USAID
FROM THE AMERICAN PEOPLE

PHRplus

June 2006

Insights for Implementers

Innovative Strategies for Mutual Health Organizations

1. Introduction – The role and the potential of mutual health organizations

In the past 15 years, the numbers of mutual health organizations (MHOs) in several West African nations have increased dramatically. MHOs function as modern solidarity mechanisms and complementary health financing systems. Based on the principles of prepayment and risk sharing at the community level, MHOs can reduce (and sometimes eliminate) people's risk of being seasonally, temporarily, or partially excluded from health care due to insufficient household revenue at the time that care is needed. As a result, MHOs are being established across Africa. Almost everywhere that an MHO or an MHO promoter is working, others are adopting the concept and creating their own organizations. These field experiences provide important lessons on best practices (and common problems) for setting up MHOs, and on the critical role that an environment supportive to MHO development can play. During this period of marked growth, there have been various efforts to capture these lessons - in training manuals and workshops, study tours, and exchanges of information through the regional MHO network, the *Concertation (Concertation entre les acteurs du développement des mutuelles de santé en Afrique)*. It is important to build on this experience and the best practices, so that MHOs can maximize their coverage of the population and therefore contribution to the health system of their nations.

The growth of the MHO movement continues at a rapid pace. Many communities, socio-professional and economic associations, and even governments are launching MHOs,

An MHO member shows his membership card.

A definition of mutual health organization

Mutual health organizations (MHOs) are health insurance organizations based on communities or socio-professional associations that are managed by their members and created to provide financial protection from health risks. Membership in an MHO is voluntary, and involves a contract between member and the MHO. MHOs have bylaws and internal management structures that include general assemblies, advisory committees, oversight committees, and executive offices to manage contractual relations between the MHO and its members. In addition, MHOs contract with health care providers (at the health center and referral levels) to provide members the health services covered by the MHO. Both the internal bylaws of the MHO and the contracts it holds with providers contain measures to minimize the risks associated with health insurance (adverse selection, moral hazard, and cost escalation): typical measures include waiting periods, family membership (whereby all members of a family must join at the same time) or group membership, co-payments, and an emphasis on prevention. Benefits packages, which are defined by each MHO and its initiators, typically include a combination of coverage for small risks that can be addressed at the health center level, and large risks usually handled at the hospital level

convinced that they have an important and viable role to play in providing access to health care for a majority of the population living in rural areas and working in the informal sector. More recently, the MHO movement has attracted the attention of the international community and of many governments in the region, which want to proceed quickly with national scale-up of MHOs.

This attention is well deserved, for the following reasons: MHOs contribute to health sector goals by mobilizing household resources, reinforcing quality improvements, and ensuring access to care for populations previously excluded from or with limited access to health care. Along with public resources, MHOs contribute to a health financing strategy based on solidarity and risk sharing, the separation of the payment for health care from the moment of need, and the support of the sick by the healthy. Moreover, MHOs contribute to a sense of dignity within the health system by, on the one hand, empowering patients with their rights to health care, and on the other, by creating a group of consumers who continually demand quality health care. Finally, MHOs are part of a poverty reduction strategy, not only because they provide improved access to health care that protects households from catastrophic health expenses, but because they serve as a mechanism for community participation in the decision making, democracy, and solidarity that are so critical to strong social capital at the community level.

There are, of course, still problems for expanding the MHO movement. Despite the fact that the steps for setting up an MHO are well-documented, much work remains to be done to create an environment that enables broader MHO development[1] : At present, the will to create MHOs is greater than the capacity to support their ever-increasing numbers.[2] Capacity building at the national and local level is a prerequisite to scale-up in every country. Moreover, innovative systems and support strategies are needed to ensure the sustainability of the MHO movement.

Through the support of the U.S. Agency for International Development (USAID), the Partners for Health Reform*plus* (PHR*plus*) project and its predecessor projects (Health Financing and Sustainability, Partnerships for Health Reform) have assisted with the development of MHOs in a number of countries more than 10 years. The projects have witnessed the progress of the MHO movement and the innovative approaches adopted to address its weaknesses and to maximize its contributions. The purpose of this *Insights for Implementers* is to document salient innovative field experiences and make them widely available, from the level of MHO managers to local and national decision makers. The nine "innovations" developed here are drawn directly from field experience. They are innovations not in the sense that the concepts are new – decentralization is happening in many sectors – but because they have been applied to the MHO movement, with important results. These approaches have been implemented successfully beyond the scope of the PHR*plus* project by MHOs themselves working with other development partners. The target audience for this document is wide – decision makers will find innovations on scaling up; technical assistance agents will find tools and examples for replicating these innovations; and MHO managers will find strategies to improve the performance of their MHOs. This document is not a substitute for existing reference guides and tools that introduce MHOs and support their setting up; rather it complements them by making available a set of innovative strategies drawn from field experience that can improve and reinforce existing MHOs and help to put in place new ones.

[1] *Many guides and manuals on the establishment of MHOs exist. Some of these are included in the reference list at the end of this document. A more complete inventory of these tools can be found on the website of the* Concertation *(www.concertation.org).*

[2] *Numerous international organizations have a long history of supporting MHO development, including the Internal Labor Organization (ILO), the German Development Agency (GTZ), the Danish Development Agency (DANIDA), World Solidarity (WSM),* L'Alliance Nationale des Mutualités Chrétiennes *(ANMC),* Programme d'appui aux Mutuelles de Santé en Afrique *(PROMUSAF). Other national and sub-regional organizations are increasingly providing support to MHO development, like the* Concertation*, and* le Groupement de recherche et d'appui aux initiatives mutualistes *(GRAIM) in Senegal, etc.*

Acronyms

AC	Administrative council
CG	Management committee
EO	Executive office
F&A	Finance and administration
GA	General assembly
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GRAIM	*Groupement de recherche et d'appui aux initiatives mutualistes*
IEC	Information, education, and communication
LMC	Local management committee
M&E	Monitoring and evaluation
MFI	Microfinance institution
MHO	Mutual health organization (*mutuelle de santé*)
MOH	Ministry of Health
MS	*Mutuelle de santé* (mutual health organization)
NGO	Nongovernmental organization
PHR*plus*	*Partners for Health Reformplus* project
USAID	*United States Agency for International Development*
ZEO	Zonal executive office
ZGA	Zonal general assembly

2. Innovative strategies to support MHO development

The following sections present nine innovative strategies (see table below) that address weaknesses currently inhibiting the performance and growth of MHOs. Common weaknesses include: a lack of competent personnel to manage MHOs, which has a negative impact on MHO operations and the mobilization and participation of their members; a generally weak ability to pay regular premiums on the part of the poorest segments of the population; and a lack of coordination and cooperation among existing MHOs, many of which are quite small. In addition, reliable data on the contribution of MHOs to the health sector are rare, and most MHOs remain "isolated" (many working with a development partner, but without the benefits of networking with other MHOs). Thus, best practices have not been shared and replicated, and local partnerships have not been formed. Moreover, the ministry responsible for overseeing MHOs itself often suffers from weak technical and institutional capacity vis-à-vis MHOs, and thus is unable to assist them.

The innovations presented here aim to strengthen MHO development and to broaden their support by involving key players at various levels:

- At the local level, MHO initiators and managers who are responsible for the operational aspects of setting up and managing MHOs.
- At the intermediate level, those who can support MHOs in their mission – networks and federations of MHOs, development partners, local promoters, locally elected leaders, etc.
- At the national level, the government, which provides strategic support to the MHO movement.

The table lists the nine innovations, their respective objectives, and their appropriate level of intervention.

Each of these innovations can be implemented individually. However, it is rare that a single innovation would be adopted, as many are interrelated and mutually reinforcing.

To facilitate the implementation of these strategies, the discussion of each includes the following: a description of the purpose of the innovation and the expected results, the process for implementing the innovation, and a list of accompanying tools that will prove useful during replication. These tools are available at www.phrplus.org. In addition, each innovation includes case studies and specific examples from the field. References and other useful links are in the bibliography.

The nine innovations

Objective	Innovation	Level of intervention
Covering the poorest	1. Covering health care for the poorest through MHOs	Local, intermediate, national
Going to scale	2. Developing a national strategic plan for MHOs	National
	3. Launching MHOs with a perspective of creating networks	Local, intermediate, national
	4. Using a pilot experience to prepare for national scale up of MHOs	National
Improving operational performance	5. Decentralization of MHO management	Local
	6. Collaborating with local radios for MHOs development	Local, intermediate
	7. Putting in place an MHO monitoring and evaluation system at the network/federation level	Intermediate
Building partnerships to improve performance	8. Building local partnerships to support MHO development	Local, intermediate
	9. Developing partnerships between MHOs and micro finance institutions	Local, intermediate

3. Innovation 1 – Covering health care for the poorest through MHOs[3]

Rationale and results

In Africa as elsewhere, financial barriers are an important reason for people not seeking care when sick. Obviously, these barriers most affect the poorest segments of the population, who tend to have greater health needs than people who are better off. While MHOs are an expression of the solidarity that still exists in most African communities, to date, research shows that the poorest are often excluded from MHO membership because even the low contribution levels are beyond the poor's ability to pay. How can the MHO movement extend its solidarity to include the poor and allow them to benefit from MHO membership? What are the potential advantages of covering the poorest through MHOs?

Covering health care for the poorest through MHOs involves a system whereby the membership fee and premiums for the poorest are paid by others: either by the MHO itself, by the government, or by other financing agents like donors, charitable organizations, and NGOs. This type of coverage of the poorest is important in promoting equity.

Those concerned with health care coverage for the poorest are increasingly convinced that MHOs could be an effective way to achieve coverage, in terms of both managing and targeting subsidies: Because MHOs operate at the community level and are managed with community participation, they have a comparative advantage in identifying and then distributing subsidies (in this case, health insurance) to the poor.

Covering the poorest through MHOs also has advantages for financing agents (charitable organizations, government, and others). For example, by investing in an MHO, financing agents are able to reach a greater number of indigents because of the risk-sharing mechanism in health insurance. From the beneficiaries' perspective, MHOs provide coverage with dignity. Whereas before there was a certain stigma associated with care seeking (they had to present proof of indigence to receive care), as MHO members they must only present their membership card, like any other member.

Covering indigents in the Bungwe MHO in Rwanda

In 2004, the Bungwe MHO had more than 20,000 beneficiaries and had mobilized large sums of money. Working together, the MHO's managers and its partner health center decided to invest a percentage of these resources in a separate bank account at the community bank, which offered an annual interest rate of 4.5%. With this investment, the MHO was able to cover the membership fees for 413 indigent households the following year (91% of all indigent households identified by the MHO). Because the co-payments required by the MHO also constituted a financial barrier for these members, the MHO also created a social fund to which visitors and benefactors could contribute to cover co-payments for the poorest members.

Expected results

There is a growing body of evidence that covering the poorest through MHOs expands health coverage, because it facilitates access for people previously excluded from care. It also rationalizes the health spending by reducing the health costs for an individual through risk sharing, and to the entire health care system by increasing the likelihood that the individual will seek care sooner (before an illness becomes more serious and therefore costly), thereby reducing overall health costs for the person as well as for the whole health system. Becoming an MHO member also protects the household income of the poorest households.

The sources of funding to cover the poorest are diversifying; resources can come from the MHO itself, from local or international development partners in the health sector, or from various government sources.

Potential funding sources to cover the indigent

Financing coverage for the indigent with the MHO's own resources. MHOs, whose mission is to extend access to health care within the community, were the first to show an interest in providing coverage to the indigent. As MHOs grow and expand membership, they are able to mobilize large sums of money that are kept in interest-bearing bank accounts. The interest generated on these resources can be used to pay the premiums for indigents, as was the case in the Bungwe MHO in Rwanda and in the Faggu MHO in Senegal (see text boxes).

[3] *This section is based on the study: Butera, Jean Damascène. December 2005.* Les Mutuelles de Santé et la prise en charge des indigents: l'étude de cas du Rwanda*. AWARE-RH (a USAID-funded project).*

Covering the most vulnerable in the Faggu MHO for retired persons in Senegal

Faggu, an MHO that provides supplemental coverage for retired persons, created a social fund to subsidize coverage for the most vulnerable retired persons. Resources for the fund come from setting aside 50% of annual membership fees, as well as 100% of the interest earned by the MHO at the bank. Those covered by the fund include widows (50% of those covered), orphans (30%), and the poorest retired persons (20%), amounting to 3% of the total MHO membership. These members have free access to all of the MHOs covered services. Eligibility for this subsidy is determined by l'IPRES (*l'Institution de prévoyance retraite du Sénégal*) based on economic criteria.

Coverage of *talibés* in Senegal

Two MHOs (Yombal Fagu Ak Wer and Mathabouf Fawzaini) created a mechanism to subsidize membership fees for a number of *talibés* (Koranic-school students who beg to earn money and food, and who had no access to health care). This system permitted those with means to cover dues and medicines for such children through a system of sponsorship.

Financing coverage for the indigent through a third party. With the rise of MHOs, charitable organizations, NGOs, and other organizations are forming partnerships with MHOs as mechanisms to directly target the indigent. Rwanda provides a rich experience in this regard, with many different organizations subsidizing the indigent through MHOs. As a result, MHOs find themselves playing the role of intermediary between financing agents and their beneficiaries, and thereby facilitating better targeting of the poor and other vulnerable groups.

The State has an important role to play in the diversification and growth of such coverage mechanisms for the poorest. Along with local government, it can mobilize funds from various development partners (donors, NGOs, or even vertical programs like the Global Fund to Fight AIDS, Tuberculosis and Malaria). In 2005 in Gitarma province in Rwanda, for example, 20 different actors (three of which were governmental) worked to cover some 42,000 indigents (5% of the total population of the province). The State can effectively make such a system of coverage a priority by identifying in its health sector strategic plan that MHOs are a valid mechanism for targeting the poorest, as well as by creating a line item in its budget to target them.

Decision to cover the poorest through MHOs

There are several options for covering the poorest through MHOs. Key questions need to be answered before creating such a system, to determine the mechanism chosen. For example, is there a formal system in place to identify who is eligible? Are there charities or other sources to subsidize membership in the MHO for those identified as eligible? Does the local government level have a budget line item for subsidies to cover the poorest? If the MHO plans to cover the poorest with its own resources, are there sufficient reserves to contribute to a new solidarity fund? Is the current management system (and tools) of the MHO adequate to ensure the transparency and accountability of such a fund for members and other funders to cover the indigent?

Process

1. **Identify/seek funds to establish a solidarity fund**. First and foremost, the source(s) of funding for covering the poorest must be identified, and then the system for coverage of target groups must be defined: the level of the subsidy for membership, for the contribution level of those eligible, as well as the co-payment. Funding sources may include interest earned on MHO investments, state subsidies, and subsidies from development partners, or from other charitable donors. At this stage, it is also important to define the number of potential beneficiaries, although this number can certainly fluctuate from year to year.
2. **Define criteria for identification of indigent, eligible families.** Sometimes there are national criteria for identifying the indigent that can be adapted/applied at the local level. In addition, other vulnerable groups, such as widows or orphans, may also need to be considered when determining potential beneficiaries. The essential point is that the MHO must have reliable, transparent criteria to

determine the number of eligible families and households. The actual process of identifying the eligible should also be participatory and transparent. There is a perception that the community itself can most credibly identify its "own" indigent; as a result, more and more MHOs are turning to community identification of the indigent. This trend is also consistent with the process of decentralization happening in many countries.

3. **Create a registration system** for indigent members. A registry must be put in place to track indigent members. Such a system allows the MHO to measure and report on the coverage of indigents and their use of services to both members and funders of the system.[4] The membership forms and cards given to subsidized members, however, should be the same as those for paying members.

Available Tools

Tool	Use	Expected Results
MHOs and coverage of the poor: Case study from Rwanda	Information source and examples from a country with extensive experience of MHOs covering poor and vulnerable groups	Better understanding of mechanisms for covering the poor and vulnerable through and by MHOs
Register of indigent members	Tool to collect data on indigent members of the MHO	Serves as a reference document for indigent members of the MHO

[4] Often, funders will have very specific, detailed requirements about the identification and tracking of beneficiaries of the coverage system. The MHO must consider these requirements from the start in the design of the system itself as well as of the registry.

4. Innovation 2 – Developing a national strategic plan for MHOs

Rationale and results

Until now, MHO development has been in an experimental phase, where most interventions have focused on testing different approaches, sharing experiences, training and management capacity building, and attempts to monitor and evaluate results. Because MHOs have often remained isolated community initiatives, "going to scale" has remained limited, as has the involvement of government and other external partners. However, governments and development partners are increasingly convinced that MHOs have great potential for development in general, and for the extension of health insurance and social protection systems in particular. As a result, a number of governments have expressed a commitment to integrate MHOs into their strategic development plans for the social sectors, their plans for expanding health insurance and social protection, as well as their strategies for poverty reduction.

As a result, there is a need to develop a strategic framework for MHOs that not only will serve as a reference point but also will create synergies among interventions at different levels: at the operational level, the establishment of MHOs and the recruitment of members; at the intermediate level, technical assistance to assist those new MHOs and to provide technical support at the field level; and at the national level, strategic interventions to create an enabling environment (legal, regulatory, fiscal, etc.) for MHO development. Developing a national strategic plan therefore establishes a framework and specific strategic roles and interventions for all stakeholders in MHO development, including the government, MHOs themselves, and development partners. It represents a shared vision for MHO development, and favors better coordination and expansion of MHOs in a given country. At today's stage of MHO development, a strategic plan is especially useful because it puts in place a common mechanism for exchange, expansion, and diversification of best practices, and therefore builds the capacity of actors at all levels simultaneously, making it less likely that MHO development becomes bogged down in politics or other agendas.

The development of a strategic plan for MHOs at the national level is a process that aims to create consensus, a plan, and a budget for a comprehensive support strategy for the development of MHOs. This plan lays out the strategic steps for putting in place MHOs, defines the needs for internal and external technical assistance to strengthen the legal and regulatory context for MHOs, and establishes national-level coordination and partnerships between MHOs and other appropriate organizations. Thus, the development of a national strategic plan defines and institutionalizes strategic support to MHO development. The many key players in this process include: MHO managers (and existing MHO federations); health care providers under contract with MHOs; various promoters and supporters of MHOs (religious organizations, associations and/or NGOs; and development partners); administrative regions and districts; representatives from the Presidency, the Prime Minister's Office, and the Ministries of Health, of Finance, of Social Affairs, and of Local Government, among others.

Raison d'être*:*

This innovation responds to a number of the obstacles to scaling up MHOs in a country. Specifically, it establishes a framework and specific strategic axes of intervention for all stakeholders in MHO development. For many years, MHOs have been inwardly focused or "introverted" – that is, each one operated individually, perhaps with the support of a particular promoter but without the benefits of a network or the experiences of other MHOs. In many countries, there has also been a lag in the development of institutional and technical capacity for MHO support at the level of the Ministry of Health (or other agency) and among development partners. This limited ability of governments and partners to contribute concretely to widening the MHO movement. Moreover, interventions to support MHOs have not always been coordinated, have typically been poorly documented and shared, and therefore have not constituted a basis for extending MHOs throughout a country and eventually going to scale.

In summary, developing a national strategic plan for MHO development can address a number of common problems, including a lack of:

- Shared vision and strategies, and therefore a lack of coordinated, coherent interventions;
- Internal capacity to develop, enlarge the MHO movement, or respond to demands from communities and associations for technical assistance;
- Structured support at the national, intermediate, and local levels;
- Formal arrangements for exchange and learning;
- Forum to reconcile political tensions, capacity, and timing in the promotion of social protection and alternative health financing policies within the context of poverty reduction.

Expected results

The principal results of developing a national strategic plan are: consensus on strategic objectives and axes of intervention, definition of expected results linked to important government objectives, well identified and defined roles for stakeholders in MHO development, and, finally, operational plans and corresponding budgets to facilitate funding and implementation by government and its partners.

Developing a national strategic plan – the case of Rwanda

After 18 months of piloting MHOs, and a further 24 months of adaptation, taking MHOs to scale became a specific priority for the government of Rwanda. The development of MHOs was written into the government's Vision 2020, as well as into the health sector development strategy, and its poverty reduction strategy plans. In his New Year's speech in 2003, the President exhorted everyone across the country to work toward extending MHOs so that the entire population might benefit. As a result, Rwanda developed a national strategic plan and succeeded in putting in place 224 MHOs covering 3,073,508 beneficiaries, or approximately 40% of the country's population (as of August 2005). The strategic plan identified financing needs for scale-up, whereby the government and its partners would need to mobilize 4.7 million francs Rwandais ($8.5 million) in three years to support training local actors and put in place adequate management systems and tools.

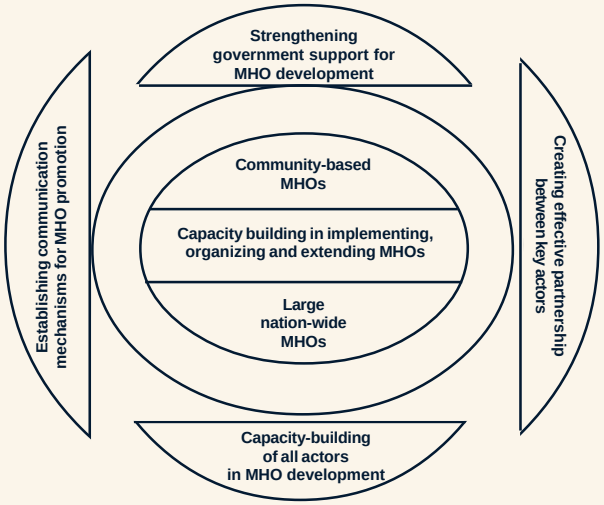
Developing a national strategic plan – Benin's experience

In Benin, a national strategic plan for MHO development was adopted in early 2006, and is part of the larger Health Sector Development Strategy 2007-2011 to improve the health sector's contribution to poverty reduction. Its primary objective is to develop MHOs through Benin to improve financial access to quality health care by the population. In order to achieve this objective, the strategic plan focuses on the following:

1. Create a favorable environment for MHO development;
2. Increase the percentage of the population covered by MHOs from 90,000 beneficiaries in 2005 to 2 million beneficiaries in 2011;
3. Build technical and institutional capacities of MHOs; and
4. Strengthen the capacities of MHO promoters and stakeholders.

Developing a national strategic plan – the case of Senegal

The development of a national strategic plan is part of an initiative to strengthen the health sector's contribution to poverty reduction strategies, and to facilitate the inclusion of MHO development in the priority activities of the second phase of the Health and Social Sector Development Plan (*Plan national du développement sanitaire et social*) and the new national strategy for social protection (*Document stratégique de réduction de la pauvreté*). In doing so, it provides the government agency responsible for MHOs (now directly attached to the Ministry of Health's cabinet) with an advocacy tool for the development of MHOs. The proposed budget, which outlines more than $8 million over five years to support the five strategic axes of the plan, provides the government and development partners with a concrete instrument to demonstrate their commitment to MHO development. This budget also facilitates effective activity planning and the development of operational plans at the intermediate level, based on available resources. The strategic axes of the Senegal plan are illustrated in the schema below.



Decision to develop a national strategic plan

Since 2004, several countries have opted for the creation of a national strategic plan for MHO development. This process results from an explicit desire by the Ministry of Health (or other supervising ministry) and stakeholders and development partners to have a mechanism for coordination and collaboration of MHO development interventions in order to maximize their reach. This may be the case in a country with many diverse MHO experiences that have not been consolidated or coordinated, or in a country planning to take MHOs to scale. Below are several scenarios that would favor the development of a national strategic plan.

- ▲ Numerous promising MHO experiences exist, but there has been no coordination or systematic exchange about approaches or among partners.
- ▲ Formal mechanisms are needed to accompany a planned extension of MHOs.
- ▲ The government needs a coherent strategic framework for MHO development in order to invest.

Given that the development of a strategic plan is both a technical and political process, it is important that the relevant ministry is motivated to launch such a process. Reaching consensus among all parties involved in the MHO movement on a strategic framework is a major objective of this process.

Process

The steps to developing a strategic plan for MHOs are outlined below.

1. **Inventory**. It is essential to begin with an inventory of the current status of MHOs in order **to** facilitate an exchange of experiences and an identification of strategic directions. There may be multiple sources of information for such an inventory (case studies, existing inventories or surveys, gray literature such as project plans and reports from MHOs and their partners). The inventory needs to document existing systems (health care providers, MHOs, federations or networks of MHOs, technical support organizations, donors, etc.) as well as to list existing tools.
2. **Workshop to validate inventory results and to reach consensus on strategic orientations**. This workshop aims to enrich the inventory by providing a forum for exchanging information and experiences about obstacles, strengths, and weaknesses encountered in establishing and implementing MHOs, as well as in promoting in the country. It also should identify and gain consensus on strategic orientations for MHO development that will frame the development of the strategic plan. All major stakeholders should participate in this workshop: MHO members, providers, technical support structures, locally elected leaders, potentially important partners for MHO expansion (such as financial institutions, public offices, like the presidency or prime ministry, and parliament). Again, the primary objective is to exchange a maximum of information in order to reach a consensus on next steps.
3. **Development of strategic plan**
   - △ Name an editorial committee
   - △ Hold multiple technical meetings

   In order to efficiently draft a plan, it is advisable to name an editorial committee to write up the strategic orientations agreed upon during the first workshop. In several meetings, this committee studies, develops, and refines the various strategic axes of the plan, which in turn become the subject of the next workshop.
4. **Workshop to validate the strategic plan**. Once the strategic plan is drafted, a workshop is organized to present and validate it. Once again, this workshop brings together all stakeholders in the MHO movement, but also includes various ministries (health, finance, decentralization, social affairs, labor, women's affairs, etc.), locally elected leaders, health care providers, and donors. The main purpose of this workshop is to obtain consensus and "buy-in" for the strategic plan before moving to the next phase of implementation.
5. **Identification of financing for the strategic plan**. This type of strategic plan provides the government with a useful instrument for explaining its policy regarding MHO development. It becomes possible, as a result, for the government to include MHO development specifically in its budget, as well as to seek financing from partners and donors for implementation of a plan which has full consensus.
6. **Dissemination of the strategic plan** (at the national and local levels). Because not everyone can attend the national validation workshop, efforts must be made to disseminate it across the country to encourage ownership by all stakeholders. The implementation planning workshops to be held at the intermediate level (often regional) are a good opportunity to present and discuss this plan with local stakeholders: MHOs, local support structures, local government, NGOs, etc.
7. **Development of implementation plans at the intermediate level**. In order to effectively implement a national strategic plan, some sort of structure for coordination must exist at an intermediate level. Implementation plans at this level can be developed during a workshop that brings together MHOs, locally elected leaders, NGOs, MHO promoters, health care providers, etc. These implementation plans outline both activities and a budget for MHO development at this level that correspond to the major strategic axes of the national plan. This process helps to identify partners for MHO development and to define both technical and financial roles and responsibilities for the various stakeholders involved in implementation. It serves as a catalyst to local participation and appropriation of the national plan by integrating it into the local planning process.
8. **Integration of the strategic plan into key national strategy documents**. To ensure the success of the strategic plan, it is essential that it be integrated into major national strategies, such as poverty reduction and 10-year development plans for the social sectors. In Senegal, for example, the

national strategic plan for MHO development was conceived during a period when the Ministry of Health was already in the process of linking the national health plan to the national poverty reduction strategies. The development and validation of the strategic plan for MHOs benefited from these efforts already underway and its integration was made easier. In Rwanda, due to the long-term development approach for MHOs, the very first poverty reduction strategy documents identified MHO expansion as a national priority. As a result, key, high-level national stakeholders, including the President's Office, the Prime Minister's office, the Ministry of Health, and international organizations like the World Health Organization and UNICEF were involved in the development of a strategic plan for MHOs. Moreover, the development of the strategic plan for MHOs happened before the development of the sector-wide health development plan and health policy, and therefore it was incorporated directly into the other two.

Perhaps the key underlying element to all of the steps outlined above is the importance of "selling" this document as an essential and useful tool at all levels – national, intermediate, and local - and encouraging its ownership by key stakeholders – administrative authorities, providers, NGOs, and other partners.

Available tools

The tools listed below cover the process of developing a national strategic plan from beginning (terms of reference for the first workshop) to end (examples of national strategic plans developed by Rwanda and Senegal) as well as an example of an implementation plan from the regional level (taken from Senegal). A policy brief from Rwanda provides an example of how to encourage the appropriation of a strategic plan.

Available Tools

Tools	Use	Expected Results
Methodology for inventory (*Canevas pour l'état des lieux de la situation des mutuelles de santé [MS]: vers l'élaboration d'un plan stratégique*)	Gives an example of a methodology to collect the necessary data during the inventory process	A methodology for data collection that covers the main fields of interest and key questions about MHOs that can serve as inputs to the process of developing a national strategic plan for MHO development
Terms of reference, first workshop for development of national strategic plan (*Atelier pour créer un plan stratégique du développement des MS*)	Provides an example of TOR and helps in the preparation of the first workshop	Workshop planned, with objectives, roles, organization, and expected results from workshop all well documented
Policy brief on preparing to develop a national strategic plan for MHOs (*Orientations générales pour le développement d'un plan stratégique*)	Provides an example of how to lay the groundwork for the process of developing a national strategic plan for MHOs	Documented objectives for the process of developing a national strategic plan that can serve as a reference point
Policy brief on the development of a national strategic plan for MHO development (example from Rwanda)	Provides an example of how policy aids can be used to strengthen the process of developing such a plan, to build consensus and to maximize information sharing	Consensus achieved on the national strategic plan
National strategic plans for the development of MHOs (from Senegal and Rwanda)	Provides two examples of actual national strategic plans that have been adopted and are being implemented to help in the development of such a plan	National strategic plan for MHOs developed
Diagram of the process of developing a national strategic plan for MHOs	Gives a visual tool that can be adapted to orient the process of developing a national strategic plan	Better understanding of the steps to the process of developing a national strategic plan
Regional implementation plan (model from Senegal)	Provides an example of a detailed implementation plan derived from a national strategic plan	Implementation plans developed at the intermediate level to operationalize the national strategic plan

5. Innovation 3 – Launching MHOs with the intention of creating networks

Rationale and results

Raison d'être

There is an emphasis today on making the process of creating MHOs more efficient and more sustainable. It is true that the process of setting up an MHO is fairly standard and well known,[5] yet field experience shows that this process is also time- and resource-intensive, especially at the start. Despite its standard nature, MHO development has hardly been systematic. The "introversion" – the lack of mutual organization or coordination among MHOs – has meant that the external technical and financial resources available have been spread thin and have only benefited a small percentage of MHOs. Despite intense demand for assistance from local communities, MHO promoters and governments have no coherent strategy for working together to respond effectively. As a result, MHO development has been slow, and the costs relatively high per MHO. The overall expansion of the MHO movement has therefore been relatively weak.

The approach of launching MHOs with the perspective of creating a network involves facilitating the simultaneous creation of several MHOs in one geographic area. In this strategy, key parameters are harmonized among all the MHOs, especially concerning the benefits package, the co-payment amount, the dues rate, and the waiting period. Efficiency gains during the set-up process are made by launching MHOs simultaneously (through common training sessions, joint promotional campaigns, etc.). Moreover, linking MHOs in a network enlarges the risk pool, and therefore permits better coverage of large risks.

The idea of launching MHOs with the intention of creating a network aims to accelerate development of new MHOs and make them stronger and more sustainable from the start, as the larger risk pool generally improves their ability to cover large risks and enhances their financial stability.

Expected results

This approach facilitates the launch of multiple MHOs in a relatively short period of time. In two years, for example, 14 MHOs were founded (13 of which are fully functional) in two communes (the lowest level of administrative decentralization) in Benin. Whereas the same process used to be repeated for every new MHO, launching MHOs in a network meant that start-up activities - feasibility studies, promotional campaigns, trainings, etc. - were carried out once, at the commune/district level, instead of multiple times at the level of individual MHOs, producing economies of scale.

This sharing of experience early on has the added benefit of stimulating collaboration and coordination within the MHO group. With the group built around a geographic center, the process builds local capacity, and therefore favors sustainability. It also tends to create a positive dynamic of emulation/rivalry, which results in the rapid spread of best practices. The network becomes a forum for participation, exchange, and collaboration that supports all of the MHOs.

Moreover, this strategy results in effective population coverage because it aligns MHO target populations with administrative geographic boundaries, which facilitates going to scale nationally. In Rwanda, this approach resulted in the establishment of 53 MHOs in three districts, the establishment of three federations of MHOs, and a coverage rate of 10% of the target population in the first year. Expanding the same strategy, Rwanda successfully put in place 224 MHOs across all its districts; they now cover some 40% of the entire population.

Networking MHOs also facilitates an evolution in MHOs' benefits packages. By expanding the risk pool, networked MHOs make possible the coverage of large risks, such as hospital care, while maintaining the original benefits package covering small risks and services available at the health center level. Coverage of hospital care generally requires a large risk pool, since such large risks are less predictable yet more expensive.

The decision to launch MHOs with a perspective of creating a network

This approach is especially well suited to a setting where there is heavy demand for starting new MHOs, and/or a desire to expand MHOs on a large scale fairly quickly. Other favorable conditions for this strategy are good quality health services and a collaborative spirit among providers; an expression of need for health financing and insurance mechanisms at decentralized levels; and the dynamic involvement of national and local authorities and opinion leaders in the MHO movement.

[5] *See for example Bennett, S., A. Gamble Kelley, and B. Silvers. September 2004.* 21 Questions on Community-based Health Financing. *Chevy Chase, Maryland: Partnerships for Health Reform Plus Project, Abt Associates.*

Process

Like any MHO start-up process, launching MHOs with the intention of creating a network follows a set of well-known steps. The innovative aspect of this approach is that a group of MHOs goes through these steps together, rather than one-by-one. All of these activities culminate in the creation of a formal network of MHOs.

1. **Identify key actors in the zone where the MHOs are being launched**. In order to stimulate participation in the MHO launch process, it is important to identify who will be key players and partners in MHO promotion and support. These may include local associations and organizations, locally elected leaders, and health care providers. Working meetings are organized with these stakeholders to discuss the following: formation of representative launch committees for each MHO; development of an activity plan for this committee, including conducting a joint feasibility study (see below); carrying out joint trainings on key concepts related to MHOs; and establishing oversight for the committee's work plan. The primary objective is to provide this committee with sufficient knowledge and tools to carry out the launch process and to represent and lobby for MHOs. (See also Innovation No. 8: "Building local partnerships to support MHO development.")

An MHO network – its role

What can a network of MHOs actually do? Here are several key functions.

1. Serve as a forum for collaboration on programs of training, technical assistance, or monitoring and evaluation;
2. Provide a forum for negotiating with partners, such a health care providers or facilities, in order to obtain preferential conditions and rates;
3. Help MHOs address needs they are unable to meet individually, by centralizing certain functions, such as:
   - Management of hospital care for MHO members at the level of regional hospital;
   - Maintenance of a database on MHOs in the area;
   - Organization and implementation of activities across MHOs in the area to promote exchange, cohesion, and collaboration;
   - Development and management of a guarantee fund for MHOs in the network;
   - Prevention and management of conflicts between MHOs or between MHOs and other partners;
4. Promote MHOs by carrying out joint promotional and mobilization campaigns;
5. Represent the network of MHOs with partners, local authorities, providers, etc.; and
6. Ensure the protection of all participating MHOs' material and ethical interests.

2. **Carry out a feasibility study**: Given the emphasis on creating a network, this stage is carried out throughout the entire zone of potential coverage. Thus, instead of each launch committee conducting its own feasibility study, the launch committees work together to contribute data from their respective areas, and if possible delegate one member to take part in a smaller technical committee that actually conducts the feasibility study. If resources permit, the technical committee may hire an expert to carry out the study. The feasibility study provides information on socio-economic and cultural characteristics of the target population, as well as the supply and costs of health services available, existing community and institutional arrangements, and other information that will help the technical committee and the launch committees to propose benefits packages, dues rates, and the organizational structure of the new MHOs.
3. **Launch promotional and mobilization activities**. The launch committees are responsible for disseminating progress reports to their target population. At this point, these launch committees are validated and may be expanded. Then, the main job begins – to initiate a promotional/mobilization campaign in collaboration with local government and providers to encourage membership in the new MHOs. Such a campaign may involve the launch committee members making the rounds of the villages in their area, as well as airing local radio campaigns that describe the principles of MHOs, how they work, and the advantages of becoming a member.
4. **Launch of multiple MHOs**. In order to ensure that key parameters of all the MHOs are harmonized, that the exchange of experiences is free-flowing, and that local capacity to support MHOs is built, launch committees participate in each step of MHO launch activities, notably:
   - △ Evaluation of the promotional/mobilization campaign;
   - △ Final determination of the benefits package and dues rate;
   - △ Training of the executive committee of the MHOs (named at each MHO's first General Assembly) and establishment of the management system for the MHOs;
   - △ Training of health care providers;
   - △ Signing of contracts with providers; and
   - △ Training of oversight committees.

   This approach relies heavily on close collaboration with local government, health authorities, and opinion leaders in the geographic area. Their participation in strategic activities during the

development process, as well as in the dissemination of results, is crucial to local support and success.

5. **Formal creation of network**. The network is composed of all the MHOs in the designated geographic area that wish to be included. To render the network functional, these MHOs need to:
   - △ Agree on the organization and functioning of the network, as well as on its objectives,
   - △ Draft the guiding principles and bylaws of the network, and
   - △ Set the contribution level for each MHO to cover the costs of the network to function.
6. **Technical assistance**. Once the MHOs are operational and the network is set up, the long-term process begins of providing oversight, guidance, and support to strengthen member MHOs, their managers, and their relations with contracted providers (See also Innovation No. 7: "Establishing an M&E system for MHOs at the federation level.")

Available tools

The tools mentioned below come from Benin and Rwanda and include examples of network statutes as well as a diagram of the structure of a federation of MHOs.

Available Tools

Tools	Use	Expected Results
Statute of network at the commune level (*Statut d'union communale*)	Provides an example of basic texts from a network in Benin	Comprehension of the basic texts that govern a functional network of MHOs; Easier development of similar texts for new networks
Statute of the Federation of MHOs in Byumba, Rwanda	Describes the roles and operation of a federation of MHOs	Legal instrument governing the federation/network developed
Report from workshop in Benin to exchange experiences among MHOs with a perspective of creating a network (*Rapport de l'atelier d'échange sur les expériences des MS des Communes de Banikoara et de Sinendé*)	Provides detailed illustration of the process of launching MHOs with a perspective of creating a network	Better understanding of the dynamics of exchange and collaboration in this approach
Diagram of the Federation of MHOs in Rwanda	Provides an illustration of the roles and operation of a federation	Ability to diagram the network/federation

6. Innovation 4: Using a pilot phase to prepare for national scale-up of MHOs

Rationale and results

Pilot phases are often useful in the development of complex policies or reforms. A pilot phase allows for a period of experimentation, which is especially important in cases where consensus is necessary to justify the reform and its relation to health sector objectives, and when capacity needs to be built in order to effectively implement the strategy on a large scale.

A pilot phase to prepare for national scale-up provides a period of experimentation with MHOs that helps stakeholders to understand the results that can be expected from establishment of MHOs, especially in relation to overall health system objectives. It also allows time to build capacity within the country to implement scale-up. A pilot phase launches a cumulative learning process about MHOs through which stakeholders (members and their promoters) work together to identify and develop the institutional and legal framework that will be the basis of MHO development, as well as to exchange information, best practices, tools, and strategies.

There is some resistance to pilots because their experience is often poorly documented, and therefore not widely used. This is certainly the case when inadequate attention is paid to developing the institutional aspects of the reform or policy, from the start. However, when a pilot phase anticipates national extension from the beginning, it can do several useful things, such as: create demand for that reform; carry out operations research to weigh reform options; develop a reform model that is tested and adapted; and build capacity to roll out the reform or policy.[6] In regard to MHO development, a pilot phase can build the technical and administrative support, as well as the confidence needed to scale up MHOs nationally.

Raison d'être

In many African countries, use of health services remains very low. Many governments are seeking ways to reduce financial barriers to utilization of services and thereby increase utilization. MHOs are increasingly perceived as one solution. Even when a country has a significant number of MHOs, they are often spread out, not well known, and poorly documented. Moreover, institutional and technical capacities to develop MHOs are generally weak.

Sometimes, the political will to develop MHOs is greater than the internal capacity to do so, and it becomes difficult to establish and implement effective strategies for MHO start-up. To expand MHOs nationally in such conditions, a pilot phase can (i) create a solid base of MHO experience and (ii) resolve technical problems (weak capacity, limited experience) before attempting to go to national scale. In other words, a pilot phase can help to anticipate the consequences of MHOs on health sector objectives and familiarize health sector stakeholders with the strategies that will be necessary to support MHO development nationally.

Expected results

In a pilot phase, systems should be designed carefully; not only the MHOs themselves but their support systems (management systems and tools, federations or networks of MHOs, monitoring and evaluation systems, provider relations, training strategies, promotional and mobilization strategies, etc.) need to be established. Pilot phases allow for trial and error, and for solving problems encountered only after implementation begins. They also focus on identifying, documenting, and disseminating best practices, all the while building technical capacity. Lastly, a pilot phase helps to identify the costs associated with launching and operating MHOs that can be used as reliable estimates in plans for national scale-up. In summary, a pilot phase permits the development of a context-appropriate system, development and refinement of management tools, and creation and consolidation of national capacities for MHO development before attempting to scale up nationally.

Today, Rwanda is the only African country to have implemented a pilot phase to prepare for national scale-up of MHOs. Following the genocide serious effort was made to solve problems within the health care system in a way that emphasized solidarity and social cohesion. The pilot phase for MHOs was successfully implemented in Rwanda, and could easily be replicated elsewhere. For now, Rwanda is a tangible example of what can be expected from a pilot phase for MHO development.

The Rwanda MHO pilot contributed to four main health policy objectives: (i) improve financial access to health care, (ii) improve the quality of health care, (iii) build management capacity, and (iv) build community participation in the management of health services. In order to track the MHO pilot's impact on each of these objectives, an emphasis was put on data collection throughout pilot phase.

[6] *Bennett, Sara and Mary Paterson. January 2003.* Piloting Health System Reforms: A Review of Experience. *Chevy Chase, Maryland: The Partners for Health Reform*plus *Project, Abt Associates Inc.*

The box below describes the main elements of Rwanda's MHO pilot experience.

At the end of the pilot phase, Rwanda had a large number of MHOs, a set of effective management tools, solid experience with MHOs at the level of government, and, in the pilot districts, a cadre of national trainers.

The pilot phase reinforced the political will to extend MHOs nationally because it had generated a database of information that demonstrated the impact of MHOs on health system objectives. Once a strategic plan for MHO development was in place, scale-up was able to happen fairly quickly, since the pilot phase had resulted in experience on the ground, capable human resources, and systems and tools to support extension in the other districts. The MHOs created during the pilot phase served as models that new MHO initiators could study and visit. They also played a critical role in expansion by pairing up with new MHOs as mentors. Major problems were identified and resolved during the pilot process. As a result, "shortcuts" were developed to adapt the pilot model to local conditions, for example, in the organizational structure, the benefits package, or the modalities of member contributions and registration. All these factors increased the likelihood of a successful rollout.

The pilot phase in Rwanda – progress towards scale-up

Pilot phase and subsequent adaptation	Scale-up 2005-present
▼ 54 MHOs created in three districts ▼ Three federations of MHOs put in place ▼ Registration of 10% of target population (90,000) during year 1 ▼ Routine statistical data and household surveys showed clear improvement in members' financial access to health care, who used on average modern health services four times more often than non-members ▼ Eighteen-month pilot phase, followed by 24 months of adaptation	▼ 224 MHOs in place covering 3,073,508 people* across all districts in Rwanda (2005) ▼ Approximately 40% of Rwanda's total population covered ▼ In the midst of a national three-year scale-up plan (2005-2007)

* Butera, J.Damascène. Forthcoming. *Etude sur la Prise en Charge des Indigents*. p.17

Decision to implement a pilot phase for MHO development

There are certain conditions that favor the choice of this strategy and its successful implementation for scaling up MHOs nationally. Is there political will to conduct a pilot phase? Are there clear objectives and commitment for this strategy within the Ministry of Health? Are the necessary resources – financial and technical – available during the necessary time period of the pilot? The clear articulation of the government's specific goals and objectives is extremely important to create a well-designed pilot.

Process

Below are the primary steps to putting in place a pilot phase for MHO development.

1. **Research the health financing context – costs, local mechanisms, etc.:** A pilot phase is operations research. Therefore, it is important that reliable data guide the process. Data may well be available, or special studies may be commissioned, but the design of a pilot phase for MHO development should be based on a thorough understanding of the situation.
2. **The government/Ministry of Health expresses its political will:** A pilot phase requires the leadership and political will of the Ministry of Health and other governmental agencies to succeed. Therefore, these leaders must have an adequate understanding of the importance of the pilot phase for MHO development so that they clearly express their expectations to technical counterparts. Advocacy documents and technical advice are extremely useful to help these leaders articulate their commitment and political will.
3. **Plan the pilot phase and establish a steering committee:** The planning of the pilot phase must involve key decision makers and technical staff. It can be done during a workshop where expectations, specific objectives, and strategic orientations for the pilot phase are defined. It is critical to make this process participatory to maximize the involvement and engagement of all of the stakeholders in the pilot phase, and later in the extension. One way to ensure this level of participation is to establish a steering committee, whose role is to guide the different phases of the development of the pilot phase, to identify and resolve political obstacles, to plan for the pilot's next steps, and to institutionalize a forum for national coordination and collaboration on MHO

development. Likely candidates for steering committee membership includes representatives from the Ministry of Health at the national and operation levels, representatives from other key ministries (finance or local administration, for example), as well as representatives of the population, such as locally elected leaders and NGO staff. This committee may be formed by a ministerial decree.

4. **Design and implementation of the pilot MHOs:** The process of designing and setting up the pilot MHOs must, again, be participatory. Technical workshops can be organized at the national level, followed by dissemination workshops at the local level, during which participants (elected leaders, providers, opinion leaders, community-based organizations' representatives, etc.) discuss the basic structure of the pilot MHOs (dues level and frequency, benefits packages, etc.).

   The design of the management system and tools also happens at this stage: First, an inventory of existing tools and practices should be done, for example at the provider level, to prevent duplication of effort or confusion. Additional tools may need to be developed. This includes tools for MHO management, for providers, and for data collection that will allow evaluation of the pilot's impact on stated objectives.

   Specific operational activities must also begin at this stage, such as setting up provisional MHO offices, training managers, conducting promotional and mobilization activities, signing contracts with health care providers.

   The decision to create a network of MHOs may also be taken during the design phase, in order to create a larger risk pool and solidarity base across a broad geographic area. Such a network, or federation, is usually made up of representatives from the pilot MHOs who are elected to play this role during their MHO's General Assembly. Networks or federations can be useful as intermediaries between MHOs and health care providers, health authorities, and political leaders; they also provide technical support and a forum for problem-solving with partners during the pilot phase. (See also Innovation No.3: "Launching MHOs with a perspective of creating networks.")

5. **Establish monitoring system for monitoring ongoing capacity building**: (See also Innovation No. 7: "Putting in place a monitoring and evaluation system at the network/federation level" for a more detailed explanation.). The monitoring system put in place should involve the regular collection of key data, accompanied by technical support and capacity building. The technical support and capacity building happens on two levels: the national steering committee can provide overall supervision and provide technical support to the MHO federation. The MHO federation level can provide supervision and technical support to the pilot MHOs. Such a system fosters an exchange of best practices as well as problem-solving both horizontally and vertically. During the pilot phase, capacity building is essential and should happen continuously at every level.

6. **Evaluate the pilot phase:** The evaluation phase of any pilot aims to measure its impact on stated expectations and objectives, as well as to draw lessons for scale-up. Because a number of data have been collected systematically throughout the pilot phase, such evaluation is possible. It is advisable to conduct a mid-term evaluation during a pilot phase to ensure that implementation is going well and is on track to meet overall objectives, and to make any necessary adjustments. The final evaluation documents the ultimate results of the pilot and its impact on pilot objectives, through the implementation and analysis of several surveys (at the level of patients, households, and providers) to document MHO impact of use of health services, etc. The dissemination of evaluation results by multiple media (reports, advocacy documents, etc.) is critical to encourage ownership.

7. **Begin phase of adapting, expanding pilot results:** Following the final evaluation is a period during which the results, lessons, and recommendations from the pilot phase are put to use, in both pilot districts and new districts. Innovations and new approaches are documented and disseminated. Also, planning begins for national scale-up. A national-level strategic plan that incorporates both technical and financial plans for MHO expansion is important in this stage, as are implementation plans at the operations level. (See Innovation No. 2: "Developing a national strategic plan for MHOs.")

Available tools

All of the tools below come from Rwanda, given that it is still the only country to have used a pilot phase to prepare for MHO scale-up. The list includes an evaluation plan for a pilot phase and survey tools, policy briefs as examples of technical support and advocacy, and a training guide used to develop a national cadre of MHO trainers.

Available Tools		
Tools	**Use**	**Expected Results**
Training guide for trainers on MHOs (Guide de formateurs sur les MS)	Contains training modules on all aspects of MHO set up and management to help create a cadre of national trainers	Cadre of trainers trained and available to support the scale up of MHOs and to train others
Policy brief on MHOs in Rwanda Policy brief (*Programme d'appui sur le développement des MS*)	Examples of how to provide technical advice and advocacy for the pilot phase of MHOs	Key decision makers are well informed and equipped to advocate for the pilot to technical counterparts and to the population at large
Baseline data collection tools (*Outils de collecte des données de base*)	Models of terms of reference for surveys, survey questionnaires, used during the pilot phase (baseline and evaluation)	Tools adapted/available for baseline data collection and evaluation
Evaluation tools (*Outils d'évaluation*) Evaluation plan for pilot phase (*Plan d'évaluation de la phase pilote*)	Methods to evaluate the performance of the pilot phase Identification of criteria and indicators for objectives of the pilot phase	Evaluation plan created and available to guide the pilot phase

7. Innovation 5 – Decentralization of MHO management

Rationale and results

Raison d'être

There are two main reasons for an MHO to decentralize[7] its management. First, an MHO may have grown so large that its management structure is no longer able to efficiently do basic tasks, such as collecting dues. The large size of an MHO also can result in management becoming too physically distant to maintain regular contact with members. By creating local management units to carry out specific tasks, decentralization boosts member participation in the daily life of the MHO and can also improve the efficiency of certain MHO functions. Tasks that may be more efficiently done by local management units include member recruitment, dues collection, managing provider contracts.

Decentralizing MHO management involves the devolution of roles, responsibilities, and resources within an MHO to management units in proximity to its members. Its objective is to increase the presence and role of the community in the MHO's life and management, as well as to create more efficient mechanisms for certain essential tasks, such as promotional and member mobilization activities, dues collection, and provider relations.

Second, decentralization can be a way to extend MHO promotional and mobilization activities leading to membership to geographically isolated population subgroups that otherwise might only be able to form small - and therefore financially unstable - MHOs.

Especially as MHOs scale up nationally, there is a growing trend to link MHO target population boundaries to the boundaries of a decentralized administrative area (Rwanda and Ghana, and increasingly in Benin and Senegal). Doing this is a good way to address the inherent tension of wanting to cover entire districts (for example) and needing to protect and maintain proximity between MHO members and their management.

Expected results

Decentralizing MHO management leads to better member participation, better member recruitment, and better dues recovery rates.[8] It also strengthens relationships between the MHO and the providers with whom it contracts. A summary of expected results from decentralizing MHO management follows:

- Improvement in dues recovery rates;
- Improved coverage of target population (% of target population who joins the MHO);
- Improved relations with health care providers;
- Better coverage for promotional and mobilization activities;
- Higher levels of member participation in decision making;
- Better representation of members within MHO management (system of delegates);
- More transparent management of the MHO.

Clear membership increases following decentralization of MHO management: Two cases

Wayerma, an urban MHO in Mali, decentralized its management in October 2003 in order to expand its social base to three new neighborhoods, where it created local management offices. As a result, Wayerma increased the number of beneficiaries from 1,700 in 2003 to more than 5,700 by the end of 2004.

Soppanté, a rural MHO in Senegal, expanded its target population by doubling the number of villages that it covered from 30 to 60. It made a huge effort to promote and recruit members during its decentralization process, and was able to increase it membership from 555 to 1,071, and the number of its beneficiaries from 3,330 to 7,456.

Decision to decentralize MHO management

The decision to decentralize management is made by the General Assembly of the MHO, and should be a strategy that is explained to and discussed with the membership. Here are several key questions to consider before adopting this strategy : Does the MHO have problems that decentralizing management could address, such as inadequate information flow between management and members, or an overburdened central management team? Is there consensus on this strategy between members and leaders of the MHO? Does the MHO have adequate human and financial resources to

[7] *The term "decentralization" is used in this document to be consistent with the terminology used in the field with MHOs, even though the process described may be more accurately termed "devolution" of the management units of an MHO.*

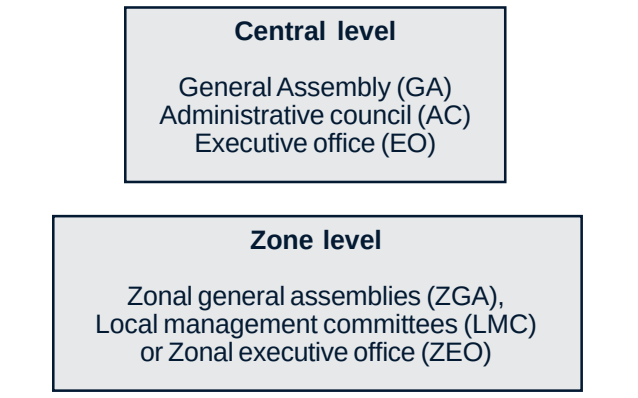
[8] *Franco, L. et al. November 2004.* Social Participation in MHO Development in Senegal. *p. 45.*

effectively decentralize management (to fill new local management positions, ensure the training of these positions, and supervise them)?

Process

After the MHO decides to decentralize management, it should follow the five-step process described below.

1. **Plan for decentralization**: Existing management should determine the plans and timeline for decentralization. Activities include the following:
   - △ Subdivide the target area into zones: This concerns both current members and target populations for recruitment. Grouping villages/neighborhoods into zones promotes efficient, effective contact between the MHO and the population. Such a decentralized management system (and its various management units) has a pyramid structure, as depicted in the figure below.



   The division into zones is done based on the number of members and their geographic distribution within the MHO catchment area. Thus, one can create several different zones.
   - △ Seek contact with leaders and decision makers at the decentralized level (zones);
   - △ Hold informational meetings in the zones with MHO leaders and members to explain the benefits and modalities of decentralizing MHO management;
   - △ Hold general assemblies at the zone level to establish local management structures for the MHO (participants are again MHO leaders and members);
   - △ Train local management structures on MHO management;
   - △ Launch the new management structure at the zone level (provision of administrative and management tools);
   - △ Develop and adopt internal regulations for local management structures; and
   - △ Program monthly local management meetings.
2. **Organize and hold general assemblies at the zone level**: The zonal general assembly becomes the main mechanism for member participation in the MHO, and it is also where zonal delegates are elected. These zonal delegates then elect the members of the local management committee.
3. **Establish the delegates for the MHO General Assembly**: As mentioned above, each zonal general assembly names delegates, who will participate in the central MHO General Assembly on behalf of the zones.
4. **Establish and train the local management committees**: Zonal delegates choose the members of the local management committee. It is important for opinion leaders to participate during the process of training local management committees, as their involvement in promotional and mobilization activities must be sought continuously.
5. **Deconcentrate functions and tasks to local management committee** (see Soppanté example in text box)
   - △ Promotional and mobilization activities;
   - △ New member recruitment;
   - △ Dues collection; and
   - △ Management of provider relations.

Supervision is needed to ensure quality management by the different management structures. Central management structures must regularly support and supervise local management committees.

As an example of the decentralized system of management, the structure, roles, and functions of the Soppanté MHO in Senegal are detailed below. Soppanté was created in 1998 and today has approximately 7,500 beneficiaries. It covers 60 villages with a target population of about 30,000. Soppanté maintains contracts with 13 health posts (five of which are private) and one regional hospital. Primary curative

Motivating local management committees in Senegal

As in most African countries, MHO management in Senegal is done by unpaid volunteers. When MHO management is decentralized, more people are needed to participate in management; in turn, incentives are needed to ensure that administrative and management tasks get done. One system of incentives being tested at present gives dues collectors 5-10% of the dues they collect each month. They are also reimbursed for fees incurred during the data collection process (gasoline, etc.).

Structure, roles, and functions of Soppanté MHO's decentralized management system

Central level

General Assembly (GA):
The GA is the guiding structure within the MHO. Because it is such a large MHO covering numerous and widespread villages, Soppanté established that each zone would be represented at the GA by delegates. Thus, the participants in the central GA are zonal delegates, who are appointed at the zone level by their respective local management committee from the membership of the zonal executive offices and the local management committees. There are approximately eight participants per zone, or 60 delegates overall.

The Administrative Council confers proposals it has received to the zonal GAs, where they are discussed and then brought before the central GA for amendment and adoption. The role of the GA is to set overall MHO policy by: (i) approving the MHO work plan; (ii) approving the strategic development plan for the MHO; (iii) setting the MHO budget; (iv) amending, adopting the MHO's bylaws and internal regulations; and (v) electing the MHO's administrators and inspectors for the central level. During a typical GA, the MHO will discuss the financial report and any changes to the internal regulations and bylaws, especially those related to changes in dues rates and benefits packages. (In reality, discussion of budgets and work plans is rare.)

Administrative Council (AC)
The AC is made up of 21 members elected during the GA. It meets once per quarter, and the meeting is open to participation by local management committees. The AC's role is to supervise the implementation of the decisions made during the GA and to report on overall MHO management. The AC submits progress reports, work plans, budgets, and proposals for MHO changes to the GA and to zonal GAs. The AC also develops quarterly work plans, and reviews the management reports provided by the Executive Office. The AC is responsible for electing the members of the Executive Office.

Executive Office (EO)
Elected by the AC, there are five members of the Executive Office – a president, vice president, a general secretary, a deputy secretary general, and a treasurer. The EO is responsible for the daily management of the MHO. It supervises the local management committees and zonal offices, and ensures overall coordination. The treasurer oversees the zonal manager's work by ensuring that it is in line with local management committees' budgets, and by reviewing monthly revenues and expenses for each zone and using the surplus to cover hospital bills for the MHO.

The EO is responsible for organizing and preparing for quarterly AC meetings by submitting budgets, annual program reports, etc. The EO is also responsible for the MHO's relations with the hospital including signing contracts, providing letters of guarantee, paying bills, etc.

At the decentralized level of the MHO

Zonal General Assembly (ZGA)
The ZGA is attended by MHO members within the zone. There is one ZGA per year where the following happens:
- MHO management reports are examined and discussed, especially as they relate to the zone itself;
- Decisions are made on whether to support proposed modifications to the MHO's internal regulations and bylaws;
- Local management committee members are elected (two per village in the zone) and delegates are named to participate in the central GA.

Local Management Committee (LMC)
The LMC is elected at the ZGA. Its size varies, depending on the size of the village it represents. The LMC elects the members of the zonal office, and is also responsible for zonal management of the MHO. The LMC carries out promotional and mobilization campaigns, and also organizes the annual ZGA, where it presents proposals for MHO modifications, the budget, and the work plan.

Zonal Office
The zonal office is made up of a president, vice president, secretary, and a deputy secretary. Its responsibilities are:
- To provide overall MHO coordination at the zone level;
- To carry out the daily activities of the MHO at the zone level;
- To supervise and support the zone manager; and
- To manage relations with health posts under contract.

Cont p. 22

Structure, roles, and functions of Soppanté MHO's decentralized management system

Zone Manager
The zone manager is responsible for the following tasks:

- Dues collection (from the 1st to the 10th of each month);
- Recruitment of new members;
- Payment of bills;
- Management and updating of membership cards and other management tools;
- Liaison between the MHO and members, including representing member complaints to zonal MHO management; and
- Monthly deposit of member dues from the zone into the central treasury.

GRAIM. Forthcoming 2006. *Etude de Cas, Mutuelle de Soppanté*. PHR*plus*.

Available tools

The tools that follow pertain to the process of decentralizing an MHO. (Once the MHO has established decentralized management, it uses the same administrative and financial tools as other MHOs, which are not included here.) A matrix for planning decentralization is included from Senegal, as well as a procedural manual for decentralized management structures. There is an example of the internal regulations and bylaws of a decentralized MHO. Finally, there is a detailed case study of the pioneering experience of Soppanté with decentralized management from the Thiès region of Senegal.

Available Tools

Tools	Use	Expected Results
Planning matrix for decentralized management (*Matrice de planification de la décentralisation de la gestion des MS*)	Planning tool to help determine steps, roles, and timeline	Solid approach for proceeding with decentralization process with clearly defined roles and timeline
Procedural manual for decentralized management structures (*Manuel de procédures administratives et financières des instances décentralisées*)	Reference manual for decentralized management structures	Local management structures have adequate information and reference material to carry out effective daily management
Example of internal regulations and bylaws of a decentralized MHO (*Règlement intérieur et statut d'une MS décentralisée*)	Example of how to formulate internal regulations and bylaws for a decentralized MHO	Internal regulations and bylaws revised to reflect decentralization of the MHO
Case study of the Soppanté MHO (*Etude de cas: la Mutuelle de santé Soppanté*)	Detailed description of the pioneer experience of decentralizing MHO management	Better understanding of the process of decentralizing MHO management

8. Innovation 6 – Collaborating with local radio for MHO development

Rationale and results

Raison d'être

Social mobilization is an ongoing activity for MHOs, to encourage recruitment as well as the regular payment of dues. Early in an MHO's development, communication strategies focus on mobilizing new members, but as it matures, these strategies focus increasingly on promoting member participation in the operation of the MHO and providing them with information about MHO activities and changes. Internal communication capacities and systems within MHOs, however, are typically weak, and MHOs tend to rely on person-to-person contact, which is not the most effective way to reach large numbers. As a result, MHOs are limited in their ability to mobilize dues payments, conduct recruitment campaigns, or transmit other important messages. By working with local radio, MHOs can dramatically improve the efficiency and effectiveness of their communication with members.

Collaborating with local radio in MHO development expands MHO promotion, helps to mobilize new members, and creates fruitful new partnerships with local media outlets. As in other developing countries, local radio reaches a majority of rural households in West Africa. It is therefore a highly effective mechanism for the widest possible transmission of MHO messages to the population. The objective of this strategy is to establish a long-term conversation and a sustainable partnership between local radios and MHOs for their mutual benefit.

Because MHOs are stronger insurance mechanisms when they have more members (by spreading risk across a larger pool of members), they constantly seek ways to grow. Collaborating with local radio allows the MHO to reach the maximum number of potential members with various messages that are most effectively transmitted orally, given the prevalence of illiteracy in rural contexts. For this reason, local radio has become ubiquitous in West Africa, and is increasingly involved in development activities.

Expected results

Partnering with local radio stations allows an MHO to reach the maximum number of households with a set of messages. Because local radio is so pervasive, MHO radio recruitment campaigns have the potential to generate large numbers of new members. Radio messages can be adapted to complementary media (brochures, cartoons, etc.) to create a multimedia mobilization campaign. More importantly, partnerships with local radio build awareness of MHOs and thereby produces advocates for the MHO movement. Local radio professionals who are invited to participate in MHO trainings and key start-up activities (promotion events, contract-signing ceremonies with providers, etc.) become valuable resources for MHO development. Increasingly, local radio is a dynamic forum for communication about and participation in the life of many MHOs (see box below on Mali).

Broadcasting MHO mobilization activities in Mali

Promotion days are a common strategy for MHO mobilization. At such an event in the city of Sikasso, for example, a local group of *balafonistes* (actors and musicians) performed songs and dances in a central square, and MHO members who had benefited from services spoke of their satisfaction. In rural Bla, a soccer game between MHO members and health care providers showed off their collaborative relationship. Prizes were offered to participants in both sites. But the key to the success of these promotion days was that they were covered live by local radio, and thus reached thousands of households.

Decision to collaborate with local radios

What are the preconditions for collaborating with local radio? Below are several pertinent questions.

- To which radio station does the MHO's target population listen most? Obviously, this strategy depends on the existence and strength of local radio.
- Are local radio stations already involved in local development activities? Do they demonstrate an interest in getting involved? A demonstrated willingness to play a role in local development is important.
- Does the MHO have an information, education, and communication (IEC) strategy with defined themes and key messages that it wishes to convey to the target population?

Evidence of the impact of radio on MHO mobilization efforts from neighboring communes in Benin

Radio spots and interviews with MHO beneficiaries that were aired by the local radio station FM Nonsina in Bembèrèkè in the north of Benin helped to convince local populations about the benefits of joining an MHO. As a result, the populations of neighboring communes (Péhonco, Gogounou etc.) have declared their intention to join the MHOs in Sinendé commune.

Process

The first step for an MHO that wishes to develop a collaboration with local radio is to identify potential radio partners based on stations' listening audience and their interest in such a partnership. Once these radio stations have been identified, the following steps help to create a long-term, constructive partnership.

Case study – Nkoranza MHO in Ghana

The Nkoranza MHO is the pioneer scheme in Ghana. Launched in 1989, Nkoranza has 68,086 beneficiaries (2005), covering 46% of the population of the district. Nkoranza has built partnerships with three local radio stations (one in its own district and two in a neighboring district) and has developed a major radio communication effort, managed within the MHO by a public relations manager. Nkoranza runs at least two major radio programs each month (for example, debates and phone-in programs). These radio campaigns target two distinct periods: i) the time of year when new members are accepted and ii) the rest of the year. During the new membership campaign, the main objectives are to solicit new members using member testimonials about the advantages of MHO membership, or by describing the process of becoming a member. During the rest of the year, focus is on sharing important information about the MHO (holding of general assemblies, etc.) or about health seeking practices (the importance of seeking primary care at the health center rather than the hospital, the importance of certain preventive care measures, etc.) Previously, the radio stations offered such public service programming free-of-charge. Now, the stations charge for the MHO broadcasts; still, Nkoranza sees this as a worthy investment, and it continues to run at least two programs per month.

1. **Advocate for local radio to become involved in promoting MHOs.** One successful way to interest radio in MHO development is to involve radio professionals in MHO start-up committees, in training workshops for MHO managers, or in other MHO activities where these individuals can learn about and participate in MHO development. The goal is to develop a partnership between the MHO and the local radio. Such a partnership can become a major support to the MHO, since local partnerships are often key to the long-term sustainability of any MHO. Local partners are pivotal in carrying on promotional and mobilization activities that are continuous in the life of the MHO. (See also Innovation No. 8: "Building local partnerships to support MHO development.")

2. **Define themes for radio programming, develop radio message content, and establish dissemination plan**. It is important to involve key stakeholders in defining themes and developing the content of radio messages. Stakeholders include radio professionals, local leaders (religious and elected), and local health authorities. The themes will depend on the stage of the MHO's development. During start-up, emphasis is on informing the population about the functions and practices of MHOs and health insurance in general (see box below). Once an MHO is operational, messages can contain member testimonials about the benefits of joining an MHO (for ongoing recruitment). Later radio communication strategies involve different types of messages: announcements (of upcoming events, for example), spots, interviews, mini-series on a given topic, additional testimonials from member who have benefited from the MHO's services, or even live coverage of demonstrations, promotion days, general assemblies, etc.

Main themes for radio messages during MHO start-up

- Explanation of an MHO and its guiding principles
- How to become a member of an MHO
- Services covered by the MHO
- How to take advantage of the MHO's services
- Conditions for benefiting from MHO covered services
- Coverage limits for health services and co-payments
- How benefits packages are determined
- How providers are paid by MHOs for member care
- General health insurance problems*

*Such as adverse selection – when sicker people join an insurance plan in greater numbers than the rest of the population. This situation can lead to financial difficulties for an insurance system because the level of expenses per insured person is high. Another problem is moral hazard – when insured persons use more health services than they would if they were not insured in order to "maximize" their investment.

3. **Validate messages**. Before they are broadcast, themes and specific messages should be "tested" or validated by target populations and those involved in MHO development such as women's groups, socio-professional organizations, cooperatives, and local leaders.

4. **Broadcast messages**. Messages are enhanced and made operational and the modalities of their broadcast are negotiated (how many times per day they will run, in what languages, at what hours, as well as the price).

5. **Evaluate the impact of radio messages**. It is always important to evaluate the results of different elements of an IEC plan, including work with local radio. One approach to evaluation is to bring together stakeholders (including radio professionals) in a workshop setting to discuss the strong and weak points of the MHO radio programs and to revise the work plan or messages as necessary. Another approach, for example to evaluate the impact of radio messages on the population's likelihood to join the MHO, is to ask members during the monthly dues collection whether they had heard and understood the radio messages. Member households that are not current with their dues could be asked the same questions, and new members could be asked if the radio messages had played a role in their decision to join the MHO.

A fruitful partnership in Mali

Kéné Radio in Sikasso, Mali participated in all the steps undertaken to develop two MHOs in the Sikasso Urban Commune — from preparing the ground for the initial baseline studies to round table discussions on various aspects of MHO life. Because Kéné Radio became so interested in the MHO topic, they rearranged their programming schedule to include a MHO section which continues to air on the radio, even after the end of the contract that the Radio had signed with the MHOs.

6. **Seek long-term partnerships with local radio.** Since communication is so essential to the good health of any MHO, local radios are priority partners. Some MHO have had difficulty establishing sustainable partnerships with local radio due to the costs of such programming, suggesting that it may be more appropriate for media activities for MHO promotion be carried out by groups at the intermediate level (MHO federations and networks), or even with government support. Such is the case in several countries where MHOs are being scaled up nationally.

Media and MHOs in Rwanda – The involvement of the Ministry of Health

During its pilot phase for MHO development, the Ministry of Health sponsored a 3.5 hour radio program during which the Minister himself, members of MHO launch committees, and the president of an MHO federation in one pilot district responded to live questions from the population. During the entire pilot phase and beyond, the ministry ran regular national radio spots to encourage the population to join an MHO and to promote the benefits of belonging to an MHO, often using member testimonials (such as a mother who was able to give birth to triplets in a modern setting, thanks to her membership in the MHO).

Available tools

The tools below include a synthesis of various radio messages developed by MHOs in Mali, two transcripts of radio spots from Rwanda, and an example of evaluating the process of developing radio programming as an element of a Malian MHO's promotional activities.

Available Tools

Tools	Use	Expected Results
Synthesis of MHO radio messages (*Synthèse des messages radio portant sur les MS*)	Provides model messages that can serve as inputs to and examples of the development of radio messages for MHO development	Better understanding of the range of messages an MHO can transmit by radio; more efficient message development
Two transcriptions of radio spots	Gives examples of radio spots actually broadcast in Rwanda	Easier, more efficient process of developing radio spots for MHOs
Evaluation workshop report for MHO IEC activities (*Rapport d'un atelier d'évaluation des activités d'IEC*)	Provides an example of how to carry out an evaluation of the process of radio programming within MHOs	Better understanding of ways to evaluate communication processes

9. Innovation 7 – Putting in place an MHO monitoring and evaluation system at the network/federation level

Rationale and results

Raison d'être

Information about the performance and impact of individual MHOs and the MHO movement is critical. To know where technical assistance is needed, consolidate the MHO movement, and incorporate MHOs into a coherent nationwide social protection policy, stakeholders such as the MHOs themselves, governments, and development partners need rigorous, timely information about MHOs' functioning and contributions within the health sector. For example, monitoring is needed on the individual MHO level, to know which MHOs are performing well and which are having problems, so that support is rationally provided support where it is needed. More broadly, they need to know exactly what percentage of the population is covered by MHOs, which segments of the population are not, and what the impact of MHOs is on members' use of health care services.

Putting in place an M&E system at the network/federation level: In this strategy, an intermediate level structure, such as a network, federation, or union of MHOs, carries out monitoring and evaluation for its member MHOs. Once MHOs are operational, it is important that there is a system in place to track how well the MHOs' activities meet their organizational objectives, as well as larger health objectives to which MHOs are expected to contribute. This requires that a set of key strategic and operational indicators be established and tracked. An M&E system generally requires technical capabilities that are not found at the MHO level, but rather at a higher level, like a federation, where strategic decision making based on M&E data can happen.

There is a general consensus that the information on MHO impact in the health sector is inadequate. Often, the only information available is what individual MHOs collect for basic operational management purposes (expenses, revenues, and membership numbers).

In addition, the intermediate level – MHO federations and similar organizations – need to compile data on MHO management, member utilization of health care services, etc. so that they can make strategic decisions about MHO development. Examples of such an intermediate level exist: in Rwanda there are MHO federations, in Senegal there are regional coordinations, and Benin is currently putting in place communal unions.

Within a monitoring and evaluation (M&E) system, household surveys, patient surveys, and provider surveys can be added to routine MHO data collection to assemble the data necessary to evaluate MHO performance. Clearly, such an M&E system requires significant financial resources and technical capacity, which exceed the MHO level and are more reasonably available at the intermediate or even national level. Moreover, it is at those levels that such information is necessary to respond to broader objectives of the MHO movement and of the Ministry of Health.

Expected results

This type of M&E system would collect data on the following, for example: the evolution of MHO membership, utilization patterns by MHO members, organizational performance of MHOs, and the financial impact of dues rates and co-payments on utilization. Such data would help decision makers to take stock of MHO development, identify major constraints, and rationally plan technical assistance efforts.

Another important feature to include in the M&E system is feedback, that is, the system facilitates the flow of information from the ground to the top and back, thereby creating a continuous process of learning and exchange. In this system, MHOs collect monthly data, on such operations as financial flow and membership, to feed into operational decision making. The MHOs then submit the data to the intermediate level, where it is added to a larger database for more thorough and comparative analysis. The intermediate level disseminates its analyses back to the MHOs through regular quarterly reports and/or meetings, and it uses the analyses to determine technical assistance activities based on individual MHO needs. Since the intermediate level is also the link between the MHOs and the central level (Ministry of Health, for example), it also disseminates information upward on a regular basis.

Decision to put in place an MHO M&E system at the federation/network level

There are several important considerations in deciding whether to adopt this strategy. First, is there a functional federation or other network at the intermediate level that could assume this function? If not, such a structure would have to be created. Second, capacity building within such a structure is essential to collect, analyze, and use information to make this strategy work. Third, do the MHOs in the network use the same management tools to collect their monthly information? If not, it will be necessary to agree on a set of key data and standard tools to enable a joint M&E system to function. Is there a good partnership with health care providers, since some data

needed for M&E must be obtained at the provider level (such as utilization trends by members)? Do the contracts between MHOs and providers provide an incentive to collect reliable and regular information? The system selected for monthly provider reimbursement (capitation or fee-for-service) can include a provision for a "quality payment" based on the quality of the data collected.

Above all, however, there must be consensus among the MHOs, the federation, the providers, and the government that such a system of M&E is absolutely vital to the MHO movement. Close collaboration among all of these entities is necessary for such a system to work well. Developing a strategic plan for MHO development (see Innovation No. 2: "Developing a national strategic plan for MHOs") can help to create this kind of consensus.

Case study Thiès, Senegal

The 39 MHOs in the Thiès region are highly diverse, having developed individually and organically over time. Despite this fact, the regional coordination of Thiès (the intermediate level) put together a set of best practices in financial and administrative (F&A) management based on its members' experiences. As a result, all of these MHOs now share the same F&A management tools, and receive the same training on their use from the regional coordination. This is the first step in putting in place an MHO M&E system at the regional level in Thiès.

The MHO M&E system at the federation level in Rwanda

To date, Rwanda is the only country to have put in place a comprehensive M&E system at the intermediate level, and it thus serves as an example of the potential of this type of system.* Conceived as part of a pilot phase (see Innovation No. 4: Using a pilot phase to prepare for national scale up of MHOs), the M&E system provided both MHOs and their federations with adequate information to track MHO performance during and after the pilot phase.

Routine data collection happens at the MHO level, as well as at the health center and district hospital levels. The data collected includes:

- At the MHO level – monthly data on membership and MHO financial status;
- At the health facility level – data on member utilization, staffing, drugs, and revenues.

At the federation level, these data are used to follow the performance of MHOs, as well as their impact on utilization, costs, and financing of health care. Moreover, the data help the federation to identify technical needs and target support, as well as to see modifications that are necessary in the MHO movement.

* During the pilot phase of MHO development, Rwanda also carried out quantitative baseline studies, household, patient, and beneficiary surveys, alongside the routine data collection, in order to evaluate the impact of MHOs on the four related health system objectives: (i) to improve access to health care, (ii) to improve health care quality, (iii) to build management capacity, (iv) to encourage community participation.

Process

The main steps to putting in place an M&E system at the federation level are the following.

1. **Defining the M&E system**: The process of defining the system should consider the following points:
   - △ Identify the objectives of the system. Is there a need for specific information? What information? How will different stakeholders use this system and the information it generates?
   - △ Outline the key categories of data (variables and indicators). Who will use each? To make what decisions?
   - △ Develop/identify the tools that will provide the necessary data. What forms for use by whom? What summary tables to aggregate the data? How often?
   - △ Define (in a participative manner) the roles for each actor in the system, from the data collection, to their analysis and interpretation.
   - △ Develop analysis and dissemination plans for the data.
   - △ Determine the frequency of data collection, analysis, and dissemination throughout the system.

   As an example, the table on the next page illustrates how to define such a system to respond to the objective "Improve financial access to health care."

Example of defining an M&E system				
Criterion	**Indicators**	**Data Sources**	**Collection methods**	**Collection Instrument**
1. Utilization of health care services	a. Difference (%) in levels of utilization of health facilities between members and non members	Health facility data	Provider survey or supplemental entries to patient registry to identify members versus non-members: Unit of observation: ▼ Health facility Unit of analysis: ▼ Health facility ▼ Health district	Health facility data collection forms
	b. Difference (%) in level of utilization of health facilities between members and non members within 40% of the poorest households	Household survey data	Household survey Sample size: ▼ X households Unit of observation: ▼ Household ▼ Individual Unit of analysis: ▼ Household ▼ Individual	Structured Questionnaires: ▼ Household ▼ Curative care seeking ▼ Preventive care seeking ▼ Socioeconomic status

2. **Implementing the M&E system**: The implementation phase includes producing and distributing the M&E tools and training MHO management committees and providers to ensure proper data collection. Given the amount of data to compile and analyze, it is advisable to computerize the system if conditions allow (if there is electricity, for example), especially at the intermediate level. In this case, training on using computers to manage data would also be done.
3. **Data collection and analysis**: Using the provided data collection tools, MHOs must gather data on new members, total members and beneficiaries who are up-to-date on dues payment, the benefits package, the functioning of MHO offices, expenses, and revenues. The Executive Office of each MHO should regularly analyze this data to track the performance of their MHO. Health facilities under contract with MHOs must collect monthly data on use of services and drugs, as well as their costs and revenues. Both the MHOs and the health facilities then transmit these data to the intermediate level for monthly analysis.
4. **Data analysis at the intermediate level**: Data from MHOs and providers needs to be compiled, aggregated, entered, and analyzed at the intermediate level. By looking at the data across MHOs, the intermediate level can distinguish utilization, cost, and financing trends (member versus non-member). Once the analysis is complete, it is important to feed information back to the MHOs through a written report and/or quarterly meetings. Results should also be shared regularly with the central level (the steering committee for MHO development, the Ministry of Health, etc.) to keep them informed and involved in the process of building capacity within the system. In this way, the intermediate level can contribute to developing effective, information-based strategies and policies for MHO development.
5. **Technical assistance**: Results from analyzing the M&E data allow the intermediate level to identify problems such as overprescription of drugs, overutilization of services, billing problems, dues recovery issues, and data keeping problems. They then determine where to provide technical assistance to MHOs and contracted providers to resolve the problems identified. Regular federation visits to member MHOs also provide a mechanism for tracking the overall performance of the M&E system.

Available tools

The tools listed below are for the intermediate level in an MHO M&E system. This list does not include other administrative and financial management tools that MHOs use for daily tracking, which also feed into the overall M&E system.

Available Tools

Tools	Use	Expected Results
Tools to track member use of health services (*Outils de suivi de la consommation des soins par les members*)	MHOs and providers	Measures: ▼ The impact of MHOs on member utilization trends ▼ Member utilization trends' effects on MHO financial status ▼ The impact of MHOs on overall use of health services
Monthly monitoring synthesis tools (*Fiche de suivi mensuel - outils de synthèse*)	Federation (intermediate level)	Results in the compilation of MHO data at the intermediate level
Organizational development checklist (*Checklist du développement organisationnel*)	Federation (intermediate level)	Facilitates evaluation of: functioning of MHO offices; state of provider relations; state of MHO relations with other partners; and administrative and financial management capacity Tool to prompt discussion, plan technical assistance needs

10. Innovation 8 – Building local partnerships to support MHO development

Rationale and results

Raison d'être

Experience shows that many different actors have complementary and constructive roles to play in MHO promotion and development. In countries where MHOs have made building local partnerships a priority, growth in terms of both the number of MHOs and their membership have been impressive.

The strategy of using local partnerships to support MHO development aims to improve MHO sustainability by responding to two major problems. First, MHOs often have weak human and financial capacity due to the relative poverty of their target populations. Moreover, MHOs tend to be inwardly focused, and thus miss out on the benefits of coordination and cooperation with other MHOs, such as the spread of best practices. Building local partnerships for MHO support establishes an environment of support and coordination at the operational level.

Building local partnerships to support MHO development is a strategy that aims to deepen the links between MHOs and their socio-economic and cultural environment to support their development and sustainability by involving the maximum number of local organizations and institutions. These local organizations include community MHOs and their federations of course, but also local health authorities, opinion leaders, local government, women's associations, producers' organizations, community health committees, health providers, NGOs, and even local financial institutions (banks, credit and savings associations). The aim of this strategy is to get these different groups to bring their specific skills to bear on MHO development, but also to provide moral, political, and financial support. Some of the roles that such partners can play include: sensitizing and mobilizing the population around MHOs, helping to generate additional funds to support MHO development providing subsidies to vulnerable groups to join MHOs, taking part in launch committees for new MHOs, providing training for MHO officers in management, and making loans to MHOs or to interested parties/groups wishing to join an MHO.

Second, there is an inherent tension between the MHO development process, which is relatively long, and the short project cycles of external partners that have traditionally provided support to MHO development. Thus, some MHO initiatives may not have access to consistent external support over time, as a project cycle ends or funding dries up. This can jeopardize the MHOs' maturation process and sustainability. Local partnerships are more likely to anchor the MHO in their communities, and provide them more consistent access to support, resulting in greater levels of community participation and sustainability within the MHO movement.

National goes local: stimulating local partnerships

National initiatives can create an enabling environment for developing partnerships that support MHO development at the local level. Often these initiatives are part of the process of decentralization, but they can also be local development projects. Here are several concrete examples of how government can stimulate a "partnership dynamic" for MHOs at the local level.

The Ministry of Heath can: inaugurate new MHOs and participate in MHO general assembly meetings; make supportive statements in national addresses about MHOs and their importance in poverty reduction; produce and disseminate management tools to MHOs free-of-charge; organize study tours of MHOs to demonstrate best practices and problems; hold periodic workshops to share techniques for MHO M&E; sponsor radio spots explaining the benefits of MHOs; produce tools, brochures, etc. for MHO sensitization campaigns.

The Ministry of Local Affairs can: advocate for the development and support of MHOs during meetings of mayors and other locally elected officials; make districts and towns responsible for carrying out activities to mobilize the population to join an MHO and for monitoring the activities of health centers that contract with MHOs; make promoting MHOs a performance evaluation criterion for decentralized government bodies.

Building local partnerships is an especially effective strategy in a context of decentralization (see box below). MHOs gain credibility within their communities when, for example, elected leaders participate in promotion and mobilization campaigns, when a mayor donates land on which an MHO can build its office, when a budget line is added to the local government budget for support to MHOs, or when local authorities offer to countersign the contracts between providers and MHOs. (See also Innovation No. 2 : « Development of a national strategic plan for MHO development.»)

The effects of local partnerships on MHO growth in Rwanda

The involvement of the Ministry of Local Government, Community Development, and Local Affairs at the provincial and district level in the launch MHOs had a catalytic effect on MHO development in Rwanda. Districts took responsibility for mobilizing and sensitizing people to join MHOs. Because the ministry had existing, well-organized channels to deliver important messages and a certain "moral authority" with the target population, the impact was immediate. On the district level, authorities were already in regular contact with the population through the exercise of their duties, whether it be community meetings, promotion activities, or administrative functions. By bringing together community members, health care providers, and districts in setting up MHOs, schemes have become infinitely more efficient and sustainable. As a result, new schemes today begin with a coverage rate of about 40% of their target population.*

* Ndahinyuka, Jovit. October 2004. *Etude de cas sur les rôles des acteurs dans le développement des mutuelles de santé au Rwanda*. AWARE-RH. p.6.

Local partnerships increase membership: Rwanda case study

In the Bungwe administrative district of Rwanda, there has been an initiative underway to strengthen synergies among local political leadership, local financial institutions (like the Popular Banks and informal system of "tontines"), local associations, and MHOs in an effort to increase MHO membership and remove barriers to dues mobilization and collection within the district. As a result of these efforts, membership grew from 7,120 members at the end of September 2001 to 11,640 at the end of December 2001, to 16,020 members at the end of September 2002: a doubling of the pool of members in one year, with fully 43% of the target population covered by the end of September. In 2005, Bungwe had 27,024 beneficiaries, and covered 95% of its target population.

In the Bugesera health district, the efforts by MHO initiators to involve and coordinate with local government bodies has made it possible for the MHOs to have high penetration rates from the beginning. Eight MHOs were launched with coverage of more than 30% of their target populations from year one, and membership pools of more than 4,000 members per MHO.

Expected results

The main result of this strategy of local partnership is that communities and other stakeholders took ownership of the MHO effort. Having coordinated support from a variety of partners means that there is complementarily rather than overlap in their interventions, with each providing support according to its area of expertise to strengthen MHOs. The dynamic unleashed leads to a more rapid, more sustainable manner of developing MHOs with results such as the following.

- More credible process of MHO development with more partners involved (local government, health providers, NGOs, etc.);

Networks: A powerful partner in Benin

The communal union of cotton producers in Banikoara commune, Benin, is a well- structured and well-financed network that has enormous power in certain areas, to the point that it makes a contribution to the commune's budget. This network made a financial commitment to supporting MHO development in the commune by recruiting and paying the salary of a technical support person for all the MHOs in the commune.

- Mobilization of logistic, financial, and human resources to support MHO development activities (local government, NGOs, producers organizations, local health committees, etc.);
- Increased community confidence in an MHO when partners like local government and health care providers take part in MHO activities, such as promotional campaigns;
- Increased MHO membership. This can happen in several ways: NGOs or other charitable organizations can support MHOs by subsidizing membership for certain vulnerable groups or other target populations (see also Innovation No. 1: "Covering the poorest through MHOs"); and the joint implication of local authorities and health professionals in promoting MHOs results in strong membership numbers in MHOs;
- Greater level of transparency in the relationships between MHOs and providers; local political authority (such as the mayor) acts as arbiter.

Decision to build local partnerships to support MHO development

This is a strategy that can be implemented in practically any context, but it works best where there is a tradition of collaboration among different actors to support local development. Moreover, given that local administrative authorities can bring so much to supporting MHOs, decentralized settings where significant authority and resources have reached the local level are ideal for this strategy.

Process

1. Identify potential partners: The first step is to inventory the potential partners (organizations and individuals) for MHO development and support within the community, and then develop such partnerships. Who does this depends on the context: where MHOs exist, they should take the initiative; where MHOs are still being established, MHO promoters or launch committees would likely carry out this first step. In either case, the inventory should gather information on areas of needed partner expertise and available resources for each. This inventory can be based on an organizational assessment of HMO needs, such as the sample below:

Assessing MHO potential partners, by MHO component
Mission of the organization
Technical areas of intervention
Structure and management of the organization
Funding sources and financial management
Geographic areas of intervention
Target populations
Human resources within the organization

Once the priority partners have been identified, the MHO should engage with these partners to define objectives and modes of collaboration.

2. Orient partners to MHO development and support: Once an agreement for collaboration has been reached, partners need orientation to the aspects of the MHO to which the partners' expertise is best suited. One way to facilitate this process is to invite partners to participate in training sessions for MHO offices, where they can determine firsthand where and how they might be useful (whether it be MHO mobilization, financial management, etc.).

3. Create a structure for coordination of support to MHO activities in order to maximize synergies among the different partners and their areas of intervention (see text box next page). There are several ways to organize this type of coordination: what is essential is that roles are well defined and there is consensus on the structure and modalities of support.

4. Hold regular meetings between MHO and local partners to exchange information in order to encourage buy-in to the MHO by these partners, to evaluate various support activities, to document and disseminate best practices, and to better define roles and responsibilities of partners. This exchange can happen in various ways: through workshops, during evaluations of activities, etc. What is essential is that there are regular occasions to share experiences and identify and disseminate best practices.

Available Tools

The tools on the next page include an example of an organizational assessment done in Mali of an NGO partner, an example of the structure for collaboration of local MHO partners in Benin, and the results of a partnership workshop in Benin.

Two examples of Coordination for Local Support to MHOs

In Benin:
In two communes in Benin, *communal committees for support to MHOs* have been established to support the development and sustainability of MHOs. The mayor of the commune is the president of the committee, the Union of Cotton producers holds one vice presidency, the communal union of women's groups holds another vice presidency, and the health zone management team holds the role of secretary. The committee meets regularly every six months, but can call a special meeting with a request from either the president or two-thirds of committee representatives. Examples of the support this committee provides include social promotion and mobilization for the MHO, payment by the commune of a technical expert to provide technical and administrative support to MHO managers (who are volunteers), and assistance in problem resolution with providers.

In Rwanda:
Districts are responsible for MHO promotion and social mobilization activities and for launching and monitoring MHOs in collaboration with local health care providers and other partners like churches and NGOs, which also partner MHO development locally.
There is an MHO steering committee within each district, made up of the mayor; the vice mayors for social affairs, for youth, and for women; representatives of local opinion leaders; health center directors; MHO presidents; and administrative sector advisors. Within this committee, however, it is the vice mayor for social affairs who has particular responsibility for launching MHOs at the district level.
MHO start-up is done with support from the MHO committees created at the lowest administrative levels of each district – zones, sectors, and cells. MHO launch committees exist at each of these levels, composed of a president, vice president, secretary, treasurer, and advisors, whose primary responsibility is to carry out promotional activities, to collect MHO dues, and to submit lists of MHO members to the management committee of the MHO at the zone level.
The provincial level also supports MHOs by helping to coordinate MHO promotional activities, to build MHO capacities, and to provide monitoring and financial assistance. The Gitarma province, for example, set up a guarantee fund of 45.000.000 FRw (or about $81,000) to guarantee the financing plans set up by the community banks in the province, allowing people to pay their MHO dues.
The provincial level has two mechanisms for coordination. The Directorate for Health, Gender and Social Affairs, which is charged with coordinating all interventions, is an important resource for the health sector in general and MHO development in particular, as it creates an institutional link between the Ministry of Health and health districts on the one hand, and the administrative districts on the other. There are also multi-sectorial provincial committees to support MHO development, whose role is to coordinate support to MHOs, especially as it relates to promotional activities, mobilization, and overall MHO policy at the province level.*

* Ndahinyuka, Jovit. October 2004. *Etude de cas sur les rôles des acteurs dans le développement des mutuelles de santé au Rwanda*. AWARE-RH. pp. 44-45.

Available Tools

Tools	Use	Expected Results
Charter of the communal committee in Benin (*Charte du comité communal*)	Model of how to organize a structure for coordination of local MHO partners	Creation of a structure for coordination of local MHO partners
Organizational assessment of NGO (*Diagnostic des ONG*)	Example of how to evaluate potential partners	Identification and evaluation of most promising partners
Report on workshop for exchange about partnerships (*Rapport de l'atelier de partage sur le partenariat*)	Example to help plan and organize forum for exchanging among partners	Building on best practices, identification of ways to improve the sustainability of MHOs

11. Innovation 9 – Developing partnerships between MHOs and microfinance institutions

Rationale and results

Raison d'être

Despite the growing presence of MHOs, certain segments of the population[9] still have trouble joining an MHO due to the irregularity of their income. Even for existing MHO members, irregular income often leads to delays in dues payments, or, in some cases, abandoning membership.

The partnership between MHOs and microfinance institutions (MFIs) aims to help poorer families join MHOs by providing them with short-term loans. Moreover, this partnership helps MHOs achieve more regular dues payments by smoothing out seasonal irregularities in income. When putting in place such a partnership, it is often advantageous to target groups with an existing connection or solidarity. In this way, the loans made tend to be even more secure. The interested group is endorsed by the MHO before applying for a loan from the MFI. Local administrative authorities (the district, for example) can also play a constructive role by facilitating the process and providing their guarantee to help the MFI recover any unpaid loans.

In order to make MHOs more sustainable, strategies need to be put in place both to enlarge the social base of MHOs, and to improve dues recovery.

One potential solution is to set up partnerships between MHOs and microfinance institutions (MFI), where the MFI pre-pays members' dues by providing small loans for approximately one year. This would allow many households facing irregular revenues to pay or renew their MHO membership and thereby overcome a financial barrier to seeking health care.

The reason MFIs are promising partners for MHOs is that they tend to offer interest rates that are more competitive (they usually charge an interest rate of 13% to 20% annually) than traditional lenders (which may charge 10% monthly, or 120% annually), which might further impoverish these segments of the population. Consistent with most decentralization policies, local authorities responsible for health ought to facilitate partnerships by endorsing them as well as by using their influence both to establish guarantee funds for this process, but also to track down those who do not reimburse their loans.

A partnership between MFIs and MHOs makes MHO membership more regular, by smoothing out seasonal and temporary income problems that may even be created by a natural disaster (a drought or flood, for example.).

Pioneering MFI/MHO partnerships in Bungwe, Rwanda

During the MHO pilot phase in Rwanda, the Bungwe MHO was experiencing a decline in membership. Household surveys and discussion groups identified the annual dues payment system as the major constraint to membership for many families wishing to join an MHO. As a result, it was recommended that the system be altered to allow payment in three installments. Also, the district mayor and the manager of a local credit and savings bank (the *Banque Populaire*) adopted a strategy to pre-finance dues: The bank provided "MHO loans" to people who had formed an association that was endorsed by local authorities to borrow for a period of one year. This strategy thereby removed the biggest obstacle to paying dues and thus to mass MHO membership. Begun as a local experiment, the strategy soon became a best practice that served as one of the pillars for expanding MHOs throughout the country.

Expected results

The primary results of a partnership between MHOs and MFIs are the following:

- Stronger capacity of the population to contribute, and therefore to join and to regularly pay dues to MHOs;
- Expanded social base for membership;
- Stronger financial sustainability of MHOs.

MFI-MHO partnerships help households join or renew their MHO membership by giving them a loan that has a competitive rate and one-year term. By providing these low-interest loans, MFIs increase the population's otherwise minimal ability to pay dues and join an MHO ; they also help protect household income, because MHO members need not sell their assets to pay for health care. Experience with such partnerships in some countries has demonstrated not only improved access to care, but improved financial capacity (in terms of revenues) for the population concerned. Rural populations have historically been reluctant to seek loans from financial institutions because they perceive interest rates as high. MFI-MHO partnerships have helped correct this misperception. While the beginnings of the collaboration may be tentative, once MFIs establish positive experiences with the population, they are enthusiastic to show them other potential areas for

[9] *This does not refer to the poorest who are totally excluded from care, for whom other subsidies and mechanisms are necessary. (See Innovation No.1: "Covering the poorest through MHOs.")*

collaboration - providing new loans for revenue-generating activities, etc. In this way, a partnership leads to increased household income and overall poverty reduction.

Another major result of the MFI-MHO partnership is an increase in the number of MHO members, and therefore a better risk-sharing mechanism, which makes the MHO more financially stable and strong. The table below shows the impact of a partnership in Rwanda, where membership in four MHOs grew impressively with the advent of MFI-MHO partnerships.

Percent growth in MHO membership following the launch of MFI-MHO partnerships

MHO	Period	Percent Growth
Bungwe	12 months	225 %
Rebero	4 months	203 %
Maraba	6 months	258 %
Rushaki	12 months	140 %

An increase in membership numbers is always accompanied by an increase in the level of financial resources within the MHO, which allows the MHO, among other things, to be in good standing with the providers with which it contracts.

Decision to create MFI-MHO partnerships

Because a MFI-MHO partnership aims to facilitate membership in an MHO, a strong demand by the population to become MHO members and a relatively weak penetration rate by MHOs are two prerequisites to this strategy. The strategy also requires a network of MFIs that are accessible to the population, such as is the case in Benin, Rwanda, and Uganda. Given their importance to the success of this strategy, political will and support at both the central and local level should be evaluated, because they are essential to guarantee loan reimbursement and to create a generally favorable environment for partnership. Obviously, for local authorities and MFIs to get involved in this type of strategy, MHOs must be functional and well perceived in the community. Finally, a dynamic local associative context favors this strategy.

Several years of poor harvests may also stimulate a partnership between MFIs and MHOs to smooth over periods of irregular revenues, and thereby allow households to continue to belong to an MHO and have access to health care.

Process

1. **Identify problems**: It is necessary to first understand what limits MHO membership. Frequently, despite households' desire to join MHOs, their income is seasonal or irregular and this limits their ability to pay dues on a periodic basis such as monthly, or they are unable to come up with a single annual contribution.
2. **Share information with the population about MFI-MHO partnership as one potential solution to dues payment problems**: Explain that through such a partnership, MFIs will offer low-interest, one-year loans to help the population pay their MHO dues. By using MFIs in this way, households can actually protect their income by protecting themselves against the risk of debilitating expenses incurred for medical treatment when one is uninsured or has to take out a high interest loan to pay such expenses.
3. **Identify and make contact with MFIs**: It is useful to conduct an inventory of local, functional MFIs and determine which would be promising partners. (See the tool for assessing potential partners in Innovation No. 8: "Building local partnerships to support MHO development") In making contact with MFIs, there should be an interest shown in promoting MFI-MHO collaboration, and a discussion of the advantages of this type of partnership. Discussions during these meetings also determine the modes of operation for the partnership, preferential interest rates, etc.
4. **Advocate with local authorities and potential partners**: Local authorities can facilitate and reinforce MFI-MHO partnerships. For example, they guarantee the loans by promising to pursue members who do not repay their loans, or by establishing a guarantee fund with other district partners, like donors and the State.
5. **Form beneficiary groups**: MFIs generally do not loan to individuals to cover MHO dues, but rather to groups/associations. Therefore, the population needs to group itself into associations, preferably of 15 to 20 persons, to facilitate social control; because the loan is made to the group/association, repayment depends on cohesion and mutual reinforcement. Loans are approved not on the basis of collateral, but on the mutual guarantee of association members, who are responsible for pursuing any member who does not repay his/her share. Each association wishing to apply for a loan needs to have/create a committee with a president, secretary, and treasurer with clearly defined roles and responsibilities for the functioning of the group.

6. **Submit loans applications to the MFI**, along with a list of the association's members and beneficiaries, endorsed by local authorities.
7. **Sign contracts**: The MFI studies the loan applications and decides which to approve. Then a loan document is prepared and signed by the MFI and the MHO.
8. **Deposit dues of beneficiary groups with MHOs**: The MFI deposits the loan amount into the MHO bank account to cover the approved associations' dues. The MFI then notifies the MHO of the deposit and provides a list of the names of those approved so that the MHO can provide membership cards to the new members and beneficiaries.
9. **Create loan recovery mechanisms**: The group/association establishes internal mechanisms for loan repayment based on discussion with members about the amount and frequency of loan payments. At monthly meetings, the association's management committee should give an update on progress toward loan repayment and any delays or problems with particular members.

Available tools

Most of the tools included for this innovation come from Rwanda. The technical report listed below details a variety of different types of MFI-MHO partnerships. Examples of contracts and endorsements for associations wishing to receive a loan to join an MHO are included in the annex to this report.

Available Tools

Tools	Use	Expected Results
Technical report: Partnership between community banks, districts, and community associations for MHO development in Rwanda (*Rapport technique: Partenariat entre districts, banques populaires et associations communautaires pour le développement des mutuelles de santé au Rwanda*)	Gain better understanding of the different types of MHO-MFI partnerships in Rwanda and their experiences	Modalities of partnership between MFIs and MHOs defined
Contract between MFI and MHO member association in Rwanda (*Contrat entre la banque populaire et une association mutualiste au Rwanda*)	Provides model contract to help formalize MHO-MFI partnership	Formal agreement mechanism in place to facilitate and regulate MHO-MFI partnerships
Certificate of endorsement by local authorities for group seeking loan (C*ertificat d'aval de l'association mutualiste par les autorités locales*)	Provides model of how to create a system of endorsement to determine groups eligible for loans and to facilitate the MFI-MHO partnership	Process for determining eligible groups in place

12. Conclusions

After a long period of experimentation, MHOs in Africa are now in a period of intense consolidation and expansion. The innovative strategies presented here have already produced concrete results and merit replication to benefit the members of MHOs, MHOs themselves, health care providers, community associations and civil society, governmental bodies, training and research organizations, as well as external partners who promote MHO development in the health sector.

Each of the strategies discussed addresses specific MHO weaknesses. Decentralizing MHO management, for example, can (i) broaden the social base of the MHO and increase membership numbers, and at the same time (ii) improve dues recovery. At the same time, many of these strategies are closely linked. For example, developing a monitoring and evaluation system within an MHO federation necessitates a certain structure at the intermediate level, and is therefore closely tied to Innovation 3: "Launching MHOs with the intention of creating a network." Moreover, the different partnerships developed in several of these innovations are essential to the consensus necessary for the development of a national strategic plan.

A combination of these innovative strategies can help build the local, intermediate, and national capacities needed to meet the growing demand for support to MHO development. They open up participation in the MHO movement to new and different partners, such as locally elected leaders and financial institutions, in order to mobilize more human, financial, and logistical resources for MHO development and sustainability. They also facilitate taking MHOs to scale by putting in place structures and processes to serve as pillars in the expansion of the MHO movement.

New mobilization strategies have also been developed within the MHO movement. More and more new types of MHOs are based on existing interest groups, like women's promotion groups and their networks, schools and their students, and networks of cooperative associations. One sees more a more structured MHO movement today, with the advent of networks of MHOs, coordinating bodies of MHOs at the national level, federations of MHOs, and other types of collaborations, not to mention more emphasis on putting in place more rigorous information systems to better monitor and manage MHOs, and to better document their impact.

Scaling up MHOs also means broadening their field of intervention. For example, MHOs are currently demonstrating promising results in fields like covering vulnerable populations and those living with HIV/AIDS, and promoting preventive services (distribution of insecticide-treated nets among other health promotion activities).

Outside the need to continue to build training, research, M&E, and communication capacities for MHO development at all levels, there is a serious need for more studies on the MHO movement. Several key topic areas include how MHOs do/should relate to formal financing mechanisms, the role of reinsurance, and creating larger risk pooling mechanisms.

An MHO general assembly

13. References and other useful links

Useful links are presented below.

La Concertation entre les acteurs du développement des mutuelles de santé en Afrique: www.concertation.org

International Labor Organization: www.ilo.org/public/french/protection/socsec/step

References:

Atim, Chris. September 2000. *Training of Trainers Manual for Mutual Health Organizations in Ghana*. Chevy Chase, MD: Partnerships for Health Reform, Abt Associates Inc.

Bennett, Sara, Allison Gamble Kelley, and Brant Silvers. September 2004. *21 Questions on Community-based Health Financing*. Chevy Chase, MD: Partner for Health Reform*plus* Project, Abt Associates Inc.

Bureau International du Travail/Stratégies et Techniques contre l'Exclusion sociale et la Pauvreté (STEP). 2005. *Guide pour l'étude de faisabilité de systèmes de micro-assurance santé. Tome 1: Démarche; Tome 2: Outils.*

———. 2003. *Guide de gestion des mutuelles de santé en Afrique*.

———. 2002. *Micro-assurance santé: Guide d'introduction aux mutuelles de santé en Afrique.*

———. 2001. *Guide de suivi et d'évaluation des systèmes de micro-assurance santé, Tome 1 et 2.*

———. 2000. *Manuel de formateurs. Mutuelles de santé en Afrique: Caractéristiques et mise en place.*

Butera, Jean Damascene. Forthcoming. *Etude sur la Prise en Charge des Indigents par des Mutuelles de Santé.* AWARE-RH.

Franco, Lynne, Mbengue, Cheikh, and Atim, Chris. November 2004. *La Participation Sociale dans le Développement des Mutuelles de Santé au Sénégal*. Chevy Chase, MD: Partners for Health Reform*plus* Project, Abt Associates Inc.

GRAIM. December 2005. *Etude de Cas de la Mutuelle de Santé de Soppanté*. Chevy Chase, MD: Partners for Health Reform*plus* Project, Abt Associates Inc.

Hohmann, Jürgen; Huber, Goetz; Reinhard, Kirsten. GTZ. 2003. *Mutuelles de santé. 5 années d'expérience en Afrique de l'Ouest. Débats, controverses et solutions proposées.*

Mbengue, Cheikh. July 2003. *Partenariat entre districts, banques populaires et associations communautaires pour le développement des mutuelles de santé au Rwanda*. PRIME II.

Ndahinyuka, Jovit. October 2004. *Etude de cas sur les rôles des acteurs dans le développement des mutuelles de santé au Rwanda*. AWARE-RH.

Schneider, Pia and Francois Diop. October 2001. *Impact of Prepayment Pilot on Health Care Utilization and Financing in Rwanda: Findings from Final Household Survey*. Chevy Chase, MD: Partners for Health Reform*plus* Project, Abt Associates Inc.

Schneider, Pia, François Diop and Charlotte Leighton. March 2001. *Pilot Testing Prepayment for Health Services in Rwanda: Results and Recommendations for Policy Directions and Implementation.* Chevy Chase, MD: Partnerships for Health Reform Project, Abt Associates Inc.

Schneider, Pia, Francois Diop and Sosthene Bucyana. March 2000. *Development and Implementation of Prepayment Schemes in Rwanda.* Chevy Chase, MD: Partnerships for Health Reform Project, Abt Associates Inc.

List of Tools

1. Prise en charge des indigents
   - △ Les MS et la prise en charge des indigents: etude de cas du Rwanda
   - △ Cahier d'indigents

2. Développement d'un plan stratégique au niveau national
   - △ Canevas pour l'état des lieux de la situation des MS (vers l'élaboration d'un plan stratégique
   - △ Termes de référence, atelier pour créer un plan stratégique du développement des MS
   - △ Orientations générales pour le développement d'un plan stratégique
   - △ Policy brief sur le développement du plan stratégique (au Rwanda)
   - △ Plan stratégique pour le développement des MS du Rwanda
   - △ Plan stratégique pour le développement des MS du Sénégal
   - △ Schéma du processus d'élaboration du plan stratégique du développement des MS
   - △ Plan opérationnel régional (modèle de Sénégal)

3. Implantation des MS dans la perspective d'une mise en réseau
   - △ Statut d'union communale
   - △ Statut de la Fédération des SSP Byumba/Rwanda
   - △ Rapport de l'atelier d'échange sur les expériences des mutuelles de santé dans communes de Banikoara et de Sinendé
   - △ Schéma de la Fédération des MS au Rwanda

4. Mise en œuvre d'une expérience pilote des MS dans la perspective d'une extension à l'échelle nationale
   - △ Guide de formateurs
   - △ Policy brief sur les MS au Rwanda
   - △ Policy brief – programme d'appui sur le développement des MS
   - △ Toolsde collecte des données de base
   - △ Toolss d'évaluation
   - △ Plan d'évaluation de la phase pilote

5. Décentralisation de la gestion des mutuelles de santé
   - △ Matrice de planification de la décentralisation de la gestion des MS
   - △ Manuel de procédures administratives et financières des instances décentralisées
   - △ Reglement intérieur et statut d'une MS décentralisées
   - △ Étude de cas : la MS Soppanté

6. Stratégie de communication avec les radios locales pour le développement des mutuelles de santé
   - △ Synthèse des messages radio portant sur les MS
   - △ Deux transcriptions « spot » radio
   - △ Rapport d'un atelier d'évaluation des activités d'IEC

7. Mise en œuvre d'un système de suivi évaluation par une fédération des mutuelles de santé
   - △ Toolss de suivi de la consommation des soins par les membres
   - △ Fiche de suivi mensuel (Toolss de synthèse)
   - △ Checklist du développement organisationnel

8. Partenariat avec les institutions et organisations locales pour le soutien au développement des mutuelles de santé
   - △ Charte du comité communal
   - △ Diagnostic des ONG
   - △ Rapport de l'atelier de partage sur le partenariat

9. Partenariat entre les mutuelles de santé et les institutions de micro finance
   - △ Rapport technique : Partenariat entre les districts, banques populaires et associations communautaires pour le développement des MS au Rwanda
   - △ Contrat entre la banque populaire et une association mutualiste au Rwanda
   - △ Certificat d'aval de l'association mutualiste par les autorités locales

Acknowledgements

This document is the result of 15 years of field experience by numerous experts who have devoted themselves to the development of mutual health organizations (MHOs). More specifically, it is the output of a workshop held in Mbour, Senegal, in December 2005 that brought together experts from Benin, Ghana, Mali, Rwanda, and Senegal, namely Abdoulaye Ba, Maxwell Baffoe Twum, Damascene Butera, Dr. Francois Diop, Dr. Lynne Franco, Allison Gamble Kelley, Assane Gueye, Mamadou Mbaye, Cheikh Mbengue, Pascal Ndiaye, Cheick Simpara, and Pascal Sogoloun, to identify and document the "innovations" of the PHR*plus* project in the area of MHOs. These individuals continued to contribute to this effort well after the workshop, by providing comments and suggestions that enriched the document and made it more representative of the field experiences from which it was drawn. Sincere thanks also go to Dr. Marty Makinen and to Yann Derriennic for their useful comments during review.

This publication was produced for review by the United States Agency for International Development. It was prepared by Allison Gamble Kelley, MA, Abt Associates Inc., Lynne Miller Franco ScD, University Research Co, LLC, Francois Pathe Diop, PhD, Abt Associates Inc., Damascene Butera, Abt Associates Inc.

DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government.

Partners for Health Reform*plus* (PHR*plus*) is funded by USAID under contract no. HRN-C-00-00-00019-00 and implemented by Abt Associates Inc. and partners Development Associates, Inc.; Emory University Rollins School of Public Health; Program for Appropriate Technology in Health; Social Sectors Development Strategies, Inc.; Training Resources Group; Tulane University School of Public Health and Tropical Medicine; and University Research Co., LLC.

Abt Associates Inc.
4800 Montgomery Lane, Suite 800
Chevy Chase, Maryland 20815 USA
Tel: 301-913-0500
Fax; 301-652-3916
Email: PHR-InfoCenter@abtassoc.com
URL: www.PHRplus.org