



Mutual Health Insurance, Scaling-Up and the Expansion of Health Insurance in Africa

ABSTRACT

The objective of this paper is to contribute to a common understanding of the concept of expansion of health insurance based on the specific features of community mutual health organizations (MHOs) in Africa. The proposed policy analysis framework presents the expansion of health insurance based on the MHO concept as a process that uses MHO principles to develop health insurance schemes that serve as the foundation for health insurance. The health insurance expansion process is presented as the product

of the synergy between bottom-up community processes and top-down modes and mechanisms of government intervention to create an environment that encourages scaling up and expanding social health protection coverage in the rural and informal sectors.

The analytical framework is the starting point for a comparative analysis of the various experiences with expanding MHOs and health insurance in a sampling of African countries: Benin, Cameroon, Ghana, Niger, Rwanda and Senegal. The analysis identifies major gaps in the policy environment in some of the French-speaking African countries where legal frameworks are still being prepared, financing support mechanisms are absent, technical assistance services are provided primarily by diverse nongovernmental organizations and foreign partners using different approaches, and supervisory and regulatory agencies have yet to be set up. By contrast, efforts to expand health insurance using the MHO concept are more coordinated in Ghana and Rwanda, where strategic support frameworks that combine complementary legislative, financial and technical interventions have enabled a rapid expansion of insurance coverage in the rural and informal sectors.

It was possible to learn lessons from this experience by identifying principles to inform the debate and strategic directions for expanding health insurance based on the MHO concept in Sub-Saharan Africa:

- The expansion of health insurance based on community MHOs should be supported by



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strong political will and leadership at several levels in order to mobilize and coordinate the efforts of multiple actors at the national and local levels in a sustainable fashion.

- The principle of equity in financing should be used to determine financing mechanisms as part of the measures to expand health insurance based on community MHOs so that the citizens who have means subsidize citizens who cannot afford to pay.
- The combination of financing sources and mechanisms as integral measures to expand health insurance through MHOs is based on the synergy between public funding (itself based on the principle of national solidarity), and the MHO concept (based on the principles of solidarity, mutual assistance and prepayment at the local level).
- Aligning community health insurance organizations with decentralized governmental units permits structural equivalence, and leveraging of the political and technical capacities of the decentralized entities to rapidly scale up community-based health insurance to the entire country.

I. INTRODUCTION

In most Sub-Saharan African countries, where incomes are among the lowest in the world, the dominant health care financing mechanism is out-of-pocket payments by households when they need care.^{1,2} Because most of the working population of African countries is employed in small businesses in the informal sector and family farms in the agriculture sector, alternative health financing mechanisms are necessary to improve accessibility to healthcare and to protect households from the financial risks and impoverishment associated with direct payment to treat diseases.³ In such economic and social contexts, the combination of community-based health insurance (CBHI) schemes, such as mutual health organizations (MHOs), and formal financing mechanisms, such as social insurance systems and public funding, has great potential for transitioning from a health system dominated by out-of-pocket payments to a health system based on prepayment, risk pooling and universal healthcare coverage.

As a result of the expansion of the associative movement in Sub-Saharan Africa, CBHI schemes began to emerge in the 1980s, a community-driven process of experimentation with social financing alternatives in health. This process incorporates the values of mutual assistance and solidarity within the targeted communities, and the organization of the associative movement itself, transforming this social capital into mechanisms which promote access to healthcare and protect against the financial risks associated with falling ill.

After two decades, MHO implementation is at a crossroads. The recognition of the social potential of MHOs is reflected in the will to move from spontaneous emergence of MHOs to a deliberate strategy of MHO development in Sub-Saharan Africa. In fact, several countries in the region view MHO scale-up as a key

¹World Health Organization (WHO). 2000. *The World Health Report 2000: Health Systems – Improving Performance*. Geneva.

² Gottret, P. And G. Schieber. 2007. *Financer la Santé: Une Nouvelle Approche – Un Guide pour les Décideurs et les Praticiens*. World Bank: Editions Saint-Martin.

³World Health Organization. 2001. *Macroéconomie et Santé: Investir dans la Santé pour le Développement Economique*. Report of the Commission on Macroeconomics and Health. Geneva.

strategy for expanding health insurance and social protection in health. This social potential of CBHI systems is now being developed in countries as diverse as Ghana and Rwanda. Although they have only recently joined the MHO movement, these two Sub-Saharan African countries have made a resolute commitment to expand health insurance based on the MHO concept as several Latin American and Asian countries, including China, have done.

The main objective of this paper is to use the components of an analytical policy framework to identify the processes and mechanisms of CBHI schemes that can be adopted for the scale-up of health insurance in the rural and informal sectors. The components of the analytical framework, presented in the second section, can help to develop a common understanding of the concept of health insurance expansion based on the specific features of CBHI in Sub-Saharan Africa.

The second objective of this paper is to identify gaps in the policy environment in Sub-Saharan Africa that impede scale-up of health insurance in the rural and informal sectors through CBHI systems. To this end, experiences in expanding MHOs in countries as diverse as Benin, Cameroon, Niger, Senegal, Ghana and Rwanda are described in the third section. The final section builds on this comparative analysis to identify gaps in the policy environment and guiding principles to inform the debate on the expansion of health insurance based on the MHO concept in the countries of Sub-Saharan Africa.

2. POLICY ANALYSIS FRAMEWORK

The remainder of the paper uses the terms “community-based health insurance scheme” and “community MHO” to describe health insurance organizations that are self-managed by their members in the rural and informal sectors. The social entities for CBHI schemes as discussed in this paper are defined on the basis of residence and geography: a village, several villages in the same rural area, one or more urban neighborhoods, a regional authority, or other territorial administrative subdivisions such as health districts, *arrondissements*, or departments.

The expansion of health insurance requires an infrastructure that is close to the potential beneficiaries, to support the administrative functions of the health insurance scheme. In traditional social insurance systems, the infrastructure used to support health insurance functions consists of businesses in the modern sector of the economy that have a relatively stable transaction structure through which the subscribers can be easily distinguished (employees and their dependents) and contributions easily collected (from employee wages).

In a society where the majority of the population is employed by small family businesses in the informal sector and on small farms, where the mechanism for financial contributions is not straightforward and where subscribers are not easily identifiable, an alternative infrastructure is necessary to support scale-up of health insurance to the majority of the population.⁴ In the policy analysis framework presented above, health insurance expansion along MHO lines is understood as a process for extending health insurance according to MHO principles, that is, using CBHI organizations as a foundation for the basic health insurance system infrastructure.⁵

⁴ Turner, Jonathan, 2000. *The Formation of Social Capital*. In Partha Dasgupta and Ismael Sirageldin (eds), *Social Capital: A Multifaceted Perspective*. Washington, DC: The World Bank.

⁵ This perspective is different from that of an isolated and autonomous MHO initiative of a community that has no functional relationship with the other development actors; this is the case in several local experiences during the MHO concept emergence phase in the countries of Sub-Saharan Africa.

With this in mind, the process of expanding health insurance is one of building institutional bridges between the community dynamics and the modes and mechanisms of government intervention to create an environment that provides incentives for expanding social protection coverage to the rural and informal sectors. In this context, community MHOs are identified as pillars of the health insurance system infrastructure that is the first link in the chain for managing the risks associated with health insurance. The local networks of community MHOs, which provide certain benefits to members, are seen as social intermediation mechanisms, an intermediate link in the health insurance risk-management chain. Finally, the statutory and regulatory frameworks, technical assistance services and financial mechanisms that serve as a support system at the macro level are identified as the central link in the chain. The central theme of the policy analysis framework is how the bottom-up expansion processes, starting with the communities, and the top-down processes, starting with the government, can build institutional bridges to connect these different links in the chain, using and promoting the MHO concept.

The policy analysis framework for the expansion of health insurance based on the MHO concept is summarized in the figure on the next page. The analysis framework specifies that the results expected from the expansion of MHO-based health insurance include improved access to care, protection of household income in health, and social inclusion. These results may be achieved by translating political will into reality as manifested by the expansion of coverage and empowerment of vulnerable populations, expanding benefit packages and health services, quantitatively strengthening social relationships that generate solidarity between patients and healthy individuals through health insurance organizations, and improving the efficiency and effectiveness of health insurance schemes. The expansion of health insurance is accomplished with bottom-up approaches that develop community health insurance systems comprising households, family groups and community-based organizations, consolidated into networks of community insurance systems. Bottom-up

approaches are strengthened by top-down policies and programs: a strategic support framework incorporating new, sustainable sources of financing, technical assistance services and an appropriate legal and regulatory environment are prerequisites for stimulating the dynamics of local health insurance organizations and extending them geographically.

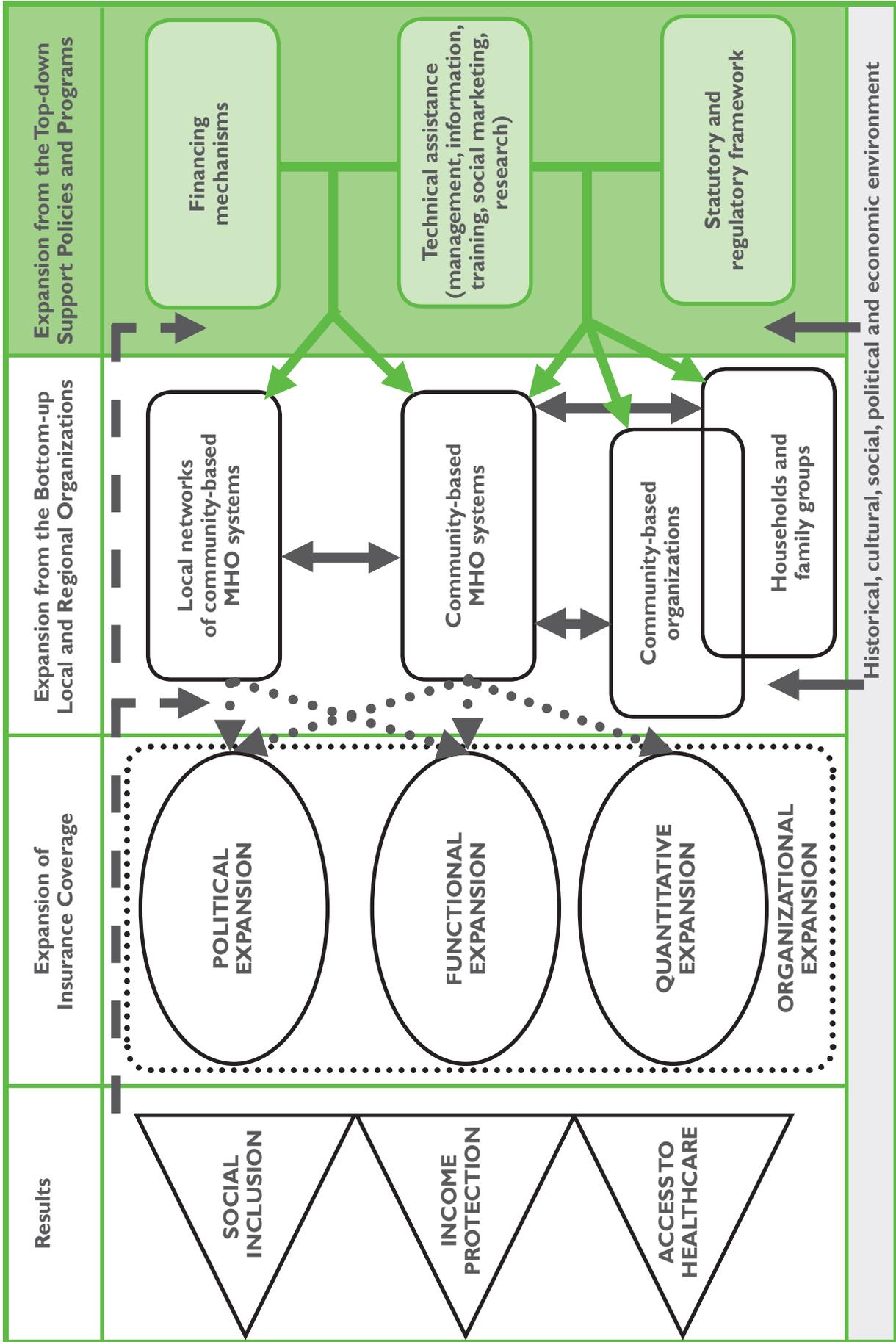
The following sub-section presents the first component of the analysis framework, i.e. the *raison d'être* for expanding health insurance in Africa. The following three sub-sections present the expansion processes that define the other components of the policy analysis framework for expanding health insurance, taking into account the specific features of community MHOs in Africa.

2.1 *Raison d'être* for the expansion of health insurance

The first component of the policy analysis framework covers the principal policy objectives of expanding health insurance in the specific context of Sub-Saharan Africa health systems. In this specific context, there is a broad consensus that the *raison d'être* for expanding health insurance is improving access to healthcare, protecting household incomes from catastrophic costs of healthcare and social inclusion for health. The key policy issues related to these objectives are, respectively: What is the level of healthcare utilization in the general population? What is the level of healthcare use among the poorest people? Do community MHO systems have an impact on the level of access to and the use of healthcare among the poor? How does the level of illness relate to out-of-pocket spending? What percentage of households incur catastrophic health expenses? Do community MHO systems have an impact on direct spending and protection from catastrophic healthcare expenses? What is the level of coverage for the poor and vulnerable groups by the community MHO systems?

Access to healthcare. Besides improving the quality of healthcare, better access to healthcare is one of the determinants of a population's health. Much effort has been invested in Sub-Saharan Africa to facilitate geographic

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accessibility and to improve the quality of healthcare using supply-based health development approaches.

The “demand” component in health development strategies has not been discussed extensively. However, it is increasingly recognized that in addition to geographic and social accessibility constraints, direct payments at the time of need are one of the principal sources of exclusion from health services in Sub-Saharan Africa.

In fact, financial barriers to accessing care generate different types of exclusion: total exclusion or indigence, seasonal exclusion, temporary exclusion or partial exclusion. First, some categories of the poorest of the poor are totally excluded from health services simply because they do not have the economic capacity to pay for health services at any time during the year: total exclusion or indigence. Second, some categories of the population may postpone the use of healthcare after they notice they are ill and see the need for care because they do not have the means to pay for the services when they are needed: temporary exclusion. Third, some categories of the population may be seasonally excluded from healthcare services due to cash flow constraints during specific seasons in the year, for example, rural populations, whose sources of income are dependent on the harvesting season and the season for selling farm products: seasonal exclusion. Finally, care providers may order tests and/or prescribe medication for patients who are unable to pay for the complete treatment: partial exclusion. MHOs are designed to mitigate exclusion of rural populations and populations working in the informal sector.

One of main reasons for pressing for the expansion of health insurance is to decrease financial barriers to access to healthcare. In many African countries, the utilization levels of modern health services are very low compared to levels observed in other countries. Moreover, inequalities in the use of modern services are considerable among the different socioeconomic categories, and between the richest and the poorest, and urban and rural populations. Consequently, the wealthiest quintile captures a disproportionate share of government subsidies channeled

through the public healthcare delivery organizations, calling into question the basic principles of public financing for health. From one country to another, the major reasons that people give for not using modern health services on a recurring basis are the costs of care and medication and their lack of money.⁶

Protection of household incomes. In most countries in Sub-Saharan Africa, households pay a growing portion of health expenses (40% to 70%) through out of pocket payments. As a result, a growing burden for financing health is borne directly by households through mechanisms that constrain financial accessibility to healthcare. It is increasingly accepted that disease and direct spending related to diseases, and catastrophic illnesses and the spending associated with them, are one of the principal sources of impoverishment for households in developing countries.⁷

Thus, African health systems are characterized by an essential paradox: Designed to contribute to the social protection of the citizens against diseases and their consequences, health systems have become a potential source of impoverishment for citizens. Consequently, in addition to improving access to care, one of the *raison d'être* for the efforts to extend health insurance in African countries is greater protection of household incomes.

Social inclusion in health. There are two dimensions to social inclusion in health that justify identifying social inclusion as one reason to expand health insurance in African countries. The first dimension is related to the coverage of health needs for the poorest people, vulnerable groups and minorities. Although poor and

⁶ Sources DHS [Demographic and Health Surveys]: Mali EDSM III 2001 (table 8.21), Rwanda DHS 2005 (table 8.16), Uganda DHS 2000-2001 (table 9.22), Uganda DHS 2006 (table 10.12), Ethiopia DHS 2000 (table 10.12), Ethiopia DHS 2005 (table 9.8), Senegal EDS IV 2005 (table 8.21), Ghana DHS 2003 (table 9.21), Nigeria DHS 2003 (9.21). See <http://www.measuredhs.com/pubs/>

⁷ See the work of Anirudh Krishna's team from Duke University at www.pubpol.duke.edu/krishna.householdpoverty. The site summarizes several research efforts on the causes of poverty and strategies to escape from poverty in the countries of Asia, Africa and Latin America.

vulnerable groups should be given priority for the benefits of healthcare in the countries of Africa, it is these segments of the population who most suffer exclusion from the health system. Thus, efforts to expand health insurance that leave out the poorest people and vulnerable groups in fact diminish the fairness of these countries' health systems and their potential impact on the population's health status as a whole.

The second dimension is related to the empowerment of the poor and users of the health sector in general.⁸ It is acknowledged that improving the capacities of individuals and communities to take responsibility for their own health is a key dimension of strategies to improve the health status of a population. Thus, efforts to expand health insurance in African countries should contribute to empowering individuals and communities to manage their own health and increase their power in the health sector and their involvement in the decisions that pertain to their health.

In summary, the first field in the policy analysis framework for expanding health insurance based on the MHO concept analyzes how efforts to expand health insurance contribute to the objectives of the health system, including access to healthcare, income protection and social inclusion for health in Sub-Saharan Africa. The policy objectives and the results envisioned in this first field of analysis facilitate the integration of the analytical work and efforts to expand health insurance in the strategies to improve health conditions, reduce poverty and strengthen democracy in the countries of Sub-Saharan Africa.

2.2 The health insurance expansion process

In the area of MHOs and expansion of health insurance, the concept of expansion can be described in terms of the typology proposed by Peter Uvin, which applies generally to community organizations and initiatives.⁹ Uvin's typology is especially useful in that MHOs work in the area of health

insurance and health financing, a domain in which the responsibility of the government in particular, and other actors also, is widely acknowledged.

The expansion of health insurance in the countries of Sub-Saharan Africa can be built on the comparative advantages of community MHOs and the other development actors. The comparative advantages of community MHOs in the expansion of health insurance are that they are rooted in the values of solidarity and mutual assistance that prevail in grassroots communities in Sub-Saharan Africa, their flexibility, their proximity to their members, and their governance structure. Since they are anchored in the community, these organizations create synergies between the formal institutional arrangements of health insurance systems and the informal institutions and social control mechanisms of their respective communities to minimize opportunistic behaviors and risks inherent in health insurance systems. However, the organizations suffer from major weaknesses related to their financial prospects and their size, both of which remain limited.

The comparative advantages of the central government and other development actors are related to the legal, human and financial resources at their disposal. It is very unlikely that community MHOs will ever have such resources. However, modern Sub-Saharan African states are still maturing and suffer from many weaknesses because they are young, as well as from interagency relationship issues inherent in government mechanisms, and often scarce understanding or influence over the daily lives of their populations. In the specific area of health, these weaknesses are manifested by vertical health interventions, decision-making processes and allocation mechanisms based on supply (which are monopolized by health administrations and health professionals to the detriment of the citizens) and the exclusion of major population segments from the benefits and services of the public health system.

Thus, to realize the social potential of community MHOs, it is necessary to create synergy between central government resources, other actors in development and the MHOs. Creating beneficial links between community

⁸ Commission on Human Security, 2003. *Human Security Now*. New York: United Nations.

⁹ Uvin, Peter. 1999. *Scaling Up, Scaling Down: NGOs Paths to Overcoming Hunger*. In Thomas J. Marchione (ed), *Scaling Up, Scaling Down: Overcoming Malnutrition in Developing Countries*. Gordon and Breach Publishers.



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expansion; (ii) functional expansion; (iii) political expansion; and (iv) organizational expansion. These different types of expansion are described in the first sub-section that follows. MHO networking is presented in the second sub-section as a specific case of expansion from the bottom-up since it combines several types of expansion among MHOs themselves.

Quantitative expansion. Quantitative expansion is a process through which a community MHO grows by increasing its social or membership base, the geographical base of its target population and/or its budget. Quantitative expansion generally refers to a community MHO increasing the number of its members and its beneficiaries. This is generally the understanding of the meaning of quantitatively expanding any given MHO. In a CBHI scheme, quantitative expansion occurs at the micro level and can also relate to an increase in the breadth of health insurance coverage at the level of the macro-health system.¹¹ Thus, key issues related to quantitative expansion are: How many beneficiaries do the MHOs cover? What percentage of the target population do the MHOs include?

Functional expansion. Functional expansion is a process through which an MHO increases the number and types of services it provides to its beneficiaries. The structure of an MHO benefit package is the key issue of the MHO insurance function and of its two dimensions: access to healthcare and protection vs the financial risks associated with illness. At the micro level of a CBHI scheme, functional expansion is the concept of increasing the depth of health insurance coverage at the macro level of the health system.¹² Thus, the key issues related to functional expansion are: What types of risks do MHO systems cover? Do benefit packages cover major and minor risks? What copayment level is used in MHO systems?

Political expansion. Political expansion is a process through which an MHO carries out activities that contribute to strengthening the power of its members and changes their social, economic and political environment,

MHOs on one hand, and central government and other actors in development on the other hand, requires two expansion processes: *from the bottom-up* and *from the top-down*. Expansion from the bottom-up is a process through which community-based MHOs establish relationships with the central government and other development actors to expand their impact. Expansion from the top-down is a process through which the government and other development actors adopt operating methods that generate significant interaction with the community MHOs.¹⁰ The two types of expansion processes build on different links in the risk management chain in the expansion of health insurance based on the MHO concept: community MHOs at the local level, local networks of MHOs at the intermediate level, and government agencies at the central level.

2.3 Expansion from the bottom-up

According to Uvin's typology and understanding of the dynamic of community MHOs in Sub-Saharan Africa, four types of expansion of health insurance based on the MHO concept can be identified: (i) quantitative

¹⁰ Bennett, Sara. 2004. The Role of Community-Based Health Insurance Within the Broader Health Financing System: A Framework for Analysis. *Health Policy and Planning*. May.

¹¹ WHO. 2008. *World Health Report 2008*. Geneva.

¹² *Ibid.*

in addition to activities which provide health insurance services. This process includes active political involvement and developing relationships with government actors. Political expansion also includes initiatives that community MHOs take to cover the costs of healthcare for the indigent and vulnerable groups. Through these exemption mechanisms, MHOs invest in an area which is usually the responsibility of the central and local government. That is why these initiatives are a part of this type of political expansion. Thus, the key issues related to political expansion are: Is there a system for providing care for the poorest of the poor and vulnerable groups within the MHO system? What is the performance level of the existing financing systems? Who pays for care for the poorest of the poor and other vulnerable groups?

Organizational expansion. Organizational expansion is a process through which an MHO increases its organizational capacity by improving its effectiveness, its efficiency and the sustainability of the benefits it provides to its members. Organizational expansion may have several dimensions, including a financial dimension and an institutional dimension. In its financial dimension, the organizational expansion of an MHO may include diversifying the MHO's sources of income, increasing its degree of self-financing or creating income-generating activities. It may also stem from establishing relations with the central government, promoting a legislative framework or a framework for cooperation so that state resources are allocated to the MHOs.

In its institutional dimension, the organizational expansion of an MHO may manifest itself by improving its internal management capacities so that the MHO's managers and members are able to learn and develop their management skills. The organizational expansion of an MHO also manifests itself by creating links with other MHOs, for example, with local networks of MHOs (as in several Western and Central African countries). It is also manifested by establishing links with micro-financing schemes or with other development actors, such as national coordination frameworks across countries

(for example, in West and Central Africa) and regional coordination with MHO promoters in the same regions.

Thus, the key issues related to organizational expansion pertain to the institutional and financial viability of MHO systems: Are MHO systems financially sustainable? Are MHO systems institutionally sustainable? What is the mode of organization and governance for MHO systems? What are the procedures for becoming a member of an MHO and systems for paying dues for households and family groups? What is the interaction scheme between MHO systems and community-based organizations?

In summary, quantitative, functional, political and organizational expansions of an MHO may have cause-and-effect relations among themselves and may influence the MHO development process. These four types of expansion identify key dimensions for evaluating the contributions that MHOs make to the expansion of health insurance. They highlight areas on which policies and programs to expand health insurance can focus to enable MHOs to play an important role as local organizations in a national health insurance system. In this context, community MHOs serve as the initial link in a risk management chain in which some basic functions of health insurance, such as community awareness, membership enrollment, dues collection, identification of the indigent, and contract management with the community health facilities are carried out by the community MHOs. Other, complementary functions are carried out by other institutional actors at the intermediate level (local MHO networks) and at the macro-social level (guarantee and/or social reinsurance agencies).

MHO network: A specific case of expansion from the bottom-up. The types of expansion addressed in the previous paragraphs apply to the specific case of an MHO taken in isolation. In addition to this micro level of individual MHOs, however, the MHO development process is also observed at a meso or intermediate level, within of a group of MHOs, for example, in a given geographical context. MHO networks serve as catalysts for the development of different types of MHO expansion.

MHO networks have major potential for contributing to the quantitative expansion of MHOs. In addition to the increase in the number of members belonging to existing MHOs, quantitative expansion is also manifested by the development of new MHOs that imitate the organizational features, routines and procedures of existing MHOs by exploiting learning opportunities offered by the experiences accumulated in the population of existing MHOs.¹³ The members of a population of MHOs in a given geographical framework may have institutional ties to carry out mid-level functions for which individual MHOs have poor comparative advantages given their relatively modest size, inadequate financial resources or limited organizational capacity.

Thus, the following key issues are related to the MHO development process at the intermediate level: How many community-based MHO systems are there? Do the community-based MHOs cover the entire country? Are there local networks of community-based MHO systems? What functions do the local networks perform? Do the networks perform risk-pooling functions? Do the networks serve as intermediaries between the community-based MHO systems and the other actors, including the central government?

Networks can fulfill various social intermediation functions for the benefit of individual MHOs in several areas:

- **Peer learning.** Learning and information-sharing opportunities between MHOs are increased considerably by the functional relationships they establish with peer MHOs. Through information-sharing, the networks serve as a framework for the selection process and the process of replicating organizational features to strengthen the adaptation of MHOs to their environment. Also, they facilitate the selection and replication of procedures and routines to strengthen MHO administration.
- **Contracting with healthcare providers.** MHO bargaining capacities with providers are enhanced when they form networks. By sharing information about care providers, the networks contribute to lowering transaction costs by negotiating contractual relationships. MHO bargaining capacities are improved when they negotiate as one voice through their network with providers at the intermediate and highest levels of the health pyramid.
- **Risk pooling and management.** MHOs can significantly improve the management of risks related to health insurance if they pool the major risks that are unpredictable for individual MHOs, but that become predictable and easier to manage if they are pooled in a large population of MHOs.
- **Advocacy.** Finally, the political expansion of individual MHOs may bear fruit in a decentralized authority. However, at the regional and national levels, expansion can work only if several MHOs or several local networks of MHOs cooperate to increase their political weight.

These different functions may become local support systems for MHOs if the relationships between MHOs are consolidated as part of a well-structured local network of MHOs. From this standpoint, the network can be seen as a type of organizational expansion in which the individual MHOs agree to expand their impact and establish significant and beneficial relationships with reference structures that provide care, such as regional and national hospitals, governments, training and research institutions and international cooperation organizations.

Context and local actors. These community processes of expanding health insurance provided by MHOs are carried out by a plurality of actors and in a diversity of economic, political, social and cultural environments. In several countries in Africa, MHOs are created, developed and managed essentially by leaders of community-based organizations and providers with the support of nongovernmental organizations (NGOs) and health development support projects with assistance from the technical and financial partners. It is likely that this pattern

¹³ See Rao, Hayagreeva and J.V. Singh. 1999. Types of Variations in Organizational Populations: The Speciation of New Organizational Form. In J.A.C. Baum and B. McKelvey (eds). *Variations in Organizational Science: In Honor of Donald T. Campbell*. SAGE Publications.

will continue to dominate the profile and interactions of actors in countries where strategic support frameworks are not yet well structured. In some countries, leadership in the promotion of MHO systems is provided by local elected officials in the context of strengthening the administrative and political decentralization movement underway in Sub-Saharan Africa. This would typically be the case when expansion is from top-down and with substantial central government support. In all likelihood, the patterns of interaction of local actors in bottom-up expansion processes will depend on the specific political context in each country.

In summary, the development of local networks of community MHOs is a specific case of expansion from the bottom-up that compensates for the deficiencies and structural limits of individual MHOs. Local MHO networks can be formalized to provide an institutional framework for risk pooling and management. With this in mind, local MHO networks serve as an intermediate link in the chain of risk management between community MHOs and mechanisms for guarantees and/or social reinsurance at the macro level. Thus, the local networks of MHOs facilitate the interface between the bottom-up expansion process inherent to the development of community MHOs and the top-down expansion process inherent in interventions by governments, training and research institutions, and international cooperation organizations.

2.4 Expansion from the top-down

Expansion from the top-down is a complementary expansion process for community-based organizations such as MHOs. Expansion from the top-down is a process by which governments, training and research institutions and international cooperation organizations adopt policies, modes of operation and procedures for significant interaction with community MHOs. This process implies efforts from the central government and other institutions in areas in which their comparative advantages are greater,

such as in technical, financial, legislative and regulatory areas.^{14,15}

The key issues in top-down expansion are related to interactions between community MHOs and governments, training and research institutions and international cooperation organizations: Is there a technical assistance program for providing support to MHO systems including assistance in management, information, training, social marketing and research? What are the modalities for providing technical assistance services? Who pays for these services? Are there financing mechanisms such as general subsidies, targeted subsidies, guarantees and reinsurance for MHO systems? Is there an insurance/guarantee fund at the macro level to support community MHOs? What are the sources and mechanisms for financing insurance or guarantee funds? Is there a statutory and regulatory framework for MHO systems? What is the process for certifying MHO systems? Is there an education and awareness program for the population in the “mutual” concept? Are these programs part of a deliberate strategic and imperative coordination framework for expansion efforts in health insurance coverage?

Technical assistance. One of the deficiencies in MHOs and the communities in which they develop is weak technical capacities. Thus, technical assistance to support the development of new MHOs and strengthening existing MHOs is essential to accelerate the quantitative expansion of MHOs. This technical assistance may include efforts to strengthen technical supervision capacities by developing training manuals and by training members of MHO initiative committees, MHO management officials and providers. It may also include capacity building and counseling support to support new MHO initiatives and the process of identifying problems and finding solutions in the existing MHOs.

¹⁴ Dror, David. 2001. Health Insurance and Reinsurance at Community Level. In David M. Dror and Alexander S. Preker (eds), *Social Re-insurance: A New Approach to Sustaining Community Health Financing*. Geneva: International Labor Office; Washington, DC: The World Bank. September.

¹⁵ Ranson, Kent and Sara Bennett. 2001. Role of Central Government in Furthering Social Goals through Microinsurance. In David M. Dror and Alexander S. Preker (eds), *Social Re-insurance: A New Approach*.

Technical assistance can also include strengthening the peer learning process through technical support for local MHO networks, documenting practices and experiences, and facilitating study tours. Finally, technical assistance has an important role to play in developing information systems to strengthen MHO management, facilitating the sharing of experiences among and between local MHO networks, evaluating progress in MHO coverage of the population and providing a basis for developing policies and programs to support MHOs.

Financing mechanisms. One of the strongest assets of community MHOs is proximity and democratic governance. This major asset, however, is generally associated with the dual challenge of their small size and limited capacity of their target population to pay. Linkages between MHOs and formal health financing mechanisms make it possible to confront this dual challenge and to leverage the potential of proximity and democratic governance of MHOs to improve coverage for the poor in the health system.

Establishing funding mechanisms based on public financing can allow for subsidization of coverage expansion, expanding benefit packages and promoting risk pooling on a larger scale. General subsidies can support the functional expansion of MHOs, allowing for funding mechanisms to support policies for better access to credit for MHO members. Several experiences with such guarantee mechanisms in the context of partnerships between MHOs and micro-finance institutions have demonstrated the mechanisms' potential for MHOs to increase membership and collect dues. Finally, policies can be put in place for subsidies to cover the indigent and vulnerable groups through MHOs, an example of how targeted subsidies can facilitate the political expansion of MHOs.

Thus, funding mechanisms can contribute to strengthening the functional expansion of MHOs in general, strengthening insurance and revenue collection functions in particular, as well as allowing for the political expansion of MHOs, and promoting equity in health financing. Such mechanisms are used in several countries as an alternative method

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for distributing subsidies in the health system (subsidizing demand). This contributes to a significant improvement in the efficiency of public expenditures and accountability while it strengthens the power of individuals and the communities in health.

Regulation. Finally, central government efforts to regulate MHOs can include promoting health education programs to inform the population of the benefits of MHOs and of their organization and operation. They may include setting up a statutory and institutional framework to ensure that MHOs are recognized, that rules are observed and that MHO members are protected.

The statutory and institutional framework plays an important role in the large-scale replication of community MHOs and setting up of funding mechanisms by aligning MHO institutional arrangements with the institutional environment of administrative and political decentralized government agencies. This alignment takes advantage of the social capital that is accumulated through building the capacities of the decentralized authorities, their structural equivalencies and fiscal relationships with three key actors, the central government and foreign partners and the decentralized authorities. Finally, this framework

may include adapting contracting policies to minimize the transaction costs associated with MHO expansion and establishing relationships with care providers.

Top-down expansion under the central government's impetus through technical assistance, financing mechanisms and regulation are typically associated with selection, replication and harmonization processes for the organizational characteristics, procedures and routines of community-based MHOs and their relationships with governmental organizations. Thus, intensive and early government intervention in the expansion of MHO-based health insurance can sometimes unfortunately generate the risks of codifying organizational, procedural and routine characteristics which are not tailored to the economic, social and cultural context or the capacities of potential community MHO members.

These risks can be minimized, however, by conducting pilot or demonstration projects to serve as platforms for the incremental development of a health insurance policy and implementation capacities depending on the stage of the policy process in a given country.¹⁶ Pilot or demonstration projects can generate the information necessary to support policy debates and reach consensus on courses of action to take in regard to expanding health insurance. They also may be a platform for adapting the grassroots health insurance organizations that will serve as the basic infrastructure for the health insurance system. They can serve as a marker to determine the fiscal relationships between the basic health insurance organizations and the formal public funding mechanisms. Finally, pilot projects can develop the information and management systems and human resources and training materials to support large-scale expansion.

The context of policies and actors. The emergence of MHOs in Sub-Saharan Africa reflects the expansion of the associative movement resulting from the democratization process that has been underway for two decades in certain countries. However, the strengthening of efforts to combat

¹⁶ Partners for Health Reformplus. August 2004. *The Role of Pilot Programs: Approaches to Health Systems Strengthening*. Bethesda, MD: PHRplus, Abt Associates Inc.

poverty since the late 1990s and the movement to expand social protection at the international level have facilitated the recognition of MHOs' social potential on a continent in which the majority of the people have no formal health insurance coverage. The emergence of MHOs in Africa has also been strengthened by the Abidjan Platform and activities and information-sharing through the *Concertation régionale des acteurs du développement des Mutuelles de Santé en Afrique de l'Ouest et du Centre (La Concertation)*.¹⁷ These movements have no doubt contributed to improving MHO visibility. They have also contributed to tensions in strategic directions and territory disputes over the supervision of MHOs due to the fact that MHOs are multisectoral. These tensions at the policy level can become a challenge to top-down expansion efforts in some countries.

However, choosing MHOs as a deliberate health insurance expansion strategy as a response to political pressures to make progress in the expansion of health insurance, results from the specific political conditions in each country and from the leadership of the political actors. In countries where political conditions are favorable and where strong political will exists for expanding social protection for health, it can be expected that comprehensive strategic support frameworks will be put in place to support expanding health insurance from the top-down. In countries where this political will is not yet apparent, much advocacy will be necessary to add the sustainable expansion of health insurance to government agendas.

¹⁷ In June 1998, the International Labor Organization (ILO), the United States Agency for International Development (USAID), Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), the National Alliance of Christian Mutual Aid of Belgium (ANMC) and the NGO World Solidarity (WSM) jointly organized a workshop in Abidjan on support strategies for MHOs in West Africa. This workshop brought together the different types of actors involved: MHO federations in Africa and other regions of the world, international organizations, cooperation agencies, local and international NGOs, healthcare providers, universities, research centers and regional workers' union organizations. The representatives of six countries and about 40 entities took part in the work. During this workshop, the Abidjan Platform was established. It is the product of the experience of many architects active in the development of MHOs in West and Central Africa. The workshop and the Abidjan Platform gave rise to the Concertation Régionale des Acteurs du Développement des Mutuelles de Santé en Afrique de l'Ouest et du Centre. See <http://www.ilo.org/public/english/protection/socsec/step/download/14p1.pdf>.

Strengthening democracy in the countries of Sub-Saharan Africa, peaceful political change and democratic handover at the highest governmental level may be particularly important to initiate or accelerate reforms to further expand health insurance coverage in the region.

In summary, expansion from the top-down is a process through which governments, training and research institutions, and international cooperation organizations adopt policies, modes of operating and procedures to provide technical assistance and set up financing mechanisms and a statutory and regulatory framework to serve as pillars in the last link of the risk management chain at the macro level in expanding MHO-based health insurance. One key element to the design of modalities for providing technical assistance services, developing financing mechanisms and promoting the statutory and regulatory framework is the design of incentive structures to motivate the people to join community MHOs and to motivate the community MHOs to join, share their information and experience, and pool risks in well-structured local networks.



Nancy Pielmeier

3. COMPARATIVE ANALYSIS OF EXPERIENCES IN SUB-SAHARAN AFRICA

The following comparative analysis of experiences in Ghana, Rwanda, Senegal, Benin, Cameroon and Niger describes the processes and mechanisms for the expansion of MHOs within the framework discussed above. Senegal and Benin were among the first countries where community MHOs emerged in Africa. MHOs in Ghana and Rwanda developed in the late 1990s, supported by lessons learned on self-management and community participation from MHO experiences in French-speaking countries. However, in the expansion of MHO-based health insurance, Ghana and Rwanda quickly moved ahead of Francophone Sub-Saharan African and many other developing countries. Consequently, their experiences are now considered full-size laboratories for the expansion of health insurance, worth more than a thousand theories on the expansion of health insurance in developing countries.

This explains why the expansion experiences of these two countries are used in this document to help analyze the expansion of MHO-based health insurance in Sub-Saharan Africa. In other words, the idea is to identify the intervention principles and mechanisms that differentiate the Ghanaian and Rwandan experiences in expanding health insurance from those of French-speaking countries in order to stimulate the debate on health insurance expansion policies throughout the countries of Sub-Saharan Africa.

3.1 Ghana

Expansion of health insurance coverage. Before 1999, Ghana had fewer than five CBHI schemes. Over the span of two years, the quantitative expansion of MHOs accelerated. The number of CBHI schemes increased to 47 in the entire country, covering roughly 87,000 beneficiaries in 2001. Similar to the health insurance scheme at the Nkoranza Hospital, the functional expansion of coverage was limited to hospitalization. The MHO expansion process was accompanied by organizational expansion, involving a change to greater community involvement in the management of CBHI schemes.

Following the government of Ghana's resolution to expand health insurance based on MHO principles in 2003, a process of quantitative, functional, political and organizational expansion of health insurance was triggered in the country as a result of the government's statutory and regulatory as well as financial and technical intervention. Quantitatively, the health insurance penetration rate at the national level increased from 1% of the population in 2001 to over 40% in 2007.¹⁸ In terms of functional expansion, benefit packages expanded to cover most health needs of Ghanaian families. In terms of political expansion, CBHI schemes now serve as channels for distributing subsidies to the poorest people and vulnerable groups for health. Finally, Ghana tailored the organization of community-based MHO systems to the institutional arrangements of decentralization with the emergence and expansion of MHO systems based on administrative districts.

Expansion process from the bottom-up. As mentioned above, Ghana had fewer than five MHOs at the end of the 1990s. Most of these early experiences were health insurance programs initiated by providers (usually hospitals) that sold their health insurance services to their catchment population. Building on the MHO experiences managed by the community, typical of the associative movement in the French-speaking countries of Africa, the Ghanaian experiences were restructured to become community-based institutional arrangements. Between 1999 and 2003, the number of MHOs in Ghana increased from four to 159, thus demonstrating communities' enthusiasm for MHOs.¹⁹ This bottom-up expansion process demonstrates the social feasibility of CBHI system organizations. It also served as a platform to develop management systems, human resources and training tools to support the expansion process from the top-down.

Expansion process from the top-down. In 2003, Ghana launched a top-down MHO expansion.¹⁹ Armed

¹⁸ Ministry of Health. 2009. Pooling together, achieving more: Independent Review – Health Sector Program of Work 2008. Draft. April.

¹⁹ Baffoe-Twum, M. And R.A. Opong. 2004. *Institutional Aspects of Scaling-Up Community-Based Health Insurance: The Case of Ghana*. AWARE-RH Project, Ghana. October.

with the newly elected president's political will, Ghana enacted a law to begin the implementation of a national health insurance system based on administrative districts (2003 National Health Insurance Act <NHIA 2003>). The district-based health insurance systems – the District Mutual Health Insurance systems or DMHI as they are called in Ghana – are a combination of the organizational features of MHOs, as their name in English indicates, and the institutional arrangements from the administrative and political decentralization now in progress in the country. Through the alignment of CBHI schemes within the district system, Ghana was able to leverage the capacities of the districts and their structural equivalence to rapidly expand health insurance to the entire country. In less than four years after NHIA 2003 was enacted, Ghana expanded the district-based health insurance system to all the districts in the country.

The 2003 NHIA established the necessary instruments to carry out a top-down health insurance expansion process: the National Health Insurance Fund (NHIF) and the National Health Insurance Council (NHIC). The NHIF is the basic instrument for the public financing of the country's national health insurance system. The fund is financed through taxes levied via the Value Added Tax (VAT) and the social security system. It plays two essential roles: (i) It ensures the equality of DMHI benefits throughout the country based on government subsidies; and (ii) it provides coverage for the indigent and vulnerable groups based on government subsidies. The NHIC regulates and provides technical support to the DMHIs. Although the DMHIs are set up by the administrative district authorities, DMHI implementation and technical assistance is supported directly by the NHIC. To better support the DMHIs, the NHIC is in the process of setting up regional offices.

3.2 Rwanda

Expansion of health insurance coverage. From just one MHO in 1999, the number of MHOs rose to 53 in 2002, covering about 100,000 beneficiaries. The political expansion of MHOs began in 2000, providing coverage for the indigent, vulnerable groups and persons living with HIV

using funding from several NGOs and a few administrative districts. There was also an organizational expansion of the MHOs with the involvement of certain administrative departments and sectors in establishing MHOs. The quantitative expansion of health insurance based on MHO systems grew substantially between 2003 and 2005. The number of MHO beneficiaries increased from 556,000 by the end of 2003 (7% of the country's population) to 3,686,000 by the end of 2005 (44% of the country's population). This was a consequence of expanding MHOs to the entire country, and also increasing the penetration of target populations. Until mid-2006, the majority of MHOs covered only minor risks, treated in health centers, and a limited package of major risks treated at district hospitals.

In mid-2006, the political expansion of MHOs took on a new dimension with the expansion of benefit packages and the institutionalization of coverage for the indigent, vulnerable groups and persons living with HIV by the government and foreign partners. The functional expansion of MHOs also grew with the expansion of benefit packages that now cover primary healthcare, secondary care and tertiary care. As a consequence of these measures, which dramatically improved the price-quality ratio for MHO services, the quantitative expansion of MHOs grew quickly in the second half of 2006, reaching a coverage of 6,283,000 beneficiaries by the end of December 2006 (73% of the country's population). By the end of August 2007, 6,497,000 Rwandans were covered by MHOs (74% of the country's population).

Integrated expansion processes from the bottom-up and the top-down. In 1998, there was only one initiative which could be identified with a community MHO and scattered experiences with provider-based health insurance schemes to facilitate access to care in a context of poverty.²⁰ The Ministry of Health (MoH) launched pilot prepayment systems in three health districts in 1999 as an initial experimentation phase, part of developing a policy to

promote MHOs in the country. It is MoH leadership that has supported MHO development since MHOs began to emerge in Rwanda, which explains the term "integrated expansion processes." MHOs developed under the supervision of the MoH and its partners (USAID, WHO, the European Union, and CARITAS and other NGOs), but did so by involving community actors in the design and by ensuring that these actors would be in charge of managing MHO systems.

Between 2001 and 2003, after the pilot experiences were evaluated, Rwanda moved to implement the recommendations of the pilot phase. The main recommendation was to adapt MHO organization to the institutional environment of decentralization. As in the pilot phase, the adaptation phase received technical supervision from the MoH, and subsequently the Ministry of Decentralization and Local Affairs, which supervised the decentralized authority and which has social protection as part of its mandate. It was the involvement of this ministry and its agencies in promoting MHOs that anchored them in the community and contributed to the extensive mobilization of the local authorities of the administrative districts and district subdivisions (sectors and cells), as well as NGOs and religious leaders, which raised the population's awareness of the importance of enrolling in MHOs. The institutional arrangements for MHOs and local MHO networks were aligned with the environment of the decentralized authorities during this adaptation phase.

Strengthening the expansion process from the top-down. Beginning in 2003, leadership at the central level was strengthened with the impetus provided by the highest authorities of the government. The MoH established a policy and strategic plan, and an MHO Technical Support Unit (to support MHO development and expansion in response to the strong demand for MHOs). To mobilize the local leadership in efforts to expand MHO-based health insurance, MHO promotion of MHOs was made one criterion for evaluating the performance of the administrative districts. Moreover, the quantitative expansion of MHOs was facilitated by adjusting MHO organization to the decentralization environment. As a

²⁰ Ndahinyaka, J. 2004. *Étude de Cas sur les Rôles des Acteurs dans le Cadre du Développement des MHOs au Rwanda*. AWARE-RH Project, Ghana. October.

consequence of implementing the expansion policy, the number of MHOs climbed from 88 in 2003 to 226 in 2004, 354 in 2005 and 392 in 2006. In 2006, all the health centers in the country had a partner MHO under the community-health center partnership. Each administrative district had a district MHO that served as a mechanism to pool the major risks for the primary MHOs.²¹

The highlight of 2006 was a crucial turning point in top-down expansion efforts in Rwanda. In June 2006, Rwanda established a National Guarantee Fund (FNG) and a District Solidarity Fund (FSD) to bolster financing mechanisms for MHO expansion in the country. The FNG and FSD system strengthens equity of access to and financing of health insurance coverage in the country through two mechanisms. First, the system supports the functional expansion of MHOs to harmonize the coverage benefits received by MHO beneficiaries and those received by the beneficiaries of the social insurance systems (Rwanda Health Insurance Company [*Rwandaise d'Assurance Maladie*, RAMA] and Military Medical Insurance, MMI).²² Second, the system supports the political expansion of MHOs by providing care for the indigent identified by the communities and for people with HIV/AIDS who have from HIV-related opportunistic infections.

The FNG is financed through contributions from the government, RAMA, the MMI, private insurance systems and foreign partners, including the Global Fund. The FSD is financed by the contributions of MHO chapters, administrative districts, transfers from the FNG and contributions from the development partners that are involved at the district level.

²¹ World Bank. Forthcoming 2009. Rwanda: A Country Status Report on Health and Poverty. The Rwanda MoH and World Bank Africa Region Human Development.

²² RAMA is the social insurance system for civil servants. The system is funded by contributions from the employees (civil servants) and the employer (the government). It was established in 2000, at the same time the MoH was supporting pilot experiments in MHOs. RAMA's target population was expanded to the semi-public organizations and now extends to businesses in the private formal sector and their employees. MMI is the equivalent of RAMA for the military.

3.3 Senegal

Expansion of health insurance coverage. Formal health insurance systems provide opportunities for social protection only for Senegalese families whose head of household is employed in the formal sector of the economy. This system leaves behind the majority of Senegalese employed in the rural and informal sectors. The government pays for a portion of healthcare for civil servants and their beneficiaries through the non-contributory system of budget allocations established in the 1960s. This regime covered approximately 820,000 beneficiaries in 2005. The contributory regime of the social protection institutions (IPMs) expanded their social protection coverage to the permanent employees of private and public businesses, and to their families, beginning with the 1975 social reforms. The IPM regime now covers about 700,000 Senegalese.²³

Since the 1980s, the non-profit insurance institutions have been emerging as MHOs among socioprofessional organizations of civil servants as well as rural and informal sectors. MHOs provided coverage for damages due to illness for 422,000 Senegalese in 2005. A few community-based MHOs provide care for the vulnerable groups with funding from NGOs.²⁴

Expansion process from the bottom-up. The process of MHO creation has accelerated during the last few years in Senegal. From 19 MHOs identified in 1997, the number of MHOs increased to 28 in 2000 and to 79 in 2003. In 2004 alone, 48 MHO initiatives were starting up in the country.²⁵ Quantitative expansion was also strengthened in several individual MHOs.

Several Senegalese MHOs began an internal functional expansion process in the late 1990s, expanding their respective benefit packages. Packages which included only

²³ Ministry of Health and Prevention, 2009. *Comptes Nationaux de la Santé – Année 2005*. Dakar.

²⁴ Sow, Ousmane. 2007. *Couverture des Indigents à Travers les MHOs: Étude de Cas sur les Expériences du Sénégal*. USAID Health Program, Financing and Health Policies Component: July.

²⁵ Republic of Senegal, 2005. *Stratégie Nationale de Protection Sociale et de Gestion des Risques*.

major risks were expanded into broader packages to include lesser risks. This functional expansion solved the member loyalty issues in the community MHO systems that had previously covered only major risks where the likelihood of benefiting was very low. Moreover, many Senegalese MHOs strengthened their organizations through functional expansion by implementing or considering small-scale lending activities to support income-generating activities for their members, in order to increase dues collection rates.

There are currently more than 130 MHOs in Senegal. The majority of these MHOs are funded essentially by membership dues. No community MHOs receives subsidies from agencies of the government of Senegal. However, MHOs do have cooperative relationships, either individually or through their regional coordination, with domestic and international NGOs, and development cooperation agencies that provide them with technical assistance that continues to be minimal.

MHO expansion in Senegal is also manifested by the dynamics of local MHO networks. The first attempts at regional coordination (Dakar, Kaolack and Thiès) were initiated by the Ministry of Health and Prevention as part of the ministry's first program to support MHOs.²⁶ In addition to these three regions, four others set up regional unions of MHOs: Diourbel, St. Louis and Louga, and more recently the Ziguinchor region. Some of these unions or regional coordination bodies support the creation of departmental organizations or unions based on the health districts to bring the network organizations closer to their MHO members, but also to adjust to the contracting frameworks being promoted by the ministry.

The networks and regional coordination bodies of MHOs in Senegal are set up to serve as a basis for various packages of services for MHO networks.^{27,28}

The MHO networks in Senegal, however, seldom have

²⁶ Wade, André. 2007. *La Mise en Réseau des MHOs au Sénégal*. In M.P. Waelkens and B. Criel (eds). 2007. *La Mise en Réseau des MHOs en Afrique de l'Ouest: l'Union Fait-Elle la Force. Les Enseignements d'un Colloque International Organisé à Nouakchott, Mauritanie: 19 et 20 décembre 2004*. April.

²⁷ Ibid.

²⁸ Ibid.

the human and technical capacities and the financial wherewithal necessary to carry out the services listed in their mandates. As far as we know, none of the MHO unions or regional coordination bodies in Senegal has risk pooling in their mandates. This function is strategically important to manage the financial risks associated with the small size and financial capabilities of the member MHOs. The coordination bodies maintain relationships with the central government agencies, and for the time being, these relationships are limited to information-sharing. No coordination bodies receive subsidies from any agency of the government of Senegal. However, the coordination bodies do maintain cooperative relationships with domestic and international NGOs and development cooperation agencies that provide them with minimal support.

Top-down expansion process. The framework for providing support to health insurance expansion based on MHOs in Senegal is limited to a law on MHOs, although the Ministry of Health and Prevention has set up a Health Financing and Partnership Support Unit (CAFSP) with a broad mandate that includes promoting MHOs. In contrast with its broad mandate, the unit's resources continue to be quite limited.

Senegal has yet to put in place a financing system to support the expansion of community MHOs. Moreover, the regulation and technical assistance functions are not yet deeply rooted. The CAFSP's support activities are already an initial milestone, but they are far from providing the support system necessary to strengthen the expansion of the country's community MHOs. Finally, the actors involved in the promotion of MHOs have set up a national forum of exchange (*Cadre national de concertation des acteurs du développement des mutuelles de santé, CNC*) that facilitates the involvement of all MHO actors in the political debate and program coordination. However, until now, the CNC has only been used for sharing information.

3.4 Benin

Expansion process from the bottom-up. The emergence of MHOs in Benin has been rapid over the last

15 years.²⁹ In 1997, there were nine functional and two nascent MHOs in the country. Between 1997 and 2003, the MHO creation process was strong. The number of MHOs increased fivefold in six years. In 2006, 142 MHOs were counted in the country.

Another hallmark of Benin's bottom-up expansion process is the growing number of local MHO networks, based mainly in the communes. For example, the MHOs supported by the *Centre International de Développement et de Recherche (CIDR)* in Borgou are organized into a network that consists of 28 MHOs and three inter-MHOs. The MHOs that are supported by the Promotion des MHOs en Afrique (PROMUSAF) program in the commune of Bembèrèké joined forces to form a network of MHOs. Through the MHO initiatives supported by USAID's Integrated Family Health Project (*Projet Intégré de Santé Familiale, PISAF*), a network of MHOs was recently founded in the commune of Sinendé and another in the commune of Banikoara.³⁰ Finally, network establishment initiatives are being discussed or implemented in other areas of the country such as the MHOs supported by BORNEfonden and the funds supported by the Association for the Development of the Agricultural MHO Movement in Benin (*Association pour le Développement de la Mutualité Agricole au Bénin, ADMAB*).

The MHOs and their respective support structures are in the process of promoting partnerships with existing organizations at the local level to enhance the institutional and financial viability of the MHOs. In many MHO initiatives, these partnership relations are strategic components of the integrated MHO development

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approach. In others, they contribute to strengthening local systems to support the development of MHOs in partnership with the development associations and the health center management committees.

Expansion process from the top-down. The will of the government of Benin to support and supervise MHO development is beginning to manifest itself with recent MoH initiatives. The promotion of MHOs is one of the main strategies to improve financial accessibility to healthcare in health sector development policy and strategy documents. An MHO development policy paper was validated with the participation of actors involved in MHO development. Finally, support for MHO development is part of the mission of the Community Health Service of the National Health Protection Directorate (*Direction Nationale de la Protection Sanitaire*).

However, the policy framework to support MHO development in Benin has some weaknesses. First, due to the lack of a legal framework specific to MHOs, most of the MHO initiatives in Benin use the provisions of the 1901 Association Act to legally create MHOs. Others use the legal framework for cooperatives. These general frameworks not only lack specific features relative to the realities of MHOs, but their use can also create some confusion in terms of supervision and regulation. With this knowledge in hand, several actors agreed that it was

²⁹ PROMUSAF. 2009. *Réseaux de Mutuelles de santé au Bénin, état de lieux et perspectives. Journées de la Mutualité de Bembèrèké*. February.

³⁰ Partners for Health Reformplus. 2005. *Stratégies novatrices de développement des mutuelles de santé*. PHRplus, Senegal, Abt Associates Inc. December.

necessary to adopt a law on MHOs in order to create a bona fide MHO movement in Benin. Since July 2005, the MoH, with the support of the ILO-Strategies and Tools against Social Exclusion and Poverty (ILO-STEP), began the process of preparing an MHO code in Benin, as part of a sub-regional initiative of the West African Economic and Monetary Union countries.

Second, in view of the lack of a legislative framework that specifies the responsibilities and indicates the central bodies in charge of supervision, the institutional support system remains weak, because several governmental supervision bodies have jurisdiction over MHOs.

There is not yet any central support body that has sufficient authority in terms of its hierarchical level and human, financial and physical resources, to monitor the implementation of the policy and strategy to develop MHOs. Because of weak support at the strategic level, the roles of the departmental and local levels, whether they are deconcentrated or commune units, have yet to be determined. Several health zones and communes are currently involved in the promotion of MHOs in their respective jurisdictions, but there is no strategic orientation or any mode of support from the central level for these local initiatives.

Finally, the weaknesses of the strategic support structure are characterized by the absence of financing mechanisms such as premium subsidization, guarantees, reinsurance, etc., for promoting the MHOs in Benin. Only BORNEfonden, an NGO, has a local subsidization program to promote provisions for the future and MHO membership.

However, support for MHO development in Benin is beginning to find a certain structure. In 1997, it was difficult to find more than three organizations involved in promoting the MHO concept at an operational level. Only the CIDR, the Obota Africa Center (Centre Afrique Obota, CAO), and the Benin Participation Institute (Institut de Participation du Bénin, IPB) had programs to promote MHOs in the country. However, since 1998, there has been an increase in the number of organizations involved in

promoting MHOs in Benin, and this is for a large part, due to the influence of the Abidjan Platform and the growing strategic interest that international bodies, bilateral cooperation bodies and both international and domestic NGOs, are expressing in the MHO concept and social protection for health. These organizations have set up a framework called the National Cooperation Frame of Supporting Structures to Healthcare Mutual Companies (*Concertation Nationale des Structures d'Appui aux MHOs, CONSAMUS*).³¹ Finally, MHO promoters in Benin are active in the La Concertation (*Concertation régionale des acteurs du développement des MHOs en Afrique de l'Ouest et du Centre*).

3.5 Niger

Expansion process from the bottom-up. Niger has recently seen an emergence of rural MHOs that cover a given geographical area, such as a village or commune, or groups and associations of men and/or women. In 2000, the inventory of MHOs commissioned by La Concertation found two initiatives in the country (Bella and Kourni).³² The 2003 inventory revised the figures upward and three operating rural MHOs were identified. By 2008, the number of MHOs had increased to 17. Between 2003 and 2008, an organizational change in the prepayment systems run by the providers moved toward member-managed CBHI schemes.³³

Today the quantitative expansion of MHOs is facilitated exclusively through learning opportunities, study tours and information-sharing in the institutions active in promoting these initiatives in Niger. Consequently, it comes as no surprise that nearly all the MHOs that are operating in the country have almost the same fundamental parameters. The functional expansion of MHOs is limited by the low amount of dues on the one hand and by the nonexistence of MHO networks throughout the country that provide coverage for secondary and tertiary healthcare, on the

³¹The first coordination framework between actors in the development of MHOs was established in Benin in September 1997, following the meeting to report on and discuss the results of the CIDR project in Parakou.

³² Proceedings of the *Forum de la Concertation*, Dakar, September 2000.

³³ Republic of Niger. 2008. *Plan Stratégique de Développement des mutuelles de santé*. Ministry of Public Health.

other. Benefit packages are limited solely to the healthcare that is available in the integrated health centers (*centres de santé*) that offer primary healthcare, except for some coverage transporting patients to the regional hospitals. AFUA, an NGO, added a network of MHOs in Zinder to its current program to provide care in the Zinder hospital and birthing center.³⁴

Expansion process from the top-down. The development and expansion of MHO-based health insurance in Niger is based on a system that includes the April 2008 law, whose implementing regulation has not yet been adopted. The law places the Ministry of the Civil Service and Labor in charge of supervising and regulating MHOs, but it does not provide technical support, nor does it promote MHOs, as the Ministry of Public Health has been assigned these activities until the present.³⁵ Despite including MHO development in the government's policy papers, and despite the institutional vagueness regarding MHO supervision that continues to thwart progress in the implementation of a strategic framework to support MHO development, an MHO development support unit was put in place in the Ministry of Public Health. However, it has insufficient human, technical and physical resources to carry out its duties.

Niger also has a national coordination framework between actors in the development of MHOs, but it is sluggish. A MHO Development Strategy Plan (*Plan stratégique de développement des Mutuelles de Santé*) was developed and adopted in April 2008 and includes development, promotion and advocacy activities, but obviously, none of these activities has been carried out due to the lack of an implementation plan. Even if the issue of funding for scaling up has not yet been raised, it is certain that partners to support MHO development exist. In fact, in Niger there are many development partners (such as the WHO, UNICEF, the UNFPA, the Netherlands Development

³⁴ AFUA established "*gestion de la santé par les initiatives locales*" (health management by local initiatives) on May 28, 2002. This organization in Niger works in three of Niger's eight regions: Diffa, Zinder and Maradi. It is the first local NGO to support MHOs in Niger.

³⁵ Mbengue, Cheikh and Abdoulaye Ba. March 2009. *Rapport de mission d'évaluation des besoins en renforcement des capacités du Cadre Nationale de Concertation du Niger*. Bethesda, MD : Health Systems 20/20

Organization [SNV], international NGOs such as Care, Save the Children, Plan Niger, and local NGOs) that have been working to develop MHOs over the past three years through experiences that are highly localized, but which could play a very important role in the expansion of CBHI in Niger.

3.6 Cameroon

Expansion process from the bottom-up. MHOs began to emerge in Cameroon in the late 1990s. In 2003, the inventory organized by *La Concertation* counted 21 functional MHOs in the country. These experiences were diverse and included several types of MHOs, in particular community MHOs, workplace MHOs to provide care for illness, MHOs founded by care providers, and MHOs created by religious congregations. These experiences were initiated in both rural and urban areas. Between 2003 and 2008, the number of MHOs increased fivefold. In 2008, 107 functional MHOs were identified, although they were unevenly distributed throughout the country.³⁶ The majority of these are community rural MHOs. Some of them are relatively large; for example, the Kumbo MHO has 14,000 beneficiaries, and the Nylon MHO in Douala has 11,000.

The functional expansion of MHOs in Cameroon is characterized by relatively broad packages of benefits even at the initial phase. The vast majority of MHOs provide 75–100% coverage for primary and secondary healthcare.³⁷ This pattern is specific to Cameroon, since in many countries, primary healthcare is covered by the individual MHOs, while secondary and tertiary care is more often covered by the network the MHO belongs to, networks that are not put in place until several years after member MHOs are created.

The creation of MHO networks is another important factor in their expansion, although this is relatively recent. Today there are four MHO networks and two provincial networks in the country. In northern Cameroon, the N'Gaoundéré provincial network on its own brings together 18 MHOs

³⁶ SAILD. Nd. *Rapport sur la situation des mutuelles de santé au Cameroun*.

³⁷ *Réplication de bonnes pratiques AWARE-RH/SAILD, rapports d'étape 2005-2008*.

and 15,500 beneficiaries.³⁸ These networks provide mediation functions for individual MHOs, negotiating agreements with healthcare providers, and communication with local authorities as part of the regulation of MHO operations, including facilitating certifications and other administrative procedures.

Expansion process from the top-down. The impetus for the expansion of MHOs in Cameroon is essentially driven by the system created to support the process of implementing MHOs in the country. In fact, in addition to the central government, there are several technical and financial partners that, through various financing mechanisms, support the process through local NGOs working throughout the country, such as Support Service to Grassroots Initiative of Development (SAILD). The Belgian, French, Swiss and Dutch development cooperation agencies, as well as the GTZ, are very active in promoting MHOs in the country and they include CBHI in their health projects and programs.

In 2001, Cameroon prepared the health sector strategy, which aims to institute social protection in health and risk-sharing throughout the country. Specifically, the idea is to (i) have communities create at least one MHO in each health district by 2010; and (ii) have MHOs cover at least 40% of the population by 2010. With this in mind, a system to support the development of MHOs was set up with an MHO Support Unit in the Ministry of Public Health. Its task is to promote MHOs in the country to improve the people's access to healthcare.

To strengthen this system further, an inter-ministerial committee was established by the authorities to support the process. This committee brings together the appropriate ministries, in particular the Ministry of Public Health and the Ministry of Employment and Social Protection, as well as other actors in the development of MHOs, to reflect on the ways and means to be implemented to develop CBHI in the country. A platform of MHO promoters with 41 members from the ministries involved, local and international NGOs,

³⁸ AWARE-RH, SAILD and UNICEF. 2008. *Réplication des bonnes pratiques dans la prise en charge des soins de santé de la reproduction, atelier national de dissémination*, Yaoundé, March.

as well as technical and financial development cooperation partners (both bilateral and multilateral) was established in 2006. This body has a functional headquarters which is used not only as a resource center, but also as a permanent secretariat. In addition, it prepares a newsletter entitled *Entre Nous les Acteurs* (Between Us -the actors) and it has a web site.³⁹ Each year it organizes a general assembly for sharing and exchanges, during which a major theme on MHO development is presented and discussed by the participants to encourage debate on the major challenges of the development of MHOs in Cameroon.

Since 2005, Cameroon, like the other West African countries, has set up a *Cadre National de Concertation* (CNC) that serves as a framework for learning and for sharing information and experiences. In 2005, this coordination framework prepared the first strategic plan for the development of MHOs in Cameroon, and the plan was revised and adopted in 2006. More generally, a steering committee in charge of reforming social security is operating under the supervision of the Ministry of Employment and Social Protection; it concentrates on mechanisms to expand social protection in Cameroon.

In an effort to support MHO development, even though there is not yet a financing system to support this expansion of MHOs, the central government plans to establish regional reinsurance funds in order to support MHO efforts to cover the most expensive risks. Along these same lines, technical units to monitor the MHOs and a national center to promote MHOs with branch offices in the country's regions and departments will be established to bolster central government efforts to promote MHOs.

³⁹ <http://www.platformmecm.org/>

4. LESSONS LEARNED ABOUT THE EXPANSION OF HEALTH INSURANCE

Health insurance expansion in Ghana and Rwanda over the past 10 years began with coverage of less than 1% of the population. Today health insurance coverage has increased to more than 50% of the population in Ghana, and to more than 80% in Rwanda. These experiences suggest that several other countries in Sub-Saharan Africa can expand their social health protection coverage to the majority of their people employed in agriculture and the informal sector.

MHO-based health insurance expansion initiatives in Ghana and Rwanda are still relatively recent, but they are producing results. Although they are new, the experiences of these two countries can help to identify principles that can aid in structuring policy discussions and strategic directions in the countries of Sub-Saharan Africa that wish to build on emerging MHOs to expand health insurance to the informal and rural sectors. The comparative analysis in the previous section identifies key principles that have important implications for the expansion of health insurance policies and strategies in the rural and informal sectors.

First, the expansion of health insurance needs to be supported by a strong political will and leadership at several levels in order to sustainably mobilize and coordinate the efforts of several actors at the national and local levels. The expansion of health insurance in Ghana and Rwanda was supported by the highest political authorities, the ministries of health and local affairs, and the local authorities.

Second, the principle of equity in financing is common to the experiences of both Ghana and Rwanda, and is not visible in the French-speaking countries covered by this comparative analysis. In Ghana and Rwanda, this principle is reflected by the desire to offer to all citizens, with no exceptions, access to a minimum package of healthcare and to minimize the impact of the financial risks associated with disease on their income. The principle of equity is manifested by establishing financing mechanisms so that the

wealthiest citizens subsidize the poorest citizens.

Third, the synergy between national and local solidarity, which is the core of both the Ghanaian and Rwandan experiences, is lacking in the French-speaking countries that were included in the comparative analysis. Furthermore, the current mechanisms for financing health in most Sub-Saharan African countries use a combination of public financing (based on the principle of national solidarity) and payment by users (private financing). Ghana and Rwanda have launched reforms to build health financing through the synergy of the two financing systems that integrate the principles of solidarity and prepayment: public financing (again, the national solidarity principle); and the MHO concept and community MHOs (incorporating principles of solidarity, mutual assistance, and prepayment at the local level).

Fourth, place of residence is the basis for health insurance schemes and MHOs in both countries that achieved massive expansion of health insurance coverage. Ghana and Rwanda used the geographical framework in their decentralized authorities (the districts) to organize their health insurance schemes around residence. This was facilitated by the decentralization processes in the two countries that have devolved financial and administrative responsibilities to the administrative districts. Through this alignment with the institutional environment of decentralization, they were able to take advantage of the structural equivalence and the political and technical capacities of the decentralized authorities to quickly establish CBHI schemes throughout the country.

These are the four principles at the core of the strategies to expand health insurance both from the bottom-up and the top-down, strategies which function along community MHO principles, and which today show positive results in Ghana and Rwanda. Building on the MHO dynamics, the expansion of the associative movement, the irreversible movement of decentralization, and the institutional arrangements for administrative and political decentralization, other countries in Sub-Saharan Africa could use the same principles to expand health insurance

coverage. If the MHOs are to serve as a strategy to expand health insurance to the rural and informal sectors, it is nonetheless crucial that MHOs and the central government maintain significant interaction for the MHOs.

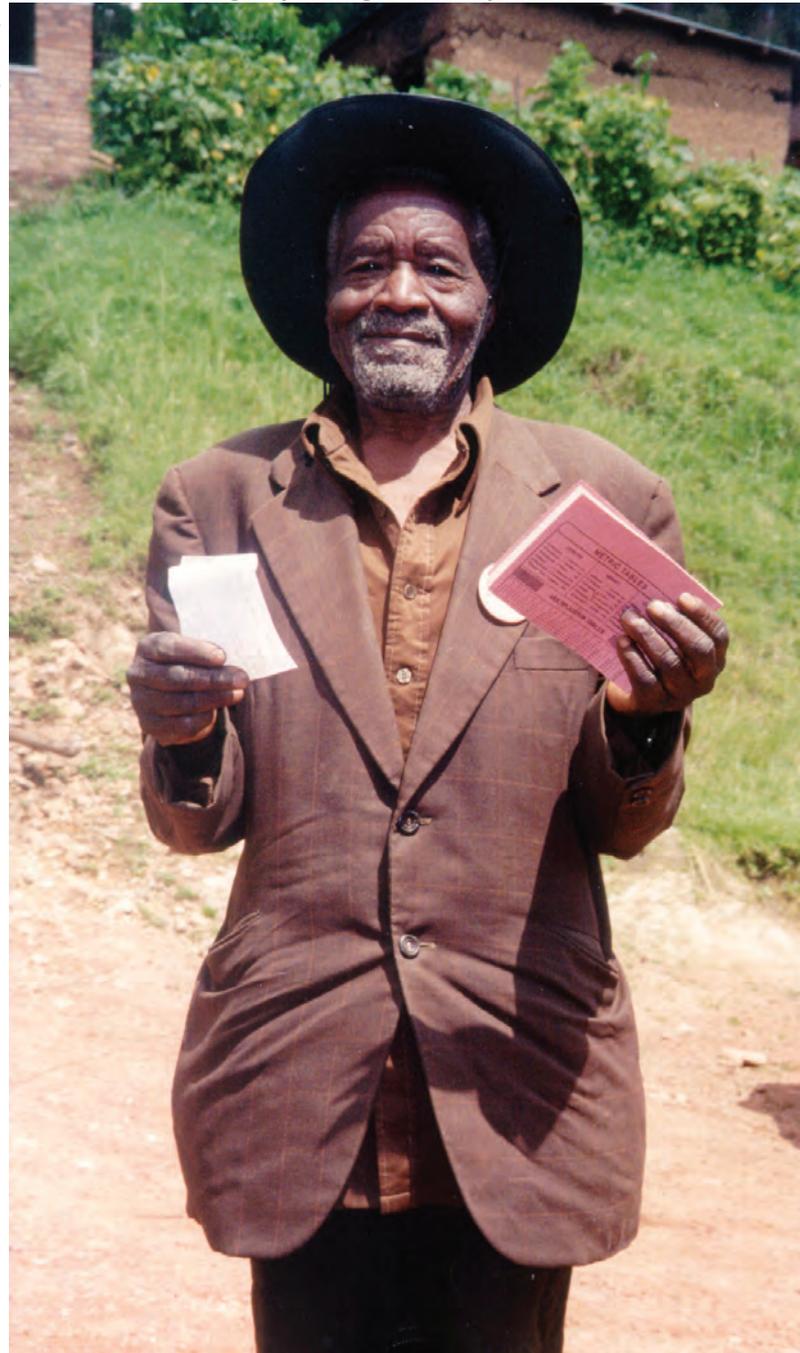
The expansion of the MHOs should be functional and organizational. The fundamental parameters of the MHOs should tend toward greater harmony to facilitate interaction with the initiatives by public authorities. Ghana and Rwanda have expanded and harmonized MHO benefit packages so that all their citizens have access to a minimum benefit package that is comparable throughout the country for the wealthiest categories of the population and for the poorest. Moreover, Ghana and Rwanda have harmonized their dues policies for community MHOs. Through these efforts, subsidization policies were devised and implemented to support the expansion and harmonization of benefit packages and to provide care for the indigent and vulnerable groups through MHOs.

It would be desirable for MHOs to be organized around social groups where size would make risk pooling possible. Ghana and Rwanda organized their community MHOs around administrative districts since their size is sufficient for risk pooling. The average population of an administrative district in Ghana is approximately 150,000, while most of the administrative districts in Rwanda have a population of 200,000 to 300,000. Rwanda built its system using existing MHOs and incorporated them as subdivisions of district MHOs. Rwanda also gave them an important role in recruiting members, collecting dues, and identifying the indigent, while allowing them to manage the resources they collect from membership dues at the local level.

The government should tailor its initiatives to create a framework of incentives for local MHO actors. One of the major current weaknesses in the development of health insurance and MHOs in the Francophone African countries covered by this comparative analysis is the lack of financing mechanisms and the weakness of the central- and intermediate-level technical assistance mechanisms with which to support the promotion of health insurance. By

contrast, Ghana and Rwanda used the principles above as a platform from which to establish a financial architecture based on a national- and district-level solidarity funds for financing community MHO systems. In Ghana, the national fund is financed from the VAT and levies from the social security system. In Rwanda, the national fund is financed through contributions from central government budget, from the social insurance system and private insurance systems, as well as from foreign partners. Moreover, they created a central agency to regulate and provide technical

Photo Georges Rotigire



ABBREVIATIONS AND ACRONYMS

ADMAB	<i>Association pour le Développement de la Mutualité Agricole au Bénin</i> (Association for the Development of the Agricultural MHO Movement in Benin)	HIV	Human Immunodeficiency Virus
CAFSP	<i>Cellule d'Appui au Financement de la Santé et du Partenariat</i> (Health Financing Support and Partnership Unit)	ILO/STEP	International Labor Organization – Strategies and Tools against Social Exclusion and Poverty
CBHI	Community-based health insurance	IPM	<i>Institutions de prévoyance maladie</i> (Social Protection Institutions)
CIDR	<i>Centre International de Développement et de Recherche</i> (International Development and Research Center)	MHO	Mutual Health Organization
CNAM	<i>Conseil National d'Assurance Maladie</i> (National Health Insurance Council)	MMI	Military Medical Insurance of Rwanda
CNC	<i>Cadre National de Concertation des Acteurs du Développement des mutuelles de santé</i> (National Coordination Council)	MoH	Ministry of Health
CTAMS	<i>Cellule Technique d'Appui aux Mutuelles de Santé</i> (MHO Technical Support Unit)	NHIA	National Health Insurance Act
DHS	Demographic and Health Survey	NHIC	National Health Insurance Council
DMHI	District Mutual Health Insurance	NHIF	National Health Insurance Fund
FNAM	<i>Fonds national d'assurance maladie</i> (National Health Insurance Fund)	NGO	Nongovernmental Organization
FNG	<i>Fonds national de garanties</i> (National Re-Insurance Fund)	PROMUSAF	<i>Promotion des mutuelles de santé en Afrique</i> (Organization for the Promotion of MHOs in Africa)
FSD	<i>Fonds de Solidarité du District</i> (District Solidarity Fund)	RAMA	<i>Rwandaise d'Assurance Maladie</i> (Rwanda Health Insurance Company)
		SNV	Netherlands Development Organization
		UNFPA	United Nations Population Fund
		UNICEF	United Nations Children's Emergency Fund
		USAID	United States Agency for International Development
		VAT	Value Added Tax
		WAEMU	West African Economic and Monetary Union
		WHO	World Health Organization

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