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Mutual Health Organizations: Lessons from 20 years of experimentation in Cameroon between 2000 and 2020

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Abstract
The direct payments which became widespread in Cameroon in the 1990s deteriorated the problem of financial inaccessibility to the health care services and medicine. To provide a solution to this problem, the National Health Development Plan 1998-2008 and the Health Sector Strategy 2001-2015 have planned to promote Mutual Health Organizations.
The present study had as objective to evaluate the experimentation process of Mutual Health Organizations in Cameroon between 2000 and 2020 and to draw lessons learn from it.
The methodology was based on a literature review and information gathering in the field.
The results show that the 2000-2010 period saw the number of Mutual Health Organizations increased from 9 to 158. However, this number fell from 158 to 58 between 2010 and 2014. The reasons of this failure are: Projects financing problems, managerial failure, mistrust of the population, poverty, non-adaptation of the model to the culture and difficulties to collaborate with health facilities.
Due to this failure of Mutual Health Organizations, we suggest experimenting with another way of promoting them and to professionalize the management. Indeed, in the perspective of the promotion of universal health insurance covering the poor or the informal and rural sector, the study suggests to professionalize and experiment the networking of Mutual Health Organizations leaned on Organizations of mutual aid and solidarity or of the social and solidarity economy which are very wide-spread and which ally with a certain success the activities of micro-insurance (including health) to those of microcredit.

Keywords: Mutual Health Organization, Experiment, Failure, Lessons, Professionalization, Cameroon.

Introduction

In sub-Saharan Africa, health care has long been officially free, until the end of the 1980s. In fact, in 1987, because of the limited resources that governments was able to generate and the budget cuts made in the context of Structural Adjustment Programs (Ridde V and Girard J.E. 2004), the Ministers of Health of Sub-Saharan African countries met in Bamako, Mali under the auspices of WHO and UNICEF to adopt resolutions known as Bamako Initiative (RIDDE V and GIRARD J-E. 2004 ; TIZIO S and FLORI Y-A. 1997 ; GBEDONOU P et al. 1994 ; McPAKE B et al. 1993).

The implementation of the Bamako Initiative in Cameroon took place from 1993 as part of the Reorientation of Primary Health Care Policy (République du Cameroun 1993) adopted in 1992. This reform recommended

to abolish free health care and to introduce cost recovery to co-finance health services and health care and medicines. From this date, the health services were now co-financed and co-managed with the beneficiary local populations as part of the community participation. In the absence of health insurance systems, cost recovery has resulted in direct payments in cash to purchase services, health care and medicines. As a result, in 2003, direct payments by households as part of cost recovery accounted for about 71.1% of health expenditure in Sub-Saharan Africa (OMS 2006). Direct payments posed the problem of having cash in sufficient quantity at the time of illness, hence the low use of health services. Indeed, direct payments have been a real barrier to poor people's use of health services and have contributed to further impoverishment (James C-D. et al. 2006 ; Mubyazi G. et al. 2006). Their introduction resulted in a drop in curative consultations in health centers of 15.4% in three years in Burkina Faso in 1997 (Ridde V 2003), 21.3% in Uganda (Kipp et al. 2001). Other authors have also noted this decline in utilization rates following the introduction or increase of direct payments (Yoder R-A 1989 ; Blas E and Limbambal M 2001).

Faced with the extent of direct payments and the financial inaccessibility of the population to health care, the State of Cameroon initiated a reflection on the promotion and development of Mutual Health Organizations since the late 1990s. Indeed, the pooling of health risks was one of the main priorities of the 1999-2008 National Health Development Plan (République du Cameroun 1998). Subsequently, the Health Sector Strategy 2001-2010 (République du Cameroun 2002) has set as one of its objectives to promote Mutual Health Organizations in communities to improve people's financial access to quality health care under the subprogram "Promotion of health insurance mechanisms". The promotion and development of Mutual Health Organizations was therefore effective in Cameroon between 2000 and 2015. What lessons can we draw from these 15 years of experimenting with Mutual Health Organizations in this country?

Methodology

This study is part of a research on collective financing mechanisms for the demand for health services in Cameroon authorized by the institutional ethics committee of the Faculty of Medicine and Biomedical Sciences of the University of Yaoundé I.

The study is a descriptive and evaluative cross-sectional study which was based on a literature review and a data collection of information in the field. The study spanned between 2018 and 2020. Data collection took place between January and April 2019.

The documentary analysis focused on the documents of the projects of promotion and development of Mutual Health Organizations in Cameroon, the reports of activities of the support organizations, of the promoters and the Mutual Health Organizations themselves, the thesis on Mutual Health Organizations, internship reports and publications on Mutual Health Organizations in Cameroon.

Regarding the collection of information in the field, the study was made among the ten Regional Delegations of Public Health (RDPH) who all accompanied the implementation of the pilot projects for the establishment of community-based Mutual Health Organizations supported by the Ministry of Public Health and its Technical and Financial Partners (TFPs). During the field missions carried out in the Regions, the five Regional Funds for Health Promotion (RFHP) which have support structures for Mutual Health Organizations were interviewed and some Health Districts where Mutual Health Organizations had been implemented have been visited to supplement the information collected at the level of the RDPH and the RFHP. Thirty-three health districts where Mutual Health Organizations were set up were visited (Table 1).

Table I: Distribution of the number of Health Districts visited by Region to collect information on the situation of Community-Based Mutual Health Organizations set up with the support of the Ministry of Public Health and its Technical and Financial Partners.

N°	Region	Number of Health Districts visited	Names of health districts visited
1	ADAMAOUA	1	Ngaoundéré Rural.
2	CENTRE	3	Cité Verte, Efoulan, Sa'a.
3	EST	2	Bertoua, Abong-Mbang
4	EXTREME-NORD	3	Meri, Mokolo, Yagoua.
5	LITTORAL	9	Cité des palmiers, Deido, New-Bell, Mbanga, Loum, Manjo, Nkongsamba, Melong.
6	NORD	0	/
7	NORD-OUEST	5	Bamenda, Tubah, Fundong, Kumbo, Mbengwi.
8	OUEST	4	Mifi, Bamendjou, Penka-Michel, Dschang.
9	SUD	1	Ebolowa.
10	SUD-OUEST	5	Buea, Tiko, Limbè, Muyuka, Kumba.
TOTAL		**33**	

Source: Author

At the level of the RDPH, the information collected through the semi-structured interviews focused on the functional status of the Mutual Health Organizations in the Region, their financial situation and that of the managers, the problems encountered and the prospects. At the Health Districts level, the information was collected using a semi-structured questionnaire which included the following headings: the year of creation, the organization(s) supporting the creation of the Mutual Health Organization(s), the evolution of the number of members to the Mutual Health Organization(s), the situation of the managers of the Mutual Health Organization(s) health, the regular organization of the staff meetings or General Assembly of the Mutual Health Organization(s), the health care providers who collaborate with the Mutual Health Organization(s), the financial situation, the problems encountered and the prospects.

Results

1. Process of the promotion of Mutual Health Organizations in Cameroon between 2000 and 2010

As part of the implementation of its Health Sector Strategy 2001-2010, which was extended to 2015 to align it with the MDGs, the Ministry of Public Health of Cameroon created in 2004 a Reflection Committee called CERAM (Experts Committee for the Reform of Health Insurance) and various cooperation organizations, particularly the German Technical Cooperation Agency GIZ, have launched projects in the field of the promotion of Mutual Health Organizations. From this year 2004, and especially after the adoption of the Strategic Plan for the promotion and development of mutual health insurance in 2006 (MINSANTE, 2006), several experiences of promotion and development of Mutual Health Organizations were supported or conducted on practically the entire territory of Cameroon by various promoters and various donors. For example, the German Technical Cooperation Agency (GIZ), the HIPC Funds of the Ministry of Health, the French Development Cooperation Agency (AFD), the Belgian Technical Cooperation, the European Union, UNICEF, the African Development Bank (AfDB), as well as other cooperation agencies and NGOs have supported the establishment of Mutual Health Organizations in several Health Districts of the country.

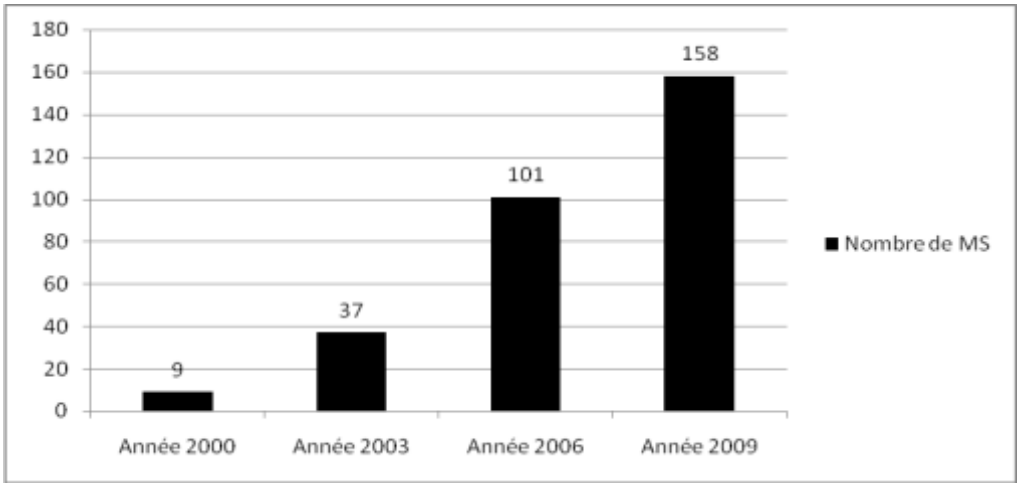
The work of Experts Committee CERAM led to the development of a Strategic Plan for the promotion and development of Mutual Health Organizations nationwide. This Strategic Plan was jointly adopted by the Ministry of Public Health and the Ministry of Labor and Social Security in February 2006.

In 2009, the Prime Ministry set up a Technical Committee at the level of the Ministry of Labor and Social Security to reflect on the Social Security Reform in Cameroon. The role of this Technical Committee made up of senior officials from the public administration and some international organizations was to develop and propose an institutional and legal framework to oversee this reform, which framework should propose a model of a social security system in general for the country, and particularly, a model of a social health insurance system. The proposals made that took into account the important role of Social Mutuals (including Mutual Health Organizations) in the social security system, remain in study until today.

2. Evolution of the number of Mutual Health Organizations in Cameroon between 2000 and 2010

The census of Mutual Health Organizations promoted in the framework of the implementation of the Health Sector Strategy 2001-2010, carried out by EPOS and SAILD (2010), showed a significant increase in these structures in Cameroon during this decade 2000-2010, from 9 in 2000 to 37 in 2003, then to 150 in 2007, and to 158 in 2009 (see Figure 1).

However, despite this large number of Mutual Health Organizations, the population covered remained very low, not exceeding 2% of the total population (EPOS and SAILD 2010).



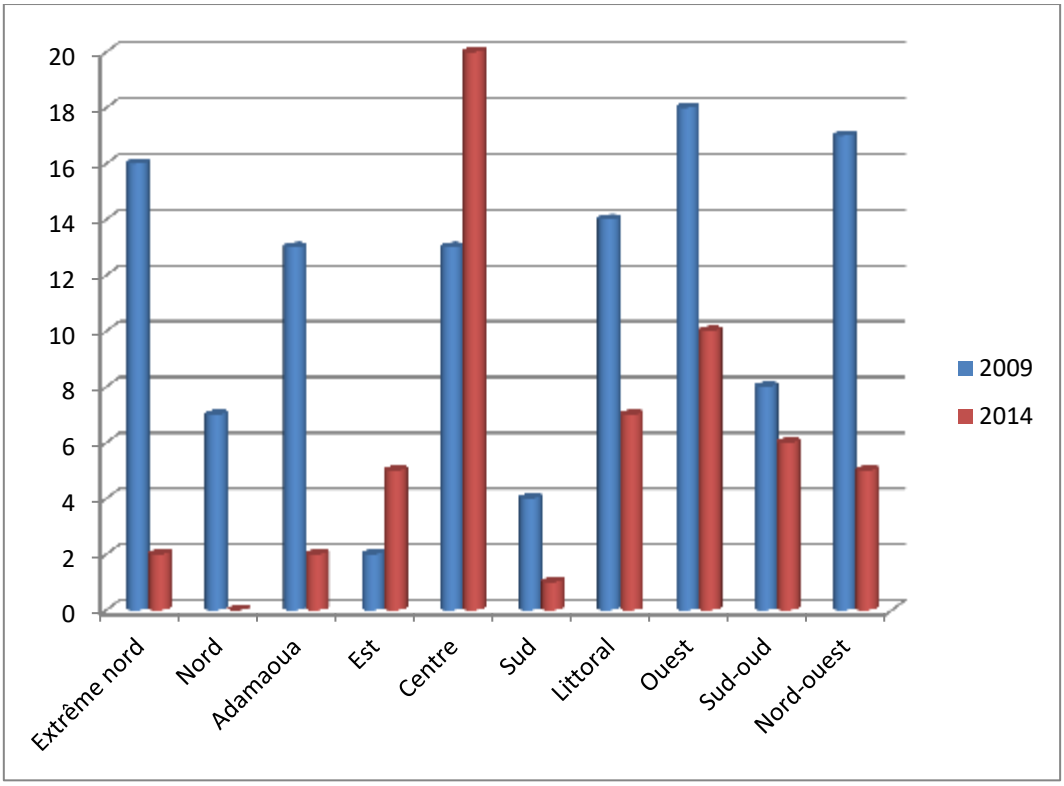
Source : EPOS and SAILD (2010).

Figure I: Evolution of the number of Mutual Health Organizations in Cameroon between 2000 and 2010.

3. Evolution of the situation of Mutual Health Organizations in Cameroon between 2010 and 2020

As mentioned above, EPOS and SAILD (2010) found in 2009 that the number of Mutual Health Organizations was 158, the percentage of Health Districts covered was 35% (70 Health Districts out of 189) and the population covered was around 300,000 individuals (approximately 1.5%). In 2011, the Platform of Promoters of Mutual Health Organizations in Cameroon (PROMUSCAM) found that those structures were deployed with difficulty throughout the country (PROMUSCAM/SAILD 2011). The experiences of setting up Mutual Health Organizations have therefore had a very limited scope and a very short lifespan. The reasons most often mentioned for this scarcity of successful initiatives are the social and economic heterogeneity, the lack of trust in the management of the funds and the quality and sustainability of the service provided, the difficulty of control in case of abusive use, the difficulty in poor environments to pay the minimum required for the operation of a mutual, bad experiences or the lack of successful examples, and the lack of health facilities effective enough to be able to attract memberships (Kotto H-E 2004).

Between 2010 and 2014, the vast majority of Mutual Health Organizations went bankrupt, going from 158 in 2010 to only 58 in 2014 (BIT 2014) as shown in Figure 2. This figure illustrates the phenomenon of "cascading bankruptcy" of Mutual Health Organizations in Cameroon from 2010. While in eight regions the number of Mutual Health Organizations still operating has dropped drastically, there has been an increase in two other regions, namely the Central and Eastern Regions. These are regions where new support organizations have started projects after 2010, like some Decentralized Territorial Communities (DTC) in the Central Region and the Swiss NGO FAIRMED in the Eastern Region.



Source : BIT (2014).

Figure II: Situation of Mutual Health Organizations in Cameroon between 2009 and 2014.

4. Reasons of the failure of the promotion and development of Mutual Health Organizations in Cameroon

4.1. Funding problems of projects for the promotion of Mutual Health Organizations

The funding of projects for the promotion of Mutual Health Organizations in Cameroon between 2000 and 2010 was provided almost entirely by the Technical and Financial Partners, as the Ministry of Health did not have a real budget line allocated to these projects. The only year in which a budget line of 250 million had been allocated was the year 2006 but, in the absence of a real body for coordination, support, monitoring and evaluation of these projects at the level of the Ministry of Health public (like the Technical Support Unit for Mutual Health Organizations - CTAMS - in Rwanda which benefits from 13% of the budget of the Ministry of Health (The Rockefeller Foundation 2010)), this budget allocation was not continued in the following years because considered ineffective. Faced with the lack of funding from the State of Cameroon, the Technical and Financial Partners who had committed to technically and financially support the projects of establishment of Mutual Health Organizations felt abandoned to themselves and got disengage, especially when the Mutual Health Organizations started to go bankrupt or to incur large debts to the health facilities under agreement.

4.2. The problem of human resources - managers of Mutual Health Organizations

The human resources in charge of the management of Mutual Health organizations were very inadequate. Most Mutual Health Organizations generally had only one Manager who was responsible for all administrative and technical tasks: sensitization, marketing, receipt and processing of files, funds/contributions or premiums collection and issuance of receipts and other documents, relationships with providers and other institutions, mail management, file archiving, etc.

This single manager of a Mutual Health Organization was very often of a low academic level, thus having very weak capacities in techniques of social mobilization, sensitization or marketing, of administrative, financial and accounting management. This made the management rudimentary, without traceability or without proof of expenses, without archives or bad archiving and without balance sheets or periodic reports.

The Boards of Directors and Supervisory Committees that were in charge of the monitoring, evaluation and control of Mutual Health Organizations also had inadequate human resources, such as those who managed them.

4.3. The problems of the management mode of Mutual Health Organization

Managers of Mutual Health Organizations generally worked without salary, which was called "Volunteering". Such status was not motivating for these Managers and did not allow the Boards of Directors and Control Committees to demand results from them. Indeed, these Managers were demotivated after a few months or years of work because of this "Volunteer" or arrears of payment of their allowance of function. This has led to a frequent change in Managers of most Mutual Health Organizations creating instability of Managers and a gradual destabilization of the functioning of these Mutuals.

The management of Mutual Health Organizations was not monitored and evaluated regularly to detect problems in order to solve them as and when. This led most Mutual Health Organizations to find themselves at some point in an irremediable situation.

The health insurance products offered by Mutual Health Organizations to their target populations were not regularly revised or adjusted or changed. This meant that, when a health insurance product was not appropriate, it was offered for several years to the population even if it was not bought or if it created losses to the Mutual Health Organization.

4.4. The problems of mistrust of populations towards Mutual Health Organizations

Many people did not join Mutual Health Organizations out of suspicion because they were afraid of being cheated by the leaders who were very often co-opted people in the community, most of the time without judging their seriousness, their honesty, their popularity or trust that the population has towards them. Some Mutual Health Organizations did not inspire public trust because they were not sufficiently involved in choosing their leaders.

In addition, other people did not join the Mutual Health Organizations because of the failure of other similar projects in the past like projects to set up microfinance institutions.

4.5. Problems related to the culture and poverty of the population

Some people did not adhere to Mutual Health Organizations because they did not really understand the principle of insurance applied by them. Indeed, when it was explained to them that the contribution or premium paid was a "lost fund" in the event of non-occurrence of the risk (absence of illness) during the month or the year, they did not understand this principle. The insurance culture was therefore insufficiently anchored within the populations.

Other people did not join Mutual Health Organizations because, they said, they did not have enough money to pay the required contributions. Indeed, there was no mechanism for the care of the poorest or indigents. Some Mayors have had to support some Mutual Health Organizations by taking ad hoc or occasional acts in the form of payment of contributions for a certain number of indigents.

4.6. Problems of collaboration with health facilities and poor quality of care

Some health facility managers were unwilling to collaborate with Mutual Health Organizations and even denigrated them to the population. This is because they do not wish to change the traditional mode of direct payment of "Third-party" proposed by these Mutual Health Organizations. In fact, the "bribes" and the parallel practices of health professionals (parallel sales of medicines, diversion of patients to the private sector, etc.) that increase their income were not favorable to the development of Mutual Health Organizations.

In addition, some people mentioned the poor quality of care in health facilities as a real obstacle to membership and development of Mutual Health Organizations.

Discussion

The problems encountered for the promotion and development of Mutual Health Organizations in Cameroon have also been encountered in several other countries in Sub-Saharan Africa.

The problem of lack of political will and non-funding or insufficient funding of projects for the promotion of Mutual Health Organizations was also reported by Turcotte- Tremblay (2010) in Benin.

The problems of managers and the the management mode of Mutual Health Organizations were also noted by Franco et al. (2006) in Mali, Wiesmann and Jütting (2001) in rural areas in Sub-Saharan Africa, De Allegri, Sanon, Bridges and Sauerborn (2006) in Burkina Faso, Basaza, Criel and Van der Stuyft (2008) in Uganda, Criel and Waelkens (2003) in Guinea.

The problem of mistrust of populations towards Mutual Health Organizations was also noted by Criel and Waelkens (2003) in Guinea.

The problems related to the culture and poverty of the population were also noted by Kamuzora and Gilson (2007) in Tanzania, Criel and Waelkens (2003) in Guinea, De Allegri et al. (2006) in Burkina Faso, Sulzbach et al. (2005) in Ghana, Franco et al. (2006) in Mali.

The problems of collaboration with health facilities and poor quality of care were also noted by Schneider (2005) in Rwanda, Basaza, Criel and Van der Stuyft (2008) in Uganda, Criel and Waelkens (2003) in Guinea, Kamuzora and Gilson (2007) in Tanzania.

It's noted through this study that the failure of the promotion and development of Mutual Health Organizations contrasts with the development of Mutual Aid and Solidarity Organizations in Cameroon. Indeed, many Mutual Aid and Solidarity Organizations formed on a community, ethnic or relational basis exist and develop endogenously in the country for decades. Some of these organizations have put the issue of financial assistance in the event of illness among the various social risks they cover. Indeed, many of these organizations combine micro-insurance and micro-credit activities with some success (Feuzeu M 2000). On the whole, they provide their members with assistance in the event of the death of a family member, in the event of funerals, sickness or other life events (Aboubakar K-Y and Develtere P 2003). In 2001, the ILO (BIT/STEP 2001) carried out a study on the "mutual health" dimension of these self-help and solidarity organizations in Cameroon. The results of this study showed that the system of lump sum support granted to the members of these Associations in case of need (death, funeral, illness or other) is not bad in itself, but that they would benefit a lot to organize and professionalize health risk management.

On the other hand, Aboubakar K-Y and Develtere P (2003) noted that in Cameroon, the solidarity organizations that form by co-optation (for example those Mutual Health Organizations promoted between 2000 and 2015) have very few members (generally less than 50), while those which are formed on the basis of ethnic or relational criteria (self-help and solidarity based ethnic, community or professional associations) have many more members (usually more than 50). Kotto H-E (2004) found that these Associations provide a very partial coverage of the disease risk to about 14% of the population (18). Indeed, in its report, it is mentioned that: "While the exclusion of urban households from formal health insurance is almost total (the heads of households rely essentially, either on themselves - 48% of cases, or on the spouse - 38% of the cases), a contribution of the Associations to the management of the health risk is found in 14% of the cases (18) ". This figure of 14% far exceeds the level reached by Mutual Health Organizations promoted with the support of the Ministry of Public Health and its partners between 2000 and 2015 and whose members were co-opted.

Conclusion

The main lesson learned from the promotion of Mutual Health Organizations in Cameroon between 2000 and 2015 is that they had great difficulty in developing. However, we note that Mutual Aid and Solidarity Organizations or Social and solidarity economy organizations which are created endogenously develop more and cover a slightly larger population for several social risks, including illness. So, can these endogenous organizations of mutual aid and solidarity, or of the social and solidarity economy constitute the pillar for the development of Mutual Health Organizations and contribute to the establishment of universal health insurance in Cameroon? Can their networking and the organization of professional management guarantee the effectiveness and sustainability of a health insurance system targeting the populations of the informal and rural economy? These are the avenues for reflection that deserve to be explored as part of the continuing

promotion and development of Mutual Health Organizations in the current and future context of promoting universal health insurance.

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