



Community Health Financing Scheme

An innovative approach to increasing access to services in rural Madagascar



Background

MAHEFA's overall goal is to conduct health promotion activities and ensure delivery of basic health services at the community level through community health volunteers (CHVs) and other health actors. The *mutuelle*, or community health financing scheme, is an activity MAHEFA implemented to ensure that community members can afford to access care beyond services offered by CHVs when necessary. Patients and families often have to pay out-of-pocket for health services in Madagascar where there is limited government and donor funding available to provide adequate health financing coverage. This is particularly burdensome given the high rates of Malagasy people who live in poor households and who also experience higher rates of illness. Community health insurance schemes are one way to address health financing burdens, since they allow community members to pool resources, share risk, and extend coverage. They can also provide a mechanism to advocate for improved accountability and quality of services at health facilities.

MAHEFA Context

In Madagascar, the total health expenditure has consistently remained below 21 USD annually; this is far below the recommended minimal level of 44 USD per capita^{1,2}. Moreover, out-of-pocket payments in Madagascar constitute more than 20 percent of the total health expenditure, meaning that households face serious financial risk due to healthcare costs.

There is a history of community health insurance schemes in Madagascar. The 2008 Guide to the Package of Community Activities integrated information on *mutuelles* in its community-level training. In 2015, the government of Madagascar developed the National Strategy for Universal Health Coverage, which addresses the need for *mutuelles* in Madagascar. In addition, the 2015-2019 Health Sector Development Plan calls for the development of a prepayment system that includes *mutuelles*. The donor response includes USAID-funded projects SantéNet I and II, and Medical Care Development International (MCDI) which have applied this approach in the regions they worked in with results indicating that *mutuelles* have the potential to address health financing gaps and increase service access for vulnerable populations across Madagascar.

The MAHEFA Approach

MAHEFA's overall goal is to conduct health promotion activities and ensure delivery of basic health services at the community level through community health volunteers (CHVs) and other health actors. The *mutuelle* is an activity MAHEFA implemented to ensure that community members can afford to access care beyond services offered by CHVs when necessary.

The *mutuelle* approach that MAHEFA introduced in its regions built on the previous *mutuelle* strategies used in Madagascar. In addition, MAHEFA integrated innovations into its *mutuelle* approach to further optimize the impact on reducing maternal, newborn and child morbidity and mortality. The innovations included formally registering the *mutuelle* as an association at the district level; linking the *mutuelles* with microfinance institutions (MFI); connecting *mutuelles* to emergency transport systems (ETS); and linking *mutuelles* with local income-generating activities (IGA), namely the enterprise box (eBox). Registration of *mutuelles* at the district level formally establishes them as an independent organization and contributes to sustainability. The ETS approach, addressed in a separate MAHEFA technical brief, helps communities identify appropriate and affordable modes of emergency transport, organizes management systems to ensure their availability to community members needing care that is beyond the CHV's capacity and increases access to emergency services. The eBox, a social micro enterprise for bicycle sale and repair shops also addressed in a separate MAHEFA technical brief, acts as another source of revenue for the *mutuelles*, with 10 percent of their profits contributing to their local *mutuelle*.

The *mutuelles* were implemented at the *fokontany* level (*fokontany* is a collection of villages). Each *fokontany* has two community health volunteers (CHVs) attached to it, who report up to the government health facility (*Centre de Santé de Base*, or CSB) at the *commune* level, the smallest territorial division as defined for administrative purposes. The microfinance institutions (MFI) MAHEFA

1. <http://www.indexmundi.com/facts/madagascar/health-expenditure-per-capita>

2. <http://www.who.int/en/ahm/issue/16/reports/state-health-financing-african-region>



worked with also have offices at the *commune* level. The office of the *mutuelle* is based at the *commune* level, but services all the *fokontany* in its territory.

Key Activities

MAHEFA adopted a seven-step process for conducting *mutuelle* activities:

1. Conducted feasibility assessment to determine commune for mutuelle activities. The assessment was conducted by the program with representatives of the *commune* and *fokontany* to explain the purpose of the *mutuelle* and assess general interest and feasibility to implement a *mutuelle*. Using resources from the Ministry of Health (MOH), MAHEFA developed a guide to build *mutuelles* and questionnaires to assess feasibility in communities. Questionnaires were administered to heads of households, CHVs, members of the *commune*-level health committees, CSBs, and MFIs. The questionnaires probed their general interest, willingness to pay, and sense of social cohesion among the community³.

2. Facilitated initial workshop to sensitize community members and local authorities on mutuelles. Using assessment results, communities that were found to have a high level of enthusiasm and commitment, as well as geographical proximity to a microfinance institution and to a CSB, were selected for implementation of the *mutuelle* approach. MAHEFA conducted workshops for these communities, including regional, district and *commune* authorities, as well as members from the *fokontany* level.

3. Selected members and trained management committee members and facilitators. Community members elected management committee members who manage all *mutuelle* activities. *Mutuelle* management committee members are not paid, though MAHEFA provides a stipend during the training described below. *Fokontany*-level facilitators were selected by the mayors and *fokontany* heads. Facilitators are responsible for recruitment of new *mutuelle* members and usually are members of the local health committee, leaders of women's associations, or other local authorities. In sites where there are ETS and *mutuelle* activities, one committee manages both services. *Mutuelle* offices are located at the *commune* level, with representation from the *fokontany* level.

4. Trained management committees on mutuelle principles, implementation steps and operations. MAHEFA adapted the training tools and sensitization guides developed by the MOH. Topics include: definitions and advantages of a health *mutuelle*, how to organize a *mutuelle*, how to sensitize people on what a *mutuelle* is, and management of the *mutuelle*. After the training, the management committee led its members to prepare their own *mutuelle* statute with rules including information on membership, payment fees, eligibility, details of care and payment allowed. MAHEFA provided technical assistance to the committee in this process.

5. Formally registered mutuelle groups at the district level. Once the *mutuelle* statute was developed it was submitted to the district office as part of an application to become a legally-recognized association. Upon approval from the district governor, the *mutuelle* has formal status as an independent and legal association to implement its activities including recruitment of members and leveraging of funds for *mutuelle* sustainability. More information on members is presented in Box 1.

6. Developed tripartite MOU between mutuelle group, CSB, and microfinance institution. MAHEFA facilitated a three-way memorandum of understanding (MOU) between the *mutuelle* group, local CSB and MFI. The MOU outlines the relationship between the parties. It discusses the roles and responsibilities, lists the health services to be reimbursed, fees for service, and payment structures.

Box 1. Mutuelles Members

Facilitators at the *fokontany* level conducted community sensitization via workshops for community members to increase awareness on benefits of the *mutuelles*. Those who are interested can sign up and join the *mutuelle* during the sensitization, or they can sign up at the *mutuelle* office at the *commune* level. To register, members must pay a household registration fee of 3,000 - 5,000 MGA (approximately 1.00-1.50 USD) which covers expenses associated with registration and creating an insurance card. These registered members can then become paying members by paying monthly fees between 200-1,000 MGA (approximately 0.05-0.30 USD). These monthly fees are paid for each individual in the household and can be paid each month or for several months at a time. *Mutuelle* members deposit their registration fees and monthly payments directly at MFI at the *commune* level, or to the management committee member who is based at the *fokontany* level, who then brings these funds to the MFI. After paying the monthly fees and waiting until the end of the three- or six-month initial start-up investment period, paying members receive their membership card and can use it for consultations at the CSB and do not pay additional service fees. The CSB then submits receipts to and is reimbursed directly from the MFI. The CSB, MFI, and *mutuelle* management committee have regular coordination meetings to ensure the efficiency of these processes and the overall functionality of the *mutuelle*. The registration fees, monthly payments and timing are established by each *mutuelle* in a general assembly therefore the details vary according to the individual *mutuelle*.

3. *Mutuelle* activities are entirely managed by the community therefore a certain level of social cohesion is required to make the *mutuelle* works



7. Provided continued support to established *mutuelles*. After the activities described above, the MAHEFA team continued to provide support through frequent visits. In sites where *mutuelle* activities were not progressing well, MAHEFA organized review workshops that brought local leaders and *mutuelle* management committee members together to discuss ways to remedy the situation. Exchange visits among *mutuelle* groups were also organized to encourage ongoing collaboration and support between *mutuelles* after MAHEFA ended.

Results

By the end of the MAHEFA program, *mutuelles* had been established in 33 *communes*, involving 388 *fokontany*. Eleven of these *communes* had ETS activities linked to their *mutuelle* activities. A total of 236 management committee members and facilitators were trained. As of February 2016, these *mutuelles* had a total of 18,300 annual paying members and of that total, 9,120 had paid their monthly membership fees (Figure 1).

By the end of the program, MAHEFA recorded 455 members who successfully used the *mutuelle* to receive care at the CSB. Because of the time required for the *mutuelles* to become registered and functional (approximately 12 months). Since 2013, a total of 237, 608 people (133,517 women and 104,091 men) participated in the awareness campaigns organized by the *mutuelle* facilitators. MAHEFA anticipates that the rate of utilization will increase over time.

Box 2. Extending Partnerships for *Mutuelles*

In one commune, MAHEFA assisted the *mutuelle* to collaborate with Madagascar Oil, a private partner who contributed additional funding to the local *mutuelle*. MAHEFA shared technical training and information materials on *mutuelles* with PlaNet Finance, another NGO active in MAHEFA zones that has its own *mutuelles* activities.

Challenges

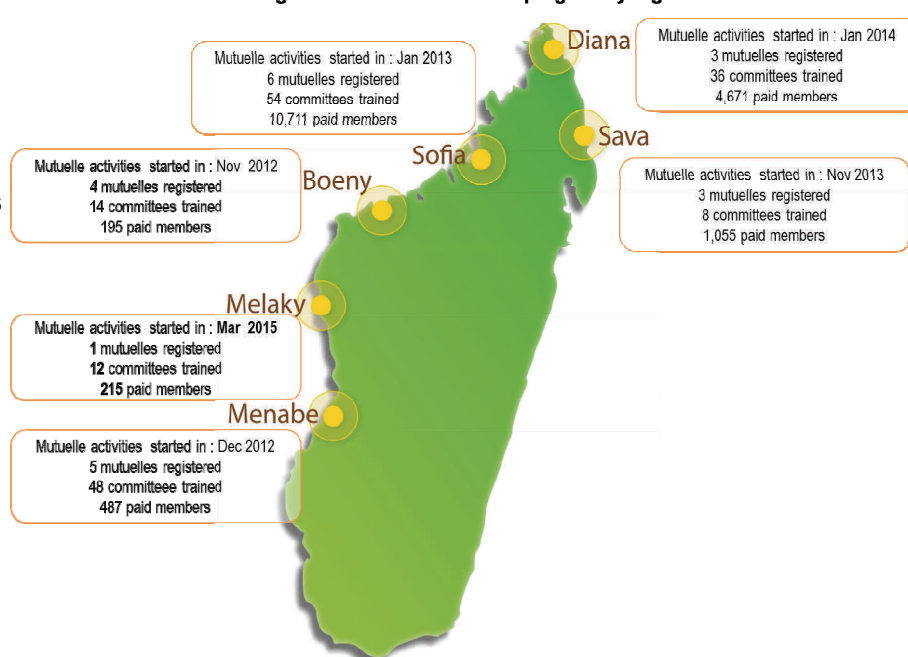
The community-based model requires time to achieve results. In poor and remote areas, it may take time for community members to fully understand and buy in to the concepts of investing for future costs and social support. Even when they are willing to pay into the *mutuelle* system, there is a low funding base so it is harder for the *mutuelle* to become viable.

Difficult to balance resource needs between specialized innovation activities and core program activities. MAHEFA's *mutuelle* activities were rolled out in the context of a larger community health program that supported CHVs to provide several types of health services for the first time in these regions. The simultaneous roll-out of the *mutuelles* approach meant that there was a limited amount of program support and monitoring available for this activity.

Non-availability of micro-finance institutes at *fokontany* level. Though MAHEFA worked to link the *commune*-level MFIs with the *fokontany*-level activities, MFIs do not have representation at the *fokontany* level. Therefore, when money needed to be deposited at the MFIs by *mutuelle* members or management committee members, there was a risk of losing the money or having it stolen during transport to the *commune* level, especially in *communes* where *fokontany* are particularly remote or there is lack of security on the roads.

Unreliable or poor quality of services at CSB. Though the *mutuelles* represented a feasible option for members to access health services at the CSB, these services are not always reliable or of good quality.

Figure 1. *Mutuelle* in MAHEFA program by region





Lessons Learned and Recommendations

Focus on local leaders. Involving the local leaders at the *fokontany*, *commune*, and district levels was critical to effectively establishing the *mutuelles* in MAHEFA communities. If they understand the concept well, they can help to mobilize people in their communities to join, and promote the social cohesion aspect of the *mutuelles*, which falls under their responsibility to connect community members with the broader public health system beyond what CHVs can provide. Moreover, they can serve as important links for the sustainability of the *mutuelles* by advocating for government support, encouraging local businesses to contribute resources, and identifying new sources of additional revenue for the *mutuelles*.

Register/link with public institutions. The innovation of registering the *mutuelle* at the district level is an additional motivation for communities to establish *mutuelles*. The formal status allows the management committee to guide the direction of the *mutuelle* and make decisions for its future, including resource mobilization and allocation.

Plan for eventual integration into core activities. For other programs considering integrating the *mutuelle* approach, adjusting the timing of roll-out to occur later in program implementation could address this challenge. Planning for frequent reviews allows all parties (program staff, management committees, MFI, CSB, community members) to understand how well activities are being implemented and targets met, and to make necessary adjustments to ensure the *mutuelles* are viable and responsive to community needs.

Plan for financial viability using local and sustainable solutions. In the context of a community-based *mutuelle* approach for poor populations with high rates of illness, *mutuelles* are likely to need other sources of funding to remain viable and to have contingency funds in cases of drain on the *mutuelle* funding (e.g., seasons with high rates of disease, cases of natural disasters). MAHEFA has initiated links with IGA activities and with corporate sources of funding to address this need. Other alternatives, such as assisting the *mutuelle* to raise funds from local businesses and other sources, will contribute to the financial sustainability of the *mutuelle* approach.

Madagascar Community-Based Integrated Health Program (CBIHP), locally known as MAHEFA, was a five-year (2011-2016), USAID-funded community health program that took place across six remote regions in north and north-west Madagascar (Menabe, SAVA, DIANA, Sofia, Melaky, and Boeny). The program was implemented by JSI Research & Training Institute, Inc. (JSI), with sub-recipients Transaid and The Manoff Group, and was carried out in close collaboration with the Ministry of Public Health, the Ministry of Water, Sanitation and Hygiene, and the Ministry of Youth and Sport. Over the course of the program, a total of 6,052 community health volunteers (CHVs) were trained, equipped, and supervised to provide basic health services in the areas of maternal, newborn, and child health; family planning and reproductive health, including sexually transmitted infections; water, sanitation, and hygiene; nutrition; and malaria treatment and prevention at the community level. The CHVs were selected by their own communities, supervised by heads of basic health centers, and provided services based on their scope of work as outlined in the National Community Health Policy. Their work and the work of other community actors involved with the MAHEFA program was entirely on a voluntary basis.

This brief is included in a series of fifteen MAHEFA technical briefs that share and highlight selected strategic approaches, innovations, results, and lessons learned from the program. Technical brief topics include *Behavior Change Empowerment*, *Community Radio Listening Groups*, *Community Score Card Approach*, *Chlorhexidine 7.1%/Misoprostol*, *Champion Communes Approach*, *Community Health Volunteer Mobility*, *Emergency Transport Systems*, *Malaria*, *Community Health Volunteer Motivation*, *Family Planning & Youth*, *WASH*, *eBox*, *Community Health Financing Scheme*, *Information Systems for Community Health* and *NGO Capacity Building*.

FOR MORE INFORMATION, PLEASE CONTACT:

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This document is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of JSI Research & Training Institute, Inc. and do not necessarily reflect the views of USAID or the United States government.