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KANDU COMMUNITY-BASED HEALTH INSURANCE SCHEME

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KAUNDU COMMUNITY-BASED HEALTH INSURANCE SCHEME, MALAWI

A community-driven health financing mechanism that is expanding access and utilization of primary healthcare services in a hard to reach rural area in Malawi.

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ADC	Area Development Committee
CBHI	Community Based Health Insurance
CHAM	Christian Health Association of Malawi
CO	Clinical Officer
DALYS	Disability Adjusted Life Years
DEC	District Executive Committee
GoM	Government of Malawi
GVH	Group Village Headman
HIC	Health Insurance Committee
HSA	Health Surveillance Assistant
HIV	Human Immunodeficiency Virus
HSSP	Health Sector Strategic Plan
KCBHI	Kaundu Community Based Health Insurance
MoH	Ministry of Health
MoU	Memorandum of Understanding
NHE	National Health Expenditure
OPD	Out Patient Department
NCD	Non Communicable Disease
NGO	Non-Governmental Organisation
RMNCH	Reproductive Maternal Neonatal and Child Health
SRHS	Sexual and Reproductive Health Services
SLA	Service Level Agreement
THE	Total Health Expenditure
UHC	Universal Health Coverage
MMR	Maternal Mortality Ratio
MDHS	Malawi Demographic Health Survey
YFS	Youth Friendly Services

CASE INTRODUCTION

In Malawi, 62% of health services are delivered by the government, through the Ministry of Health, 29% of health services are delivered by faith-based health providers, through the Christian Health Association of Malawi (CHAM), and approximately 9% of health services are provided by private for profit health facilities. Government-provided health services are free at point of service. Out-of-pocket co-payments by clients are required for CHAM-based health services, most of which are located in hard-to-reach rural areas.

Kaundu Health Centre, a CHAM facility, is located in the Dedza-East region of Malawi. This health centre serves a rural population of 24,950 in 40 villages. Prior to the initiation of a community-based health insurance scheme at Kaundu Health Centre, service utilisation was poor due to the prohibitive out-of-pocket fee for service costs.

Talking to people in the community, we learned that people could not come because they were not able to pay when (they were) sick. (Mr Simbi, Implementer)

In September 2015, Kaundu Health Centre launched a community-based health insurance scheme. Technical expertise was provided to the Kaundu Health Centre staff by the CHAM secretariat. In turn, the staff mobilised local leaders and community members to form health insurance committees. Volunteers from within the communities have taken over the leadership, governance and oversight of the scheme. Health Insurance Committees, together with community health workers, sensitise, mobilise, register

members and collect premiums which are forwarded to the health centre. All collected funds are kept at the health centre and are offset against contributions when a client seeks health care.

Monitoring data from Kaundu Health Centre shows an increase in service utilisation since the implementation of the scheme. From 2014-15 to 2016-17, facility-based deliveries increased 10-fold, and the utilisation of health services by children < 5 years and by adults at the Out Patient Department (OPD) had nearly doubled.

The health insurance scheme has reduced the out-of-pocket payment to 20% of the original service cost. From 2015 to 2018, membership of the scheme increased to a total of 4,476 members. With income generated through the insurance scheme, Kaundu Health Centre has been able to employ two additional nurses and procure essential drugs.

Kaundu Community Based Health Insurance (CBHI) provides an example of how community engagement, ownership, leadership and governance can be used to improve health outcomes and increase accountability of programs among underserved communities. It highlights the fact that effective interventions do not have to be high cost or technologically dependent.

Innovation Value

1. INNOVATION PROFILE AT A GLANCE

Organisation details

Organisation name	Kaundu Health Centre
Founding year	2015
Founder names	Honourable Julian Lunguzi, Member of Parliament, Dedza East, and Christian Health Association of Malawi (CHAM).
Implementer	Kaundu Health Centre and community members
Founder nationality	Malawian
Current head of organisation	CHAM
Organisational structure	Non-Governmental Organisation (CHAM) and community leaders
Main value proposition	A rural health facility that employs a community health insurance scheme to improve utilisation and access to healthcare, and so reduce maternal and child mortality.

Project stage

Size	One health centre, 6 Group Village Headmen, 28 health centre staff, 80 community volunteers and 1,416 insurance members
Main income streams	CHBI supported by monthly members' premiums. Health services supported by out-pocket contributions, CHAM and government funding
Annual income from CBHI	MK784, 300.00 (USD 1089.31) for 2016/2017.

Operational details

Country/countries of operation	Malawi
Type of beneficiaries	Low income rural men, women and children around Kaundu health centre.
Number of beneficiaries (annually)	1,416
Cost per client	MK300.00 (USD 0.42) each expectant woman; MK150.00 (USD 0.21) each under-five child and MK200.00 (USD0.28) everyone else above 6 years.
Local engagement	The project is fully implemented and managed through community members and health centre staff. Governance and oversight is provided by local traditional leaders.
Innovative elements of the model are:	
Innovative elements	<ul style="list-style-type: none"> • Community-owned and managed health insurance scheme • Membership contributions affordable for a rural population • Collaborative implementation by different actors - member of parliament, CHAM, health centre staff, community leaders and members

This model would be scalable under the following conditions:

Scaling Considerations

- A rural community with embedded functional community-governance structures
- Support from traditional authorities
- Technical support and seed capital
- Health centre staff willing to oversee implementation

Sustainability of the insurance scheme will be based on these aspects:

Sustainability Considerations

- Regular ongoing membership contributions and an extension of membership numbers.
- Community members, traditional leaders and health centre staff willing to volunteer their time to support implementation
- Supporting community-income generating activities which can enable community members to pay the insurance premium.

Key lessons:

Health Systems Lessons

- Engaging community members early, seeking permission and implementing with them leads to ownership.
- Existing local leadership and governance structures and volunteers are effective resources to be tapped into for increased ownership and sustainability of programs among communities.
- Where communication and sensitisation is constant and contextualised, community uptake of interventions is maintained even with populations that are hard to reach or with low literacy levels.
- Continued and constant feedback to the community on facility operations ensures that communities are up-to-date and more engaged in their local health facility.

2. CHALLENGES

Malawi is a landlocked country in southeast Africa with an estimated population of 17.5 million in 2018 (NSO, 2018). The majority (84%) of the population lives in rural areas, with 50.7% living below USD 1.25 and 70% below USD 1.90 per day (Integrated Household Survey, 2016-2017). Communicable diseases are a leading cause of Disability Adjusted Life Years (DALYS) in Malawi although concurrently, non-communicable diseases (NCDs) are on the rise (GoM, 2017; MDHS, 2016).

Multiple barriers exist in accessing healthcare in Malawi (Ustrup et al, 2014). Geographic accessibility of facilities is a key determinant of utilisation, and factors such as rural residency, long distance, and high travel costs reduce accessibility (Munthali et al, 2014; Buor, 2003; Rainey et al, 2011; Gabrysch et al, 2009). Economic affordability is another major determinant, and low household income and high care-seeking costs are proven barriers to healthcare (Munthali et al, 2014; Buor, 2003; Rainey et al, 2011).

Health care service provision in the Malawian health system fall into three main categories: public, private for profit and private not for profit. The public health sector, the largest in Malawi, is run by the Ministry of Health and services are free at point of service (GoM, 2017). The private-for-profit and private not-for-profit sectors provide approximately 40% of health-services in Malawi (USAID, 2013). The Christian Health Association of Malawi (CHAM) is a faith based institution and the largest private not-for-profit health provider; it provides about 29% of all health services (GoM, 2017). Geographically, CHAM facilities are located in hard to reach rural areas. Unlike public health facilities, both private for-profit and not-for-profit providers charge user fees for their services. Costs for accessing diagnosis and treatment for children < 5 years average MK3, 127.85 (USD 4.34); maternity services - three antenatal visits and vaginal delivery - average MK1, 688.67 (USD 2.35) (GoM and CHAM, 2018).

To improve access to health services among underserved rural populations, MoH signed a Memorandum of Understanding (MoU) with CHAM

facilities. Through service level agreements (SLAs), CHAM provides a package of essential services (for maternal, neonatal and child health) free at point of service, and later seeks reimbursement from MoH through District Health Offices. Of the 172 health facilities operated by CHAM, SLAs are only in place in 74 health facilities (Lungu, 2011, USAID 2013). Furthermore, implementation of the SLAs has faced several challenges, leading to some CHAM facilities abandoning them (USAID, 2013).

Kaundu Health Centre is a CHAM health facility located in Dedza East, rural Malawi. The health centre serves a population of 24,950 people, with communities residing up to 24kms away from the facility. Prior to 2015, there was low utilisation of health services by the population. A rapid community assessment by Kaundu Health Centre in 2014 revealed that out-of-pocket payments were prohibitive in the local population accessing health services. From Kaundu, the next nearest health facility is Mua Community Hospital, a CHAM paying referral facility, and Golomoti Health Centre (about 20kms away), a government non-paying facility facing systemic challenges (shortages of medical supplies, medical personnel, transport etc). SLA at Kaundu was introduced in June, 2017, and only covers maternal health (from conception up to 28 days post-delivery) and newborn care (from birth to 28 days only). Communities around Kaundu Health Centre experienced financial and physical challenges in accessing and utilising other health services. One beneficiary noted:

In the past, we used to suffer. When a person wanted to go to the hospital [name of hospital] was too far. And you may not have the money to pay for transport and medicine. So people would just go to traditional healer rather than find money for transport and medicine and go to [name of hospital] (Beneficiary 1)

3. INNOVATION IN INTERVENTION

The Kaundu Community Health Insurance Scheme is comprised of three core elements: Collaborative implementation between health system actors; a community-owned and managed health insurance scheme; and affordable membership contributions.

3.1 CO-CREATION BETWEEN HEALTH SYSTEM PARTNERS

To address the challenge of poor access to and utilisation of health services because of costs of care, a Member of Parliament, Juliana Lunguzi, proposed a community-owned insurance scheme at Kaundu Health Centre. This project required the collaboration of various health system partners. The shared vision of the implementing partners was to develop a community-insurance model founded on the principles of primary health care, which aims to provide access to the essential healthcare package but also aims to empower community members with the skills and knowledge necessary for sustainability.

The Christian Health Association of Malawi (CHAM) embraced the idea and offered comprehensive technical expertise on health insurance for six months to the implementing team. The team included the health facility health management team, community governance structures, and community members. CHAM also provided initial seed capital (see more below). CHAM developed a conceptual framework for Community Based Health Insurance (CBHI). The framework included training the health facility management team, community sensitisation, developing a microfinancing strategy for a village savings and loan to boost income levels of community members, and defining membership, benefit package, premiums and roles of different governance and health structures. These were revised in discussion with the existing governance structure of the facility and community members. The Ministry of Health District Health Office provided its support for the initiative.

Staff at Kaundu Health Centre (clinicians, nurses, HSAs), under the leadership of Muonenji Banda and Mr Matthews Simbi (a Desk Officer from CHAM and a Senior Health Surveillance Assistant respectively),

took responsibility for mobilising and educating the community on health insurance, collecting payments, and providing all aspects of financial management. The concept was first presented to Dedza District Executive Committee (DEC) before it was presented to the local Area Development Committee (ADC). Within Malawi, each area under the jurisdiction of a traditional authority (TA) has a local ADC. The ADC is comprised of representative group village headmen and the Senior Chief, with the role to oversee all development related issues in the area. The early engagement of the ADC and traditional leaders was key to sensitising the community and gaining community acceptance.

What motivated us to start the community health insurance scheme was that we were not seeing many clients at the health centre. Or those who were coming, were very sickly. But when we would do community visits we would find people who are sick or hear stories of women giving birth in the community. And we used to ask ourselves, why is this the case? The next government hospital is far away, about one hour or two hours on a bicycle. And people would often not find drugs there. I remember one day, when I was at the health centre, a mother came with a child who was clearly anaemic. The child did not take long here. He died. Eventually, talking with people in the community, we learned that people could not come because they were not able to pay when sick (Mr. Simbi, Implementer)

3.2 COMMUNITY-OWNED AND MANAGED HEALTH INSURANCE SCHEME

The day to day running of the insurance scheme would not have been possible without ownership and leadership of the local community and Kaundu Health Centre staff. Engagement of Health Surveillance Assistants (HSAs), who are community health workers in the model, is vital because they are already conversant with social-cultural values, beliefs and practices in relation to health and economic vulnerabilities of community members. Since they live in the same communities, they were ideal advisors both to the system and the community they serve.

Key principles of the insurance scheme are social mobilisation, accountability and transparency, and given this, Health Insurance Committees (HIC) were established in the villages. These committees are comprised of HSAs (from Kaundu Health Centre), traditional leaders (Chiefs and Village Headmen) and community members. The committees and Kaundu Health Centre staff meet once a month to review the progress of the insurance scheme. The HIC is responsible for sensitising the community, registering new beneficiaries and collecting monthly premiums. Monthly premiums are deposited at the Kaundu Health Centre against each member's name. Upon seeking health services, a member will only be required to pay 20% of the service fee. The insurance is applicable for services offered at Kaundu Health Centre only, and not for the next level of health care.

The same community leadership structures and the ADCs monitor implementation, help solve challenges and provide advice where needed. On a monthly basis, the ADCs audit the financial records to ensure all payments and disbursements are accounted for. This enhances the spirit of agency and ownership.

There are a lot of things that we discuss- the advantages of life insurance, how things are so far, what is it that we can do and we also envision the future to say what our future plans are? It's not something that is forced on people. It's only those who can see the benefits that can join after listening

to advice that will say ok I will join. So actually people may join because of what they have heard from those who are members about the advantages of the programme (HIC member)

3.3 AFFORDABLE MEMBERSHIP CONTRIBUTIONS

In order to launch the scheme and attract membership, a creative small-enterprise model of a village and loans group was used. CHAM provided seed capital, offered as small community loans to enable community members to participate in the insurance scheme. The capital was used to establish small scale businesses, such as buying and selling farm produce such as rice and maize, dried fish, and baking and selling cookies. The profits generated from these small enterprises are used to fund membership fees. Interest from the loans is used to grow the fund and benefit other members of the health insurance scheme.

The current 2018 membership contribution is set at a fixed fee of MK300.00 (USD 0.42) for a pregnant woman, MK150.00 (USD 0.21) for every child under-five, and MK200.00 (USD 0.28) for anyone above 6 years. Thus far rural community members have been able to sustain their monthly contributions.

4. IMPLEMENTATION

4.1 INNOVATION IN IMPLEMENTATION

Through a collaborative process, three years on (from 2015), the insurance scheme is flourishing and is now owned and managed by the community itself. There is no policy context in Malawi guiding and influencing the establishment and operation of the scheme. However, Mr Simbi, the focal person of the scheme, observes that running the scheme requires *"building collaborations which demands cooperation,*

patience and humility and hard work since you cover large distances sometimes on foot to mobilise and engage communities."

To build the scheme from bottom up, a key challenge was a knowledge gap among some community members on the importance of the medical scheme. Community members demotivated colleagues from joining by mocking them: *"the scheme is there to*

steal your money. How can you pay when you don't know when you will fall sick!?" However, through ongoing community engagement, these attitudes are slowly changing, as evidenced by an increasing number of beneficiaries joining the scheme. Lack of transport to cover long distances is another challenge. HSAs and HIC members travel on foot to meetings in the communities or use their own money to hire bicycle taxis. Data management for the scheme is done manually, and so is not efficient. Premiums paid by members are kept on the premises, which is a security risk.

4.2 ORGANISATION AND PEOPLE

The idea to establish the Kaundu Health Centre insurance scheme started when the sitting Member of Parliament, Juliana Lunguzi, observed the relationship between access and affordability of care. Her drive to innovate arose from her deep-seated passion to improve the well-being of the people she is serving. Juliana is a registered nurse by profession, has served in the Malawi Health System, and has worked with the United Nations in various capacities.

The Kaundu Health Centre is run by the facility health management team under the leadership of the Officer-in-Charge (OC) who is responsible for clinical management. Health services are provided by a clinical officer, nurses, and HSAs. HSAs also provide robust community outreach services in the catchment area. In total, the facility employs 28 personnel, both technical and non-technical.

For the implementation of the insurance scheme, the HIC play important roles in mobilising and sensitising communities, registering new members, receiving and remitting to the health centre monthly premiums, and monitoring and undertaking advisory roles. Community Leaders are part of the HICs. In total, the scheme has 80 volunteers in six HICs. The ADC, constituted by all group village heads and headed by a TA, plays an advisory role to the scheme. All people involved in the scheme volunteer their time.

4.3 FINANCIAL ASPECTS

As noted above, the following monthly premiums operate: pregnant women MK300.00 (USD 0.42); children under five MK150.00 (USD 0.21) and anyone above 6 years old MK200.00 (USD 0.28). Scheme members only pay 20% of the medical bill at the point of service. CBHI members stated that the insurance facilitates their access to health services because of the reduced medical bill.

As CBHI membership has grown, funds collected have also increased from MK269,850.00 (USD 374.79) in 2015 to MK784,300.00 (USD 1089.31) in 2017. The facility has been able to employ and retain two nurses using some funds from the CBHI. Funds are also used to buy essential drugs, thus easing drug stock outs.

5. OUTPUTS AND OUTCOMES

5.1 IMPACT ON HEALTH DELIVERY

Through the insurance scheme, Kaundu has registered success in reducing barriers to accessing and utilising health care, as shown in table 1 below.

Table 1: IMPACT OF KAUNDU CBHI ON HEALTH DELIVERY

Period	Facility based deliveries/ANC	Access of OPD services
September 2014-September 2015	106	Under five children: 2884 Others: 4325
September 2016-September 2017	1016	Under five children: 4891 Others: 8443

Before-and-after data as presented in Table 1. above Shows that from September 2014 to September 2015, 106 women delivered at the facility; and 2884 under five children and 4,325 people accessed OPD services. From September 2016 to September 2017 when the CBHI was operational, 1,016 women accessed antenatal care and delivered at the facility, and 4,891 underfive children and 8,443 people accessed OPD services.

Health centre staff report that before the insurance scheme started, Kaundu Health Centre had a long list of community members unable to pay their medical bills. The majority of people are now able to pay. Through the scheme, the health centre is able to procure some drugs on its own, so avoiding stock-outs. Through the scheme, the health centre pays the salary of two nursing officers. Community members now receive timely health care, leading to a reduction in underfive and maternal mortality. Although maternal care is covered under SLA with the Ministry of Health, some health conditions are still covered by the scheme. Attendance in the Out Patient Department (OPD) has also increased because of the scheme.

The health insurance scheme has expanded access to care at community level and enhanced community member's relationship with the health facility. Through the monthly CBHI meetings, community members lobbied for the establishment of a community outreach under 5 clinic to ease distance and increase the utilization of Reproductive, Maternal, Neonatal and Child Health (RMNCH) services.

5.2 COMMUNITY PERCEPTIONS

The beneficiaries of the insurance scheme are all community members, inclusive of gender and age. All health conditions included in the primary healthcare package are covered under the health insurance scheme: maternal, neonatal and child health, HIV Counselling and Testing (HTC), Sexual and Reproductive Health Services (SRHS) including Youth Friendly Services (YFS), and both communicable and non-communicable health services.

The value added to the community by the insurance programme at Kaundu Health Centre is highly rated as reported by participants:

We are able to access care close to home now. When the programme just started, most people had doubts. They thought they would just eat our money. But everything is working now. You can leave for the hospital anytime because it is near us. (Beneficiary 2).

Beneficiaries also observed that the introduction of health insurance has enabled people to access health care at very affordable rates:

Let's just imagine like at Kaundu Health Centre, you can go when you are not on insurance, when you have been assisted, may be they may tell you to pay K2000. While when someone who is on life insurance, when told to pay K2000, it means you will have to pay 20%, which is like for the K2000, you will pay K200 only. (Beneficiary 4)

A male beneficiary observed that before the introduction of the insurance program, access to care was often impoverishing: *"to find money to go to the hospital, you would have to borrow money or sell chickens"* (Beneficiary 2)

Despite recommending the initiative from the community perspective, some key operational areas require improvements. Members of Insurance Health Committees, key implementers who work on voluntary basis, observed that they needed some incentives such as bicycles for transport to move easily in communities, branded T-Shirts, and periodic training to gain further skills to improve their work.

What we need most is transport to help us reach out to more people, to collect funds from people and deliver to Kaundu. Otherwise we walk or use our own money to hire bicycle taxis to go to Kaundu. We need T-Shirts branded Life insurance Kaundu Health centre so that others know about this initiative. We also need meetings now and then so that we can learn a lot about insurance. But also at least a workshop once in a year where committee members can at least get an allowance. (Chair, Village Insurance Committee)

6. SUSTAINABILITY

From qualitative interviews conducted with the founder, implementers, beneficiaries and community members, it is clear that the model still requires some investment in the forms of capital, further technical skills/capacity building, and the creation of smart partnerships and strategic alliances.

As observed by the founder, Honourable Julian Lunguzi, it is possible, through the creation of partnerships with either Airtel or Telekom Networks Malawi telecommunication companies, to create a system whereby members pay premiums directly into a bank account, so easing the burden of collecting premiums from members and security of funds kept onsite. With the help of an insurance company (NICO or Old Mutual), an agreement could be reached on how to invest excess funds to generate profit to sustain operations of the scheme. With these innovations, HIC members and health facility staff could focus on the delivery of health services, sensitization and oversight. Further capital outlay is needed to build proper data management systems for the purposes of monitoring and evaluating the scheme; to procure motor-cycles and bicycles to ease transport problems; and to build capacity among key implementers. However, the model is sustainable as is, because:

a) **The health insurance scheme is low cost:**

The model aims to provide primary health care (essential healthcare package), which is fundamental to the Ministry of Health as outlined in the Health Sector Strategic Plan II and the National Community Health Strategy 2017 to 2022. As a CHAM private not-for-profit facility, critical overheads are covered either by CHAM or the Ministry of Health through the existing Memorandum of Understanding and SLA

(CHAM, 2015). Through the agreement, the Government refunds the facility for providing maternal, neonatal and child health services. The government also pays the salaries of core health care workers. Monthly premiums are not used to cover overheads or daily operational costs, but primarily to help member's access health services. Hospital staff and community members work on the insurance scheme on voluntary basis. The health facility uses funds generated from the scheme mainly to purchase drugs and other medical consumables. Premiums are kept low so that most low-income community members can afford to pay.

b) **Sustained community engagement and involvement**

is a major factor contributing to sustainability. The challenge is to keep community members interested in paying monthly premiums. One way is by providing quality care. Another way is through improved transparency and accountability to members through the established community governance structures.

c) **The model is sustainable because it uses existing community leadership structures**

to mobilise and sensitise communities, and implement and govern the insurance scheme. These community leadership structures have low monetary maintenance costs as long as community trust is gained and maintained through respect of community values and norms. HSAs, the "foot soldiers" in the implementation of the scheme, are an asset as they come from the communities. They are aware of community values and norms, and easily interact with community members

7. SCALABILITY

The Government of Malawi through the Ministry of Health recognises that the current funding mechanism for health is neither sufficient nor sustainable to achieve Universal Health Coverage (UHC) (GoM, 2017). Discussions are ongoing to start

a National Health Insurance Scheme to complement current health financing mechanisms (through taxation, donations, out-of-pocket payments and private insurance schemes). Timelines to implement the initiative have not been established. However,

the Kaundu community-based insurance scheme is a learning point for other communities, the country, and other countries who are contemplating to replicate the model prior to implementing a nation-wide health insurance scheme.

7.1 INTERNAL SCALE-UP

Currently, the insurance scheme only covers 8 out of 40 villages in the catchment area of Kaundu Health Centre. To scale up to the rest of the villages, plans are underway to:

- Recruit more health workers and HSAs in order to reach out to all communities served by the health centre.
- Identify partners and interested stakeholders who can finance capital investments to set up data management systems, establish a digitalised system for the payment of premiums through Telekom Network Malawi Mpamba or Airtel money, and support capacity building and operational costs like motor cycles, bicycles, branded materials for promotion, and incentives for volunteers such as a loan and savings platform.
- Intensify the training of Health Insurance Committee members in entrepreneurship to enable

them to run successful ventures to effectively help members pay monthly instalments, especially very impoverished members of the communities.

If internal scale up is to be achieved, the key challenge to be overcome is the cost of employing and sustaining more staff. An expanded insurance programme will require more staff and therefore more funds for pay or incentives. This calls for efforts to increase access to funds for salaries, or requires the renegotiation of arrangements between CHAM and the government.

7.2 NATIONAL SCALE-UP

There are no plans at this stage to scale up to other health facilities in Dedza district or at a national level. However, other people wishing to implement the model in a similar setting can learn from Kaundu Health Centre.

When expanding either internally or externally, the following core elements in the model are indispensable: community engagement, involvement and ownership; community leadership and governance; creation of smart partnerships; and strategic collaborations.

8. KEY LESSONS

The Kaundu Community Health Insurance Scheme illustrates how community engagement, ownership, leadership and governance can be harnessed to improve health outcomes among underserved communities. It highlights that, to be effective, an intervention does not have to be high cost or technologically dependent. While maintaining low operational costs (and low contributions from community members as insurance payments), the insurance scheme has managed to improve access to health care for the communities it serves, reduce maternal and child mortality, reduce mortality due to malaria, and reduce the incidence of cholera, with no reported cases among under five children for the past three years. Again, the programme has significantly reduced cases of home delivery among

women, with most women now opting for facility based-delivery.

While the Health Centre reports challenges in terms of growing the membership of the health insurance, community sensitisation is a major tool at Kaundu. Communities are constantly reminded about the value of joining the scheme and paying monthly premiums. These messages are cemented through the use of traditional leaders like chiefs and HSAs. These people are already held in high esteem within the communities, making the adoption of messages more likely.

The health centre also encourages people to pay by providing good quality care so that community members appreciate the value for their

contributions. As reported by one health worker, the care is client centred:

People complained that handover take too long so we decided to have a nurse or clinician on standby to assist them when we are doing handovers. (Officer in-charge, Kaundu Health Centre)

CASE INSIGHTS

The following are key insights provided by Kaundu Community Based Insurance initiative:

- Kaundu CBHI illustrates how community engagement, ownership, leadership and governance can be accessed to improve health outcomes and increased the accountability of programs among underserved communities. It highlights that to be effective, an intervention does not have to be high cost or technologically dependent.
- Constant, contextualized and localized communication and sensitisation ensures community uptake of interventions is maintained, even when populations are hard to reach or with low literacy levels. CHAM and Kaundu staff, working with local leaders, conducted six months of intensive community sensitization when introducing the insurance scheme, using existing community platforms and leaders. Community health workers, HICs and traditional leaders continue to meet monthly with community members, fostering membership growth and community engagement.
- Underserved rural communities can contribute to their own healthcare through health financing interventions that are owned and managed by the community with affordable membership contributions and creative financing models such as village saving and loans groups.

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