



BLUEPRINT

Community-Based Social Health Insurance Programme (CBSHIP)

NIGERIA



...easy access to healthcare for all

June 2009



***Blueprint for the Implementation
of Community-Based Social Health
Insurance Programme (CBSHIP)
Nigeria***



National Health Insurance Scheme

...easy access to healthcare for all

June 2009



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FOREWORD



In response to the deplorable health indices in the country, the Federal Ministry of Health has instituted a mechanism for the sustained reform of the health system. The Health Sector Reform (HSR) initiative aims at a drastic overhaul of all components of the health system towards achieving effectiveness and efficiency in service delivery so that Nigerians are guaranteed access to qualitative and affordable healthcare irrespective of socio-economic status.

Recognizing financial and physical barriers to access to healthcare services as the key challenge to improving the health indices in the country, a key component of the HSR has been to reposition and strengthen the NHIS to put in place a Social Health Insurance mechanism as a complementary funding source to ensure equity and quality in service delivery.

The NHIS has a Presidential Mandate to achieve universal coverage/access to healthcare services for all Nigerians by 2015. This is being achieved through the various programmes which are designed to target the different social-economic groupings in the country.

The NHIS Public Sector Programme has been officially flagged off, covering federal civil servants and their dependants. So far over 4.5 million beneficiaries have been enrolled. For the purpose of expanding coverage of the public sector, strategic effort is being made to reach out to the states of the federation and the FCT that are yet to log onto the public sector programme.

It is generally agreed that for the presidential mandate of universal coverage to be achieved, there is the serious need for the NHIS to extend the benefits of social health insurance to the informal sector (comprising over 70% of the total population). Towards achieving this noble objective, the Scheme has developed informal sector programmes (Rural Community & Urban Self Employed Social Health Insurance Programmes) as well as a Blueprint/Framework for the implementation of these programmes.

This document is a product of practical lessons from pilot CBSHIPs in Nigeria, best practices from global literature on CBSHIPs, international study tours and stakeholder consultation. It incorporates practical input from a wide range of stakeholders brought together at a consultative summit that reviewed the initial draft document. The document presents a strategy to facilitate the achievement of universal access to healthcare services for all Nigerians, with the aim to improve the deplorable health indices in the country, achieve accelerated socio-economic development and the attainment of Vision 20-2020. It presents models for the establishment of CBSHIPs in Nigeria, in pursuit of the Presidential mandate of Universal Access to Healthcare Services for all Nigerians by 2015.

It is my sincere wish that stakeholders will find this document a good guide as we strive collectively to extend the benefits of social health insurance to the informal sector, towards improving the deplorable health indices in the country.

Mr. M. B.W. Dogo - Muhammad, FRCS, mni
Executive Secretary/CEO



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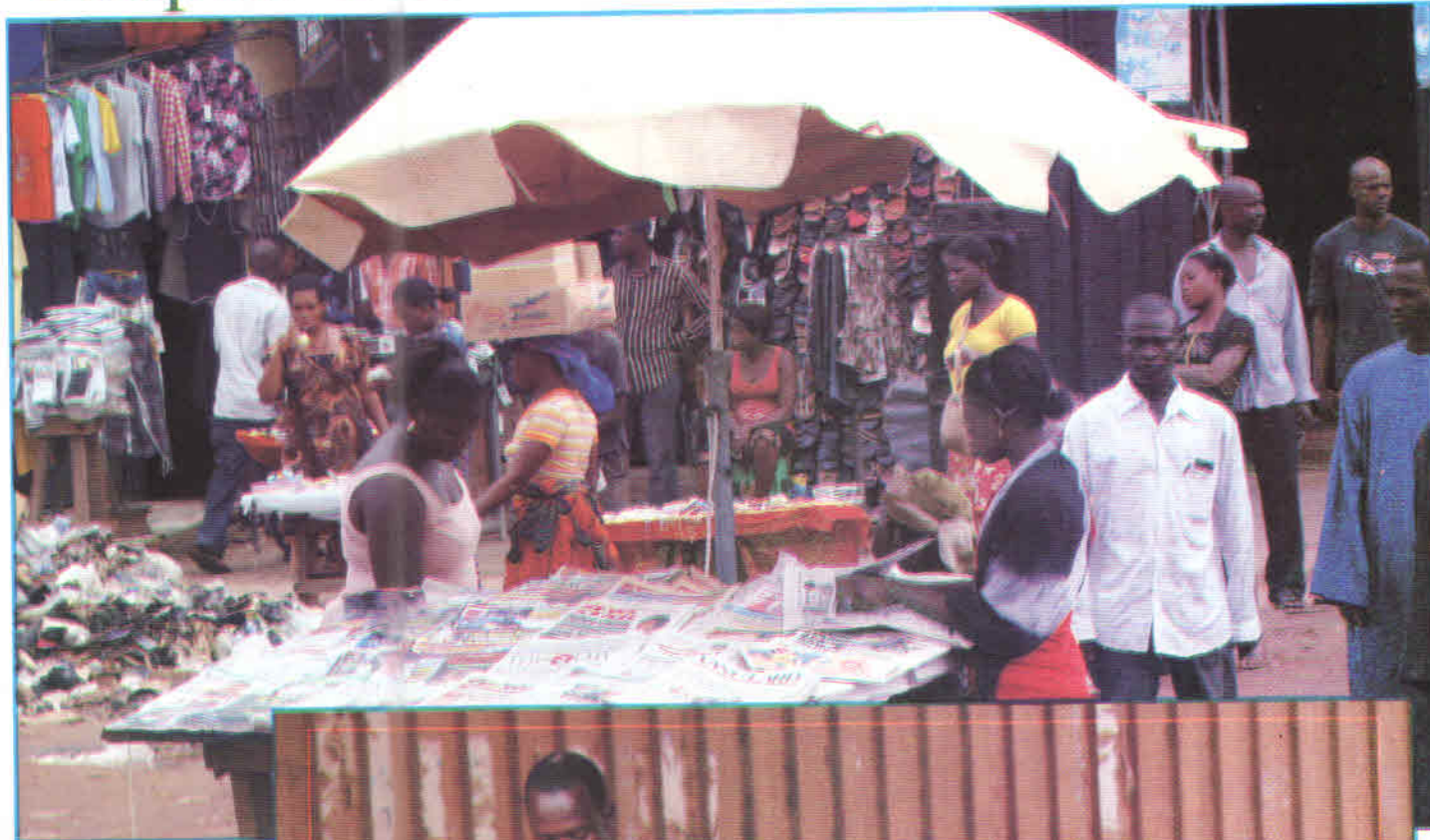
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ACRONYMS

1.	NHIS	-	National Health Insurance Scheme
2.	UN	-	United Nations
3.	WHO	-	World Health Organization
4.	AU	-	African Union
5.	OOP	-	Out - of - Pocket
6.	HSR	-	Health Sector Reform
7.	CBSHIP	-	Community-Based Social Health Insurance Programme
8.	HMOs	-	Health Maintenance Organizations
9.	HCPs	-	Health Care Providers
10.	FSP	-	Formal Sector Programme
11.	OPS	-	Organized Private Sector
12.	IFSP	-	Informal Sector Programme
13.	USESHIP	-	Urban Self Employed Social Health Insurance Programme
14.	RCSHIP	-	Rural Community Social Health Insurance Programme
15.	BoTs	-	Board of Trustees
16.	TFs	-	Technical Facilitators
17.	cHMOs	-	Community Health Maintenance Organizations
18.	NGOs	-	Non Governmental Organizations
19.	CBOs	-	Community Based Organizations
20.	FBOs	-	Faith Based Organizations
21.	MHAs	-	Mutual Health Associations
22.	CAC	-	Corporate Affairs Commission
23.	LGA	-	Local Government Authority
24.	CHISNEF	-	Community Health Insurance Safety Net Fund
25.	IEC	-	Information, Education and Communication Programme Managers
26.	PMs	-	Programme Managers
27.	IGR	-	Internally Generated Revenue
28.	IUHI	-	Igbokwu Health Insurance Scheme
29.	LHIS	-	Leguru Health Insurance Society
30.	DHIF	-	Dutch Health Insurance Fund
31.	LUTH	-	Lagos University Teaching Hospital
32.	GTZ	-	German Technical Organisation
33.	DRF	-	Drug Revolving Fund
34.	VAT	-	Value Added Tax
35.	CSOs	-	Civil Society Organizations
36.	NPHCDA	-	National Primary Health Care Development Agency
37.	QA	-	Quality Assurance
38.	ID	-	Identity
39.	MoU	-	Memorandum of Understanding
40.	MDG	-	Millennium Development Goals
41.	GSM	-	Global System Mobile
42.	MoH	-	Ministry of Health
43.	PHC	-	Primary Health Care
44.	SMOH	-	State Ministry of Health

Chapter One





1.0 INTRODUCTION

The health status of Nigerians is poor as evidenced by very high mortality and morbidity indices:

- | | | |
|----------------------------|-------------------------------------|--------------|
| • Infant Mortality Rate | 75/1000 live births | } NDHS-2008 |
| • Under 5 Mortality Rate | 157/1000 live births | |
| • Maternal Mortality Rate | 800/100,000 live births | - FMOH 2004 |
| • Live expectancy at birth | 47years(males) & 48 years (females) | } WHS - 2007 |
| • Healthy Life Expectancy | 41years(males) 42years (females) | |

One of the reasons for this poor health status is the weak health care delivery system. Nigeria's health care delivery system was ranked 187th among the 191 UN member states (WHO, 2000).

The weak, ineffective and inefficient National Health System is characterized typically by:

- Low annual National Budgetary Allocation for health, <5% of total budget ; (WHO recommends 5% of the total GDP while the African Union recommends 15% of the national budget). This amounts to approximately US \$4 per capita expenditure on health (WHO recommends US \$14 per head for developing countries while the Macroeconomic Commission on Health recommends \$34 per head).
- Unbalanced and inefficient resource allocation between and within the three levels of care (Tertiary, Secondary and Primary).
- High proportion of health expenditure from Out-of-Pocket (OOP), over 65% of total health expenditure, with little or no safety net for the largely poor Informal Sector, who are mostly rural dwellers.
- Very high user fees in both public and private facilities.
- Inequitable distribution of health care resources between urban and rural areas and between the different zones of the country.
- Dilapidated, under funded and poorly equipped health facilities.
- Unregistered, fake, substandard, adulterated drugs, which are the norm in the market.
- Inability of the healthcare delivery system to deliver a minimum package of quality health care (e.g. routine Immunization, emergency obstetric care, prevention and management of communicable diseases, etc.).
- General dissatisfaction of consumers with the quality of health care available particularly in public facilities.



1.1.1 Who bears the brunt?

The negative impact of this systemic weakness in the health sector impacts disproportionately on the **INFORMAL** sector of the Nigerian population. This group has the greatest burden of disease and the least access to health resources and services.

The Nigerian population (projected at 148 million) is largely informal (rural dwellers and the urban/semi-urban self employed, constituting over 70% of total population). The poverty level among this segment of the population is high, (~58%); their situation is worsened by low literacy, highly irregular income (subsistence economy) and high fertility. Characteristically, both financial and geographical access to health care services are grossly lacking for this large informal sector of the Nigerian population.

1.1.2 Poverty & Ill - health

There is a synergistic relationship between poverty and ill-health. Poverty is a major determinant of ill health and ill health aggravates poverty. The pervasive poverty in the country, may in part explain the poor national health indices. It becomes easily understandable therefore, that national efforts towards poverty reduction/eradication are only realizable with a deliberate strategy aimed at improving access to healthcare services for Nigerians and vice versa.

1.1.3 National Response

The Nigerian government, in line with its stewardship role, has responded by putting in place short, medium and long term strategies to reform the health sector for both effectiveness and efficiency so as to ensure the delivery of healthcare services of acceptable quality to the entire population, in a sustainable and equitable manner.

A key component of the **Health Sector Reform (HSR)** is the repositioning of the National Health Insurance Scheme (NHIS) to put in place a Social Health Insurance structure to provide sustainable complementary funding, by injecting fresh funds outside the conventional tax revenue and the highly inequitable user charges (out - of - pocket payments) that hitherto fuelled the comatose health system. The NHIS has a Presidential Mandate to achieve **Universal Coverage of health services for all Nigerians by 2015**.

1.1.4 Achieving the Presidential Mandate

Notwithstanding the daunting task of achieving this mandate, it goes without saying that this mandate is achievable with sustained multi - stakeholder effort aimed at eliminating both physical and financial barriers to access to healthcare services. The NHIS, whose primary mandate is to eliminate the economic barrier, is poised to achieve this through its various programmes tailored to target the different social-economic groupings in the country.

1.1.5 The Big Challenge

Recognising the fact that universal coverage is only achievable with a significant coverage of the more than 70% of the Nigerian population that constitutes the **INFORMAL SECTOR**,



this Blueprint is developed to guide the design/planning and implementation of **INFORMAL SECTOR COMMUNITY-BASED SOCIAL HEALTH INSURANCE PROGRAMME**, with the aim to address the critical problem of financial and geographical access to health care services for the informal sector. It is intended that the Framework contained in this document will serve as a guide for the numerous stakeholders wishing to support or participate in the establishment of Informal Sector Social Health Insurance Programmes across the country.

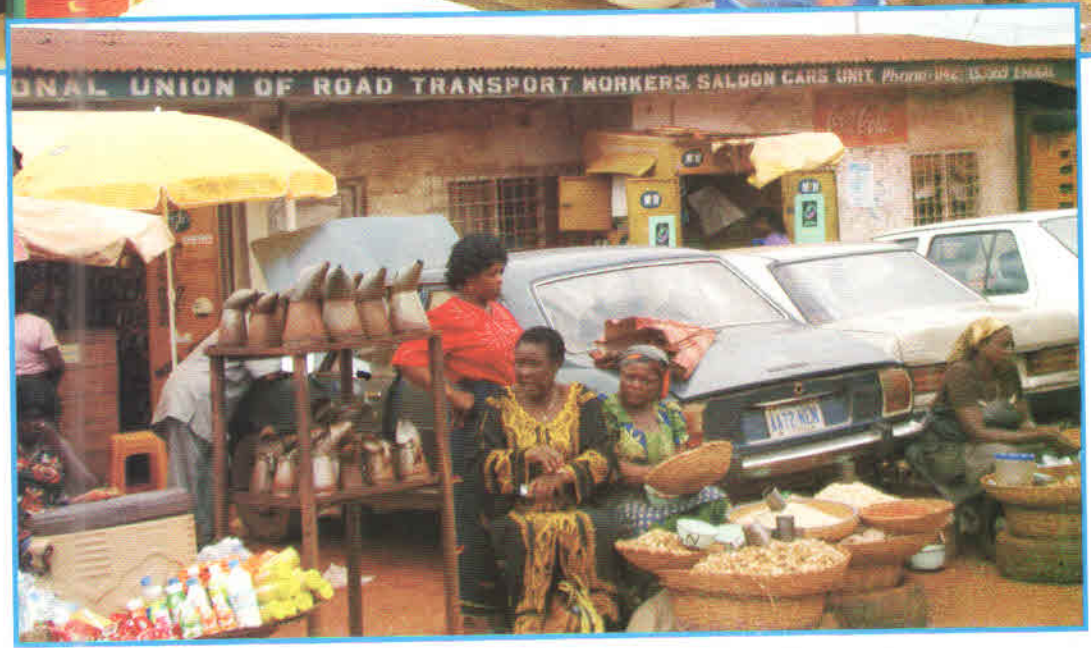
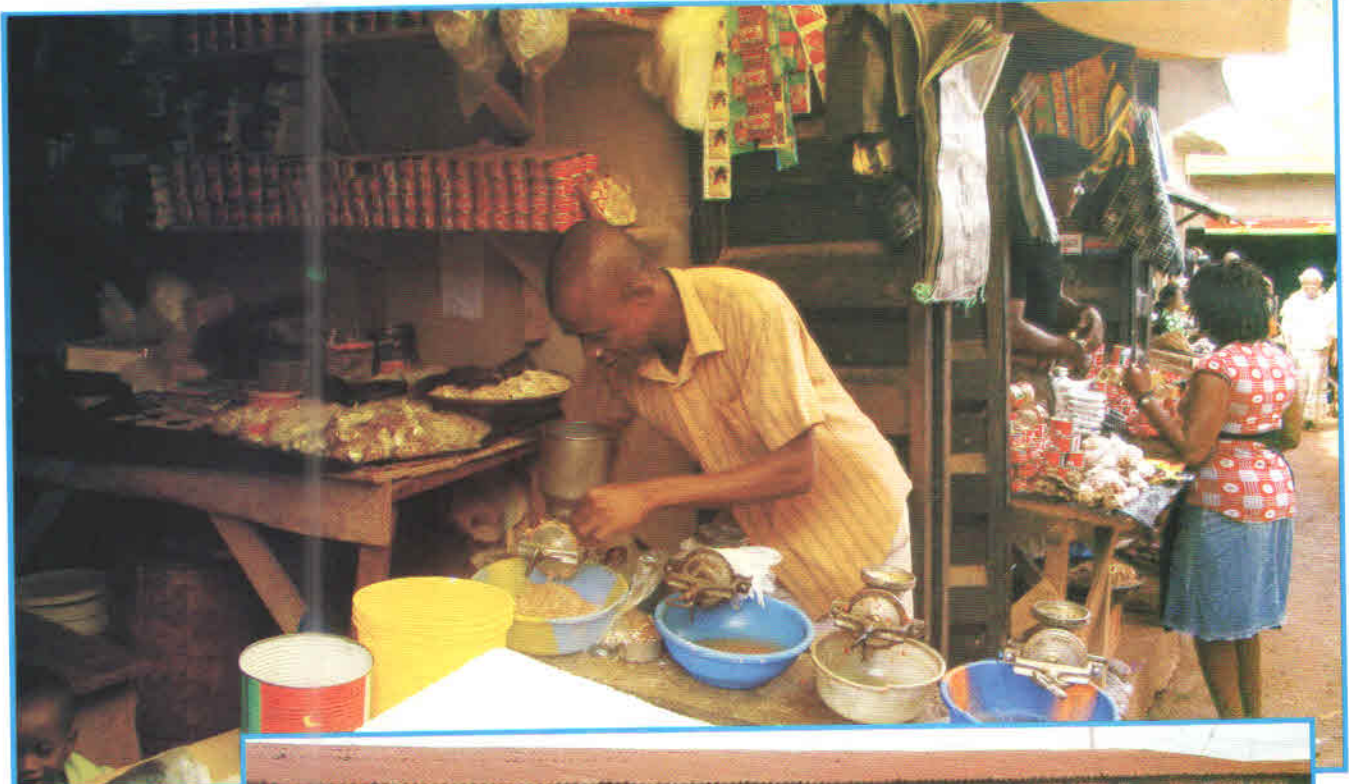
No doubt, a big challenge is posed on the NHIS, by the large population and geographical size of the country, coupled with an equally large informal sector. It is recognised that the **UNIVERSAL COVERAGE** desired by the Nigerian government is only achievable by strategically targeting the informal sector, mobilizing all stakeholders to operate in a synergistic manner to support as many rural and other informal sector groups as possible, to establish sustainable/viable Community-Based Social Health Insurance Programmes (CBSHIP).



This document is a product of practical lessons learnt from pilot CBSHIPs in the country, best practices from global literature on CBSHIPs, international study tours and stakeholder consultation. It incorporates practical input from a wide range of stakeholders brought together at a consultative summit that reviewed the initial draft document.

The document presents a strategy to facilitate the achievement of universal access to healthcare services for Nigerians, with the aim to improve the deplorable health indices in the country, towards socio - economic development and the attainment of vision 20-2020.

It presents models for the cascaded establishment of CBSHIPs in Nigeria, in pursuit of the presidential mandate of universal access to healthcare services for all Nigerians by 2015.





1.2 National Health Insurance Scheme

The NHIS is an agency of the Federal Government established under Act 35, 1999 to promote, regulate and administer the effective implementation of Social Health Insurance Programmes in order to ensure easy access to qualitative and affordable health care services for all Nigerians.

1.2.1 Vision

A strong, dynamic and responsive government agency that is totally committed to securing universal coverage and access to adequate and affordable health care in order to improve the health status of Nigerians, especially for those participating in the various programmes/products of the Scheme.

1.2.2 Mission

To facilitate fair financing of health care costs through pooling and judicious utilization of financial resources to provide financial risk protection and cost-burden sharing for people, against high cost of health care, through various prepayment(s) programmes/products prior to their falling ill. This is in addition to providing regulatory oversight on Health Management Organizations (HMOs) and participating Health Care Providers.

1.2.3 Goal

To enhance the health status of Nigerians, through the provision of financial protection against high cost of healthcare services in addition to ensuring consumer satisfaction.

1.2.4 Objectives

- To ensure that every Nigerian has access to good healthcare services;
- To protect families from the financial hardship of huge medical bills;
- To limit the rise in the cost of health care services;
- To ensure equitable distribution of healthcare costs among different income groups;
- To maintain high standard of healthcare delivery services;
- To Improve and harness private sector participation in the provision of healthcare services
- To ensure equitable patronage of all levels of healthcare; and
- To ensure the availability of funds to the health sector for improved services.

1.2.5 Core Functions

- To maintain and operate a health insurance fund,
- To develop, promote and ensure the quality of health insurance programmes under the Act.
- To issue guidelines and set standards for providers and health insurance programmes,
- To regulate the activities of health insurance actors,
- To mobilize additional resources (domestic and external) to fund the health



- sector,
- To conduct research and develop interventions to improve health insurance practice,
 - To define benefit packages and to introduce and market health insurance products,
 - To register HMOs and healthcare providers and approve contracts between various actors,
 - To build the capacity of health insurance operators to deliver quality services effectively and efficiently,
 - To issue appropriate guidelines in order to maintain the viability of the scheme,
 - To undertake periodic actuarial analysis and determine after negotiation, capitation and other payments,
 - To determine the remunerations and allowance of staff of the scheme.

1.2.6 Stakeholders

Health Maintenance Organisations (HMOs)

Health care providers (HCP)

- Primary
- Secondary
- Tertiary

Financial Institutions

- Banks
- Insurance companies
- Insurance Brokers

Governments and other employers of labour

Enrolees/beneficiaries

1.2.7 Programmes

I Formal Sector Programmes (FSP)

- Public Sector (Federal, State & Local Governments),
- Armed Forces, Police and other Uniformed Services,
- Organized Private Sector (OPS),
- Students of Tertiary Institutions and Voluntary Participants.

II Informal Sector Programme (IFSP)

- Rural Community Social Health Insurance Programme (RCSHIP)
- Urban Self-Employed Social Health Insurance Programme (USESHP)

III Vulnerable Group Programme

- Permanently disabled persons and the aged,
- Children under five
- Pregnant Women
- Prison in-mates.
- Retirees



Chapter Two

FRAMEWORK FOR COMMUNITY-BASED SOCIAL HEALTH INSURANCE PROGRAMME – (CBSHIP)

2.1 Introduction

This FRAMEWORK is designed to serve as a guide for all partners in the establishment/implementation of sustainable CBSHIP across the country.

2.1.1 Guiding Principle

The desire to achieve universal coverage and access to qualitative health care services for the Nigerian Informal Sector, irrespective of location and socio-economic status, by eliminating financial and geographical barriers to access.

2.1.2 Vision Statement

To improve the health status of the largely informal Nigerian populace, through their individual and collective participation to ensure access to adequate, qualitative, affordable and equitable health care services.

2.1.3 Mission Statement

To facilitate the establishment of community owned Social Health Insurance Programmes that protect members against high cost of health care by pooling health risks and resources in the spirit of social solidarity.

2.1.4 Objectives

- To significantly improve on the morbidity and mortality indices in the country, by addressing the critical problem of financial and geographical access to health care services for the informal sector populace;
- To provide a common framework to guide stakeholders in the establishment of community-based programmes;
- To bring out the key roles of stakeholders in the development of Social Health Insurance as option for financing health services for the informal sector;
- To establish partnering relationships between stakeholders;
- To develop a funding mechanism that will address the problem of access to health care services for disadvantaged groups (under5, the aged, the indigent);
- To provide an opportunity to generate valuable and qualitative data to strengthen the Health Management Information System in the country and to exchange such information with the social security services in the country.

2.2.1 Definition of CBSHI

Community-Based Social Health Insurance is a non-profit health insurance programme for a cohesive group of households/individuals or occupation based groups, formed on the basis of the ethics of mutual aid and the collective pooling of health risks, in which members take part in its management.

2.2.2 Objectives of CBSHIP

- Community-Based Social Health Insurance Programme serves as a mechanism for mobilizing community resources to share in the financing of local health services for

the informal sector. In addition, these schemes aim to achieve the following objectives:

- Improve access to health care services by eliminating or by significantly reducing out-of-pocket payment for services;
Improve quality of care by increasing both the amount and reliability of resources available for providers;
- Improve efficiency in the allocation and use of available financial resources through improved accounting, financial management and utilization management tools, which in turn will help prevent fraud and abuse of the system;
- Make health services more equitable.



2.2.3 Stakeholders

- Community Members
- Programme Managers - Board of Trustees (BoT) or Technical Facilitators (TFs)
- Technical Facilitators (CHMOs, NGOs, CBOs, FBOs and Limited Liability Companies, or companies limited by guaranty.)
- Healthcare Providers
- Organized Private Sector
- Development Partners
- Governments (LGA, State & Federal)
- NHIS



2.2.4 Guidelines for Implementing Stakeholders

- Board of Trustees (BoT)
- Technical Facilitators (TFs)
- Healthcare Providers

2.2.4.1 Board of Trustees (BoT)

- These are elected community representatives who function either as Programme Managers, responsible for the day to day management of Mutual Health Associations (MHAs), or support Technical Facilitators in the management of Community Health Insurance Programmes.
- The BoT members comprising of a Chairman, Secretary, Financial Secretary, Treasure, Public Relations Officer, Clerk and two others, are elected by community members (sometimes the BoT is a transformation of existing community structures such as Community Development Committees, etc). They conduct their functions in line with a Constitution developed and adopted by the community members.
- Mutual Health Associations (MHAs) as this collection of community members is termed, are governed by this constitution and usually secure a form of legal status through registration with relevant authorities of the State and Local Government.

Remuneration of BoT Members

As much as voluntary work is encouraged, Members of the BoT shall be entitled to monthly remuneration as determined by the members of the MHA. Any such remuneration to the Clerk must take into consideration the logistics of carrying out functions assigned to him/her.

Guideline

- BoT members shall be resident members of the community,
- BoT members shall be elected in a democratic manner acceptable to the generality of the community members,
- BoTs shall operate in line with a constitution developed and adopted by the community members,
- BoTs shall register MHAs with Local/State Government authorities and the Corporate Affairs Commission (CAC) as applicable and seek accreditation with the NHIS.

2.2.4.2 Technical Facilitators (TFs)

- These are NHIS accredited bodies engaged to provide both initial and on-going technical facilitation (or programme management where applicable) for the establishment and implementation of CBSHIPs.
- All NHIS accredited HMOs automatically qualify to function as TFs, whereas NGOs, CSOs, FBOs and limited liability companies, or companies limited by guaranty shall

seek accreditation with the NHIS having met the under-listed requirements and any other that may be set up from time to time by the regulatory body:

- Registration with Corporate Affairs Commission (CAC) as an Incorporated Trustee, limited liability company, or company limited by guaranty;
- Evidence of at least 3 years experience in implementing health-related community development activities, including monitoring and evaluation;
- Sound administrative and management structure;
Competence as evidenced by qualification and experience of the managers;
- Presence of operational office with full staff complement (administrative, technical, etc) in the intended State/LGA of operation;
- Non involvement in any other activity other than health care management;
- Demonstrable evidence of financial viability and sound financial management structure'
- Minimum working capital of N5.0 Million deposited with any of the NHIS accredited banks, where the TF functions as the Programme Manager'
- Re-insurance with an NHIS accredited insurance company, where the TF functions as programme manager; and
- Payment of registration fee of Ten Thousand Naira (N10,000,00) only to the NHIS.
- Administrative costs of TFs shall be funded by volunteer philanthropic individuals, the Organized Private Sector (OPS) or from a percentage of the Community Health Insurance Safety Net Fund (CHISNEF) set aside for the management of CBSHIPs, especially towards meeting the subsidy gap.

Guidelines for TFs

- TFs shall register and obtain accreditation from the NHIS,
- TFs shall seek for re-accreditation from the NHIS after every 2 years,

2.2.4.3 Healthcare Providers

These are primary, secondary or tertiary (where applicable) facilities engaged by MHAs to provide healthcare services to enrollees

NOTE: See the NHIS Operational Guideline for requirements and guidelines for healthcare providers.

2.3 Role of Key Stakeholders

2.3.1 National Health Insurance Scheme (NHIS)

The NHIS shall assume a purely regulatory and supportive role, to regulate and promote the establishment of sustainable Community Based Social Health Insurance Programmes (CBSHIPs) in collaboration with key stakeholders. NHIS key roles shall be to:

- Regulate the practice of CBSHIP including the development and periodic review (based on lessons learnt) of strategies to promote CBSHI Programmes.



Setting standards for Health Care Providers.

- Accredit Health Care Providers.
- Accredit Technical Facilitators.
- Support Technical Facilitators in actuarial review for the determination of contribution rates and payment (capitation & fee-for-service) to service providers.
- Provide capacity building support to Technical Facilitators and Programme Managers.
- Collaborate with key stakeholders such as governments, OPS, Community members and development partners to generate financial support towards funding the Community Health Insurance Safety Net Fund (CHISNEF).
- Develop IEC strategies for the purpose of generating awareness on CBSHIPs.
- Develop Standard Treatment Protocol for use by health care providers.
- Provide high level advocacy to generate support from policy makers at the different levels of government.
- Contribute to the establishment and management of the CHISNEF.

2.3.2 Programme Managers (PMs)

- Conduct advocacy outreach targeting policy makers at State and LGA levels
- Conduct advocacy activities to sensitize and mobilize community, religious and opinion leaders and the leadership of occupation based groups, for the purpose of generating awareness for the establishment of CBSHIPs,
- Conduct IEC activities to sensitize and mobilize community members and occupation based groups (including cooperatives) to buy-in to CBSHIP,
- Generate primary and secondary data (surveys, etc) for the purpose of programme planning, monitoring and evaluation,
- Determine benefit package and contribution rates in consultation with community members,
- Sign contractual agreement with participating communities and occupation based groups,
- Pool contributions collected,
- Ensure prudent financial management of pooled resources,
- Sign contractual agreements with service providers,
- Purchase health care services on behalf of participating communities and occupation based groups,
- Conduct medical auditing and quality assurance,
- Conduct health promotion and prevention activities,
- Conduct capacity building activities for the BOTs and participating healthcare providers
- Supervise and monitor Programme activities,
- Generate and contribute additional funding into CHISNEF,
- Assist new participating communities to set up Board of Trustees (BOTs),
- Send regular reports/feedback to the NHIS, communities & providers.

2.3.3 Technical Facilitators (TFs) - in models where BoTs function as Programme Managers

- Generate primary and secondary data (surveys, etc) for the purpose of programme design and monitoring,

- Determine benefit package and contribution rates in consultation with community members,
- Conduct medical auditing and quality assurance,
- Conduct capacity building activities for the BOTs and participating healthcare providers
- Supervise and monitor Programme activities,
- Assist new participating communities to set up Board of Trustees (BOTs),
- Send regular reports/feedback to the NHIS, communities & providers.

2.3.4 *Board of Trustees (BOTs)*

- Conduct mobilization & sensitization of community members,
- Register and regularly update the record of members,,
- Collect contribution from participating members and keep record of same,
- Pay contributions collected to TFs in TF- managed programmes,
- Pay Healthcare Providers in BOT-managed programmes,
- Screen members to benefit from CHISNEF,
- Ensure that there is no abuse of the system
- Support health promotion and prevention activities
- Provide community level quality assurance
- Organize regular community meetings (for feedback),
- Send regular reports/feedback to community members, providers and TFs where applicable.



2.3.5 *Community Members*

- Pay contributions due,
- Elect members of the BOT;



- Utilize services
- Attend general meetings,
- Provide regular feed back to programme managers

2.3.6 Development Partners

- Contribute to the funding of CHISNEF.
- Provide appropriate technical support to all other stakeholders, including the regulatory body (NHIS),

2.3.7 Governments (Fed., States & LGAs)

- Provide enabling legislative and policy environment;
- Upgrade of existing government owned health care facilities for the use of participating communities
- Allow retention of Internally Generated Revenue (IGR) in government owned facilities;
- Contribute appropriately to the funding of the CHISNEF.

2.3.8 Providers of Care

- Sign contractual agreement with Programme Managers,
- Provide quality services to registered members,
- Maintain all records of services given and payments received,
- Provide health prevention and promotion services,
- Provide regular feedback to Programme Managers.

2.3.9 Organized Private Sector (OPS)

- Contribute to the funding of CHISNEF,
- Support the establishment of healthcare facilities for the use of participating communities,
- Engage TFs for promoting CBSHIPs.

2.4 Critical Success Factors for the Viability/Sustainability of CSHIPs

2.4.1 Community Characteristics

- Community confidence in the project's concept and initiators;
- Existence of a real need for financing health care;
- Existence of community bonds and mutual self-help among the residents;

2.4.2 Enabling Environment

- Supportive government policy environment;
- Availability of quality health services;
- Favourable socio-economic development in the locality (Micro-finance schemes);
- Cooperation of all key stakeholders (including traditional authorities, service providers, CSOs, etc).

2.4.3 Planning/Implementation

- Objective selection of communities (using criteria) to ensure viability/sustainability



- of schemes (see annex for selection criteria).
- Community involvement/participation all through the planning process (e.g selection of benefit package, premium setting, etc), to ensure programme ownership.
 - Intensive and continuous IEC to generate and sustain awareness and understanding of the concept of social solidarity as the basis for social health insurance programmes.
 - Continuous identification and engagement of stakeholders such as Development Partners, Financial Institutions, Oil Companies etc for technical and financial support.
 - Provision of funds to address the subsidy gap required for the Informal Sector.
 - Availability of health care services of reasonable quality.
 - Close supervision and monitoring.

2.5 *Experiences in Implementing CBSHIPs in Nigeria*

The CBSHIP implementation experiences described in this section can be classified into two depending on the time of implementation. In the first group are programmes predating the launching of the NHIS, while the second group consists of programmes that came after the official launching of the NHIS. In the first group are the **Igbo-Ukwu Health Insurance Scheme (IUHI)**, located in Igbo-Ukwu, Anambra State and the **Leguru Health Insurance Society (LHIS)**, located in Ala - Idowa, Ogun State. The second group consists of a number of CSHIPs piloted by the NHIS across the country and the **pilot CBSHIPs funded by the Dutch Health Insurance Fund (HIF)**. The latter was directed at substantial augmentation of the shortfall in total programme costs from enrollee contributions alone. This shortfall is referred to as subsidy-gap and the pilot programme is being implemented in two states: Kwara and Lagos States.

The IUHI was introduced in 2003 by the traditional ruler of Igbo-Ukwu, a semi-urban community in Aguata Local Government Area of Anambra State, with a projected population of 70,000. The Igbo-Ukwu Development Union (IDU) played a leading role in the design of IUHI and in mobilizing the population through intensive publicity and awareness-creation usually done by way of public meetings. The scheme is managed by six elected officials from the Igbo - Ukwu Development Union (IDU) consisting of a Chairman, Vice Chairman, Secretary, Financial Secretary and two other members. The Programme Managers (PMs) are responsible for community mobilization and sensitization, determination and review of benefit package, determination and review of contribution rate, financial management, day-to-day administration and monitoring health care delivery by service providers.



Participation is voluntary and open to all willing members of the community. There is no waiting period for contributors to access service and access to services began in February 2004. The number of beneficiaries was 12,450 as at 2006; which is 18% of the target population assuming all the beneficiaries are financial members. A flat rate of N100 per month per adult and N50 per month per child is paid to coordinators at the health facility. The rate was arbitrarily fixed without any actuarial study. Other means of generating funds to run the programme include donations in form of drugs from government and individuals and other forms of donations like block payment of premium. However, there is no arrangement for covering non-contributors, nor those who cannot pay. The health facility used is community-owned but government - supported and providers are paid a fixed monthly remuneration by programme managers to support recurrent and capital costs of the health facility. The services offered are broad, covering primary and secondary (referral) services and services are given by presentation of membership card. The records kept by the programme are membership/enrolment records, financial records and utilization data.



The IUHI which is managed by elected officials (a type of BOT) has very strong community-ownership spearheaded by the strong backing of the IDU. The state government also recognizes and provides some support for the programme. A medical doctor with strong commitment is chairman of the programme while there is multiple provider network, providing choice for enrolees and enhancement of geographical access. However, the IUHI suffers from weak technical capacity of PMs with very minimal support from government or NGOs. In addition it is involved in wide latitude of support (recurrent and capital) to the health facility which may drain their contributions. There is weak financial management and service provision by the health facility is poor.

The L^{HIS} was established in 1996 in the Leguru District of Odogbolu LGA of Ogun State. The District consists of three settlements Ala, Idowa and Ososa. The total target population is 45,000 and the programme is located at the Ala/Idowa General Hospital, midway between the Ala and Idowa Communities. The scheme was initiated by community members in response to the findings of a WHO-funded study on the utilization of health services in the LGA. The community played an active role in the design and operations of the programme through regular meetings of the



Community Union. The programme also has technical support of the Department of Community Medicine of the Olabisi Onabanjo University and Professor Akin Osibogun of LUTH. The programme is co-managed by Community represented by BOT members and providers. Membership, which is voluntary, is open to any willing person irrespective of geographical residence but the focus is on Leguru residents. The number of beneficiaries is 754, which is just 1.7% of the target population. The premium of N500 per annum, was arbitrarily determined without any actuarial study. The premium, paid monthly, is usually paid to the Matron - in - Charge of the hospital. The benefit package covers only drugs for treatment of all non-chronic ailments and services are offered on presentation of enrollee membership card.

PMs are responsible for registration of members, periodic review of premium, collection of premium, health education, and monitoring/supervision of services provided to members. However, there is no autonomy in funds management as PMs have to seek approval of members at the monthly general meetings. The records kept by the programme are membership/enrolment, financial records, utilization pattern and morbidity and mortality statistics. Strong and committed leadership is regarded as being responsible for the long history of the programme, as well as strong community desire. The technical support given by the university is also a big



advantage as is active community mobilization. Excellent record keeping and very low administrative costs have also added to the success and longevity of the programme. However, the programme, in spite of being BOT-managed with technical support, still exhibits weak technical capacity. Other limitations include restriction of benefit package to drug provisions only, problem of adverse selection as a result of absence of waiting period and the lack of PM's autonomy.

The NHIS piloted a number of CBSHIPs from 2002 to 2005, using the Mutual Health Association (MHA) model. The MHAs used were mainly community-based associations and trade-based associations.

One of these NHIS piloted schemes is the **Ijah MHA**, located in Tafa LGA, Niger State. In Ijah, first an association was formed for the purpose and a BoT was elected to manage the programme. The Clerk of the BoT was paid by NHIS. Enrolees from the community contributed a fixed amount, N120 per individual per month. The NHIS donated seed grant of N1,000,000.00 in addition to seed drugs for DRF, renovated the healthcare facility, etc, at the inception of the programme. The LGA also donated N120,000 to the CBSHIP fund at inception. The health facility used is owned by the LGA and the BoT meets with the LGA before funds are disbursed. The programme increased financial access to healthcare services in the community. The programme also runs a subsidy programme for pregnant women and children. However, the Ijah programme has a number of challenges including low contributions as a result of high poverty rate, low awareness and reduced tempo of beneficiaries.

The **Zango Aya CBSHIP** in Kaduna State was launched on 8 February 2003. It is managed by an elected BoT of eight members and an office clerk who collects monthly contributions from members. The BoT which meets monthly has three sub-committees: finance, mobilization and conflict-resolution sub-committees. General meeting of members is held quarterly. It also runs a subsidy programme for pregnant women and children paid for by the NHIS. The programme has improved access of community members to health care. However, the non-participation of the state and local governments is a big challenge. Collection of members' contribution is irregular, posing sustainability problems.

The **Warake CBSHIP** is unique in that it has no government and individual participation. It was funded by NHIS totally through the supply of drugs and provision of operating expenses. It was not sustainable because it lacks community involvement and commitment. It collapsed once the NHIS funds and drugs finished.

Note: see Annex II for a Table of NHIS Pilot Programmes

The **Shonga Kwara State CBSHIP** is based on the principle that in informal sector health insurance, there is the challenge of being able to cover the cost of health care from contributions of enrolees alone due to poverty. The funding gap between cost of care and affordable cost is funded by the Dutch Government through the Health Insurance Fund (HIF). In the Shonga case, the annual per capita cost of



cost of care and affordable cost is funded by the Dutch Government through the Health Insurance Fund (HIF). In the Shonga case, the annual per capita cost of providing care is N5,000, while the annual contribution is N200 per capita, resulting in a funding gap of N4,800 per capita. The programme also gets other support from the Kwara state government and the Zimbabwean farmers. The HCHP (Hygeia Community Health Plan) was launched in Nigeria early 2007, targeting the Shonga farmers and their families as well as the market women in Lagos. Currently, there are 50,000 individuals enrolled, out of which 32,025 are in Kwara State. The provider Network includes 3 private and 3 public hospitals in Kwara State (with the Shonga PHC as the pivotal healthcare delivery centre). Kwara State Government contributed more than \$130,000 for the upgrade of the Shonga PHC. Two years after implementation, with three years to the end of the grant, the level of subsidy has not scaled down. The problem of this scheme as promising as it is, is that it is not likely to be sustainable in view of the very high subsidy and weak community participation and ownership.

Among the key challenges confronting CBSHIP relate to presence of fragmented, small and insignificant pools (necessitating external funding), arbitrary determination of contribution rates without formal actuarial study due to lack of technical capacity, lack of studies to determine ability to pay and lack of financial incentives for BOT members in spite of continuous costs incurred by many of them; and poor programme management capacity. Additionally, none of the models described has safety nets to take care of those unable to pay, thus inequity in access is not addressed and feasibility of universal coverage by 2015 frustrated.

2.5.1 Stakeholders Summit

At the Stakeholders Consultative Summit held from 21st - 23rd January 2009, in Bauchi, Bauchi State, where community representatives, traditional rulers, development partners, Governments (Federal, States and LGAs), Mos, NGOs and academicians met to deliberate on issues related to the design and implementation of the CBSHIP in Nigeria, and where the above experiences of implementation of community-based health insurance were shared, the following observations and resolutions were made:

2.5.1.1 Observations

The health indices of Nigeria are still far from the desirable levels that will position Nigeria among the top 20 countries by the year 2020;

Evidence exists that households spend a high proportion of their incomes on health-related expenditures even though the quality of these purchases may be doubtful

The poverty level in Nigeria imposes a financial barrier to access to quality health care services

NHIS has rolled out the Formal Sector Health Insurance Scheme which even at full coverage can only provide cover for about 25% of Nigerians

There is now a need to implement a scheme for the informal sector (constituting about 75% of the Nigerian population) at the community level to ensure significant coverage of Nigerians

2.5.1.2 Resolutions

A community-based social health insurance programme as part of social protection



will afford opportunity of pooling resources and sharing risks to improve health of the population. This scheme should be established as a priority, Sources of funding can be identified and attracted to meet the envisaged financial gap so as to ensure coverage of vulnerable groups and provide “safety nets”. Management of the subsidy fund should ensure accountability and transparency at all times

Sources of funding such as Value Added Tax (VAT) and dedicated tax can be used to fill the subsidy gap for the provision of CBSHIP

HMOs who benefit from the formal sector programme could be mandated to participate in CBSHIP so as to allow for some cross subsidies of the CBSHIP from the formal sector.

No one management model can fit all communities in all parts of the country. The Scheme must therefore retain a flexibility to adapt to situations in different parts of the country.

Research and development and a strong monitoring and evaluation system should be built into the programme to allow for learning even at implementation.

The NHIS is encouraged to facilitate CBSHIP implementation by continuous policy dialogue for implementation of pro-poor strategies, eg. the use of generic drugs.

NHIS should constitute a small committee including representatives of stakeholders in order to use the output of this Summit to finalise the blue print and pass it through the various approval processes.

2.6 *Management Models*

Based on the lessons learned from the review of experiences in running CBSHIPs in Nigeria and the observations and recommendations from the Stakeholders' Consultative Summit, it was noted that given the heterogeneity of the country, no single CBSHIP management model will satisfy the needs of the different communities in the country. Based on this, the following Management Models are proposed:

- BoTs as Programme Managers
- BoTs as Programme Managers with external Technical Facilitators
- Technical Facilitators as Programme Managers.

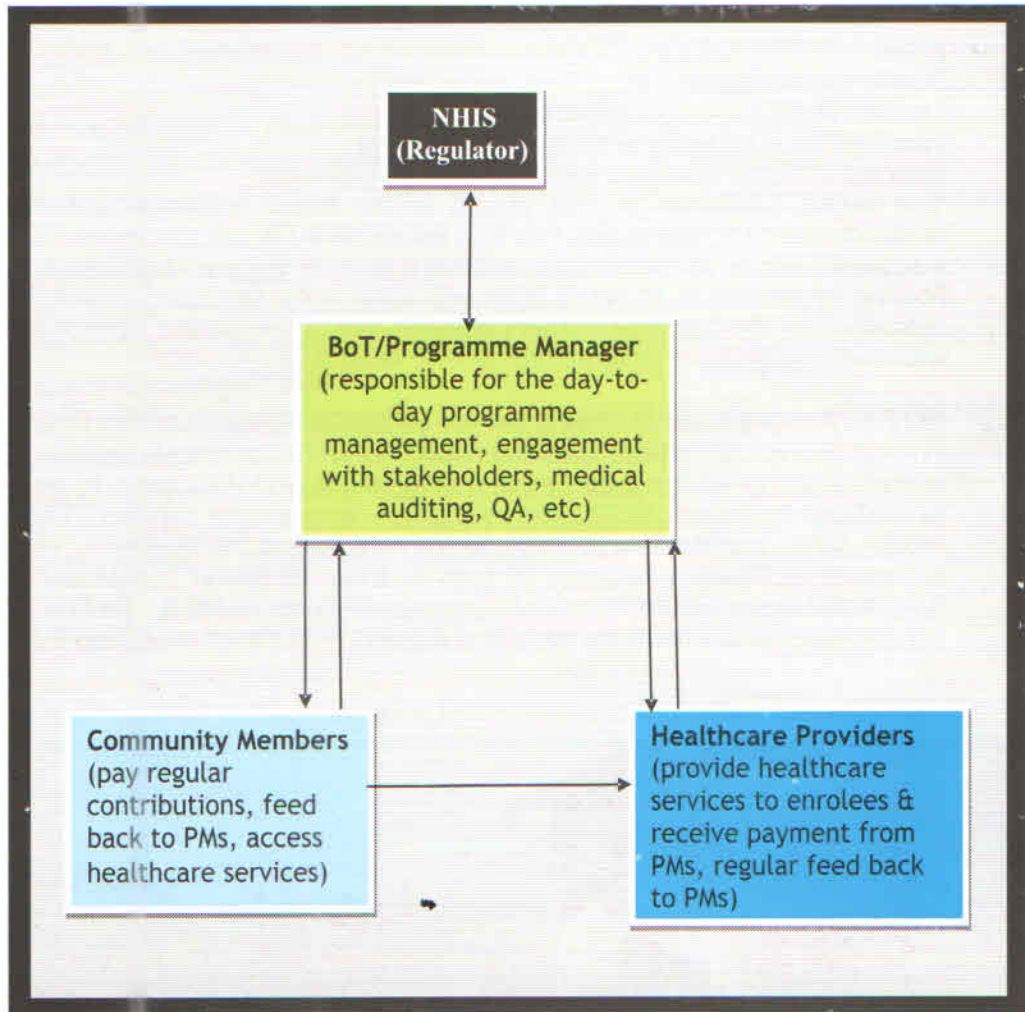
2.6.1 *BoTs as Programme Managers*

This model recognises community elected Board of Trustees (BoTs) as the programme managers, carrying out the day-to-day management of the programme, including engagement with all other stakeholders. The model is obtainable where the community elected BoTs have sufficient technical capacity that they do not require external technical facilitation, (TF) or where they are not privileged to engage a TF. This model is most appropriate for communities that have developed long term practical experience in implementing successful CBSHIP.

Existing community structures and organizations such as village, community development committees, CSOs, and existing health facilities and workers provide the platform for easy programme take off.

The BoTs in this model have dual roles; they function both as BoTs as well as PMs. The organogram for this model is shown in Figure 1

Figure 1: Management Model for CBSHIP where BoT function as Programme Managers





Strengths

Strong community programme ownership and participation which promote sustainability;
Comparatively low programme administrative cost;
Ease of local resource mobilization to address subsidy gap;

Weaknesses

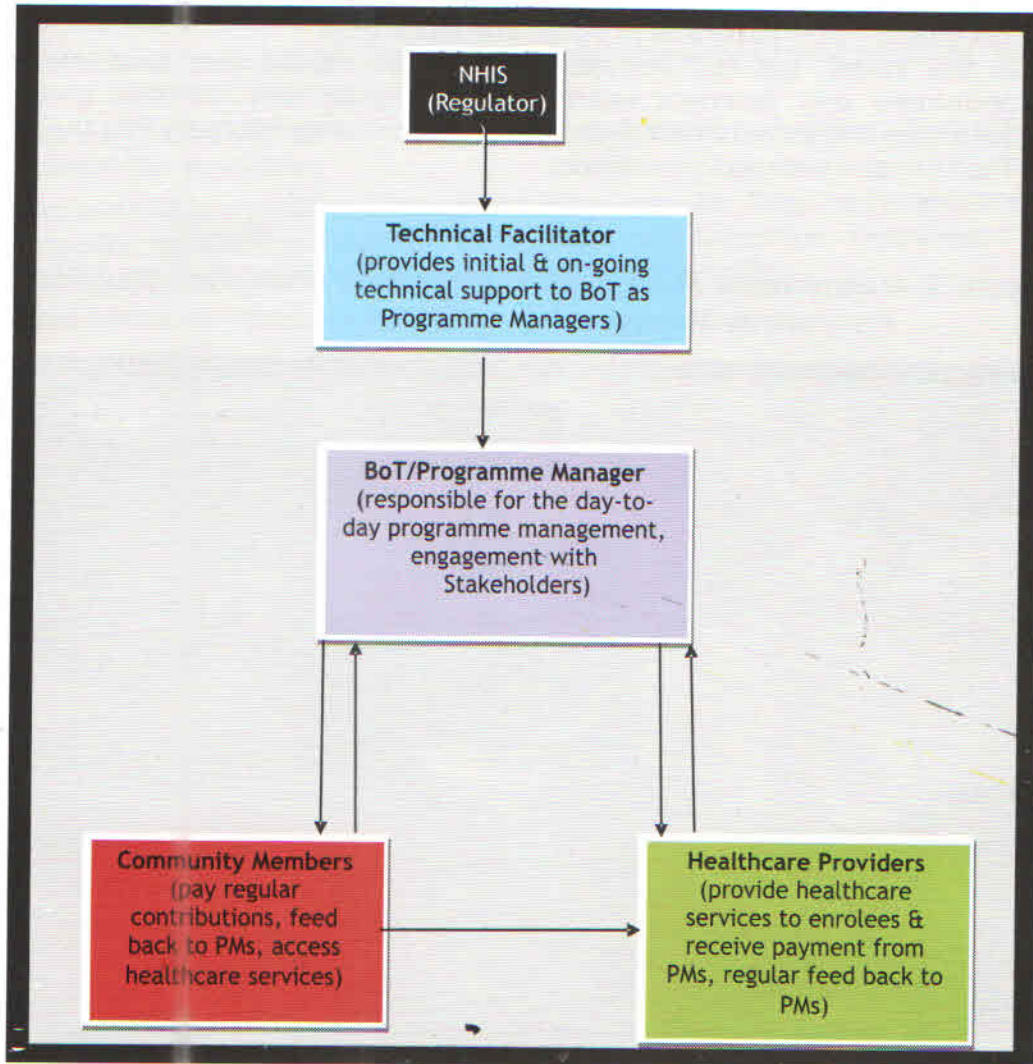
Small resource pool;
Limited population and service coverage;
Poor technical capacity of program managers;
Overlap of responsibilities and stretching of members
The major limitation of this model is the small resource pool. One strategy recommended for addressing this is to establish BOTs, not at community level but at ward or LGA level so that resources from a number of communities could be pooled. Pooling of resources at ward level will align with the ward health system being promoted by the National Primary Health Care Development Agency (NPHCDA) and will lead to synergy of programmes at that level.

2.6.2 BOT as Programme Managers with External Technical Facilitation

This model recognizes the inherent weakness in the technical capacity of the BOT to effectively implement programme management and thus seeks to engage an NHIS accredited technical facilitator to provide programme support. The BOT in this model, while maintaining programme ownership and management, resort to use of technical facilitators because of gaps in their technical competence. They thus function in areas where technical competence is not needed. Technical facilitators will provide complementary technical support as outlined in section 2.3.3



Figure 2: Management Model where BoTs function as Programme Managers with External Facilitator



Strengths

- Enhanced technical competence in programme management;
- Reduced workload for BOT resulting in improved performance;
- Better negotiation with providers resulting in lower cost;
- Improved capacity for medical audit and quality assurance which translates to improved quality of service delivery;
- Better ability to attract funds leading to larger resource pool.

Weaknesses

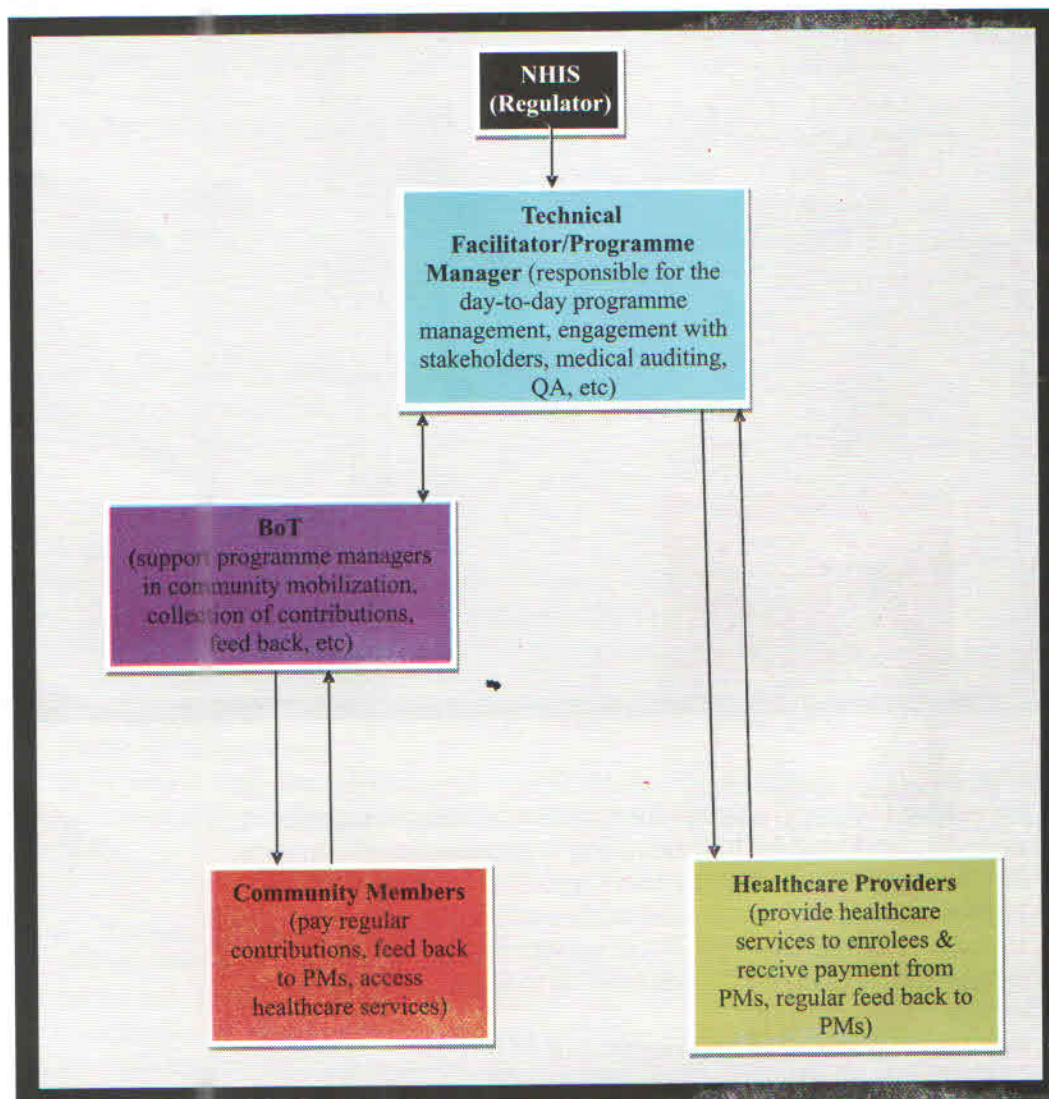
- Increased programme cost because of TF hire;
- Possible role conflicts between TF and BOT



2.6.3 Technical Facilitators as Programme Managers

In this model, the BOT relinquishes technical management functions to TFs, performing only functions ascribed to BOT. Essentially the BOT gives policy guidelines and serve to recruit and monitor community members into the scheme. The TF implements policy guidelines

Figure 3: Management Model where Technical Facilitators function as Programme Managers





Strengths

Clear split between ownership and management leading to possible improved performance;

- Enhanced technical performance which may result in enhanced quality of service delivery;
- Potential for large resource pool.

Weaknesses

- Limited community ownership resulting in compromised community confidence and poor buy-in leading to possible lowered resource pool;
- Inherent principal-agency problems in which the objectives of the programme managers may not be in concert with those of the community represented by the BOT;
- High programme cost;
- Excessive pursuit of profit by programme managers, which may lead to disillusionment of enrolees resulting in lowered utilization.
- Compromised sustainability care, taking into cognisance the prevailing local morbidity and mortality profile, including pre- & post-natal care, normal delivery, child welfare services (including immunization), family planning and health education services.

2.7 Operational Issues

2.7.1 Membership

This shall be voluntary and open to all residents (families) of the participating communities/occupation-based groups. The family or individual members shall be the unit of registration. In order to achieve a critical pool of funds to ensure financial viability, as well as to address the problem of adverse selection, communities/occupation based groups shall have at least 50% of members willing to participate (or a minimum of 1000 members).

2.7.2 Registration Procedure

Each programme shall have a clearly defined procedure for registering enrolees as well as a form of identification (such as membership card) to assist in the identification of scheme members.

2.7.3 Benefit Package

The benefit package shall reflect preventive, promotive and curative components of health care delivery. It shall aim at minimum primary and secondary curative care, taking into cognisance the prevailing local morbidity and mortality profile, including pre- & post-natal care, normal delivery, child welfare services (including immunization), family planning and health education services.



2.7.4 Potential Sources of Funds

2.7.4.1 Contribution/Premium

This shall be actuarially determined flat rate fee per household/individual household member or member of an occupation based group and paid in cash monthly or seasonally in advance.

2.7.4.2 Donations

PMs may seek for donations/grants by way of formal launching/fund raising events, or by targeting individuals, governmental and non-governmental organizations, including private companies, with the aim to boost the financial base of these schemes.

2.7.4.3 Investment

PMs may invest idle funds in minimal risk ventures to generate revenue which may augment other sources of funding.

2.7.5 Provider Payment

PMs shall engage the services of both public and private health care providers that are accredited by NHIS and located as close as possible to participating communities.

Provider payment shall be by:

Primary Benefit Package: actuarially determined Capitation.

Secondary (referral) Benefit Package: actuarially determined Fee-for-Service.



2.8 Risks

Community Based Schemes are prone to inherent risks which invariably present themselves as real threats to viability:

2.8.1 **Adverse Selection: this shall be addressed by:**

Waiting period which ensures that enrolees have to wait for a defined period before accessing care.

Minimum of 50% of households or members of occupation based group required to enrol (minimum 1000 members for each).

2.8.2 Moral Hazard: this shall be addressed by a gate keeping mechanism. A member of the BOT shall serve as a Gatekeeper to screen contributors before issuing out utilization forms.

2.8.3 Cost Escalation: e.g from unnecessary prescription by providers. This may be addressed by using appropriate provider payment mechanisms such as capitation.

2.8.4 Fraud & Abuse: e.g non-members pretending to be members and gaining access to services. This may be addressed by measures such as gate-keeping and the use of member identification tools (photo ID cards).

2.8.5 Covariate Risks: e.g resulting from epidemics and other natural disasters. These are best covered by government and other disaster relief agencies.



2.9 SUBSIDY GAP





2.9.1 Funding the Subsidy Gap

For the purpose of ensuring sustainability/viability of community-based programmes, this FRAMEWORK recognises the need to address the inherent problem of Subsidy Gap so characteristic of CBSHIPs.

2.9.2 Subsidy Gap

This refers to the difference between actuarially determined contribution rates needed to fund specific benefit packages for community-based health insurance programmes and what the community members are actually able to pay. There are two main reasons for this subsidy gap, first, because of the relatively high poverty level in Nigeria (CBSHIPs are compelled to set contribution rates at a level low enough for community members to afford), This results in a wide gap between the actual cost of care and the premiums charged Secondly, there are some members of the community who are unable to pay any premium at all because of extreme poverty. This gap can be quite wide and poses real threat to the viability of CBSHIP.

The net result of subsidy gap is limited population coverage, limited benefit package and quality of service delivery, widening of inequity, all of which will result in reduction of programme effectiveness and impact.

Pursuit of equity is central to the attainment of Health for All and the health specific MDGs. It is also a key component of the National Health Policy and the National Health Sector Reform. In 2005, a Presidential mandate was issued to ensure universal health access for all Nigerians by 2015. Removing the subsidy gap will be a major strategy to redressing inequity and ensuring universal access to healthcare services and contribute to the attainment of these policies and declarations.

2.9.3 Options for Addressing the Subsidy Gap

There are direct and indirect strategies for reducing this gap. The indirect options which are medium to long term include:

- Empowering community members through poverty alleviation programmes so as to increase their income generating potentials and hence ability to pay the actuarial cost of care.
- Identifying and implementing strategies to reduce cost of resource input into the health care system, which will result in lowered cost of the benefit package
- The direct option, which is short term and has limited sustainability is to source for the money to fund the subsidy gap.

2.9.4 Filling the Subsidy Gap - Direct/Short Term Strategies

Recognizing the weak capacity of CSHIPs to adequately address this gap, there is the need for stakeholder collaboration to identify, mobilize and harness potential sources of funds and to target these funds towards addressing this gap.



2.9.5 Funding Sources

There exist a myriad of potential sources of funds for addressing the Subsidy Gap which the NHIS in collaboration with other stakeholders could mobilize. Some of these include:

- Cross subsidy from the NHIS Formal Sector Programmes,
- Contributions from Governments (Federal, State and LGAs),
- Contributions from Development partners,
- Corporate Organizations; Multinational Oil Companies, Financial Institutions, GSM Operators, etc,
- Civil Society Organizations
- Nigerian Philanthropists



2.9.6 Community Health Insurance Safety Net Fund (CHISNEF)

Considering the potentially large number of stakeholders/funding sources, it appears desirable to establish a FUND to serve as a melting pot for these multiple sources, with the aim to bring in harmony in utilization and also to ensure equity in the use of these funds between different informal sector groups.

2.9.7 Management of the Fund

The management of the Fund shall be decentralized, with a four tiered management structure: Federal, State, Local Government and the Community . Standing committees shall be constituted to manage the fund at each level. The composition of the standing committees at each level is as follows:

2.9.7.1 Federal Level

- NHIS
- Fed. Ministry of Health
- Fed. Ministry of Finance
- National Planning Commission
- Representatives from States & LGAs
- Representative of the Organized Private Sector
- Representative of Development Partners
- Representative of CSOs
- Community representative



Role:

- High level advocacy and other activities for Fund Mobilization,
- Maintenance of a central pool of all funds generated for the purpose of addressing the subsidy gap,
- Setting and periodic review of criteria for the administration of the Fund,
- Disbursement of funds to the lower level committees,
- Monitoring funds utilization by the lower level committees,

2.9.7.2 State Level

- NHIS
- State Ministry of Health
- State Ministry of Finance
- Representative of LGAs



- Representative of Development Partners with local presence
- Representative of Organized Private Sector
- Representative of CSOs.
- Representatives of traditional and religious institutions
- Representatives of training institutions (Economics Dept and Community Medicine Department)

Role:

- Advocacy and other activities for Fund mobilization,
- Maintenance of a central pool of all funds received and generated for the purpose of addressing the subsidy gap,
- Setting and periodic review of criteria for the disbursement of the Fund,
- Disbursement of funds to lower level committees
- Administration of the Fund
- Monitoring of Programme implementation and funds utilization at the LGA level

2.9.7.3 LGA/Ward Level

- Representative of SMoH
- LGA Chairman
- MoH/LGA PHC Coordinator
- LGA supervisory councillor on health
- LGA Director of Finance
- LGA Development officer
- Representatives of traditional /religious institutions
- Representatives of CSO, development partners

Role:

- Advocacy and other activities for Fund mobilization,
- Maintenance of a central pool of all funds received and generated for the purpose of addressing the subsidy gap,
- Setting and periodic review of criteria for the disbursement of the Fund,
- Disbursement of funds to lower level committees
- Administration of the Fund
- Monitoring of Programme implementation and funds utilization at the LGA level

2.9.7.4 Community Level

- BoT members
- Religious and traditional institutions
- Technical Facilitators
- Programme Managers
- Health Care Providers
- Representatives of CBO

Role:

- Advocacy and other activities for Fund mobilization,
- Mobilization of resources locally
- Maintenance of a separate pool for funds generated locally and funds received from

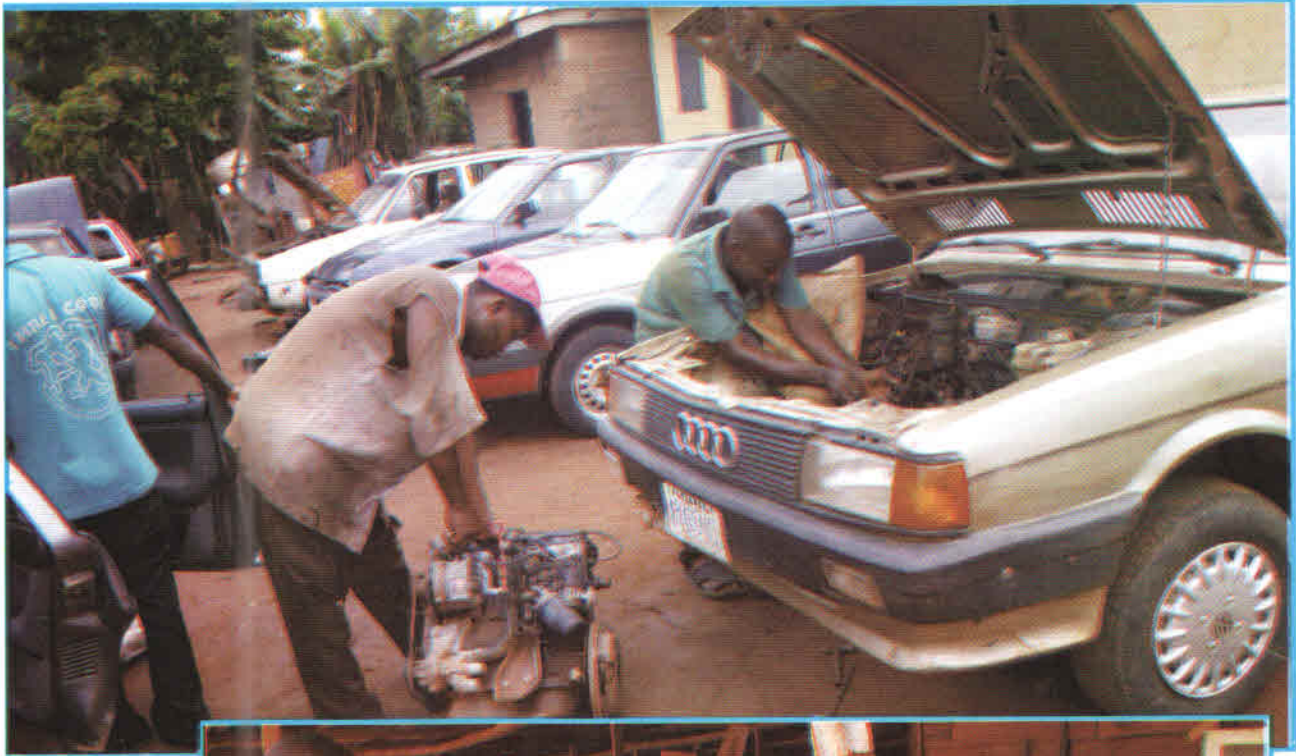


- higher levels for the purpose of addressing the subsidy gap,,
- Identification of eligible beneficiaries
- Disbursement of funds to beneficiaries
- Administration of the Fund
- Monitoring of implementation of funds utilization at the community level

2.9.8 Administration of the Fund

The proposed fund may be administered in the following manner:

- Payment of contribution/premium for the very poor and the vulnerable groups (the Physically & Mentally Challenged, under-5, pregnant women, the Aged, etc),
- Meeting the subsidy gap
- Finance specific components of benefit package, eg. Immunization, Maternity Services, HIV/AIDS, Tuberculosis, etc.
- Payment of administrative charges to participating Technical Facilitators and honorarium for BoT members and TF where applicable
- Use of 10% of the funds as contribution to advocacy, community mobilization, rapid needs assessments, baseline surveys, actuarial analysis etc.





2.10 PRACTICAL STEPS FOR PROGRAMME INITIATORS/PROMOTERS IN THE ESTABLISHMENT OF CBSHIPS

- I. **Advocacy visits to State/LGA policy makers:** the initial visit is aimed at securing approval and support for community entry. Following the conduct of needs assessment subsequent visits should be undertaken to secure support for specific community needs such as upgrading health facilities, allowing public facilities retain internally generated revenue, contribute to CHISNEF, setting up schemes to ensure the regular supply of drugs and consumables, etc.).
- II. **Identification of potential beneficiary Communities/Occupation Based Groups and conducting Rapid Needs Assessment:** this is a very critical step and should be done objectively, using laid down criteria (see annex I) to ensure that selected communities and groups have the potential to provide the right environment to support the growth of viable/sustainable schemes.
- III. **Advocacy Visits to Community/Occupation Based Leaders:** this follows the objective selection of communities/occupation based groups and provides the first opportunity to consult and dialogue with the group leaders. The aim at this stage is to sensitize/mobilise these leaders to understand the concept of social health insurance and to support the establishment of schemes in their communities/groups.
- IV. **Engagement of policy makers at states and LGA levels:** this includes signing of MoU by Programme Managers and working out planning and implementation modalities with state and LGA representation
- V. **Identification of existing Community Structures such as Village or Ward Development Committees, Community Contact Persons** such as representatives of the traditional institution, teachers, local community health workers, representatives of social groupings (e.g women groups, development unions, etc.) for early engagement, to represent community members/occupation based groups in subsequent programme planning and mobilization activities. This could serve as a platform for the election of the BoTs. ▶
- VI. **Identification and Engagement of relevant Local Governmental and Non - Governmental bodies Promoting Community Development Efforts:** this is to promote collaboration and synergy in programme implementation.
- VII. **Commencement of Community Mobilization & Sensitization:** with support from the Community Contact Persons identified from the earlier advocacy/sensitization visits programme promoters/initiators shall mobilize/sensitize community members/occupation based groups, employing intensive marketing strategies such as rallies, community meetings, etc, (inculcating the concept of social solidarity) to participate in the establishment of the scheme. This however is not a one off activity and the mobilization effort has to be sustained to be able to achieve and sustain a critical mass of enrolees to guarantee sustainability.



VIII. **Election of Members of the Board of Trustees (BOT);** for the purpose of ensuring community participation and ownership in programme management, it is imperative to put in place a democratically elected Board of Trustees to represent the community members in early programme planning as well as subsequent management processes.

IX. **Conduct of Baseline Surveys:** this is aimed at generating baseline data to guide planning and for the purpose of future monitoring and evaluation.

- i. House hold survey to generate information on:
 - Socio-economic status of communities.
 - Demographic profile.
 - Willingness/ability to pay for health services/premium.
 - Morbidity and Mortality profile
 - Health seeking behaviour.
- ii. Facility survey to generate information on:
 - Inventory of existing facilities/personnel and their spread.
 - Condition of existing facilities in terms of physical structures, manpower, equipment, etc.
 - Morbidity and mortality pattern.
 - Hospital utilization pattern.

Note: the NHIS may provide technical support to facilitate the conduct of these surveys.

X. **Conduct of Actuarial Analysis:** with support from the NHIS where necessary, programme managers and TFs (where applicable) shall engage the services of actuarial experts to provide the costing on specific ailments, to guide the selection of Benefit Package and to fix contribution rates.

XI. **Definition of Benefit Package:** based on the results of the baseline surveys and the actuarial costing of ailments, programme managers shall dialogue with community members to define a suitable and realistic benefit package to be adopted.

XII. **Identification of NHIS Accredited Healthcare Providers:** at this point, programme managers shall identify potential healthcare providers from the NHIS list of accredited providers.

XIII. **Engagement of Providers and Signing of MoUs:** programme managers shall sign MoUs with all implementing stakeholders (BoTs, TFs and the healthcare providers where applicable).

XIV. **Registration of Community Members and Payment of Contributions:** PMs shall register community members (using established registration procedure) and collect their contributions (premium), issuing out membership cards to all registered members. This should be supported with continuous active community mobilization effort.



XV. Training Relevant Implementing Partners:

- a. **BoTs:** provide early training on basic administration and financial management (book keeping) to members of the BoTs.
- B. **Healthcare Providers:** provide early training to facility staff on the concept of social health insurance and the guidelines for operating community based social health insurance schemes.

- XVI. **Commencement of Capitation Payment to Healthcare Providers:** this is paid in advance and tied to the number of enrolees registered with the healthcare facility prior to enrolees accessing service. Thereafter, the BoT and PM can decide modalities for remuneration of health care providers, either capitation or fee for service.
- XVII. **Commencement of Access to Health Care Services:** After establishing clear procedures for accessing service including determination of waiting period and gate keeping criteria, enrolees should commence accessing service.
- XVIII. **Setting up local safety net structures:** This is to ensure access to services for those who cannot afford to pay at all and also meet other subsidy gap.
- XIX. **Initiation and promotion of the establishment of income-generating activities:** this should done in collaboration with other relevant partners for the economic empowerment of the members of the community in an effort to reduce the subsidy gap in the medium and long term.
- XX. **Establishment of structures for Programme Supervision and Monitoring:** Structures should be put in place for external supervision and monitoring at LGA, State and federal level in addition to internal monitoring by the Programme Managers.



SELECTION CRITERIA

Annex I

These criteria should serve as a guide for stakeholders in the process of selecting Communities for establishing Community Social Health Insurance Programmes.

Criteria for Selection of Communities

- Existence of palpable difficulty in accessing health care services so as to motivate community members to accept Programme.
- Willingness to participate minimum of 1000¹ enrolees .
- Presence of community organizations e.g cooperative societies, saving schemes, development associations, social clubs, etc.
- Experience with a community - based economic empowerment project/programme.
- Availability of health care facility.

¹ This figure was arrived at from the experience of a long standing viable pool (Leguru Health Insurance Scheme)



THE NHIS PILOT SCHEMES

Annex II

S/N	MHA Community	LGA	State	Geo-political Zone	No. of Enrollees at Inception	Date Launched	Healthcare Facility	Technical Partner/s
1	Ijah	Tafa	Niger	North Central	3,000	22 nd March, 2003	Ijah Basic Health Centre	NHIS
2	Zangon Aya	Igabi	Kaduna	North West	8,000	8 th February, 2003	Zangon Aya Primary Health Centre	NHIS
3	Jada	Jada	Adamawa	North East	6,000	24 th August, 2002	Jada Mutual Health Care	NHIS
4	Warake	Owen East	Edo	South South	6,000	18 th January, 2004	Owen East Urban Health Centre	NHIS
5	Ibogun-Olaogun	Ifor	Ogun	South West	6,392	4 th October, 2002	Primary Healthcare Centre	NHIS
6	Kwaka	Gurara	Niger	North Central	1,513	8 th July, 2004	Primary Healthcare Centre, Kwaka	NHIS & GTZ
7	Enagi	Edati	Niger	North Central	1,524	1 st July, 2004	Basic Health Centre, Enagi	NHIS & GTZ
8	Wawa	Borgu	Niger	North Central	2,404	15 th July, 2004	Compr. Health Centre, Wawa	NHIS & GTZ
9	Pandogari	Kusherki	Niger	North Central		15 th December, 2004	Pandogari Primary Healthcare Centre	NHIS & GTZ



Annex II (Cont'd)

10	Sahorami	Zugurma	Niger	North Central			Sahorami Rural Hospital	NHIS & GTZ
11	Ehere Model Traders Association	Aba	Abia	South East	750	15 th December, 2004		NHIS
12	Performing Shoes Manufacturers Association	Aba	Abia	South East	1,500	11 th June, 2002	St. Paul's Hospital, Aba	NHIS
13	Umuehilegbu Shoe Makers Association	Aba	Abia	South East	2,500	11 th June, 2002	Living Word Hospital, Ivory Hospital, St. Paul's Hospital	NHIS
14	Dei-Dei International Timber Traders Association	AMAC, Abuja	FCT	FCT	1,480	22 nd March, 2002		NHIS

