TOGETHER, MORE THAN EVER,
LET'S FIGHT TO CHANGE THE WORLD!

HEALTH: WHAT ARE THE ACTIONS AND DEMANDS FOR THE FUTURE?

I. WHY AND HOW WAS THIS DOCUMENT DRAWN UP?

In the early 2000s, the Emmaus movement set about creating mutual health organisations in response to the glaring inequalities in access to health care within the movement itself. Two mutual health programmes were set up in Burkina Faso and Benin in 2002, followed by two others in India and Bangladesh in 2011. The gradual development of these community-based social protection systems, managed by the excluded people themselves, has enabled them to reclaim a fundamental right of which they were mostly deprived: the right to health.

In order to allow a real evaluation of the collective work initiated by the movement since the beginning of the 2000s, an in-depth evaluation was carried out in 2021. It is available to the members of the movement. This document, drawn up based on the in-depth evaluation and the discussions of the Emmaus International Board, aims to outline the main points and propose ways to give a new impetus to our common work, in order to collectively carry forward the movement's demands for access to to quality health care.

II. WHICH WORLD ASSEMBLY DEBATE DOES THIS REFER TO?

This document is intended to help you prepare for the following debate, as proposed in the 2021-2025 Guidance Report that you have received:

Subject 4:

Why and how can we take action and speak out together?
How have our joint initiatives helped us to tackle the causes of poverty?
How can we go further and make our demands known?
What struggles should the movement engage in for the future, given the democratic and ecological challenges, and in light of the exacerbation of the inequalities and forms of racism directed at migrants in particular?

III. PRESENTATION OF THE DOCUMENT

Analysis

Despite the progress made over the last ten years, 5 billion people still do not have access to quality and affordable medical care, and more than half the world's population has no social security coverage. Poor health and poverty are closely linked: poverty leads to health problems and poor health keeps people poor. It was in order to break this causal link that the Emmaus movement began to look at access to health in the early 2000s. It noted the glaring inequalities within the movement, which it considered unacceptable. In the majority of countries where it operates outside Europe, low incomes, the prominence of the informal sector and the scarcity of public resources restrict health coverage and access to quality health care.

The increased liberalisation of economies over the last few decades has transformed the health sector into a market good and accentuated the existing inequalities in access to health care between the poorest and the wealthiest populations. But this dynamic is not unique to the so-called "poor" countries – it is also increasing today, for the same reasons, in the richest countries.

It was against this backdrop that members of the Emmaus movement and, at the time, its founder, decided to launch a collective action of solidarity. This action took several forms (working group, African health insurance fund) before quickly becoming the first African mutual health organisation. In order to set it up, representatives from Emmaus Africa mobilised the members of their groups and organised regular meetings to explain, raise awareness and lay the foundations for the functioning of the mutual organisation. After several months of discussion, the first local mutual organisations – resembling a basic social security scheme – were launched in Benin and Burkina Faso in the groups.

In 2007, the movement's General Assembly adopted the right to and access to health as one of Emmaus International's priority areas of work. A work process was then set in motion, focusing on the national structuring of mutual organisations in Africa and the launch of new pilots in the Asia region.

Today, the Emmaus movement has four mutual health organisations with more than 5,000 members: a national mutual organisation in Benin, a national mutual organisation in Burkina Faso, a community-based mutual organisation in a slum in south-east New Delhi and a community-based mutual organisation in the Rajshahi district in north-west Bangladesh. These four mutual organisations operate in different geographical and socio-economic contexts and therefore do not all function in the same way. While the membership and subscriptions systems, the health care provision and the type of health service contracts[1] with local health facilities differ, certain similar characteristics make the Emmaus mutual organisations unique: solidarity-based financial mechanisms, the involvement of excluded people in the management of the organisations, which requires constant capacity building, and the particular focus put on participative leadership.

[1] Being subject to an agreement with the mutual organisation regarding rates.

Operation of the mutual organisations

All our mutual organisations were built independently of any power (economic, trade union or political), with democratic governance in place or under construction. They are based on principles of solidarity, both between mutual members who share the health risk and at the international level, since Emmaus groups contribute to supporting this programme.

The mutual health organisations in Africa

In Africa, the two mutual organisations are national and each one brings together the Emmaus groups in the country, which operate in different areas (rural/urban). The beneficiaries of the mutual organisations are the groups' companions, employees and beneficiaries. The Benin mutual organisation has around 940 members and the Burkina Faso mutual organisation has more than 1,000 members.

The African mutual organisations have set up agreements with health facilities (hospitals, testing laboratories, etc.) in order to obtain preferential rates, automatic treatment of mutual members and the implementation of third-party payment. Education sessions on health care take place regularly and present an opportunity to answer mutual members' questions and develop ownership of this collective tool.

They are based on a system of family membership, which has enabled the number of mutual members to increase steadily over the past 10 years, to cover all persons in the same family and to better share the health risk.

The governance is that of a French "association" with elected members, a board and an executive committee. Local representatives, the secretaries of the national organisations in Benin and Burkina Faso and the members of the mutual health organisation are responsible for the coordination.

The financial autonomy of the mutual organisations is 37% for the Benin mutual organisation and 69% for the Burkina Faso mutual organisation[2].

The mutual health organisations in Asia

In Asia, the mutual organisations are not national but local, as they are linked to a single Emmaus group. The Indian mutual organisation is linked to the Tara Projects group and the Bangladeshi mutual organisation to the Thanapara Swallows group. The former is located in an urban area and the latter in a rural area. Rates are individual, but they vary according to the number of people in the family. They both operate with employees (project managers, social workers, doctors, etc.). The ratio of health expenditure to resources is at acceptable levels despite the existing economic, health and structural constraints. The financial autonomy of the Tara Projects mutual organisation is 27% and that of Thanapara Swallows is 19%.

[3] Figure for 2019

The Tara Projects mutual organisation has launched the construction of a health centre in the Badarpur district where it is established. For its inhabitants, who have little or no alternative for health care, this centre has become a very important place for socialisation, education and access to health care. All the inhabitants of the district can benefit from the mutual organisation and the centre. It currently has 2,368 members[3] and gives them access to medical consultations as well as the dispensing of medicines, outpatient care (day hospitalisation), hospitalisation in network hospitals covered by an agreement requiring more equipment, physiotherapy and various basic medical tests, and access to specialists once or twice a month (eye care, gynaecologists, etc.).

Coordination and participation are strongly developed by the Indian mutual organisation, which has set up collective spaces to promote community participation, particularly of women, and to strengthen democratic management. The employees run spaces that enable them to strengthen the knowledge of mutual members about basic health care procedures and practices, and also about the operational functioning of the mutual organisation.

As for the Thanapara Swallows mutual, it has almost 600 members and has also set up a medical centre. It is working on building partnerships, particularly with Rajshahi Medical University, to benefit from more specific medical services. It offers a similar range of services: access to medicines, consultation with a nurse, day hospitalisation, physiotherapy, basic medical tests, and access to specialists once or twice a month (eye care, gynaecologists, etc.).

Key lessons from the mutual organisations

The Emmaus mutual organisations are a real alternative. They demonstrate that with solidarity-based support, the involvement and joint mobilisation of people who want to take action together, excluded and vulnerable people are able to reclaim their right to health and to be actors of social change.

Since the beginning of the pandemic, the mutual organisations have played a vital role in ensuring compliance with individual and collective barrier measures and in reducing the socio-economic consequences. Today, they play the role of basic social security and social support for the most disadvantaged people in countries without public health policies and/or health facilities.

There are several major lessons to be learned from these mutual organisations today:

- **Long-term commitment**: time is a prerequisite for working towards lasting change, even more so in contexts of poverty, illiteracy, limited access to public services, etc. This is a real challenge for the movement, which must encourage the mobilisation and involvement of groups over a long period of time.
- **The construction of spaces for participation and the involvement of the people concerned**: each actor must feel involved and be able to contribute. This is a condition for the

[3] Figure from 2020

sustainability of actions. The construction of community-based social protection systems controlled by individuals is also a powerful means of permanently breaking out of poverty.
- **The adaptation of mutual health programmes to local contexts**, in terms of health, economic and cultural aspects.
- **The importance of collective organisation**, both within the mutual organisations and the movement. In Africa as in Asia, the launch of the mutual organisations has led the movement to engage in concerted support work with elected representatives and collective working spaces (workshops during World Assemblies, annual meetings, etc.). These moments of sharing strengthen involvement. However, since 2016, we have noticed a clear loss of momentum in the movement's support, whether from elected representatives of national groups where the mutual programmes are established or groups of the movement that support these programmes.

Proposal

Several prospects and possibilities are available to the movement today.

Improve the existing mutual health programmes

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. Nevertheless, the in-depth evaluation brings to light many ways to improve the four mutual organisations and the long-term support of these programmes. Choosing to improve what already exists would make it possible to develop the self-sufficiency of the mutual organisations, both in Asia and in Africa.

Support for these programmes can be revitalised in several ways: political support for the movement's elected representatives, regional support and support for national organisations, support for local groups (e.g., new meetings with the leaders of local Emmaus groups and national organisations, creation of involvement tools, increased financial support, etc.).

Set up new pilots

Health care systems are in dire straits in many countries and the pandemic has only aggravated inequalities in access to care. As such, the movement could therefore also consider launching new mutual health pilots. There are two possibilities available to the movement:

1. Set up mutual health programmes in new regions

Several Emmaus groups have already indicated that they are interested in launching a mutual health programme. There are many factors to consider before setting up new pilot schemes:

- Where should a new pilot be set up?
  Should preference be given to a region where several Emmaus groups are based in order to pool human and financial resources?

- What is the capacity of the group(s) for collective work and human and financial investment?

It is also important to be aware of the time needed to get the programme up and running properly: the time it takes to carry out a survey and analyse the context, the time it takes to raise awareness and provide training, the time it takes to prepare the group(s), etc., all of which represents one to two years of preparation before the mutual organisation begins to operate.

Here again, the involvement of the movement, the elected representatives and the leaders of the groups concerned is crucial.

Based on these ideas, the strategy to bolster our collective work could focus on three key areas:

OR

2. Create a global Emmaus health access tool

Given the extent and magnitude of inequalities in access to health care, it might be appropriate to consider creating a global health access tool within our movement – a kind of "internal Emmaus mutual health scheme". To do this, a process of in-depth reflection would be required to define the scope and feasibility of such a scheme. This global instrument, which would be part of an international ambition, would enable the movement to carry out an action on an unprecedented scale.

If this option were to be considered, the movement would have to address the issues of financing, management and monitoring.

It should be noted that La Mutualité Française seems to be willing to support the movement.

Use the experience of the mutual organisations to campaign for the right to health

Emmaus' mutual health programme cannot be carried out without a parallel campaigning effort to try to change public health policies and to ensure that stakeholders of the mutual health organisations, that uphold the values of solidarity and economic ethics by including the most vulnerable, are recognised and given priority.

The pandemic has reminded humanity of the fragility of each person and our collective vulnerability. We all have a right to health and it is our collective duty to call on states to commit to guaranteeing this right.

In their operation and purpose, the Emmaus mutual organisations meet the three requirements that we set out in our Global Report: involve vulnerable people so that they have a full place in society, put the common good at the heart of public policy, and develop an economy that truly serves people and the planet.

We must remember that it is the responsibility of public policy to integrate excluded people in the collective construction of public action that concerns their region and to guarantee the fundamental right to health, which must be protected from any sort of privatisation.

First of all, at the local level, it may be interesting for mutual organisations to develop networking in their region. Bringing together actors involved in the same struggle would make it possible to pool strengths and experiences and, perhaps, to have more influence with the public authorities.

Strengthening political support (in a form to be defined) at the various levels would enable members of the mutual organisations to better champion their work and its impact and make it more visible. Bringing together other civil society actors committed to defending the right to health is vital to establish a balance of power.

At the international level, we could join or initiate, with others, a campaign to raise awareness of, or advocate for, the right to health which mutual members could use to champion their programme.