronger. Reflect on fundraising solutions: savings, for example.

3. Once a significant number is reached, working on family membership and stricter membership criteria and access to health care (do not limit access to health care, but make mutual members more responsible).

Membership fees

1. Although it seems very tricky in light of the socio-economic context of the mutual member population, study the possibility of tiering contribution levels according to the families' income.

2. Study the option of changing the frequency of contribution payments.

Services and partnerships

1. Review and redesign the health care package rates for members and non-members.

2. Continue raising awareness among mutual members (specifically new members) about the fragile balance of the mutual organisation and the danger of it being overused.

"Expenditure-resources" ratio

1. Implement a rule to limit salary increases within the Badarpur centre.

2. Review the rates at the centre, reaffirm them and ensure their proper application.

THANAPARA

Memberships

1. Relaunch the programme in a general manner. Reaffirm the aims, run awareness-raising sessions for mutual members.

2. Conduct a social study (family composition), then rework the membership policy (move towards family memberships).

Membership fees

1. Rework the methods of collecting contributions for each category of mutual member with a predefined organisation and method;

2. Continue the progressive inclusion of micro-borrowers: develop a step-by-step strategy.

3. Review the policy in terms of contributions according to the category and membership type:

   > Adjust the contribution rates according to the categories and income;
   > Suggest a preferential rate for family memberships (50 takas per month and per family?).

4. Set up a way of presenting and proposing the different change scenarios to mutual members.

Services and partnerships

1. Rework the tiering of services and health benefits at the centre for members and non-members, communicate and apply them.

2. Review the reimbursement grid for hospitalisation to reach 80% reimbursement on hospital stays where the costs are highest.

"Expenditure-resources" ratio

1. Using the same budget matrix every year, review, redo the budgets, support the group.

2. Implement a rule to limit salary increases within the health centre.

3. Study and review the allocation of ambulance-related costs on the different programmes that use it.

4. In the short term, should we approve the use of the budget before its implementation?

Ways exist to improve this ratio, but the movement should provide support.

DETAILED AREAS OF WORK TO IMPROVE THE MHO OPERATIONS

TARA AND THANAPARA

Governance

1. Support the development of a strategy to set up a system of governance that is similar to that of an organisation. Informal, taking into consideration the existing legal context, but with elected members, by defining roles, spaces for reflection and making proposals, with a clear framework, etc.

2. Support and consolidate people's skills.

Coordination

1. Involve stakeholders more and build skills in terms of managing the mutual organisation.

2. Support the Thanapara group to reflect on, work and set up an organisational system, to coordinate the mutual programme, redefine the role of invested employees. Does the programme coordinator have the legitimacy and/or the necessary availability? Could the nurse be more involved in coordinating the mutual programme if we build up skills?

Management tools

1. Develop a budget monitoring tool to make the monthly monitoring smoother: structure and specifically identify the accounts, provide bank account statements with an exhaustive list of income and expenditure.

2. Computerise the monitoring tools that are not yet in digital format.

3. Ask Thanapara to construct and draw up a general policy document.

Reporting tools

1. Develop or reconstruct some tools to adapt them to change or enable better monitoring and a more in-depth analysis.

2. Computerise all the documents, even if it takes longer initially. Provide technical support by the movement to set up tools and create work procedures.

3. Study the option of potentially purchasing network software to manage both mutual organisations' memberships, or all four.

4. Set up more qualitative monitoring tools.

5. Draw up a common activity report and annual financial report template for the different mutual organisations, by specifying the information desired (Emmaus International) and support the mutual organisations in carrying out this work.

6. Set up work meetings to pool practices between both mutual organisations in Asia (then across all four) to standardise the management and reporting tools, if possible.

Budget, financial and self-sufficiency monitoring

1. Review budgets and breakdown of operating costs and specify the different income and expenditure.

2. Set up discussions (with Emmaus International) and rules on the payroll: should wages be limited (operating and/or access to health) or should there be a constant increase in wages each year? Should we ask the group to cover the payroll costs not covered by the Emmaus International budget? (Hence the requirement to build capacities of mutual members in actively participating in coordination and governance).

3. Set up discussions (with Emmaus International) and rules of use for the reserves linked to the contributions made and/or the unused annual funds from Emmaus International.

Note: With regard to Thanapara, an Emmaus support group is in place and should visit Thanapara to study the difficulties encountered by the group, which also have consequences on the health access mutual programme.

In the two MHOs in Asia, despite the stakeholders' will to set up an alternative, the social context and structural constraints are weakening the development of mutual systems.

The following question could be raised: is the system as it stands viable in the long term? Without the systematic financial link between members and groups, without an obligatory family membership, with populations that are a lot poorer (and much higher operating expenses as the centre's operating costs have to be covered), is self-sufficiency attainable?

Self-sufficiency, which is levelling off today, can undoubtedly progress further if the means identified are used. However, if the movement would like to go further, it must support stakeholders more and better and commit to pursuing this international financial solidarity.

Question for the movement: would it be appropriate to use the services of an external expert, as in Africa after ten years of existence, to conduct a precise assessment and a health and social study?

Contact details for the Secretariat of Emmaus International

Thomas Bodelet
International Solidarity and Campaigning Department Officer

t.bodelet@emmaus-international.org

Anaïs Gournay
Advocacy officer

a.gournay@emmaus-international.org

CONTACT

Emmaus International
47 avenue de la résistance
93104 Montreuil Cedex-France
Tel. +33 (0)1 41 58 25 50
Fax +33 (0)1 48 18 79 88
contact@emmaus-international.org
www.emmaus-international.org

Capitalisation and production:
Thomas Bodelet

Editorial committee:
Anaïs Gournay, Stéphane Melchiorri,
Pascale Naquet and Nathalie Péré-Marzano

Translation:
Rebecca House and Charlotte Hardy

Photos credits:
Didier Gentilhomme, Digital Rangrez,
and Emmaus International

emmaus INTERNATIONAL
ACTIVISTS FOR CHANGE

Emmaüs International
emmausinternational
EmmausInter_fr
Emmaüs International
emmausinternational