

Workshop Summary: PHRplus Community- Based Health Financing Coordination Meeting

Information
Sharing, Key
Findings,
Knowledge-
Building Needs

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Mission

The Partners for Health Reformplus (PHRplus) Project seeks to improve people's health in low- and middle-income countries by supporting health sector reforms that ensure equitable access to efficient, sustainable, quality health care services. In partnership with local stakeholders, PHRplus promotes an integrated approach to health reform and builds capacity in the following key areas:

- ▲ *better informed and more participatory policy processes in health sector reform;*
- ▲ *more equitable and sustainable health financing systems;*
- ▲ *improved incentives within health systems to encourage agents to use and deliver efficient and quality health services; and*
- ▲ *enhanced organization and management of health care systems and institutions to support specific health sector reforms.*

PHRplus advances knowledge and methodologies to develop, implement, and monitor health reforms and their impact, and promotes the exchange of information on critical health reform issues.

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The opinions stated in this document are solely those of the authors and do not necessarily reflect the views of USAID.

Abstract

PHR*plus* held a workshop on January 30, 2002 to discuss the work PHR*plus* has done with community-based health insurance/financing (CBHI/F). The purpose of the meeting was to exchange information, reflect on lessons learned, identify outstanding questions, and promote better information sharing across the project. The team recognized the continuing need for technical assistance to CBHI/F schemes especially in the areas of financial management and training. The team also concluded that as the schemes become larger and multiply, technical assistance must be provided in a more economical way.

Given the experience PHR*plus* has in the field of CBHI/F schemes, workshop participants felt that facilitating information sharing on this subject is crucial. The idea of creating a portion of the website for best practices and discussion on the CBHI/F schemes was one such idea for promoting exchange. Workshop participants recognized that it is important to learn as much as possible from the activities PHR*plus* is undertaking presently. Monitoring and evaluation of technical assistance and some in-depth research into CBHI/F is needed.

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Acronyms

CBHF	Community-based Health Financing
CBHI	Community-based Health Insurance
CHF	Community Health Fund
MHO	Mutual Health Organization
NGO	Non-governmental Organization
PHR<i>plus</i>	Partners for Health Reform <i>plus</i>
USAID	United States Agency for International Development

Executive Summary

PHR*plus* held a workshop for all PHR*plus* staff working on CBHI/F and MHOs on January 30, 2002 in Bethesda, Maryland. Overall the meeting's purpose was fourfold:

- ▲ To exchange information about PHR*plus* work on CBHI/F and MHOs across countries and project areas
- ▲ To reflect upon what PHR*plus* has learned to date from providing technical assistance in the context of the global debate
- ▲ To identify key outstanding questions about CBHI/F and what PHR*plus* can contribute to answering these questions
- ▲ To agree on how PHR*plus* can promote better information sharing, dissemination and collaboration across the project

This is a brief document summarizing the events of the day. The meeting was structured into two main sections:

1. Lessons learned from past and current CBHI/F schemes
2. What we still need to learn about CBHI/F schemes.

While there are few commonalities shared by all the CBHI/F schemes discussed, there were some similar “lessons learned” that emerged. Popularity of CBHI/F schemes with local populations was almost universal. Technical assistance on financial management, operations procedures and training is a felt need across all the schemes and continues to be a crucial service PHR*plus* provides. However, as CBHI/F schemes become larger and multiply, technical assistance must be provided in a more economical way.

Shared concerns across all schemes include the role politics and the government can play in CBHI/F expansion and success. The impact that CBHI/Fs have on the moderately poor versus the poorest of the poor is also unclear and needs attention.

The workshop showed the PHR*plus* team that it is useful and important to share experiences across countries. PHR*plus* needs to find mechanisms to facilitate this interaction. The idea of a special section of the PHR*plus* website for information sharing and gathering best practices was suggested as one such mechanism.

Given the significant scale of PHR*plus* activity in this area and the existing knowledge gaps, we need to ensure that we learn as much as possible from the activities we are currently undertaking in Africa and elsewhere. Monitoring and evaluation of our technical assistance activities on a regular basis should be given high priority. PHR*plus* will also pursue in-depth research in this area focusing on one or two of the topics discussed during the afternoon session of the workshop.

1. Introduction

1.1 Meeting Purpose

PHR*plus* held a workshop among all PHR*plus* staff working on community-based health insurance and community-based health financing (CBHI/F) and mutual health organizations (MHOs) on January 30, 2002. Overall the meeting's purpose was fourfold:

- ▲ To exchange information about PHR*plus* work across countries and project areas
- ▲ To reflect upon what PHR*plus* has learned to date from provided technical assistance in the context of the global debate
- ▲ To identify key outstanding questions about CBHI/F and what PHR*plus* can contribute to answering these questions
- ▲ To agree on how PHR*plus* can promote better information sharing, dissemination, and collaboration across the project

1.2 Structure of the Workshop

This is a brief document summarizing the events of the day. The meeting was structured into two main sections:

1. Lessons learned from past and current CBHI/F schemes, and
2. What we still need to learn about CBHI/F schemes.

See Annex A for the workshop agenda. See Annex B for a list of participants.

1.3 Working Definitions

Community-based Health Insurance/Financing Scheme- any scheme managed and operated by an organization, other than government or a private for-profit company, that provides risk pooling to cover the costs (or part thereof) of health care services. The scheme is voluntary in nature but could be owned by a variety of organizations and covers a variety of benefit packages.

Special examples of CBHI/F schemes are:

Mutual Health Organizations or “Mutuelles de Santé”- autonomous, non-profit community or enterprise-based health financing schemes based on the up-front contributions of many people for the health care costs of a few. Contributions are rated on a community basis as opposed to an individual basis. MHOs attempt to maintain democratic accountability to their members and promote solidarity and mutual aid between members. MHOs can increase access to health care by reducing financial

barriers, enable access to quality health care for marginalized sections of the population, help stabilize the incomes of poor people, contribute to resource mobilization for the health sector, and help make public providers more efficient and responsive to consumer needs. MHO is a term specific to Ghana.

¹ “Mutuelles de Santé” are found in francophone West Africa.

Community Health Fund (CHF)- a voluntary community-based financing scheme whereby households pay contributions to finance *part* of their basic health care services to *complement* the government health care financing efforts.² The CHF term is specific to Tanzania.

¹ Apoya presentation, 30 January 2002

² Community Health Fund Act, 2001

2. Lessons Learned about CBHI/F Schemes

2.1 Tanzania Presentation – Ongoing Work of PHR*plus* (Grace Chee)

Community Health Fund in Tanzania

The Community Health Fund began as a pilot program in December of 1995 as a component of the larger Tanzanian health financing strategy (which includes cost sharing with hospitals and a national health insurance scheme). According to the Tanzanian CHF Act of 2001, “CHF is ... a voluntary community-based financing scheme whereby households pay contributions to finance part of their basic health care services to complement the Government health care financing efforts.”³ It is further complemented by a social health insurance fund for formal sector workers. In practice, the CHF concept in Tanzania is understood by communities and health staff to encompass both user fees and the pre-payment program.

The objectives of the CHF in Tanzania are:

- ▲ To mobilize community financial resources
- ▲ To provide quality and affordable health care services through a sustainable funding mechanism
- ▲ To improve health care services management through community empowerment⁴

In 1998, CHF expanded to 10 districts. The CHF Act passed in April 2001 aims at expanding CHF to all rural districts by the end of 2003. In order to help create a plan of action for this massive growth, PHR*plus* conducted an assessment of the Hanang district in December of 2001 to identify strengths and weaknesses of the existing CHF program there.

The objectives of PHR*plus* work with CHF in Tanzania include:

- ▲ To assess the CHF to identify strengths and weaknesses
- ▲ To provide technical assistance to improve the performance of CHF in Hanang District
- ▲ To test the impact of implementation changes
- ▲ To use the experience in Hanang district to strengthen the CHF in other districts
- ▲ To compile tools and lessons learned to support implementation throughout Tanzania
- ▲ To contribute to regional knowledge on how to implement community-based financing schemes

³ Community Health Fund Act, 2001

⁴ Ibid.

To assess the CHF in Hanang, the team used key informant interviews, reviews of reports and documents, site visits to both public and private dispensaries and health centers, focus group discussions and patient exit interviews. The team focused on CHF membership and utilization, management and organizational structure, financial management, policy for exemption from fees, and the general public's knowledge and attitudes toward the CHF program.

Planned PHR*plus* activities for 2002 in Tanzania:

- ▲ Present findings in Hanang District March/April 2002
- ▲ Develop work plan for coming year March/April 2002
- ▲ PHR*plus* will continue to provide implementation assistance
- ▲ PHR*plus* plans to conduct an assessment after one year to measure results
- ▲ PHR*plus* will document work and results and disseminate them broadly within Tanzania and region

Lessons learned and conclusions:

- ▲ Membership levels in CHF programs are lower than anticipated (around only 2.8 percent of target population in Hanang District)
- ▲ CHF membership levels and revenues from premiums are both decreasing
- ▲ There has been a modest increase in user fees collected since the implementation of the CHF (1998-2001)
- ▲ The District Council is not implementing a proposed exemption policy that would allow free membership into the CHF for those that are unable to pay because the lists of proposed persons to be exempted are "too long"
- ▲ Most people have heard of CHF but level of detailed knowledge varies
- ▲ The opinions of most target populations were generally favorable
- ▲ High cost of premiums was cited as a barrier to entry into the CHF
- ▲ There is a need to clarify within Tanzania the CHF objectives and what it can accomplish
- ▲ Although most people think of CHF as insurance, the main risk pooling still occurs through government budgeting revenues
- ▲ CHF (including user fees) has had a positive impact on funding availability at the local level
- ▲ Capacity building is still needed in areas of financial management, operations procedures, data analysis, and marketing/promotion of CHF
- ▲ The political push to expand CHF rapidly might compromise effective implementation

Issues that still need to be addressed:

- ▲ Implementation of national exemption policies at the local level
- ▲ Assessment of impact of CHF benefit to working poor (as opposed to poorest of poor)
- ▲ Appropriateness of insurance for primary health care services
- ▲ Assessment of benefits of high levels of enrollment

- ▲ Discussion of possible expansion of CHF to be an insurance scheme to cover higher cost services

2.2 Ghana Presentation – Ongoing Work of PHR*plus* (Patrick Apoya)

CBHI/F Schemes in Ghana

Since 1985, Ghana has sought to finance health care delivery through several different methods. These include different kinds of geographically based mutual health organizations, social health insurance for the formal sector, and private health insurance. Within these three categories, the Ghanaian government estimates that private health insurance and social health insurance cover only an estimated 15 percent of the population. MHOs are expected to cover the remaining 85 percent of the population. Because MHOs are expected to cover such a large percentage of the population, the technical assistance PHR*plus* provides is crucial.

Since 1985, the objectives of health care financing in Ghana include:

- ▲ Cost recovery*
- ▲ Increased community participation in management and financing of health care
- ▲ Increased quality of care

The objectives of PHR*plus* work with CBHI/F schemes in Ghana include:

- ▲ Assisting existing MHOs through capacity strengthening
- ▲ Continuing promotion of MHOs throughout Ghana especially to underserved regions
- ▲ Helping to develop a national financing strategy
- ▲ Assisting MHOs to advocate for better quality of care provided to MHO members
- ▲ Promoting the expansion of MHO benefits to include reproductive health, HIV/AIDS support and maternal/childcare services
- ▲ Improving efficiency of project management and coordination
- ▲ Monitoring the impact of PHR*plus* activities

PHR*plus* has been able to meet many of the objectives outlined above. Recent achievements of PHR*plus* in Ghana include:

- ▲ Increased awareness of the MHO concept (Before PHR interventions began in 1999, few knew about MHOs despite the existence of MHOs in Nkoranza and Damongo)
- ▲ An increase in actual number of MHOs (from four in 1999 to 47+ in 2001)
- ▲ Development of local management capacity of MHOs
- ▲ A shift towards participatory models of MHOs and away from provider-owned schemes

* In the 2001 presidential election, the mandate of full cost recovery for health care financing was amended to partial cost recovery. The issue remains in flux.

- ▲ Development of training tools and educational materials including:
 - △ A “Training of Trainers” manual for MHOs in Ghana
 - △ A pamphlet providing information and facts about MHOs
 - △ An informational leaflet about MHOs
 - △ A documentary film of MHO best practices (including a local version in the Twi language)
 - △ An information management tool for MHOs
- ▲ Development of technical expertise pool to support MHOs including research on technical information
- ▲ Additional targeted support of specific MHOs:
 - △ Nkoranza scheme: After a nine-year period of stagnation, the scheme has had the most remarkable growth of its history- from 30,000 to more than 48,000 members after PHR interventions
 - △ Tiyumtaaba scheme: Decentralization of management to individual village level and managed mostly by nonliterate community members
- ▲ Production of reports including:
 - △ An evaluation report on the Nkoranza scheme
 - △ A report of a survey of health financing in Ghana
- ▲ Special initiative for the Ashanti Kingdom (which includes the Ashanti region and parts of the Brong, Ahafo, Eastern, and Volta regions) to promote MHO development in partnership with the King of the Ashanti

Planned PHR*plus* activities for the year 2002 in Ghana:

- ▲ Conducting a costing study for Komfo Anokye Hospital
- ▲ Conducting a viability analysis for the Ashanti Civil Servants Scheme
- ▲ Conducting a feasibility analysis for Aninwah Community Health Insurance Scheme (currently defunct)
- ▲ Explaining the MHO concept to policy makers including a one day workshop for the Parliamentary sub-committee on health
- ▲ Explaining the MHO concept to media practitioners including a one day media workshop on advocacy and the basic concept of MHOs
- ▲ Providing technical assistance for the design of specific social reinsurance-type fund (Otumfuo Health Fund)
- ▲ Disseminating findings of the health care financing study completed in September 2001
- ▲ Continuing technical assistance (training, feasibility studies, and scheme design) to specific MHOs
- ▲ Developing more resource persons for the region
- ▲ Strengthening administrative support through new office location in Kumasi and expanded support staff

Lessons learned and conclusions:

- ▲ Exploding MHO growth requires more economical ways to provide technical assistance
- ▲ Participatory models tend to work better than provider owned ones
- ▲ Programs have increasingly shifted to participatory approaches.
- ▲ MHOs play an important role in social development and can enhance the role of civil society
- ▲ Stakeholders starting schemes tend to copy design of existing schemes hence PHR*plus* found it important to correct flawed design of well-known schemes
- ▲ Expansion of benefits package is an important adjustment to increase participation
- ▲ Exploring reinsurance as a possible buffer between MHOs and external threats

Issues that still need to be addressed:

- ▲ Excessive political and/or external interest threatens to overtake the process and may “swamp” schemes.

2.3 Mali Presentation – Ongoing Work of PHR*plus*

MHOs in Mali

The concept of MHOs in Mali is relatively new. In cooperation with the government, PHR*plus* is implementing four pilot MHOs in two locations.

The objectives of MHOs in Mali are:

- ▲ To increase access to health care
- ▲ To improve the quality of health care available
- ▲ To improve service delivery

The objectives of PHR*plus* work with MHOs in Mali include:

- ▲ Implementing MHOs in Mali
- ▲ Documenting the processes in which MHOs are implemented
- ▲ Evaluating the impact of MHOs on the utilization of health services
- ▲ Assisting the government to improve health policy using the results of MHO projects

Recent achievements of PHR*plus* in Mali include:

- ▲ Baseline studies in Bla (rural setting) and Sikasso (urban setting)
- ▲ Identifying priority health problems with lower utilization of health services
- ▲ The formation of an action plan to address priority problems including an awareness

campaign

- ▲ Formation of pilot MHO planning committees in the two test sites
- ▲ Four feasibility studies in the two sites selected
- ▲ Community dissemination of feasibility results
- ▲ PHR*plus* presented three options for benefits packages with their relative costs and is leaving it up to each MHO to decide what to include

Planned PHR*plus* activities for 2002 in Mali:

- ▲ Support the formulation of internal rules and regulations to manage the MHOs
- ▲ Support general assemblies to adopt the rules and regulations of the MHOs
- ▲ Administrative and management training for all MHO office staff
- ▲ Committees will decide what they want in benefits packages
- ▲ Monitor the initial activities of the four separate MHOs planned- two in Bla, two in Sikasso

Lessons learned and conclusions:

- ▲ There is a strong community interest in MHOs in the two sites selected
- ▲ There is a need for technical assistance as this is a relatively new concept

Issues that still need to be addressed:

- ▲ Funding for management and human resources of MHOs are lacking at local level
- ▲ The purchasing power of the population is not great

2.4 Senegal Presentation – Ongoing Work of PHR*plus*

In the past, PHR technical assistance addressed MHO design flaws, lack of insurance and managerial skills, and low population coverage rates in Senegal. PHR-supported innovations in Senegal include the decentralization of management, increased marketing of MHOs, and technical assistance in design, management, and training.

As MHOs in Senegal grow, PHR*plus* understands there is a high cost incurred by multiple feasibility studies. More and more communities are setting up MHOs and it is impractical to do feasibility studies for each one. The team created a new type of feasibility study to address this issue. The new feasibility study is based on the past experiences of all MHOs in the region and uses generic regional feasibility studies.

The PHR*plus* team also is concerned about the small size of pools of insured that may undermine long-term viability of the MHOs. Low contribution rates yield limited benefits packages. Exposure to external risks like hyperinflation, macroeconomic shocks, and higher than expected morbidity also incurs additional risk to MHOs. As a result, the PHR*plus* team is exploring reinsurance as a way to cushion MHOs from these additional challenges.

2.4.1 MHOs in Thies, Senegal (Abdoulaye Ba)

MHOs in Thies are well established and have a long history in the region. *PHRplus* provides support to multiple MHOs concentrated around Thies.

Objectives of the Thies programs include:

- ▲ Technical assistance to improve management capacity in MHOs
- ▲ Advice on resolving specific problems
- ▲ Production of adapted management tools
- ▲ Research and study on improving the functioning of MHOs

The partners of the Thies program include:

- ▲ And Fagaru MHO
- ▲ Sopante MHO
- ▲ Fissel MHO
- ▲ Tivaouane MHO
- ▲ UFCT MHO
- ▲ Degoo MHO
- ▲ GRAIM (a regional body that supports development of MHOs in the region)

Recent achievements of *PHRplus* in Thies include:

- ▲ Capacity reinforcement of individual MHOs
 - △ And Fagaru MHO: capacity of 57 neighborhood leaders increased, 457 new members admitted, and 2493 beneficiaries recruited
 - △ Sopante MHO: capacity of 21 zone captains increased, 232 new members admitted, and 29,000 beneficiaries recruited
 - △ Fissel MHO: capacity of 70 village delegates increased, 139 new members admitted and 800 beneficiaries recruited
 - △ Tivaouane MHO: office members capacity increased, 45 new members admitted, and 170 beneficiaries recruited
 - △ UFCT MHO: capacity of 30 members of initiative committee increased, social mobilization including 19 education sessions
 - △ Deggo MHO: capacity of 30 members of initiative committee increased
- ▲ Consulting support
 - △ Support in construction of conventions and rules of operation of MHOs
 - △ Support in negotiation of conventions with new members
- ▲ Producing adapted management tools for MHOs
 - △ Adapted financial management computer program

- △ Produced models of documents for administrative and financial management
- △ Produced a document on decentralized management
- ▲ Study and research
 - △ Regional feasibility study in progress
 - △ Regional reinsurance study in progress
 - △ Long-term viability study of MHOs will be finished by the end of March

Lessons Learned and conclusions:

- ▲ MHOs need technical assistance in improved management techniques
- ▲ MHOs need support to enlarge their membership base
- ▲ More providers need to be included in collaboration efforts and providers need to be better involved in MHOs in general
- ▲ Development of MHOs must be accompanied by capacity reinforcement
- ▲ A certain level of socioeconomic development is necessary for the proper functioning of MHOs
- ▲ Good collaboration with health care providers favors development of MHOs
- ▲ The formation of a venue for exchanging experiences is important to nurture partnerships

Issues that still need to be addressed:

- ▲ What role does voluntary work play in MHOs?
- ▲ Low percentage of cost recovery through collection
- ▲ Low levels of literacy
- ▲ Providers do not always respect the conventions of the MHO
- ▲ Absence of formal legislation

2.4.2 MHOs in Darou Mousty, Senegal (Bocar Daff)

The MHO in Darou Mousty is a unique collaborative effort between the health personnel and the health committee of Darou Mousty Health Center. The strong participation of health providers in the MHO is markedly different from other MHOs in the region.

Objectives of the Darou Mousty program include:

- ▲ Mastering the concepts and mechanisms of installing an innovative new MHO model
- ▲ Reinforcing technical management of the MHO
- ▲ Assuring long-term viability of the MHO
- ▲ Raising the percentage of the local population covered by the MHO

Recent achievements of *PHRplus* in Darou Mousty include:

- ▲ Training of leaders of MHOs including the formation of a pilot committee to determine the process of MHO formation
- ▲ Promotion of MHOs in the community by identifying target populations for education
- ▲ Follow up on advice to managers and inspectors of MHOs
- ▲ Follow up and evaluation of progress thus far
- ▲ An initial informational meeting helped to involve religious leaders, locally elected officials, the local administration, representatives of various groups and associations (including NGOs), local press and immigrant representatives
- ▲ *PHRplus* has been successful in rallying support for the MHO concept:
 - △ 100 percent of the rural community presidents in the area have expressed their desire to have an MHO
 - △ A women's savings and loan cooperative of more than 1000 members has expressed interest in an MHO
 - △ Several NGOs are interested in the MHO idea and have participated in training and educational activities
 - △ Multiple formal and informal requests for an MHO have been noted
- ▲ Follow-up meetings on advancement and planning of activities
- ▲ Identifying strategies for the implementation of an MHO
- ▲ A mission to identify how to incorporate NGOs in the MHO process has been launched
- ▲ The adoption of a plan of action that includes:
 - △ Educating of the target population
 - △ Training MHO staff
 - △ Applying various management tools
- ▲ The MHO has currently enrolled 200 members and more than 500 beneficiaries
- ▲ The protocol for the feasibility study has been completed and approved
- ▲ A sample study was conducted by a random selection among census districts

Planned *PHRplus* activities for 2002 in Darou Mousty, Senegal:

- ▲ The MHO plans to offer benefits starting after the general assembly meeting on February 22, 2002
- ▲ A feasibility study for MHOs in the region
 - △ A training for survey takers and the writing of the questionnaire
 - △ A survey of households
- ▲ Reinforcing capacities of NGOs
- ▲ Reinforcing capacities of promoters
- ▲ Social marketing for MHOs
- ▲ Forming a partnership of other local organizations and MHOs

- ▲ A press campaign involving local administrative and health authorities to raise awareness and facilitate membership

Lessons learned and conclusions:

- ▲ Recruitment based on existing, well structured associations has been successful
- ▲ Existence of a good community leadership base that can count on the trust of religious leaders has been helpful
- ▲ Support from all levels of decision makers is also key to success of MHOs
- ▲ The involvement of local technicians has been beneficial and helpful in dispelling any worries of the regional government
- ▲ A local health committee played an important role by providing the MHO with office space, mobile equipment, a computer, and help with the recruitment of a manager
- ▲ The MHO is utilizing mechanisms previously put in place by the health system
- ▲ The Darou Mousty case is the only example in Senegal where health care providers have engaged in an effective way with MHO promoters
- ▲ Health care providers helped the MHO avoid problems that might have occurred during the initial phases of the MHO due to haste
- ▲ The involvement of providers continues to be increasingly felt
- ▲ In the course of establishing an MHO, it is important not to skip any of the developmental steps
- ▲ PHR*plus* must assure technical assistance, the transfer of competencies and expertise, and the follow-up
- ▲ Partnerships must be reinforced on all levels

Issues that still need to be addressed:

- ▲ The definition of which priority services to cover was postponed to permit the MHO to gauge the expected responses
- ▲ Many of the stakeholders are very busy and do not make time for management of MHO activities
- ▲ The possibility of political control of MHOs is problematic
- ▲ There is a possibility for confusion of roles between the MHO and the health committee
- ▲ There is the possibility for a conflict of interest between care providers and promoters of the MHO
- ▲ The absence of an administrative structure to drive the development of MHOs is a challenge
- ▲ There is a continuing need for technical assistance

2.5 CBHI/F and Strategic Objective Specific Work

PHR*plus* conducts work using core (USAID/Washington) funds that relates to specific USAID Strategic Objectives. As a part of these programs, PHR*plus* has been examining the role of CBHI/F schemes in supporting the delivery of priority services.

2.5.1 MHOs and Impact on Maternal and Child Health Services (Janet Edmond)

PHR*plus* plans to examine MHO impact on Maternal and Child Health Services. PHR*plus* will:

- ▲ Develop methodology and tools for gathering baseline information on how USAID priority services are included and/or promoted in MHO benefits packages
- ▲ Conduct fieldwork and implementing data gathering activities using the above methodology and tools
- ▲ Produce a report that summarizes the findings from the survey and makes recommendations for possible technical assistance and follow-on activities concerning the use of priority services by MHO members

2.5.2 CBHI/F and the Potential for Addressing HIV/AIDS in Africa (Janet Edmond and Natasha Hsi)

CBHI/F strengths for addressing HIV/AIDS:

- ▲ CBHI/F is community-based and responsive to local needs
- ▲ Public-private partnerships are possible
- ▲ CBHI/F is positioned to target youth and other high risk populations
- ▲ CBHI/F increases overall access to services

CBHI/F weaknesses for addressing HIV/AIDS:

- ▲ Infrastructure limitations (including human resources, drugs, facilities)
- ▲ Sustainability issues (HIV positive individuals could damage the risk pool)
- ▲ Identification of seropositive status and stigma associated with positive status

Gaps in existing knowledge:

- ▲ How can CBHI/F mechanisms help absorb resources from external sources to provide HIV services?
- ▲ How do schemes tailor benefits packages to avoid moral hazard and adverse selection with high-risk populations?
- ▲ What effect do CBHF schemes have on HIV service utilization?

Recommendations for future research:

- ▲ Contract CBHI/F mechanisms for HIV/AIDS related service delivery
- ▲ Incorporate HIV services into benefits packages (especially home-based care and voluntary counseling and testing)
- ▲ Explore impact of inclusion of HIV services on seropositive member behavior

3. What We Still Need to Learn about CBHI/F Projects

The afternoon session consisted of four main working groups:

1. Equity
2. Financial Sustainability
3. Technical Assistance
4. Roles of Government

3.1 Equity Working Group

How is it possible to assure that CBHI/F schemes serve the needs of the poor?

Preliminary work

- ▲ The group defined the differences between the poor and very poor
- ▲ The group defined equity as beyond material wealth to include interactions between urban and rural, adults and children, gender issues, etc.
- ▲ Barriers to CBHI/F schemes better serving the poor include:
 - △ High premiums
 - △ Little information and education
 - △ Different values placed by the poor on health care as opposed to housing, food, etc. Geographic barriers to accessing health care services
 - △ Attitudes of providers to poor
 - △ Relatively small risk pools due to relatively high premiums
 - △ Benefit package does not meet the needs of the poor
 - △ Poor excluded from design and management of the program
- ▲ On the ground, there is no conscious effort to address equity- no attention paid to different needs of people of different income levels
- ▲ Findings from Rwanda:
 - △ Poorest joined less than others (8 percent joined overall)
 - △ All members used services at same rate
 - △ Churches paid contributions for widows, groups of households shared contributions, and other special mechanisms to help poorest join the scheme

What mechanisms can be implemented to help CBHI/F schemes better serve the poor?

- ▲ CBHI/Fs should advocate for government subsidies for the poor
- ▲ Reinforce solidarity among communities
- ▲ CBHI/Fs can search for other sources of contributions for the poor
- ▲ Could link CBHI/F to micro-credit organizations
- ▲ Benefits package could be redesigned to address needs of poor
- ▲ Improved quality of care for poor
- ▲ Improved health worker attitudes towards the poor
- ▲ Covering cost of transport for poor
- ▲ In some cases, CBHI/F might not be the best means of addressing the needs of the poor- exploring other possibilities should be an option

Current technical assistance for CHBI/F covers equity issues by:

- ▲ Addressing design and management issues
- ▲ Encouraging participation of all community members including the poor
- ▲ Addressing some aspects of quality control of care

What needs to be added to PHR*plus* technical assistance to make it more responsive to needs of poor?

- ▲ Incorporation of a facilitator to ask community or CBHI/F structure to identify poverty indices for themselves (i.e., Who qualifies as poor?)
- ▲ Creation of mechanisms for raising additional revenue for the poor (e.g., income-adjusted premiums)
- ▲ Incorporation of mechanisms for evaluating impact on poor within CBHI/F structure
- ▲ Concentration on improving quality of care

3.2 Financial Sustainability Working Group

What are the factors contributing to the longevity of CBHI/F schemes?

- ▲ Reinsurance is emerging as a new issue to address
- ▲ Reinsurance can be incorporated as a mechanism of good design
- ▲ Design flaws are at fault for many early failures in terms of financial sustainability, but this is increasingly being fixed with technical assistance and hence there is a better opportunity to examine real exogenous threats to financial sustainability
- ▲ Premiums are limited by population income
- ▲ Most schemes are subsidized in some way (government paying some costs or NGO/private facilities dependent on other sources of income)- this must be clarified to stakeholders and the implications of government subsidies need to be better understood.

- ▲ What kind of risk pool management do CBHI schemes currently undertake?
- ▲ What is the nature of the risk pool? What are the high-level risks?
- ▲ Which piece of the risk pool is the re-insurable part?
- ▲ In what terms should reinsurance coverage be defined? (It is not desirable for reinsurance to simply cover all tertiary services.)

3.3 Technical Assistance Working Group

What is the most effective way for external organizations to provide technical assistance?

- ▲ Technical assistance is essential but time and labor intensive
- ▲ Finding more economic ways to provide technical assistance
- ▲ What is already being done?
 - △ Community-level training for MHO promoters: concepts and process to implement
 - △ Awareness building in population with technical assistance support (including video, plays, theater, songs, other materials developed)
 - △ Feasibility studies conducted by promoters with technical assistance support or consultants
- ▲ Methods to enable success:
 - △ Respecting rules of community
 - △ Independence in priority setting and decision making
 - △ Responding to specific needs identified by community
- ▲ Monitoring and evaluation to measure impact
 - △ Central level: “Comité de concertation”
 - △ Elaboration of indicators for monitoring and evaluation
 - △ Coordination of MHOs: analysis and reporting, information needed for decision makers
- ▲ Extra resources needed:
 - △ Adapted management tools including local language translation, monitoring and evaluation
 - △ Creating regional support structures/networks
 - △ Additional training materials including finance, administration and organization tools- production of these tools in local languages

3.4 Role of Government Working Group

What is the appropriate role of government with respect to CBHI/F schemes?

- ▲ Government role in support of CBHI/F is important but unclear- we lack consensus on what that role should be- some possibilities include the following questions:
 - △ Some think that there should be no government intervention, but is this really feasible or desirable?

- △ Could government provide consumer protection- government mechanism, audits, fraud and theft protection, provision for bailouts, reserve requirements for each CBHI/F scheme?
- △ Could government track CBHI/F schemes to have a clear record of what is happening?
- △ Could government solicit community participation in legislation development? (The Ghana technical assistance is currently working on this role for government.)
- △ Could government coordinate/facilitate technical assistance, training, and dissemination of knowledge?
- △ Could benevolent governments certify scheme design and accredit providers to assure some quality control?
- △ Could government identify and pay for poorest citizens to assure equity?
- △ How can we expedite the bureaucratic process in order to make it more useful?
- ▲ Role of local government is important and becoming clearer:
 - △ Should continue and expand local government participation in start-up, action committees, etc.
 - △ Should continue to build on local government knowledge and awareness
- ▲ Government should not push CBHI/F schemes too fast or without a design validated
- ▲ Many governments don't know what goals they expect to achieve through CBHI schemes in the long term
- ▲ If government goal is increased revenue for the health sector, they should facilitate sound CBHI/Fs
- ▲ If government goal is equity in health care services, they should pay CBHI/F premiums for the poorest
- ▲ If government goal is community empowerment, they should not impose mandatory CBHI/Fs. CBHI/Fs should be allowed to grow from the grassroots and government should involve the community in legislation and regulation formation
- ▲ If government goal is access and utilization of health services, they should facilitate sound CBHI/Fs
- ▲ If government goal is sustainability of CBHI/F schemes, they should implement accreditation, regulation, reinsurance and bailout programs

4. Conclusions

The workshop showed the *PHRplus* team that it is useful and important to share experiences across countries. *PHRplus* needs to find mechanisms to facilitate this interaction. The idea of a special section of the *PHRplus* website for information sharing and gathering best practices was suggested as one such mechanism.

Given the significant scale of *PHRplus* activity in this area and the existing knowledge gaps, we need to ensure that we learn as much as possible from the activities we are currently undertaking in Africa. Monitoring and evaluation of our technical assistance activities and the schemes we are working with on a regular basis should be given high priority.

PHRplus will also pursue in-depth research in this area focusing on one or two of the topics discussed during the afternoon session.

Annex A: Workshop Agenda

Agenda for CBHI Meeting

Bethesda – 30 January 2001, Maryland Room.

Chair for the morning session: Marty Makinen

- 9.00 – 9.15 Introduction
Welcome to the meeting, introduction of participants.
Purpose of meeting, review of agenda (Sara Bennett)
- What have we learnt until now?*
- 9.15 – 11.15 PHR_{plus} ongoing work in country.
Tanzania – Grace Chee
Ghana – Chris Atim
Mali – S & S
Senegal – Dr Daff and Dr Ba
- 11.15 – 11.30 Break
- 11.30 – 12.00 CBHI and SO-specific work (child health, maternal health, and HIV)
Bryn Sakagawa, Janet Edmond
- 12.00 – 12.30 What have we learnt? Key lessons emerging. (Introduced by Charlotte Leighton and Chris Atim followed by plenary discussion)
- 12.30 – 1.00 Brainstorming: How can we better disseminate, collaborate and exchange information more about what we are doing in order to make the most of our technical assistance?
- 1.00 – 2.00 Lunch

Chair for the afternoon session: Chris Atim

- 2.00 – 2.15 *What do we still have to learn about CBHI schemes?*
Introduction, and explanation of group work (Sara Bennett)
- 2.15 – 3.15 Group work
- 3.15 – 3.30 Break
- 3.30 – 4.30 Plenary – report out from groups

4.30 – 5.00 Summary of discussion. Agreement on responsibilities for taking work forward (Sara Bennett)

Group work in the afternoon

Possible themes for the different groups:-

- ▲ How to ensure that CBHI schemes serve the needs of the poor
- ▲ Sources of risk for CBHI schemes and the role of reinsurance (if any!)
- ▲ How best can external organizations provide technical assistance and other forms of support to CBHI schemes while ensuring that they retain their ‘grassroot’ nature
- ▲ What is the role of government with respect to CBHI schemes e.g., in regulating and policy making

Questions for the groups to address:

- ▲ What work on this topic is already embedded within our technical assistance plans?
- ▲ What would it be desirable to add on to our technical assistance work to ensure that we really were able to learn lessons?
- ▲ What extra resources should be brought to bear to allow this to happen?

Guidance for those making country presentations:

Note: we advise presenters against including any information on the country (its population size, epidemiology, etc.) ...assume participants have some knowledge of this.

Focus on:

- ▲ How do CBHI schemes fit into the bigger picture in terms of government policy and broader health financing strategy?
- ▲ What are the specific objectives of PHR*plus* technical assistance work on CBHI in the country where you are working?
- ▲ What have we already achieved under PHR*plus*, and what type of activities are planned for the future
- ▲ What are the key lessons (3-5) that you have learnt from the work so far?
- ▲ What are the unresolved problems/issues faced (1-3)?

Annex B: Workshop Participants

Patrick Apoya	PHR <i>plus</i> , Ghana
Sara Archibald	PHR <i>plus</i> , Bethesda
Chris Atim	PHR <i>plus</i> , West Africa regional office
Abdoulaye Ba	Consultant, PHR <i>plus</i> , Senegal
Sara Bennett	PHR <i>plus</i> , Bethesda
Christian Baeza	STEP, ILO
Grace Chee	PHR <i>plus</i> , Bethesda
Bocar Daff	Consultant, PHR <i>plus</i> , Senegal
Janet Edmond	PHR <i>plus</i> , Bethesda
Allison Gamble Kelley	PHR <i>plus</i> , Bethesda
Natasha Hsi	PHR <i>plus</i> , Bethesda
Charlotte Leighton	PHR <i>plus</i> , Bethesda
Marty Makinen	PHR <i>plus</i> , Bethesda
Kent Ranson	London School of Hygiene and Tropical Medicine/SEWA, India
Bryn Sakagawa	PHR <i>plus</i> , Bethesda
Ousmane Sidibe	PHR <i>plus</i> , Mali
Cheick Simpara	PHR <i>plus</i> , Mali
Kim Smith	PHR <i>plus</i> , Bethesda
David Hotchkiss	PHR <i>plus</i> , Bethesda