SCALING UP COMMUNITY-BASED HEALTH INSURANCE IN MALI: A CASE STUDY

August 2012

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CONTENTS

Acronyms vii

Acknowledgments ix

Executive Summary xi

1. Introduction 1

2. Overview of Community-Based Health Insurance 3

2.1 Universal Coverage 3
2.2 Community-based Health Insurance 4
2.3 The Role of Donors in Supporting CBHI 5

3. Background on the Mali CBHI Experience 7

3.1 CBHI Overview in Mali 7
3.2 Government of Mali 9
3.3 Union Technique de la Mutualite Malienne 9
3.4 International Partners 10

4. The National CBHI Strategy in Mali 11

4.1 Summary of the Strategy 11
4.2 Phase One of the Roll-Out 12

5. Success Factors in CBHI Strategy Development 13

6. Implications for Donors and Countries 15

Annex: Sources of Information 17

LIST OF FIGURES

Figure 1. The Stages of Reaching Universal Coverage 3
Figure 2. Out-of-Pocket Payments and Health Insurance from a Sample of African Countries 5
Figure 3: Target Population of the Social Protection System in Mali 8
Figure 4: Timeline of the Development of the National CBHI Strategy 8
Figure 5: Structure of the National CBHI Strategy 11

ACRONYMS

AMO	*Assurance Maladie Obligatoire* (Mandatory Health Insurance)
CBHI	Community-based Health Insurance
CPS	*Cellule de Planification et de Statistique* (Planning and Statistics Unit)
DNPSES	*Direction Nationale de la Protection Sociale et de l'Économie Solidaire* (Directorate of Social Protection and Economic Solidarity)
GOM	Government of Mali
MLI	Ministerial Leadership Initiative
MDSSPA	*Ministère du Développement Social, de la Solidarité et des Personnes Âgées* (Ministry of Social Development, Solidarity and the Elderly)
MOH	Ministry of Health
PHR*plus*	Partners for Health Reform*plus*
RAMED	*Régime d'Assistance Médicale* (Medical Assistance Scheme)
USAID	United States Agency for International Development
UTM	*Union Technique de la Mutualité Malienne*

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We would like to thank USAID for the funding with which this work was conducted.

We would like to convey our thanks to the many individuals that were interviewed for this case study including: Amadou Diallo (Direction de la Protection Sociale et de l'Économie Solidaire, or DNPSES), Francois Diop (former World Bank), Amanda Folsom (Results for Development), Allison Kelley (Results for Development), Issa Sissouma (Union Technique de la Mutualité Malienne, or UTM), Luc Togo (DNPSES), and Cheickna Toure (UTM).

Numerous partners worked together to support the Government of Mali on its path towards universal coverage. These partners include the Bill & Melinda Gates Foundation and Packard Foundation-funded Ministerial Leadership Initiative for Global Health, implemented by Results for Development; Health Systems 20/20; and the World Bank.

Most important was the contribution of the Ministry of Social Development, Solidarity and the Elderly; the Ministry of Health; and the UTM staff who drove the development and successful adoption of the national strategy for CBHI and continue to work towards increased health coverage and financial protection in Mali.

EXECUTIVE SUMMARY

This case study provides to policymakers, technical staff, implementers, and donors an overview of well over a decade of community-based health insurance (CBHI) experience in Mali. It discusses the context, lessons learned, and key components of the process that began with isolated, individual community initiatives, continued with the strengthening of the schemes, and led to the successful adoption by the President and the Board of Ministries in 2011 of a national strategy for the expansion of health coverage through a phased scale-up of CBHI. The key components of the process are strong government stewardship and commitment, access to local technical assistance, collaboration across ministries, complementary contributions by partners, and consensus on a national strategy for the roll-out of CBHI.

Health Systems 20/20 selected the experience in Mali for a case study because it can provide insight for other countries seeking to initiate or scale up CBHI, including the demonstrated commitment by the Government of Mali to support CBHI through its leadership and co-financing of CBHI, as well as the stakeholder-driven and consensus-based approach used to develop the national strategy.

This case study includes an overview of CBHI in the context of working towards universal coverage, a description of what has occurred in Mali over the past several years that contributed to the successful development of the national strategy for expanding CBHI and the first phase of national roll-out, a summary of the national strategy, the success factors in CBHI strategy, and the implications for donors and countries involved with CBHI.

Specific success factors worth highlighting include the following:

- High-level government commitment to develop the CBHI strategy to expand coverage to underserved populations
- Development of an operational plan to implement the strategy
- In-country technical expertise, especially the Union Technique de la Mutualité, the national umbrella organization that provides support to schemes
- Partner collaboration, especially the partnership between Health Systems 20/20, Ministerial Leadership Initiative for Global Health, and the World Bank, all of which worked closely together to support the process
- Stakeholder-driven process that resulted in consensus among a wide range of stakeholders at all levels on the strategy

1. INTRODUCTION

This case study provides to policymakers, technical staff, implementers, and donors an overview of well over a decade of community-based health insurance (CBHI) experience in Mali. It discusses the context, lessons learned, and key components of the process that began with isolated, individual community initiatives, continued with the strengthening of the schemes, and led to the successful adoption by the President and the Board of Ministries in 2011 of a national strategy for the expansion of health coverage through a phased scale-up of CBHI. The key components of the process are strong government stewardship and commitment, access to local technical assistance, collaboration across ministries, complementary contributions by partners, and consensus on a national strategy for the roll-out of CBHI. This case study will discuss in detail these key components of the process that enabled the successful adoption of a national CBHI strategy in Mali.

With funding from USAID, the Health Systems 20/20 project and its predecessor projects Partners for Health Reform (PHR) and Partnerships for Health Reform*plus* (PHR*plus*) have supported the development and implementation of CBHI schemes for over 15 years in multiple countries. Health Systems 20/20 specifically selected the experience in Mali as a case study because of several factors that can provide insight for other countries seeking to initiate or scale up CBHI, including the demonstrated commitment by the Government of Mali (GOM) to support CBHI through its leadership and co-financing of CBHI, as well as the stakeholder-driven and consensus-based approach used to design and standardize the national strategy that builds on nearly two decades of CBHI implementation in Mali.

This case study begins with an overview of CBHI in the context of working towards universal coverage and is followed by four main sections: a description of what has occurred in Mali over the past decades that contributed to the successful development of the national strategy for expanding CBHI and the first phase of national roll-out; a summary of the national strategy; a presentation of the success factors in CBHI strategy; and a discussion of implications for donors and countries involved with CBHI.

To develop this case study, a review was completed of available reports and documentation of the CBHI experience in Mali and the region. These publications are listed in the Sources of Information Section (see Annex). Key informant interviews were conducted with counterparts and stakeholders from January 9 to 13, 2012 in Bamako, Mali. Telephone interviews were conducted in February and March 2012 with partners directly involved with CBHI in Mali. A complete list of interviews is included in the Sources of Information Section.

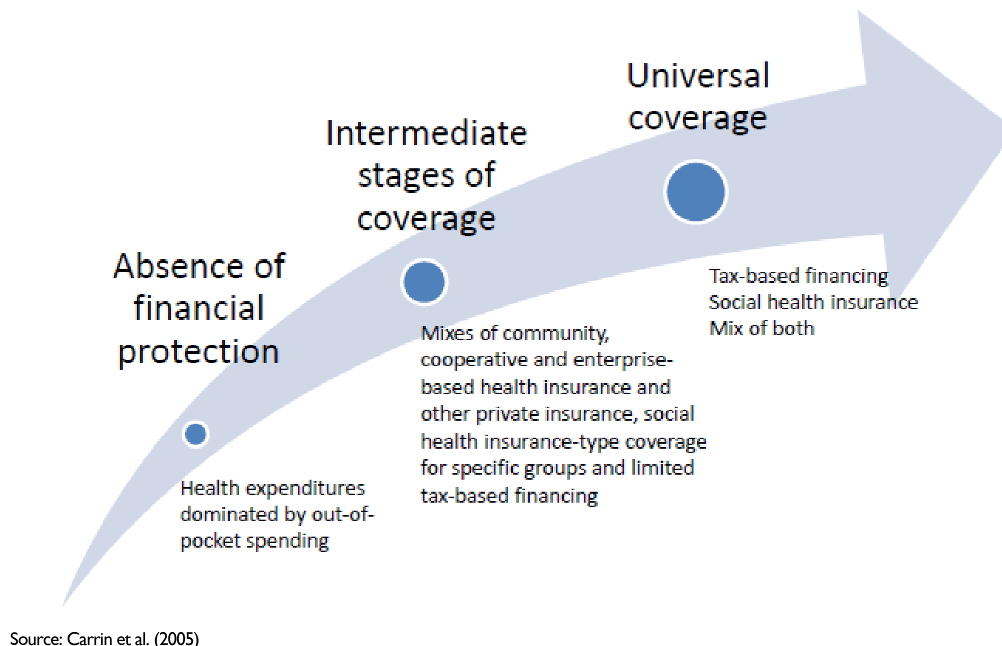
2. OVERVIEW OF COMMUNITY-BASED HEALTH INSURANCE

2.1 UNIVERSAL COVERAGE

In 2005, the World Health Assembly called upon its member states to work towards achieving universal health coverage. This coverage was defined to include access for all to promotive, preventive, curative, and rehabilitative services at an affordable cost. Such an ambitious goal requires financial protection with a specific focus on the poor, availability of and access to quality health services, and optimal use of resources. Increasingly, many countries across Africa and Asia have turned to CBHI mechanisms to help address challenges in the access to and utilization of priority health care services with the ultimate goal of reaching universal coverage.

Although there is no one path to achieving universal coverage, over two decades of experience with CBHI has shown that the mechanism has the potential to act as a platform for catalyzing progress towards universal coverage in low-income countries. Figure 1 shows key health financing options at different stages of the process in reaching universal coverage. As coverage increases, mixes of different insurance types, including CBHI, are used to help increase financial protection of the population.

FIGURE 1. THE STAGES OF REACHING UNIVERSAL COVERAGE



Source: Carrin et al. (2005)

2.2 COMMUNITY-BASED HEALTH INSURANCE

CBHI, a not-for-profit mechanism of health financing grounded in principles of solidarity and risk sharing, is a tool increasingly used by developing countries to address issues of limited access to and low utilization of priority health services. Over the past two decades, CBHI mechanisms have grown significantly across developing countries in Asia and Africa. In most developing countries that are implementing CBHI programs, many with USAID support, out-of-pocket spending on health by households accounts for more than half of all health financing. Often, CBHI is adopted to help reduce financial barriers to seeking health care, with a focus on the informal and agricultural sectors.

Often referred to as mutual health organizations, or *mutuelles* in French,[1] CBHI schemes cover a broad spectrum of community-based health financing approaches that differ in terms of design, membership, coverage, and scope. Given the range and variation across CBHI schemes, different CBHI experiences provide important opportunities to draw lessons learned and explore factors that contribute to successful processes, outcomes, and impact. On the spectrum of CBHI scale-up, Ghana and Rwanda are often used as examples of countries that have successfully achieved high CBHI coverage rates. Several other African countries are making progress towards increasing population coverage of health insurance through CBHI including Benin, Mali, and Senegal.

CBHI schemes are voluntary organizations that provide health insurance coverage to their members. Members pay a small premium for a defined benefit package on a regular basis to reduce the risk of needing to make a large payment for health care after falling ill. In many cases, CBHI mechanisms grew from a need to address large segments of the population which have traditionally been underserved and excluded from formal risk protection programs.

Many countries in Africa turned to CBHI following the economic crises in the 1970s that negatively impacted the quality and availability of health services. Donors familiar with social health insurance systems in Europe provided funding and technical assistance in the 1980s and 1990s to implement CBHI in several countries including the Democratic Republic of Congo and Burkina Faso. A review of functioning mutuelles in West Africa in the 1997 to 2003 period showed a dramatic increase from 76 to 348 schemes (La Concertation 2004).

More countries are turning to CBHI as experience demonstrates its potential to increase financial protection of the poor and improve access to and utilization of priority health services. The CBHI experiences of countries like Ghana and Rwanda are often discussed to learn how such countries have achieved high levels of CBHI coverage. Figure 2 shows the out-of-pocket payments and the health insurance coverage from a sample of African countries. In each of these countries, CBHI mechanisms contribute to a portion of the health insurance coverage.

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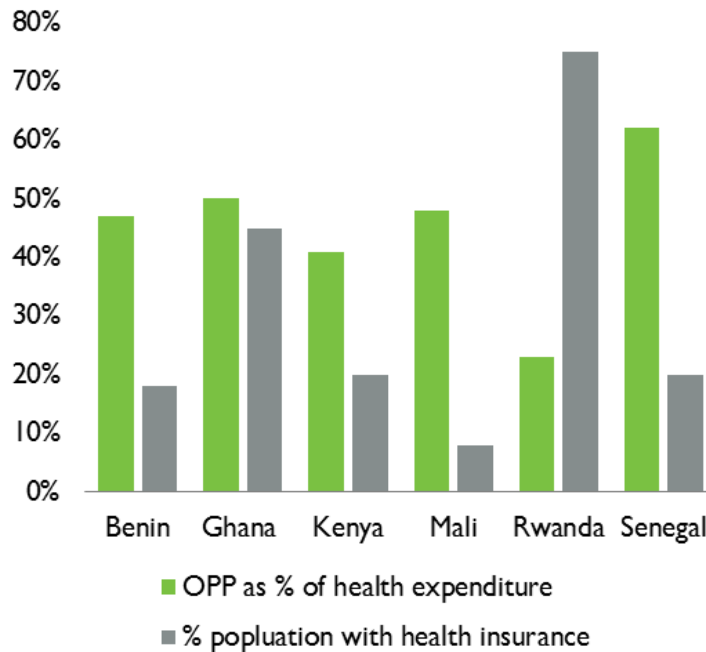
[1] The term mutuelles is used interchangeably with CBHI throughout this case study.

FIGURE 2. OUT-OF-POCKET PAYMENTS AND HEALTH INSURANCE FROM A SAMPLE OF AFRICAN COUNTRIES



Source: Mbengue (2011)

In Mali, mutuelle members receive coverage for all services provided by public health facilities that require a co-payment. Mutuelle members pay a regular premium and in return co-payments for services at public health facilities are reduced. An individual in Mali typically pays about $2.50/month to join, plus approximately $5 per year for each additional family member. Each time a mutuelle member visits a health facility, the mutuelle covers about 75 percent of the cost and the mutuelle member covers the remaining 25 percent. Across several African countries including Mali, mutuelles can provide a mechanism to increase financial protection from high out-of-pocket health care expenses and mobilize communities to seek and demand quality health services.

2.3 THE ROLE OF DONORS IN SUPPORTING CBHI

Since the 1980s, the donor community has been active in providing technical assistance, evidence-based research, and funding to support policymakers and implementers across a diverse range of countries as they work towards sustainable health financing solutions. Multiple donors, including USAID, have worked with governments, and leveraging their own experiences and making financial and technical contributions to strengthen mechanisms for the efficient and equitable pooling of resources to provide risk protection for the populations of the rural and informal sector.

3. BACKGROUND ON THE MALI CBHI EXPERIENCE

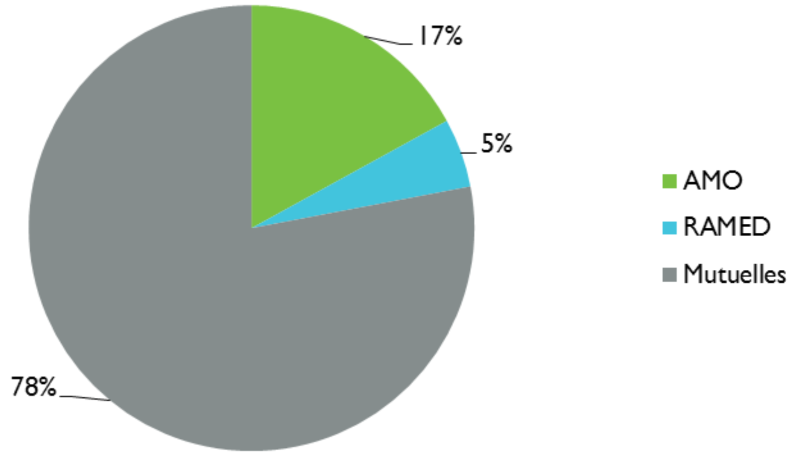
3.1 CBHI OVERVIEW IN MALI

Although Mali has made progress toward strengthening health indicators, utilization of health services by its citizens remains unacceptably low at about 0.3 new contacts per inhabitant per year. According to the most recent (2006) Demographic and Health Survey (Cellule de Planification et de Statistique du Ministère de la Santé et al. 2007), less than half of women give birth in a health care facility. This is a major reason for Mali's high maternal mortality ratio of 464 maternal deaths per 100,000 live births, and the highest burden is among the poor.

In 1996, the GOM adopted a legal framework to support mutuelles, but for lack of strong, coordinated political commitment to a standardized national approach until 2009, sustained momentum was a challenge. In 1998, the Union Technique de la Mutualité (UTM) was created as an association of mutuelles and a nongovernmental organization that provides technical assistance to mutuelles. There was gradual progress towards creating mutuelles – by 2006, there were an estimated 102 mutuelles in Mali (Ndiaye et al. 2007) – but they were created by individual communities and work-based organizations (e.g., the *Mutuelle des Travailleurs de l'Education et de la Culture*), and were often limited in size, which resulted in a small risk pool. Many operated in isolation, as there was no overarching national structure for implementation.

To increase equitable access to and use of health care services, the GOM created a risk protection framework in 2009 that established mandatory health insurance (*Assurance Maladie Obligatoire*, or AMO), a non-contributory assistance scheme for the poor (*Regime d'Assistance Medicale*, or RAMED), and mutuelles as the three pillars to ultimately provide universal coverage. Together, AMO and RAMED are intended to cover about a fifth of the 14.5 million people in Mali (Figure 3). The AMO mechanism, funded by mandatory salary contributions from government and formal sector employees, covers about 17 percent of the population. It is anticipated that RAMED, funded by the national and local governments, will cover about 5 percent of the population. With AMO and RAMED together covering 22 percent of the population, there was a need to advocate for government and partner support in the development of mutuelles to provide health care for the remaining 78 percent, employed in the informal and rural sectors.

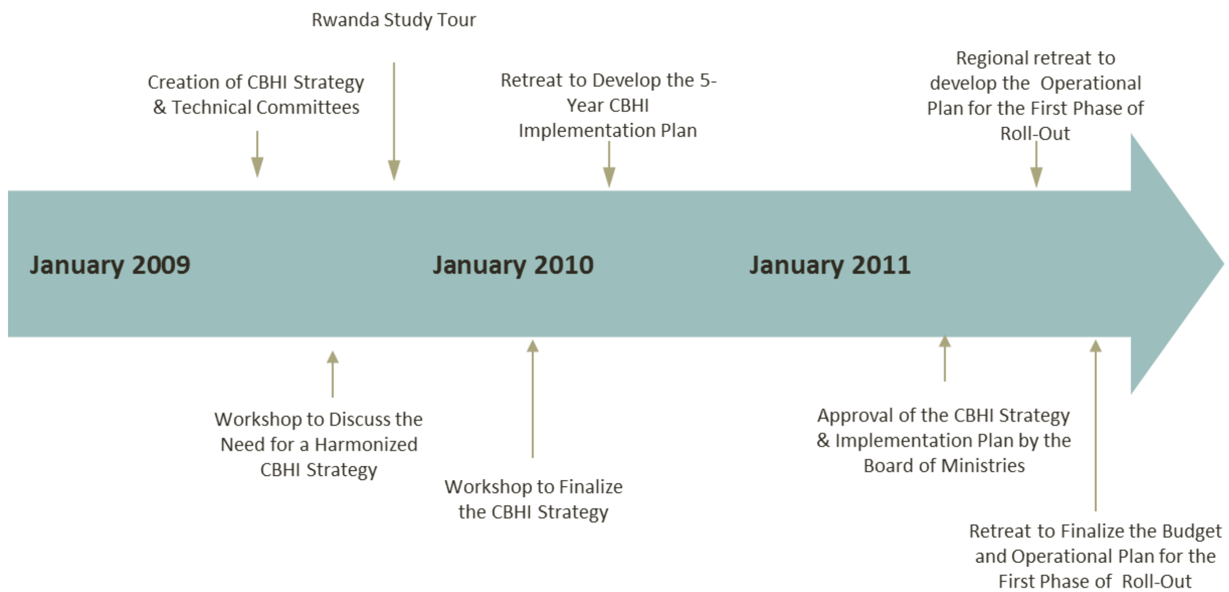
FIGURE 3: TARGET POPULATION OF THE SOCIAL PROTECTION SYSTEM IN MALI



The current GOM strategy for CBHI outlines a harmonized structure that aims to standardize structure and benefits across mutuelles. The GOM plans to formally engage UTM to provide technical support for the implementation of the national CBHI strategy.

The sections below describe the process and key components to the successful adoption of the national CBHI strategy. Figure 4 highlights critical points along the process that included multiple workshops with varied stakeholders, which built the foundation for success in a consensus-based approach.

FIGURE 4: TIMELINE OF THE DEVELOPMENT OF THE NATIONAL CBHI STRATEGY



3.2 GOVERNMENT OF MALI

All three pillars of the GOM's risk protection framework (AMO, RAMED, and the mutuelles) fall under the scope of the Directorate of Social Protection and Economic Solidarity (*Direction Nationale de la Protection Sociale et de l'Économie Solidaire*, or DNPSES), created in 2000 within the Ministry of Social Development, Solidarity and the Elderly (*Ministère du Développement Social, de la Solidarité et des Personnes Âgées*, or MDSSPA). In close collaboration with the Ministry of Health (MOH), the DPSES drives the CBHI movement and guides the implementation of the phased approach to CBHI scale-up. The Planning and Statistics Unit (*Cellule de Planification et de Statistique*, CPS) is shared by the MOH, the MDSSPA, and the Ministry of Women's Affairs and Family. The CPS plays a fundamental role in linking the MOH with the DNPSES for coordinated planning of CBHI roll-out and is actively engaged in the CBHI movement.

One example of the partnership among the various stakeholders is the collaboration of representatives from the MDSSPA (DNPSES and other directorates), MOH, Ministry of Finance and other ministries, and UTM, in the form of two multi-sectoral committees established in 2009 to sustain the development of the CBHI strategy: The National CBHI Strategy Technical Committee led the process of developing both the strategy and the pilot (phase one) framework. The National CBHI Strategy Steering Committee, composed of high-level representatives from the various stakeholder institutions, provided guidance, feedback, and oversight during the development of the national CBHI strategy. It also pre-approved the strategy before submitting it to the government for final approval.

3.3 UNION TECHNIQUE DE LA MUTUALITE MALIENNE

Local technical expertise is provided to mutuelles in Mali mainly through UTM. Created in 1998 as a national umbrella organization to provide technical support for mutuelles, UTM provides support across seven of the eight regions in Mali and currently consists of more than 70 mutuelles. UTM provides direct technical support to the mutuelles and liaises with international networks of mutuelles that provide perspective from other settings. Historically, UTM has supported mutuelles for formal sector employees. UTM advocates for increased social protection and access to health services using its experience in implementing and supporting mutuelles to demonstrate the potential contribution of mutuelles in increasing financial protection and access to care for populations that have traditionally been excluded from formal risk protection programs.

One example of the type of support provided by UTM is its current work in the Sikasso region. Through funds provided by the Bill & Melinda Gates Foundation through the International Labor Organization's Microinsurance Innovation Facility, UTM works with the *Société de Coopération pour le Développement International* (SOCODEVI), and MACIF, a French mutual insurance company, to implement the operational aspects of the structure outlined in the national CBHI strategy, including the management of co-financing provided by the GOM in Sikasso. Implementation also involves restructuring some existing mutuelles to fit into the national vision of the CBHI structure. In addition to supporting direct implementation, UTM plays a critical role in development of national-level policy. UTM organized the 2009 stakeholder workshop that brought together the major stakeholders in Mali to agree on the necessity of a consensus-based national CBHI strategy and commit to moving towards a shared CBHI vision. During this workshop the MOH and MDSSPA called for a paradigm change in respect to the approach and development of mutuelles. The GOM plans to engage UTM formally to support the CBHI roll-out and UTM continues to strengthen relationships with international partners and networks.

3.4 INTERNATIONAL PARTNERS

In addition to the local partners, multiple international organizations contributed throughout the process of developing a standardized and phased approach to scale up CBHI across Mali. These partners include the Bill & Melinda Gates and Packard Foundation-funded Ministerial Leadership Initiative for Global Health (MLI), the World Bank, and USAID's Health Systems 20/20 project. Each partner provided complementary inputs to strengthening the overall national vision for CBHI.

In 2003, the Health Systems 20/20 predecessor project PHR*plus* supported the launch of four mutuelles in two districts in 2003 in the regions of Sikasso and Ségou. This effort responded to the findings of a baseline provider and household survey that identified causes of low utilization of health services, one of which was financial barriers. PHR*plus* support continued through the implementation and an evaluation of the four mutuelles. The case-control study (Franco et al. 2008) that evaluated the mutuelles informed the scale-up of mutuelles at the national level. Its findings provided evidence that mutuelles could have positive effects on increasing the utilization of priority health services, targeting the poor and providing financial protection. It also pointed out that the mutuelles had been initiated and organized by individual communities with the support of a development partner. There was limited collaboration and interaction between mutuelles and no systematic, national approach to CBHI. After the study was completed and the PHR*plus* project ended, the management, organization, and functioning of the mutuelles involved in the study deteriorated.

The initial focus of Health Systems 20/20 support to the GOM was to revitalize the mutuelles in Sikasso. As this support was getting started, the GOM requested funding and technical assistance from the MLI and the World Bank to develop a standardized national strategy to guide the phased implementation of CBHI to ultimately achieve financial risk protection across the population. The three partners – MLI, World Bank, and Health Systems 20/20 – joined forces to provide coordinated support.

The priority of the GOM from the beginning was to focus on national strategy development to document the shared vision and structure of a CBHI system to roll out nationally. The revitalization and network strengthening were eventually integrated into the phase one roll-out of the national strategy.

The MLI, a program of Aspen Global Health and Development in partnership with the Results for Development Institute (R4D), provided technical and financial support to the CPS and worked closely with the GOM to develop and implement health financing reforms to strengthen access to health care at the national level. The MLI focused on country-led planning, south-to-south collaboration, and strategic communications. It sponsored a study tour to Rwanda by representatives from Mali, to see that country's experience with mutuelles, and it helped the GOM develop and implement a communication strategy to inform communities about the benefits of participation in mutuelles, with a specific focus on preventive health services.

Since the World Bank's first project in Mali in 1983, it has worked with the GOM to strengthen service delivery within the national health system. As support evolved, developing mechanisms to strengthen financial protection and access to health services by the poorest became increasingly important to address. Based on decades of such support, it was natural that the GOM would request the World Bank's participation in the 2009 workshop, which mobilized stakeholders to develop a consensus-based national CBHI strategy. The World Bank continued to provide technical support throughout the CBHI strategy design and implementation planning.

All three partners, Health Systems 20/20, the MLI, and the World Bank, collaborated closely to accompany the government-led process of building consensus to design a national strategy for the roll-out of CBHI. The partners leveraged resources to respond to the technical requests made by the GOM to strengthen the application of CBHI as a platform for increased social protection.

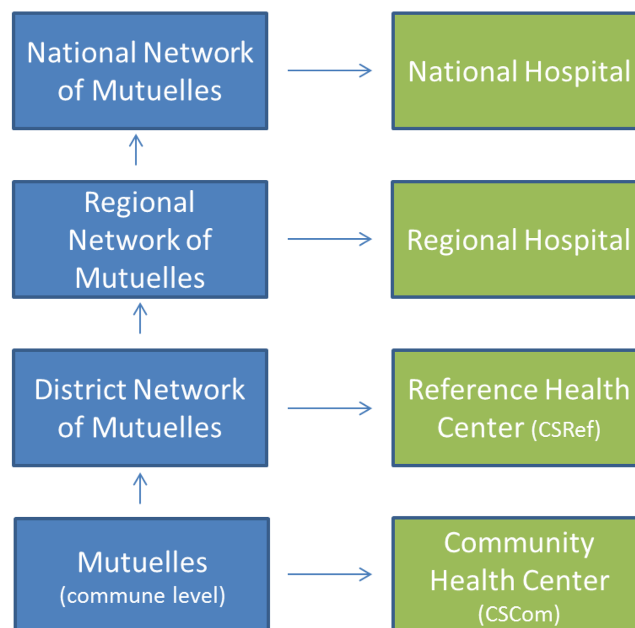
4. THE NATIONAL CBHI STRATEGY IN MALI

4.1 SUMMARY OF THE STRATEGY

The overall objective of the harmonized national CBHI strategy is to reduce the financial barriers to health services that are encountered by people in the rural and informal sectors and thus to improve their access to quality health services. To do this, Mali's CBHI strategy clearly commits the GOM to provide direct contributions to subsidize CBHI premiums. Mutuelle members contribute a one-time enrollment fee and pay a monthly or annual premium; in return, their co-payments for selected services at health facilities are reduced.

The CBHI strategy aligns the mutuelle administrative structure with the existing administrative structure of Mali, that is, the mutuelle structure matches the three administrative levels of the subnational government: 1) regions, 2) *cercles* (equivalent to districts), and 3) communes. Mali has eight regions, 49 cercles, and 703 communes. Figure 5 illustrates the administrative and the health system levels in relation to the CBHI strategy. At the level of the community, there will be one mutuelle per commune. Each of these mutuelles will be linked to its associated community health center (*centre de santé communautaire*, or CSCom) and will be connected to a network of mutuelles at the cercle level. Each of these district-level networks will be linked to the associated regional reference health center (*centre de santé de reference*, or CSRef). The regional networks will be linked to the national level. This structure reflects a lesson learned from the study tour to Rwanda, which demonstrated the importance of aligning the CBHI design with existing government administrative structures.

FIGURE 5: STRUCTURE OF THE NATIONAL CBHI STRATEGY



The national CBHI strategy highlights core components for successful implementation of the strategy. One component is community mobilization, collaboration, and empowerment. Membership in mutuelles is voluntary. Therefore, the GOM recognizes that to encourage enrollment in mutuelles, community members must understand what mutuelles are, how they function in terms of benefits and fee structure, and their role in strengthening community health. Community members who are uninformed about and disengaged from the health of their community are less likely to manage their own health risks, to demand quality health services that improve health status, and to enroll in mutuelles. Effective information dissemination increases enrollment, which in turn expands the risk pool and enhances scheme sustainability and access to services. The GOM is integrating issues around community mobilization into the design and roll-out of a strategic and targeted communication strategy to sensitize communities about the CBHI strategy and the first phase of the CBHI roll-out. The MDSSPA is currently working with the National Center for Health Information, Education and Communication based at the MoH, to finalize the communication strategy.

4.2 PHASE ONE OF THE ROLL-OUT

Critical components of the first phase of CBHI currently under development include the communication strategy, implementation plans for each mutuelle and district network, as well as the establishment and implementation of the monitoring and evaluation plan.

The first phase of the roll-out of the standardized national CBHI approach will take place in 21 cercles of three regions: Sikasso, Ségou, and Mopti. The targeted number of beneficiaries is approximately 1.2 million people, or about 40 percent of the population in the three regions. This first phase will last three years and aim to result in 150 mutuelles, some of which will be existing mutuelles that are restructured to align with the national strategy and others that will be created. Mutuelles in 12 of the 21 health districts will create CBHI networks. The district-level CBHI networks will be responsible for managing the government co-payment and facilitating the relationships between the district hospitals and the regional hospitals. Both the DNPSES and MOH are involved with the implementation of the first phase and the GOM continues to engage UTM to provide in-country technical assistance at all levels of the system.

The first phase of the CBHI roll-out will allow time to make adjustments and reflect on the most efficient structure for further scale-up. Any needed adjustments in the CBHI strategy found by phase one monitoring and evaluation of CBHI implementation will be made in the strategy before phase two (full national scale-up) begins.

5. SUCCESS FACTORS IN CBHI STRATEGY DEVELOPMENT

Five factors have been key to the successful development of a harmonized national CBHI strategy in Mali and the first phase of its implementation. The five factors are the following: government commitment, operational plan development, in-country technical assistance, partner collaboration, and consensus-building. This section will discuss these components and investigate their impact on the expansion of mutuelles.

Government Commitment. Social solidarity is a theme that is woven throughout key strategic policies that guide the GOM. Beginning in 1996, the GOM adopted a legal framework that provided governance of CBHI schemes. The legislation described management and financial practices for mutuelles and a system for registration, but it did not have a vision for national CBHI scale-up, which necessitated the development of supportive policies to provide additional structure and guidance. In 2000, the DNPSES was created in part to strengthen the capacity of mutuelles. In 2002, the GOM adopted a national social protection policy and then created action plans (for 2005-2009 and 2010-2014) to describe how to increase national coverage of social health protection. The latest Health and Social Development Program (PRODESS III) describes a five-year plan (2012-2016) to address defined priorities, which include extending social health protection.

Commitment by the GOM has also been demonstrated through the collaboration of ministries and stakeholders throughout the process of consensus-building for a shared vision of the national CBHI strategy and co-financing of CBHI premiums. For example, the MOH and MDSSPA agreed on the need to subsidize premiums. Importantly, the collaboration extended to senior representatives from the ministries of social welfare, finance, and the prime minister's office. This high-level involvement was critical throughout the decision-making phases of the strategy development process.

Operational Plan Development. Complementary to the national CBHI policies and strategy, the GOM developed an operational plan and budget to accompany the strategy. These documents provided a basis for discussion with the Ministry of Finance and the Prime Minister's Office. Based on these discussions, the GOM agreed to subsidize premiums by matching each member's contributions. Although the mechanism for the GOM's subsidies is still being worked out, a budget line item has been included for the financing of the mutuelles through the GOM. The GOM has estimated that over the next three years the CBHI scale-up will cost about $25 million and it has committed to subsidize the premiums by matching member contributions.

In-country Technical Capacity. The adoption of a national strategy for the expansion of health coverage through mutuelles was grounded in experience implementing and providing support to a broad range of mutuelles over the past decade in Mali. Alongside the community mutuelles, UTM has built its technical expertise and ability to strengthen the capacity of mutuelles in terms of management, governance operations, and evaluation. UTM is a unique local partner for the GOM and helps position Mali for successful scale-up of CBHI. Through established and proven relationships with the GOM and international donors and partners, UTM has illustrated the tremendous opportunities that can be generated when local expertise is strengthened and available.

Partner Collaboration. Through close collaboration and complementary approaches, the international partner organizations supporting the GOM (the MLI, the World Bank, and Health Systems

20/20) leveraged resources and provided a coordinated response to GOM requests for technical assistance.

One example of donor coordination was the study tour for GOM representatives took to Rwanda to learn from that country's CBHI experience, which would inform GOM policy decisions regarding its approach to CBHI. The study tour challenged the team to think through which elements could be adapted to the Malian context. Another example was the synergy developed by Health System 20/20's focus on support to the DNPSES while the MLI worked primarily with the CPS, DNPSES, and MOH. This encouraged and strengthened the collaboration between both the DNPSES and CPS, and between the international partners, and simultaneously built capacity and knowledge within the DNPSES and CPS.

Building Consensus. The GOM-led process that facilitated the adoption of the national CBHI strategy in 2011 was based in engagement of ministries, local authorities, stakeholders, and partners to gain consensus on a shared national CBHI vision. To catalyze the process, the UTM in 2009 organized the stakeholder workshop that brought together the major CBHI stakeholders. Following that workshop, two years of additional workshops and meetings at various levels of the system drew in the senior representatives required for high-level decision-making as well as working with local government authorities and civil society to seek feedback.

Experience has shown that for CBHI to be scaled up it must designed so that its structure is acceptable to the stakeholders and communities. By actively engaging stakeholders and partners in multiple rounds of discussion and debate to gain consensus on the national CBHI strategy, the GOM was able to design a structure in which the administrative and organizational features of the scheme aligned with the administrative divisions of the country. Although it took time to meaningfully involve national partners, local stakeholders, and development organizations, the result of such consensus building is a CHBI design that is broadly accepted by stakeholders

6. IMPLICATIONS FOR DONORS AND COUNTRIES

In many sub-Saharan African countries, CBHI has the potential to be used as a platform for national health insurance coverage reform and provides a tremendous opportunity to help address financial barriers in accessing and utilizing priority health services, especially by the informal and agricultural sectors. As demonstrated in Mali, a successful process towards a national CBHI strategy requires a government-led approach, strong stewardship, stakeholder engagement, operational planning, in-country technical capacity, alignment of partner support, and consensus-building to involve stakeholders and partners in strategic and thoughtful discussions to improve health financing for the long term.

Mali's rich experience with CBHI over the past two decades offers many lessons to donors and countries interested in scaling up CBHI coverage.

- Accompany government-led processes: Donors and partners can contribute to more sustained progress through accompanying country-led processes and being responsive to requests from governments that provide strong stewardship and commitment to CBHI.
- Ensure an institutional focal point: An institutional focal point – in Mali's case, the DNPSES – is an essential ingredient in scaling up to provide leadership for the scaling up effort.
- Strengthen in-country technical capacity: Externally led CBHI schemes risk failure once the project or aid stops. Strengthening in-country capacity at the institutional level provides a basis for sustained access to technical expertise from within the country.
- Leverage partner contributions: Aligning external partner goals and developing synergies between partners will improve progress within countries and at the global level. An approach with several partners will also ensure that the CBHI process does not depend only on one partner.
- Build consensus to improve acceptability and ownership: Although it can take more time to actively engage partners and stakeholders at multiple levels, the result is a CBHI structure that is widely acceptable and therefore more likely to be scaled up successfully.
- Government co-financing: A clear commitment and demonstration of leadership on the part of the government is shown by providing direct contributions to support the financing of premiums for CBHI.
- Support opportunities for joint learning and cross-fertilization: Donors and partners can empower counterparts and facilitate knowledge sharing through structured exchange opportunities that enable countries to learn from each others' experiences. The Joint Learning Network for Universal Health Coverage, which Mali joined in 2011, is one example of such an opportunity.

ANNEX: SOURCES OF INFORMATION

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