Original Research Article

DOI: https://dx.doi.org/10.18203/2394-6040.ijcmph20220683

Community-based mutual aid for improving financial access tos healthcare: case study of 150 community-based organizations in Cameroon

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Received: 18 January 2022 Revised: 18 February 2022 Accepted: 19 February 2022

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ABSTRACT

Background: Financial access to health care has been sharply reduced in Africa following the introduction of cost recovery recommended by the Bamako initiative of 1987. Like in many countries in the world, in Cameroon, community-based organizations (CBO) which assist their members in the event of a financial crisis, death, funeral, birth, marriage, etc. added financial assistance in case of illness to alleviate this situation. This study aimed to determine models of financial assistance practiced by these organizations to rescue their members in event of illness. **Method:** Study was based on a sample of 150 CBO selected for convenience in 3 zones, including 50 in urban areas, 50 in semi-urban areas, and 50 in rural areas. Previously trained interviewers organized group discussions to collect data from these organizations using structured interview guide. The analysis of data collected was done manually. **Results:** The results show that 82.66% of organizations practice the "rescue quest model", 10.67% the "lump sum health assistance model", 2.67% "health tontine model", 2% "sickness deposit model", and 2% "subcontracting model" with an insurance company. The analysis shows that the "health tontine" and "sickness deposit" models are more forward-looking because they can make money available in time, before seeking care/before disease worsens. **Conclusions:** The systematization of these models could make it possible to mobilize funds on a community basis to extend the coverage of the financial risk linked to the disease to the populations of the informal and rural sector.

Keywords: Community-based mutual aid, Financial access to healthcare, CBO

INTRODUCTION

The financial access to healthcare constitutes a major concern for every health system worldwide. This is why international bodies (WHO, WB, UN) recommend today those countries set up universal health coverage (UHC) systems.¹⁻³

In Africa, the cost recovery and direct payments that resulted from the implementation of the 1987 Bamako Initiative have compounded the problem of financial inaccessibility to health care in Africa.⁴⁻⁷ This is why African countries have been looking for solutions for the

past three decades through the promotion of community-based mutual health organizations.⁸

In Cameroon, financial access to quality health care is far from guaranteed in the villages and towns. Indeed, according to these authors, the financial accessibility to health care in Cameroon can be estimated at less than 50% of the population because of the absence of a generalized system of health insurance for the entire population.⁹ This pushed the country to promote community-based health mutuals or insurance from the 2000s like many other low and middle-income countries

in the world in general and in Africa in particular, and today the concern is the establishment of UHC.⁸

The CBO which functione as micro health insurance schemes has been identified as good channel/ mechanism for improving financial access to healthcare for poor populations in many countries. 10-12 CBO contribute also to promote community medicine/ community health. 13-18

In Cameroon, many CBO have existed and have been developing endogenously for a long time, especially from the promulgation of the laws on the freedoms, and particularly that on the freedom of association in 1990. According to Aboubakar et al in the face of difficulties in accessing healthcare, some of these organizations set up a disease-related financial risk coverage system to reduce the health costs of their members.¹⁹ On the whole, they provide their members with assistance in the event of the death of a member himself or someone in his family, in the event of funerals, sickness or other events in his life. Kotto estimates that these organizations provide a very partial coverage of the financial risk of the disease to only about 14% of the population.²⁰ What are the methods of covering financial risk practiced by these organizations?

The present study was conducted to determine the different models of coverage of the financial risk related to the disease practiced by the CBO in Cameroon and to analyze the development stakes of the basic or proximity health coverage from these organizations.

METHOD

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. Data collection took place between January and April 2019. The sample size was set arbitrarily to cover a minimum of 30 CBOs in each type of living environment. This is how we chose to cover 50 CBOs in each type of living environment.

The study was based on a sample of 150 CBO selected by convenience in 3 sites representing 3 different living environments. The sample size was set arbitrarily to cover min of 30 CBOs in each type of living environment.

This is how we chose to cover 50 CBOs in each type of living environment. It was a question of studying practice of covering financial risk related to disease in 3 different socio-economic contexts. Therefore: A group of 50 CBO has been selected in urban areas in the city of Yaoundé; A group of 50 CBO in semi-urban areas, 25 in Bafoussam and 25 in Nkongsamba and A group of 50 CBO in rural areas, 25 in Melong and 25 in Penka-Michel.

The criteria for selection and inclusion of the CBO were as follows: To be a CBO that practice mutual aid or financial assistance of members for social events; Exist for at least 6 months; Have at least 30 members and hold at least one meeting per month between members.

The data were collected using a structured questionnaire completed by previously trained investigators. To collect the data in 50 organizations, each of the 3 trained investigators spent 3 months in his study site. The filling of the questionnaire took place during the meeting sessions through focus groups. The questionnaire consisted of two parts, a first part to collect the data on the identification of the organization and a second part to collect the data on the practice of the financial risk coverage of the disease by the organization.

At the end of the collection, data was analyzed manually and using a simple calculator for calculating percentages.

RESULTS

Different models of financial risk coverage related to the disease identified

The study of 150 CBO identified 5 models of financial risk coverage systems related to the disease as presented in Table 1. These are: The occasional "rescue quest model" in case of serious illness concerning a member of the organization observed in 82.66% of cases; Fixed-rate (lump sum) of "health assistance model" attributable to a member of the organization who applies for the assistance in case of sickness, observed in 10.67% of cases; The of "health tontine model" with fixed amount paid at meetings by each member of the organization, observed in 2.67% of cases; The fixed or variable amount of "sickness deposit model", observed in 2% of cases and The "subcontracting model" of health coverage with an insurance company, observed in 2% of cases.

Table 1: Different models of financial risk coverage systems related to the disease listed in a sample of 150 CBO in Cameroon.

Model designation	No. of cases observed in urban zone	No. of cases observed in semi- urban zone	No. of cases observed in rural zone	Total no. of cases observed	Percentage (%)
Rescue quest model	42	44	38	124	82.66
Lump sum health assistance model	4	5	7	16	10.67
Health tontine model	1	1	2	4	2.67
Sickness deposit model	0	0	3	3	2
Subcontracting model	3	0	0	3	2
Total	50	50	50	150	100

Description of the different models listed

The "rescue quest model"

This model consists of organizing an occasional quest called "release", during a meeting of the CBO, or by door-to-door, when a member of the CBO is seriously ill, was the victim of a serious accident or has been operated and is hospitalized. The announcement of the sickness situation and the degree of seriousness of the case is enough for the members of the office of the CBO to take the decision or propose to organize the quest. The situation of the sick member's relief fund, its behavior, and the place he/she occupies in the CBO influence the decision to organize the quest. The total amount of funds that the CBO mobilizes in this model varies between 10,000 and 75,000 CFAF depending on whether one is in a rural or urban area and according to the number of members and their income levels.

Once the quest is organized, the amount of money raised is donated to a member or small group of members who will hand over the sick member with a message of moral comfort and the CBO's wishes for prompt healing.

This model is the most practiced by the CBO studied. In fact, apart from the CBO which practice another model, almost 83% of the 150 CBO studied (124 in total) practice this model at varying degrees. CBO that do not practice it officially at their meetings announce cases of illness among their members and each individual member voluntarily provides moral, material, or financial assistance to them at the hospital or at home.

The "lump sum health assistance model"

This model consists of lump-sum financial assistance to a member of the CBO who suffers from an illness, an accident or who has been operated, generally when the case is serious and requires significant expenses. The severity of the case of illness is measured by hospitalization for a minimum of 3 to 5 days according to the CBO, by the degree of surgery (medium or heavy), or by the severity of an accident (physical trauma of medium or high importance requiring fairly expensive care).

The amount of the assistance is generally recorded in the statutes or rules of procedure of the CBO and each member is entitled to the same amount, either in a single installment or in several installments corresponding to several episodes of illness, and this up to all members benefit from it or, when the aid can be renewable, it is awarded once a year or in two years.

When the case arises, the members of the CBO's office are informed and a delegation of two to three people will visit the patient on the 3rd or 5th day of hospitalization in order to confirm the seriousness of the illness and decide to hand over the financial assistance.

The amount of assistance varies between 10,000 and 50,000 CFAF depending on whether one is in a rural or urban area, or according to the number of members and their income levels. This model was found in sixteen CBO, seven in rural, five semi-urban and fourth urban areas.

The "health tontine model"

This model consists in setting up within the CBO a tontine formally called "health tontine" or "disease-tontine" according to the organizations. The amount of the contribution to this tontine is generally not high. It varies between 200 and 2,000 CFAF depending on whether one is in a rural, semi-urban or urban area and according to the number of members and their income levels.

This tontine has two variants: the model restored to one or more members and the model not restored.

In the model restored to the member, the amount collected at each meeting is given to one or more members of the CBO to help them pay their bills of healthcare or those of their family members as needed. The disadvantage in this model is that the member may not have a case of illness at the time he benefits from the money from the tontine and he uses it for other purposes unrelated to health. When the illness will occur at another time, he will manage himself to find the money needed to heal.

In the model not restored to the member(s), the amount collected at each meeting is kept in the cash-desk of the CBO to constitute an "individual health fund" for each member or a "common health fund" that is used as in the "lump sum health assistance model".

When the health fund is individual, it is a kind of "health savings" that is given to the member when needed, when he has a case of illness.

This model of "health tontine" was found in four CBO, two in rural, one in semi-urban and one in urban areas.

The "sickness deposit model"

This model consists of introducing a system of mandatory deposit funds for all members of the CBO. The funds deposited and kept in the coffers of the CBO are individual and are paid back to the member only in case of sickness also concerning the member of his family. This model has two variants: the "single-rate lump sum deposit model" and the "variable-rate progressive deposit model".

The "single-rate lump sum deposit model" was found in two CBO in rural areas. It consists of depositing a fixed sum (30,000 CFAF for these two cases) in the CBO's cash-desk and this amount is only refunded to the

member in the event of illness or serious accident with hospitalization. After leaving the hospital, the member has 3 months to replenish the same amount in the cask-desk of the CBO.

The "variable-rate progressive deposit model" has been described in a CBO still in rural areas. It consists in depositing necessarily a percentage (5% for the case of this CBO) of the amount of the tontine that the member benefits in the cash-desk of the CBO on behalf of the member. In addition to this amount which is deducted obligatorily, the member is free to supplement by depositing other funds from his pockets during the meeting sessions. The amounts thus collected vary from one member to another and the amount available or requested is paid to the member in the event of illness affecting him or another member of his family.

The "subcontracting model"

This model consists of subcontracting the health insurance coverage of members of the CBO from a private insurance company. It is the insurance company that offers one or more health insurance products to the CBO and the CBO chooses the appropriate product or products for its members.

This model was found in three CBO in urban areas. The peculiarity of this model is that the health insurance premiums paid to the Insurance Company are so high that only CBO with members with high incomes are able to subscribe. This is why the three CBO found are public administration staff associations in urban area.

DISCUSSION

Community-based mutual aid or community-based health insurance (CBHI) is an emerging concept for providing financial protection against the cost of illness and improving access to quality health services for lowincome rural households who are excluded from formal insurance.21 This study showed that CBO can improve access to healthcare for poor population in Cameroon just as Jütting also demonstrated in his study carried out in rural Senegal.²² It also confirms the findings of Feuzeu who observed that some CBO have put the issue of financial assistance in the event of illness in their regulations and that, they are successfully combining micro-insurance activities with those of microcredit. 23 BIT/STEP, which also carried out a study on the "mutual health" dimension of mutual aid and solidarity organizations, also concluded that the system of "lump sum support" granted to their members in the event of death, funeral, illness or other unfortunate or happy event is not bad in itself, but it would be very beneficial to organize and systematize the management of the disease risk.²⁴ This can also be drawn as conclusion of this study.

Although this study was limited to only three zones in three out of ten regions of the country and to CBO

belonging mostly to the "Bamileke" ethnic group, it showed that all the CBO studied are sensitive to the health problems of their members, especially when the life of one of them is in danger. When the CBO has not subscribed to health insurance for its members in a private insurance company (which is practiced in only 3 of the 150 CBO studied), or when the "health assistance" is not systematically introduced (which is practiced in only 16 out of 150 CBO studied), the alternative is the use of a "rescue quest model" to financially and morally assist the sick member (which is practiced in the great majority of CBO, i.e., 124 on 150 studied). The "Health tontine" and "sickness deposit" models seem more forward-looking because they can make money available in time, before seeking care, or before the disease worsens. Unfortunately, they are practiced only in respectively 4 and 3 CBO out of the 150 studied. These findings are consistent with the study by Doris et al who stated that: "The majority of Sub-Saharan African citizens-informal sector workers and the rural populationhave never had access to wage-based social health insurance or privately run health insurance. As a response to the lack of social security, to the negative side-effects of user fees introduced in the eighties and to persistent problems with health care financing, non-profit, voluntary CBHI schemes for urban and rural self-employed and informal sector workers have emerged. The CBHI seems to be a promising attempt to improve access to health care, health outcomes and social protection in the case of illness. Given the unique ethnic, lingual and cultural diversity within African nations, the CBHI approach may be particularly valuable because it allows adaptation to local conditions". 25

They are consistent with the study by Adebayo et al who stated that: "The health insurance scheme particularly suitable for the rural poor and the informal sector in LMICs is CBHI, that is, insurance schemes operated by organizations other than governments or private for-profit companies". 26 It also corroborates with the publication of USAID and health finance and governance which suggests focusing on following groups of organizations community/mutual-type through which insurance initiatives could scale up: (a) micro-finance institutions and self-help groups, (b) the more than 600,000 cooperatives in India, (c) micro-enterprise and small- and medium-size enterprise clusters, and (d) urban labor markets (such as auto driver unions) and migrant clusters in several cities in India. suggests focusing on following of organizations through community/mutual-type insurance initiatives could scale up: (a) micro-finance institutions and self-help groups, (b) the more than 600,000 cooperatives in India, (c) microenterprise and small- and medium-size enterprise clusters, and (d) urban labor markets (such as auto driver unions) and migrant clusters in several cities in India.²⁷ Also, in the study of SARA BENNETT (2004), we saw that there is increasing advocacy for community-based health insurance (CBHI) schemes as part of a broader solution to health care financing problems in low-income countries.²⁸

CONCLUSION

CBO in Cameroun practice five models of financial assistance to their members in event of illness. Among these models, two seem more likely to make the money available on time: the "health tontine" and the "sickness deposit" models.

The systematization of "health tontine" or "sickness deposit" models could make it possible to mobilize funds on a community basis to extend the coverage of the financial risk linked to the disease to all population groups, particularly those in the informal and rural sector, and thus generalize health insurance (and UHC) in the country.

Funding: No funding sources Conflict of interest: None declared

Ethical approval: The study was approved by the

Institutional Ethics Committee

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Cite this article as: Fouakeng F, Njoumemi Z, Mbacham WF, Angwafo III F. Community-based mutual aid for improving financial access to healthcare: case study of 150 community-based organizations in Cameroon. Int J Community Med Public Health 2022;9:1257-62.