Community Based Health Insurance Model (CBHI)

Our CBHI model addresses the risks of the uninsured poor of the informal sector. These risks condemn them to poverty, ill health and uncertainty. The model is voluntary, contributory and contextualised. The conceptual framework of this model includes tailoring benefits to local risks at premiums perceived locally as affordable. The Benefit Package Design is decided by the community keeping in mind the local health needs and the local availability of health services. The implementation model is founded on a partnership model through the application of trusted governance at local level. The unique feature of this model is to enable target communities to take decisions that affect their member’s lives, enabling communities to be in control of the money paid by members to CBHI, enabling communities to control and govern the CBHI on their own. The benchmark to the success of the schemes are :- i) coverage should deal with the risks of the insured, ii) price should be affordable, iii) value proposition of the insurance should be positive and clear, iv) process should be transparent and trusted by the insured, v) viable supply and demand should be established.

Community Based Health Insurance schemes are voluntary and contributory. They are tailor made as per the needs of the Community. It varies from village to village, area to area. It depends on the package that the community decides for their health cover.

The CBHI schemes have been successful in retaining most enrollees beyond the one year contract and have also attracted new enrollees in the subsequent years. The achievement has been without premium subsidies and on a voluntary basis as members agreed to pay the health insurance premiums. From a development perspective, this is a remarkable and rare demonstration that contributory Health insurance without premium subsidies can be attractive to rural poor. This voluntary, contributory, needs based and demand driven implementation model has met with a very good response at the grassroot level and it responds to the wishes of the community to retain decisions, funds, priorities and operations locally.

Success:

- CBHI has shown a reduction of Self-medication as the communities have become more aware about their health and now more often visit the Health Providers as they are insured.
- Decrease in Out of Pocket Expenses (OOPS) on Health of the insured community members.
Repliability:

The positive results of the CBHI and the small scale size implementations are undisputed facts and surely can be replicated at larger scales provided there are adequate funds available.

Our Model relies on a three pronged approach (capacity building, governance and insurance) each of which leverages local function, purpose and culture. The model establishes good governance that has been used to usher in further change. Therefore we confidently say that all essential components are widely transferable within the informal sector:

- The poor in informal sector can drive their own development without any subsidy by catalyzing solvent demand to spark the P2P sharing economy.
- The basic business process that starts with awareness and ends with local servicing of claims fits very well with community specific functions in most low and middle income countries.
- The training of communities in governance, management and operations is generally transferable (once tailored) and insurance specific training is transferable to all classes of risk.
- Subsidiary–based decision making that leverages community practice is universally transferable.
- Our reliance on evidence based Data and analysis techniques for decision support and implementations is fully transferable, although data collection must be tailored
- Once a scheme is established, the community has a valuable platform to introduce other social changes, including government and NGO-sponsored programmes.

Costs in implementation of these projects are front loaded in the first few years but over time the success of the CBHI model will show lower costs.

Implementation

MIA works with local partners to build successful microinsurance programs. Driven by the desire to develop insurance schemes that make a real difference for vulnerable households, MIA supports our partners to design locally-relevant insurance packages, develop adequate business processes, lead interactive insurance education and awareness campaigns, and create financially viable insurance schemes. We provide comprehensive training programs to local partners, equipping them with the skills to engage community members in the design, management and governance of microinsurance. As a result, programs meet the unique needs of each community and the structure is locally owned and trusted. Our microinsurance programs cover families from health, life, crop, livestock and natural catastrophic risks.
**Micro Insurance Academy**

**Implementation Approach**

1. **Engage the Community**
   MIA and our local partners identify a community in need where microinsurance could be available. Together MIA and the partner meet with the community members to discuss the risks faced by the community and to explain the benefits of using microinsurance to mitigate these risks. If the community expresses interest in microinsurance, the project continues.

2. **Identify the Risk**
   Insurance can cover a variety of risk classes - life, health, crop, livestock and natural disaster, to name a few. By listening to the community, which determine the most pertinent risks and begin supporting the establishment of an insurance scheme to cover these specific risks.

3. **Appraise the Risk**
   Even when it's "micro", insurance requires technical know-how to appraise a risk. MIA starts by collecting data to evaluate the community's exposure to the risk. We use this data to calculate benefit options and premiums for the community. In Insurance, this process is known as risk modelling, and it's one of the many technical skills MIA offers the community at no cost.

4. **Insurance Education**
   MIA regularly works with communities that have never been insured, so we place an emphasis on insurance education. Our awareness campaigns are designed to explain the benefits of insurance and notify all community members that an insurance scheme is coming to their village. Community members select the communication channels such as songs, street plays and posters, and then lead an awareness campaign.

5. **Select the Benefit Package**
   MIA regularly works with communities that have never been insured, so we place an emphasis on insurance education. Our awareness campaigns are designed to explain the benefits of insurance and notify all community members that an insurance scheme is coming to their village. Community members select the communication channels such as songs, street plays and posters, and then lead an awareness campaign.

6. **Set up the Operating Infrastructure**
   MIA trains community members to operate every aspect of the microinsurance scheme. We know the scheme will be more successful if it is owned and operated by the community and local partners.

**Claims Committee**
The community elects a committee of trusted villagers to govern the scheme, manage the finances and oversee claim payouts.

**Insurance Coordinator**
This locally appointed official manages membership and financial data using MIA’s data management software.
INSURANCE ACTIVIST
Community members are trained to conduct awareness campaigns, enroll members and assist the insured in filling a claim.

VILLAGERS
The scheme is open to all village members. Households enroll by paying a premium and submit a claim when necessary.

LOCAL PARTNER ORGANIZATIONS
Our partners work closely with the claims committee, insurance activist and villagers throughout the project.

MIA
MIA provides ongoing technical assistance and training to communities.

ENROLLMENT
07
Households can enroll in the insurance scheme by paying a premium for all family members - typically 1.50 to 4 EUR per person for a year of coverage. Premiums are collected into a common fund, which is managed by the Claims Committee. It is from this fund that claims will eventually be paid.

Unlike a commercial approach, no insurance company makes a profit from the community scheme. The community fully owns the scheme.

08
CLAIM SUBMITTED
If the household experiences a covered calamity, for example an insured family member falls ill, the policyholder submits claim with the help of an insurance activist.

The Claims Committee ensures the claim is valid and approve a payout from the common fund.

09
REIMBURSEMENT
After the Claims Committee approves the claim, the policyholder receives a reimbursement of all covered costs. Community members typically gather to witness the policyholder receiving their reimbursement.

10
RE-ENROLLMENT
Each year, households can re-enrol in the insurance scheme. Typically, up to 60% of policyholders choose to re-enroll, which is significantly higher than industry standards. The high re-enrollment rates reflect the satisfaction and need for community-based microinsurance.

11
PHASING OUT
MIA aims to build the capacity of our partners to independently maintain viable insurance schemes. MIA withdrawals from project sites when the insurance schemes become self-sufficient.
Pilot Projects of CBHI have been successfully implemented in District Kalahandi in **Odisha**, District Vaishali in **Bihar**, District Rajnandgaon in **Chhattisgarh**, Districts Kanpur Dehat, Pratapgarh and Allahabad in **Uttar Pradesh** and in Districts Dhading and Banke in **Nepal**. CBHI has also been successful with the **Central Tibetan Administration** in 32 Tibetan settlements across 12 states of India.

CBHI schemes require like any other projects (e.g. projects funded by donors or like any other National Scheme) continuous support to ensure its smooth functioning, but costs reduce over time.

The pilot project in District Vaishali in **Bihar** is an ongoing scheme. Schemes in District Muzaffarpur in Bihar and District Beed in **Maharashtra** are being launched soon.

### Learn More About Our Current Implementation Projects:

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<th>Project Title</th>
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<td><strong>Strengthening Health Systems in Rural India</strong></td>
<td>Odisha, India</td>
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**Background**

Odisha is one of the most impoverished states in India. Tribal villagers in the Kalahandi district earn meagre incomes as smallholder farmers, day labourers, shop owners or foragers. The average household income per year ranges from EUR 445 – 573. Many villagers belong to disadvantaged tribes and castes.

In addition to extreme poverty, health crises plague the tribal populations of Kalahandi; malaria is endemic in the region and maternal death rates are dangerously high, to name a few. The challenges in the region’s health situation stem from two primary gaps; adequate healthcare options are extremely limited, and villagers cannot afford to seek qualified care. Public healthcare facilities are often geographically inaccessible, lacking in supplies and insufficiently staffed. As a result, villagers will typically forego treatment, visit unqualified traditional healers, or travel far distances to seek private care.

**Nature of the Project**

MIA and our local partner, Mahashakti Foundation, first implemented a micro health insurance scheme in Kalahandi district in 2009. The scheme, called “Niramaya”, has become an important feature in the communities where it is operational. Community members were originally skeptical of Niramaya, but now they confidently seek healthcare when required, knowing they will be reimbursed for their expenses.

Through funding from UKAID’s Global Poverty Action Fund, MIA has been able to expand Niramaya across three blocks of Kalahandi district: Madanapur Rampur, Narla and Kesinga. Ultimately, the project is designed to improve access to health services and offer households a mechanism to help pay for these services. This project is unique to MIA because it looks to build both the demand of insurance and supply of healthcare, whereby MIA normally focuses on demand. Our
partnership with Catholic Health Association of India (CHAI) will enable us to build a team of local health workers and establish health clinics.

**Status of the Project**
Since April 2012, MIA and its partners have expanded Niramaya across 178 villages. Efforts are underway to build 3 health clinics and train 75 village health champions as healthcare advocates to promote available health services. MIA will continue to provide technical assistance in the district through 2015 under UKAID funding to further expand the CBHI scheme to reach a greater portion of the population.

The cumulative members from 2010-2015 were 23,999. The active members in July 2015 were 6,286.

### Setting up a Holistic Tibetan Medicare System for the Tibetan Population in India

**Background**
Over 100,000 Tibetans live in exile in India. Operating from Dharamsala, India, the Central Tibetan Administration (CTA) oversees the needs of the displaced Tibetan population, including health, education and cultural heritage. In 2010, MIA undertook a feasibility study for the CTA’s Department of Health, following which the Tibetan Cabinet decided to establish the Tibetan Medicare Scheme. As an initiative by the Department of Health, the Tibetan Medicare Scheme was created in partnership with private providers to reduce financial insecurity and hardship associated with unexpected medical expenses and hospitalization.

**Nature of the Project**
After the study, CTA approached MIA to assist with the launch and implementation of the Tibetan Medicare Scheme. The scheme aims to create a sustainable financing mechanism that will leverage CTA’s resources along with individual contributions in the form of insurance premiums to provide quality healthcare to the community.

MIA produced implementation guidelines, delivered training programs on insurance operations, helped the community to design insurance packages, sourced IT solutions and developed insurance education and awareness tools. The insurance packages are offered on both an individual and household basis as the Tibetan family is the central social unit.

**Status of the Project**
Enrollment started in February 2012 and membership in the insurance scheme was generated from 32 Tibetan settlements across 12 states of India (Karnataka, Chhattisgarh, Maharashtra, Odisha, Himachal Pradesh, Uttarakhand, Jammu and Kashmir, Delhi, Arunachal Pradesh, Sikkim, West Bengal and Meghalaya).

Insurance education and awareness efforts are underway, preparing communities for the second phase of enrollment. The campaigns are structured to inform communities about the health risks they face, the benefits of insurance and how
they can join the insurance scheme.

The cumulative members from 2012-2014 were 32,453. The active members in 2014 were 13,146.

### Climate Resilience Through Risk Transfer (RES-RISK)

#### Background
It is generally accepted that climate trends are changing, leading to more volatile and extreme weather events. For vulnerable communities, changes in climate trends pose a substantial threat to their financial and physical well-being. Extreme heat or cold can ruin a harvest. Excessive rainfall can create breeding grounds for mosquitoes that spread malaria. Floods can wipe out livestock, crops and personal property. The vulnerable have limited mechanisms to cope with changing climate conditions and the subsequent financial implications of crop failures, loss of livestock or health events.

#### Nature of the Project
The main objective of the multi-year RES-RISK project is to enhance the resilience of vulnerable communities to climate change by developing and implementing pro-poor microinsurance solutions covering health, crop and livestock risks in two locations lying in different agro-climatic zones: (i) the Middle Gangetic Plains region, with activities in North Bihar; namely Vaishali and Muzaffarpur, and (ii) the West Coast Plains & Hills region of Beed, in Maharashtra.

MIA (lead) and BASIX (co-implementing partner), through funding from the Climate Change and Development Division of the Embassy of Switzerland in New Delhi, are pioneering an innovation in microinsurance to directly meet the needs of vulnerable communities impacted by climate change. We are developing composite insurance – which combines coverage for health, crop, livestock and natural disaster – and using our community-based insurance model to help communities set up and govern their own schemes. Through this project, communities will be able to manage the range of risks associated with changes in climate trends.

The RES-RISK project is being implemented through partnerships with local NGOs, namely VASFA and NIDAN in Vaishali, Meenapur SHG Federation in Muzaffarpur and JVSS in Beed.

#### Status of the Project
In 2013, MIA and our partners have conducted more than 4,200 household interviews, 50 focus group discussions (FGDs) and 50 key informant interviews as part of this project in Bihar and Maharashtra. In 2015 another 3,000 households have been interviewed and 16 FGDs and 49 KIIIs have been conducted.

Extensive quantitative, qualitative and spatial data has been collected on socio-economics, agricultural activities, livestock rearing, health related issues, perception on climate change, financial coping mechanisms and local hazards. Primary data has
been complemented by climate data procured from the Indian Meteorological Department (IMD) and satellite data. Using the collected data, benefit options for schemes that cover various climate-related risks have been designed and priced. Various research studies on climate change impact on groundwater availability for domestic use and climate impact on agricultural risks have been conducted. Insurance awareness tools have been designed, awareness campaigns conducted and a local ground structure to administer the insurance schemes are being established. In the next phase of the project, communities will select an appropriate insurance package and begin enrolling households into schemes.

The risk transfer measures are being embedded into a comprehensive adaptation framework. As a first layer adaptation measures for risk reduction (e.g. agriculture value chain services) have the potential to address the larger portion of the risk cost efficiently. By reducing the risk, other financial solutions like risk transfer become affordable. The residual risk, which cannot be transferred cost efficiently, has to be taken prudently. Agriculture value chain benefits could cover dissemination of better agricultural practices to farmers, access to quality seeds and fertilizers, watershed management practices, agro-met services and better access to markets etc.

Since July 2015, in Vaishali district, Bihar, 3,311 individuals have been covered by health insurance, from which 75 have additionally availed livestock and 232 crop insurance. MIA pioneered a composite risk, multiple underwriting models: The health risks are fully mutualized and covered by the community, the crop risks are fully underwritten through group (not individual) polices by a commercial insurer, and livestock risks are covered through a combination of mutual-aid and commercial underwriting. The community decided on the risk coverage and is responsible for enrollment and awareness creation as well as settlement to the individual members.

The cumulative enrollment figure is 6,973 individuals (Vaishali: 2014/15 for Hajipur and Bidupur blocks and 2015/16 for Hajipur, Bidupur and Vaishali blocks).

The preparation of the launch of the schemes in Muzaffarpur district, Bihar, and Beed district, Maharashtra, is ongoing.

<table>
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<tr>
<th><strong>Facilitating Self-Reliant Community-Based Health Insurance Schemes for Low-Income Communities in Remote Regions of India</strong></th>
<th><strong>Chhattisgarh, India</strong></th>
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<tr>
<td><strong>Background</strong> Early in 2013, MIA presented our experience in micro health insurance at the India Development Marketplace supported by the World Bank. We were recognized as one of the leading social enterprises in India and received a grant to implement our innovative business model in Rajnandgaon district of Chhattisgarh state, India. Within Rajnandgaon district 26% of the population belongs to a Scheduled Tribe and 10% to Scheduled Castes. Furthermore, the average household was found to spend 25 – 30% of their total income on healthcare, according to household survey</td>
<td><strong>Implementation</strong></td>
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under Rashtriya Samvikas Yojna by Jila Panchayat in 2005.

**Nature of the Project**
The project launched in June 2013 in partnership with CF-SHORE, the community arm of Christian Fellowship Hospital. CF-SHORE was established in 1953 and is a leading non-profit healthcare provider well known in Chhattisgarh for providing community health services. Together, MIA and CF-SHORE aim to increase access to healthcare by establishing a Community-Based Health Insurance (CBHI) scheme that offers valuable insurance packages, client awareness and satisfaction, service quality, financial prudence and prompt reimbursement of claims.

**Status of the Project**
A baseline study was carried out across 4,798 households to assess local health risks and willingness to pay for insurance. Another study to map health infrastructure in the area was also conducted. Various trainings and workshops were organized to build capacity within the community to establish the CBHI scheme and manage the operational processes. Community members led an awareness campaign to sensitize households on the insurance scheme and trainings for the enrollment campaign are currently underway.

The cumulative members from 2013-2014 were 2,313. The active members in 2014 were 1,736.

**Community-Based Micro Health Insurance in Nepal**

**Background**
Residents of Banke and Dhading districts in Nepal, like many rural villagers, face significant health issues and have few options for financing healthcare. MIA conducted a study in these districts in 2009 and found that 97% of households faced health costs in the last year. Families estimated that their annual expenditure on health was EUR 86. Amongst households who reported an illness in the month prior to the survey, 19% had to borrow money to cover the costs and 53% had to borrow in the case of hospitalization. Vulnerable groups, like the elderly and children, were even more likely to experience an illness. As would be expected, many of these poor households did not possess the financial means to pay for care and were forced to borrow money to cover health related costs.

**Nature of the Project**
MIA and our partners, Nirdhan NGO and DEPROSC, implemented health insurance schemes which leverage existing women’s networks associated with local Self Reliant Groups (SRGs). The women, through their membership in these groups, possess strong community ties and experience with financial mechanisms. MIA and our partners offered these women and other members of their community technical assistance in setting up, operating and governing a health insurance scheme.

Starting in 2010, workshops with the community were held to train local leaders on
insurance operations and interactive awareness campaigns were conducted. The scheme began enrolling women and their families in January 2011.

**Status of the Project**
The health insurance schemes in Banke and Dhading are two of MIA’s longest running projects. Their successes have been significant. The schemes continue to scale their operations and have experienced impressive growth rates. Year on year, almost 70% of beneficiaries choose to renew their family’s membership, indicating they are satisfied with the scheme. These renewal rates are significantly higher than standards across the health insurance industry as a whole. As part of the Nepal schemes, MIA has developed numerous communication tools for conducting insurance education and awareness campaigns. These tools have been modified and used across our other project locations. MIA has also written several journal articles related to the Nepal schemes.

At the 2013 Microfinance Summit, the Government of Nepal endorsed MIA’s community-based insurance model. The Government selected five districts to pilot Universal Health Coverage; MIA and Nirdhan NGO were assigned Banke to implement our microinsurance model and determine the feasibility of replicating it across the country.

The cumulative members in District Dhading from 2011-2015 were 16,800. The active members in 2015 were 4,280.

The cumulative members in District Banke from 2011-2015 were 49,851. The active members in 2015 were 13,696.

**Developing Efficient and Responsive Community-Based Health Insurance in India**

**Background**
In most low-income countries, the lion’s share of health spending is made out-of-pocket. This leads to impoverishment and limited uptake of healthcare, especially for vulnerable segments of the population. Micro health insurance has the potential to reduce the financial consequences of unforeseen illnesses and to create access to healthcare. MIA’s microinsurance model is designed to be affordable, responsive and inclusive, while aiming to create equitable access to healthcare and provide financial protection. In order to test the effectiveness and impact of our model, a detailed and evidence-based understanding of our process is required.

Uttar Pradesh and Bihar are among the poorest states in India. As in many parts of India, the poor populations of these states lack financing options for healthcare. The districts selected for implementation are diverse in their socio-economic, epidemiological and cultural profiles. We seek this diversity in order to enhance the validity of the claim that our implementation model can be applied to other settings as well.
**Nature of the Project**

In August 2009, MIA and our partners set out to implement Community-Based Health Insurance (CBHI) schemes across 3 districts in the Indian states of Uttar Pradesh and Bihar with funding from the Seventh Framework Programme of the European Commission. To test the impact of microinsurance and the effectiveness of our approach, we applied quantitative research along with in-depth qualitative analysis and spatial data. Microinsurance was introduced to the target population in three waves and a Randomized Control Trial (RCT) was carried out to analyze the situation before and after CBHI implementation. MIA’s research has included over 5,000 household surveys, 3,000 spatial surveys of health service providers, and more than 100 focus group discussions and key informant interviews.

**Status of the project**

Three CBHI schemes have been established under the administration of strong local partners. Since this project has a large research component, the number of beneficiaries was controlled. The final research study is currently underway and once completed the schemes will open membership to additional communities.

Our research to date has resulted in five peer reviewed articles published by MIA and our partners, with additional articles forthcoming. MIA shares research and implementation results with policy officials and practitioners to promote growth in the microinsurance sector. MIA also produced a Bollywood-style movie as part of the insurance education efforts for this project.

The cumulative members in districts Kanpur Dehat and Pratapgarh, Uttar Pradesh, from 2011-2013 were 5,909. The active members in 2013 were 2,453.

The cumulative members in districts Mahua, Bihar, from 2011-2013 were 4,723. The active members in 2013-2014 were 1,487.

**Piloting Community-Based Life and Health Insurance in India**

**Background**

A shared understanding of the immense potential held within India’s low-income market brought an Indian private insurer and MIA together to develop a new viable model of demand-driven insurance in rural India.

**Nature of the Project**

MIA developed an implementation model that combines principles of community-based insurance with commercial underwriting. In this model, Self Help Groups (SHGs) are responsible for administering and governing the insurance scheme, while also mutually underwriting the health component of the insurance package. The private insurer complements this by underwriting the life component. The project embodies principles of financial inclusion and is being implemented in Bidhanu block, Kanpur district, Uttar Pradesh.
**Status of the Project**

Training programs on insurance operations were conducted with SHGs and an insurance education campaign was carried out across 20 villages. Enrollment in the life and health insurance scheme, entitled *Suraksha Kavach*, began in September 2013 and the scheme went live on October 18th. The health package provides coverage for hospitalisation (up to Euro 238), lab tests, imaging and x-rays, and transportation at premium of Euro 2.67 per person per year. Life insurance allows a choice of pure term for Euro 1.61 per person per year, or money-back for Euro 21.68. Both life insurance packages provide a payment of Euro 238 in the event of a death.

The cumulative members in districts Kanpur, Uttar Pradesh, from 2013-2014 in two phases of enrollments were 496 for health and 365 for life insurance.

**Piloting Community-Based Agriculture Insurance in Vietnam**

**Background**

As a country with a long coastline positioned in the tropical monsoon region of South East Asia, Vietnam has been identified as one of the most likely countries to be severely affected by climate change. Harsh weather events such as drought, flooding, typhoons and cold temperatures put smallholder farmers at risk of crop loss which can be detrimental to their livelihoods.

A community-based model implemented under local administration, is the foundation of the agricultural insurance pilot carried out by SNV Vietnam (Netherlands Development Organisation) and MIA. The Agricultural Community-Based Insurance Pilot, or “Agri CBI Pilot”, is a key component of a wider program implemented by SNV to promote innovative financing to build community resilience to climate change in coastal Vietnam.

**Nature of the Project**

MIA provided a comprehensive training program to Vietnamese colleagues and local government officials to administer and manage the Agri CBI Pilot. The Agri CBI Pilot was implemented in 81 villages in Nghi Loc district of Nghe An province. The target area is home to 9,500 households, and approximately 80% of these households are involved in rice farming on more than 18,000,000 sq. metres of land. The Agri CBI Pilot tested the provision of rice insurance through an area yield product which triggers a payment when the actual rice yield is less than 90% of the average yield for the last three crop seasons. As an additional benefit, farmers receive compensation if rice crops are damaged during the sowing period.

**Status of the Project**

Based on MIA's experience with the Agri CBI Pilot, four important lessons can be drawn as encouraging innovations in agriculture insurance:
1. A common premium rate for all farmers demonstrates a uniform price for risk transfer and builds equity in the program.

2. Reinsurance provides additional protection to the community-based scheme. Subsidizing the reinsurance premium rather than the premium payable by farmers is beneficial because subsidised insurance premiums can lead to market distortion and moral hazard. Equal risk exposure commands an equal premium.

3. Development of local operational and management capacity in insurance facilitates the efficient delivery of the insurance product and promotes trust amongst community members which can lead to higher affiliation rates.

4. Farmers demand products that reflect their actual risk and capture micro-climate fluctuations, thus reducing basis risk. Yield measurements should be as localized as possible.

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**Reforming the Community Health Funds of Dodoma Region under the Health Promotion and System Strengthening Project**

**Background**

Uninsured people in Tanzania are required to pay user fees at the point of care. Community Health Funds (CHF) have existed across Tanzania for around a decade to provide insurance cover to the informal sector. A situational analysis conducted by MIA in Dodoma region found a variety of obstacles to making the CHF work better both for households and healthcare providers. Recommendations flowing from the situational analysis included introducing a purchaser-provider split between the CHF and the healthcare provider, which were previously both under the authority of a single institution. Moreover, process innovations including using mobile technology to make enrollment and claiming more efficient, and introducing portable membership cards that guarantee access to care across the whole of Dodoma region for member households, were also proposed. It is expected that the changes made to the CHF will turn the tide on 10 years’ stagnation, helping strengthen the health system from the financing perspective and protecting household income whilst also giving people greater choice.

**Nature of the Project**

The CHF district schemes rely on the institutional architecture of local government. Enrollment is conducted by locally recruited enrollment officers, who, through a mobile phone, can capture member details and photos and send these directly to a newly built and purposely designed Insurance Management Information System (IMIS). As well as removing the costly burden of having to provide a photo for enrollment, the new system also allows each individual in the household to have their own membership card, which can be used in any facility across Dodoma region.

Mobile phones in conjunction with IMIS also speed up the claiming process. Health facilities can verify the CHF membership status of patients with the phone and also
submit claims data directly from the phone to IMIS so that CHF back office staff can begin processing claims swiftly. The IMIS is also equipped with a tool that can request field staff to obtain feedback on certain claims to prevent fraud.

**Status of the Project**

The revamped CHF, known in Kiswahili as *CHF Iliyoboreshwa*, is just over a year old, and has seen impressive enrollment rates thus far in the 7 implementation districts within Dodoma region. Agreements have been signed with government health providers to confirm the benefit package offered to insured households. The CHF reform that MIA has been involved in is part of the wider Health Promotion and System Strengthening (HPSS) program, the goal of which is to strengthen healthcare delivery transversally as well as improving health financing. In this way, drug shortages and quality issues in healthcare provision are also being addressed, which will hopefully have a positive impact on the desire of families to prepay for their healthcare through health insurance.