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SOCIAL HEALTH PROTECTION PROJECT

SOCIAL HEALTH PROTECTION

COMMUNITY-MANAGED HEALTH EQUITY FUNDS

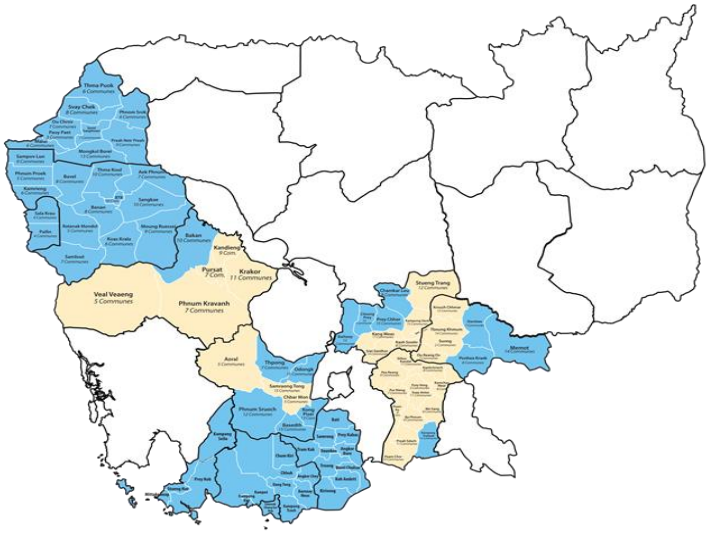
BACKGROUND

Buddhism for Health (BfH) is a local non-governmental organization (NGO), implementing development activities in Cambodia in a neutral, non-profit basis without regard to race or religion. BfH was founded and officially registered at the Cambodian Ministry of Interior in 2004. Since its establishment, BfH has been active in social health protection in Cambodia, dedicated to working with communities to enable the poor and marginalized to integrate in society through increased social capital. BfH currently works as a sub-partner to University Research Co., LLC (URC) in the implementation of the USAID Social Health Protection Project. Through this project and in partnership with other development partners, BfH has led the management and implementation of community-managed health equity funds (CMHEFs). Previous activities included acting as a HEF Operator under the National Health Equity Fund system, operating community-based health insurance schemes (CBHI), and implementing programs concerning social accountability for health.

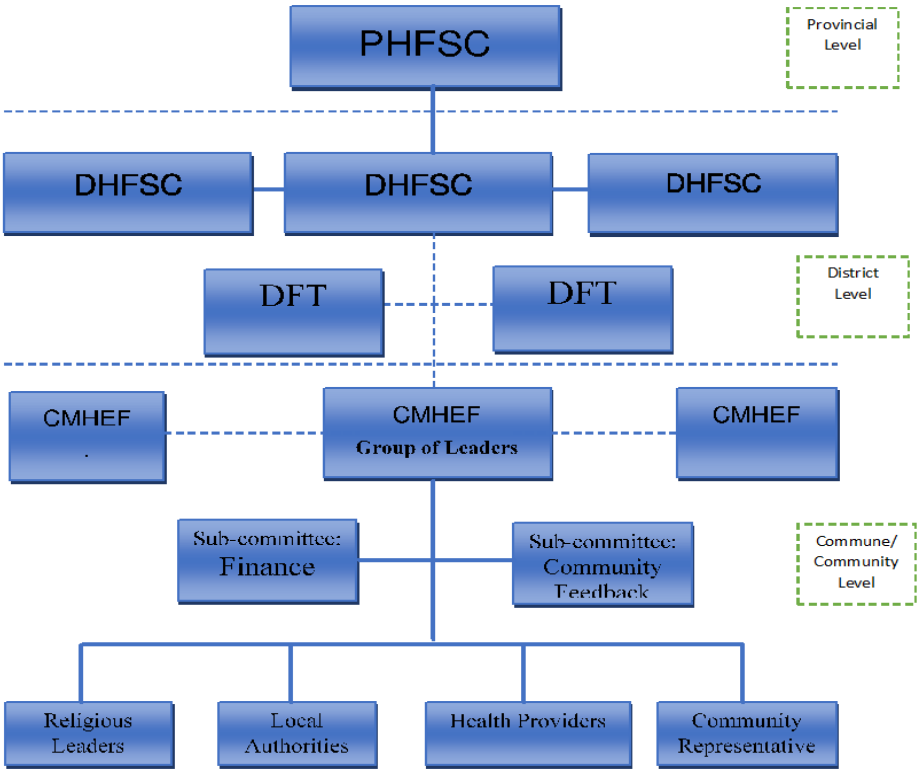
BfH established the community-based approach to managing Health Equity Funds using Buddhist monasteries (pagodas) in 2004 in Kirivong, Takeo Province through support from the Swiss Red Cross. This approach later evolved into CMHEFs which encompass all religious communities, especially the Cham Muslims. By focusing on issues that affect health of the poorest and most vulnerable populations, including social determinants and aspects advancing social capital, CMHEFs promote people's participation in local governance and create accountability of local authorities and public health care.

Since their establishment, CMHEF structures have proven to be stable structures that remained active during periods without external funding and have geographically expanded to new areas. These resilient and flexible structures have been incorporated into the national poverty identification process of the Ministry of Planning (ID-Poor) and are aligned with expansion of the national HEF system. Along with USAID through the SHP Project, BfH has also received financial support for CMHEF management from the Cambodian Government, Enfants & Développement, People in Need, and Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ). As of August 2018, BFH coverage includes:

- 430 CMHEFs (*in light blue, 274 are within the 9 USAID target provinces under SHP*)
- 5,317 Villages, 578 Communes, 63 Districts, and 12 Provinces
- 1,857 Participating Pagodas
- 174 Participating Mosques
- 244 participating other faith-based organizations
- 18,046 Volunteers, citizen, monks, imams, authorities



INTRODUCTION



Each CMHEF is a self-funded and sustained social structure established and operating in the catchment area of the local health center. It focuses on overcoming access barriers for national Health Equity Fund Beneficiaries (HEFB) and complements the official approach of the national HEF system by defining, targeting, and funding a set of additional benefits to meet specific needs of other poor and vulnerable people to access healthcare. While BfH supports the National Poverty Identification Programme to identify eligible national HEF beneficiaries, exclusion errors and other barriers not sufficiently addressed by the national Health Equity Fund leave many vulnerable populations, including the elderly and disabled, with insufficient access to care. Local communities working through the CMHEF in their area are able to decide which additional vulnerable groups they would like to support and the benefits that support their need. CMHEFs do so by employing mechanisms that harness local contributions, volunteer action, and linkages with local authorities to enhance and refine Cambodia's social health protection system.

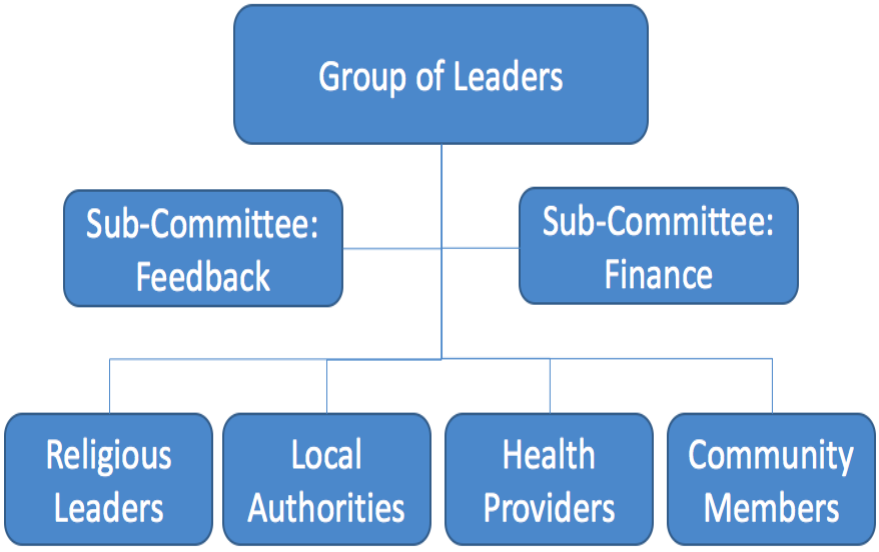
In addition to funding specific benefits for poor and vulnerable people in their area, the CMHEF also creates a governance structure with broad community representation and engagement that is active in representing the needs of their communities through participation at meetings by Health Center Management Committees and Provincial and District Health Financing Steering Committees. CMHEF representatives can advocate for improved quality of care, promote HEF and public health services, collect feedback and resolve conflicts, and provide oversight and support. The latter is also extended to the Ministry of Planning's National Poverty Identification Process (ID-Poor)

STRUCTURE

The governance body of a CMHEF is a committee composed of religious leaders (i.e. Monks, Achaas, Imams, Christian Laders), village health support group members (at least one per village), commune committees for women and children (CCWCs), local authorities from the commune council and village administration, service providers (health, education, agriculture), local association leaders and active community members.

Within each committee, there are three sub-groups: a group of leaders (5 to 9 persons), a finance sub-committee (3 to 5 persons), and a feedback sub-committee (3 to 5 persons).

All CMHEF committee members meet at least twice a year at plenary sessions to conduct review and planning exercises that include a review of income, expenditures, and activities conducted during the previous year along with a plan for the coming year. The Group of Leaders and the subcommittees for finance and feedback meet every three months.



The National HEF includes established district/provincial health financing steering committees (D/PHFSCs) that meet on a quarterly basis and play a key governance role in the system. Each D/PHFSC is composed of a wide variety of representatives from line ministries and the concerned civil societies in the given district and province and is chaired by a deputy district/provincial governor. A Senior Provincial/District Chief Monk and Imam are always included as members of the P/DHFSCs. These committees provide a forum for political support and oversight and to resolve any conflicts or issues identified by the CMHEFs operating in districts within the select province.

Within the CMHEF system, a district facilitation team (DFT) is established to facilitate information flow between the CMHEF in the community and the D/PHFSC. The DFT is organized at the Administrative District level and composed of motivated local authorities from various district offices of line ministries. The DFT is responsible for providing support, advice, and follow-up on CMHEF recommendations, including quarterly reporting to the District Governor and the D/PHFSC. Quarterly updates include specific items from CMHEFs in each administrative district, touching on both strong points and weaknesses encountered.

OPERATIONAL ASPECTS

CMHEF Committee

The CMHEF committee is responsible for fundraising, determining benefits and eligible target populations, purchasing health services from the health center, and day-to-day financial management. CMHEF committees also monitor health service utilization by respective HEFB and other vulnerable population groups supported by the CMHEF and identify locally appropriate solutions to address access barriers. Funds are raised using a variety of activities such as special ceremonies at the pagoda, donation boxes, allocation of funds from the pagoda and mosque annual operational budgets, together with soliciting donations from wealthy individuals and businesses operating in the area. Based on projected income, the committee decides what specific benefits they will provide and to whom. Benefits could include transportation costs to the health center for poor families and other identified population groups including the elderly, disabled or other vulnerable people within their village. Costs covered through CMHEFs are not covered under the national Health Equity Fund and the aforementioned people also tend to require accompanying caretakers.

The CMHEF committee establishes a written contract with the local health center for purchase of services under the national HEF system. Based on actual utilization, the committee makes

monthly payments for services delivered. Beyond the provision of these direct benefits, the CMHEF committee activates a group of volunteers who organize two-way communication with poor and marginalized households. Through their existing social networks and using their linkages with the health center, the CMHEF improves communication between service providers and users thus advocating to improve service provision. Through the two subcommittees identified above (financial and feedback), the CMHEF manages funds and monitors the provision of benefits through a systematic collection of feedback on health services.

District Facilitation Team (DFT)
Each DFT member is responsible for providing support, advice, and follow-up to 1-3 CMHEFs including collection of quarterly reports for aggregation and submission to District Governor and Health Financing Steering Committees.

To ensure ongoing support from DFTs to CMHEF committees, an Administrative District CMHEF Support Fund (CMHEF-S) is established. The source of financing for this solidarity fund comes from all CMHEFs within a given Administrative District. In each Administrative District, the precise arrangements vary slightly but follow the same basic model which includes:

- Each CMHEF contributes about 200,000 Riels (US$50) per year.
- In some Administrative Districts, there is a possibility for additional contributions to CMHEF-S from the district administration, dependent upon availability of funding.
- The CMHEF-S is used to support travel and other expenses of DFT members who are required to follow-up with each CMHEF on a monthly or quarterly basis to provide technical support and community feedback on the quality of health service provision. They also provide supplemental financial support to poorer CMHEFs.
- Mutual trust and cooperation is stimulated by the direct relationship between provision of funding by CMHEFs in exchange for support by DFT members.

Provincial and District Health Financing Steering Committees (P/DHFSCs)
CMHEF activities are discussed during every quarterly P/DHFSC meeting, in addition to discussions relating to national Health Equity Fund operations. Specific CMHEF related discussions include:

- Review of quarterly CMHEF summary reports concerning financing, service utilization, and critical issues raised by communities related to quality of healthcare services.
- Review of scheme monitoring activities by the DFT.
- Monitoring access and utilization of health services by the target beneficiaries, adequate fundraising, providing advice and recommendations to improve operations.

RESULTS

Summary: To date, 274 CMHEFs have been established and are currently operational under the SHP Project. These CMHEFs are supported by 13,767 pious volunteers, monks, imams, public service providers and administrative authorities. The CMHEFs operate in 3,557 villages located in 326 communes in 39 administrative districts (within 22 Operational Health Districts), across the eight USAID target provinces.

Membership Composition:

Type	%
Administrative Authorities	36
HCMC/VHSG	23
Buddhism	20
Public Service Providers	12
Active Representatives of Beneficiaries	7
Other Religions	2

Coverage and Beneficiaries: Utilization of CMHEF services has increased markedly, especially in early 2017. The majority of CMHEF funds raised through annual flowering (fundraising) ceremonies. BfH has also worked to ensure that support for CMHEFs are integrated in commune investment plans (CIPs) and district development plans (DDPs) to ensure their sustainability after the end of the SHP Project. Due to time constraints, only 44 of 274 total CMHEFs (in nine of 39 total administrative districts) were able to officially integrate CMHEF funding into their CIP or DDP in 2018. Collaboration is ongoing between DFTs and respective leader groups to ensure integration of CMHEFs into DDPs and CIPs for 2019.

The figure below describes usage of health services among the poor nationwide and also in CMHEF-specific areas. A higher proportion of pre- and post-ID users accessed health services in CMHEF areas (listed as "per capita").

	Nationwide	CMHEF Areas
Pre and Post ID		
2016	2,759,285	819,106
2017	2,555,973	738,335
General Utilization by the poor at HC		
2016	2,075,558	712,930
2017	2,287,113	810,556
Per capita		
2016	0.75	0.87
2017	0.89	1.10

As CMHEF works to promote awareness of CMHEF and national HEF services, CMHEF members interact at the grassroots level with poor users and serve as advocates for the ID Poor process in their communities.

274
CMHEFs

13,767
Volunteers monks, imams, public service providers and administrative authorities

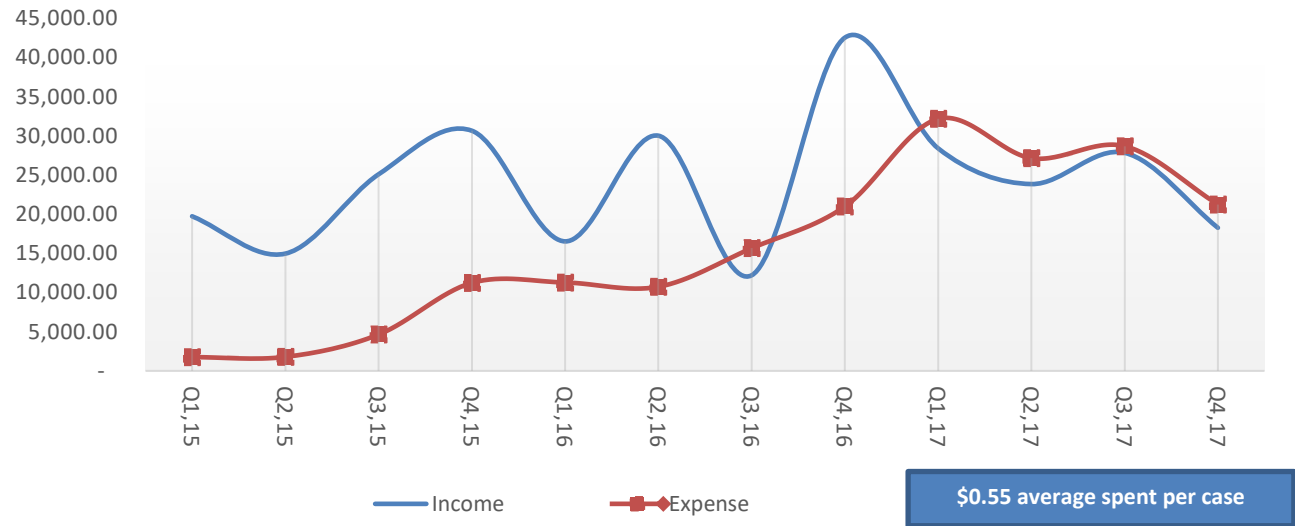
3,557
Villages

326
Communes

39
Administrative Districts

22
Operational Districts

8
USAID Target Provinces



As shown in the above figure, the income of CMHEF generally exceeds its expenses. Events including political instability/actions can contribute to rare cases when expenditures exceed funding.

RECOMMENDATIONS AND NEXT STEPS

While the current income of most CMHEFs is acceptable, many have not made sufficient efforts to collect more funds. While options like annual flowering (fundraising) ceremonies stand as possible sources of income, alternative sources including those from the private sector (corporate social responsibility) and from international donors should be considered to ensure more reliable funding which does not rely solely on community members themselves.

Awareness of CMHEF is high in the community and the proportion of pre- and post-ID users is higher in CMHEF areas than the national average. CMHEFs currently target the most vulnerable, i.e. the elderly poor, people with disabilities, poor pregnant women and orphans in order to raise awareness and advocate for ID Poor. With appropriate financing and technical assistance through NGO support, CMHEFs have the opportunity to expand their reach to target those living with HIV, TB, malaria and those suffering from chronic conditions.

SUMMARY

The CMHEF initiative is a successful model that has been tried and tested for more than thirteen years and proven to be self-sustained and dynamic. Beyond the core activities of raising local funds to provide poor and vulnerable with additional benefits complementary to the national HEF system, it creates a governance structure that has an active purchaser role in making sure that poor and vulnerable people have effective access to quality services.

SEPTEMBER 2018

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